The Therapeutic Alliance:
How Clients Categorize Client-Identified Helpful Factors

by

Arlene Joyce Simpson
B.A, Vancouver Island University, 2006

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Abstract

This study examined the client's perspective of the therapeutic alliance using written statements collected from clients in a previous study (Bedi & Duff, 2008). The 125 statements describe factors clients believe to be fundamental in the development of a strong alliance with their counsellor. Fifty participants sorted the statements into thematically similar piles and then gave each pile of statements a title. Multivariate concept mapping statistical methods (The Concept Systems, 2008, Version 4) were used to obtain the most representative sort across participants. The resulting 14 categories and associated ratings for helpfulness (on the scale of 1-5) are represented on scaled Concept Maps. Category titles selected are: Emotional Support, Ability to Relate, Sharing the Counsellor's Personal Experience, Good Boundaries, Interpersonal Demeanour, Body Language, Provided Resources and Homework, Availability, Planning and Approach, Directed Process Appropriately, Attentiveness, Approachable, Non-Judgemental, and Effective Listening. Female and male helpfulness evaluations were not statistically significantly different.

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CHAPTER 1

Introduction

Common Factors and the Therapeutic Alliance

Clinicians and psychotherapists have long been interested in what contributes to a positive outcome for clients. Various theories of human development and the process of change have resulted in many theoretical orientations; each contributing new ideas and perspectives to the literature and impacting the focus of applied research and interventions. Studies attempting to validate the efficacy and effectiveness of particular approaches, relative to others, can be taken to suggest that there are likely beneficial effects in most approaches and that there may be factors common to many therapeutic approaches which are responsible for client change and a positive outcome (Frank, 1961; Greenberg & Pinsof, 1986; Horvath & Greenberg, 1989; Shapiro & Shapiro, 1983; Strupp & Hadley, 1979). One frequently researched factor is the therapeutic alliance and the various subjective perspectives of the alliance, specifically, the client's, the clinician's and that of an independent observer. The objective of this study is to investigate the nature of the client's perspective of the therapeutic alliance.

In the literature, client outcome is described and evaluated in many different ways including progress toward client goals, symptom reduction, or change on a specific behavioural scale. Measures include self and clinician report instruments, as well as behavioural indices (e.g., amount of alcohol consumed daily, panic attacks per month). Positive client outcome can be attributed to four main areas: (a) extra-therapeutic factors (which include social support, client factors, and environmental change), (b) expectancy (such as the placebo effect), (c) specific techniques (for example, exposure and response prevention), and (d) common factors,

that is processes commonly found across all types of counselling and psychotherapy (such as empathy, trust, and therapeutic alliances) (Lambert & Barley, 2001). Lambert and Barley estimated the relative impact of these four domains on client change (in terms of proportion of variance accounted for): extra-therapeutic factors are responsible for 40% of client change; expectancy is responsible for 15%; specific techniques are responsible for 15%; and common factors are responsible for 30%. As indicated, Lambert and Barley's analysis estimates that common factors, like the therapeutic alliance, account for twice as much of the variance responsible for positive outcome as do techniques.

The therapeutic alliance has frequently been identified as one of the most powerful factors common to effective therapeutic approaches (Krupnick et al., 1996; Lambert & Barley, 2001). While specific therapeutic approaches theoretically attribute varying significance to the alliance (Bordin, 1979), research shows that the therapeutic alliance is the strongest consistent predictor of a successful outcome in counselling and psychotherapy across the various approaches (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross, 2001). In other words, the reduction of distressing symptoms, an increase in the client's sense of well-being, or change on a particular behavioural scale correlates positively with the strength of the alliance as rated on existing therapeutic alliance measurement scales.

In response to the proliferation of research advocating the use of Empirically Supported Treatments (ESTs), the American Psychological Association's Division 29 (Psychotherapy) commissioned the Task Force on Empirically Supported Therapy Relationships (Norcross, 2001). The Task Force concluded that, on an empirical basis, the therapeutic alliance is "demonstrably effective" (p. 350) in promoting positive outcome. Consequently, understanding

how to develop a strong therapeutic alliance with clients may be one of the most important goals for researchers and clinicians in their quest to help clients (Bordin, 1979).

The Therapeutic Alliance

The therapeutic alliance is also referred to as the working alliance, the ego alliance, the helping alliance, and the counselling alliance (Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005; Horvath & Bedi, 2002; Mohr & Woodhouse, 2001) depending on the author. However, despite the broad interest in, and study of, this construct, there is still no single, widely agreed upon definition of the therapeutic alliance (Horvath & Bedi, 2002). And, while measures of the therapeutic alliance are highly inter-correlated (Horvath & Bedi, 2002), this does not mean that all instruments are working from the same definition or tapping into an identical underlying construct (Horvath & Bedi, 2002). Further, the variables which comprise the alliance in these studies are researcher-selected and may or may not represent aspects of the alliance central to the client's subjective experience. The defining features of the alliance vary according to specific researchers and measurement instruments. However, there are high inter-correlations between alliance measures as well as some overlapping theoretical features (Horvath & Bedi, 2002) that support the use of a general underlying working definition.

Working Definition of the Therapeutic Alliance

In the literature, the therapeutic alliance refers to the working relationship that operates between the clinician and the client in counselling and psychotherapy (Bedi, Davis, & Arvay, 2005). It arises out of the ability of the clinician and the client to form a relationship conducive to accomplishing the goals of counselling and psychotherapy (Bordin, 1979; Horvath & Bedi, 2002). It is also comprised of factors brought by both the clinician and the client and the

consequent interaction of these factors (Horvath & Bedi). Therefore, the alliance is comprised of the relationship formed between the client and clinician, which encompasses the ability of the client and clinician to work together on a consensual therapeutic mandate (Bedi, Davis, & Arvay; Gelso & Carter, 1994).

Theories of the Therapeutic Alliance

In the following discussion of the therapeutic alliance, it is important to bear in mind that the alliance does not exist as an objective reality. Rather, as a part of the therapeutic relationship, the alliance is comprised of the subjective perception of two or more individuals. As such, it may or may not be perceived differently for each of the individuals engaged in the relationship. In other words, the clinician's perception of the strength and quality of the alliance may or may not be the same as the client's view. Hence, to speak of "the alliance" one must continuously bear in mind that at least two subjective experiences (i.e. client and clinician) are to be considered. Considering only one perspective is inadequate for developing a fuller understanding of the construct.

While there are various theories of the therapeutic relationship (Gelso & Carter, 1994; Greenson, 1967; Rogers, 1951; Sterba, 1934; Strong, 1968; Zetzel, 1988), one of the most cited theories of the therapeutic alliance was proposed by Bordin (1979). Bordin (1979) suggested that the therapeutic alliance was possibly the key to client change regardless of counselling or psychotherapy genre. He believed that the strength of the working (therapeutic) alliance was the major factor in change, and the strength of the alliance was dependent on the "goodness of fit of the respective personalities of the patient and the therapist" (Bordin, p. 252). Bordin conceptualized the alliance to be the context, or vehicle, required in all types of counselling and

psychotherapy through which interventions could be executed and successfully employed. He further argued that all interventions, in any type of helping relationship, are dependent on the strength and quality of the therapeutic alliance (Bordin).

Bordin (1979) further proposed that the alliance is composed of three components: mutual agreement on goals, collaboration regarding the kinds of tasks to be completed, and a bond of trust and attachment. Goals, as conceptualized by Bordin, were the desired outcomes of counselling and psychotherapy; the client and the clinician should agree on what would comprise success. Tasks referred to the therapeutic activities that occur in counselling and psychotherapy, and bond was described as the complex positive interpersonal relationship between the clinician and the client (Bordin). Bordin further acknowledged that, although the methods by which these three dimensions would be accomplished varied with the type of approach, the integration of these three dimensions was central to the development and maintenance of the therapeutic alliance and fundamental to all theoretical approaches. In support of his position, factor analysis has shown that Bordin's conception of bonds, goals, and collaboration on tasks is represented in the most commonly used measures of the alliance (Horvath & Bedi, 2002).

Mutuality and collaboration between clinician and client, as opposed to simply the client's perception of, or the existence of clinician attributes and behaviours, distinguishes Bordin's (1979) conceptualization of the alliance from the popular theories of Strong (1968) and Rogers (1951) (Horvath & Greenberg, 1989). After reviewing the alliance literature, Horvath and Bedi (2002) concurred with Bordin that collaboration and consensus between the clinician and the client proposed by Bordin were, perhaps, the key components of the alliance. However,

while much of the literature appears to support this view, due to the covert nature of the client's perspective, the best way to further elucidate "collaboration" is to ask the client. Research that directly solicits the client's subjective perspective will be necessary to determine if this is in fact the case.

Although Bordin's (1979) theory is frequently cited, partly because it was developed to be trans-theoretical, other theories do exist. Luborsky (2000) proposed another well known theory. His review of psychotherapy sessions that resulted in the highest and lowest levels of client change led him to suggest a two type model of the alliance. Type I was associated with the client feeling understood by the clinician and hopeful that treatment would be helpful, and Type II focussed on the client's sense of working with the clinician in a collaborative effort; sharing a similar conception of the problem. Both Type I and Type II alliances are associated with the client's perceptions (not the clinician's) and are not solely dependent on clinician qualities. Luborsky's theory of alliance types provides clear support for the investigation of client perception and conceptualization of the therapeutic alliance. Assuming the supported stance that the client's subjective perception of collaboration and consensus are critical to the alliance, and remembering that the alliance only exists as the subjective perception of the client and the subjective perception of the clinician, it then becomes imperative to have a clear understanding of the client's view in addition to the clinician's view.

Helpful Factors in Alliance Formation

The working definition of the therapeutic alliance clearly acknowledges the necessity of both clinician and client contributions to the development of the alliance. Reviews of previous research findings show that the contribution of the clinician has especially robust effects on

therapeutic alliance development (Ackerman & Hilsenroth, 2003; Norcross, 2001). With this in mind, it is also important to look at past research regarding both clinician and client behaviours and attitudes that impact the alliance.

Clinician Attitudes and Behaviours

Again, remembering that the therapeutic alliance does not exist apart from subjective perception, it is also important to note that reviews of clinician contributions to the alliance often do not clearly differentiate between clinician variables identified by clinicians themselves and those identified by clients. In this regard, researchers tend to amalgamate factors identified by clients in an open-ended manner with those mediated by clinician/researcher understandings (Elliott & James, 1989). This needs to be kept in mind when considering the following summary of clinician contributions to the alliance.

The alliance is partly predicated on the clinician's ability to connect with the client (Ackerman & Hilsenroth, 2003). However, the strength and quality of this connection can be best evaluated by the client. Empathy, acceptance, and the ability to communicate understanding and positive regard seem to be key factors in establishing this connection (Ackerman & Hilsenroth; Hilsenroth & Cromer, 2007). This alliance is further strengthened by the ability of the clinician to communicate the belief that he or she can help the client, as well as the clinician's confidence in the client's ability to change (Ackerman & Hilsenroth; Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005). The clinician's ability to inspire the client's confidence and trust is also positively related to the development of a strong alliance (Ackerman, 2003; Bachelor, Laverdiere, Gamache, & Bordeleau, 2007). In addition, clients seem to feel more connected to clinicians who are able to explore problems and who are

perceived to be on the client's team (Ackerman & Hilsenroth; Hilsenroth & Cromer). Moreover, clients generally build stronger alliances with clinicians who encourage a sense of hope (Clemence et al., 2005), validate client progress, and communicate respect for the client (Ackerman & Hilsenroth). A strong alliance seems to be further facilitated by the clinician's ability to communicate the necessity for exploration, hard work, and honesty (Ackerman & Hilsenroth). However, it is important that clients value significant autonomy in the exploration process and the identification of relevant issues (Hilsenroth & Cromer). Research further supports the benefit of exploration that respects the client's personal comfort with openness (Horvath & Bedi, 2002), as behaviour that is interpreted as caring and sensitive to one client may seem intrusive to another. Therefore, the ability of the clinician to discern what is appropriate for individual clients will act as a moderator on the strength of the alliance (Bachelor, 1988; Horvath & Bedi).

Horvath and Bedi (2002) discussed the impact of the clinician's interpersonal skills, communication, and empathy on alliance formation. Concurring with Ackerman and Hilsenroth's (2003) conclusion, they found that clinicians who are responsive to client needs, sensitive to the challenges that occur in counselling and psychotherapy, and able to express empathy in a way that fits the individual client, are more likely to build a strong alliance (Bachelor, 1995). Other helpful factors found in their review included specific verbal behaviours (such as self-disclosure and active listening) and specific nonverbal behaviours (including eye contact and posture) (Ackerman & Hilsenroth; Horvath & Bedi).

Client Attitudes and Behaviours

Client factors have also been investigated for their relationship to the development of a good therapeutic alliance. As stated previously with regard to clinician attitudes and behaviours, the research does not clearly differentiate between client factors identified by clients and client factors identified by researchers (Elliott & James, 1989). Nevertheless, existing research suggests that the severity of client impairment, the type of disorder experienced by the client, and the attachment style of the client may moderate the client's ability to form a good alliance (Horvath & Bedi, 2002).

Some studies suggest that more severely disturbed clients (i.e., clients with personality disorders or strong perfectionism) develop weaker alliances (Yeomans et al., 1994; Zuroff et al., 2000), while others suggest there is little difference between severely and mildly disturbed clients (Gaston, Marmar, Gallager, & Thompson, 1991; Joyce & Piper, 1998; Lieberman, von Rehn, Dickie, Elliott, & Egerter, 1992; Lingiardi, Filapucci, & Baiocco, 2005; Paivio & Bahr, 1998). Mixed results in studies investigating the impact of the severity of the disorder on alliance formation are likely due to research design; the most common weakness being that severely disturbed clients are least often employed as participants (Horvath & Bedi, 2002) making it difficult to compare this group with mildly disturbed participants. Other studies have a restricted range of participants, for example hospital inpatients, and therefore are not comparable to less disturbed clients. Studies have also suggested that clients diagnosed with personality disorders (Andreoli et al., 1993; Hersoug, Monsen, Havik, & Hogland, 2001; Lingiardi et al., 2005; Muran et al., 1995), delinquents, homeless individuals, and some drug

dependent clients (Barber et al., 1999; Florsheim et al., 2000; Gunderson, Najavits, Leonhard, Sullivan, & Sabo, 1997; Hersoug et al., 2000) may have more difficulty in establishing a strong alliance.

The quality of the client's attachment style or the impact of relational experiences in the client's early development may also impact the way in which the individual works towards or views the therapeutic alliance. While there are also mixed results on how much this affects the therapeutic relationship (Hersoug et al., 2001; Mallinckrodt & Leong, 1992), most results suggest that attachment style significantly affects the quality of the alliance (Eames & Roth, 2000; Hillard, R. B., Henry, W. P., & Strupp, H. H., 2000; Joyce & Piper, 1998; Mallinckrodt & Leong, 1992; Piper, Joyce, & McCallum, 2000; Rubino, Baker, Roth, & Fearon, 2000; Tyrrel et al., 1999). Specifically, these studies report that poor alliances correlate with fearful, anxious, dismissive, and preoccupied attachment styles (Eames & Roth; Ogrodniczuk et al; Tyrrel et al.).

Lack of Investigation Directly Accessing the Client's Perspective

Research specifically accessing the way in which clients view the therapeutic alliance is conspicuously meagre relative to the abundance of literature on the alliance. The alliance has been the focus of numerous studies in the past several years, however few researchers have directly asked clients to describe their experience and conceptualization of the alliance in their own vocabulary; nor have clients typically been given the opportunity to independently identify factors they view as instrumental in the development of a strong alliance. As a result, we cannot be certain that the way clients subjectively experience and understand the alliance is accurately represented in the literature (Bedi, 2006). Further, even when asked directly, clients often do not express their thoughts and frequently censor their reactions in the counselling process (Rennie,

1994). Therefore, the covert nature of the client experience makes it especially difficult for researchers and clinicians to access accurate information regarding the meaning clients ascribe to therapeutic interventions or phenomena like alliance formation (Elliott & James, 1989). All the same, only clients themselves can accurately describe their own personal experience of the therapeutic process (Elliott & James).

Alliance Measures

This lack of client description and vocabulary in alliance research is likely reflected in alliance measures. Measures of the alliance have been developed by various research centers with minimal, if any, consultation with clients, and as such, likely reflect researcher's theoretical (or pan theoretical) bias (Bachelor, 1995; Elliott & James, 1989; Horvath & Bedi, 2002; Luborsky, 2000). It also appears that researchers implicitly treat the alliance as a construct independent of the subjective perception of either the client or the clinician. However, they seem to agree on the central ideas of the therapeutic alliance (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) and research shows significant and high inter-correlation among the measures (Horvath & Symonds; Martin, Garske, & Davis). Because development of measurement instruments has been based on the underlying theories and definitions of the developers (Horvath & Bedi; Luborsky), alliance variables have been generated based on what researchers believe to be relevant; and questions are worded in vocabulary that reflect this perspective. Clients usually have little or no formal input with regard to selection of variables or factor categorization (Bedi, 2006). They are typically invited to endorse, deny, or rate researcher or clinician formulated variables but rarely given the opportunity to contribute their unqualified perspective to instrument formation. For example, the development of the Working Alliance

Inventory (WAI) (Horvath & Greenberg, 1989) was based on items generated by researchers, and evaluated and validated by psychologists. These experts identified, reviewed, and reworded potential questions (Horvath & Greenberg). Research that utilizes the WAI, both client and clinician versions, is therefore premised on concepts and vocabulary grounded in researcher and clinician theory and perspective (Horvath & Greenberg). Therefore, current alliance theories and measures may not accurately reflect the client's experience or subjective perception (Bachelor, 1995). Despite this lack of direct input, strong client ratings of the therapeutic alliance are still regularly demonstrated to be a better predictor of a positive outcome than observer or clinician ratings (Horvath & Bedi; Horvath & Symonds).

Recent research supports the view that existing theories and therapeutic alliance measurement instruments do not include all the specific elements clients view as central to their perception of the alliance (Bachelor, 1995; Bedi, 2006; Fitzpatrick, Janzen, Chamodraka, & Park, 2006; Horvath & Bedi, 2002). It is possible that the correlation between client's rating of the alliance and a positive outcome may be further improved by the use of measures that more validly assess variables that clients believe are important. The emergence of the therapeutic alliance as the most reliable predictor of a positive outcome (Horvath & Bedi; Horvath & Symonds, 1991), despite the likely limitations of present measures, highlights the importance of continued investigation into this powerful phenomenon from the client's direct perspective.

Relevant Current Research Investigating the Client Perspective

Qualitative Research

Qualitative methods explicate researcher perspectives and better acknowledge the co-constructed nature of qualitative data, which includes the perspective of both the researcher and

the client. Clients usually make use of their own vocabulary to identify what they believe is important rather than simply endorsing factors presented by researchers. Open-ended questions and interviews are commonly used to co-construct data with the individuals who are directly involved in counselling or psychotherapy (Bachelor, 1995; Bedi, 2006; Creswell, 2008). For example, participants who believe they have a good alliance with their clinician can be asked to describe the factors that they believe are responsible for their views. Further, asking clients to describe their experience provides access to the client's global perceptions regarding the therapeutic alliance (Elliott & James, 1989), and includes rich information not available in the self-report instruments typically used to measure client perception of the alliance (Elliott & James).

Several qualitative studies have investigated the client's perspective on the alliance using the client's subjective experiences and understandings; the first major one of which was conducted by Bachelor (1995). Employing an open-ended self-report inquiry design used in phenomenological research, Bachelor asked clients to describe, in their own words, "a good client-therapist relationship" and the "main characteristics of this relationship" (p. 324). They were asked to write a detailed description of a counselling session where they had experienced this relationship (Bachelor). Content analysis of these descriptive statements distilled from short essays, revealed three conceptual types of alliance grounded in clients' experiences: (a) Nurturant, (b) Insight-oriented, and (c) Collaborative.

The nurturant-type alliance, found in 46% of the overall accounts, was characterized by a climate of trust (Bachelor, 1995). Clients valued a friendly relationship which included humour, patience, and a description of what the client could expect (Bachelor, 1995). The

insight-oriented type alliance (39%) was described by clients who expected the clinician to facilitate improved self-understanding (Bachelor). Finally, the collaborative type alliance, depicted in only 15% of clients' descriptions (Bachelor), acknowledged the active role of the client in working with the clinician to co-create an atmosphere of respect and trust. This study is important in demonstrating that clients do not share a common view of what is important or helpful in developing the alliance. Some participants in the study apparently value factors that other participants view as unimportant or undesirable. However, it would be necessary to have participants review these findings in order to better validate the researcher identified categories.

Nevertheless, this study suggests that clients attach varying importance to components of the therapeutic alliance and respond differently to the factors involved in forming the alliance (Bachelor, 1995). It could be postulated that clinicians who are responsive to these types of client preferences and perceptions may be better able build a strong therapeutic alliance with their clients. It is also interesting to note that, while alliance measures and definitions emphasize the importance of collaboration (Bordin, 1979; Horvath & Bedi, 2002), relatively few participants described the collaborative type alliance in Bachelor's study. Clients instead focused on clinician attributes and behaviours to a much greater extent than mutual or collaborative characteristics and appeared to understand a good alliance more as a function of clinician characteristics.

The client essays yielded "alliance-relevant response units" (most often simple phrases) (Bachelor, 1995, p.326) that were subsequently assigned to various categories. In this study, the greater number of variables assigned to the 'therapist' category (16, including respectful, non-judgmental, and self-disclosing) further supports the suggestion that clients place the greatest

value on the attitudes and behaviours of the clinician. The other four categories for this analysis were: (a) client (10 variables including items pertaining to self-disclosure and expression of emotion), (b) mutual (7 variables involving both the clinician and the client, including such things as choice of goals and solutions), (c) climate (5 variables including an atmosphere of trust), and (d) effects (4 variables that did not fit other categories) (Bachelor). While specific factors can be important to most clients, the relative emphasis and importance of each factor varies for individual clients (Bachelor). For example; respect, listening, empathy, and a climate of trust were reported as valuable by all clients in all types of alliance. However, while the atmosphere of trust was viewed as central and crucial for nurturant types, trust was viewed as secondary in importance to other variables for insight and collaborative types (Bachelor). Again, while participant validation of the categories and the associated "alliance-relevant response units" would allow for greater confidence in the study's findings, this study reveals differences in how individuals view the alliance and provides support for the idea that clients place varying degrees of value on variables. Further investigation would be helpful to provide greater validity for this concept and help us to more clearly understand the relative value clients place on individual helpful factors.

Building on Bachelor's (1995) study, Mohr and Woodhouse (2001) developed and tested the Therapy Priorities Q sort (TPQ), a card sort measure designed to capture the relative importance clients place on specific psychotherapy factors. Researchers created 92 items based on the client perceived characteristics in Bachelor's (1995) analysis. Participants sorted the positive and negative statements into 12 groups designed to reflect, on a continuum, what they thought would be the most helpful or the most harmful to their psychotherapy (Mohr &

Woodhouse). Congruent with Bachelor's findings, Mohr and Woodhouse found participants placed differing value on the factors. Q-technique factor analysis revealed two types of process were preferred by participants. One was labelled Personal Alliance, reflecting the importance of a warm, friendly relationship, and the other was labelled Professional Alliance, characterized by objectivity and clinician competency (Mohr & Woodhouse).

This preference for two different types of therapeutic alliance (Mohr & Woodhouse, 2001) was further validated by essays clients wrote to describe a good therapeutic alliance. Again, it seems likely that clients vary in their view of what is most important for a good alliance, and what some clients find helpful may in fact hinder the alliance for other clients (Mohr & Woodhouse). Specific factors involved in the alliance may moderate the establishment of a good alliance (Mohr & Woodhouse). For example, clinician self-disclosure may positively impact the relationship for clients who value the personal relationship and negatively impact those who prefer a professional therapeutic alliance (Mohr & Woodhouse). Also, participants describing the personal type alliance generally rated emotional connection and friendship as beneficial, while some participants describing the professional type alliance believed these factors could be potentially harmful (Mohr & Woodhouse).

Fitzpatrick et al. (2006) investigated the significance of ~~a~~ client-identified critical incidents for their contribution to a good therapeutic alliance. This study solicited the client's identification of a critical incident in the therapeutic session that the client believed contributed to a good working relationship with the clinician, and interviewed clients to obtain a detailed description of the event in the client's own words. Fitzpatrick et al. used the consensual qualitative research method (CQR; Hill et al., 2005; Hill, Knox, Thompson, & Nutt Williams,

1997) to analyze the obtained data. These researchers agreed upon 4 domains to help describe the clients' responses: (a) Description of the Critical Incident, (b) Meaning of the Incident, (c) Client Contribution to the Incident, and (d) Impact of Incident on the Relationship. They also developed categories and subcategories for each domain. The categories included such headings as: (a) Therapist Helped Client Think in New Ways, (b) Therapist Shared Something Meaningful, (c) I'm Important, (d) I'm the Center, (e) I Can Do This Myself Too, and (f) Trust or Confidence in the Therapist (Fitzpatrick et al., p.489). The rigorous method employed to make meaning of the data that clients contributed, the use of client understanding, client election of important data, transcription of client interviews, and the attempt to "adhere to the client's language" (Fitzpatrick et al.) are important factors that contributed to a more trustworthy analysis and understanding of what clients believe is important in the development of the therapeutic alliance. However, like previous studies cited, the use of researcher understanding to develop the framework for organizing the data inevitably imposes the inherent role bias each investigator brings to the process. While this analysis contributes to our understanding, we still do not confidently know how clients themselves would organize and make meaning of the obtained information.

Using another exploratory, qualitative design (the Critical Incident Technique, CIT), Bedi, Davis, and Arvay (2005) interviewed 9 clients and asked them to describe what was helpful in forming a good alliance with their clinician. CIT analysis methods were used to sort client-identified factors helpful for forming the alliance into eight conceptual categories: (a) General Counselling Skills, (b) Expression of Positive Affect and Sentiment, (c) Tracking the Counselling Process, (d) Counselling Environment, (e) Punctuality and Use of Time, (f) Going

Beyond Normative Expectations, (g) Personal Attributes of the Counsellor, and (h) Positive First Encounters.

This study directly accessed the client's perspective in specifically asking participants for their subjective description of what was important in developing the alliance. The participants described the factors they perceived to be important rather than simply choosing from a researcher-constructed list. The researchers relied on discussion and consensus amongst the researchers to construct the list of variables from the transcribed interviews, to sort the client-identified variables into categories that seemed to best represent the data, and to choose category names (Bedi, Davis, & Arvay, 2005). The results of this study suggest some new possibilities for understanding the client's perspective. For example, findings suggest alliance formation may be facilitated by concrete factors that operate before the client and the clinician meet; for example, factors such as the counselling environment and reception staff.

In a larger-scale replication of Bedi, Davis, and Arvay, (2005) clients were asked to identify specific, observable behaviours helpful in establishing a good alliance (Bedi, Davis, & Williams, 2005). Interviews were transcribed and researchers extracted lists of incidents from each interview for comparison. Researcher evaluation and consensus were again used to identify variables and choose categories. The researchers provided titles for 25 categories that subsumed the 376 individual critical incidents identified as helpful in alliance formation: (a) Technical Activity, (b) Nonverbal Communication, (c) Active Listening, (d) Choices, (e) Psychotherapy Environment, (f) Client Agency, (g) Personal Characteristics, (h) Service Beyond Normative Expectation, (i) Self-disclosure, (j) Positive Commentary, (k) Greetings and Farewells, (l) Positive Initial Contact, (m) Normalization and Validation, (n) Respecting Agreements, (o)

Positive Sentiment, (p) Recommendations, (q) Confidentiality, (r) Candour, (s) Crying in the Presence of the Psychotherapist, (t) Role Induction, (u) Humour, (v) Emphasizing Client Expertness, (w) Previous Knowledge of Psychotherapist, (x) Openness to Personal Criticism, and (y) External Contact. The category names were again created by the researchers.

According to this study, some of the factors that clients believed were important in the development of a good alliance may be overlooked by clinicians and researchers because they appear too obvious, simple, or unsophisticated (Bedi, Davis, & Williams, 2005). For example, eye contact, warmth, greetings and farewells, and reference to subject matter from previous sessions were all listed by clients as criteria that critically impact the therapeutic alliance. These client descriptions provide important insight useful for further consideration and investigation. The significant overlap in the categories of the initial study with the categories of the replication support the importance of the counselling environment, the personal characteristics of the clinician, the expression of positive affect, active listening and general counselling skills, the effect of initial encounters and farewells, and service beyond normative expectations.

Additionally, the participants in this study identified elements of the alliance that, to date, are not well-researched or understood with respect to fostering the alliance (Bedi, Davis, & Williams, 2005). For example, the participants suggested that the clinician's age, gender, body type, ethnic background, and attire, as well the clinician's office size, lighting, décor, and books displayed, could have an impact on the alliance. Further, participants perceived specific therapeutic interventions as linked to the development of the therapeutic alliance. This supports previous research suggesting the alliance is improved in conjunction with the effective

application of particular techniques (Kivlighan, 1990; Luborsky, 2000; Mohr & Woodhouse, 2001).

However, while Bedi, Davis, and Arvay (2005) and Bedi, Davis, and Williams, (2005) were significant in providing client-identified variables for further investigation and understanding, the use of researchers alone to assign variables to categories and also to name the categories limits the trustworthiness of these studies in contributing to our understanding of the client's perspective (Bedi, 2006). Researcher vocabulary and theoretical knowledge informs the researcher's perspective and greater client participation is required to understand the client-identified alliance variables. Including clients in the categorization of variables, naming the categories, and later of review of the conclusions would provide a more valid understanding of conceptual structures (Bedi). In other words, because researchers alone determined the categories and the category names, we cannot be certain that the results of these studies accurately represent clients' conceptualization of the alliance (Bedi).

In summary, the reviewed literature (i.e., Elliott & James, 1989; Bachelor, 1995; Mohr & Woodhouse, 2001; Fitzpatrick et. al., 2006; Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005) provides insight into the client's view of a sound therapeutic alliance. For example, the literature suggests that not all clients have the same conceptualization of a good alliance. Bachelor's study identified three types of alliance (nurturant, insight-oriented, and collaborative) while the Mohr and Woodhouse study revealed two types (personal and professional). Further, they suggest that many factors that clients report as important in alliance development are scarcely represented in existing alliance theory and research (Bedi, Davis, & Arvay; Bedi, Davis, & Williams). The studies reviewed also demonstrate the varying ways

clients value the factors that contribute to a good alliance and the ways that researchers can categorize these factors (e.g. Fitzpatrick et al.). The names assigned to the types of alliance or categories of alliance factors are important for understanding the concepts involved in alliance formation. Labels provided by the clients themselves would provide a more valid view of client understandings. Completion of these past studies still leaves us with an unanswered question: "How would clients categorize factors they identify as helpful in the formation of a positive therapeutic alliance?"

Mixed Methods: Qualitative and Quantitative

As already mentioned, these qualitative studies, while significant in providing client-identified factors (and alliance types), did not allow clients to categorize the factors in ways that were meaningful to them. Researchers used consensus to agree on what best described the category; however, we still do not know if this is how clients would categorize and name these factors. Further, we do not know if the analysis of the data is congruent with their perception of the factors and the factor's importance to their subjective view of the alliance. Much of the client's perspective remains unknown.

In order to address these questions, employing both qualitative and quantitative methods, Bedi (2006) further investigated client perceptions of alliance formation. Counselling clients were interviewed and asked to describe observable behaviours and verbalizations that contributed to the development of the alliance. Seventy-four common factors identified by clients were recorded on index cards and sorted by the same set of clients into what they viewed to be conceptually congruent categories (Bedi). Additionally, participants were asked to provide a name for each category they had created and also to rate each factor in the study as to how

important they believed the factor was in establishing the alliance. Factors were rated on a 5-point Likert-type scale ranging from 1 (not important) to 5 (extremely important). Factors that were not explicitly observable were included if they yielded information that was easy to communicate and focused on a description of what happened rather than on how or why. This study included testimonial validity by inviting participants to modify the researcher's understanding of their statements, preserving the participant's language as much as possible in each statement, and asking participants to evaluate the final results for how well they represented the participant's understanding. The use of client categorization and vocabulary for category names increased validity and therefore contributes important data useful in modeling the client's conceptualization of the alliance (Bedi).

Concept mapping statistical procedures enabled Bedi (2006) to compute the "most representative" sort summarizing participants and a label was chosen from the set of participant elicited labels for each of the 11 categories. The categories identified were: (a) Nonverbal Gestures, (b) Emotional Support and Care, (c) Presentation and Body Language, (d) Setting, (e) Session Administration, (f) Client's Personal Responsibility, (g) Referrals and Recommended Materials, (h) Guidance and Challenging, (i) Education, (j) Honesty, and (k) Validation. While Bedi is pivotal in its attempt to systematically investigate the client-identified helpful factors in alliance formation using client vocabulary and allowing clients to categorize factors utilizing their own subjective conceptualization, it also carried notable limitations (as to be outlined later).

The statements that make up the 11 client-titled categories of Bedi (2006) have significant overlap with the critical incident statements in Bedi, Davis, and Arvay (2005) and the

client-identified statements in Bedi, Davis, and Williams (2005). While each study produced a different number of categories, the concepts reflected in both the titles and the individual statements that make up each category overlap significantly. For example, Non-verbal Communication (Bedi, Davis, & Williams) is very similar to General Counselling Skills (Bedi, Davis, & Arvy) and Non-verbal gestures (Bedi). Participants in all three studies identified the counselling environment (lighting, décor, organization, and clinician attire), greetings and farewells, and going beyond normative expectations as critical factors in alliance formation.

Further, the critical incidents identified by clients in Fitzwilliam et al. (2006) included both client statements and researcher-identified categories similar to Bedi (2006). Client statements such as "she asked me a question that made me think in a different way", and "[I was] afraid of being judged" and the categories Provided Compliment, Reassurance, and Positive Feedback, Therapist Gave Tools or Assignments, Acceptance and Validation, and Comfort and Safety seem to share conceptual similarity to Bedi's Guidance and Challenging, Validation, Referrals and Recommended Materials, and Emotional Support and Care. The similarity in statement content among studies, along with the inclusion of factors not commonly addressed in theoretical discussions of alliance formation again highlights the importance of validating results from previous studies and gaining a more reliable understanding of the client's perception.

Role of Research Replication

In order to establish more depth and breadth of understanding, along with reliability and confidence in generalization, it is important to replicate studies. Researchers, following the example of established scientific inquiry, must rely on replication for generalizable results (Cohen, 1994). Generalization implies that the results of a study can reliably be applied to other populations in different settings (Language Teaching Review Panel, 2008). Similar results obtained in various settings have a greater degree of generalizability (Language Teaching Review Panel). If the present study produces results similar to Bedi (2006), this would support generalizability, suggesting that Bedi's findings are relevant to general theory development and useful in various settings (Language Teaching Review Panel).

Replication is also a critical tool for correcting bias and adding evidence (Fahs, Morgan, & Kalman, 2003; Language Teaching Review Panel, 2008; Thompson, 1999). Literal or exact replications require the same participants to be examined using the same methodology as the study being replicated (Language Teaching Review Panel). Because this presents logistical as well as methodological difficulties that could confound the results, a conceptual replication was designed allowing key variables to be changed (e.g., new participants were recruited at a different time and place) while retaining the basic conceptual features of the original research. The new sample, recruited in a different location reduced the likelihood of sampling error in Bedi's (2006) study (Hunter, 2001). Similar results with a different sample would validate the findings of Bedi by demonstrating that similar outcomes hold true for different participants or sample groups (Schneider, 2004; Cozby, 2003; Palys, 2003: Language Teaching Review Panel)

thereby supporting their generalizability (Hunter; Sohn, 1998; Language Teaching Review Panel).

Study Rationale

The goal of the present study was to build on previous research in working to more directly include the client's perspective in our overall conceptualization of the alliance. Qualitative research has enabled clients to express, in their own words, their subjective view of the therapeutic alliance, thereby giving researchers new understandings about how clients view counselling and the therapeutic alliance. A few research studies solicited the direct input of clients in their investigations of the therapeutic alliance (Bachelor, 1995; Bedi, 2006; Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005; Fitzpatrick et al., 2006; Mohr & Woodhouse, 2001). These studies were particularly important as they provided new conceptualizations of the alliance that are not presently emphasized in current theories. However, the overwhelming evidence supporting the predictive role of the client's perspective of the alliance in positive client outcome underlines the need to more thoroughly understand the client's perspective (Elliott & James, 1989). An increase in our present understanding would contribute to a better foundation for developing valid and reliable measures of this important construct. More importantly, this increased awareness could be helpful in improving clinicians' ability to provide more effective counselling and psychotherapy.

Previous studies employed qualitative methods to elicit the client's perspective, in the client's own words, regarding factors that were helpful in building the therapeutic alliance. Bedi (2006) built on this identification of factors by asking clients to categorize the factors, name the categories they created, and later validate the results. The present study is a conceptual

replication of Bedi's study in that client-identified alliance formation factors were sorted into client-created categories and subsequently named using client generated titles. While Bedi's study was based on interviews designed to elicit observable behaviours; in order to assess the robustness of his results across data collection method, this study was based on clients' written descriptions of what was helpful in forming the therapeutic alliance with their clinician. This difference, while introducing an additional source of variation, was useful to assess the extent to which Bedi's results would hold up across various data collection methods.

The written descriptions in this replication allowed for open-ended, client reporting regarding the factors that clients considered crucial to the development of the alliance. Further, unlike Bedi (2006) this study did not limit variables to unitary, behavioural type factors that could be observed or concretized; clients were able to express, in their own vocabulary, helpful factors or perceptions of behaviours that could not be directly or easily observed, as well as composite and interactional factors and behaviours. For example, the perception of being treated as a unique individual, validated, or being heard would be difficult to assess by an observer. The opportunity to describe the experience of what was helpful, free of interviewer guidance toward concreteness; could allow participants to share novel alliance building factors that could have been overlooked in the results of Bedi. In an attempt to further increase the generalizability of the results, a greater proportion of men as participants was solicited, thereby broadening sample characteristics and allowing for a better examination of possible gender differences, a key limitation of Bedi.

Like Bedi (2006), participants were asked to sort client-identified factors into conceptually similar groups and choose an appropriate title for each category they created.

Concept mapping was used to allow quantitative statistical procedures to compute the most typical category sort across participants and calculate the client generated label most likely to best describe factors included in each category, thereby including the client's voice in naming the resulting categories.

Any resulting differences between this study and Bedi (2006), need to be carefully examined to determine what may have contributed to the differences (Language Teaching Review Panel, 2008) in order to determine if differences reflected real differences in how clients viewed the therapeutic alliance, whether they were due to sample selection and reflected the characteristics of each specific sample selected for the investigation (e.g., large, west coast Canadian city clients) (Thompson, 1999; Language Teaching Review Panel), or they were the result of a change in methods.

The paucity of research directly investigating the client's perspective of the therapeutic alliance, along with the fact that the findings of Bedi (2006) were not well-predicted by current theory, made this replication even more important, as replication is part of the process necessary to establish the validity of findings that appear to diverge from current theory and measurement. In sum, this conceptual replication of Bedi that included exact replication of several aspects of his method and design, will allow the results to be evaluated and assessed by further research in the same area in order to gain a more accurate representation of the client's perception of factors and categories that contribute to development of a strong therapeutic alliance (Sohn, 1998; Language Teaching Review Panel, 2008).

CHAPTER 2

The Study

Method

This section lays out a detailed description of (a) the characteristics and recruitment of the participants, (b) the characteristics of the research assistants, (c) the procedures and tasks that were completed by the participants, (d) the specific statistical analyses that were employed, and (e) the strategies used for establishing and assessing reliability and validity. The research study was evaluated and approved by the University of Victoria's and Vancouver Island University's Human Research Ethics Boards.

Participants

A sample of 50 participants who were either currently in counselling or had received outpatient counselling within the previous 30 days were invited to participate. The average sample size for multivariate concept mapping (MVCM) studies is $N = 15$ ($M = 14.6$, $SD = 5.8$) according to Trochim (1993). Therefore, the sample of 50 participants seems more than adequate. Recruitment was conducted through the following means: (a) flyers posted at the University of Victoria and Vancouver Island University, (b) flyers posted at various mental health clinics in Victoria and Nanaimo, and (c) letters addressed to independent clinicians in Victoria and Nanaimo requesting them to invite their clients' participation. In order to obtain a sample more reflective of the general population and a sample that more significantly includes the perspective of men compared to Bedi (2006), clinics serving the male population were especially targeted. This also helped to address concerns of past research on the client's perspective of the alliance (e.g., Bedi, 2006; Davis, & Williams, 2005), where the samples included less than 25% men.

Telephone or email screening interviews were conducted to ascertain the participant's ability to meet the requirements for participation in the study. In order to minimize possible doubt regarding the participant's ability to give informed consent, only participants who were of legal age in British Columbia were included (i.e., 19 years of age and older). Additionally, a minimum of a Grade 10 education was required to ensure that the participant's reading comprehension level was adequate for understanding and categorizing the statements in the sorting procedure. In order to conduct the research in a confidential site, participants needed to be able to travel to either a research laboratory at the University of Victoria or a private office at a mental health clinic in Nanaimo: 76% of the participants completed the research procedures at the University of Victoria and 24% at a mental health clinic in Nanaimo. A summary of participant demographics is given in Table 1 and Table 2.

Table 1

Participant Age Statistics

	N[a]	*M(SD)*	Median	Mode	Min	Max
Age	49	31.59 (12.45)	27	22	19	69

[a] Data was missing for one participant; *N* refers to the number of participants with valid data.

Table 2

Categorical Sample Demographics

Demographic	Characteristic	% of Sample
Gender	Female	52%
	Male	46%
	Self-Identified as both Male and Female	2%
Ethnicity	Caucasian	84%
	Bi/Multi-Racial	10%
	Asian	6%
Occupation	Student	56%
	Unemployed	10%
	Administrative	8%
	Construction	6%
	Child Care	4%
	Sales	4%
	Disability Pension	4%
	Retired	4%
	Unknown	2%
	Teacher	2%

Education Completed	Elementary	1%
	High School	6%
	Some Post Secondary	77%
	Bachelor's Degree	12%
	Master's Degree	4%
Marital Status	Single	66%
	Married/Common-law	18%
	Divorced/Separated	16%

Research Assistants

Sorting procedures were overseen by the current researcher and two senior undergraduate research assistants (RA) who had completed over 20 hours of training and supervised practice specifically related to this study.

Origin of Statements

Statement Collecting Procedures

This study made use of previously collected statements (not analyzed or published) describing the most important factors clients attribute to alliance formation (Bedi & Duff, 2008). In the interests of efficient use of both researcher and participant time, a written description format was chosen. As a side part of the Bedi and Duff (2008) study, participants were asked to

describe in writing the three most important elements that had contributed to the development of a strong alliance with their clinician (see Appendix A). Because the term "therapeutic alliance" can be confusing to clients, in that it is usually associated with researcher vocabulary, the terms "counselling or therapeutic relationship" were used. Specifically, participants were asked, "What were the three most important things that helped form and strengthen the counselling or therapy relationship? Please describe each behaviour or event completely and in as much detail as possible." Each participant was given three answer sheets, one for the description of each important factor. Instructions were briefly reiterated at the top of each answer sheet. These participant descriptions then formed the basis of the statements created for the present study. The research team, which included the principal investigator of this study, developed the variables that were sorted by the participants in this study.

Extraction of Statements

Returning to Bedi & Davis (2008), 42 participants [1] completed the questionnaires, producing 126 statements. One participant submitted a clear reiteration of the same event so the repeated description was excluded, leaving a total of 125 descriptions available for extraction. Consensus methods were employed in order to extract the key elements of each response and condense the participants' descriptions into a shorter, more manageable format for sorting. First, Dr. Bedi and four RAs immersed themselves in the descriptions generated; reading the statements several times to familiarize themselves with the content and format of the individual descriptions. After reviewing the descriptions, everyone agreed that because many descriptions contained unique client vocabulary and personal expression, it was important to retain as much

[1] 85.7% of the participants were women and participants' age ranged from 19 to 65 years ($M = 29.4$, $SD = 10.9$). Ethnic background was described as European (80.9%), Asian (9.5%), or biracial/multiracial (7.1%), and 69.0% of the sample identified as single. Participants had completed a median of 11 sessions with their most recent mental health practitioner ($M = 25.5$, $SD = 44.6$).

of the participants' writing as possible. Consequently, the 125 responses were not combined even though some of the responses seemed to refer to a similar factor. Accordingly, all 125 descriptions were included and editing was limited by guidelines that attempted preserve the description in the participant's own words while correcting only the most elementary grammar and spelling, and by limiting a few longer descriptions to one or two sentences. Descriptions were also edited to remove references to a specific gender.

Next, the statements were divided equally amongst the four RAs with instructions to extract the core of the description (preserving the client's words as much as possible). Guidelines for this process were as follows:

1. Include concrete, observable, and behavioural factors. Do not omit factors that are not concrete, observable, or behavioural.
2. Do not include how or why the factor was helpful or how it impacted the relationship.
3. Include the context if it clarifies the factor described.
4. If each description seems to include more than one factor, assume they all go together unless it is really obvious that they are talking about two or three completely separate things, and then pick the one they spent the most time talking about or the one that you think they gave the most weight to. Make a running commentary regarding your decision making process so that other auditors will be able to understand your decision making logic.
5. Maintain the flavour and original wording as much as possible.
6. If the description is not grammatically correct, this can be corrected if needed for clarity, but don't rewrite the whole sentence. Keep corrections minimal. Also, it is acceptable to add transitional words if needed.

7. Try to extract 1-2 sentences.

Once the first round of extractions was completed, they were forwarded to the principal researcher who was acting as Lab Manager and auditor (a student in the Counselling Psychology M.A. Program). The extractions were reviewed by the principal researcher who suggested revisions that were further re-evaluated by the RA who had done the initial extraction. Differing evaluations were discussed and mutually resolved. Once the extraction was agreed upon, the principal researcher waited one week before conducting further review of the extractions. Finally the extractions were forwarded to Dr. Bedi who reviewed the 125 extractions and suggested revisions which were forwarded to the Lab Manager for condensation and editing.

Revisions made throughout this process included the following:

1. Some sentences were made shorter.
2. Some grammatical corrections were made.
3. All references to the counsellor or therapist were made consistent and gender neutral. References to the clinician/therapist/psychologist/etc. became "my counsellor" and "he/she" to avoid confusion during the sorting procedure.

Due to logistical and ethical constraints which prevented researchers from further consulting with the participants responsible for creating the statements, editing was deliberately minimal and conducted consensually by researchers in an attempt to minimize the changes that would alter meaning. Editing was designed to allow clients, rather than researchers, significant participation in interpreting ambiguous or plural meanings. Once editing was complete, the edited statements were reviewed by the RAs and Dr. Bedi together, revisions were thoroughly discussed and consensus reached

regarding the final statements. This extraction, review, and audit-consensus process took approximately 6 weeks.

The 125 finalized statements are listed below.

1 My counsellor had a non-judgmental and supportive manner and was familiar with the subject.

2 My counsellor helped me with tangible things related to my problems, contacting doctors and other professionals, as well as informing me of the variety of resources available.

3 My counsellor let me guide the subject matter of our meetings; anything was acceptable to talk about.

4 My counsellor openly invited me to share my concerns and didn't make any assumptions about what was happening or what I was feeling.

5 My counsellor was direct and straightforward regarding possible outcomes to my situation.

6 My counsellor gave me permission to cry. He/she showed empathy without becoming involved in my emotion.

7 My counsellor made him/herself very approachable as someone who listened to me and how I felt.

8 My counsellor listened with undivided attention and did not interrupt with analytical questions before my story was over.

9 My counsellor gained knowledge by what I told him/her and did not assume other aspects that may have seemed possible.

10 My counsellor used his/her real life experiences and examples from others he/she knew.

11 My counsellor was open to being challenged on any comments or observations etc. and did not take offence.

12 My counsellor was willing to call me and have further phone conversations about additional thoughts after a session if he/she felt he/she had misinterpreted/misread anything we discussed and was open for me to do the same.

13 My counsellor asked me to return to the underlying issues when I had digressed.

14 My counsellor treated me as an individual and not as a type, and my objections to completing classification questionnaires were acceptable to my counsellor.

15 My counsellor monitored shifts in perception throughout the counselling process and was able to chart perceptual movement and major changes.

16 My counsellor was sympathetic and able to see my point of view/perspective; could 'take my side' when I needed that support, could be a bit biased in my favour, and could 'paraphrase' or summarize my most recent issue.

17 My counsellor did not judge me and made me feel like everything I was dealing with was normal.

18 My counsellor always remembered very specific details about my life and circumstances.

19 My counsellor was very interested in other ways of healing (e.g. my spiritual guide).

20 My counsellor was genuinely concerned for my well-being and sometimes gave me a call or asked me to leave a message to see how things were going.

21 My counsellor worked close to where I lived and worked.

22 My counsellor maintained a sense of confidentiality and sincerity.

23 My counsellor was polite and respectful and showed this through smiling, handshaking, greeting, and taking time to answer questions outside of regular sessions.

24 My counsellor had a sense of humour; cracking jokes, sarcastic remarks, and laughing.

25 My counsellor treated me more like a person in need than a "client".

26 My counsellor listened attentively.

27 My counsellor encouraged me to come back and was interested to know how/if things had progressed.

28 My counsellor was very present to me; to my energy, and to the truths in my body.

29 My counsellor was willing to look at what I felt was important.

30 My counsellor was consistent and calm and gave me tea.

31 My counsellor explained his/her approach to counselling to me on the phone before we had our first appointment and the reasons why he/she used the counselling techniques.

32 My counsellor shared a personal anecdote with me.

33 My counsellor carved out a space for humour when appropriate.

34 My ability to open up, trust and talk to my counsellor.

35 My counsellor listened, accepted, and encouraged me to open up.

36 My counsellor remembered small things and treated me like he/she actually knew me.

37 My counsellor was able to small talk about things like office decorations, music, and various things but still remain professional and not too personal.

38 My counsellor listened very intently and took good notes of whatever he/she thought was important.

39 My counsellor would sometimes ask specifically what I wanted to accomplish or what would need to happen to make me feel better.

40 My counsellor listened, validated my feelings, and told me what I was experiencing was normal.

41 My counsellor was warm and friendly when greeting me; he/she made eye contact, remembered my name, and offered me a coffee.

42 My counsellor sat patiently and helped me find my voice to figure out what I needed to say by giving me time and encouraging me.

43 My counsellor asked questions gently but fearlessly, rather than "judge" the individual aspects of my story.

44 My counsellor maintained a light tone and not a harsh, confrontational tone.

45 My counsellor and I devised homework together, tailoring the information and exercises, and we always went over the homework at the next session.

46 My counsellor appeared to be in my age group.

47 My counsellor gave me names of authors, names of books, and we discussed new age theories that I hadn't heard of before.

48 My counsellor's voice was calm, nurturing, and somewhat monotone. Although my counsellor disclosed a couple things, I never felt like the focus was on him/her.

49 I didn't feel as though my counsellor was "studying" me or that I was just another chore or patient on his/her schedule of people or things to do and see that day.

50 My counsellor always made time for me. He/she would always fit me in somehow.

51 My counsellor would add things about him/herself in relation to what I was saying and did not act like an authority/medical figure to me.

52 My counsellor assured me that what we discussed would never leave the room without my permission. I was not being judged (my counsellor let me know that my issues were things he/she dealt with all the time) and my counsellor also gave me some personal history of his/her past issues.

53 My counsellor would do extra legwork and would accommodate my needs regarding session times, session frequency, personal goals, etc.

54 My counsellor encouraged me to talk or cry, would listen to me talk in a negative way about myself, and would accept my thoughts before he/she would gently ask questions that shed new light on the origins or fallibility of these negative thoughts.

55 My counsellor went beyond his/her duties and showed he/she sincerely cared.

56 My counsellor listened very well. He/she would speak when I stopped talking or when I asked a direct question and would ask excellent thought provoking questions and give his/her own opinion.

57 My counsellor told me information about his/her life and relationships with his/her children.

58 My counsellor never showed shock, disgust, or any abnormality when I showed how I felt or what I thought.

59 My counsellor was not "mother" like, which helped me feel comfortable addressing more than surface issues.

60 My counsellor was upfront and told me to not tell him/her what he/she wanted to hear.

61 My counsellor treated me as an intelligent and normal person. He/she saw me as an individual, and more than a condition or problem.

62 My counsellor was friendly and made an effort to begin appointments with small talk and my counsellor made a point of remembering details about my life not related to the to the problems I saw him/her for.
problems I saw him/her for.

63 The way my counsellor sat, moved, etc. indicated that he/she was comfortable and he/she was not somehow threatened, closed-off, or upset.

64 At the first session we discussed the direction the counselling would take – what I wanted from it, what the counsellor could offer me, and what approach we would use.

65 When my counsellor gave me a task/homework he/she gave me ideas on how to complete it, and we talked about what I would do to try and complete it.

66 When my counsellor's schedule was full he/she moved things around so I could have an appointment the following week.

67 My counsellor was happy looking and his/her body language was peaceful and calm.

68 My counsellor never pushed for questions. He/she simply expressed interest and was a good listener.

69 My counsellor dressed professionally the office was clean, warmly decorated, and organized.

70 My counsellor asked specific questions that made me sure he/she was thinking carefully about what I was saying.

71 My counsellor's office space was professional but cozy and intimate, and had warm colours and a pleasant view.

72 My counsellor was very reassuring, i.e. saying "you're on the right path" or "I think this is the right thing for you to do".

73 My counsellor was positive and encouraging. He/she always pointed out the good things I was doing and the progress I had made.

74 My counsellor was non-judgmental. He/she didn't criticize anything I had done.

75 My counsellor was a real and honest person who was open to connecting on an emotional and spiritual level through self-disclosing appropriately and allowing me to know when I had impacted her/him.

76 I knew that if I was in a distressed state, I could get in contact with my counsellor.

77 My counsellor was always willing to help me with forms or provide me with information about a particular program.

78 My counsellor always remembered my life events and didn't have to refer to a file.

79 My counsellor was open and upfront about the fact that there was a monetary factor in our relationship. When I said that I wouldn't be able to afford to come in for awhile, my counsellor did not become uncomfortable or act as if that was not a valid reason to have fewer visits.

80 My counsellor struck a good balance between the professional and personal aspects of our relationship. He/she was kind and friendly to me and would talk about him/herself and her/his experiences when they were relevant, but he/she had clear and firm boundaries with me.

81 My counsellor didn't talk down to me and was honest and straightforward in her/his reactions to my problems and thoughts. He/she didn't try to convince me that everything was fine when it wasn't.

82 My counsellor revealed to me within the first few sessions that he/she had battled the same issue as me in the past.

83 My counsellor was able to understand the root/source of the problem before I even understood.

84 My counsellor was the same gender as me.

85 My counsellor was interested in what I wanted to say.

86 My counsellor asked lots of questions and wasn't afraid to take more talk time than me.

87 My counsellor reaffirmed many things I already knew.

88 My counsellor was friendly (but not overly so), quiet, and didn't rush me at all.

89 My counsellor shared his/her personal experience with me when we were in sessions.

90 My counsellor asked "what is bothering you the most?" and his/her quiet, warm and non-rushing manner gave me time to think about it seriously.

91 My counsellor assured me that he/she was realistic about the life the average person carried out.

92 My counsellor told me that my mother had approached the counsellor after one of my sessions and assured me that the counsellor had allowed none of my privacy to be invaded.

93 My counsellor paraphrased what I said.

94 My counsellor provided assistance outside of our sessions by allowing me to e-mail to ask questions.

95 My counsellor was able to ask critical questions so that I could start thinking about and finding/identifying the problems.

96 My counsellor provided me with emotional support and was able to express sympathy.

97 My counsellor smiled and listened to my issues, but didn't make me feel like I was alone or different.

98 My counsellor facilitated my thought process and allowed me to find my own answers, rather than directing he/she made me feel like I had the answers, and it was just a matter of uncovering them.

99 My counsellor made lots of eye contact, didn't make notes, and tilted his/her head in sympathy.

100 In the first session, I was allowed to spend the whole hour telling my life story and the counsellor briefly shared the same circumstance that happened to him/her.

101 My counsellor picked a method that seemed right for me.

102 I was offered tea and welcomed not as a patient, but as an equal human being and there was a sense that I was in control of the session.

103 My counsellor took my perceptions and beliefs at face value without putting his/her meaning on my experience. My counsellor worked with me, not the counsellor's story of me.

104 My counsellor didn't judge me. He/she stepped into my world and my meanings and worked from that place.

105 My counsellor met me where I was, but knew when to challenge me and was very honest.

106 My counsellor facilitated the creation of an environment where I could express myself without him/her panicking. He/she did not show fear or impinge on my right to experience the feeling I needed to get better.

107 Nothing was able to faze the working relationship. The counsellor remained solid.

108 My counsellor genuinely smiled.

109 My counsellor shared stories about his/her own family and relationships, and issues that were troubling for him/her in those relationships.

110 My counsellor shared his/her previous issues.

111 My counsellor did not invade my personal space, and had a non-aggressive, non-judgemental, and respectful attitude towards me.

112 My counsellor always seemed happy to see me, greeting me with warmth and excitement and a solid hug. He/she commented on my strengths as an individual and expressed heartfelt happiness when things were going well in my life.

113 My counsellor told stories from his/her own life and professional career.

114 My counsellor was very intuitive and empathic. I knew that my counsellor would know if I wasn't telling the truth or was holding back about something.

115 My counsellor listened to my stressors and established trust.

116 My counsellor tried to get to know me before he/she offered advice.

117 My counsellor was positive, cheerful, didn't say 'oh how bad", looked at the good side of things, and smiled.

118 My counsellor had good body language – he/she shook hands, seemed relaxed, and made eye contact.

119 My counsellor helped me see positives in myself, through analogies and mental exercises.

120 My counsellor treated me as an individual with unique problems/issues, called me by name or nickname, and made me feel like I was the only person they had seen that day.

121 My counsellor shared unrelated details and idiosyncrasies that made him/her seem human. This comfort and openness was also seen in my counsellor's ability to laugh and joke, and recognize that I was sometimes joking too!

122 My counsellor understood where I was going with a train of thought when I got stuck trying to explain something.

123 My counsellor stressed that I was not crazy even when I believed I was. He/she would not make fun or make light of any thought/feeling I shared.

124 My counsellor asked about things in my life other than the problem I was there for and remembered things I had mentioned in previous sessions.

125 When I told my counsellor that I was uncomfortable with a certain subject, he/she never mentioned it again without asking first whether he/she could or not, unless I brought it up first.

Procedures

Potential participants who did not answer the pre-screening questions affirmatively (as indicated earlier) were thanked for their interest and informed that they did not meet the requirements for participation in the study. Participants meeting inclusion criteria were invited to participate and an appointment was made to meet with an RA at the appropriate research site, at a mutually convenient time. Victoria participants travelled to an office at the University of Victoria and Nanaimo research was conducted in a private office at a mental health clinic in Nanaimo.

Participants were read the informed consent document and given the opportunity to ask questions. After informed consent was received, participants were asked to complete a short demographic questionnaire (see Appendix B) and were given instructions regarding the sorting task. Brief and specific instructions were also posted on the wall, clearly visible to participants and available for reference while completing the sorting task. Additionally, the RA or principal investigator was present so the participant was able to consult with him or her during the process. Participants were encouraged to take a ten minute break each hour.

As a way to compensate participants for any inconvenience related to their participation, and because it is customary to pay honorariums to counselling clients from the community who participate in research, participants were given a $20 honourarium to offset travel expenses and thank them for time spent on completion of the project. Although no participants withdrew from the study before completion, they were informed that they would receive the full $20 honourarium, regardless of the length of time it required for them to complete the task. However, one participant informed the RA that he was unwilling to sort or rate statements that he had not personally experienced in counselling. The resulting sorting and rating was inadequate for

inclusion in the study. However, the participant was thanked for his contribution and paid the full honorarium. The compensation was not intended to be coercive as it is unethical to provide undue compensation or inducements to research participants.

Sorting Task

Each participant was asked to sort the 125 extracted statements into categories. Each statement was written on an index card and numbered (on the back of the index card) so that they could be tracked and analyzed. Although the numbers had no value relative to the content of the statement and were written on the back of the card, the cards were arranged in random order for each participant. A program found on the website www.random.org was used to generate a unique random order for each participant.

Sorting Task Instructions

Instructions for the card sort were as follows:

> You will be given 125 index cards. On each card is a statement that represents one way to help build a good working relationship between a counsellor and client. These cards represent common things mentioned by people who previously completed questionnaires about what was helpful in forming a good working relationship.
>
> Your task is to look at all the cards and then sort them into categories according to how they seem to go together in a way that most makes sense to you. In other words, you are asked to group cards representing a similar idea/theme together in piles. You are also asked to provide a name or title for each pile. This name/title should be a word or short phrase that best summarizes or describes the statements in that pile.

We will provide paper for you to write down category names/titles as you sort the cards. Please feel free to change any name/title if you come up with a better name/title at any time during this procedure.

You can sort the cards in any way that makes sense to you. You can create as many different categories as you'd like, and you can put as many cards as you like into each pile, according to the guidelines below. You can also change which pile you have placed a card in at anytime. Each pile can have a different number of cards in it. There are no right or wrong answers; we are interested in whatever way you make sense of the cards. However, please remember, each pile should contain cards that you see as similar to each other in some way.

Guidelines[2]:

1. Please do NOT put each card in its own pile, that is, you cannot have 125 separate piles (but there can be a few piles with just one card in them).
2. Please do NOT put all the cards in one large pile (but you can create as many piles as you think are appropriate).
3. Please do NOT create a miscellaneous pile. Every card should be placed in a category that relates to a particular theme or ideas. If it is one of a kind, please place it in its own category.
4. Each card can only be placed in one pile.

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[2] These restrictions facilitate optimal multidimensional statistical analyses and prevent statistical problems that arise from very large piles (Trochim & Setze, 1994; Weller & Romney, 1988). Creation of a miscellaneous pile effectively obscures the participant's understanding of statement; the researcher is therefore limited in her ability to understand this participant's sort (i.e. do the statements in the miscellaneous pile somehow relate to one another or is the participant unable to create a more descriptive label for the pile?)

5. No pile can have more than 42 cards in it (although you may have many piles with far fewer cards in them).

Reminder:

If you have any questions, please do not hesitate to ask; we are here to help you.

First Run

- Sort cards that have a common theme into the same pile – each pile must be titled, so all cards in the pile must, in your opinion, have something in common with each other.
- You can have piles of one card, but you cannot have 125 piles.
- No more than 42 cards per pile maximum.
- Label piles as you create them – these labels can be changed as you see fit.

Take a Break

Second Run

- Go through each pile: finalize your piles and their titles.

The categorical piles created by the participants were not permitted to include more than 33% of all the cards (for a detailed rationale of the 33% strategy, see Campbell & Salem, 1999; Jackson & Trochim, 2002; Trochim, Cook, & Setze, 1994). The rationale for these sorting limitations is presented in Bedi (2006), but they are generally done to encourage thoughtfulness, discourage response sets, and optimize the statistical analyses.

Rating Task

In order to compare the relative value participants place on specific statements, they were asked to rate statements for relative importance in developing a strong alliance (see Appendix C). Due to the large number of statements participants were required to sort, and resulting possible fatigue, they were only asked to complete the rating exercise for half of the statements. The first 63 statements made up one set of statements for sorting and the last 62 statements made up the second set. A constrained random order program was used to randomly determine which set of statements each participant sorted and ensure that each set was sorted the same number of times.

Participants were asked to rate each statement in terms of how helpful (or unhelpful) they thought it would be in developing a strong alliance with their clinician, *relative* to all other statements in the study. Specifically, each statement was rated on the following scale:

1 = Not helpful at all (compared to the rest)

2 = Somewhat helpful (compared to the rest)

3 = Moderately helpful (compared to the rest)

4 = Very helpful (compared to the rest)

5 = Extremely helpful (compared to the rest)

Experience Endorsement Task

Participants were also asked whether or not they had experienced the behaviours and attitudes described in each statement they rated (see Appendix C). Percentages were computed to describe subsets of individuals who had experienced versus not experienced the alliance formation factors described on the index cards.

Categorization Task

In order to embed this study with the previous work that examined the client's subjective description of their preferred type of alliance, participants were also asked to state their preference for a clinician who is primarily the type described as nurturant, insight-oriented, or collaborative (cf. Bachelor, 1995) (see Appendix D). Participants were also asked whether they preferred the professional or personal type of alliance that is described by Mohr and Woodhouse (2001) (see Appendix D). In order to avoid participants' endorsement of a particular type based on the label, a description of the alliance type was offered without the label that was assigned by researchers. This allowed participants to assess the description of the type of alliance they would prefer based on words that were similar to those used by counselling clients in previous studies. Participants were asked the following:

> We are interested in your understanding of an ideal (yet realistic) working relationship with your counsellor. If you were to see another counsellor in the future, what do you wish he/she would be like? One way of understanding the working relationship is to classify them into one of three types (Bachelor, 1995). Please read the following descriptions and choose the type that best describes your preference.
>
> A. Most individuals will see some factors of all three types in their preferred counselling relationship. Which ONE of the three descriptions MOST CLOSELY resembles your preferred counselling relationship?
>
> Please check ONE box.
>
> ☐ The professional is very friendly, warm, respectful, and patient. He or she does not pressure me or try to rush me but rather listens intently and takes extra effort to establish an atmosphere of trust and help me feel at ease.

☐ The professional emphasized the exploratory nature of our work together and encourages my free, uninterrupted self-expression. He or she is great at keeping me on track and has a remarkable ability to assist me in better expressing myself and in gaining a greater self-understanding than I could on my own.

☐ The professional is very involved and he or she and I are equal partners. We have a very collaborative, two-way relationship with mutual trust and respect. The climate is very professional and we are both actively involved in determining the details of the service that I receive.

B. The following describes another way of viewing the working relationship you can have with your counsellor. Please choose ONE of the two following descriptions that would best fit your idea of a preferred counselling relationship.

☐ The working relationship is more professional than personal. The mental health professional keeps an objective distance from me rather than getting very personally involved with and affected by my issues. He or she is able to be impartial and competent while facilitating emotional expression, exploration, and insight.

☐ The working relationship is like a good friendship. The mental health professional is very warm and emotionally connected, and much more personal than professional. I feel free to explore difficult issues and let my feelings come to the surface. He or she is willing to share relevant personal information.

Data Analysis

Category and Category Title Computation and Analysis

Categories and category names created by participants were analyzed using multivariate concept-mapping (MVCM) statistical procedures to compute the most typical representation category sort across participants and to provide a list of client-identified category names that most closely fit the computed categories (The Concept Systems, 2008, Version 4; Trochim, 1989). In sum, MVCM is a statistical analysis that incorporates multidimensional scaling (MDS) sequentially with a cluster analysis approach. The selected solution models a conceptual structure that best describes the participants' understanding of how these factors are related to each other. A more technical description of the type of MVCM used here can be found in Bedi and Alexander (2009).

In the Concept Systems program, individual participants' sorting data were placed into a symmetrical binary similarity matrix (BSM). Rows and columns in this matrix correspond to specific statements in the study, and endorsement of particular cell indicates that the corresponding statements were sorted into the same pile (Shern, Trochim, & LaComb, 1995). Next, the matrices for all participants were summed to obtain the group similarity matrix (GSM). This matrix indicates how many times two specific statements are sorted into the same pile. In other words, it indicates how many participants agree that these two statements are conceptually similar. Un-weighted, non-metric multidimensional scaling (nMDS) of the GSM was then computed.

MVCM analysis required the analyst to specify the range of dimensions represented. For example, the one-dimensional solution displays each point along a single line and the two-dimensional solution plots each point into a bivariate plot. Due to the difficulty of displaying and

interpreting solutions that are higher than three-dimensions, along with the usefulness of visually displaying the two-dimensional clustering results, the two-dimensional solution, which is generally considered to be the best choice for MVCM analysis (Fitzgerald & Hubert, 1987; Jackson & Trochim, 2002; Kruskal & Wish, 1978), was used in this study.

Stress values were examined to determine how adequately the two-dimensional solution fit the data. The stress value represents the extent to which data point distances in nMDS map match the observed similarities in the proximity matrix (0 = no discrepancy and 1 = the distances are completely random). This is a relative measure of how well the data fit the two-dimensional solution and lower values are preferable.

Using Ward's (1963) minimum variance algorithm, hierarchical cluster analysis (hCA), was then applied to the nMDS coordinate data (Concept Systems Inc., 2008, Version 4). Concept Systems, by default, computes a range of a 20 cluster solution down to a 8 cluster solution. The resulting cluster solutions were examined for interpretability. The average number of piles created by participants in the sorting study was compared to the cluster solutions created by Concept Systems to help select the interpretable number of categories that most closely represented the participants' collective conceptualization. In order to better understand the solutions, standardized bridging value means for the different category solutions were also examined. The bridging value indicates the average of how often statements within one particular cluster were sorted with statements that are close to them on the data plot, compared with statements that are further away. Values range from 0 to 1. Lower bridging values indicate that fewer participants sorted these statements with the statements in another cluster. Therefore, a cluster solution with the lower average bridging value is considered preferable.

For the final selected solution, Concept Systems (2008, Version 4) supplied a list of titles which had been created by participants for each cluster. The titles are rank ordered to indicate how close the centroid of each participant's pile fell in relationship to the centroid of the aggregated plotted final pile when the piles were plotted in two-dimensional space. The principal investigator examined the participant suggested titles in order to determine the label that best described the concepts in the pile; considering both the rank order, the title meaning and the agreement of other suggested titles. The conclusions were discussed and revised in consultation with Dr. Bedi.

Comparison of Preferred Relationship Type with Previous Studies

Percentages of participants who indicated that they preferred each type of therapeutic alliance were calculated and compared to those found in previous studies (i.e., Bachelor, 1995; Bedi & Duff, 2008; Mohr & Woodhouse, 2001).

Group Comparisons

Subsets of the sample, with their respective ratings, were compared in order to evaluate the similarities and differences in the way the alliance categories were rated by those subsets. Specifically, the importance of each category was compared for male and female participants, for participants who preferred a professional or personal alliance type, as well as for those who preferred nurturant, insight-oriented, or collaborative alliance types. This analysis allowed us to better understand the alliance forming factors preferred by various subsets of clients.

Reliability and Validity Analyses

Testimonial validity refers to the agreement between a participant's intended meaning and the researcher's interpretation. In other words, it asks if the results of the study reflect the understanding of those it purports to investigate (Elliott, Fischer, & Rennie, 1999; Stiles, 1993).

When researchers ask for the participant's understanding (i.e. what are the factors they believe are important in developing a good therapeutic alliance) "the validity of the researcher's interpretations is, in principle, decided by the subject" (Kvale, 1996. p. 217). In this study, testimonial validity was specifically established by (a) retaining the participant's words, as much as possible, in constructing the statements for sorting, and (b) asking the participants to use their own conceptual framework and vocabulary to organize and name the categories in the sorting task.

Reliability for this study was established by the following processes: (cf. Bedi, 2006)

1. The reliability of the individual sorting was determined by correlating each participant's BSM with all of the other BSMs and computing the average correlation (analogous to the average of inter-item correlations).
2. The association of each individual sort with the aggregated sort solution (a form of average item-total correlation) was determined by correlating each BSM with the GSM and taking the average.
3. The split-half reliability was determined in two ways: 1) BSMs of odd -even numbered participants were compared and 2) the GSMs of male-female participants were correlated on the two respective matrices.
4. Internal consistency was evaluated by examining stress values computed on both the 1) odd-even participant split and 2) the male-female participant split matrices.

Concept Maps

The Concept Systems software computes several types of maps. The point map plots the individual statements sorted by participants in two-dimensional space. Each statement is

represented by a point on the graph. Statements that participants view as similar were plotted closer together than statements that participants view as dissimilar. The more dissimilar the statements are, as viewed by participants, the further apart they are plotted on the Concept Map. For example, in Bedi's (2006) study, statements such as "the counsellor's office had flowers/plants" and "the counsellor's office had books on shelves" are represented as closer in two-dimensional space than "the counsellor's office had flowers/plants" and "the counsellor taught me skills".

Similarly, each category is represented by a polygon plotted in two-dimensional space (i.e., the cluster map). In general, the relative size of each polygon, on the cluster map, visually demonstrates how much the statements in that category resemble each other (in the participants' estimation). Larger (in area) polygons show that participants view the statements in that category to be conceptually related, but not as closely related as the statements in a smaller polygon. The larger the polygon, the more diversity in is represented by the statements in that category. The distance between categories demonstrates how alike participants conceive the categories to be. Categories that are further apart in two-dimensional space are viewed as more diversified in the participants' conceptual understanding. Again, to use an example from Bedi (2006), categories titled "Setting" and "Presentation & Body Language" are closer on the Concept Map of categories than "Setting" and "Education".

Other maps useful for understanding participants' conceptualization of the alliance are the cluster rating map and the cluster bridging map. These maps visually represent the relative importance participants allocate to each cluster or category on the cluster map. On the cluster rating map, clusters are composed of 1 to 5 layers reflecting the relative ratings assigned to statements by participants. Specifically, a cluster having only one layer shows that participants

have assigned a lower average value to statements in this cluster than a cluster having 5 layers. The cluster bridging map, gives the numerical bridging values for each cluster. Lower bridging values show that more participants sorted the statements in the cluster together while higher bridging values show that fewer participants sorted the statements together. The cluster bridging map was helpful in determining which cluster solution was the best fit for the data. A cluster solution with lower bridging values is more likely to be a valid representation of the participants' aggregate conceptualization than the cluster solution with higher bridging values.

Concept maps in this study were visually compared to the concept maps generated in Bedi (2006). Similarity in titles assigned to the various categories, similarities in the size of each category, as well as similarities in individual statements grouped together in piles was taken to assess the agreement between participants in this study and participants in Bedi (2006) with regard to factors deemed important for alliance formation.

CHAPTER 3

Results

This chapter will present the results of data analysis including the descriptive results related to individual statements, statement sorting, statement rating with regard to helpfulness of the statement, and statement rating with regard to participant's experience of the statement. Results related to multi-dimensional scaling (MDS) analyses include stress values calculated for the determination of the best dimensional solution (which are discussed and presented graphically), statement coordinate maps, and statement rating maps. Results related to hierarchical cluster analysis (hCA) include bridging values for individual statements, statement bridging maps, assessment of different cluster solutions, potential titles for clusters (based on client-provided titles), selected category names, statement composition of the final categorical solution, various concept maps, the average bridging value of each cluster, and the average rating of importance for each cluster. Underlying dimensions are suggested for the category solution and results of helpfulness ratings for male and female participants will also be presented. Finally, the reliability and validity of the multivariate concept mapping (MVCM) analysis will be determined.

Results Related to the Individual Statements

Statement Sorting

This section outlines and describes the results relating to each participant's sorting. Participants sorted the 125 statements into what they perceived to be conceptually similar groupings, creating varying number of piles, containing various numbers of statements. The average number of piles created by the 50 participants was approximately 13 (M=13.1, SD = 6.62), and the median number of piles was 14 with a range of 4 to 32 piles.

Statement Ratings: Helpfulness and Experienced

Participants were given half of the statements (63 or 64 of 125 statements) and asked to rate how helpful they believed each factor to be in the development of a strong therapeutic alliance with their counsellor and also to indicate whether or not they had experienced the factor that was described in the each statement. Participants were randomly assigned to complete one of two sets of statements (Statements 1- 63 or 64 -125; see Appendix C for a list of the statements included in each set).

Helpfulness Ratings

The mean of the average rating of helpfulness for each statement was $M = 3.96$ ($SD = .47$) showing that, on average, participants rated the statements as approximately 4 (Very helpful) on a Likert scale of 1 to 5, where 1 = Not at all Helpful to 5 = Extremely Helpful. Only two of the statements achieved an average rating below 3 (Moderately Helpful). These two statements were "My counsellor was the same gender as me" and "My counsellor appeared to be in my age group". The high average rating suggests that most participants agree that the concepts described in the statements presented in the study do in fact represent behaviours that clients find helpful in developing a strong therapeutic alliance with their clinician. Average ratings of helpfulness for each statement are listed in Table 3.

While most statements received high ratings of helpfulness, the highest average ratings included concepts such as listening, trust, acceptance, non-judgmental attitude, assistance in problem identification, and confidentiality, and lower ratings were ascribed to gender, age, location, and the clinician sharing their own experiences. Thus, participants rated the helpfulness of each factor with notable variability. For example, listening, encouraging the client to open up,

asking critical questions, being non-judgmental, and confidentiality were rated as Very Helpful, whereas the age and gender of the clinician, on average, were rated as Somewhat Helpful.

Table 3

Helpfulness Ratings for Statements Describing Factors Participants Indicate Are Important in Alliance Formation

Statement Number	Statement	Helpfulness Rating
35	My counsellor listened, accepted, and encouraged me to open up.	4.80
34	My ability to open up, trust and talk to my counsellor.	4.80
26	My counsellor listened attentively.	4.80
95	My counsellor was able to ask critical questions so that I could start thinking about and finding/identifying the problems.	4.71
1	My counsellor had a non-judgmental and supportive manner and was familiar with the subject.	4.65
22	My counsellor maintained a sense of confidentiality and sincerity.	4.64
7	My counsellor made him/herself very approachable as someone who listened to me and how I felt.	4.60
56	My counsellor listened very well. He/she would speak when I stopped talking or when I asked a direct question and would ask excellent thought provoking questions and give his/her own opinion.	4.56

63	The way my counsellor sat, moved, etc. indicated that he/she was comfortable and he/she was not somehow threatened, closed-off, or upset.	4.52
61	My counsellor treated me as an intelligent and normal person. He/she saw me as an individual, and more than a condition or problem.	4.52
58	My counsellor never showed shock, disgust, or any abnormality when I showed how I felt or what I thought.	4.48
43	My counsellor asked questions gently but fearlessly, rather than "judge" the individual aspects of my story.	4.48
29	My counsellor was willing to look at what I felt was important.	4.48
108	My counsellor genuinely smiled.	4.46
105	My counsellor met me where I was, but knew when to challenge me and was very honest.	4.46
104	My counsellor didn't judge me. He/she stepped into my world and my meanings and worked from that place.	4.46
18	My counsellor always remembered very specific details about my life and circumstances.	4.44
17	My counsellor did not judge me and made me feel like everything I was dealing with was normal.	4.44
70	My counsellor asked specific questions that made me sure he/she was thinking carefully about what I was saying.	4.40

27	My counsellor encouraged me to come back and was interested to know how/if things had progressed.	4.40
115	My counsellor listened to my stressors and established trust.	4.36
92	My counsellor told me that my mother had approached the counsellor after one of my sessions and assured me that the counsellor had allowed none of my privacy to be invaded.	4.36
8	My counsellor listened with undivided attention and did not interrupt with analytical questions before my story was over.	4.36
118	My counsellor had good body language – he/she shook hands, seemed relaxed, and made eye contact.	4.32
81	My counsellor didn't talk down to me and was honest and straightforward in her/his reactions to my problems and thoughts. He/she didn't try to convince me that everything was fine when it wasn't.	4.32
52	My counsellor assured me that what we discussed would never leave the room without my permission. I was not being judged (my counsellor let me know that my issues were things he/she dealt with all the time) and my counsellor also gave me some personal history of his/her past issues.	4.32
49	I didn't feel as though my counsellor was "studying" me or that I was just another chore or patient on his/her schedule of people or things to do and see that day.	4.32

4	My counsellor openly invited me to share my concerns and didn't make any assumptions about what was happening or what I was feeling.	4.32
97	My counsellor smiled and listened to my issues, but didn't make me feel like I was alone or different.	4.29
85	My counsellor was interested in what I wanted to say.	4.28
62	My counsellor was friendly and made an effort to begin appointments with small talk and my counsellor made a point of remembering details about my life not related to the problems I saw him/her for.	4.28
42	My counsellor sat patiently and helped me find my voice to figure out what I needed to say by giving me time and encouraging me.	4.28
41	My counsellor was warm and friendly when greeting me; he/she made eye contact, remembered my name, and offered me a coffee.	4.28
96	My counsellor provided me with emotional support and was able to express sympathy.	4.25
124	My counsellor asked about things in my life other than the problem I was there for and remembered things I had mentioned in previous sessions.	4.24

106	My counsellor facilitated the creation of an environment where I could express myself without him/her panicking. He/she did not show fear or impinge on my right to experience the feeling I needed to get better.	4.21
98	My counsellor facilitated my thought process and allowed me to find my own answers, rather than directing he/she made me feel like I had the answers, and it was just a matter of uncovering them.	4.21
119	My counsellor helped me see positives in myself, through analogies and mental exercises.	4.20
55	My counsellor went beyond his/her duties and showed he/she sincerely cared.	4.20
36	My counsellor remembered small things and treated me like he/she actually knew me.	4.20
28	My counsellor was very present to me; to my energy, and to the truths in my body.	4.20
25	My counsellor treated me more like a person in need than a "client".	4.20
14	My counsellor treated me as an individual and not as a type, and my objections to completing classification questionnaires were acceptable to my counsellor.	4.20
83	My counsellor was able to understand the root/source of the problem before I even understood	4.16

67	My counsellor was happy looking and his/her body language was peaceful and calm.	4.16
44	My counsellor maintained a light tone and not a harsh, confrontational tone.	4.16
13	My counsellor asked me to return to the underlying issues when I had digressed.	4.16
6	My counsellor gave me permission to cry. He/she showed empathy without becoming involved in my emotion.	4.16
3	My counsellor let me guide the subject matter of our meetings; anything was acceptable to talk about.	4.16
111	My counsellor did not invade my personal space, and had a non-aggressive, non-judgemental, and respectful attitude towards me.	4.13
101	My counsellor picked a method that seemed right for me.	4.13
125	When I told my counsellor that I was uncomfortable with a certain subject, he/she never mentioned it again without asking first whether he/she could or not, unless I brought it up first.	4.12
123	My counsellor stressed that I was not crazy even when I believed I was. He/she would not make fun or make light of any thought/feeling I shared.	4.12
114	My counsellor was very intuitive and empathic. I knew that my counsellor would know if I wasn't telling the truth or was holding back about something.	4.12

76	I knew that if I was in a distressed state, I could get in contact with my counsellor.	4.12
66	When my counsellor's schedule was full he/she moved things around so I could have an appointment the following week.	4.12
54	My counsellor encouraged me to talk or cry, would listen to me talk in a negative way about myself, and would accept my thoughts before he/she would gently ask questions that shed new light on the origins or fallibility of these negative thoughts.	4.12
23	My counsellor was polite and respectful and showed this through smiling, handshaking, greeting, and taking time to answer questions outside of regular sessions.	4.12
112	My counsellor always seemed happy to see me, greeting me with warmth and excitement and a solid hug. He/she commented on my strengths as an individual and expressed heartfelt happiness when things were going well in my life.	4.08
39	My counsellor would sometimes ask specifically what I wanted to accomplish or what would need to happen to make me feel better.	4.08
122	My counsellor understood where I was going with a train of thought when I got stuck trying to explain something.	4.08
116	My counsellor tried to get to know me before he/she offered advice.	4.08

90	My counsellor asked "what is bothering you the most?" and his/her quiet, warm and non-rushing manner gave me time to think about it seriously.	4.08
78	My counsellor always remembered my life events and didn't have to refer to a file.	4.08
60	My counsellor was upfront and told me to not tell him/her what he/she wanted to hear.	4.08
40	My counsellor listened, validated my feelings, and told me what I was experiencing was normal.	4.08
120	My counsellor treated me as an individual with unique problems/issues, called me by name or nickname, and made me feel like I was the only person they had seen that day.	4.04
80	My counsellor struck a good balance between the professional and personal aspects of our relationship. He/she was kind and friendly to me and would talk about him/herself and her/his experiences when they were relevant, but he/she had clear and firm boundaries with me.	4.04
64	At the first session we discussed the direction the counselling would take – what I wanted from it, what the counsellor could offer me, and what approach we would use.	4.04
102	I was offered tea and welcomed not as a patient, but as an equal human being and there was a sense that I was in control of the session.	4.00

74	My counsellor was non-judgmental. He/she didn't criticize anything I had done.	4.00
73	My counsellor was positive and encouraging. He/she always pointed out the good things I was doing and the progress I had made.	4.00
51	My counsellor would add things about him/herself in relation to what I was saying and did not act like an authority/medical figure to me.	4.00
53	My counsellor would do extra legwork and would accommodate my needs regarding session times, session frequency, personal goals, etc.	3.96
48	My counsellor's voice was calm, nurturing, and somewhat monotone. Although my counsellor disclosed a couple things, I never felt like the focus was on him/her.	3.96
11	My counsellor was open to being challenged on any comments or observations etc. and did not take offence.	3.96
9	My counsellor gained knowledge by what I told him/her and did not assume other aspects that may have seemed possible.	3.96
103	My counsellor took my perceptions and beliefs at face value without putting his/her meaning on my experience. My counsellor worked with me, not the counsellor's story of me.	3.96

15	My counsellor monitored shifts in perception throughout the counselling process and was able to chart perceptual movement and major changes.	3.96
65	When my counsellor gave me a task/homework he/she gave me ideas on how to complete it, and we talked about what I would do to try and complete it.	3.92
50	My counsellor always made time for me. He/she would always fit me in somehow.	3.88
107	Nothing was able to faze the working relationship. The counsellor remained solid.	3.88
75	My counsellor was a real and honest person who was open to connecting on an emotional and spiritual level through self-disclosing appropriately and allowing me to know when I had impacted her/him.	3.84
5	My counsellor was direct and straightforward regarding possible outcomes to my situation.	3.84
121	My counsellor shared unrelated details and idiosyncrasies that made him/her seem human. This comfort and openness was also seen in my counsellor's ability to laugh and joke, and recognize that I was sometimes joking too!	3.80
94	My counsellor provided assistance outside of our sessions by allowing me to e-mail to ask questions.	3.80
33	My counsellor carved out a space for humour when appropriate.	3.80

19	My counsellor was very interested in other ways of healing (e.g. my spiritual guide).	3.79
88	My counsellor was friendly (but not overly so), quiet, and didn't rush me at all.	3.76
30	My counsellor was consistent and calm and gave me tea.	3.76
72	My counsellor was very reassuring, i.e. saying "you're on the right path" or "I think this is the right thing for you to do".	3.72
79	My counsellor was open and upfront about the fact that there was a monetary factor in our relationship. When I said that I wouldn't be able to afford to come in for awhile, my counsellor did not become uncomfortable or act as if that was not a valid reason to have fewer visits.	3.68
59	My counsellor was not "mother" like, which helped me feel comfortable addressing more than surface issues.	3.68
16	My counsellor was sympathetic and able to see my point of view/perspective; could 'take my side' when I needed that support, could be a bit biased in my favour, and could 'paraphrase' or summarize my most recent issue.	3.68
93	My counsellor paraphrased what I said.	3.64
77	My counsellor was always willing to help me with forms or provide me with information about a particular program.	3.64
24	My counsellor had a sense of humour; cracking jokes, sarcastic remarks, and laughing.	3.63

82	My counsellor revealed to me within the first few sessions that he/she had battled the same issue as me in the past.	3.60
38	My counsellor listened very intently and took good notes of whatever he/she thought was important.	3.60
89	My counsellor shared his/her personal experience with me when we were in sessions.	3.56
71	My counsellor's office space was professional but cozy and intimate, and had warm colours and a pleasant view.	3.56
2	My counsellor helped me with tangible things related to my problems, contacting doctors and other professionals, as well as informing me of the variety of resources available.	3.56
113	My counsellor told stories from his/her own life and professional career.	3.52
10	My counsellor used his/her real life experiences and examples from others he/she knew.	3.48
117	My counsellor was positive, cheerful, didn't say 'oh how bad", looked at the good side of things, and smiled.	3.44
99	My counsellor made lots of eye contact, didn't make notes, and tilted his/her head in sympathy.	3.42
20	My counsellor was genuinely concerned for my well-being and sometimes gave me a call or asked me to leave a message to see how things were going.	3.40

45	My counsellor and I devised homework together, tailoring the information and exercises, and we always went over the homework at the next session.	3.38
12	My counsellor was willing to call me and have further phone conversations about additional thoughts after a session if he/she felt he/she had misinterpreted/misread anything we discussed and was open for me to do the same.	3.36
109	My counsellor shared stories about his/her own family and relationships, and issues that were troubling for him/her in those relationships.	3.33
86	My counsellor asked lots of questions and wasn't afraid to take more talk time than me.	3.32
32	My counsellor shared a personal anecdote with me.	3.32
31	My counsellor explained his/her approach to counselling to me on the phone before we had our first appointment and the reasons why he/she used the counselling techniques.	3.29
87	My counsellor reaffirmed many things I already knew.	3.24
100	In the first session, I was allowed to spend the whole hour telling my life story and the counsellor briefly shared the same circumstance that happened to him/her.	3.21
69	My counsellor dressed professionally the office was clean, warmly decorated, and organized.	3.16

57	My counsellor told me information about his/her life and relationships with his/her children.	3.16
37	My counsellor was able to small talk about things like office decorations, music, and various things but still remain professional and not too personal.	3.16
91	My counsellor assured me that he/she was realistic about the life the average person carried out.	3.12
68	My counsellor never pushed for questions. He/she simply expressed interest and was a good listener.	3.12
110	My counsellor shared his/her previous issues.	3.08
47	My counsellor gave me names of authors, names of books, and we discussed new age theories that I hadn't heard of before.	3.08
21	My counsellor worked close to where I lived and worked.	3.00
84	My counsellor was the same gender as me.	2.64
46	My counsellor appeared to be in my age group.	2.17

Note. Statements were rated for helpfulness on a 5-point Likert-like scale where 1 = *Not at all Helpful*, 2 = *Somewhat Helpful*, 3 = *Moderately Helpful*, 4 = *Very Helpful*, and 5 = *Extremely Helpful*.

Experienced Ratings

Participants also indicated whether or not they had experienced each specific statement in the study. Again, participants were randomly assigned to complete one of two sets of statements (Statements 1- 63 or 64 -125; see Appendix C for a list of the statements included in each set) for this question. For the half of the statements that were rated by each participant, 75 of the

statements (60%) were experienced by over 80% of the participants; 107 of the statements (86%) were experienced by over 60% of the participants; 116 of the statements (93%) were experienced by over 50% of the participants, and only 9 of the statements (7%) were experienced by less than 50% of the participants. This indicates that, much more often than not, participants were rating a factor they had actually experienced. Table 4 shows the number and percentage of statements that experienced a specific percentage of factors.

Table 4

Proportions of Statements Experienced by Participants

Number of Statements (% of Statements)	Percentages of Participants Who Experienced the Factor Described in Statements
12 (10%)	100%
75 (60%)	≥ 80%
107(86%)	≥ 60%
116 (93%)	≥ 50%

Bridging Values of Statements

Mean bridging value for the 125 statements was $M = .30$ ($SD = .18$). The bridging value indicates the relative extent to which a particular statement was sorted with other statements. Statements having low bridging values (i.e. those closer to 0.00) were sorted in a similar way by more participants than those with a higher bridging value. Specifically, a bridging value of 0.00 indicates that all participants sorted the statement in the same way and a bridging value of 1.00

indicates that none of the participants sorted the same way. Therefore, low bridging values are associated with a higher degree of conceptual homogeneity and reliability with regard to the way participants view the specific statement. Bridging values associated with each statement are presented in Table 5.

Table 5

Average Bridging Value (in Ascending Order) for Statements Describing Factors Clients Believe are Helpful in Alliance Formation

Statement Number	Statement	Bridging Value
109	My counsellor shared stories about his/her own family and relationships, and issues that were troubling for him/her in those relationships.	0.00
110	My counsellor shared his/her previous issues.	0.01
10	My counsellor used his/her real life experiences and examples from others he/she knew.	0.01
57	My counsellor told me information about his/her life and relationships with his/her children.	0.02
89	My counsellor shared his/her personal experience with me when we were in sessions.	0.02
17	My counsellor did not judge me and made me feel like everything I was dealing with was normal.	0.03

113	My counsellor told stories from his/her own life and professional career.	0.06
51	My counsellor would add things about him/herself in relation to what I was saying and did not act like an authority/medical figure to me.	0.07
123	My counsellor stressed that I was not crazy even when I believed I was. He/she would not make fun or make light of any thought/feeling I shared.	0.08
32	My counsellor shared a personal anecdote with me.	0.08
104	My counsellor didn't judge me. He/she stepped into my world and my meanings and worked from that place.	0.08
58	My counsellor never showed shock, disgust, or any abnormality when I showed how I felt or what I thought.	0.10
43	My counsellor asked questions gently but fearlessly, rather than "judge" the individual aspects of my story.	0.10
106	My counsellor facilitated the creation of an environment where I could express myself without him/her panicking. He/she did not show fear or impinge on my right to experience the feeling I needed to get better.	0.11
6	My counsellor gave me permission to cry. He/she showed empathy without becoming involved in my emotion.	0.11
59	My counsellor was not "mother" like, which helped me feel comfortable addressing more than surface issues.	0.11

107	Nothing was able to faze the working relationship. The counsellor remained solid.	0.11
8	My counsellor listened with undivided attention and did not interrupt with analytical questions before my story was over.	0.12
103	My counsellor took my perceptions and beliefs at face value without putting his/her meaning on my experience. My counsellor worked with me, not the counsellor's story of me.	0.12
26	My counsellor listened attentively.	0.13
14	My counsellor treated me as an individual and not as a type, and my objections to completing classification questionnaires were acceptable to my counsellor.	0.13
1	My counsellor had a non-judgmental and supportive manner and was familiar with the subject.	0.13
49	I didn't feel as though my counsellor was "studying" me or that I was just another chore or patient on his/her schedule of people or things to do and see that day.	0.14
82	My counsellor revealed to me within the first few sessions that he/she had battled the same issue as me in the past.	0.15
56	My counsellor listened very well. He/she would speak when I stopped talking or when I asked a direct question and would ask excellent thought provoking questions and give his/her own opinion.	0.15

121	My counsellor shared idiosyncrasies that made him/her seem human. This openness was also seen in my counsellor's ability to laugh and joke, and recognize that I was sometimes joking too!	0.15
111	My counsellor did not invade my personal space, and had a non-aggressive, non-judgmental, and respectful attitude towards me.	0.16
42	My counsellor sat patiently and helped me find my voice to figure out what I needed to by giving me time and encouraging me.	0.16
34	My ability to open up, trust and talk to my counsellor.	0.17
11	My counsellor was open to being challenged on any comments or observations etc. and did not take offence.	0.17
68	My counsellor never pushed for questions. He/she simply expressed interest and was a good listener.	0.17
125	When I told my counsellor that I was uncomfortable with a certain subject, he/she never mentioned it again without asking first whether he/she could or not, unless I brought it up first.	0.17
97	My counsellor smiled and listened to my issues, but didn't make me feel like I was alone or different.	0.18
62	My counsellor was friendly and made an effort to begin appointments with small talk and my counsellor made a point of remembering details about my life not related to the problems I saw him/her for.	0.18
48	My counsellor's voice was calm, nurturing, and somewhat monotone. Although my counsellor disclosed a couple things, I never felt like the focus was on him/her.	0.18

22	My counsellor maintained a sense of confidentiality and sincerity.	0.18
70	My counsellor asked specific questions that made me sure he/she was thinking carefully about what I was saying.	0.18
120	My counsellor treated me as an individual with unique problems/issues, called me by name or nickname, and made me feel like I was the only person they had seen that day.	0.18
25	My counsellor treated me more like a person in need than a "client".	0.18
35	My counsellor listened, accepted, and encouraged me to open up.	0.18
40	My counsellor listened, validated my feelings, and told me what I was experiencing was normal.	0.19
116	My counsellor tried to get to know me before he/she offered advice.	0.19
44	My counsellor maintained a light tone and not a harsh, confrontational tone.	0.19
63	The way my counsellor sat, moved, etc. indicated that he/she was comfortable and he/she was not somehow threatened, closed-off, or upset.	0.19
102	I was offered tea and welcomed not as a patient, but as an equal human being and there was a sense that I was in control of the session.	0.20
33	My counsellor carved out a space for humour when appropriate.	0.20
38	My counsellor listened very intently and took good notes of whatever he/she thought was important.	0.20

41	My counsellor was warm and friendly when greeting me; he/she made eye contact, remembered my name, and offered me a coffee.	0.20
37	My counsellor was able to small talk about things like office decorations, music, and various things but still remain professional and not too personal.	0.21
9	My counsellor gained knowledge by what I told him/her and did not assume other aspects that may have seemed possible.	0.21
61	My counsellor treated me as an intelligent and normal person. He/she saw me as an individual, and more than a condition or problem.	0.22
7	My counsellor made him/herself very approachable as someone who listened to me and how I felt.	0.22
85	My counsellor was interested in what I wanted to say.	0.22
88	My counsellor was friendly (but not overly so), quiet, and didn't rush me at all.	0.23
3	My counsellor let me guide the subject matter of our meetings; anything was acceptable to talk about.	0.23
16	My counsellor was sympathetic and able to see my perspective, could 'take my side' when I needed support, could be a bit biased in my favour, and could "paraphrase" or summarize my most recent issue.	0.23
69	My counsellor dressed professionally; the office was clean, warmly decorated, and organized.	0.25
30	My counsellor was consistent and calm and gave me tea.	0.25

114	My counsellor was very intuitive and empathic. I knew that my counsellor would know if I wasn't telling the truth or was holding back about something.	0.25
80	My counsellor struck a good balance between the professional and personal aspects of our relationship. He/she was friendly, would talk about her/his experiences when they were relevant, but he/she had clear and firm boundaries with me.	0.26
93	My counsellor paraphrased what I said.	0.26
4	My counsellor openly invited me to share my concerns and didn't make any assumptions about what was happening or what I was feeling.	0.26
67	My counsellor was happy looking and his/her body language was peaceful and calm.	0.26
54	My counsellor encouraged me to talk or cry, would listen to me talk in a negative way about myself, and would accept my thoughts before gently asking questions that shed new light on the origins or fallibility of these thoughts.	0.26
24	My counsellor had a sense of humour; cracking jokes, sarcastic remarks, and laughing.	0.27
23	My counsellor was polite and respectful and showed this through smiling, handshaking, greeting, and taking time to answer questions outside of regular sessions.	0.27

100	In the first session, I was allowed to spend the whole hour telling my life story and the counsellor briefly shared the same circumstance that happened to him/her.	0.27
18	My counsellor always remembered very specific details about my life and circumstances.	0.27
118	My counsellor had good body language – he/she shook hands, seemed relaxed, and made eye contact.	0.27
74	My counsellor was non-judgmental. He/she didn't criticize anything I had done.	0.28
81	My counsellor didn't talk down to me and was honest and straightforward in her/his reactions to my problems and thoughts. He/she didn't try to convince me that everything was fine when it wasn't.	0.28
108	My counsellor genuinely smiled.	0.28
115	My counsellor listened to my stressors and established trust.	0.28
75	My counsellor was a real and honest person who was open to connecting on an emotional and spiritual level through self-disclosing appropriately and allowing me to know when I had impacted her/him.	0.29
52	My counsellor assured me that what we discussed would never leave the room without my permission. I was not being judged (my issues were things he/she dealt with all the time) and my counsellor also gave me some personal history of his/her past issues	0.30

13	My counsellor asked me to return to the underlying issues when I had digressed.	0.31
112	My counsellor always seemed happy to see me, greeting me with warmth and a solid hug. He/she commented on my strengths as an individual and expressed heartfelt happiness when things in my life were going well.	0.31
96	My counsellor provided me with emotional support and was able to express sympathy.	0.31
117	My counsellor was positive, cheerful, didn't say 'oh how bad', looked at the good side of things, and smiled.	0.31
29	My counsellor was willing to look at what I felt was important.	0.32
79	My counsellor was open about the fact that there was a monetary factor in our relationship. When I said that I wouldn't be able to afford to come in for awhile, my counsellor did not become uncomfortable.	0.32
60	My counsellor was upfront and told me to not tell him/her what he/she wanted to hear.	0.33
28	My counsellor was very present to me; to my energy, and to the truths in my body.	0.34
98	My counsellor facilitated my thought process and allowed me to find my own answers, rather than directing he/she made me feel like I had the answers, and it was just a matter of uncovering them.	0.35

122	My counsellor understood where I was going with a train of thought when I got stuck trying to explain something.	0.35
78	My counsellor always remembered my life events and didn't have to refer to a file.	0.38
95	My counsellor was able to ask critical questions so that I could start thinking about and finding/identifying the problems.	0.38
101	My counsellor picked a method that seemed right for me.	0.40
36	My counsellor remembered small things and treated me like he/she actually knew me.	0.41
90	My counsellor asked "what is bothering you the most?" and his/her quiet, warm and non-rushing manner gave me time to think about it seriously.	0.41
53	My counsellor would do extra legwork and would accommodate my needs regarding session times, session frequency, personal goals, etc.	0.41
31	My counsellor explained his/her approach to counselling to me on the phone before we had our first appointment and the reasons why he/she used the counselling techniques.	0.43
99	My counsellor made lots of eye contact, didn't make notes, and tilted his/her head in sympathy.	0.43
27	My counsellor encouraged me to come back and was interested to know how/if things had progressed.	0.43

124	My counsellor asked about things in my life other than the problem I was there for and remembered things I had mentioned in previous sessions.	0.44
12	My counsellor was willing to call me and have further phone conversations about additional thoughts after a session if he/she felt he/she had misinterpreted/misread anything we discussed and was open for me to do the same.	0.44
105	My counsellor met me where I was, but knew when to challenge me and was very honest.	0.44
94	My counsellor provided assistance outside of our sessions by allowing me to e-mail to ask questions.	0.45
87	My counsellor reaffirmed many things I already knew.	0.46
71	My counsellor's office space was professional but cozy and intimate, and had warm colours and a pleasant view.	0.46
64	At the first session we discussed the direction the counselling would take – what I wanted from it, what the counsellor could offer me, and what approach we would use.	0.47
66	When my counsellor's schedule was full he/she moved things around so I could have an appointment the following week.	0.48
86	My counsellor asked lots of questions and wasn't afraid to take more talk time than me.	0.48

92	My counsellor told me that my mother had approached the counsellor after one of my sessions and assured me that the counsellor had allowed none of my privacy to be invaded.	0.48
72	My counsellor was very reassuring, i.e. saying "you're on the right path" or "I think this is the right thing for you to do".	0.49
2	My counsellor helped me with tangible things related to my problems, contacting doctors and other professionals, as well as informing me of the variety of resources available.	0.50
65	When my counsellor gave me a task/homework he/she gave me ideas on how to complete it, and we talked about what I would do to try and complete it.	0.51
76	I knew that if I was in a distressed state, I could get in contact with my counsellor.	0.51
39	My counsellor would sometimes ask specifically what I wanted to accomplish or what would need to happen to make me feel better.	0.52
50	My counsellor always made time for me. He/she would always fit me in somehow.	0.52
5	My counsellor was direct and straightforward regarding possible outcomes to my situation.	0.52
77	My counsellor was always willing to help me with forms or provide me with information about a particular program	0.53
83	My counsellor was able to understand the root/source of the problem before I even understood.	0.53

55	My counsellor went beyond his/her duties and showed he/she sincerely cared.	0.54
45	My counsellor and I devised homework together, tailoring the information and exercises, and we always went over the homework at the next session.	0.54
15	My counsellor monitored shifts in perception throughout the counselling process and was able to chart perceptual movement and major changes.	0.55
20	My counsellor was genuinely concerned for my well-being and sometimes gave me a call or asked me to leave a message to see how things were going.	0.56
46	My counsellor appeared to be in my age group.	0.57
73	My counsellor was positive and encouraging. He/she always pointed out the good things I was doing and the progress I had made.	0.62
84	My counsellor was the same gender as me.	0.63
119	My counsellor helped me see positives in myself, through analogies and mental exercises.	0.63
91	My counsellor assured me that he/she was realistic about the life the average person carried out.	0.67
47	My counsellor gave me names of authors, names of books, and we discussed new age theories that I hadn't heard of before.	0.71
19	My counsellor was very interested in other ways of healing (e.g. my spiritual guide).	0.89

21	My counsellor worked close to where I lived and worked.	1.00

For example, Statement 109, which describes the clinician sharing stories from personal experience, had a bridging value of 0.00. This means that all participants more often sorted it in an identical manner, in relation to the other statements, and it is therefore associated with the lowest possible bridging value.

Conversely, Statement 21, "My counsellor worked close to where I lived and worked", was understood very differently by participants and was sorted with a wide variety of other statements, yielding the highest possible bridging value (1.00). This result demonstrates how one statement, although seemingly a very concrete idea, can be interpreted very differently by participants in the study. Further, it limits the validity of the statements' placement in a specific category.

Results Related to Non-metric Multidimensional Scaling (nMDS)

Stress and Dimension Selection

A two-dimensional nMDS solution was selected for the nMDS analysis. Concept Systems computes the two-dimensional solution using a Group Similarity Matrix (GSM). The final stress was .29, .16 *SD* above the average stress value across 38 MVCM studies (Trochim, 1993). Although this is higher than much of the literature for multidimensional scaling suggests is optimal, these studies in the literature are typically measuring more stable phenomena that can be measured more precisely (i.e. perception of color similarities). Thus, the abstract nature of the data for concept mapping studies using sorting for similarity measurement data, such as the present study, often yields higher, but acceptable, stress values (Trochim, 1993).

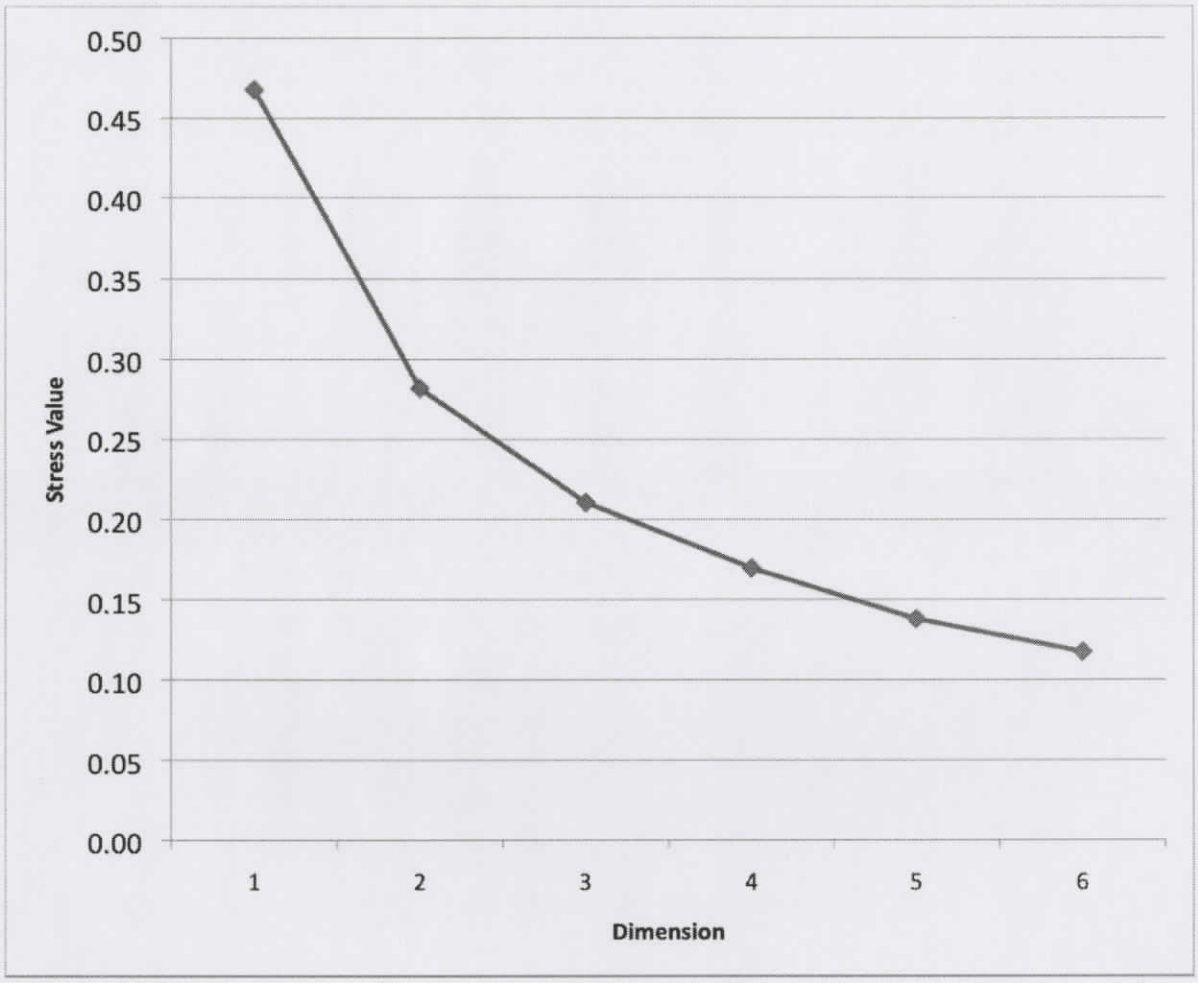
The two-dimensional solution is often considered the most useful for providing a descriptive model that is appropriate for interpretability of the data (Kruskal & Wish, 1978). However, it is prudent to minimize stress, therefore the comparison of stress values for each of the six dimensions is useful to demonstrate that the two-dimensional solution is acceptable (Kruskal & Wish). The most significant reduction in stress values was attained at the two-dimensional solution. Stress values for each dimension (calculated in SPSS) are presented in Table 6 and plotted in Figure 1.

Table 6

Stress Values (Calculated in SPSS) for One to Six Dimensions

Dimension	Stress Value
1	0.47
2	0.28
3	0.21
4	0.17
5	0.14
6	0.12

Figure 1. Stress values for one to six-dimensional solutions.



Statement Coordinate Maps

The Statement Point Map of the two-dimensional nMDS coordinates is shown below in *Figure* 2.1 (without statement numbers) and in *Figure* 2.2 (with statements numbers). The map without statement numbers provides a clear view of the plotted coordinates for each statement and possible clustering patterns).

Figure 2.1. Statement point map of two-dimensional nMDS coordinates (without statement numbers).

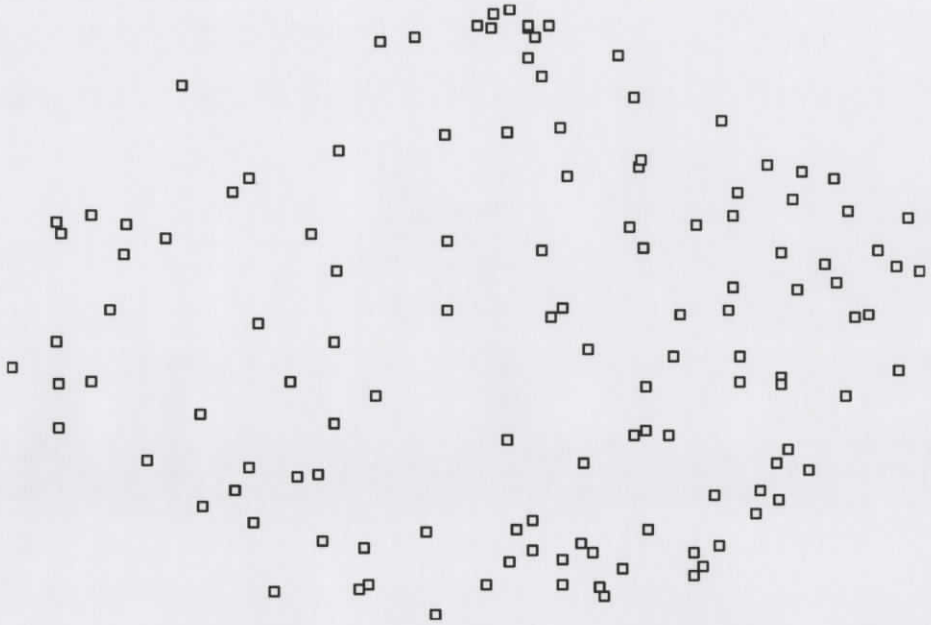
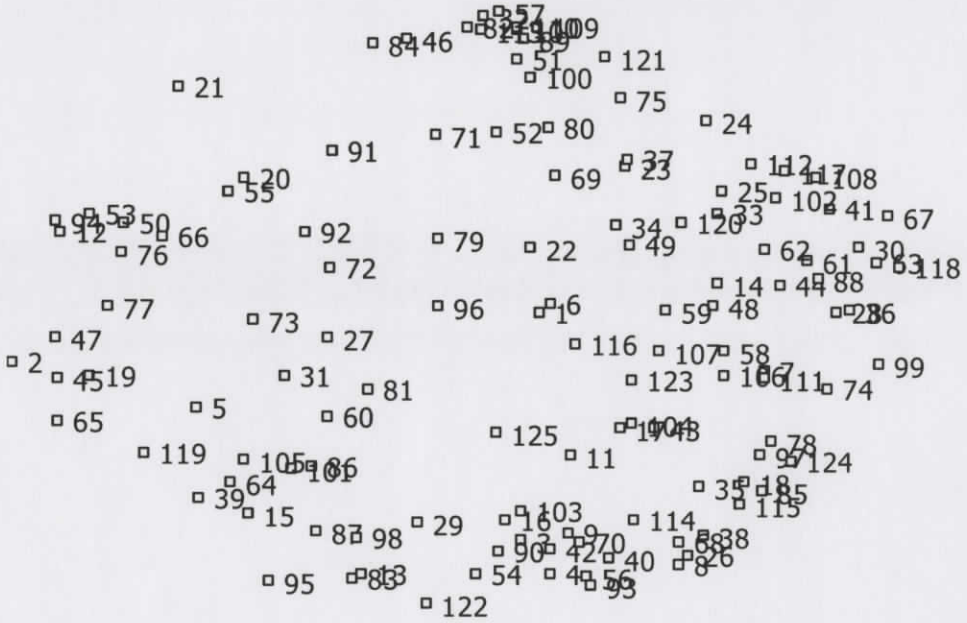


Figure 2.2. Statement point map of two-dimensional nMDS coordinates (with statement numbers).



The spread of distance between points on the Statement Point Maps (see *Figures* 2.1 and 2.2) visually demonstrates the different conceptual associations between elicited factors in alliance formation perceived by participants. Statements that are represented close together on the Statement Point Map are perceived to be more conceptually similar, on average, across participants than statements that are represented on opposite sides of the map. For example, Statement #2, "My counsellor helped me with tangible things related to my problems, contacting doctors and other professional, as well as informing me of the variety of resources available", and Statement #99, "My counsellor made lots of eye contact, didn't make notes, and tilted his/her head in sympathy", are seen as conceptually different and therefore fall on opposite sides of the map. Alternately, Statement #2 and Statement #47, "My counsellor gave me names of authors, names of books", and "discussed new age theories that I hadn't heard of before", are seen as conceptually similar by participants and therefore are plotted very close to each other on the map.

Statement Bridging Maps

The Statement Bridging Maps (with and without statement numbers) are presented in *Figure 3*.1 and *Figure* 3.2. These two figures represent the overlaying of bridging values on the nMDS plotted coordinates. Bridging values can be seen more clearly in *Figure* 3.1 - without statement numbers. See Table 5 for specific bridging values associated with each statement.

Figure 3.1. Statement bridging map without statement numbers.

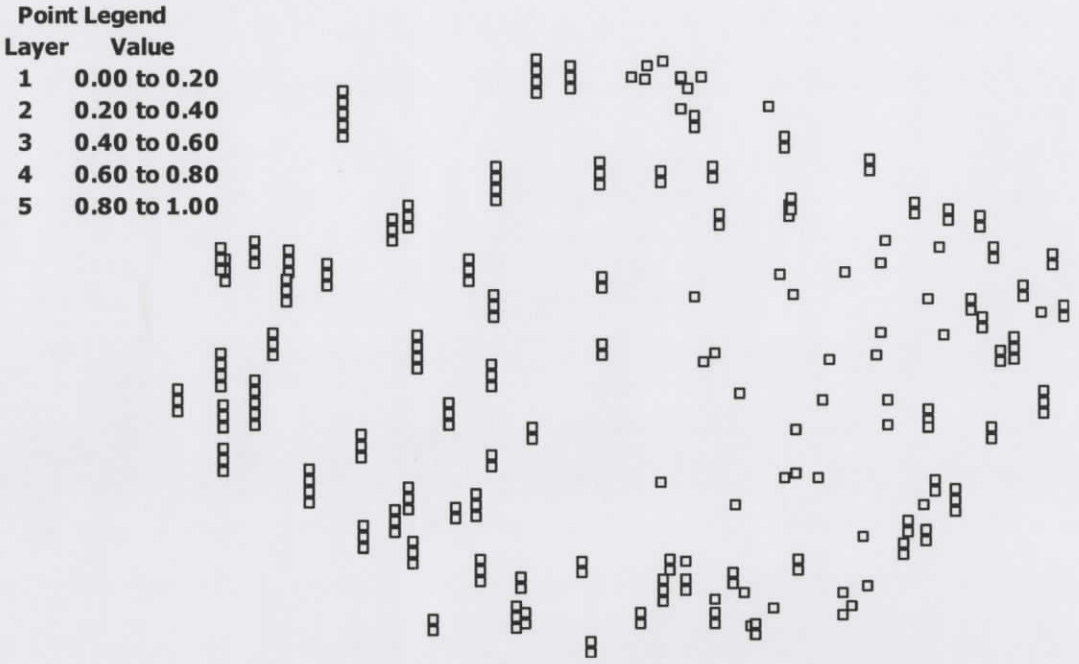
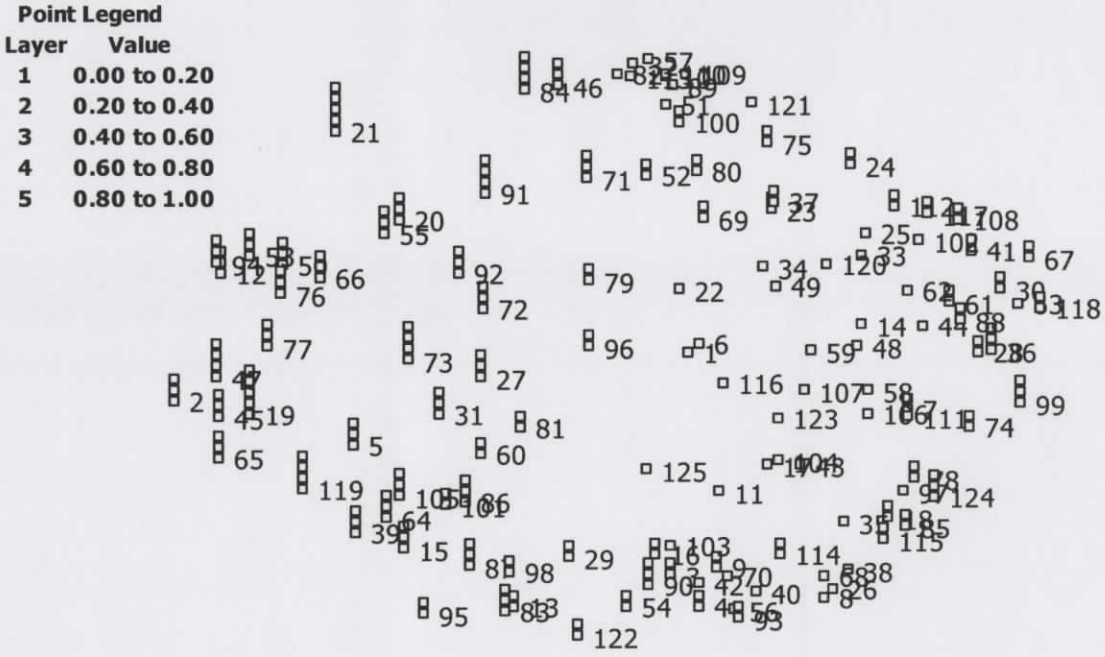


Figure 3.2. Statement bridging map with statement numbers.



The Statement Bridging Maps visually illustrate how conceptually homogenous participants view statements to be. The more conceptually homogenous statements are associated with low bridging values (i.e., one layer or small square versus five layers or small squares). As seen in *Figure* 3.1 and 3.2, most of the lowest bridging values (or conceptually similar statements) are found just below the top of the Statement Bridging Map and down to the right of the center line (i.e., Statements 121, 34, 22, 6, and 125 etc.) Many higher bridging values (and less conceptually homogenous statements) are found on the left side of the map (i.e., Statements 21, 91, 73, 119, and 19 etc.).

Statement Rating Maps

Statement Rating Maps are presented in *Figure* 4.1 and *Figure* 4.2. These figures represent the overlaying of ratings of helpfulness in alliance formation for each statement in nMDS coordinates.

Figure 4.1. Statement helpfulness rating map without statement numbers.

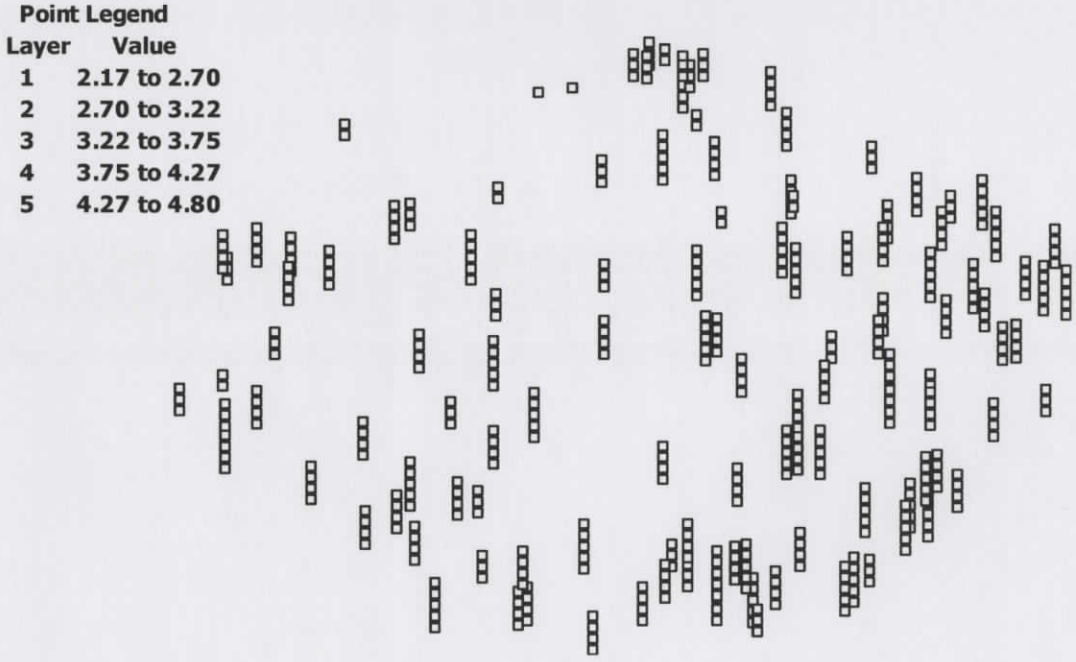


Figure 4.2. Statement helpfulness rating map with statement numbers



The Statement Helpfulness Rating Maps visually demonstrate which factors participants believed to be most and least helpful. Statements associated with 5 layers on this map, were reported to be the most helpful (i.e., Statements 65, 95, 92, and 81 etc.), and those with only 1 layer were reported to be the least helpful (i.e., Statements 84 and 46).

Results Related to Hierarchical Cluster Analysis (hCA)

The following section presents the empirical justification for the selection of a 14 cluster solution to best describe the 125 statement coordinates, the rationale for the selection of descriptive titles for each cluster, the statement composition of each cluster/category, cluster maps, cluster bridging values, and average ratings of helpfulness for each cluster in facilitating alliance formation.

Cluster Solution Selection

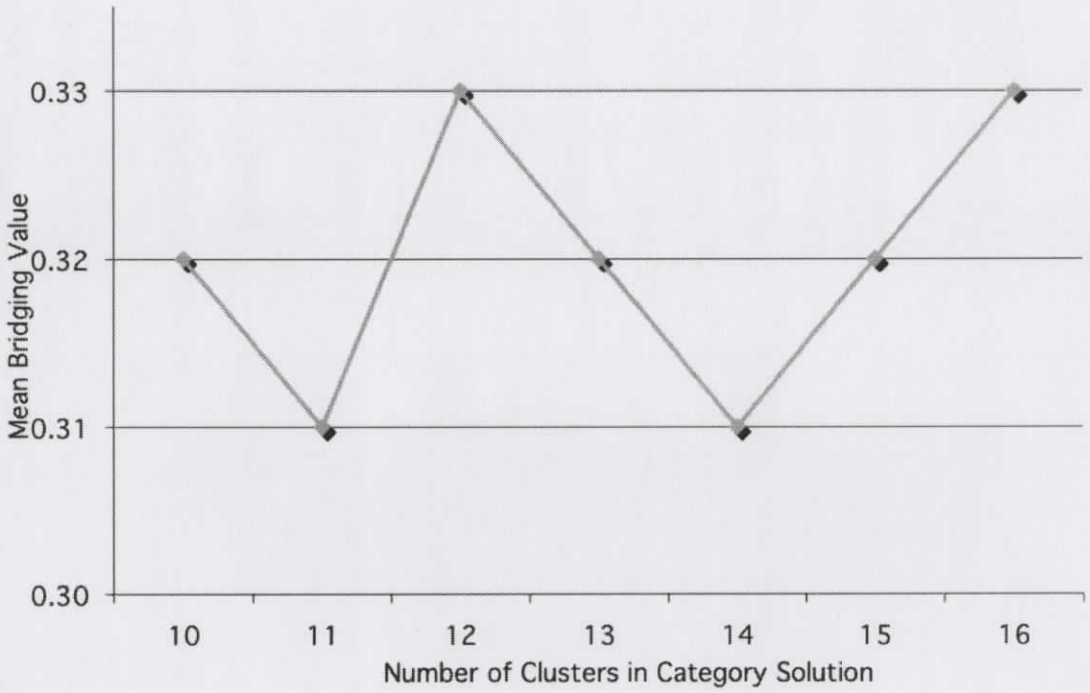
Hierarchical cluster analysis (hCA) was employed to mathematically construct cluster solutions to represent the statements as presented on the point map. Concept Systems Cluster Replay Map and Analysis generates cluster solutions from the 20 cluster solution down to the 3 cluster solution. The solutions are examined in order to select the most representative cluster solution. Four heuristics were employed in this selection process:

1. average number of piles created by participants
2. the median number of piles created by participants
3. average bridging values for each cluster solution
4. interpretability of statements within each cluster solution.

Initial consideration was given to central tendency with regard to the number of piles selected by the participants ($M = 13.17$ ($SD = 6.68$); *Median* = 14). The cluster solutions close to these numbers (i.e., 10 - 16) whose mean bridging values were .32, .31, .33, .32, .31, .32, and .33 respectively (see *Figure 5*) were examined for bridging values and interpretability. The 14 cluster solution (which was the median number of piles created by the participants) had the lowest bridging value, by a slight margin ($M = 0.31$, 0.17 *SD*). Further, examination of the interpretability of cluster solutions (beginning with the 20 cluster solution and reviewing cluster solutions in decreasing order from 20 to 8), showed interpretability to be more difficult and less justifiable after the 14^{th} cluster solution. Interpretability of statements in combining clusters made sense and seemed reasonable until the 13^{th} cluster solution, and average cluster bridging values were lowest at the 14^{th} cluster solution (0.31). The 14 cluster solution fell within 0.12 *SD* of the mean number of piles created by participants. The difficulty interpreting the 13 cluster solution, the slightly higher bridging value associated with the 13 cluster solution, along with a

median value of 14 piles per participant, supported the selection of the 14 cluster solution as the best representative fit across participants.

Figure 5. Mean bridging values for cluster solution.



Cluster Titles Selection

In selecting the most appropriate title for each of the 14 clusters, participant provided titles were examined for the best representation of the statements in each category. Specifically, Concept Systems Incorporated ® (2008) identifies the 10 titles that fall closest to the centroid of each cluster (in terms of Euclidian distance). In order to choose the title which would best represent the concept described by the statements in each cluster, the researchers considered the

1. list of possible titles
2. content of the statements comprising each cluster
3. bridging values associated with each statement and cluster

Notable weight was given to the title that fell closest to the centroid of the cluster. Further consideration was given to the repetition of words or concepts represented in the complete list of 10 suggestions. The selected titles for the 14 clusters are: Emotional Support, Ability to Relate, Sharing the Counsellor's Personal Experience, Good Boundaries, Interpersonal Demeanour, Body Language, Provided Resources and Homework, Availability, Planning and Approach, Directed Process Appropriately, Attentiveness, Approachable, Non-Judgemental, and Effective Listening. The final title selections along with the 10 closest client suggested titles are listed in Table 7. Participant suggested titles that match the selected title are shown in bold type.

Table 7

Final Selected Title for Each Cluster and the 10 Closest (in terms of Euclidian distance) Individual Titles Associated With Each Cluster

	Selected Title	10 Closest Individual Sort Titles [a]
1.	Emotional Support [b]	Reinforcement
		Emotional Support
		Trust/Confidentiality
		Trusting
		Professional
		Grounding Approach
		Power Struggle
		How the Counsellor Made Me Feel
		Professional
		Professionalism
2.	Ability to Relate [b]	**Ability to Relate** Outside Peer Group
		Client-counsellor Boundary
		Accessibility
		Organizational
		Office Space/Décor
		Location

		Office
		Similarities/On the Same Level/Small Details
		Convenience
		Comfort in Setting
3.	Sharing the Counsellor's Personal Experience	**Sharing the Counsellor's Personal Experience**
		Relate to Experiences of Counsellor in Work/Personal Life
		Counsellor's Personal Sharing (Insufficient Boundaries)
		Self-disclosure
		Disclosure
		Personal Experience/Openness
		Empathy
		Disclosure
		Counsellor Sharing Personal Life with Client
		Comparing/Relating To
4.	Good Boundaries	**Good Boundaries**
		Maintains Professional Distance
		Building a Less Intense Environment (Casual)
		Sense of Humour
		Almost Friendship
		Genuine
		Age

		Relatedness
		Doctor Relation
		Trustworthy
5.	Interpersonal Demeanour	Personal Characteristics of Counsellor
		Treats Me Like an Individual
		Counsellor's Non-verbal Skills
		Descriptive Info About the Counsellor
		Interpersonal Demeanour
		Being Treated as an Individual/Equal
		Small Talk
		Small Talk Ability of the Counsellor
		Acknowledgement (of individual circumstances or challenges)
6.	Body Language [b]	Physical Presence/Attentiveness
		Positive **Body Language**
		Good **Body Language**
		Demeanour - **Body Language**
		Body Language
		Body Language
		Body Language/Tone/Eye contact
		Body Language of Counsellor
		Body Language
		Mannerisms (how he/she talks)

7.	Provided Resources & Homework [b]	Strategies for Success
		Alternate Methods Resources
		Multidimensional
		Interests Outside of Counselling Realm
		Open Mindedness
		Learning
		Opening New Awareness
		Homework
		Provided Resources and Homework
		Homework/Extra Reading
8.	Availability [b]	Counsellor Contact-ability (Phone, Email, etc.) **Availability**
		Availability
		Available Beyond Sessions
		Accommodating
		Above and Beyond
		Accommodating Flexible
		Above and Beyond
		Helpful Outside of Session
		Practical
		Available

9.	Planning & Approach	**Planning and Approach**
		Honesty
		Strategies (Prudence)
		Informative
		Helpfulness of Counsellor
		Honest/Straightforward
		Clear Objective
		Guidance
		Providing Focus/Structure to the Process
		Direct/Doesn't Skirt Around Important Issues
10.	Directed Process	Taking Action on the Problem
	Appropriately [b]	Counsellor Helps Me to Find My Own Answers
		Counsellor Was knowledgeable
		Root Problem
		Expertise
		Skilled Counsellor
		Can Identify Source/Problem
		Tools for Helping the Process Move Along
		Directed Conversation **Appropriately**
		Familiar With Client Thought

11.	Attentiveness	Paraphrasing
		Not Make Assumptions
		Non-assuming
		Counsellor **Attentiveness**/Listening/Perceiving
		Listening
		Unassuming
		Feedback
		Lack of Direction
		Listened **Attentively**
		Paraphrased What Client Said
12.	Approachable [b]	**Approachable**
		Counsellor Memory
		Personal Knowledge Regarding Me
		Counsellor Remembered
		Open/Light/Warm Listening Style
		Ability to Remember Things About Patient
		Good Memory (Comprehension)
		Tone of Voice
		Respect
		Emotional Safety in Counselling Session

13.	Non-judgmental [b]	Comfort Level for Client
		Patient, Instilled Trust
		Non-pushy
		Not Take Client's Statements Personally
		Respect
		Intuitive, Let Patient Lead, Almost Passive
		Sympathy
		Non-judgmental
		Relationship Between Counsellor and Client
		Unconditional Positive Regard
14.	Effective Listening [b]	Presence and Commitment
		Being Heard
		Effective Listening and Recall
		How Counsellor Recorded Session
		Listening Skills
		Listening
		Counsellor's **Listening** Skills
		Listens and Remembers/Interested
		Counsellor Respects Emotional Boundaries
		Counsellor's **Listening** Ability

[a] The titles listed in this column are the actual titles given by participants and are listed in ascending order of geometrical distance from the centroid of each final cluster when plotted in two-dimensional nMDS space.

[b] Although the chosen title is not the one that falls *geometrically* closest to the centroid of the cluster, it seems to *linguistically* be the best representation of the concept described by the statements in the cluster.

Statement Composition of Each Cluster

The statements that make up each of the 14 clusters are presented in Table 8. The table allows for examination of the individual statements with respect to the chosen title. Statements in each cluster are ordered from highest to lowest helpfulness ratings.

Table 8

Statement Composition of Each Cluster

Cluster	Statements
Emotional Support	My counsellor provided me with emotional support and was able to express sympathy.
	My counsellor gave me permission to cry. He/she showed empathy without becoming involved in my emotion.
	My counsellor had a non-judgmental and supportive manner and was familiar with the subject.
	My counsellor tried to get to know me before he/she offered advice.

	My counsellor was open about the fact that there was a monetary factor in our relationship. When I said that I wouldn't be able to afford to come in for awhile, my counsellor did not become uncomfortable.
	My counsellor maintained a sense of confidentiality and sincerity.
Ability to Relate	My counsellor went beyond his/her duties and showed he/she sincerely cared.
	My counsellor was very reassuring, i.e. saying "you're on the right path" or "I think this is the right thing for you to do".
	My counsellor was genuinely concerned for my well-being and sometimes gave me a call or asked me to leave a message to see how things were going.
	My counsellor's office space was professional but cozy and intimate, and had warm colours and a pleasant view.
	My counsellor assured me that he/she was realistic about the life the average person carried out.
	My counsellor told me that my mother had approached the counsellor after one of my sessions and assured me that the counsellor had allowed none of my privacy to be invaded.
	My counsellor worked close to where I lived and worked.
	My counsellor was the same gender as me.
	My counsellor appeared to be in my age group.

Sharing the Counsellor's Personal Experience	My counsellor would add things about him/herself in relation to what I was saying and did not act like an authority/medical figure to me.
	My counsellor revealed to me within the first few sessions that he/she had battled the same issue as me in the past.
	My counsellor shared his/her personal experience with me when we were in sessions.
	My counsellor told stories from his/her own life and professional career.
	My counsellor used his/her real life experiences and examples from others he/she knew.
	My counsellor shared stories about his/her own family and relationships, and issues that were troubling for him/her in those relationships.
	My counsellor shared a personal anecdote with me.
	In the first session, I was allowed to spend the whole hour telling my life story and the counsellor briefly shared the same circumstance that happened to him/her.
	My counsellor told me information about his/her life and relationships with his/her children.
	My counsellor shared his/her previous issues.
Good Boundaries	My counsellor assured me that what we discussed would never leave the room without my permission. I was not being judged (my issues were things he/she dealt with all the time) and my counsellor also gave me some personal history of his/her past issues.

My counsellor struck a good balance between the professional and personal aspects of our relationship. He/she was friendly, would talk about her/his experiences when they were relevant, but he/she had clear and firm boundaries with me.

My counsellor was a real and honest person who was open to connecting on an emotional and spiritual level through self-disclosing appropriately and allowing me to know when I had impacted her/him.

My counsellor was polite and respectful and showed this through smiling, handshaking, greeting, and taking time to answer questions outside of regular sessions.

My counsellor shared idiosyncrasies that made him/her seem human. This openness was also seen in my counsellor's ability to laugh and joke, and recognize that I was sometimes joking too!

My counsellor had a sense of humour; cracking jokes, sarcastic remarks, and laughing.

My counsellor dressed professionally; the office was clean, warmly decorated, and organized.

My counsellor was able to small talk about things like office decorations, music, and various things but still remain professional and not too personal.

Interpersonal Demeanour	My counsellor genuinely smiled.
	I didn't feel as though my counsellor was "studying" me or that I was just another chore or patient on his/her schedule of people or things to do and see that day.
	My counsellor treated me more like a person in need than a "client".
	My counsellor treated me as an individual and not as a type, and my objections to completing classification questionnaires were acceptable to my counsellor.
	My counsellor always seemed happy to see me, greeting me with warmth and a solid hug. He/she commented on my strengths as an individual and expressed heartfelt happiness when things in my life were going well.
	My counsellor treated me as an individual with unique problems/issues, called me by name or nickname, and made me feel like I was the only person they had seen that day.
	I was offered tea and welcomed not as a patient, but as an equal human being and there was a sense that I was in control of the session.
	My counsellor's voice was calm, nurturing, and somewhat monotone.
	Although my counsellor disclosed a couple things, I never felt like the focus was on him/her.
	My counsellor carved out a space for humour when appropriate.
	My counsellor was not "mother" like, which helped me feel comfortable addressing more than surface issues.
	My ability to open up, trust and talk to my counsellor.

My counsellor was positive, cheerful, didn't say 'oh how bad", looked at the good side of things, and smiled.

Body Language

The way my counsellor sat, moved, etc. indicated that he/she was comfortable and he/she was not somehow threatened, closed-off, or upset.

My counsellor had good body language – he/she shook hands, seemed relaxed, and made eye contact.

My counsellor was warm and friendly when greeting me; he/she made eye contact, remembered my name, and offered me a coffee.

My counsellor was friendly and made an effort to begin appointments with small talk and my counsellor made a point of remembering details about my life not related to the problems I saw him/her for.

My counsellor treated me as an intelligent and normal person. He/she saw me as an individual, and more than a condition or problem.

My counsellor was very present to me; to my energy, and to the truths in my body.

My counsellor remembered small things and treated me like he/she actually knew me.

My counsellor maintained a light tone and not a harsh, confrontational tone.

My counsellor was happy looking and his/her body language was peaceful and calm.

My counsellor was consistent and calm and gave me tea.

	My counsellor was friendly (but not overly so), quiet, and didn't rush me at all.
Provided Resources & Homework	When my counsellor gave me a task/homework he/she gave me ideas on how to complete it, and we talked about what I would do to try and complete it.
	My counsellor was always willing to help me with forms or provide me with information about a particular program.
	My counsellor helped me with tangible things related to my problems, contacting doctors and other professionals, as well as informing me of the variety of resources available.
	My counsellor and I devised homework together, tailoring the information and exercises, and we always went over the homework at the next session.
	My counsellor gave me names of authors, names of books, and we discussed new age theories that I hadn't heard of before.
	My counsellor was very interested in other ways of healing (e.g. my spiritual guide).
Availability	I knew that if I was in a distressed state, I could get in contact with my counsellor.
	When my counsellor's schedule was full he/she moved things around so I could have an appointment the following week.
	My counsellor would do extra legwork and would accommodate my

	needs regarding session times, session frequency, personal goals, etc.
	My counsellor always made time for me. He/she would always fit me in somehow.
	My counsellor provided assistance outside of our sessions by allowing me to e-mail to ask questions.
	My counsellor was willing to call me and have further phone conversations about additional thoughts after a session if he/she felt he/she had misinterpreted/misread anything we discussed and was open for me to do the same.
Planning & Approach	My counsellor picked a method that seemed right for me.
	At the first session we discussed the direction the counselling would take – what I wanted from it, what the counsellor could offer me, and what approach we would use.
	My counsellor would sometimes ask specifically what I wanted to accomplish or what would need to happen to make me feel better.
	My counsellor helped me see positives in myself, through analogies and mental exercises.
	My counsellor explained his/her approach to counselling to me on the phone before we had our first appointment and the reasons why he/she used the counselling techniques.
	My counsellor was positive and encouraging. He/she always pointed out the good things I was doing and the progress I had made.

	My counsellor monitored shifts in perception throughout the counselling process and was able to chart perceptual movement and major changes.
	My counsellor was direct and straightforward regarding possible outcomes to my situation.
	My counsellor asked lots of questions and wasn't afraid to take more talk time than me.
	My counsellor was upfront and told me to not tell him/her what he/she wanted to hear.
	My counsellor met me where I was, but knew when to challenge me and was very honest.
	My counsellor encouraged me to come back and was interested to know how/if things had progressed.
	My counsellor didn't talk down to me and was honest and straightforward in her/his reactions to my problems and thoughts. He/she didn't try to convince me that everything was fine when it wasn't.
Directed Process Appropriately	My counsellor asked me to return to the underlying issues when I had digressed.
	My counsellor facilitated my thought process and allowed me to find my own answers, rather than directing he/she made me feel like I had the answers, and it was just a matter of uncovering them.
	My counsellor understood where I was going with a train of thought when I got stuck trying to explain something.

	My counsellor reaffirmed many things I already knew.
	My counsellor was able to understand the root/source of the problem before I even understood.
	My counsellor was willing to look at what I felt was important.
Attentiveness	My counsellor listened very well. He/she would speak when I stopped talking or when I asked a direct question and would ask excellent thought provoking questions and give his/her own opinion.
	My counsellor paraphrased what I said.
	My counsellor asked specific questions that made me sure he/she was thinking carefully about what I was saying.
	My counsellor openly invited me to share my concerns and didn't make any assumptions about what was happening or what I was feeling.
	My counsellor sat patiently and helped me find my voice to figure out what I needed to say by giving me time and encouraging me.
	My counsellor encouraged me to talk or cry, would listen to me talk in a negative way about myself, and would accept my thoughts before gently asking questions that shed new light on the origins or fallibility of these thoughts.
	My counsellor listened, validated my feelings, and told me what I was experiencing was normal.
	My counsellor let me guide the subject matter of our meetings; anything was acceptable to talk about.

	My counsellor asked "what is bothering you the most?" and his/her quiet, warm and non-rushing manner gave me time to think about it seriously. My counsellor gained knowledge by what I told him/her and did not assume other aspects that may have seemed possible. My counsellor took my perceptions and beliefs at face value without putting his/her meaning on my experience. My counsellor worked with me, not the counsellor's story of me. My counsellor was sympathetic and able to see my perspective, could 'take my side' when I needed support, could be a bit biased in my favour, and could "paraphrase" or summarize my most recent issue.
Approachable	My counsellor was non-judgmental. He/she didn't criticize anything I had done. My counsellor made him/herself very approachable as someone who listened to me and how I felt. My counsellor never showed shock, disgust, or any abnormality when I showed how I felt or what I thought. My counsellor facilitated the creation of an environment where I could express myself without him/her panicking. He/she did not show fear or impinge on my right to experience the feeling I needed to get better. My counsellor did not invade my personal space, and had a non-aggressive, non-judgmental, and respectful attitude towards me. My counsellor made lots of eye contact, didn't make notes, and tilted

	his/her head in sympathy.
Non-judgmental	My counsellor didn't judge me. He/she stepped into my world and my meanings and worked from that place.
	My counsellor did not judge me and made me feel like everything I was dealing with was normal.
	My counsellor stressed that I was not crazy even when I believed I was.
	He/she would not make fun or make light of any thought/feeling I shared.
	My counsellor asked questions gently but fearlessly, rather than "judge" the individual aspects of my story.
	When I told my counsellor that I was uncomfortable with a certain subject, he/she never mentioned it again without asking first whether he/she could or not, unless I brought it up first.
	My counsellor was open to being challenged on any comments or observations etc. and did not take offence.
	Nothing was able to faze the working relationship. The counsellor remained solid.
Effective	My counsellor listened attentively.
Listening	My counsellor listened, accepted, and encouraged me to open up.
	My counsellor always remembered very specific details about my life and circumstances.

My counsellor listened to my stressors and established trust.

My counsellor listened with undivided attention and did not interrupt with analytical questions before my story was over.

My counsellor smiled and listened to my issues, but didn't make me feel like I was alone or different.

My counsellor was interested in what I wanted to say.

My counsellor asked about things in my life other than the problem I was there for and remembered things I had mentioned in previous sessions.

My counsellor was very intuitive and empathic. I knew that my counsellor would know if I wasn't telling the truth or was holding back about something.

My counsellor always remembered my life events and didn't have to refer to a file.

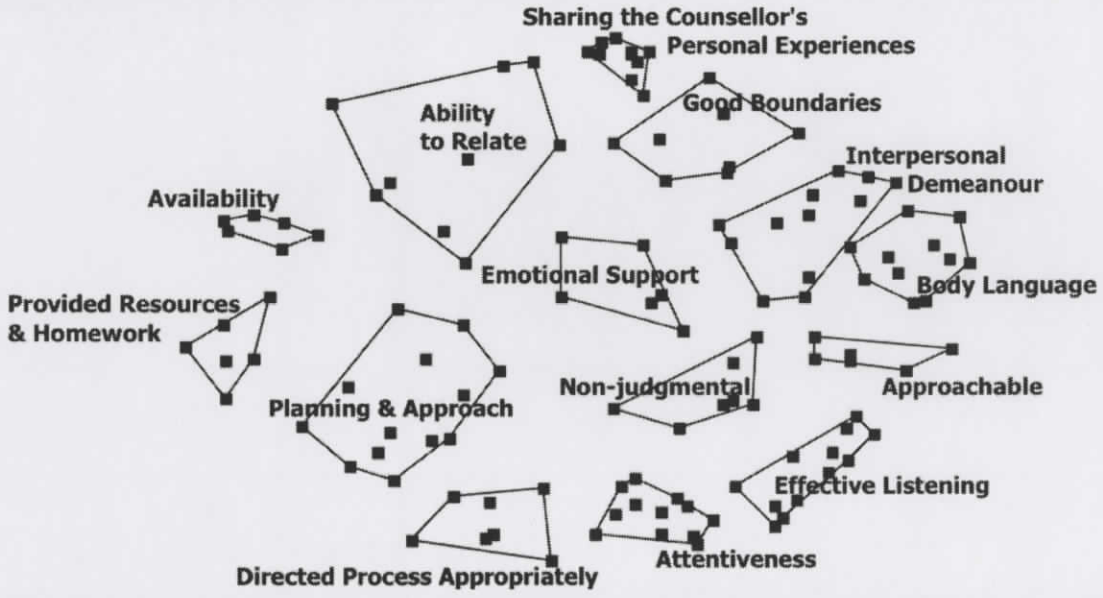
My counsellor listened very intently and took good notes of whatever he/she thought was important.

My counsellor never pushed for questions. He/she simply expressed interest and was a good listener.

Cluster Maps

The cluster map for the final solution is presented in *Figure* 6. This map combines the nMDS statement coordinates, the hCA cluster solution, and the selected category labels and presents them in a visual format. Participants identified 14 categories of statements to best describe their understanding of what was helpful in developing a good relationship with their clinician.

Figure 6. Cluster map showing categories of client-identified factors helpful in alliance formation.



As can be seen from the cluster map in *Figure 6,* participants identified 14 categories they perceived to be most helpful in establishing a strong therapeutic alliance with their clinician: Emotional Support, Ability to Relate, Sharing the Counsellor's Personal Experiences, Good Boundaries, Interpersonal Demeanour, Body Language, Provided Resources & Homework,

Availability, Planning & Approach, Directed Process Appropriately, Attentiveness, Approachable, Non-judgmental, and Effective Listening.

In the cluster map shown in *Figure 6,* proximity is an indicator of conceptual similarity; categories that are closer together on the map are perceived by participants as being more conceptually similar than categories that are farther apart. For example, "Body Language" and "Interpersonal Demeanour" are understood to be more similar in meaning than "Body Language" and "Provided Resources & Homework". Similarly, "Provided Resources & Homework is understood to be more similar to "Planning & Approach" than "Approachable" or "Effective Listening". Concepts that are intuitively perceived to be similar by the participants in this study are generally reflected in the spatial proximity of categories on the map. However, it important to note that statement inclusion in a category does not always precisely reflect this perception. Specifically, statements located at the edges of the cluster may in fact be closer to statements in the adjoining cluster. Cluster selection, as performed by statistical software, is not able to interpret meaning and therefore can only be taken to show the best statistical estimation of the data which would be best further interpreted by participants.

Further, the geometric size of the category is negatively related to the relative conceptual consistency of the category. Larger sized categories generally indicate a higher bridging value and imply that *less* conceptually homogenous statements make up the category. Categories that are smaller are perceived across participants as being *more* conceptually homogenous (i.e. they were more often sorted the same way across participants) and tend to have lower bridging values. For example, the statements comprising the category titled "Sharing the Counsellors Personal Experiences", were sorted very similarly and therefore are perceived to be *more* conceptually homogenous. Conversely, the statements that make up the category "Ability to Relate" were

sorted together less often across participants and therefore are perceived to be *less* conceptually homogenous.

Bridging Values for Statements in Each Cluster

Bridging values have a possible range of 0 to 1, where lower numbers indicate that participants viewed the statements as more conceptually similar (participants sorted them together more often) and higher numbers indicate less conceptually similar statements (participants sorted these together less often). Bridging values for statements in each category are presented in Table 9, along with the mean bridging value for that category.

Table 9

Bridging Values

Category	Statements	Bridging Value
Sharing the Counsellor's Personal Experiences	My counsellor shared stories about his/her own family and relationships, and issues that were troubling for him/her in those relationships.	.00
	My counsellor shared his/her previous issues.	.01
	My counsellor used his/her real life experiences and examples from others he/she knew.	.01
	My counsellor told me information about his/her life and	.02

	relationships with his/her children.	
	My counsellor shared his/her personal experience with me when we were in sessions.	.02
	My counsellor told stories from his/her own life and professional career.	.06
	My counsellor would add things about him/herself in relation to what I was saying and did not act like an authority/medical figure to me.	.07
	My counsellor shared a personal anecdote with me.	.08
	My counsellor revealed to me within the first few sessions that he/she had battled the same issue as me in the past.	.15
	In the first session, I was allowed to spend the whole hour telling my life story and the counsellor briefly shared the same circumstance that happened to him/her.	.27
	Mean Bridging Value	**.07**
Non-judgmental	My counsellor did not judge me and made me feel like everything I was dealing with was normal.	.03
	My counsellor stressed that I was not crazy even when I believed I was. He/she would not make fun or make light of any thought/feeling I shared.	.08
	My counsellor didn't judge me. He/she stepped into my world and	.08

	my meanings and worked from that place.	
	My counsellor asked questions gently but fearlessly, rather than "judge" the individual aspects of my story.	.10
	Nothing was able to faze the working relationship. The counsellor remained solid.	.11
	My counsellor was open to being challenged on any comments or observations etc. and did not take offence.	.17
	When I told my counsellor that I was uncomfortable with a certain subject, he/she never mentioned it again without asking first whether he/she could or not, unless I brought it up first.	.17
	Mean Bridging Value	**.11**
Interpersonal Demeanour	My counsellor was not "mother" like, which helped me feel comfortable addressing more than surface issues.	.11
	My counsellor treated me as an individual and not as a type, and my objections to completing classification questionnaires were acceptable to my counsellor.	.13
	I didn't feel as though my counsellor was "studying" me or that I was just another chore or patient on his/her schedule of people or things to do and see that day.	.14
	My ability to open up, trust and talk to my counsellor.	.16
	My counsellor's voice was calm, nurturing, and somewhat	.18

	monotone. Although my counsellor disclosed a couple things, I never felt like the focus was on him/her.	
	My counsellor treated me as an individual with unique problems/issues, called me by name or nickname, and made me feel like I was the only person they had seen that day.	.18
	My counsellor treated me more like a person in need than a "client".	.18
	I was offered tea and welcomed not as a patient, but as an equal human being and there was a sense that I was in control of the session.	.20
	My counsellor carved out a space for humour when appropriate.	.20
	My counsellor genuinely smiled.	.28
	My counsellor always seemed happy to see me, greeting me with warmth and a solid hug. He/she commented on my strengths as an individual and expressed heartfelt happiness when things in my life were going well.	.31
	My counsellor was positive, cheerful, didn't say 'oh how bad", looked at the good side of things, and smiled.	.31
	Mean Bridging Value	**.20**
Emotional Support	My counsellor gave me permission to cry. He/she showed empathy without becoming involved in my emotion.	.11
	My counsellor had a non-judgmental and supportive manner and	.13

	was familiar with the subject.	
	My counsellor maintained a sense of confidentiality and sincerity.	.18
	My counsellor tried to get to know me before he/she offered advice.	.19
	My counsellor provided me with emotional support and was able to express sympathy.	.31
	My counsellor was open about the fact that there was a monetary factor in our relationship. When I said that I wouldn't be able to afford to come in for awhile, my counsellor did not become uncomfortable.	.32
	Mean Bridging Value	**.21**
Attentiveness	My counsellor took my perceptions and beliefs at face value without putting his/her meaning on my experience.	.12
	My counsellor worked with me, not the counsellor's story of me.	
	My counsellor listened very well. He/she would speak when I stopped talking or when I asked a direct question and would ask excellent thought provoking questions and give his/her own opinion.	.15
	My counsellor sat patiently and helped me find my voice to figure out what I needed to say by giving me time and encouraging me.	.16
	My counsellor asked specific questions that made me sure he/she was thinking carefully about what I was saying.	.18

My counsellor listened, validated my feelings, and told me what I was experiencing was normal.	.19
My counsellor gained knowledge by what I told him/her and did not assume other aspects that may have seemed possible.	.21
My counsellor let me guide the subject matter of our meetings; anything was acceptable to talk about.	.23
My counsellor was sympathetic and able to see my perspective, could 'take my side' when I needed support, could be a bit biased in my favour, and could "paraphrase" or summarize my most recent issue.	.23
My counsellor paraphrased what I said.	.26
My counsellor openly invited me to share my concerns and didn't make any assumptions about what was happening or what I was feeling.	.26
My counsellor encouraged me to talk or cry, would listen to me talk in a negative way about myself, and would accept my thoughts before gently asking questions that shed new light on the origins or fallibility of these thoughts.	.26
My counsellor asked "what is bothering you the most?" and his/her quiet, warm and non-rushing manner gave me time to think about it seriously.	.41
Mean Bridging Value	**.22**

Approachable	My counsellor never showed shock, disgust, or any abnormality when I showed how I felt or what I thought.	.10
	My counsellor facilitated the creation of an environment where I could express myself without him/her panicking. He/she did not show fear or impinge on my right to experience the feeling I needed to get better.	.11
	My counsellor did not invade my personal space, and had a non-aggressive, non-judgemental, and respectful attitude towards me.	.16
	My counsellor made him/herself very approachable as someone who listened to me and how I felt.	.22
	My counsellor was non-judgmental. He/she didn't criticize anything I had done.	.28
	My counsellor made lots of eye contact, didn't make notes, and tilted his/her head in sympathy.	.43
	Mean Bridging Value	**.22**
Effective Listening	My counsellor listened with undivided attention and did not interrupt with analytical questions before my story was over.	.12
	My counsellor listened attentively.	.13
	My counsellor never pushed for questions. He/she simply expressed interest and was a good listener.	.17

	My counsellor smiled and listened to my issues, but didn't make me feel like I was alone or different.	.18
	My counsellor listened, accepted, and encouraged me to open up.	.18
	My counsellor listened very intently and took good notes of whatever he/she thought was important.	.20
	My counsellor was interested in what I wanted to say.	.22
	My counsellor was very intuitive and empathic. I knew that my counsellor would know if I wasn't telling the truth or was holding back about something.	.25
	My counsellor always remembered very specific details about my life and circumstances.	.27
	My counsellor listened to my stressors and established trust.	.28
	My counsellor always remembered my life events and didn't have to refer to a file.	.38
	My counsellor asked about things in my life other than the problem I was there for and remembered things I had mentioned in previous sessions.	.44
	Mean Bridging Value	**.24**
Good Boundaries	My counsellor shared idiosyncrasies that made him/her seem human. This openness was also seen in my counsellor's ability to laugh and joke, and recognize that I was sometimes joking too!	.15

My counsellor was able to small talk about things like office decorations, music, and various things but still remain professional and not too personal.	.21
My counsellor dressed professionally; the office was clean, warmly decorated, and organized.	.25
My counsellor struck a good balance between the professional and personal aspects of our relationship. He/she was friendly, would talk about her/his experiences when they were relevant, but he/she had clear and firm boundaries with me.	.26
My counsellor had a sense of humour; cracking jokes, sarcastic remarks, and laughing.	.27
My counsellor was polite and respectful and showed this through smiling, handshaking, greeting, and taking time to answer questions outside of regular sessions.	.27
My counsellor was a real and honest person who was open to connecting on an emotional and spiritual level through self-disclosing appropriately and allowing me to know when I had impacted her/him.	.29
My counsellor assured me that what we discussed would never leave the room without my permission. I was not being judged (my issues were things he/she dealt with all the time) and my counsellor also gave me some personal history of his/her past issues.	.30

	Mean Bridging Value	**.25**
Body Language	My counsellor was friendly and made an effort to begin appointments with small talk and my counsellor made a point of remembering details about my life not related to the problems I saw him/her for.	.18
	My counsellor maintained a light tone and not a harsh, confrontational tone.	.19
	The way my counsellor sat, moved, etc. indicated that he/she was comfortable and he/she was not somehow threatened, closed-off, or upset.	.19
	My counsellor was warm and friendly when greeting me; he/she made eye contact, remembered my name, and offered me a coffee.	.20
	My counsellor treated me as an intelligent and normal person. He/she saw me as an individual, and more than a condition or problem.	.22
	My counsellor was friendly (but not overly so), quiet, and didn't rush me at all.	.23
	My counsellor was consistent and calm and gave me tea.	.25
	My counsellor was happy looking and his/her body language was peaceful and calm.	.26
	My counsellor had good body language – he/she shook hands, seemed relaxed, and made eye contact.	.27

	My counsellor was very present to me; to my energy, and to the truths in my body.	.34
	My counsellor remembered small things and treated me like he/she actually knew me.	.41
	Mean Bridging Value	**.25**
Directed Process Appropriately	My counsellor asked me to return to the underlying issues when I had digressed.	.31
	My counsellor was willing to look at what I felt was important.	.32
	My counsellor facilitated my thought process and allowed me to find my own answers, rather than directing he/she made me feel like I had the answers, and it was just a matter of uncovering them.	.35
	My counsellor understood where I was going with a train of thought when I got stuck trying to explain something.	.35
	My counsellor was able to ask critical questions so that I could start thinking about and finding/identifying the problems.	.38
	My counsellor reaffirmed many things I already knew.	.46
	My counsellor was able to understand the root/source of the problem before I even understood.	.53
	Mean Bridging Value	**.39**

Availability	My counsellor would do extra legwork and would accommodate my needs regarding session times, session frequency, personal goals, etc.	.41
	My counsellor was willing to call me and have further phone conversations about additional thoughts after a session if he/she felt he/she had misinterpreted/misread anything we discussed and was open for me to do the same.	.44
	My counsellor provided assistance outside of our sessions by allowing me to e-mail to ask questions.	.45
	When my counsellor's schedule was full he/she moved things around so I could have an appointment the following week.	.48
	I knew that if I was in a distressed state, I could get in contact with my counsellor.	.51
	My counsellor always made time for me. He/she would always fit me in somehow.	.52
	Mean Bridging Value	**.47**
Planning & Approach	My counsellor didn't talk down to me and was honest and straightforward in her/his reactions to my problems and thoughts. He/she didn't try to convince me that everything was fine when it wasn't.	.28

My counsellor was upfront and told me to not tell him/her what he/she wanted to hear.	.33
My counsellor picked a method that seemed right for me.	.40
My counsellor explained his/her approach to counselling to me on the phone before we had our first appointment and the reasons why he/she used the counselling techniques.	.43
My counsellor encouraged me to come back and was interested to know how/if things had progressed.	.43
My counsellor met me where I was, but knew when to challenge me and was very honest.	.44
At the first session we discussed the direction the counselling would take – what I wanted from it, what the counsellor could offer me, and what approach we would use.	.47
My counsellor asked lots of questions and wasn't afraid to take more talk time than me.	.48
My counsellor would sometimes ask specifically what I wanted to accomplish or what would need to happen to make me feel better.	.52
My counsellor was direct and straightforward regarding possible outcomes to my situation.	.52
My counsellor monitored shifts in perception throughout the counselling process and was able to chart perceptual movement and major changes.	.55

	My counsellor was positive and encouraging. He/she always pointed out the good things I was doing and the progress I had made.	.62
	My counsellor helped me see positives in myself, through analogies and mental exercises.	.63
	Mean Bridging Value	**.47**
Ability to Relate	My counsellor's office space was professional but cozy and intimate, and had warm colours and a pleasant view.	.46
	My counsellor told me that my mother had approached the counsellor after one of my sessions and assured me that the counsellor had allowed none of my privacy to be invaded.	.48
	My counsellor was very reassuring, i.e. saying "you're on the right path" or "I think this is the right thing for you to do".	.49
	My counsellor went beyond his/her duties and showed he/she sincerely cared.	.54
	My counsellor was genuinely concerned for my well-being and sometimes gave me a call or asked me to leave a message to see how things were going.	.56
	My counsellor appeared to be in my age group.	.57
	My counsellor was the same gender as me.	.63
	My counsellor assured me that he/she was realistic about the life	.67

	the average person carried out.	
	My counsellor worked close to where I lived and worked.	1.00
	Mean Bridging Value	**.60**
Provided Resources & Homework	My counsellor helped me with tangible things related to my problems, contacting doctors and other professionals, as well as informing me of the variety of resources available.	.50
	When my counsellor gave me a task/homework he/she gave me ideas on how to complete it, and we talked about what I would do to try and complete it.	.51
	My counsellor was always willing to help me with forms or provide me with information about a particular program.	.53
	My counsellor and I devised homework together, tailoring the information and exercises, and we always went over the homework at the next session.	.54
	My counsellor gave me names of authors, names of books, and we discussed new age theories that I hadn't heard of before.	.71
	My counsellor was very interested in other ways of healing (e.g. my spiritual guide).	.89
	Mean Bridging Value	**.61**

Tables 9 & 10 show that clients view some categories as more conceptually uniform than other categories. "Sharing the Counsellor's Personal Experiences" and Non-judgmental" both understood the most uniformly across participants, while "Ability to Relate" and "Provided Resources and Homework" are understood quiet differently across participants, in terms of statement composition. Table 10 lists categories in ascending average bridging value showing the categories that are perceived to be more conceptually homogenous at the top of the table and the less conceptually homogenous at the bottom of the table.

Table 10

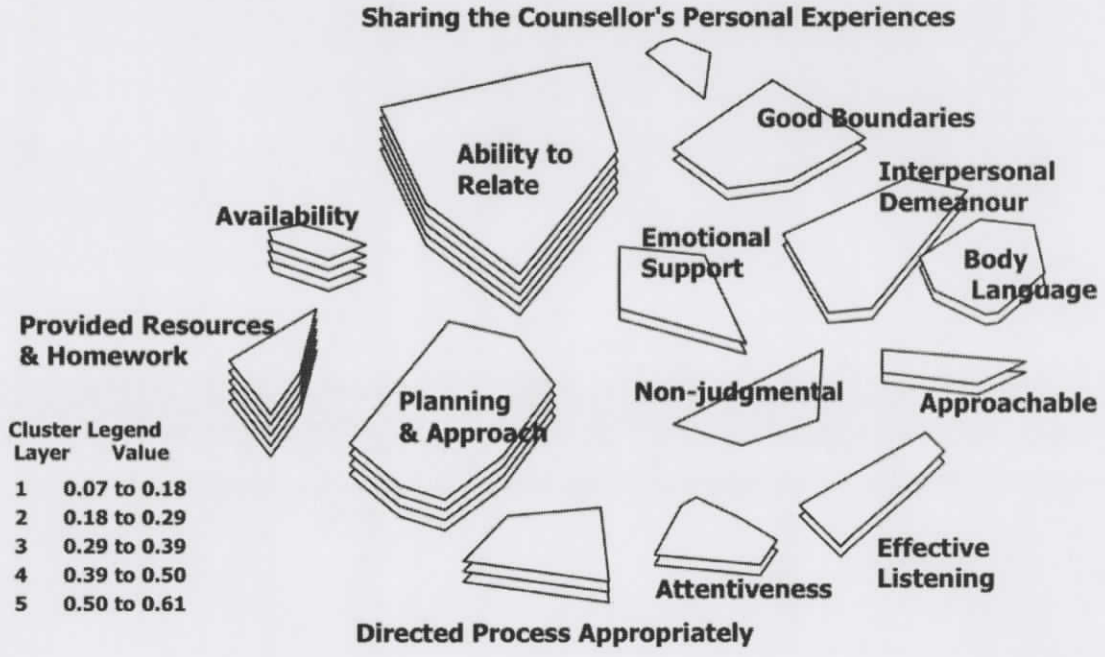
Category Titles with Bridging Values in Ascending Order

Category Title	Mean Bridging Value
Sharing the Counsellor's Personal Experiences	.07
Non-judgmental	.11
Interpersonal Demeanour	.20
Emotional Support	.21
Attentiveness	.22
Approachable	.22
Effective Listening	.24
Good Boundaries	.25
Body Language	.25
Directed Process Appropriately	.39
Availability	.47
Planning & Approach	.47
Ability to Relate	.60
Provided Resources & Homework	.61

The Cluster Bridging Map in *Figure 7* visually demonstrates the average bridging values associated with each cluster for the 14 cluster solution. Variable conceptual homogeneity for

each cluster is indicated by the number of layers presented for each category. Clusters having fewer layers have lower average bridging values (and therefore greater homogeneity) than clusters with more layers. Specifically, "Sharing the Counsellor's Personal Experiences" and "Non-judgmental" (one layer) are understood to be more conceptually uniform constructs/categories by participants while "Ability to Relate" (5 layers) or "Planning & Approach" (4 layers) were not. Stating this idea in a different way; a category such as "Ability to Relate", which has a relatively high bridging value, means more different things to different participants than "Non-judgmental" which has a relatively low bridging value. Bridging values give an indication of how uniform participant understanding of a category are.

Figure 7. Cluster bridging map with category titles.



Helpfulness Ratings for Each Cluster

The average rating of helpfulness for each category in developing a good working alliance with a clinician, as understood by participants, was calculated by taking the average of all the ratings of importance for each statement in the category. These average ratings of importance for each category are shown in Table 11. Participants rated "Emotional Support", "Non-judgmental", and "Effective Listening" as the most helpful categories in developing a good relationship with their clinician. "Sharing the Counsellor's Personal Experiences" and "Ability to Relate" received the lowest ratings in terms of helpfulness for developing a good alliance.

"Emotional Support" and Non-judgmental" both have relatively low bridging values, indicating that these categories are viewed in a similar manner by most participants. The agreement by participants by what is meant by the statements in these categories compliments the high rating they also ascribe to these categories. i.e., most participants understood these categories similarly and consistently rate them as important.

Table 11

Average Rating of Helpfulness for Each Category

Category	Average Helpfulness Rating
Emotional Support	4.24
Non-judgmental	4.21
Effective Listening	4.21
Body Language	4.20
Directed Process Appropriately	4.15
Approachable	4.14
Attentiveness	4.10
Interpersonal Demeanour	4.08
Planning & Approach	4.01
Availability	3.87
Good Boundaries	3.76
Provided Resources & Homework	3.56
Sharing the Counsellor's Personal Experiences	3.35
Ability to Relate	3.35

Dimensionality

Based on nMDS analysis, it is expected that continuous dimensions underlie the clusters of alliance formation factors described by participants. Point and cluster maps are proximity maps where distance between points or clusters is meaningful and remains intact regardless of the rotation of the map. The map can be rotated infinitely without compromising the validity of the map. Therefore, axes can be drawn through the map in any direction.

One possible axis, see Figure 8, could be drawn from the bottom left to the top right of the concept map showing a progression from a Professional Relationship (i.e., Provided Resources & Homework, Planning & Approach, and Directed Process Appropriately) to Personal Relationship (Sharing the Counsellor's Personal Experiences, Good Boundaries, Interpersonal Demeanour). Emotional Support falls in the center of this axis, reflecting its importance to participants and allowing these factors to be included in both the Professional and Personal Relationship dimension. The Helpfulness rating for this category is 4.24, or Very Helpful.

The Professional/Personal axis demonstrates a progression from factors that deal with behaviours found in a professional counselling relationship to factors that are most likely to be associated with a personal relationship or friendship. Categories on the Professional Relationship end of the axis include statements referring to contacting professionals, help with homework and forms, supplying names of authors and books, choosing a helpful method, explaining the clinician's approach, interest in the client's progress, knowing when to challenge client, discussing the direction of counselling, client's expectations, what the clinician can offer, highlighting progress, direction to underlying issues, focus on what the client sees as important,

facilitating the client's thought process, helping the client to find his or her own answers, and understanding the root problem.

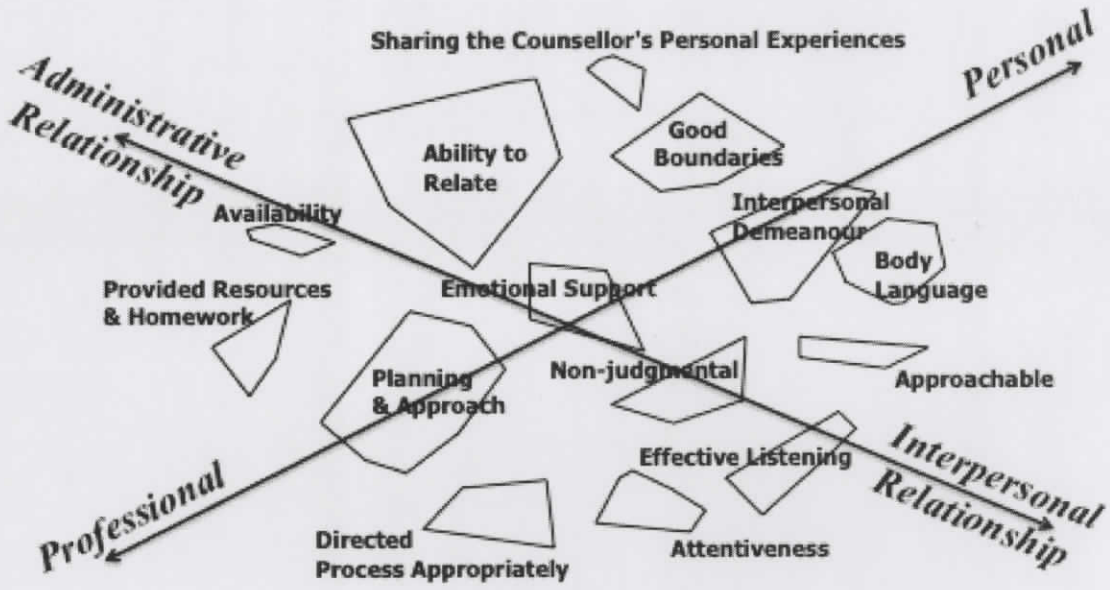
At the Personal Relationship end of the axis, references refer to the clinician's ability to laugh and joke, the clinician making small talk, the clinician's attire, answering questions outside regular sessions, the clinician being open to connecting on an emotional and spiritual level through appropriate self-disclosure, the clinician sharing his or her personal history, treating the client as an individual and not just another patient, the clinician being happy to see the client, expressing happiness when things are going well for the client, sharing stories about clinician's family and friends, and revealing personal issues. Clients appear to value differential degrees of the factors on either end of the Personal/Professional Relationship axis.

The second axis could be drawn from the top left through middle to the bottom right showing a possible progression from the Administrative Relationship (i.e., Availability, and Ability to Relate) to the Interpersonal Relationship (i.e. Attentiveness, Effective Listening, and Approachable). The category Ability to Relate includes factors that refer to behaviours or factors that are not related exclusively to the interaction between clinician and client during the counselling session. Specifically statements in this category include references to office décor, confidentiality, going beyond duties to show sincere caring, calling client between sessions, proximity of the clinician's office to client's home and work, and clinician's age and gender.

Categories found on the Administrative Relationship end of the axis include statements referring to extra legwork, scheduling session times, communication outside the sessions, office décor, confidentiality, reassurance, beyond duties, communication outside sessions, age, gender, location, contacting professionals, help with homework, information regarding other resources, names of authors and books, and other ways of healing.

Categories found at the Interpersonal Relationship end of the axis include statements that refer to interactional behaviours that occur directly between the clinician and the client as they are working together in the counselling session and express the client's perception of how the clinician is hearing the client and working in the process. They include factors such as did not interrupt, expressed interest, good listener, accepted client, encouraged client to open up, intuitive, empathic, remembered details, worked with my story, helped me find my voice, patient, validated feelings, does not make assumptions, allows client to guide session, paraphrase what client says, understands client's perspective, encourages client to talk or cry, never shows shock or disgust, non-aggressive, non-judgmental, respectful attitude, does not criticize, and sympathetic.

Figure 8. Dimensions of Professional/Personal and Administrative/Interpersonal Relationship



Comparisons of Male and Female Helpfulness Ratings by Category

Overall correlation for Helpfulness ratings for statements between Males (n=23) and Females (n=26) in the sample was moderately high, $r = .67$, $p < .001$. Independent t-tests were performed to compare male and female ratings of helpfulness for each category. Mean helpfulness ratings for males and females for each category are shown in Table 12. Although no statistically significant differences were found between the mean ratings of males and females

for individual categories (possibly due to low statistical power), males in this sample descriptively gave the highest rating to Effective Listening (4.23; rated number 3 by Females) and Females gave the highest rating to Emotional Support (4.36; rated number 5 by Males). Non-judgmental was rated as number 2 by males and number 5 by women. Approachable was rated as number 3 for Males (4.10) and number 2 for Females (4.24). Body Language, Attentiveness, and Interpersonal Demeanour were numbers 6, 7, & 8 respectively for both Males and Females. Males rated Ability to Relate (3.26) as the least important category and Females rated Sharing the Counsellor's Personal Experiences (3.16) as the least important category.

Table 12

Male and Female Mean Helpfulness Ratings for Each Category in Descending Order

	Males		Females	
1	Effective Listening	4.23	Emotional Support	4.36
2	Non-judgmental	4.14	Approachable	4.24
3	Approachable	4.10	Effective Listening	4.20
4	Directed Process Appropriately	4.09	Directed Process Appropriately	4.20
5	Emotional Support	4.09	Non-judgmental	4.19
6	Body Language	4.06	Body Language	4.12
7	Attentiveness	4.03	Attentiveness	4.01
8	Interpersonal Demeanour	3.99	Interpersonal Demeanour	4.01
9	Availability	3.96	Planning & Approach	3.98
10	Planning & Approach	3.91	Availability	3.82
11	Good Boundaries	3.82	Provided Resources & Homework	3.72
12	Sharing the Counsellor's Personal Experiences	3.65	Good Boundaries	3.67
13	Provided Resources & Homework	3.39	Ability to Relate	3.38
14	Ability to Relate	3.26	Sharing the Counsellor's Personal Experiences	3.16

Results Related to Alliance Type Preference

Nurturant, Insight-Oriented and Collaborative Alliance Types

Participants were asked to endorse the type of alliance they thought they would prefer given the choice of the three types identified by Bachelor (1995): nurturant, insight-oriented, or collaborative. For this sample, 20% of the participants endorsed nurturant (as compared to Bachelor's 46%), 54% endorsed insight-oriented (as compared to Bachelor 's 39%), and 26% endorsed collaborative (as compared to Bachelor's 15%). For the two samples Bedi and Duff (2009) surveyed, 8% and 22% endorsed nurturant, 38% and 52% endorsed insight-oriented, and 54% and 26% endorsed collaborative (for Study 1 and Study 2 respectively). The participants in the present study endorse a preferred alliance type very similar to those found in Bedi and Duff (2009) Study 2. This could be taken to imply that perhaps most clients prefer an insight-oriented alliance over a nurturant or collaborative one. See Table 13 for comparison of results between studies.

Table 13

Comparison of Alliance Type Preferences: Nurturant, Insight-oriented, & Collaborative

	The Present Study	Bachelor (1995)	Bedi & Duff (2009) Study 1	Bedi & Duff (2009) Study 2
Nurturant	20%	46%	8%	22%
Insight-Oriented	54%	39%	38%	52%
Collaborative	26%	15%	54%	26%

Personal and Professional Alliance Types

Participants were also asked to endorse the type of alliance they would prefer based on the main factors identified by Mohr & Woodhouse (2001): personal (the factor which Mohr & Woodhouse found to be associated with 40% of the variance in their participants view of what was helpful in the therapeutic alliance) and professional (the factor Mohr & Woodhouse found to be associated with 36% of the variance of what is helpful in the alliance). For the present study, 68% endorsed the description of the personal type alliance and 32% endorsed the professional type alliance. Bedi and Duff found 56% endorsed personal alliance for Study 1 and 55% for Study 2, while 32% endorsed professional for Study 1 and 44% for Study 2. It seems that consistent across the 3 studies overall, clients prefer a personal alliance over a professional one. See Table 14 for comparison of results with related studies.

Table 14

Comparison of Alliance Type Preferences: Personal & Professional

	The Present Study	Bedi & Duff Study 1	Bedi & Duff Study 2
Personal	68%	56%	55%
Professional	32%	44%	45%

Reliability of Sorting, nMDS and Concept Maps

This section provides results regarding the reliability of the MVCM analysis. It includes correlations between the total group similarity matrix (GSM) and various sub-group GSMs (GSMs for males, females, odd/even numbered participants) as well as comparisons of stress values for the GSMs of subsets of the data.

The correlation between the GSM of the male participants and the GSM for female participants was $r = .82$ ($p < .001$), indicating a very high positive correlation between the way male and female participants sorted the statements since 67% of the variability is shared by both genders. Correlation between the GSM for all participants and the GSM for male participants was $r = .95$, ($p < .001$), and correlation between GSM for all participants and the correlation between the GSM for female participants was $r = .96$. ($p < .001$). This indicates a very high positive correlation between the gender specific GSMs and the GSM for all participants. Both gender-specific GSMs demonstrate very high correlations with the GSM for all participants, indicating that the final concept map represents the perspective of both genders well.

The correlation between the GSM for odd numbered participants ($n = 25$) and even numbered participants ($n = 25$) was high at $r = .84$, $p < .001$. This demonstrates a high internal consistency of the sorting results. The correlation between the GSM for the total number of participants and the GSM for odd numbered participants was $r = .96$, $p < .001$ and the correlation between the GSM for even numbered participants and the total GSM was $r = .96$, $p < .001$. This demonstrates a very high positive correlation between the odd numbered, even numbered and total group of participants, providing further consistency between results for subsets of the data and lending support to the internal consistency reliability of the analysis.

Stress values for the odd and even split of participants were .33 ($n = 25$) and .31 ($n = 25$) respectively. These stress values are .66 and .28 *SD*, respectively, above the mean of split half samples for MVCM concept mapping projects (Trochim, 1993).

The average point biseral correlation of each BSM with the aggregated sort solution (GSM) was $r_{pb} = .46$ ($SD = .11$, minimum = .27 , maximum = .67, median = .45) indicating a moderate correlation between the average sort and the aggregated sort matrix on which subsequent analyses were based. This result compares favourably with Bedi's (2006) average point biseral correlation of $r_{pb} = .45$ ($SD = .11$, minimum = .20, maximum = .62). Applying Trochim's (1993) Spearman-Brown correction formula to the average point biseral result of this study, yields a reliability coefficient of .98 which is 2.14 *SD* above the mean for MVCM studies (Trochim), demonstrating very high reliability, again indicating that the GSM is a reasonably trustworthy indicator of individual sorting.

The average phi correlation between individual sort matrices (BSMs), $\Phi = .20$ ($SD = .08$, minimum = .04, maximum = .52, median = .18) indicating significant ($p < 0.05$) but very low correlation, but higher than Bedi's (2006) average phi correlation of $\Phi = .17$. These results suggest that there is a fairly high degree of variability in participants' understanding of alliance factors. However, application of Trochim's (1993) Spearman-Brown correction yields a reliability coefficient of .93, which is .11 *SD* above Trochim's average corrected solution. As the mean BSM/ BSM correlation in MVCM studies is only .82 (Trochim), it can be stated that these results are favourable in comparison to most MVCM studies, indicating good reliability across sorters.

CHAPTER 4

Discussion

This chapter provides a discussion of the results of the study. A brief review of the rationale for the study and its results will be presented, followed by a discussion of client-identified alliance formation factors and the categories clients created for these factors. The findings of this study will be incorporated into the existing psychotherapy and counselling literature. Finally, the end of the chapter will include a review of the limitations of the study along with suggestions for further research in this area.

Overview of Study and Rationale

While a wealth of previous research has shown the therapeutic alliance to be the strongest predictor of a positive outcome for counselling and psychotherapy (Horvath & Symonds, 1999), there exists a significant lack of research that *directly* accesses the client's perception of what factors contribute to the development and maintenance of the alliance. Clients have been asked to endorse, deny, or rate items and concepts generated by clinicians and researchers based on the professional's conceptualization of the alliance. However, clients are rarely given the opportunity to offer direct input, in their own vocabulary, regarding factors they believe to be critical based on their personal experience and subjective perception. Therefore, while research has established the overwhelming importance of the alliance, existing theories, measures, and models of the alliance are based on *indirect* investigation of the client's perceptions.

This omission in the literature becomes more significant in the light of the large number of studies that reveal the clinician's inability to assess the alliance quality and strength at the

same level as the client (Bachelor, 1991; Elliott & James, 1989; Marmar, Weiss, & Gaston, 1989; Rumpold et al., 2005; Tichenor & Hill, 1989). Further, due to the nature of the alliance as the subjective experience of both the clinician and the client, researchers and clinicians cannot validly articulate the client's experience without directly asking the client for their perspective. Not surprisingly, therefore, studies which compare clinician, client, and observer ratings, show significant differences between the three groups. Given the critical impact of the alliance, along with the known differences between the client's and the clinician's perception of the strength of the alliance, it seems imperative to directly investigate the client's observations and evaluations. Therefore, the current study included client participation in the analysis of client-generated factors in an effort to access a more comprehensive representation of the client's perception of the therapeutic alliance.

The present study relates to a previous line of research initiated by Bachelor (1995) and continued by Mohr and Woodhouse (2001). These studies explored the client's perception of themes and characteristics pivotal to the alliance. Further research (Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005, Bedi, 2006) directly solicited client perceptions through interviews where clients identified events and behaviours they believed were critical to alliance formation. In the present study, participants who were currently or recently involved in counselling, organized 125 client-generated factors into thematic categories; each category was composed of statements participants viewed as relating to a similar concept. Participants then gave each category a title. Participants in a previous study created the 125 statements when asked to identify the most important factors in a strong therapeutic alliance. Participants were free to include any factor that they believed was helpful, regardless of its nature – concrete or

abstract, observable or unobservable. This design facilitated the possible inclusion of factors not previously considered in previous research or alliance theory. Additionally, the current study included counselling clients in the analysis of data by recruiting participants who were currently or recently in counselling to organize the client-generated statements into thematic categories; each category was comprised of factors the participant viewed as related to a similar concept. Participants then gave each category a title. The client's "voice" was thereby included in the organization of client-generated factors as well as the vocabulary used to title the categories.

MDS and hCA were used to identify the most representative categorization scheme across participants. The Concept Systems (2008, Version 4) statistically identified the ten category titles (generated by the participants) that were positioned closest to the centroid of each category on a cluster map. Researchers selected the most representative title from the list for each category taking into account the closest title, the number of times participants chose similar vocabulary, and the appropriateness of the title for the concepts expressed by the statements in the category.

Overview of the Results of the Study

Most Helpful Factors

When participants were asked to rate the client-identified factors for helpfulness in alliance formation on a 5-point likert scale, the ten most highly rated factors included the clinician's ability to listen, acceptance of the client by the clinician, the clinician's ability to encourage the client to open up, the clinician's attentiveness, the clinician posing critical questions that helped the client identify the problem, the clinician conveying a non-judgmental and supportive attitude, confidentiality, perceived clinician sincerity and approachableness,

familiarity of the clinician with subject matter, use of body language to communicate that the clinician is comfortable, and treating the client as a normal intelligent person rather than a condition or problem. Also included (one of the three statements which received the highest rating) was the client's "ability to open up, trust and talk" to the clinician.

All of these factors are very relational and familiar to Rogerian or client-centered clinicians who emphasize the critical need for clients to experience unconditional positive regard and empathy from their therapist (Rogers, 1957). These factors are also congruent with Bordin's (1979) discussion of the role of the bond between the client and the clinician in developing a strong therapeutic alliance which he suggests, "may often be the main vehicle of change" (p. 255). Ratings of helpful factors by clients in this study show that clients highly value the respect and acceptance of their clinician.

Nine of the top ten rated statements related to the client's perception of clinician behaviours and attitudes and one pertained to client behaviour.

The highest rating (4.80) was associated with three statements:

1. My counsellor listened, accepted, and encouraged me to open up.
2. My ability to open up, trust and talk to my counsellor.
3. My counsellor listened attentively.

These three statements present the two sides of the alliance and suggest that clients in this study understand the contributions of both the clinician and the client in a strong alliance. These statements and their position at the top of the helpfulness-rating list suggest that clients believe it is important for both the clinician and the client to be engaged in the counselling process. While clients believe it is helpful to have a clinician who is accepting and encouraging,

they also appear to understand that they have a role in developing trust and openness and that it is important for the client to demonstrate openness and honesty.

The statement which received the second highest rating, "My counsellor was able to ask critical questions so that I could start thinking about and finding/identifying the problems", suggests that clients believe it important for them to discover the problem for themselves: the clinician asks questions that will facilitate the client in problem identification. Participants in this study appear to believe that the alliance is built through clinician and client interactions.

Other Highly Rated Factors

Other highly rated statements reiterate the concepts stated in the top ten and provide related elaborations such as the importance of the clinician's willingness to explore what the client thinks is important, the ability to challenge the client, honesty, genuine smiling, remembering details about the client's life, encouragement to return, interest in how things are progressing for the client, and questions that indicate the clinician is thinking carefully about what the client is saying. These factors are also highly relational and likely evidence of the clinician's genuine respect for the client – i.e., unconditional positive regard (Rogers, 1957). This respect is demonstrated by the clinician's willingness to allow the client to determine what he or she wants to work on, along with the clinician's expression of genuine interest in and relating to the client as a valued individual. Participants also gave high ratings to statements that indicate clients believe the alliance is greatly facilitated by the clinicians who convey a sense that the client is not a defective or abnormal person, but a healthy human being capable of intelligent evaluation of his or her problems who has the ability to problem solve, and is able to benefit from a real relationship with the clinician.

Factors with Lower Ratings

Statements that received the lowest ratings for helpfulness in alliance building referred the gender and age of clinician, the location of clinician's office, the clinician's self-disclosure including his or her previous issues and information about the clinician's family and personal life, information regarding authors, books and new age theories, clinician attire, office décor, and small talk. Other concepts that received low helpfulness ratings were eye contact, taking or not taking notes, calling the client between sessions, working on homework with the client, asking questions and talking more than the client, explaining the counselling approach to the client, affirming what the client already knows, and allowing the client to take the whole hour to tell his or her story. While these factors are not rated as highly significant to most clients, it is important to remember that the statements were created by participants who stated the factor was helpful and other participants rated the factor as helpful. The variable rating of statements supports previous research findings that clients prefer different types of alliance and that there appears to be no one 'correct' set of factors that will be valued and successful with all clients (Bachelor, 1995; Mohr & Woodhouse, 2001; Bedi, 2006). Rather it is important to discover and respect individual client values and concerns. Therefore, the strongest alliances will likely be based on the fit of the clinician with the client, and the clinician's ability to discern and work with client preferences.

Most highly rated factors fall on the lower right of the concept map and are associated with one end of the dimension titled Interpersonal Relationship, which includes the categories titled Effective Listening, Attentiveness, and Body Language. The factors that received lower ratings are associated with the end of the dimension labelled Administrative Relationship, which

includes the categories Availability, Provided Resources and Homework, and Ability to Relate. These categories are associated with factors such as session scheduling, gender of clinician, location of office, contact outside of the session, and homework.

Conceptual Homogeneity of Statements

Participants categorized some statements more uniformly than others. In other words, some statements were more consistently organized into the same group. This similarity in categorization (associated with a lower bridging value) indicates that the statement is understood more homogenously across participants. Ratings associated with statements having high conceptual homogeneity are therefore likely more reliable than ratings associated with low conceptual homogeneity as participants generally will likely understand the concept in a more similar manner. Specifically, participants are more likely to actually be rating the same construct, increasing the validity and the reliability of the rating.

Statements with High Conceptual Homogeneity

Interestingly, statements that fall in this category overlap very well with highly rated statements. This high conceptual homogeneity provides support for the helpfulness ratings of statements that clients perceive as the most helpful factors. Statements that have high conceptual homogeneity include the concepts of listening attentively, the client opening up, trusting and talking to the clinician, the clinician being non-judgmental and supportive, confidentiality, the clinician asking thought provoking questions and giving his/her opinion, the clinician never showing shock or disgust, the clinician stepping into the client's world, and the clinician making the client feel that what he or she is dealing with is normal.

Statements with Low Conceptual Homogeneity

Statements having the least conceptual homogeneity overlap closely with the statements that are rated as less helpful. These include factors such as the location of clinician's office, interest in other ways of healing, names of books and authors, gender, age, and communication between sessions. These factors are considered less helpful by most participants and were also less likely to be sorted into the same category than more highly rated factors.

Categorization of Helpful Factors

A 14 category solution was determined to be the best representation of the 125 client-identified helpful factors, across participants. In descending order of mean helpfulness ratings, these categories are: Emotional Support, Non-judgmental, Effective Listening, Body Language, Directed Process Appropriately, Approachable, Attentiveness, Interpersonal Demeanour, Planning and Approach, Availability, Good Boundaries, Provided Resources and Homework, Sharing the Counsellor's Personal Experiences, and Ability to Relate. While some categories receive higher helpfulness ratings that others, mean helpfulness ratings for these groups all fall in the range of ratings corresponding to "Very Important' or "Moderately Important" indicating that across participants, clients agree that all the categories include factors that are helpful in establishing a strong therapeutic alliance.

It is also important to note that the categories created are interpreted by the researchers to be the best fit across cluster solutions suggested by the statistical software. Statements with high bridging values located at the outer edges of a cluster could reasonably be associated with the statements in another cluster. Therefore, it is possible that some statements in each category

could arguably also fit into another category, and are placed in their current category due to measurement error.

Emotional Support

This category received the highest mean rating by participants ($M = 4.24$, Very Important) and had a mean bridging value of .21. This shows that generally statements in this category are both highly rated by participants and also enjoy a high level of conceptual homogeneity. Statements in this category referred to the clinician giving the client permission to cry, being empathetic, being non-judgmental, supportive, confidential, sincere, able to express sympathy, getting to know the client before offering advice, and being open about the monetary factor in the relationship. This category is located in the center of the concept map, falling midway between the Professional and Personal end of one axis, and midway between Administrative Relationship and Interpersonal Relationship ends of the contrasting axis.

Non-judgmental and Effective Listening

These two categories received the same helpfulness rating ($M = 4.21$, Very Important) and had mean bridging values of .11 and .24 respectively (1.06 and .33 *SD* above the mean bridging value), again demonstrating high conceptual homogeneity which increases the reliability of the high rating these statements received. Statements in the Non-judgmental category used the vocabulary "non-judgmental" and included the phrases "stressed that I was not crazy even when I believed I was", "would not make fun or make light of any thought/feeling I shared", and "did not take offence". The word "listened" was included in many of the statements in the Effective Listening category along with "did not interrupt with analytical questions", "expressed interest", "smiled", "accepted", "encouraged me to open up",

"remembered specific details", "asked about things in my life", "intuitive", "empathic", and "took good notes".

Body Language

This category also received a very high helpfulness rating ($M = 4.20$, Very Important) with a mean bridging value of .25 (.28 *SD* above the mean bridging value). Statements in this category used phrases like "was friendly", "treated me as an intelligent and normal person", "saw me as an individual", "he/she was comfortable… and not threatened", "shook hands, seemed relaxed, and made eye contact", "warm and friendly", "very present", "treated me like he/she actually knew me", "light tone", "happy looking…peaceful and calm", "quiet and didn't rush me", and "consistent and calm". These factors reflect the client's high value on the clinician's friendly and calm personal demeanour.

Interestingly, some statements in this and other categories do not appear directly related to the title of the category. In other words they do not have good face validity. For example, the phrases "treated me as an intelligent and normal person" and "saw me as an individual" are not phrases that usually are associated with the term body language. In order to increase the validity of this category, it would be necessary to ask participants to explain their rationale for including this type of statement in the category.

Directed Process Appropriately

This category also received a high helpfulness rating ($M = 4.15$, Very Important) with a mean bridging value of .39. Statements included phrases such as "return to the underlying issues", "look at what I felt was important", "facilitated my thought process", "allowed me to find my own answers", "understood where I was going…when I got stuck", "ask critical questions", " reaffirmed things I already knew", and " understood the root/source of the problem". These statements relate to the clinician's ability to track the client's thought and speech, facilitate the client's narrative, and demonstrate attention to what the client wants to process. The abstract nature of these concepts is likely reflected in the slightly lower than average bridging value.

Approachable

The mean helpfulness rating for this category was 4.14, Very Important, with a mean bridging value of .22. This reflects the relatively high conceptual homogeneity of statements in this category. Participants used phrases and vocabulary such as "never showed shock, disgust", "made him/herself very approachable", "created an environment where I could express myself", "non-aggressive", "non-judgmental", "respectful attitude", "didn't criticize anything I had done", and "made lots of eye contact". Factors in this category describe the client's experience of acceptance and comfort.

Attentiveness

This category was also rated Very Important ($M = 4.10$) with a mean bridging value of .22. Even though this category is one of the largest in terms of the number of statements, it has a high degree of conceptual homogeneity. Statements described the following concepts: took client's perceptions and beliefs at face value, listening, asking questions, thinking carefully about what client shares, inviting client to share concerns, not making assumptions, patience, helping the client find his/her voice, letting client guide subject of discussion, encouragement to talk or cry, validating feelings, telling client that his or her experience is normal, being quiet and non-rushing, working with the client's story, being sympathetic, being biased in client's favour, and paraphrasing. These statements suggest that clients value being heard and understood. Again, some of the statements in this category do not seem to easily fit with the category title. For example, "took client's perceptions and beliefs at face value", "telling client that his or her experience is normal", and "being biased in client's favour" do not seem as congruent with the title as other statements in the category.

Interpersonal Demeanour

Interpersonal Demeanour is rated as Very Important ($M = 4.08$) with a bridging value of .20 (.56 *SD* above the mean), again showing high conceptual homogeneity. Interestingly, this category includes the statements that refer to the client's ability to open up, trust and talk to the clinician as well as the client feeling that he or she was not being studied and was not just a patient on the clinician's 'to do' list as well as concepts referring to the clinician's behaviour. Statements referring to clinician behaviour included references to genuine smiling, treating client like a unique and equal person, accepting client objections to questionnaires, being happy

to see client, hugging the client, commenting on client strengths, happiness when things were going well for the client, calm, nurturing voice, self-disclosure that kept focus on the client, and positive, cheerful manner. As stated earlier, some of these statements are less easily understood as part of a category titled Interpersonal Demeanour, specifically statements referring to the client's ability to open up and the clinician accepting the client's objections to questionnaires. Further conversations with participants would likely be helpful in understanding the meaning associated with their sorting choices and increasing the validity of this category.

Planning and Approach

This category was the lowest of the categories rated as Very Important ($M = 4.01$) and has a mean bridging value of .47 (.94 *SD* below the mean). This category is one of the largest in terms of number of statements and while the level of homogeneity is acceptable (less that one *SD* below average) participants did not appear to see this category as definitively as other categories. Statements discussed knowing when to challenge the client, the clinician being honest and straight forward in his/her reactions, encouraging the client to come back, interest in how the client is progressing, choosing an appropriate method for the client, enquiring about client goals, asking for honesty from the client, discussing the direction of counselling and what the client expected from counselling, what the clinician could offer, and the approach to be used, highlighting client's progress, and asking questions. This category encompasses the clinician's way of approaching the client and the client's concerns as well as the theoretical orientation of the clinician to the clients concerns.

Availability

This category was rated as Moderately Important ($M = 3.87$) and also had a mean bridging value of .47. It includes a relatively small number of statements and describes the clinician doing "extra legwork', the clinician accommodating the client's needs regarding session times, and session frequency, being able to contact clinician when distressed, and phone calls and emails between sessions. This statement falls close to the end of the axis titled Administrative Relationship. Although it does not include a large number of statements, it is moderately important to clients, and shows that participants in this study agree with Bedi's (2006) findings that behaviours outside the counselling session are considered very helpful by many clients but rarely mentioned in the alliance literature or researched specifically for their contribution to the alliance.

Good Boundaries

Good Boundaries is rated as Moderately Important ($M = 3.76$) with a mean bridging value of .25, indicating high conceptual homogeneity. Statements in this category used phrases such as " shared idiosyncrasies", "ability to laugh and joke", "remain professional and not too personal", " dressed professionally", " firm boundaries", "polite and respectful", "honest person open to connecting on an emotional and spiritual level through self-disclosing appropriately and allowing me to know when I had impacted her/him", "what we discussed would never leave the room without my permission", "I was not being judged", "my clinician gave me some personal history of his/her past issues", and a "sense of humour". These statements reflect the various

ways clients perceive the clinician balancing being a genuine and real human being with respectful and professional ways of interacting with clients.

It is important to note that statements in this category do not comprise what is conventionally thought of by clinicians as good boundaries. For example, statements describing a clinician that dressed professionally or had a good sense of humour, could not be assumed to be associated with good boundaries. Therefore, while this category apparently has high conceptual homogeneity, it would be helpful to be able to discuss with participants their perception of how these statements fit within this category and possibly create a more representative title for the category.

Provided Resources and Homework

Rated as Moderately Important ($M = 3.56$) with a bridging value of .61 (1.72 *SD* below the mean). This category has very few statements in it and low conceptual homogeneity. Participants often sorted these relatively conceptually concrete statements into different piles demonstrating their relative lack of agreement over which category these statements belonged to. Statements described factors such as the clinician giving the client ideas on how to complete the homework, the clinician being interested in other ways of healing, the clinician helping with forms, providing information about resources or contacting other professionals, and suggesting authors and books. Further, although some participants in this study rate this category as important, high bridging values indicate that participants are not in as much agreement as to which category individual statements belong to.

Sharing the Counsellor's Personal Experiences

Sharing the Counsellor's Personal Experiences was rated 3.35, Moderately Helpful, with a mean bridging value of .07. Clients ascribe high conceptual homogeneity to this category and rate it the lowest (along with Ability to Relate) in terms of helpfulness in building a strong alliance. It falls toward the Personal end of the axis titled Personal/Professional and reflects the differential value clients ascribe to the clinician sharing his or her personal story and life concerns with the client. Statements assigned to Sharing the Counsellor's Personal Experiences referred to the clinician adding things about him/herself, the clinician revealing a struggle with the same issues as client, and the clinician telling personal stories about self, family, and others.

The "Moderately Helpful" rating given to clinician self-disclosure is consistent with the findings of Mohr and Woodhouse (2001) who found clients preferred two different types of alliance: professional and personal. The personal alliance includes significantly more sharing by the clinician of his or her personal experience. Clients who preferred the professional alliance type did not believe the sharing of the clinician's personal experiences was helpful. These clients preferred sessions to focus on the client's concerns with little or no reference to the clinician's personal experiences while other client's indicate that they believe the clinician's self-disclosure very helpful in alliance building. In fact, some participants in the present study rated the self-disclosure statements as "Not at all Helpful" and indicated that they believed the clinician who self-disclosed had poor boundaries.

Ability to Relate

This category is also rated 3.35, Moderately Helpful, and has a mean bridging value of .60. Ability to Relate has lower conceptual homogeneity and includes references to office décor, confidentiality, going beyond duties to show sincere caring, giving reassurance, concern for client's well-being, calling client between sessions, proximity of office to client's home, and clinician age and gender. This conceptual heterogeneity is also apparent in the client suggested titles. The titles for this category share very little overlap. The final selection was closest in proximity and includes factors outside the actual counselling session that clients believe contribute to clinician's Ability to Relate.

For example, the statement in this category that received the highest helpfulness rating refers to the clinician being approached outside the counselling session by the client's mother and the clinician maintaining the client's confidentiality. The next most highly rated statement refers to the clinician "going beyond his or her duties". Thus, the clinician's Ability to Relate, in the perception of participants, is demonstrated by relatively concrete factors such as confidentiality, office décor, gender and location. These statements and their ratings support Bedi's (2006) findings that office décor, and behaviours apart from the actual counselling session are perceived by some clients to build a strong alliance. However, the low bridging values associated with this category and the diversity of suggested titles, limits the validity of composition of this category.

Relationship of Study Results to Relevant Literature

Rogers (1957)

The top ten most highly rated factors are congruent with Roger's conceptualization (1957) of unconditional positive regard and empathy for the client. Clients clearly value acceptance, warmth, and a non-judgmental attitude along with the perception that the clinician is able to accurately sense and understand the client's experience. However, the results of this study include other factors not specifically mentioned by Rogers, including the client's "ability to open up, trust and talk" to the clinician. Clients appear to understand their responsibility and role in the alliance rating client participation and engagement as a very important factor. Factors not included in Roger's theory, that clients believe to be helpful, include gender and age of the clinician, office décor and location, clinician self-disclosure, contact outside of counselling sessions, homework and resources.

Bordin (1979)

Bordin's (1979) well-accepted theory of the alliance focuses on three main aspects: agreement on goals, and tasks, and shared bonds. Statements such as "the counsellor posing critical questions that helped the client identify the problem" (rated the second most helpful factor), "My counsellor was willing to look at what I felt was important", "we discussed the direction the counselling would take – what I wanted from it, what the counsellor could offer me, and what approach we would use", "My counsellor would sometimes ask specifically what I wanted to accomplish or what would need to happen to make me feel better", and " My counsellor and I devised homework together, tailoring the information and exercises, and we

always went over the homework at the next session", provide client validation for Bordin's emphasis on agreement on goals and tasks.

Bordin uses the term "collaboration" or shared agreement on goals and tasks, discussing the need for the clinician to work with the client to identify goals and tasks that fit the client's sense of what would be helpful and possible for him or her to accomplish. While the explicit statement of goals may not be specified in some types of psychotherapy, or may only become clear over time in other forms of therapy, Bordin's (1979) theory states the tacit agreement on goals is necessary for counselling to proceed. Although participants do not use the same vocabulary (i.e., collaboration), the statements listed above describe the process of collaboration, specifically referring to both client and clinician agency.

Bordin states that some level of trust is necessary for all therapeutic alliances. Trust is clearly validated by participants in this study. The statement, "My ability to open up, trust and talk to my counsellor" received the highest helpfulness rating. While participants in this study apparently validate the three aspects of Bordin's (1979) theory, as found in Bedi (2006), these three factors do not encompass all the factors participants in this study believe contribute to a strong alliance.

Bachelor (1995) and Bedi and Duff (2009)

Bachelor's (1995) phenomenological content analysis of the client's description of what was characteristic of a good working relationship found clients to prefer different types of alliance. Specifically, 46% preferred a nurturant-type alliance, 39% an insight-oriented alliance, and 15% a collaborative alliance. Twenty percent of clients in the present study endorsed a nurturant-type alliance, 54% endorsed insight-oriented and 26% endorsed collaborative. Bedi

and Duff (2009), in two separate studies, asked participants to endorse the types of alliance described by Bachelor yielding percentages that differed from each other as well as from Bachelor. Interestingly, Study 2's (Bedi & Duff) results were very close to those found in the present study.

Variations in alliance preferences endorsed by participants in the different studies are likely due, at least in part, to the methods employed. In the present study, as well as in Bedi and Duff (2009), participants were asked to choose a set of statements describing their preferred type of alliance. Researchers analyzed descriptive written accounts by clients to arrive at the conclusions in Bachelor's study. The two sets of statistics are likely at least partially the result of different procedures and analysis. However, while percentages associated with the various alliance types investigated vary, the participants in all studies seem to agree that clients value aspects of the alliance differently and support the conclusion that "one size does not fit all".

Along with differing alliance types, Bachelor's (1995) work, like the present study, found clients' perception of the alliance to include factors that are not generally included in alliance theory. In the written accounts, Bachelor's participants described the helpfulness of trust, a non-judgmental or non-evaluative relationship, friendliness, the use of humour, explanatory interventions (e.g., discussing how counselling works and what the client can expect), counsellor competency in terms of choice and delivery of appropriate methods, feedback and direction, improved self-understanding or insight into problems, clinician self-disclosure, and the clinician's ability to challenge and be challenged.

Mohr and Woodhouse (2001)

A proposed dimension for the current study, Professional/Personal, is congruent with the findings of Mohr and Woodhouse (2001). They found clients valued emotional connection, clinician friendliness, professionalism, and self-disclosure differently. Some participants in their study stated that certain behaviours, especially self-disclosure, were helpful while other participants believed the same behaviours to be detrimental. Participants in this study also indicated that clients find some behaviours helpful for a strong alliance while others believe the same behaviours are reflective of poor boundaries on the part of the clinician. Some clients believe the behaviour would likely create a rupture in the alliance, prevent the development of a strong alliance, or increase the likelihood of termination of the relationship.

Bedi, Davis, and Arvay (2005)

This exploratory study (having 9 participants) identified several categories (Counselling Environment, Expressions of Positive Affect, Tracking the Counselling Process, and Personal Attributes of the Counsellor) and sub-categories (i.e., counsellor self-disclosure), which are not usually addressed in alliance theory and were also cited by participants in the present study. Participants in both studies identified many of the same factors. However, the individual factors are often categorized differently, likely at least partially due to research methodology. Further, Bedi, Davis, and Arvay (2005) solicited client reports of verbalizations and observable behaviour, while the present study used client–generated statements that were sometimes ambiguous or abstract in nature and often dealt with client perception or response to clinician behaviours rather than specific observable behaviours. Further, Bedi, Davis and Arvay relied on

researcher analysis of factors while the present study recruited counselling clients to categorize factors. However, despite the different categorization schemes, some participants in both studies stated that they placed high value on environmental factors such as the clinician smiling, the office decor, the clinician's age, gender, and attire and counselling session factors such as providing direction towards client goals, paraphrasing, verbal support, and providing the client with an overview of the counselling process.

Bedi, Davis, and Arvay (2005) also found that 66% of their participants believed the alliance was significantly enhanced by the clinician's self-disclosure. This finding relates directly to the Sharing the Counsellor's Personal Experiences category in the present study which received a Moderately Helpful rating. These findings provide support for the hypothesis that clinician self-disclosure can be a significant alliance-building factor for many clients. However, it is also important to note that this factor is not endorsed by all participants in Bedi, Davis, and Arvay or the present study, and some participants in the present study actively stated that it was not helpful. Therefore, clinician self-disclosure appears to be a factor that requires clinician discernment regarding client-specific needs.

Bedi, Davis, and Williams (2005)

The critical incident technique used in Bedi, Davis, and Williams (2005) to identify observable behaviours and verbalizations that were helpful for alliance formation resulted in considerable overlap with the content of statements in this study; identifying factors that are often appear elementary or are not mentioned by prevalent alliance theories. The following are examples of categories from Bedi, Davis, and Williams and the present study, respectively, having conceptual overlap. Examples of client-identified factors are listed in brackets:

Nonverbal Communication and Body Language (eye contact; the way my counsellor sat, moved, etc. indicated that he/she was comfortable), Active Listening and Effective Listening (remembered and repeated back to me things that I had said in previous sessions; my counsellor listened attentively), Psychotherapy Environment and Ability to Relate (the therapist had a bookshelf full of clinical books on forms of abuse; office décor), Service Beyond Normative Expectations and Availability (The therapist said, "Call anytime…"; I knew that if I was in a distressed state, I could get in contact with my counsellor."), Self-disclosure and Sharing the Counsellor's Personal Experiences ("I've gone through that experience too."; "My counsellor revealed to me within the first few sessions that he/she had battled the same issue as me in the past), Positive Commentary and Planning and Approach (The therapist made positive comments about me"; "My counsellor helped me to see positives in myself"), Greetings and Farewells and Interpersonal Demeanour ("The therapist greeted me at the beginning of each session with a smile"; "My counsellor genuinely smiled"), Normalization and Validation, and Attentiveness ("The therapist normalized my feelings, saying, "This happens to couples"; "My counsellor listened, validated my feelings, and told me what I was experiencing was normal"), Confidentiality and Emotional Support ("explained the limits of confidentiality"; "My counsellor maintained a sense of confidentiality"), Crying in the Presence of the Psychotherapist and Emotional Support ("The therapist gave me a tissue when I was crying"; "My counsellor gave me permission to cry"), Role Induction, and Planning and Approach ("explained to me how therapy would work"; "we discussed the direction the counselling would take"), and Humour and Good Boundaries ("therapist made intelligent jokes to break the ice"; "My counsellor had a sense of humour; cracking jokes, sarcastic remarks, and laughing").

As was found with Bedi, Davis and Arvay (2005), the categorization and titles for each category differed from the present study, but significant similarity was evident in the conceptual content of the critical incidents and the statements generated by clients despite the variation in methodology. This agreement between participants in different studies suggests similar perceptions of the importance of these factors among counselling clients.

Bedi (2006)

Although factors in Bedi (2006) were almost exclusively verbalizations or observable behaviours, and factors in the present study are more evaluative of clinician behaviour and the client's perception of the effect the behaviour had on him or her, the factors valued by participants in both studies are remarkably similar and often refer to the same concept. Organization of factors into categories is less consistent, often using different names for a similar concept or grouping factors into several categories in one study while similar factors are found in one category in the other study. This could possibly be due to the methodology employed: Bedi's participants were invited to evaluate results and subsequently endorsed them as valid, while participants in the present study were not given the opportunity to validate the results.

Factors that are found in both studies include references to calm body language, eye contact, smiling, warm and friendly greetings, permission to cry, a sense of humour, ability to laugh and joke with the client, confidentiality, office décor, the inclusion of counselling books on the office shelves, well-groomed and appropriately dressed counsellor, counsellor's age and gender, offering food and/or drinks, contact outside the counselling session in the form of phone calls or emails, explanations regarding the process of counselling and what the client can expect

from counselling, referrals to other community services, suggestions for helpful materials, remembering and referring to details from previous sessions, discussion of client's goals, reference to the counsellor's personal experiences, treating the client as a person capable of understanding themselves and making decisions, allowing the client to choose the topic of the session, assigning and reviewing homework together, validating and normalizing client experiences and feelings, paraphrasing the client's story, summarizing the client's story, keeping the client on topic, and making positive comments about the client.

In both studies, clients specifically make statements about the client's responsibility and contribution to the alliance. Participants in Bedi (2006) wrote about choosing the counsellor, coming to sessions on time, and informing counsellor when he/she would be late, while participants in the present study stated the alliance was strengthened by the client's ability to open up, talk and trust the counsellor. Again, while the different methodology likely elicits a different type of statement, both studies show that clients believe they have some agency in building the alliance.

The emphasis on clinician behaviours apparently contrasts with theoretical and clinical emphasis on collaborative and client related factors, and clients generally do not directly identify factors in terms like collaboration and client agency. However, the most highly rated factors, as well as most other factors identified for this study indicate that a strong alliance is related to the behaviours and attitudes that *encourage* or *facilitate* client agency and collaboration. Specifically, clients believe the alliance to be related to client's perception that the clinician listens and attends to the client, the clinician helps the client identify the problem, the clinician is non-judgmental and supportive, the clinician is approachable with open body

language, and the clinician conveys to the client that what the client is experiencing is normal, and the clinician conveys the belief that the client is an intelligent individual. These factors are likely to *facilitate* client agency and collaboration with the clinician.

Interestingly, organization of factors into categories is not constant across studies, often using different titles for a similar concept or grouping factors into several categories in one study while similar factors are found in only one category in the other study (see Table 13). One possible explanation for this difference may lie in the composition of the statements. Statements in Bedi (2006) were, for the most part, singular observable behaviours while the statements in the present study were more abstract and often ambiguous – sometimes seemingly combining factors that could belong to one or more different categories. For example, the statement "My counsellor was positive, cheerful, didn't say "oh how bad", looked at the good side of things, and smiled", lists five separate things – one is observable, one describes what the clinician *didn't* do, and three describe attitudes perceived by the client which may or may not describe the same concept, even in the mind of the participant who composed the statement. Similarly, the statement "My counsellor went beyond his/her duties and showed he/she sincerely cared" communicates that somehow the client felt the clinician was sincere in his or her caring, but we are unable to accurately ascertain what the client believes are the clinician's duties and thereby understand what the clinician did that went "beyond" these duties. On the other hand, most of the statements in Bedi's (2006) study were observable and concrete behaviours such as "the counsellor nodded", or "the counsellor invited me to call or email in between session, if I needed to". These differences likely affect the way participants perceive the factor and consequently impact the sorting process.

However, though methodology produced notable differences in the composition of statements and therefore likely affected the categorization of statements, there are remarkable similarities in the categories that resulted from the two studies. Participants in both studies identified body language, emotional support, resources and homework, setting, validation, session administration, and the personal responsibility of the client as categories of factors that were helpful in alliance building. Bedi's (2006) Session Administration had similar concepts as the present study's Ability to Relate. Both categories related to processes that often occurred outside of the counselling session. Bedi's Presentation and Body Language and Nonverbal Gestures are similar to the category Body Language in the present study. These three categories contain statements referring to the way the clinician uses nonverbal communication to build the alliance. Additionally, Guidance and Challenging (Bedi) contained similar factors to Planning and Approach (the present study), for example, "The counsellor confronted or challenged me" (Bedi), and "My counsellor met me where I was, but knew when to challenge me and was very honest" (the present study). Therefore, while the categories clients created in Bedi are different in number, statement composition, and titles, the overlap suggests that clients in both studies value factors that are not often discussed in alliance theory or included in research studies. Specifically, these include administrative details that may occur outside the clinician's counselling space, referrals, and resources, as well as clinician attitudes that communicate respect and support for the client as a human being.

Table 15

Comparison of Category Titles for Present Study and Bedi (2006)

Present Study Category Titles	Bedi (2006) Category Titles
[a] ***Body Language***	Presentation and **Body Language**
Interpersonal Demeanour	*Nonverbal Gestures*
Emotional Support	**Emotional Support** and Care
Ability to Relate	Setting
[b] *Provided Resources and Homework*	*Referrals and Recommended Materials*
Directed Process Appropriately	Education
Sharing the Counsellor's Personal Experience	Guidance and Challenging
Good Boundaries	Honesty
Availability	Validation
Planning and Approach	*Session Administration*
Attentiveness	Client's Personal Responsibility
Approachable	
Non-Judgemental	
Effective Listening	

[a] Words shown in bold lettering highlight shared vocabulary between studies.

[b] Italicized words indicate somewhat similar concepts.

Dimensionality

The Professional/Personal Relationship axis suggested for factors in this study supports Mohr and Woodhouse (2001) findings. Both studies show a similar division in alliance type preference. Clients place varying degrees of importance on clinician's friendliness, self-disclosure, professionalism, and emotional connection; some clients wanting the clinician to be like their best friend while others want a more professional relationship that focuses on the client's experience. Factors falling midpoint on the axis, described in the category Emotional Support (i.e., a non-judgmental and supportive attitude, empathy, and confidentiality) and endorsed highly by most participants, are congruent with the atmosphere of trust and respect for the client that Mohr and Woodhouse found to be considered essential by all participants.

Male and Female Perception of the Alliance

Male and female participants in this study rated helpfulness categories in a very similar manner: no statistically significant differences were found between the ratings for the two groups. Effective Listening and Approachable were rated in the top three most helpful categories by females and males. Concepts described in the statements that comprise these two categories; good listening skills, acceptance, interest in the client, establishment of trust, absence of shock or disgust, encouragement of self-expression, non-judgmental attitude and respect, are highly endorsed by both male and female participants.

Non-significant statistical differences for helpfulness ratings between males and females are possibly due to sample size. Comparable female and male sample sizes were obtained, making t-tests a reasonable statistical analysis. However, given an α of .05, Cohen (1992) specifies a sample size of 26 for each group to detect a large effect, a sample size of 64 for each

group to detect a medium effect, and a sample size of 363 for each group to detect a small effect. According to Cohen's recommendations, the sample sizes for this study (n = 26, n = 23, for women and men respectively) would likely be sufficient to detect a large effect, but not a medium or small effect. This makes it reasonable to state that there while there is not a big difference between the factors that men and women believe contribute to a strong alliance, there could be more finely nuanced differences in what is important to men and women that would be important to research as these smaller differences could likely impact alliance strength, but not likely detectable through a study with this number of participants.

Limitations

While the results of this study support the findings of Bedi (2006) and reinforce the need for continued research investigating the client's perception of the alliance, it is important to note methodological limitations. Logistical and ethical limitations prevented the researchers from conducting this study precisely as recommended by the creators of the Concept Systems software (The Concept Systems, 2008, Version 4). This would have included using the same individuals to create the statements, organize the statements into categories, suggest titles for the categories they created, choose the appropriate cluster solution, and validate the final results. As this was not logistically possible (i.e., ethical considerations would make it extremely difficult to recruit a sample of counselling clients from the community that would be willing and able to commit to this process) the statements and the results could not be validated by the participants.

The statements composed by participants were kept close to their form as written and only minimally revised for grammatical and gender inclusive vocabulary. Again, due to logistical and ethical constraints, participants were not included in the extraction/interpretation

step of the study. This potentially decreased validity of the statements as the participants were not able to verify that the resulting statements accurately represented their perceptions. It also resulted in many statements that were somewhat ambiguous; the precise meaning of some statements is unclear and therefore debatable. Other statements appeared to include at least two factors that could be interpreted as belonging to more than one category. Rather than have researchers evaluate the statements and make changes that would clarify and separate factors, participants were asked to interpret the focus of each statement. In cases where statements seemed to include potentially more than one factor, participants were asked to interpret factors for importance and choose which factor to focus on for both categorization and rating. Some statements appeared to have factors that could belong to two different categories and participants were asked to interpret the meaning such that each statement was placed in only one category. While participants were not the same individuals that created the statements, researchers believed that process would allow for additional counselling client input. However, this likely resulted in the same statement being ascribed different meanings by different participants and organized into categories accordingly.

Although recruiting was aimed at a cross-section of university and community participants, the sample was comprised of more than fifty percent university students and over ninety percent of the sample completed at least some post-secondary education, proportions not reflective of the general counselling population, thereby limiting generalizability.

Further, unlike Bedi (2006) statements were not limited to observable and behavioural factors and therefore required much greater participant interpretation as to the ambiguous meaning of each statement: the same statement could be interpreted in different ways by

different participants and there was no mechanism for verifying the congruence of the sorter's interpretation with the precise meaning intended by the composer of the statement. Also, allowing participants to include any type of factor, not just observable or behavioural factors, increased the abstract nature of the statements and participants were required to make inferences that may or may not be congruent with what the composer of the statement meant or congruent with the interpretation of the statement by other participants. In order to decrease the ambiguity of the statements and increase their validity, it would be helpful for researchers in future studies to meet with participants to explore the factor described and give the composer of the statement the opportunity to clarify the factor as well as organize statements that seem to describe two different factors into two different statements.

Sorting performance was likely decreased due to both the ambiguity of the statements and the large number of statements to be sorted. While some participants appeared to find the task relatively straightforward, many stated that they found the task difficult and confusing. Results may have been affected by fatigue or discouragement on the part of participants. Conversely, rating statements appeared easier than researchers expected. Therefore asking participants to rate all the statements for helpfulness, rather than only rating half the statements would have increased the reliability of helpfulness ratings by doubling the sample size that rated each statement.

Future Research

It would be helpful for future research to address the limitations described earlier. Also, a larger sample that is more reflective of the general population in terms of education and occupation could yield a result that is potentially more reflective of the general counselling

population. Future research could target community-counselling centers to recruit the non-student population less likely to have completed as much post-secondary education. As stated earlier, in order to address the ambiguity of some statements and inclusion of more than one factor in each statement, it would be helpful for researchers to meet with participants after they had composed their responses or use an interview process. This would allow participants to clarify meaning and make sure that each statement described only one helpful factor. The opportunity for participants to review statements with researchers could provide a set of statements more easily interpreted by sorters and evaluators. Overall, these methodological changes would increase the validity of both the statement composition (researchers would be more confident that the participants were in agreement with the final statement construction) and the need for participants to interpret ambiguity would be decreased.

Further, a richer and more comprehensive view of the client's perspective of the alliance would likely be revealed if clients were asked to report factors that had contributed to a rupture in, or termination of the alliance. Clients could also be asked what behaviours clinicians had performed that enabled them to rebuild a faltering or weak alliance. Client input with regard to the positive, negative, and reparative behaviours of the therapist would likely result in a more comprehensive and instructive picture of what clients find helpful in building the alliance.

Closing Statement

This study builds on and supports decades of thoughtful investigation regarding what works in the therapeutic process. In their desire to alleviate suffering and facilitate human growth, clinicians and researchers have developed theories and therapies shown to be effective in producing a positive outcome for clients. Research supports the conclusion that the

therapeutic alliance is one of the common factors in counselling that works to produce change. However, it is important to remember that the therapeutic alliance, while a useful and descriptive construct, exists only as the subjective perception of the individuals involved in the therapeutic relationship but it is the client's perception of the alliance that is most important in counselling outcome.

The results of this study support previous research (Bachelor, 1995; Mohr & Woodhouse, 2001; and Bedi, 2006) in investigating the client's subjective perspective of the therapeutic alliance. Clients in these studies identified factors that are not usually included in alliance theory. The studies also show that, for all the factors clients identify as critical and helpful, some clients find some of these factors helpful while other clients indicate that these same factors may in fact hinder the alliance: there is no ideal alliance that will be equally effective for all clients. Further, these studies support existing alliance theories that focus on the clinician communicating "unconditional positive regard" for the client (Rogers, 1957), the client feeling understood by the clinician and having a sense of working with the clinician in a collaborative effort (Luborsky, 2000); and the "goodness of fit of the respective personalities of the patient and the therapist" (Bordin, 1979, p. 252).

While further research into the client's perspective is important, this process is not uncomplicated. It is difficult to describe the dynamics of human relationships and clients are able to profit from a relationship although they cannot easily communicate why the relationship is helpful. Therefore much thoughtfulness and skill is required to facilitate an environment that is conducive to a clear understanding of what clients find helpful. We must continue to search for research designs that continue conversations with clients and include avenues for feedback

to validate and refine both our theories and therapies. It is hoped that future research will continue to address the need to hear the client's 'voice' more clearly in order to better understand and develop a theory of the therapeutic alliance that will support both the clinician and the client in working toward the client's personal goals.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33.

Andreoli, A., Frances, A., Gex-Mabry, M., Aapro, N., Gerin, P., & Dazord, A. (1993). *Journal of Nervous and Mental Disease, 181*, 732-737.

Bachelor, A. (1988). How clients perceive therapist empathy: A content analysis of 'received' empathy. *Psychotherapy: Theory, Research, Practice, Training, 25*, 227-240.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology, 42*, 323-337.

Bachelor, A., Laverdière, O., Gamache, D., & Bordeleau, V. (2007). Clients' collaboration in therapy: Self-perceptions and relationships with client psychological functioning, interpersonal relations, and motivation. *Psychotherapy: Theory, Research, Practice, Training, 44*, 175-192.

Barber, J., Luborsky, L., Crits-Christoph, P., Thase, M., Weiss, R., Frank, A., Onken, L., & Gallop, R. (1999). Therapeutic alliance as a predictor of outcome in treatment of cocaine dependence. *Psychotherapy Research, 9*, 54-73.

Bedi, R. P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology, 53*, 26-35.

Bedi, R. P., & Alexander, D.A. (2009). Using multivariate concept mapping for examining client understandings of counselling. *Canadian Journal of Counselling, 43, 76-91.*

Bedi, R. P., Davis, M. D., & Arvay, M. J. (2005). The client's perspective on forming a counselling alliance and implications for research on counsellor training. *Canadian Journal of Counselling, 39*, 71-85.

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

Bedi, R. P., Duff, C. T. (2009). Prevalence of counselling alliance type preferences across two samples. *Canadian Journal of Counselling, 43,* 151-164.

Bedi, R. P., Duff, C. T. (2008). Client as expert: A Delphi Poll of therapeutic alliance formation factors. Manuscript submitted for publication.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*, 252-260.

Campbell, R., & Salem, D. A. (1999). Concept mapping as a feminist research method. *Psychology of Women, 23*, 65-89.

Clemence, A. J., Hilsenroth, M. J., Ackerman, S. J., Strassle, C. G., & Handler, L. (2005). Facets of the therapeutic alliance and perceived progress in psychotherapy: Relationship between patient and therapist perspectives. *Clinical Psychology & Psychotherapy, 12*, 443-454.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159.

Cohen, J. (1994). The earth is round. *American Psychologist, 49*, 997-1003.

Concept Systems Incorporated. (2008). *The concept system: Facilitator training seminar manual* (Version 4 Ed.). Ithaca, New York: Concept Systems Incorporated.

Cozby, P. C. (2003). *Methods in behavioral research,* (7th ed. Ed.). New York: McGraw Hill.

Creswell, J. W. (2008). *Educational research* (3rd. Ed. Ed.). Upper Saddle River, New Jersey: Pearson Prentice Hall.

Eames, V., & Roth, A. (2000). Patient attachment orientation and the early working alliance: A study of patient and therapist reports of alliance quality and ruptures. *Journal of Psychotherapy Research, 10*, 421-434.

Elliott, R. E., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related field. *British Journal of Clinical Psychology, 38*, 215-229.

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9*, 443-467.

Fahs, P. S., Morgan, L. L., & Kalman, M. (2003). A call for replication. *Journal of Nursing Scholarship, 35*, 67-72.

Fitzpatrick, M. R., Janzen, J., Chamodraka, M., & Park, J. (2006). Client critical incidents in the process of early alliance development: A positive emotion-exploration spiral. *Psychotherapy Research, 16*, 486-498.

Fitzgerald, L. F., & Hubert, L. J. (1987). Multidimensional scaling: Some possibilities for counseling psychology. *Journal of Counseling Psychology, 34*, 469-480.

Florsheim, P., Shortorbani, S., Guest-Warnick, G., Barratt, t., & Hwang, W. (2000). Role of the working alliance in treatment of delinquent boys in community-based programs. *Journal of Clinical Child Psychology, 29*, 94-107.

Frank, J. D. (1961). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore: The Johns Hopkins Press.

Gaston, L., Marmar, C., Gallagher, D., & Thompson, L. (1991). Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy processes. *Psychotherapy Research, 1*, 104-112.

Gaston, L., Thompson, L., Gallagher, D., Cournoyer, L., & Gagnon, R. (1998). Alliance, technique, and their interactions in predicting outcome of behavioral, cognitive, and brief dynamic therapy. *Psychotherapy Research, 8*, 190-209.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*, 296-306.

Greenberg, L. S., & Pinsof, W. M. (1986). *The psychotherapeutic process: A research handbook*. New York: Guilford Press.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis*. New York: International Universities Press.

Gunderson, J. G., Najavits, L. M., Leonhard, C., Sullivan, C. N., & Sabo, A. N. (1997). Ontogeny of the therapeutic alliance in borderline patients. *Psychotherapy Research, 7*, 301-309.

Hersoug, A. G., Hogland, P., Monsen, J. T., & Havik, O. E. (2001). Quality of working alliance in psychotherapy: therapist variables and patient/therapist similarity as predictors. *Journal of Psychotherapy Practice and Research, 10,* 205-216.

Hill, C. E., Knox, S., Thompson, B. J., & Nutt Williams, E. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25,* 517–572.

Hill, C. E., Knox, S., Thompson, B. J., Nutt Williams, E., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196-205.

Hillard, R. B., Henry, W. P., & Strupp, H. H. (2000). An interpersonal model of psychotherapy: Linking patient and therapist developmental history, therapeutic process, and types of outcome. *Journal of Consulting and Clinical Psychology, 68*, 125-133.

Hilsenroth, M. J., & Cromer, T. D. (2007). Clinician interventions related to alliance during the initial interview and psychological assessment. *Psychotherapy: Theory, Research, Practice, Training, 44*, 205-218.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* (pp. 37-69). New York, NY, US: Oxford University Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology, 36*, 223-233.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.

Hunter, J. E. (2001). The desperate need for replications. *Journal of Consumer Research, 28*, 149-158.

Jackson, K. M., & Trochim, W. M. K. (2002). Concept mapping as an alternative approach for the analysis of open-ended survey responses. *Organizational Research Methods, 5, 307-335.*

Joyce, A. S., & Piper, W. E. (1998). Expectancy, the therapeutic alliance, and treatment outcome in short-term individual psychotherapy. *Journal of Psychotherapy Practice and Research, 7*, 236-248.

Kivlighan, D. M. (1990). Relation between counselors' use of intentions and clients' perception of working alliance. *Journal of Counseling Psychology, 37*, 27-32.

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology, 64*, 532-539.

Kruskal, J., & Wish, M. (1978). *Multidimensional scaling.* Beverly Hills, CA: Sage.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* London: Sage.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*, 357-361.

Language Teaching Review Panel. (2008). Replication studies in language learning and teaching: Questions and answers. *Language Teaching, 41*, 1-14.

Lieberman, P. B., von Rehn, S., Dickie, E., Elliott, B., & Egerter, E. (1992). Therapeutic effects of brief hospitalization: The role of the therapeutic alliance. *Journal of Psychotherapy Practice and Research, 1*, 56-63.

Lingiardi, V., Filapucci, L., & Baiocco, R. (2005). Therapeutic alliance evaluation in personality disorders psychotherapy. *Psychotherapy Research, 15*, 45-53.

Luborsky, L. (2000). A pattern-setting therapeutic alliance study revisited. *Psychotherapy Research, 10*, 17-29.

Mallinckrodt, B., & Leong, F. T. L. (1992). Social support in academic programs and family environments: Sex differences and role conflicts for graduate students. *Journal of Counseling & Development, 70*, 716-723.

Marmar, C. R., Weiss, D., & Gaston, L. (1989). Towards a validation of the California therapeutic alliance rating system. *Journal of Consulting and Clinical Psychology, 1*, 46-52.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

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

Muran, J. C., Gorman, B. S., Safran, J. D., Twining, L., Samstag, L. W., & Winston, A. (1995). Linking in-session change to overall outcome in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology, 63*, 651-657.

Norcross, J. C. (2001). Purposes, processes and products of the task force on empirically supported therapy relationships. *Psychotherapy: Theory, Research, Practice, Training, 38*, 345-356.

Ogrodniczuk, J. S., & Piper, W. E., Joyce, A. S., & McCallum, M. (2000). Different perspectives of the therapeutic alliance and therapist techniques in 2 forms of dynamically oriented psychotherapy. *Canadian Journal of Psychiatry, 45*, 452-458.

Paivio, S. C., & Bahr, L. B. (1998). Interpersonal problems, working alliance, and outcome in short-term experiential therapy. *Psychotherapy Research, 8*, 392-406.

Palys, T. (2003). *Research decisions* (3rd Ed.). Scarborough, Ontario: Thomson Nelson.

Rennie, D. L. (1994). Client deference in psychotherapy. *Journal of Counseling Psychology, 41*, 427-437.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Counseling Psychology, 21*, 95 -103.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and theory*. Boston: Houghton Mifflin.

Rubino, G., Baker, C., Roth, T., & Fearon, P. (2000). Therapist empathy and depth of interpretation in response to potential alliance ruptures: The role of therapist and patient attachment styles. *Psychotherapy Research, 10*, 408-420.

Rumpold, G., Doering, S., Smrekar, U., Schubert, C., Koza, R., Schatz, D. S., Berti-Schuessler, A., Janecke, N., Lampe, A., & Schuessler, G. (2005). Changes in motivation and the therapeutic alliance during a pretherapy diagnostic and motivation-enhancing phase among psychotherapy outpatients. *Psychotherapy Research, 15*, 117-127.

Schneider, B. (2004). Building a scientific community: The need for replication. *Teachers College Record, 106*, 1471-1483.

Shapiro, D. A., & Shapiro, D. (1983). Comparative therapy outcome research: Methodological implications of meta-analysis. *Journal of Consulting and Clinical Psychology, 51*, 42-53.

Shern, D. L., Trochim, W. M., & LaComb, C.A. (1995). The use of concept mapping for assessing fidelity of model transfer: An example from psychiatric rehabilitation. *Evaluation and Program Planning, 18*, 143-153.

Sohn, D. (1998). Statistical significance and replicability: Why the former does not presage the latter. *Theory & Psychology, 8*, 291-311.

Sterba, R. (1934). The fate of the ego in analytic therapy. *International Journal of Psycho-Analysis, 15*, 117-126.

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13*, 593-618.

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology, 15*, 215-224.

Strupp, H. H., & Hadley, S. W. (1979). Specific vs. nonspecific factors in psychotherapy: A controlled study of outcome. *Archives of General Psychiatry, 36*, 1125-1136.

Thompson, B. (1999). If statistical significance tests are broken/misused, what practices should supplement or replace them? *Theory & Psychology, 9*, 165-181.

Tichenor, V., & Hill, C. E. (1989). A comparison of six measures of working alliance. *Psychotherapy, 26*, 195-199.

Trochim, W. (1989). An introduction to concept mapping for planning and evaluation. *Evaluation and Program Planning*, 12, 1-16.

Trochim, W. M. (1993, November). The reliability of concept mapping. *Paper Presented at the Annual Conference of the American Evaluation Association, Dallas, TX.*

Trochim, W. M., Cook, J. A., & Setze, R. J. (1994). Using concept mapping to develop a conceptual framework of staff's views of a supported employment program for individuals with severe mental illness. *Journal of Consulting and Clinical Psychology, 62*, 766-775.

Tyrrell, C. L., Dozier, M., Teague, G. B., & Fallot, R. D. (1999). Effective treatment relationships for persons with serious psychiatric disorders: The importance of attachment states of mind. *Journal of Consulting and Clinical Psychology, 67*, 725-733.

Weller, S. C. & Romney, A. K. (1988). Systematic data collection. Newbury Park, California: Sage.

Yeomans, F. E., Gutfreund, J., Selzer, M. A., Clarkin, J., Hull, J. W., & Smith, T. E. (1994). Factors related to drop-outs by borderline patients: Treatment contract and therapeutic alliance. *Journal of Psychotherapy Practice and Research, 3*, 16-24.

Zetzel, E. R. (1988). Current concepts of transference. *International Journal of Psychoanalysis, 37*, 369-376.

Zuroff, D. C., Blatt, S. J., Sostky, S. M., Krupnick, J. L., Martin, D. J., Sanislow, C. A., & Simmens, S. (2000). Relation of therapeutic alliance and perfectionism to outcome in brief outpatient treatment for depression. *Journal of Consulting and Clinical Psychology, 68*, 114-124.

Appendix A

Please think back over the meetings that you had with your current or last counsellor/therapist, paying particular attention to the working relationship that was developing between you and the mental health professional. [Please take a few moments to remember this clearly and put your thoughts in context] *What were the three most important things that helped form and strengthen the counselling or therapy relationship?* We are most interested in specific behaviours and other observable things. These can be things that either you or the professional did, things you did together or something else that happened within or outside the sessions. *Please describe each behaviour or event completely and in as much detail as possible.*

Before answering, please remember that we are asking about factors that helped form or strengthen your working relationship with the counsellor or psychotherapist – not factors that helped you get better or resolve the issues that brought you to counselling (i.e., you can have a good working relationship with your counsellor but still not be making much progress). For the purposes of this research study, please only focus on things that helped form or strengthen the working relationship regardless of whether or not counselling or therapy helped. If you are unsure about whether something is about the working relationship or progress, please discuss this with the research assistant.

Question: *What were the three most important things that helped form and strengthen the counselling or therapy relationship? Please describe each behaviour or event completely and in as much detail as possible.*

Appendix B

1.) Please indicate your gender.
□ Male □ Female □ other (please specify) _____

2.) Please indicate your birth date: Month _____ Year_____

3.) Please indicate your current marital status.
□ Single □ Married/Common-law □ Divorced/Separated □ Widowed

4.) Please indicate the highest level of education that you have completed.
□ Elementary School
□ High School
□ Bachelor's degree
□ Master's degree
□ Ph.D., M.D. or equivalent doctoral degree

5.) Please indicate your current occupation (includes full-time student).

_____

6.) Please indicate your ethnicity. _____

Appendix C

Statement Rating (H)

1. Does this statement describe something that happened in your counselling sessions? Please circle Y (Yes) or N (No) for each statement.

2. Also, please circle the number that best describes how helpful you believe this statement is (or was) in developing a strong working relationship with your counsellor. Please answer in the context of your current or most recent counselling experience. If you did not experience this factor, please rate how helpful you think it would have been if it had occurred.

1	2	3	4	5
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful	Extremely helpful

		Did this happen? Circle One	Helpfulness Rating Circle One
1	My counsellor had a non-judgmental and supportive manner and was familiar with the subject.	Y N	1 2 3 4 5
2	My counsellor helped me with tangible things related to my problems, contacting doctors and other professionals, as well as informing me of the variety of resources available.	Y N	1 2 3 4 5
3	My counsellor let me guide the subject matter of our meetings; anything was acceptable to talk about.	Y N	1 2 3 4 5
4	My counsellor openly invited me to share my concerns and didn't make any assumptions about what was happening or what I was feeling.	Y N	1 2 3 4 5
5	My counsellor was direct and straightforward regarding possible outcomes to my situation.	Y N	1 2 3 4 5
6	My counsellor gave me permission to cry. He/she showed empathy without becoming involved in my emotion.	Y N	1 2 3 4 5
7	My counsellor made him/herself very approachable as someone who listened to me and how I felt.	Y N	1 2 3 4 5

8	My counsellor listened with undivided attention and did not interrupt with analytical questions before my story was over.	Y	N	1 2 3 4 5
9	My counsellor gained knowledge by what I told him/her and did not assume other aspects that may have seemed possible.	Y	N	1 2 3 4 5
10	My counsellor used his/her real life experiences and examples from others he/she knew.	Y	N	1 2 3 4 5
11	My counsellor was open to being challenged on any comments or observations etc. and did not take offence.	Y	N	1 2 3 4 5
12	My counsellor was willing to call me and have further phone conversations about additional thoughts after a session if he/she felt he/she had misinterpreted/misread anything we discussed and was open for me to do the same.	Y	N	1 2 3 4 5
13	My counsellor asked me to return to the underlying issues when I had digressed.	Y	N	1 2 3 4 5
14	My counsellor treated me as an individual and not as a type, and my objections to completing classification questionnaires were acceptable to my counsellor.	Y	N	1 2 3 4 5
15	My counsellor monitored shifts in perception throughout the counselling process and was able to chart perceptual movement and major changes.	Y	N	1 2 3 4 5
16	My counsellor was sympathetic and able to see my point of view/perspective; could 'take my side' when I needed that support, could be a bit biased in my favour, and could 'paraphrase' or summarize my most recent issue.	Y	N	1 2 3 4 5
17	My counsellor did not judge me and made me feel like everything I was dealing with was normal.	Y	N	1 2 3 4 5
18	My counsellor always remembered very specific details about my life and circumstances.	Y	N	1 2 3 4 5
19	My counsellor was very interested in other ways of	Y	N	1 2 3 4 5

healing (e.g. my spiritual guide).

20	My counsellor was genuinely concerned for my well-being and sometimes gave me a call or asked me to leave a message to see how things were going.	Y	N	1 2 3 4 5
21	My counsellor worked close to where I lived and worked.	Y	N	1 2 3 4 5
22	My counsellor maintained a sense of confidentiality and sincerity.	Y	N	1 2 3 4 5
23	My counsellor was polite and respectful and showed this through smiling, handshaking, greeting, and taking time to answer questions outside of regular sessions.	Y	N	1 2 3 4 5
24	My counsellor had a sense of humour; cracking jokes, sarcastic remarks, and laughing.	Y	N	1 2 3 4 5
25	My counsellor treated me more like a person in need than a "client".	Y	N	1 2 3 4 5
26	My counsellor listened attentively.	Y	N	1 2 3 4 5
27	My counsellor encouraged me to come back and was interested to know how/if things had progressed.	Y	N	1 2 3 4 5
28	My counsellor was very present to me; to my energy, and to the truths in my body.	Y	N	1 2 3 4 5
29	My counsellor was willing to look at what I felt was important.	Y	N	1 2 3 4 5
30	My counsellor was consistent and calm and gave me tea.	Y	N	1 2 3 4 5
31	My counsellor explained his/her approach to counselling to me on the phone before we had our first appointment and the reasons why he/she used the counselling techniques.	Y	N	1 2 3 4 5
32	My counsellor shared a personal anecdote with me.	Y	N	1 2 3 4 5
33	My counsellor carved out a space for humour when	Y	N	1 2 3 4 5

appropriate.

34	My ability to open up, trust and talk to my counsellor.	Y N	1 2 3 4 5
35	My counsellor listened, accepted, and encouraged me to open up.	Y N	1 2 3 4 5
36	My counsellor remembered small things and treated me like he/she actually knew me.	Y N	1 2 3 4 5
37	My counsellor was able to small talk about things like office decorations, music, and various things but still remain professional and not too personal.	Y N	1 2 3 4 5
38	My counsellor listened very intently and took good notes of whatever he/she thought was important.	Y N	1 2 3 4 5
39	My counsellor would sometimes ask specifically what I wanted to accomplish or what would need to happen to make me feel better.	Y N	1 2 3 4 5
40	My counsellor listened, validated my feelings, and told me what I was experiencing was normal.	Y N	1 2 3 4 5
41	My counsellor was warm and friendly when greeting me; he/she made eye contact, remembered my name, and offered me a coffee.	Y N	1 2 3 4 5
42	My counsellor sat patiently and helped me find my voice to figure out what I needed to say by giving me time and encouraging me.	Y N	1 2 3 4 5
43	My counsellor asked questions gently but fearlessly, rather than "judge" the individual aspects of my story.	Y N	1 2 3 4 5
44	My counsellor maintained a light tone and not a harsh, confrontational tone.	Y N	1 2 3 4 5
45	My counsellor and I devised homework together, tailoring the information and exercises, and we always went over the homework at the next session.	Y N	1 2 3 4 5
46	My counsellor appeared to be in my age group.	Y N	1 2 3 4 5

47	My counsellor gave me names of authors, names of books, and we discussed new age theories that I hadn't heard of before.	Y N	1 2 3 4 5
48	My counsellor's voice was calm, nurturing, and somewhat monotone. Although my counsellor disclosed a couple things, I never felt like the focus was on him/her.	Y N	1 2 3 4 5
49	I didn't feel as though my counsellor was "studying" me or that I was just another chore or patient on his/her schedule of people or things to do and see that day.	Y N	1 2 3 4 5
50	My counsellor always made time for me. He/she would always fit me in somehow.	Y N	1 2 3 4 5
51	My counsellor would add things about him/herself in relation to what I was saying and did not act like an authority/medical figure to me.	Y N	1 2 3 4 5
52	My counsellor assured me that what we discussed would never leave the room without my permission. I was not being judged (my counsellor let me know that my issues were things he/she dealt with all the time) and my counsellor also gave me some personal history of his/her past issues.	Y N	1 2 3 4 5
53	My counsellor would do extra legwork and would accommodate my needs regarding session times, session frequency, personal goals, etc.	Y N	1 2 3 4 5
54	My counsellor encouraged me to talk or cry, would listen to me talk in a negative way about myself, and would accept my thoughts before he/she would gently ask questions that shed new light on the origins or fallibility of these negative thoughts.	Y N	1 2 3 4 5
55	My counsellor went beyond his/her duties and showed he/she sincerely cared.	Y N	1 2 3 4 5
56	My counsellor listened very well. He/she would speak when I stopped talking or when I asked a direct question and would ask excellent thought provoking questions and	Y N	1 2 3 4 5

give his/her own opinion.

57	My counsellor told me information about his/her life and relationships with his/her children.	Y	N	1 2 3 4 5
58	My counsellor never showed shock, disgust, or any abnormality when I showed how I felt or what I thought.	Y	N	1 2 3 4 5
59	My counsellor was not "mother" like, which helped me feel comfortable addressing more than surface issues.	Y	N	1 2 3 4 5
60	My counsellor was upfront and told me to not tell him/her what he/she wanted to hear.	Y	N	1 2 3 4 5
61	My counsellor treated me as an intelligent and normal person. He/she saw me as an individual, and more than a condition or problem.	Y	N	1 2 3 4 5
62	My counsellor was friendly and made an effort to begin appointments with small talk and my counsellor made a point of remembering details about my life not related to the problems I saw him/her for.	Y	N	1 2 3 4 5
63	The way my counsellor sat, moved, etc. indicated that he/she was comfortable and he/she was not somehow threatened, closed-off, or upset.	Y	N	1 2 3 4 5

Statement Rating (T)

1. Does this statement describe something that happened in your counselling sessions? Please circle Y (Yes) or N (No) for each statement.

2. Also, please circle the number that best describes how helpful you believe this statement is (or was) in developing a strong working relationship with your counsellor. Please answer in the context of your current or most recent counselling experience. If you did not experience this factor, please rate how helpful you think it would have been if it had occurred.

1	2	3	4	5
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful	Extremely helpful

		Did this happen? Circle One	Helpfulness Rating Circle One
64	At the first session we discussed the direction the counselling would take – what I wanted from it, what the counsellor could offer me, and what approach we would use.	Y N	1 2 3 4 5
65	When my counsellor gave me a task/homework he/she gave me ideas on how to complete it, and we talked about what I would do to try and complete it.	Y N	1 2 3 4 5
66	When my counsellor's schedule was full he/she moved things around so I could have an appointment the following week.	Y N	1 2 3 4 5
67	My counsellor was happy looking and his/her body language was peaceful and calm.	Y N	1 2 3 4 5
68	My counsellor never pushed for questions. He/she simply expressed interest and was a good listener.	Y N	1 2 3 4 5
69	My counsellor dressed professionally the office was clean, warmly decorated, and organized.	Y N	1 2 3 4 5
70	My counsellor asked specific questions that made me sure he/she was thinking carefully about what I was saying.	Y N	1 2 3 4 5
71	My counsellor's office space was professional but cozy and intimate, and had warm colours and a pleasant view.	Y N	1 2 3 4 5

72	My counsellor was very reassuring, i.e. saying "you're on the right path" or "I think this is the right thing for you to do".	Y N	1 2 3 4 5
73	My counsellor was positive and encouraging. He/she always pointed out the good things I was doing and the progress I had made.	Y N	1 2 3 4 5
74	My counsellor was non-judgmental. He/she didn't criticize anything I had done.	Y N	1 2 3 4 5
75	My counsellor was a real and honest person who was open to connecting on an emotional and spiritual level through self-disclosing appropriately and allowing me to know when I had impacted her/him.	Y N	1 2 3 4 5
76	I knew that if I was in a distressed state, I could get in contact with my counsellor.	Y N	1 2 3 4 5
77	My counsellor was always willing to help me with forms or provide me with information about a particular program.	Y N	1 2 3 4 5
78	My counsellor always remembered my life events and didn't have to refer to a file.	Y N	1 2 3 4 5
79	My counsellor was open and upfront about the fact that there was a monetary factor in our relationship. When I said that I wouldn't be able to afford to come in for awhile, my counsellor did not become uncomfortable or act as if that was not a valid reason to have fewer visits.	Y N	1 2 3 4 5
80	My counsellor struck a good balance between the professional and personal aspects of our relationship. He/she was kind and friendly to me and would talk about him/herself and her/his experiences when they were relevant, but he/she had clear and firm boundaries with me.	Y N	1 2 3 4 5
81	My counsellor didn't talk down to me and was honest and straightforward in her/his reactions to my problems and thoughts. He/she didn't try to convince me that everything was fine when it wasn't.	Y N	1 2 3 4 5
82	My counsellor revealed to me within the first few sessions that he/she had battled the same issue as me in the past.	Y N	1 2 3 4 5

83	My counsellor was able to understand the root/source of the problem before I even understood.	Y N	1 2 3 4 5
84	My counsellor was the same gender as me.	Y N	1 2 3 4 5
85	My counsellor was interested in what I wanted to say.	Y N	1 2 3 4 5
86	My counsellor asked lots of questions and wasn't afraid to take more talk time than me.	Y N	1 2 3 4 5
87	My counsellor reaffirmed many things I already knew.	Y N	1 2 3 4 5
88	My counsellor was friendly (but not overly so), quiet, and didn't rush me at all.	Y N	1 2 3 4 5
89	My counsellor shared his/her personal experience with me when we were in sessions.	Y N	1 2 3 4 5
90	My counsellor asked "what is bothering you the most?" and his/her quiet, warm and non-rushing manner gave me time to think about it seriously.	Y N	1 2 3 4 5
91	My counsellor assured me that he/she was realistic about the life the average person carried out.	Y N	1 2 3 4 5
92	My counsellor told me that my mother had approached the counsellor after one of my sessions and assured me that the counsellor had allowed none of my privacy to be invaded.	Y N	1 2 3 4 5
93	My counsellor paraphrased what I said.	Y N	1 2 3 4 5
94	My counsellor provided assistance outside of our sessions by allowing me to e-mail to ask questions.	Y N	1 2 3 4 5
95	My counsellor was able to ask critical questions so that I could start thinking about and finding/identifying the problems.	Y N	1 2 3 4 5
96	My counsellor provided me with emotional support and was able to express sympathy.	Y N	1 2 3 4 5
97	My counsellor smiled and listened to my issues, but didn't make me feel like I was alone or different.	Y N	1 2 3 4 5

98	My counsellor facilitated my thought process and allowed me to find my own answers, rather than directing he/she made me feel like I had the answers, and it was just a matter of uncovering them.	Y N	1 2 3 4 5
99	My counsellor made lots of eye contact, didn't make notes, and tilted his/her head in sympathy.	Y N	1 2 3 4 5
100	In the first session, I was allowed to spend the whole hour telling my life story and the counsellor briefly shared the same circumstance that happened to him/her.	Y N	1 2 3 4 5
101	My counsellor picked a method that seemed right for me.	Y N	1 2 3 4 5
102	I was offered tea and welcomed not as a patient, but as an equal human being and there was a sense that I was in control of the session.	Y N	1 2 3 4 5
103	My counsellor took my perceptions and beliefs at face value without putting his/her meaning on my experience. My counsellor worked with me, not the counsellor's story of me.	Y N	1 2 3 4 5
104	My counsellor didn't judge me. He/she stepped into my world and my meanings and worked from that place.	Y N	1 2 3 4 5
105	My counsellor met me where I was, but knew when to challenge me and was very honest.	Y N	1 2 3 4 5
106	My counsellor facilitated the creation of an environment where I could express myself without him/her panicking. He/she did not show fear or impinge on my right to experience the feeling I needed to get better.	Y N	1 2 3 4 5
107	Nothing was able to faze the working relationship. The counsellor remained solid.	Y N	1 2 3 4 5
108	My counsellor genuinely smiled.	Y N	1 2 3 4 5
109	My counsellor shared stories about his/her own family and relationships, and issues that were troubling for him/her in those relationships.	Y N	1 2 3 4 5
110	My counsellor shared his/her previous issues.	Y N	1 2 3 4 5

111	My counsellor did not invade my personal space, and had a non-aggressive, non-judgemental, and respectful attitude towards me.	Y N	1 2 3 4 5
112	My counsellor always seemed happy to see me, greeting me with warmth and excitement and a solid hug. He/she commented on my strengths as an individual and expressed heartfelt happiness when things were going well in my life.	Y N	1 2 3 4 5
113	My counsellor told stories from his/her own life and professional career.	Y N	1 2 3 4 5
114	My counsellor was very intuitive and empathic. I knew that my counsellor would know if I wasn't telling the truth or was holding back about something.	Y N	1 2 3 4 5
115	My counsellor listened to my stressors and established trust.	Y N	1 2 3 4 5
116	My counsellor tried to get to know me before he/she offered advice.	Y N	1 2 3 4 5
117	My counsellor was positive, cheerful, didn't say 'oh how bad", looked at the good side of things, and smiled.	Y N	1 2 3 4 5
118	My counsellor had good body language – he/she shook hands, seemed relaxed, and made eye contact.	Y N	1 2 3 4 5
119	My counsellor helped me see positives in myself, through analogies and mental exercises.	Y N	1 2 3 4 5
120	My counsellor treated me as an individual with unique problems/issues, called me by name or nickname, and made me feel like I was the only person they had seen that day.	Y N	1 2 3 4 5
121	My counsellor shared unrelated details and idiosyncrasies that made him/her seem human. This comfort and openness was also seen in my counsellor's ability to laugh and joke, and recognize that I was sometimes joking too!	Y N	1 2 3 4 5
122	My counsellor understood where I was going with a train of thought when I got stuck trying to explain something.	Y N	1 2 3 4 5

123	My counsellor stressed that I was not crazy even when I believed I was. He/she would not make fun or make light of any thought/feeling I shared.	Y N	1 2 3 4 5
124	My counsellor asked about things in my life other than the problem I was there for and remembered things I had mentioned in previous sessions.	Y N	1 2 3 4 5
125	When I told my counsellor that I was uncomfortable with a certain subject, he/she never mentioned it again without asking first whether he/she could or not, unless I brought it up first.	Y N	1 2 3 4 5

Appendix D

Preferred Counselling Relationship

We are interested in your understanding of an ideal (yet realistic) working relationship with your counsellor. If you were to see another counsellor in the future, we are wondering what you wish he/she would be like? One way of understanding the working relationship is to classify it as one of three types (Bachelor, 1995). Please read the following descriptions and choose the type that best describes your preference.

A. Most individuals will see some factors of all three types in their preferred counselling relationship. Which ONE of the three descriptions MOST CLOSELY resembles your preferred counselling relationship?

Please check ONE box.

☐ The professional is very friendly, warm, respectful and patient. He or she does not pressure me or try to rush me but rather listens intently and takes extra effort to establish an atmosphere of trust and help me feel at ease.

☐ The professional emphasized the exploratory nature of our work together and encourages my free, uninterrupted self-expression. He or she is great at keeping me on track and has a remarkable ability to assist me in better expressing myself and in gaining a greater self-understanding than I could on my own.

☐ The professional is very involved and he or she and I are equal partners. We have a very collaborative, two-way relationship with mutual trust and respect. The climate is very professional and we are both actively involved in determining the details of the service that I receive.

B. The following describes another way of viewing the working relationship you can have with your counsellor. Please choose ONE of the two following descriptions that would best fit your idea of a preferred counselling relationship.

☐ The working relationship is more professional than personal. The mental health professional keeps an objective distance from me rather than getting very personally involved with and affected by my issues. He or she is able to be impartial and competent while facilitating emotional expression, exploration, and insight.

☐ The working relationship is like a good friendship. The mental health professional is very warm and emotionally connected, and much more personal than professional. I feel free to explore difficult issues and let my feelings come to the surface. He or she is willing to share relevant personal information.

Thank you for your participation! Your responses will greatly assist us in understanding how clients view their relationship with their counsellor.