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A Phenomenological Study of the Perceptions of Beginning Counselors about the Development of the Therapeutic Alliance over the Practicum Experience

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A PHENOMENOLOGICAL STUDY OF THE PERCEPTIONS OF
BEGINNING COUNSELORS ABOUT THE DEVELOPMENT OF THE
THERAPEUTIC ALLIANCE OVER THE PRACTICUM EXPERIENCE

by

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DEDICATION

To Pietro & Francesco

ACKNOWLEDGEMENTS

Thank you to my lovely husband, Pietro:

I am so grateful for your love, patience, and all the sacrifices you make for our family.

Thank you to our adorable son, Francesco:

You add so much joy and fun in our family every day!

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ABSTRACT

The purpose of this qualitative study is to explore master students' experience regarding the development of the therapeutic alliance with first clients over the length of the practicum experience.

The American Psychological Association (APA) emphasizes the importance of studies that identify factors involved in the therapeutic alliance. In the literature on the therapeutic alliance, there is a lack of qualitative research on the perceptions of graduate level counseling students regarding their ability to build and maintain a therapeutic alliance with their first clients during the therapeutic process. The problem in the counselor education profession is the urgent need of assessment procedures that evaluate the development of relational skills during the practicum experience.

The research instrument of this study consist of interviews provided at the end of the Fall semester 2013 to 2nd year Ed.S. practicum students in Marriage, Couples and Family Counseling (MCFC) program at University of South Carolina. Interviews aim to explore students' understanding about the evolution of relational skills during their practicum, incorporating clients' feedback in both clinical and supervision sessions.

Both theoretical and practical implications for pedagogy and supervision in counselor education profession will be discussed.

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CHAPTER 1

INTRODUCTION

Decades of scientific research have documented the effectiveness of psychotherapy. Qualitative and quantitative reviews of thousands of scientific studies have shown that about 70%-80% of patient demonstrate benefits from the therapeutic process, and an estimated 5%–10% of adult clients participating in therapeutic process leave treatment worse off than they began treatment. These findings are across different types of disorders, therapy formats, models and theoretical approach (Lambert & Ogles, 2004; Wampold, 2001).

Recently, research has focused on factors that contribute to the success or the failure of the psychotherapy intervention. Meta-analyses have found two important findings. First, people who receive psychotherapy do better compared to those who do not. Second, there are minimal differences in the yield of different theories and techniques. In the analysis of what accounts for the effectiveness of different treatments, researchers have differentiated “common” factors from factors “specific” to particular treatment interventions. These four common factors are: client and extra-therapeutic factors, therapeutic relationship factors, model/technical factors, and expectancy or placebo effects (Miller, Duncan & Hubble, 1997; Thomas, 2006). For the variations in clients’ improvements, common factors shared by all psychotherapies are considered “active ingredients” (Drisko, 2004). The common factors framework is the contemporary focus of psychotherapy literature, research and clinical practice.

Norcross and Lambert (2010) found that the therapeutic relationship is the key element for the therapy effectiveness and treatment outcome. Positive treatment outcome and the continuation of the therapeutic work are mainly related to the therapist's ability to develop and maintain an emotionally positive therapeutic alliance with all members of the system in treatment. The development and maintenance of the therapeutic relationship is a primary curative component of therapy and the relationship provides the context in which the specific techniques exert their influence (DeFife & Hilsenroth, 2011; Hilsenroth & Cromer, 2007).

The American Psychological Association (APA) sponsored an urgent need to identify and spread what works in the therapeutic relationship (Norcross, 2001). Some researchers have begun to focus on practitioner characteristics that contribute to alliance development and on the client's perspective of the alliance (Audet & Everall, 2010; Baldwin, Wampold & Imel, 2007; Blow, Sprenkle, & Davis, 2007; Davis & Piercy, 2007a, 2007b; Duff & Bedi, 2010; Green, 2011). However, the construct "therapeutic alliance" has been mostly analyzed with quantitative research designs which aim to give the therapist the opportunity to receive feedback from clients on the treatment process using quantitative measures and rating scales (Miller, Duncan, Brown, Sorrel, & Chalk, 2006). To know what is effective in the therapeutic relationship, it seems recently important to collect clients' feedback. Practitioners are encouraged to routinely monitor patients' responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to repair alliance ruptures, improve the relationship with clients, modify technical strategies, and avoid premature termination. The Feedback Informed Treatment is a recent approach that aims to monitor therapists contribution to

the alliance from clients feedback (Ancar, Dunkan, & Sparks, 2009; Shimokawa, Lambert, & Smart (2010).

Despite development of scales to measure the therapeutic alliance and research investigating its role in treatment outcome, there has been relatively little work on interventions designed to develop or enhance the therapeutic alliance. The educational training for beginning therapists is focused on both the development and the clinical competence. The primary concern of supervision is not just related to strength students' technical skills, but even relational skills (Morgan & Sprenkle, 2007). However, there is a deficiency in our knowledge about whether or not the use of qualitative instruments to explore the therapeutic alliance may inform trainees and supervisors regarding the development of relational skills with clients and the use of self in therapy.

1.1 PROBLEM STATEMENT

This study investigates the problem of the assessment of relational skills developed by Ed.S. Marriage, Couples and Family (MCFC) counseling students during their practicum experience, which includes both clinical and supervision sessions. Although two qualitative studies on the therapeutic alliance have been conducted (Horvath & Bedi, 2002; Krause & Altimir, 2011), the majority includes a quantitative approach to measuring this construct in clinical settings, focusing on what factors are helpful in therapy (Elvins & Green, 2008; Horvath, Del Re, Fluckiger, & Simonds, 2011; Martin, Graske, & Davis, 2000). A qualitative approach provides more information about what clients perceive the relationship with their therapists is. With qualitative feedback forms, clients can report their thoughts, concerns, desires and not just measure the quality

of the session using a scale. This research design addressed the deficiencies of previous methods in the current counselor education professional knowledge.

Furthermore, some researchers have taken into account the importance of the supervisory alliance experience for helping therapists learn to develop their therapeutic alliances (Gard & Lewis, 2008; Safran, Muran, Stevens, & Rothman, 2007). Lambert and Hawkins (2001) have discussed the potential advantages of using client outcome data for counselor training and supervision. According to these authors, monitoring client feedback could help provide rich information for use in supervision by enabling supervisors to monitor supervisee progress more closely. Reese, Usher, Bowman, Norsworthy, Halsted, Rowlands, and Chisholm (2009) have found that the exploration of continuous client feedback in supervision facilitate the counselor self-efficacy and outcome. This is one of few studies with a specific focus on the use of clients' feedback in supervision. Although supervision is central to counseling training, there is a lack of supervision research in this area (Freitas, 2002). This study gives a contribution to the literature showing how the use of clients' feedback may be beneficial in the practicum experience, which includes supervision hours.

In addition, graduate level counseling students often report a lack of qualitative feedback regarding the client's experience and evaluation of the counseling process. Beginning therapists want to know whether they are being helpful to clients. For this specific need, it could be useful for students to use an assessment during the sessions with the goal to analyze it in supervision to improve the quality of the therapeutic alliance with clients. According to the literature, supervisory feedback has been found to influence trainees' self-efficacy (Daniels & Larson, 2001). Moreover, it has been found that, if

trainees receive ongoing feedback from their clients, they show more improvement at the end of their practicum, indicating that feedback may help students in an accurate assessment of their own counseling skills (Reese et al., 2009).

1.2 NATURE OF THE STUDY

The research question of this study was: How do second year Ed.S. students enrolled in Marriage Couples and Family Counseling (MCFC) program reflect on the evolution of the therapeutic alliance over the length of the practicum experience?

The variables of this qualitative research were:

- the therapeutic alliance between practicum students and their first clients
- the time frame, which means the entire period of the practicum experience
- the use of the Client Feedback Note (Haber, Carlson, & Braga, 2014) form, which was the intervention of choice and is composed by 4 open questions the client is asked to fill out at the end of each session:

- my (client) feelings/thoughts about the therapeutic session,
- what I (the client) learned,
- what I (the client) did not like,
- what I (the client) wish would have happened.

The population was composed of second year Ed.S. students in Marriage, Couples and Family Counseling (MCFC) program who start their practicum in Fall 2013.

As research instrument, semi structured interviews were used. Interviews provided data regarding the students' perceptions about the development of the therapeutic alliance over the length of the practicum experience. Interviews were provided at the end of the Fall semester 2013 which coincided with the end of students'

practicum experience. To create valid questions for interviews on the dimensions of the therapeutic alliance and its development over the time, comparative analysis of quantitative measures of therapeutic alliance from the literature were adopted.

1.3 PURPOSE OF THE STUDY

The purpose of this research was to explore master students' experience regarding the development of the therapeutic alliance with their first clients over the length of the practicum experience, incorporating clients' feedback. This study aimed to answer to the problem raised by Reese et al. (2009) on the utility of continuous client feedback in counselor training and supervision. According to the authors, despite of difficulties and challenges in conducting supervision research with focus on client outcome, the research in this area is relevant because of the centrality of supervision to counselor training.

1.4 CONCEPTUAL FRAMEWORK

1.4.1 Qualitative paradigm

The aims of this research were best met by a research strategy within the qualitative paradigm. Qualitative research aims to build theory by turning to those individuals who have personal experience with the phenomenon under study, and giving them a voice to express their own experiences and meanings. The features of the qualitative design – focus on individual meaning and experience, emphasis on context, open-ended data, emergent design, and inductive interpretation (Maxwell, 2013) – are appropriate for dealing with the nature of the research problem in this study. Maxwell (1996) adds, “in a qualitative study, you are interested not only in the physical events and behavior that is taking place, but also in how the participants in your study make sense of

this and how their understandings influence their behavior” (p. 17). The similarities in assumptions and methods that exist between counseling and qualitative research processes (Gama, 1992) create what seems to be a natural union (Morrisette, 1999).

1.4.2 Phenomenology framework

Interpretivism was the theoretical framework of this research, since the central purpose is to understand and analyze the perception of beginning therapist regarding their therapeutic alliance. In particular, the content analyses of students’ reports are in according with the phenomenological approach (Merriam, 2002). A researcher applying phenomenology is concerned with the lived experiences of people involved, or who are involved, with the issue that is being researched (Groenewald, 2004). The benefit of phenomenological methodology in exploring the therapeutic relationship is that it includes all aspects of participants’ experiences. According to Hycner (1999) “the phenomenon dictates the method (not vice-versa) including even the type of participants” (p.156).

Purposive sampling, considered by Welman and Kruger (1999) as the most important kind of non-probability sampling, was considered the best to identify the participants of this research. The sample was selected based on researcher’s judgment and the purpose of the research (Babbie, 1995; Greig & Taylor, 1999; Schwandt, 1997), looking for those who “have had experiences relating to the phenomenon to be researched” (Kruger, 1988 p. 150). The inclusion of all perspectives contributes to the knowledge of the themes of lived experiences.

According to the phenomenological approach, interview questions are “directed to the participant’s experiences, feelings, beliefs and convictions about the theme in

question” (Welman & Kruger, 1999, p. 196). Moreover, in line of the root of phenomenology, the intent of the interviews is “to understand the phenomena in their (participants) own terms, to provide a description of human experience as it is experienced by the person herself” (Bentz & Shapiro, 1998, p. 96) and allowing the essence of participant’s personal experiences and subjective meanings to emerge (Cameron, Schaffer & Hyeon-Ae, 2001) by minimally imposing predetermined conceptualizations onto the data (Audet, Everall, 2010). Consistent with this approach, each component of thematic categories, obtained by the analyses of interviews, is a necessary component for understanding the experiences as lived by participants (Creswell, Hanson, & Morales, 2007).

1.5 OPERATIONAL DEFINITIONS

For the purpose of this study, the following definitions are provided: therapeutic alliance, Marriage, Couples and Family (MCFC) counselor education program, practicum students, and self-report.

1.5.1 Therapeutic Alliance

In therapy, alliance refers to “[the] quality and strength of the collaborative relationship between client and therapist ... [it] is inclusive of: the positive affective bonds between client and therapist, such as mutual trust, liking, respect and caring ... consensus about, and active commitment to, the goals of therapy and to the means by which these goals can be reached ... a sense of partnership” (Horvath & Bedi, 2002, p.41).

From the debut of this construct in the literature of the 1930s, and well into the 1970s, various proposal have been put forth about which elements- the patient’s capacity

to connect with the therapist, the therapists' personal characteristics, the client being on board with the tasks of treatment, the emotional bond between therapist and client, and so forth – are most critical. A vast number of publications are available about the alliance, how it relates to outcome (Horvath et al., 2011; Martin et al, 2000), the therapists' role (Baldwin, Wampold, & Imel, 2007), its development (Castonguay, Constantino, McAleavey, & Godfried, 2010), and training implications (Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002), but relatively little work has been done to clarify how the alliance is experienced by the participants. Also, the idea of the concept of the alliance has undergone substantial development but very little work has been done to clarify and document these evolving changes since the pioneering work on the subject. As theories of the alliance developed, various modifiers were attached to the term, including ego alliance, working alliance, therapeutic alliance, helping alliance. In the late 1970s, Bordin (1979) suggested a pantheoretical definition that incorporated most of these elements. Even if this conceptualization is dated, it has been the most heuristically rich and influential model of alliance in both conjoint and individual psychotherapy. According to Bordin (1979), the working alliance includes three components: (a) agreement between therapist and client about the goals of treatment, (b) agreement about the therapy tasks needed to accomplish the goals, and (c) affective bonds, necessary to sustain the hard work of therapeutic change. The heuristic values of Bordin's (1979) thinking and intuitive appeal of the alliance as an explanatory construct can be seen in its application across different schools of therapy. Although this construct has its roots in psychoanalysis, the concept of the alliance has been the subject of a great deal of attention by theorists, researchers and clinicians working from different treatment models

(Hatcher, 2010; Horvath et al., 2011a). Bordin's factors of goal-task agreement and therapeutic bond remain firmly imbedded in current conceptualizations and measurement instruments of therapeutic alliance (Bordin, 1994; DeFife & Hilsenroth, 2011; Hatcher, 1999; Hatcher & Barends, 1996; Horvath, 2000).

1.5.2 Marriage, Couples, and Family (MCFC) counselor education program

Marriage, Couples and Family Counseling (MCFC) counselor education program is a graduate level specialized training program that prepare students to become family counselors. Additional information on University of South Carolina program admission, degree requirements, and learning outcomes can be found in the following Graduate School and Academic Bulletins link:

[http://bulletin.sc.edu/preview_program.php?catoid=35&poid=4039#Marriage Couples and Family Counseling](http://bulletin.sc.edu/preview_program.php?catoid=35&poid=4039#Marriage_Couples_and_Family_Counseling)

1.5.3 Practicum Students

Practicum students are students enrolled in the second year graduate training program, which requires a practical experience in clinical setting. For counseling students at University of South Carolina (CACREP standards), the practicum experience is designed and supervised by the instructor of EDCE 802F (a graduate course) and by the field site supervisor. Students enrolled in the practicum are required to accumulate a minimum of 150 clock hours. For Ed.S. students enrolled in Marriage, Couples, and Family Counseling (MCFC), of these 150 hours, a minimum of 60 hours must be in direct service work with clients appropriate to the MCFC specialization. The practicum student is to have one hour per week in supervision with the site supervisor, one hour of supervision per week with a program faculty member or student supervisor working

under the supervision of a program faculty member, and one and one-half hours per week in group supervision. Supervision is defined by Bernard and Goodyear (2004) as an intervention provided by a senior member of a profession to a junior member or members of that same profession. The relationship between them is evaluative, it extends over time and it has two simultaneous purposes. The first is enhancing the professional functioning of the more junior member(s), and monitoring the quality of professional services offered to the clients that she/he/they see. The second is acting as a gatekeeper for those who are to enter the particular profession. Supervised practice is typically perceived as a necessary intervention of excellent graduate psychotherapy training, since it aims to help students develop their therapy skills (Reese et al., 2009).

For further information about the practicum in MCFC, please refer to the manual at <http://www.ed.sc.edu/edst/ce/pdf/MCFCManualRevAugust2012.pdf>, and to the Appendix A (“Marriage, Couples, and Family Counseling practicum application”).

1.5.4 Self-Reports

Self-reports are data obtained directly from people who explore their own experiences and report to the researcher. Qualitative methods are specifically constructed to take account of the particular characteristics of human experience and to facilitate the investigation of experience. To capture the richness and fullness of an experience, researchers use first-person or self-reports of participants’ own experience. The advantage of this method is that people give their personal perspective. The disadvantage is related to the fact that because experience is not directly observable, data about it depend on the participants’ ability to reflectively discern aspects of their own experience

and to effectively communicate it (Polkinghorne, 2005). The main qualitative self-report methods are questionnaires and semi-structured interview.

1.6 ASSUMPTIONS AND LIMITATIONS OF THE STUDY

1.6.1 Assumptions

It was assumed that students who will participate to this study had achieved a solid theoretical and technical knowledge about the counseling profession, since they will be at the end of their graduate studies in counseling. Also, it was assumed that students were opened to discuss their improvements about the therapeutic alliance with their first clients during their supervision sessions. A final assumption was that students will be supervised by competent supervisors who took into account the importance of students' development of therapeutic alliance during their practicum.

1.6.2 Limitations

Potential weaknesses of this study were related to some aspects of the qualitative methodology.

First of all, the number of participants and their characteristics was a limitation. The sample of this study was composed of second year Ed.S. practicum students in Marriage, Couples and Family Counseling (MCFC) program at University of South Carolina. The number of second year Ed.S. practicum students in the Counselor Education program is not large, and this number decreases if only students enrolled in the Marriage, Couples, and Family Counseling specialty are selected. Also, those students were all enrolled at the University of South Carolina and this was another restriction for what concern the peculiarity of the sample. Moreover, the focus of the study was just on

the practicum experience of counseling practicum students, who can be considered beginning therapists. Because of the quantity and the uniqueness of the participants, findings of this study might not be generalizable and they might not be considered valid for other populations. In qualitative research, this limitation is called transferability. Transferability refers to the extent to which one can extend the account of a particular situation or population to other persons, times or setting than those directly studied (Maxwell, 2002). Results of this research might be different from professionals trained at other Universities, from other programs, and at different levels of expertise.

Also, students were interviewed at the end their practicum and they provide self-report data. Interviewer's biases might interfere with the analyses of the content of the interviews and in the exploration of students' experience. Those limitations regard the trustworthiness and the confirmability of this study (Yin, 2003).

1.7 SIGNIFICANCE OF THE STUDY

The results of this study can be used to advance intentionality of the counseling alliance by working with practicum students, to help professionals understand factors that could be impairing their therapeutic alliances, and to evaluate differing modalities designed to instruct trainees on alliance development.

1.7.1 Knowledge generation

This study may be useful in academic terms. Focusing on clients' feedback seems to be one of the interests for researchers who want to explore the topic of the therapeutic alliance and common factors approach. This approach is recent and it is mainly related to the literature on family therapy (Friedlander, Escudero, Horvath, Heatherington, Cabero, & Martens, 2006). This study, starting from the exploration of the present literature on

the Common Factors Model in Psychotherapy and the Feedback Informed Treatment, and suggesting a consideration of clients' feedback during students' practicum experience, may provide an important contribution to both the professional literatures of counselor education and supervision and family therapy.

1.7.2 Professional Applications in Clinical Settings

For the success or the failure of a counseling treatment, not only are theories and techniques used by the therapist in the counseling sessions important, but also the quality of the relationship between the therapist and the client is a fundamental ingredient. Especially for students who are starting a career as counselors, it is relevant to be aware of the importance of building and maintaining a working alliance with their clients. According to Davenport and Ratliff (2001, p.443), "measures of therapeutic alliance during the training process could possibly prove to be a useful indicator of trainees' clinical abilities, as well as the quality of training received, allowing clients of trainees to potentially add to the training evaluation process in new and meaningful ways". The collection and the analysis of clients' narratives on their experience at the end of each therapeutic session, help beginning therapists to better understand what specific aspects of the therapeutic process clients consider most helpful, leading therapists to more effective interactions with clients.

1.7.3 Professional Applications in Supervision Settings

Trainees, especially at the beginning of their professional experience as therapists, are expected to apply different skills. Most of them retain technical skills, while others are related to interpersonal aspects and the use of self in the therapeutic sessions. The beginning therapist is required to pay attention to a bewildering variety of

dimensions of the therapeutic context, such as the content of what the person is saying, the affect associated with that content, diagnostic issues, and any reactions the therapist is having to the client. “However, because of the multiple demands placed on beginning therapists and their supervisors, the therapeutic relationship is often neglected during supervision, often with problematic results” (Gard & Lewis, 2008, p.39). Analyzing students’ reports regarding their therapeutic alliance during the entire therapeutic process and the use of clients’ feedback for training purposes, it is expected from this research to notice patterns that allow to better understand the importance of the use of this qualitative feedback form in educational settings, such as in the supervision setting. The analyses in supervision may help the supervisor make an interpersonal assessment of the trainee’s relational abilities. At the same time, supervisees could increase their use of self during therapeutic process by using clients’ feedback, by a discussion about those feedback in supervision and by the incorporation of the supervisor’s suggestions in the following counseling sessions.

1.8 CONCLUSION

In this chapter, the main aspects of this research have been provided. This is a qualitative study on practicum students’ perceptions regarding the development of their therapeutic alliance with their first clients. In particular, the goal is to explore how the integration of clients’ feedback may increase students’ improvements in the therapeutic alliance over the length of their practicum experience.

In chapter two, the literature review will be on beginning therapists’ development skills, previous studies which have already measure the therapeutic alliance construct,

and the common factor model in therapy which mostly considered the relevance of the therapeutic alliance in therapy.

In chapter three, the qualitative methodology, study design, sample, instrumentation, intervention of choice, data collection, and data analyses will be presented.

In chapter four, data obtained from this research will be provided.

In chapter five, findings, limitations of this research, implications and suggestions for future researches will be discussed.

CHAPTER 2

LITERATURE REVIEW

The purpose of this chapter is to address the constructs “therapeutic alliance” and “client feedback”. The researcher introduces these main concepts from the broad psychotherapy approach that considers the importance of the therapeutic alliance, which is the “common factors psychotherapy”. In particular, an analysis of common factors and their impact on therapy outcome is provided.

After reviewing the theoretical literature on this approach, the researcher focuses on the historical development of the therapeutic alliance construct and on its most main definition adopted by other researchers. It is also pointed out what is known and what is not known from the literature about the therapeutic alliance. Moreover, most common measures of this construct are presented and analyzed.

The third portion of this chapter gives attention to the “feedback informed treatment” as recent approach to monitor and assess the development of the therapeutic alliance by the consideration of clients’ feedbacks. The most used and famous measures about the collection of clients’ feedbacks are provided. Finally, the researcher focuses on the importance of this approach for training purposes by a deep analyses of most recent empirical studies on the importance of clients’ feedbacks in supervision.

2.1 STRATEGY USED FOR SEARCHING THE LITERATURE

The strategy used for conducting a literature search on the topic of working alliance began with at the University of South Carolina library in 2012. In particular, online resources (article database, electronic resources) from PsycINFO were considered by the researcher.

The first search was very general with a consideration of the therapeutic alliance as one of the common factor in psychotherapy. 78 journal articles using this category were selected by the researcher from the psychotherapy field, couples and family therapy, and counseling.

The researcher performed an in-depth search looking for the therapeutic alliance construct in relation to the client feedback approach between the years 2005 and 2014. Not just 20 journal articles, but also 3 textbooks were found from psychotherapy, counseling, and counselor education fields. To be more precise in the search of scholarly sources about the use of client's feedback in supervision for helping students build an intentional therapeutic alliance, which is the goal of the current research, the researcher used the key words "therapeutic alliance", "client's feedback" and "supervision". 6 journal articles from 2006 to 2014 were found in the counselor education and supervision literature.

2.2 COMMON FACTORS PSYCHOTHERAPY

Clinical services make a difference in the lives of clients. In fact, the effect size of psychotherapy is remarkably robust, about .85, meaning that the average treated client is better off than 80% of those untreated. However, we have yet to agree on what enables our therapy work. If therapy is a might engine that helps convey clients to places they

want to go, what provides the power? The search for what works has fueled research and sparked debate for over 50 years. The critical mass of data reveals no differences in effectiveness between the various treatments for psychological distress (Wampold, 2001, Lebow, 2008). If specific models can't explain why therapy works, what does? Enter the common factors.

In 2002, Saul Rosenzweig republished his classic paper "Some Implicit Common Factors in Diverse Methods of Psychotherapy" (1936) where he began the discussion on common factors in psychotherapy. He concluded that, since no form of psychotherapy or healing is without cures to its credit, its success is not reliable proof of the validity of its theory. Instead, he suggested that some potent implicit common factors, perhaps more important than the methods purposely employed, explained the uniformity of success of seemingly diverse methods.

Rosenzweig, noting that all forms of psychotherapy have cures to their credit, invoked the famous Dodo Bird verdict from Alice in Wonderland, "Everybody has won and all verdict have prizes" to characterize psychotherapy outcomes. Rosenzweig said: "What accounts for the result that apparently diverse forms of psychotherapy prove successful in similar cases? Or if they are apparently diverse, what do these therapies actually have in common that makes them equally successful? ... it is justifiable to wonder ... whether the factors that actually are in operation in several different therapies may not have much more in common than have the factors alleged to be operating" (Hoch, 1955, p.412-413).

Over time, Rosenzweig's prophetic insight garnered increasing interest. The seminal idea of "common factors" which refers to the finding that all forms of

psychotherapy seem to share, to some agree, a small number of effective change ingredients – remains highly influential in psychotherapy integration today (Rosenzweig, 2002). “With little evidence to recommend the use of one type of therapy over another” (Norcross & Goldfried, 1992, p.9), psychotherapies observes and researchers redirected their attentions away from a “mine’s better” focus and, instead, attempted to identify the pantheoretical elements that made various treatments effective. The question become: which are the common therapeutic factors?

2.2.1 What are Common Factors?

By definition, common factors is a pantheoretical framework defined by factors shared by all treatment approaches. Common factors are nonmodel-specific and considered efficacious above specific treatment effects (Wampold, 2001). The common factors framework seeks to determine the core ingredients shared by different therapies with the eventual goal of developing more efficacious treatments based on these components.

Theorists have attempted to organize levels of common factors within various framework (Castonguay, 1993; Duncan, Miller & Sparks, 2007; Frank & Frank, 1991; Goldfried, 1982; Patterson, 1989; Grencavage & Norcross, 1990; Miller, Duncan & Hubble, 2004; Wampold, 2001). Different authors focused on different domains or levels of psychosocial treatment, and, as a result, diverse conceptualizations of these commonalities have emerged.

Rosenzweig (1936) identified five general factors or processes used by various schools of psychotherapy that he considered to play a role in beneficial treatments and that helped to explain the “problem” of outcome equivalence: (a) the relationship

between patient and therapist; (b) the patient's emotional catharsis; (c) the impact of the therapist's personality; (d) the patient's development of a consistent "schema for achieving some sort and degree of personality organization" (p. 413) via therapist adherence to any one specific model or ideology; and (e) the complexity of "psychological events" and the interdependent nature of personality such that there will invariably be more than one justifiable formulation, and that any significant intervention will have an impact on the total system "and so begin the work of rehabilitation" (Rosenzweig, 1936, p. 414).

A systematic review of 50 publications by Grennevage and Norcross (1990) to discern commonalities among proposed therapeutic common factors, revealed that the number of factors per publication ranged from 1 to 20, with 89 different commonalities proposed in all. Across all categories, the most consensual commonalities were the development of a therapeutic alliance (56% of all authors), the opportunity of catharsis (38%), the acquisition and practice of new behaviors (32%), client's positive expectancies (26%), beneficial therapist qualities (24%), and the provision of a rationale as a change process (24%). The single most frequent commonality is the development of a collaborative therapeutic alliance. This emphasis reflects the often asserted notion that techniques are inextricably embedded within the relationship.

The "big four" (Hubble et al., 1999) label for common factors is inspired by the work of Michael Lambert (1992). Lambert suggested a four-factor model of change based upon his review of empirical studies of outcome research (Norcross & Goldfried, 1992). The four factor model includes: extra-therapeutic change factors, common factors, technique factors, and expectancy factors (Lambert, 1992). The model consists of

estimated percentages of variance in outcome that each factor contributes to change in the therapeutic process. Miller, Duncan, and Hubble (1997) modified the four-factor model by placing all of the factors under the rubric of common factors and modifying the estimated percentages. The modified four-factor model is composed of: client and extra-therapeutic factors; relationship factors; model or techniques, and expectancy factors (Sprenkle & Blow, 2004). Client extra-therapeutic factors are estimated to contribute 40% to change (Miller et al., 1997). Sprenkle and Blow (2004) reported that client factors are the characteristics of personality of the client. Extra-therapeutic factors are components in the life and environment of the client that affect the occurrence of change, such as the client's inner strengths, support system, environment, and chance events. Relationship factors are estimated by Hubble and associates (1999) to account for 30% of the change. This set of factors represents the strength of the therapeutic alliance between the therapist and client(s). This alliance is the joint product of the therapist and client together focusing on the work of therapy (Sprenkle & Blow, 2004). Relationship factors also include behaviors provided by the therapist such as warmth, empathy, encouragement, and acceptance (Miller et al., 1999). The last two components of the model, model/technique and hope/expectancy each attributed 15% to the change process. The model/technique component consists of the therapist's theoretical orientation, therapeutic methods, strategies, or tactics implemented to move clients to take some action to improve themselves or their situation (Miller et al., 1999). These factors represent the unique parts to specific theories of therapy (Sprenkle & Blow, 2004). Lastly, hope or expectancy refers to the client becoming hopeful and believing in the credibility of the treatment (Sprenkle & Blow, 2004).

Recently, Fife, Whiting, Bradford, and Davis (2014) proposed an interesting model of common factors. Authors discussed their model in pyramid format, with techniques on top, the therapeutic alliance in the middle, and therapist way of being as the foundation. According to this meta-model, there is a relationship not just between the therapeutic alliance and techniques, but also between these two common factors and a therapist's way of being, which is considered as foundational to all the aspects of an effective therapy.

2.2.2 Common factors and therapeutic outcomes

Meta-analyses and reviews of psychotherapy have suggested that factors are more important to positive outcome than are specific techniques (Ahn & Wampold, 2001; Humble, Duncan & Miller, 1999; Lambert & Bergin, 1994; Luborsky et al., 2002; Wampold, 2001).

Thomas (2006) analyzed the client's and therapist's perceptions about the degree to which each of four common factors in therapy (client's hope and expectations, client's extratherapeutic factors, theories and techniques of the therapist, therapeutic relationship) contribute to change in the therapeutic process. Therapists and clients have different perceptions on what factor contribute the most to change. Both of them believe that the client contributes the most to change in a therapeutic process. Among the common factors, the highest percentages for the therapists are placed on the therapeutic relationship and for the leading contributor to change the clients have the greater percentage. The rank order for therapists in the common factors are (1) therapeutic relationship, (2) client's hope and expectations, (3) client's extra-therapeutic factors, and (4) model/techniques of therapist. For clients, the highest percentages are placed on the

client's hope and expectations of therapy and the client is also believed to be the leading contributor to change. The rank order for the clients in the common factors are (1) client's hope and expectations of therapy, (2) therapeutic relationship, (3) model/techniques of therapist, and (4) client's extra-therapeutic factors.

The review from DeFife and Hilsenroth (2011) showed that fostering realistic and positive expectancies, role preparation for treatment, and collaborative goal setting are three core psychotherapeutic factors that influence early psychotherapy process and are empirically linked with subsequent treatment outcomes.

Moreover, Tschacher, Junghan, and Pfamatter (2012) did a review of identified 22 common factors discussed in psychotherapy research literature. Common factors differed largely in their relevance for technique implementation. Patient engagement, affective experiencing and therapeutic alliance are found connected with therapeutic outcomes.

Finally, Falkenstrom, Granstrom, and Holmqvist (2013), founded a statistically significant effect of the within-patient variation in therapeutic alliance on symptom change from session to session. According to this study, there is an evidence for a reciprocal causal model between the symptom level and the quality of the alliance. The results of this research showed that the quality of the alliance between counselors and clients predicted subsequent change in symptoms while prior symptom change also affected the alliance.

2.3 WORKING ALLIANCE THEORY

The working alliance concept, which is one of the common factors in psychotherapy, is rooted in psychotherapy theory and research. Psychoanalytic

perspectives have long emphasized the contributions of transference and countertransference phenomena to a therapeutic relationship (e.g., Freud, 1912/1958; Greenson, 1965; Sterba, 1934; Zetzel, 1956). Humanistic and experiential perspectives have focused on the patient's experience of the relational conditions the therapist offers (e.g., Rogers, 1957; Yalom, 2002). However, the most influential theoretical conceptualization of the working alliance has been offered by Bordin (1979, 1980, 1994). The robustness of Bordin's work in large part stems from his effort to provide a pantheoretical model of the working alliance. He argued that the continued bifurcation of treatment techniques was less important than establishing the general effectiveness of the components common to all forms of psychotherapy. Beyond its independence from specific treatment theories and techniques, Bordin's model of the working alliance provides a widely applicable way of organizing information about the change processes that occur in any interaction between two individuals.

In his 1979 paper, Bordin stated that a working alliance occurs anytime an individual seeks change and another individual serves as the agent of that change. It is both a byproduct of collaborative, purposive work and an indicator of its occurrence. Bordin suggested that collaborative work involves three essential components: goal agreement, task agreement, and bond. Goal agreement involves the parties having a shared understanding of the goals for change. Task agreement entails them having a shared understanding of and confidence in the activities that will accomplish these goals. Bond consists of an emotional attachment between the parties that arises through their work together. Bordin (1980, 1994) later explained that strains in the alliance would likely occur when patients in psychotherapy were given therapeutic tasks that activated

the problematic behaviors that had brought them to treatment. He argued that these moments posed challenges for agreement on tasks and goals as well as the quality of the bond. Preserving the working alliance requires working to repair these inevitable strains.

According to Bordin's theory, the goal agreement, task agreement, and bond components of a collaborative interaction uniquely contribute to the quality of the working alliance. Careful evaluations of these components can yield valuable information about the state of a working alliance and the effectiveness of the collaboration in bringing about the desired change.

Importantly, Bordin (1979) recognized that different types of collaborations would emphasize or place demands on different components. Thus, working alliance strength is determined in part by the fit between the structure and demands of the situation and the unique characteristics of the parties involved.

Bordin's (1979) model has been widely researched (Bachelor & Salame', 2000; Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005; Dunkle & Friedlander, 1996; Horvath & Greenberg, 1989; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Watson & Geller, 2005) and stands as the dominant model in the literature. This conceptual model is the theoretical framework of the present research.

Looking at the most recent publications on the therapeutic alliance construct, therapeutic collaboration is defined as a central avenue to healing and problem solving (Suggese, 2005). The establishment of collaboration is particularly pertinent in psychotherapy (Tryon & Winograd, 2010) and lies at the heart of modern psychotherapy. In the 2nd edition of Norcross and Wampold (2011) as "probably effect" (p.424), Levin (2007) used the following definition of collaboration: "to work jointly with others or

together especially in an intellectual endeavour” (p.115). Gergen and Gergen (2007) maintain that collaboration “requires mutual adjustments” (p.398). Collaboration is seen as a key feature of the therapeutic alliance by Horvath and Bedi (2002) who reported preliminary evidence indicating that collaboration is linked to a better alliance and thus, to a better outcome. Tryon and Winograd (2002) reported the necessity for therapists to attend to patients’ concerns and disagreements and to clarify these thorough agreed treatment goals. Friedlander, Escudero, and Heartherington (2006) reporting on the therapeutic alliance within couple and family therapy, linked collaboration to increased engagement with the family. The empirical literature also seems to indicate that alliance quality correlate positively with some client characteristics and behaviors (e.g., psychological mindedness, expectation for change, quality of object relations) and negatively with others (e.g., avoidance, interpersonal difficulties, depressogenic cognitions) (Constantino et al., 2002). Furthermore, research suggests that certain therapist characteristics and behaviors are positively associated with quality alliances (e.g., warmth, flexibility, accurate interpretation) (Ackerman & Hilsenroth, 2003). In addition, evidence suggests that the alliance is particularly predictive of outcome when measured early in treatment. Moreover, poor early alliance predicts client dropout (Constantino et al., 2002). Finally, although the alliance has been linked with outcome, the causal direction of the relationship has not been clearly established. More studies are needed to clarify this issue (Costonguay, Constantino, & Holthforth, 2006). In addition to clarify the relationship among alliance, improvement, and outcome, it seems important to add more theoretically based explanations to alliance outcome linkages (Horvath, 2005; Costonguay et al., 2006).

2.3.1 Measures of Therapeutic Alliance

Over 1,000 research findings (Orlinsky, Ronnestad, & Willutzky, 2004), demonstrate that a positive alliance is one of the best predictors of outcome. It is critical for therapists to attend closely to the alliance developed with their clients, and regularly monitor its quality. Influencing the client's perceptions of the alliance represents the most direct impact that mental health professionals can have on change (Duncan, Miller, & Sparks, 2004). Description and measurement of the therapeutic alliance has been a major focus of theoretical and empirical studies in the last two decades. There is a variety of approaches for evaluating the alliance. While these multi-dimensional assessments of the alliance are valid and reliable, they were developed largely for research purposes and are not intended to be used as everyday clinical tool (Duncan, Miller, Sparks, Claud, Reynolds, Brown, Johnson (2003). Whipple, Lambert, Vermeersch, Smart, Nielsen, and Hawkins (2003) found clients of therapists who had access to outcome and alliance information were less likely to deteriorate, more likely to stay longer, and twice as likely to achieve a clinically significant change. These findings make a strong argument for developing not only a reliable and valid alliance measure, but one that is feasible in therapists' minds for routine clinical use.

As a consequence of the many years of research on the alliance, there is a number of psychometrically measure of this construct from client, therapist, and observer perspectives (Constantino et al., 2002). Here are presented the basic psychometric data for the three scales most widely used. These scales predict therapeutic outcome, with the patient report version providing the most robust data (Summers & Barber, 2003).

Luborsky's *Penn Helping Alliance scales* (PHAS) (Luborsky, Crits-Christoph, Alexander, Margolis & Cohen, 1983) were the first therapeutic alliance widely used. Penn Helping Alliance questionnaire (PHAS) was recently revised into a 19-item scale (Luborsky, Barber, Siqueland, Johnson, Najavits, Frank, & Daley, 1986) because the earlier questionnaire included some scale items which reflected how much the patient had benefited from therapy. Some researchers suggested that the measurement of the alliance should be as independent as possible of how much the patient had already benefited from treatment. Thus, six out of the 11 original PHAS items were eliminated and 14 new items were added in the revised 19-item questionnaire in which each item is rated on a 6-point Likert scale.

Horvath and Greenberg's *Working Alliance Inventory* (WAI) (Horvath & Greenber, 1989) is a three subscale measure based on Bordin's (Bodin, 1979) tripartite definition of the alliance: agreement on tasks and goals and the patient-therapist bond. The self-report and observer-rater versions use 7-point Likert type scales in a 36-item measure and also a shorter 12-item version. The three subscales of 12 items each are highly intercorrelated (Horvath & Greenber, 1989). The observer version of the WAI has been found to have good inter rater reliability (Tichenor & Hill, 1989; Fenton, Cecero, Nich & Carroll, 2001) and to correlate highly with other measures of alliance such as the California Psychotherapy Alliance Scales (CALPAS) (Marmar, Gaston, Gallagher, Thompson, 1989) but to correlate more moderately with the Penn Helping Alliance Scale (PHAS) (Tichenor & Hill, 1989; Fenton, Cecero, Nich & Carroll, 2001).

The *California Psychotherapy Alliance Scales* (CALPAS) (Marmar, Gaston, Gallagher, Thompson, 1989) is a 24-item self-report questionnaire that measures patient-

therapist therapeutic alliance as a multidimensional construct. The CALPAS four subscales assess (Gaston, 1990): (i) the patient's capacity to work purposefully in therapy, (ii) the affective bond with the therapist, (iii) the therapist's empathic understanding and involvement, and (iv) the agreement between patient and therapist on the goals and tasks of treatment. Each item is rated on a 6-point Likert scale. Relatively high inter correlations among CALPAS subscales have also commonly been observed (Tichenor & Hill, 1989; Cecero, Fenton, Fankforter, Nich, & Carroll, 2001; Barber, Connolly, Crits-Christoph, Gladis & Siqueland, 2000; Hatcher & Barends, 1996), leading many investigators to primarily use the total score. Acceptable inter rater reliabilities were obtained for the observer version (Tichenor & Hill, 1989; Fenton, Cecero, Nich, Fankforter & Carroll, 2001), which has been found to be highly inter correlated with the WAI (Tichenor & Hill, 1989). The CALPAS may have adequate predictive validity in different therapies, including cognitive behavioral therapy (Fenton, Cecero, Nich, Fankforter & Carroll, 2001), psychodynamic psychotherapy (Barber, Connolly, Crits-Christoph, Gladis & Siqueland, 2000), and across different treatments (Gaston, Marmar, Gallagher & Thompson, 1991), especially among "neurotic" patients, but it may be a weak predictor of outcome with cocaine-dependent patients (Barber, Luborsky, Crits-Christoph, Thase, Weiss, Frank, Onken & Gallop, 1999).

Each of the three major therapeutic alliance measures—the Penn Helping Alliance, the Working Alliance Inventory, and the California Psychotherapy Alliance Scales —includes a therapist and patient rated version as well as an independent observer version. There is clear evidence that patient self-report is a better predictor of outcome than therapist self-report (Horvath & Symonds, 1991), especially when assessed early in

treatment. On average, the effect size of the correlation between the therapeutic alliance and therapeutic outcome is 0.22, based on a meta-analysis of 79 studies (Martin, Garske & Davis, 2000).

2.3.2 Therapeutic Alliance and Clinical Training

The most important finding that has emerged from a considerable number of studies is that the alliance correlates positively with therapeutic change across a variety of treatment modalities and clinical issues (Castonguay & Beutler, 2005a; Constantino et al., 2002). Although substantial evidence points to the importance of treatment success, there is a need of having a better understanding of how the therapeutic alliance develops during the course of treatment, which factors make the alliance successful or not (Horvath and Luborsky, 1993) and the role of the alliance training (Constantino, Morrison, MacEwan, and Boswell, 2013).

Because the alliance is arguably the most robust predictor of change, training therapists on how to foster the alliance, as well as how to negotiate any emergent alliance problems is likely to be the first and most logical step to follow in order to test this research strategy. Several studies have examined the effectiveness of implementing techniques specifically designed to foster the alliance and to address alliance ruptures (Castonguay et al., 2006; Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005; Safran et al., 2002; Whipple et al., 2003). While the preliminary findings are promising, there is a need of more convincing evidence, in both efficacy and effectiveness studies, that such techniques have direct, unique, and causal effects of improvement.

According to Spruill, Rosensky, Stigall, Vasquez, Bingham, and Olvey (2004), the development of a therapeutic alliance or relationship is based on the interpersonal and communication skills of the clinician, coupled with client variables. Conveyance of warmth, empathy, genuineness, and respect for the patient are attributes that, to some extent, the clinician brings to the training situation. These personal characteristics can be enhanced—but it is unlikely that we can teach someone to be genuine or respectful if these qualities are lacking in the person. Application of most interventions requires that the clinician establish an effective relationship with the client. Thus, the development of relationship skills is a foundational component of the acquisition of effective intervention skills. The beginning clinician must be educated about ways to establish a therapeutic alliance. It is the strength of the therapeutic alliance that insures positive change and growth for the client (Martin, Garske, & Davis, 2000); in order to become a competent clinician, students must receive training in the further development of their relationship skills. Most textbooks used in beginning psychotherapy classes have a section devoted to building relationship skills (e.g., Brems, 2001). The trainee's experience in supervision is crucial to development of skills in assessment and intervention (Holloway & Neufeldt, 1995). The beginning clinician typically is very dependent upon his/her supervisor for guidance and assistance in most aspects of a case. As they become more experienced and gain competence in intervention, trainees are more autonomous, less dependent upon detailed guidance from the supervisor, but still seek supervision when needed for a case (Kaslow & Deering, 1993). One of the primary duties of the supervisor is to promote the supervisee's self-awareness and ability to recognize personal issues as they arise in therapy. The role of the supervisor is both to protect the client and to train the supervisee

to recognize his/her limitations, blind spots, and personal characteristics and/or mannerisms that may influence negatively the intervention process (Holloway & Neufeldt, 1995). Authors suggested a didactic assessment of intervention competencies through examinations of client satisfaction surveys/questionnaires.

Johnson and Ketring (2006) said that if the therapeutic alliance is influential on therapy outcomes, “therapy training needs to focus on the skills necessary to reach the level of alliance needed of change” (p.346). A pilot study of Carpenter, Escudero, and Rivett (2008) tried to assess the effectiveness of training family therapy students in their acquisition of conceptual, observational, and executive skills relating specifically to the therapeutic alliance. The authors used the System for Observation Family Therapy Alliances (SOFTA) model (Friedlander et al., 2006a) which is composed by four dimensions: engagement in the therapeutic process, emotional connection with the therapist, safety within the therapeutic system, and shared sense of purpose within the family. A workshop consisting of the observation and the analysis of a sample short of videotaped segments of simulated therapy sessions illustrating segments of simulated positive and negative alliance behavioral indicators was implemented. Supervisors used the same SOFTA to give specific feedback to the student on their therapeutic alliance behaviors.

Crits-Christoph, Gibbons, Narducci, Schamberger, Gallop (2006) designed a study to provide preliminary data on whether therapists could be trained to enhance the quality of their alliances with patients. Authors construct a treatment model that focused on therapist actions that might help foster the alliance. This treatment approach (alliance-fostering therapy) was developed to be used with patients who have a diagnosis of major

depressive disorder (MDD). The primary outcome of the study was an examination of changes in alliance scores from before to during and after training in the alliance-fostering treatment model. Secondary outcomes examined changes in patient outcomes as a function of receiving training in alliance-fostering therapy. The study assessed alliances formed by five psychotherapists relatively inexperienced PhD or PsyD with 1 or 3 years postdegree experience. Each of them treat patients with MDD before, during, and after training in alliance-fostering therapy. During the pretraining study phase, each therapist treated three patients using their usual approach to psychotherapy. During the training phase of the study, therapists learn and are supervised in manual-based alliance-fostering therapy (CritsChristoph et al., 1998); each treated an additional three patients using this treatment. In the posttraining phase of the study, each therapist treated three patients using the alliance-fostering psychotherapy but without intensive supervision. In all three phases of the study, treatment consisted of 16 weekly 50-min individual therapy sessions. The specific techniques used to enhance the alliance were organized according to the three component theory (agreement on tasks, agreement on goals, therapeutic bond) of the alliance described by Bordin (1979). Measures of the alliance were the primary outcome measures for the study. The therapeutic alliance was measured using two self-report scales: the California Psychotherapy Alliance Scale, patient version (CALPAS) (Gaston, 1991) and the Helping Alliance Questionnaire (HAQ-II) (Luborsky et al., 1996). Both the CALPAS and HAQ-II are administered at the end of every treatment session during all three (before, during, and after training) phases of the study. A statistically significant difference between therapists in the improvement in their alliances was found for the Working Capacity scale of the CALPAS but not the other alliance scales. Authors

expressed that it might be that certain alliance techniques are relatively easy to learn, and all therapists master these.

This study is a great recent empirical research on the power of the supervision for fostering therapeutic alliance skills. However, there are important limitations to be considered. First of all, the use of therapists with 1 to 3 postdoctoral years of experience might have limited authors' ability to detect training effects. Since they were post-doctoral therapists, which means highly experienced therapists, they would have already evolved their own ways of successfully fostering the alliance and may be less open to training than relatively less experienced therapists. To achieve a stronger training effect, it might be necessary to conduct a study with inexperienced therapists (i.e., preinternship graduate students). This is the population that is considered in the current research.

Another important explanation of the findings related to the nature and quality of the training and supervision process. Improving therapists' alliances might be more a function of the nature of the training and trainer rather than anything to do with the treatment model, the therapists, or the patients. A number of aspects of the supervision process, including supervisor style, supervision alliance, and supervisor interventions, might have affected the supervision and the treatments. This is a relevant aspect that is taken into account in the present research and its potential limitations.

Another study which focuses on clinical supervision is from Bambling, King, Raue, Schweitzer, and Lambert (2006). This study evaluated the impact of clinical supervision on client working alliance and symptom reduction in the brief treatment of major depression. The authors randomly assigned 127 clients with a diagnosis of major depression to 127 supervised or unsupervised therapists to receive eight sessions of

problems-solving treatment. Supervised therapists were randomly assigned to either alliance skill-focus condition or alliance process-focused supervision and received eight supervision sessions. In the process supervision condition, case discussion focused on assisting therapists to develop an understanding of the interpersonal dynamics occurring during the therapy. Supervision case discussions focused on monitoring implicit client feedback, changes in client anxiety level, flow of exchanges, resistance, and perceived dynamics in the relationship with the therapist. It was expected that increased therapist awareness of the interpersonal processes within the therapy as impacting on alliance would assist therapists to make adjustments in their approach toward clients that would enhance the alliance. Therapists in this condition were not, however, given specific recommendations for alliance-promoting behavior. Before beginning treatment, therapists received one supervision session for brief training in the working alliance supervision approach and in specific characteristics of each case. Standard measures of therapeutic alliance and symptom change were used as dependent variables. To assess the working alliance, it was used the Working Alliance Inventory, which is a 36-item inventory rated on a 7-point Likert scale made up of three alliance subscales assessing bond, task, and goal. The results showed a significant effect for both supervision conditions on working alliance from the first session of therapy, symptom reduction, and treatment retention and evaluation but no effect differences between supervision conditions. WAI scores were significantly superior for participants in supervised groups compared to those in the unsupervised group. The results of this study provide qualified support that supervision that focuses on working alliance can influence client perception of alliance and enhance treatment outcomes. The study was designed to detect total differences between groups

over time. Therefore, any tensions that were resolved in therapy as a result of supervision could also have influenced working alliance and not be reflected in the data. In the present research, the goal is to interview beginning therapist for obtaining data regarding the influence of supervision in strength therapists' therapeutic alliance skills.

2.4 FEEDBACK INFORMED TREATMENT

The practice of tracking client change during therapy has been studied by research teams around the world and is referred to in vary ways, including Client-Directed, Outcome-Informed therapy (CDOI) (Miller, Duncan, & Hubble, 2004), Patient Reported Outcome Measures (PROMs) (Barkhman, Mellor-Clarck, Connell, Evans, Evans, & Margison, 2010); Feedback Informed Treatment (FIT) (Miller & Bergmann, 2011); client feedback (Lambert and Shimokowa, 2011).

This practice takes advantages of the extent literature on the role of nonspecific factors, particularly client variables and engagement via the therapeutic alliance, client perceptions of early progress and the alliance, and known trajectories of change. According to Prochaska, DiClemente, and Norcross (1992), clients will more likely engage in change projects when their therapists and other interested parties “assess the stage of a client’s readiness for change and tailor their interventions accordingly” (p.1110). Moving beyond theory-based treatment toward client-informed practice avoids the common factors paradox – how to use what is known about common processes of change without losing a shared, or common, orientation. The Feedback Informed Treatment requires the tailoring of treatment to each unique situation based on client feedback. A client-directed, outcome-informed, approach represents a logical evolution of the ideas first expounded by the earliest common factors theorists and offers a

progressive perspective on psychotherapy theory, research, and practice in the twenty-first century.

A comprehensive meta-analysis by Sapyta, Riemer, & Bickman (2005) indicated that the effectiveness of feedback is likely to vary as a function of the degree of discrepancy between therapists' views of progress and measured progress, and that the greater the discrepancy the more likely feedback will be helpful. A key element of effective feedback is bringing into the recipient's awareness the discrepancy between what is thought and what is reality, thereby prompting corrective action. In general, this research supported the conclusion that feedback in clinical practice could support the patients' outcomes improvements. This finding is consistent with feedback theories that suggest feedback will only change behavior when the information provided indicates the individual is not meeting up to an established standard (e.g., Riemer, & Bickman, 2004). Riemer and Bickman (Riemer & Bickman, 2004; Riemer, Rosof-Williams, & Bickman, 2005) have developed a Contextual Feedback Intervention Theory to explain how feedback is interpreted and made useful. Basic tenets of this theory are that clinicians (and professionals, generally) will benefit from feedback if they are committed to the goal of improving their performance, aware of a discrepancy between the goal and reality (particularly if the goal is attractive and the clinician believes it can be accomplished); the feedback source is credible; and if feedback is immediate, frequent, systematic, cognitively simple, unambiguous, and provides clinicians with concrete suggestions of how to improve. As feedback research suggests, the value of monitoring and systematic feedback through psychological assessments hinges on the degree to which the information provided goes beyond what a clinician can observe and understand about

patient progress without such information. It is important for the information to add something to the psychotherapist's view of patient well-being and future actions. Patients' response to treatment is, especially in the case of a worsening state, a likely place where outside feedback might have the greatest chance of impact. Helping the therapist become aware of negative change and discussing such progress in the therapeutic encounter are much more likely when formal feedback is provided to therapists. Such feedback helps the client communicate and helps the therapist to become aware of the possible need to adjust treatment, alter or addresses problematic aspects of the treatment as appropriate (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment) (Lambert & Shimokawa, 2011).

2.4.1 Measures of Client Feedback

Research has led to the creation of numerous psychometrically sound measures that can be integrated into practice, each with the goal of helping practitioners improve clinical decision making and ameliorate treatment outcomes. The most recent review of popular progress monitor in measures is made by Overnngton and Ionita (2012) and it includes the Behaviour and Symptom Identification Scale-24 (BASIS-24) (Eisen, Normand, Belanger, Spiro, & Esch, 2004), the Behavioural Health Measure-20 (BHM-20) (Kopta & Lowry, 2002), the Clinical Outcomes in Routine Evaluation System-Outcome Management (CORE-OM; Barkham et al., 1998, and CORE-5; Barkham et al., 2010), the Outcome Questionnaire-45 (OQ-45; Lambert, Hansen et al., 1996), the Partners for Change Outcome Management System (PCOMS), which is comprised of the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) (Miller, Duncan, Sorrell, & Brown, 2005), the PolarisMental Health (Polaris-MH) (Grissom, Lyons, &

Lutz, 2002); formerly the Treatment Evaluation and Management), and the Treatment Outcome Package (TOP) (Kraus et al., 2005).

Although we know a lot about the effect of feedback, we do not know much about what happens within therapy sessions when such feedback is made available to therapists. Also, although several feedback measures have appeared in the literature, most are designed for research and are too time-consuming for everyday use. A recent trend in clinical practice involves regularly monitoring and tracking client treatment response with standardized scales throughout the course of treatment and then providing clinicians with this information. Several recent studies have documented significant improvements in both retention in and outcome from treatment when therapists have access to formal, real-time feedback from clients regarding the process and outcome of therapy (Duncan & Miller, 2000; Duncan, Miller, & Sparks, 2004). The basic rationale is that collecting client feedback about what seems to be working and more importantly what is not working, the therapist's responsiveness to clients will improve.

The need for quick, practical and ongoing feedback measures, led to the development of the Outcome Rating Scale (ORS) (Miller & Duncan, 2001) and Session Rating Scale (SRS) (Johnson, Miller, & Duncan, 2000). These tools assess research-identified elements of outcome and alliance from the client's perspective and, in most situations, can be administered in about one minute. Both scales use a visual analog format of four 10-centimeter lines, with instructions to place a mark on each line with low estimates to the left and high estimates to the right. The four 10-cm lines add to a total score of 40. The ORS is administered at the beginning of, or just before, every session to assess the client's perception of: (1) individual (personal) well-being; (2) interpersonal

well-being (family, intimate relationships); (3) social satisfaction with work, school, and peers; and (4) overall well-being—all valid indicators of successful outcomes (Lambert et al., 1996). The total score is the sum of the client's four marks to the nearest millimeter measured by a centimeter ruler or 10-cm template. Forty is the highest possible score, and scores in the 20's or below indicate significant distress. The SRS is completed at the end of the session to assess alliance. It obtains client feedback on the counselor and session in regard to: (a) relationship and respect; (b) goals and topics; (c) approach or method; and (d) overall effectiveness—key aspects of an effective alliance (Bachelor & Horvath, 1999). As with the ORS, the SRS is scored by adding all four lines (0-34 = poor alliance; 35-38=fair; 39-40=strong). The main purpose of the SRS is to detect and correct emerging alliance problems. Low scores should be welcomed and discussed in a candid, non-defensive way with clients.

The ORS and SRS have demonstrated adequate reliability and validity, and have resulted in higher success rates in several counseling settings (Duncan, Miller, & Sparks, 2004). In addition to alerting counselors to the type of relationship the client wants, the SRS provides immediate feedback that allows us to follow up and address alliance problems right when they occur. These measures can be used in conjunction with other methods of evaluating services, such as emotional and behavioral inventories, checklists, interviews, and observations (Murphy, 2008). In addition to ensuring for responsive services and valid indicators of counselor and counseling effectiveness, client-based assessment enhances client involvement and strengthens the all-important alliance.

There is a large amount of information on the psychometric properties of various measures (Hatcher & Gillaspy, 2006; Elvins & Green, 2008), but the evidence supporting

the use of patient ratings of the alliance for evaluating therapist is limited. Shaw and Murray (2014) argued that quantitative data obtained with scales like the SRS limit clients' responses in a few questions and analog ratings. Also, Aveline (2006) asked for qualitative investigations of what happens in sessions where such feedback is applied. The present research addresses these main research needs, which specifically concern the use of qualitative clients' feedback for evaluating the development of the therapeutic alliance of beginning therapist.

2.4.2 Use of Clients' Feedback in Clinical Training

According to Devenport and Ratliff (2001), few efforts have been made to incorporate the clients' voices into the evaluation process. When solicited, this additional feedback has shown that positive gains in trainees' skills found by trainers and supervisors are not necessarily echoed by clients (Perlesz, Stolk, & Firestone 1990; Stolk & Perlesz, 1990). Numerous studies of clinical outcome have found ratings of therapeutic alliance to be a variable that correlates strongly and consistently with clinical effectiveness (for example, Horvath & Symonds, 1991; Lambert, 1992; Quinn, Dotson, & Jordan, 1997). Client ratings of therapeutic alliance are especially high in correlation with later measures of therapy outcome (Horvath & Greenberg, 1989; Luborsky, 1994; Miller, Duncan, & Hubble, 1997). Therefore, measures of therapeutic alliance during the training process could possibly prove to be a useful indicator of trainees' clinical abilities, as well as the quality of training received, allowing clients of trainees to potentially add to the training evaluation process in new and meaningful ways. Among variety of methods currently used to evaluate MFT training, no valid assessments of trainee clinical competence exist that include client feedback (Perosa and Perosa, 2010). Alliance

measures have the potential to fill this void, with an additional advantage in that they have a greater ability to compare performance across clinical models. Furthermore, evaluation measures that are not biased toward a single model of therapy are crucial in program evaluation. However, the authors do not intend to imply that alliance ratings should be the only source of assessing clinical competence within training evaluations. Alliance ratings measure only one facet of the therapeutic interaction, the degree to which each client feels the therapist understands his or her goals, has rapport with him or her, and assigns tasks that address the client's goals. Trainer- and trainee-based measures of therapeutic outcome, as well as the therapeutic process, are still useful in providing a comprehensive view of trainees' clinical competence. In general, as trainees gained experience, they also received more consistently positive alliance ratings from their clients. At early stages in training, trainees have greater variability in ratings. One implication for supervision is that trainees can usually find one good client. Many supervisors allow trainees to self-select the cases that are presented in supervision, which can allow a trainee to present an overly favorable view by choosing the "good" client. Alternatively, trainees may present only difficult cases, which may also influence the supervisor's impression of competence. Supervisors need to be aware of each trainee's entire caseload and must work to develop an environment in which trainees feel the needed safety to fully disclose challenges with clients. Consistent with previous research, the number of sessions attended by clients also correlated significantly with levels of therapeutic alliance. Clients in earlier sessions of the therapeutic process are more likely to rate therapeutic alliance marginal than those in later sessions. Most likely, clients with a poor perception of alliance would have terminated therapy prematurely, while clients

who are satisfied with the therapeutic relationship continue in therapy. Within a training program, supervisors can examine premature terminations of clients as an early indicator of deficiencies in clinical competency.

This study on the use of clients' feedback in training suggests the need to incorporate measures of the therapeutic alliance in supervision, as a tool to assess therapists' ability to build and maintain a working relationship with clients and avoid early termination about the therapeutic process.

Worthen and Lambert (2007) argued that it is time for therapists and supervisors to incorporate outcome monitoring and brief client assessments into ongoing counseling supervision. In their system, they require clients to fill out a weekly outcome measure, the Outcome Questionnaire-45 (OQ-45) (Lambert et al., 2004) that assesses symptoms, interpersonal problems, social role functioning, and well-being. In this study, the difference between providing feedback and withholding seems significant. Since this early beginning counselors and supervisors have become increasingly positive about the usefulness of feedback, culminating in the decision by this staff to discontinue treatment as usual, all therapy in the center where authors work is offered only with feedback reports. Counselors simply consider the evidence of client benefit too persuasive to ignore. Authors have continued to use progress feedback in supervision increasing the likelihood of discussion of this information by notifying supervisors each time to discuss with the counselor a case in supervision as a matter of routine practice. According to authors, the use of progress feedback in supervision provides at least five important contributions to training and treatment. First, it provides a source of standardized performance feedback that is critical for training purposes. Since this feedback is

generated by client responses, it has the advantage of reflecting the client's experience. Second, the evidence suggests that counselors are often inaccurate in their clinical predictions of treatment failures, tending towards overly optimistic appraisals of our clients' progress (Hannan et al., 2005; Norcross, 2003). While authors view therapist optimism as highly valuable to client outcome, especially with difficult and unstable clients, they also believe it is important to have an independent source of information that identifies clients that will provide a focus for supervision where the attention is most needed. Third, feedback from clients provides information supervisors may have unintentionally overlooked or underemphasized. Systematic progress feedback may allow supervisors to become quickly aware of factors that impede treatment progress and may point to effective interventions. Fourth, the use of clients' feedbacks may enhance counselors' treatment efficacy by identifying problematic domains that may hinder progress (e.g., therapeutic alliance, motivation for therapy, social support, perfectionism, need for medication) and point towards potential interventions. Fifth, the use of additional information beyond counselors' own clinical intuition may provide another window on therapy. It is the combination of clinical wisdom informed by standardized sources of information that may ultimately contribute to improved outcomes and give us a powerful new focus in supervision.

Moreover, the purpose of Reese, Usher, Bowman, Norsworthy, Halstead, Rowlands, and Chisholm's (2009) study is to investigate the use of continuous client outcome data in psychotherapy supervision. The study is also designed to help redress the lack of research on the influence of psychotherapy supervision on client outcome, as well as to assess how using such data in supervision might influence known correlates of

effective supervision (i.e., the supervisory alliance and satisfaction with supervision) and counselor self-efficacy. Authors expect that supervisees in a feedback condition (using a continuous assessment feedback measure with clients and in psychotherapy supervision) demonstrate greater client outcomes, as measured by the Outcome Rating Scale and Session Rating Scale (Miller, Duncan, Sorrell, & Brown, 2005) than supervisees in the no-feedback condition over the course of an academic year. Second, authors expect that supervisees in a feedback condition rate the supervisory alliance and their satisfaction with supervision more favorably than would their counterparts in a no-feedback condition. Third, they hypothesize that supervisees in the feedback condition report higher counseling self-efficacy than those in the no-feedback condition, but they expect the relationship between counselor self-efficacy and client outcome is similar for supervisees in both conditions. Participants are 28 trainees assigned to a continuous feedback condition or no-feedback condition for one academic year. Results indicate that trainees in both conditions demonstrate better client outcomes at the end of their practicum training than at the beginning, but those in the feedback condition improve more. However, those in the feedback condition do not rate the supervisory alliance or satisfaction with the supervision process differently. The relationship between counselor self-efficacy and outcome is stronger for trainees in the feedback condition than for those in the no-feedback condition, perhaps indicating that feedback may facilitate a more accurate assessment of one's skills.

Authors pointed out that, although conducting supervision research that focuses on client outcome is difficult and challenging, such research is important and necessary given the centrality of supervision to counselor training. The question of whether

supervisory training is beneficial is in part still unanswered because of limited research in this area. Although the use of client feedback data has been proffered to be of value in the supervisory process, there is no a large body of research to support this contention. Just recently, Swift, Whipple, Dexter, Callahan, and Wrape (2014) discussed three strategies for integrating client outcome data and standardized feedback into the supervisory process: training students to obtain and use objective client feedback, using specific client data to inform discussions of clients, and identifying patterns of outcomes across clients to facilitate supervisee development. Authors pointed out that research is in need to examine if informed supervision has a positive impact on the supervisory process.

The present research attempts to address this lack of research about collecting clients' feedback and providing them to supervisors for use within supervision. This purpose is in line with the recent manuscript published by Haber, Carlson, and Braga (2014) on the use of the Client Feedback Note form as a qualitative methodology for collecting clients' feedback. The authors expressed the need of a systematic research on the use of this new methodology in both clinical and supervision settings.

2.5 SUMMARY

As is evident in this chapter, the literature on the working alliance construct is large and with a long tradition in both counseling and psychotherapy fields, but there are few empirical studies on the use of client feedbacks in supervision. In addition, there are few empirical studies with the purpose to improve trainees' relational skills through the analysis of client feedbacks using continuous measures as method of intervention.

Therefore, it is essential to ascertain how counselors in training could improve their working alliance with their clients by discussing with their supervisors ongoing

clients' feedback based on qualitative data. The data drawn from this new method will promote a more deep knowledge regarding clients' perceptions about the relationship with their therapists and their consideration for educational purposes.

2.6 CONCLUSION

The theoretical and the empirical literature review show the importance of the therapeutic alliance as one of the therapeutic factors which is determinant for therapeutic outcomes.

The question becomes: "How is the experience of practicum counseling students regarding the development of the therapeutic alliance with their first clients? This is the central question of the present qualitative research. In chapter three, the methodology of the study is presented with specification regarding the phenomenological approach, the context of the study, the selection of participants, the analyses of data, and the role of the researcher. In chapter four, data obtained from research instruments will be presented. In chapter five, data will be discussed in depth and professional implications will be provided.

CHAPTER 3

METHODOLOGY

The purpose of this chapter is to present the methodology regarding how the researcher explored the perceptions of graduate level students about their improvements of the therapeutic alliance from the beginning to the end of their practicum experience incorporating clients' feedback. The research question of the study is the following: "how do second year Ed.S. students enrolled in MCFC program reflect on the evolution of the therapeutic alliance over the practicum experience?".

The qualitative approach that the researcher adopted is phenomenological in nature and its rationale will be presented in this chapter. Also, the role of the researcher in the data collection will be described. The context of the study, participants and measures for their ethical protection will be presented. Moreover, the research instrument will be highlighted as well as data collection and data analyses.

This study represents an important step in the literature of counselor education and supervision. It aims to answer to the problem raised by Reese et al. (2009) on the utility of continuous client feedback in counselor training and supervision. According to the authors, despite of difficulties and challenges in conducting supervision research with focus on client outcome, the research in this area is relevant because of the centrality of supervision to counselor training. Because there are no qualitative instruments to collect client feedback as well as there are no recent qualitative research that study students' self-reports about their clinical improvements during their first clinical experiences as

counselors, the researcher decided that the qualitative methodology was appropriate. The qualitative research gave the opportunity to both clients and students to provide different aspects of their perceptions in depth which quantitative data could not capture.

3.1 RESEARCH PARADIGM

This study is phenomenological in its nature. Literally, phenomenology is the study of “phenomena”: appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our experience (Stanford Encyclopedia, 2008). Creswell (1998) contends that a phenomenological study describes the meaning of the lived experiences for several individuals about a concept or the phenomenon (p.51). In the human sphere, this normally translates into gathering “deep” information and perceptions through inductive qualitative research methods such as interviews and observation, representing this information and these perceptions from the perspective of the research participants (Lester, 1999). Furthermore, Schwandt (2007) said that phenomenology is a method that attempts “... to get beneath or behind subjective experience to reveal the genuine, objective nature of things, and as a critique of both taken-for-granted meanings and subjectivism” (p.226). The rationale of this study is to explore in depth the experience of practicum students about their perceptions of the development of the therapeutic alliance during their training.

A researcher applying phenomenology is concerned with the lived experiences of the people (Maypole & Davies, 2001) involved, or who were involved, with the issue that is being researched. Since the goal of the researcher in this study was the exploration of the students’ clinical experience with their first clients, the purpose of each interview questions was to access the subjective experience in order to bring clarity to its objective

nature (Glesne, 2006; Maxwell, 2005; Merriam et al., 2002). Even if there is a lot of literature on the therapeutic alliance construct, few studies have considered the development of this important clinical skill in relation to the supervision and training. The choice of the phenomenological paradigm for this research is in line with what Shank (2006) said: “exploration is necessary when the research community as a whole has absolutely no clear picture of what is going on” (p.104).

Although other qualitative choices were available to the researcher, they seemed not as appropriate as the phenomenology approach for the purpose of the study. The benefit of phenomenological methodology in exploring the therapeutic relationship is that it includes all aspects of participants’ experiences. The inclusion of all perspectives contributes to the knowledge of the nuances and themes of lived experiences. This purpose mirrors Kline’s (2008) assertion regarding the choice of phenomenology: “a study that has the purpose of describing the central theme that emerges from the lived experiences of persons who share an experience...would use phenomenological assumptions” (p.212). Other qualitative means were not considered as appropriate as the phenomenology. For instance, case study is “...an intensive description and analysis of a phenomenon or social unit such as an individual, group, institution, or community” (Merriam et al., 2002, p.8). The research had more than one single person to access information regarding the development of the therapeutic alliance skill. Another qualitative paradigm that the researcher decided to not choose is the narrative analysis which entails “... the use of stories as data, and more specifically, first-person accounts of experience told in story form” (Merriam et al., 2002, p.9). The researcher looked for the specific training experience of students regarding their perceptions about personal

improvements of the relational skills during their practicum, and not the entire stories/narratives about the practicum experience itself. Phenomenological interviewing seemed to be the best research paradigm because it "...focuses on the essence or structure of an experience" (Merriam et al., 2002, p.7).

3.2 ROLE OF THE RESEARCHER

The research ideas came from the researcher's experience as a therapist and as a supervisor.

As a therapist, the researcher considered relationship aspects as important factors for counseling outcomes. According to the researcher, not only are theories and techniques used by the therapist in the counseling sessions important, but also the quality of the relationship between the therapist and the client (the therapeutic alliance) is a fundamental ingredient for the success or the failure of a counseling treatment.

As a supervisor, the researcher noticed that trainees needed to be supervised in the application of theories and techniques and in their ability to build a relationship with their clients. Beginning therapists should know and apply theories and techniques. But, at the same time they need to be aware about the use of self in session and they are required to improve their personal ability to establish a working therapeutic alliance with clients.

In particular, the researcher discovered from her personal and professional experience that there is the possibility to improve the quality and the effectiveness of the therapeutic intervention by using clients' feedback. In 2011, the researcher started thinking about her role as counselor educator, and she realized the possibility of using clients' feedback in supervision. After a literature review on "therapeutic alliance", "client feedback" and "supervision", the researcher found there is a lack of supervision-related studies that address client outcome (Freitas, 2002; Goodyear & Bernard, 1998),

even if some authors have discussed the potential advantages of using client outcome data for counselor training and supervision (Lambert & Hawkins, 2002) in terms of counselor self-efficacy, strong supervisory alliance and positive therapeutic alliance (Reese, Usher, Norsworthy, Rowlands, & Chisolm, 2011). The researcher looked for clinical instruments which aim to collect client feedback and from the literature she found that the majority of client feedback forms are quantitative (Horvath & Bedi, 2002; Krause & Altimir, 2011). In collaboration with Dr. Russell Haber, the researcher started thinking about a qualitative client feedback form as a tool that can be used during the students' training to improve the development of the working alliance with clients (Haber, Carlson, & Braga, 2014).

3.2.1 Positionality

Peshkin (1988) discussed the importance of researchers being aware of their own subjectivity so as not to insinuate the researcher is completely objective. Peshkin (1988) stated “when researchers observe themselves in the focused way I propose, they learn about the particular subset of personal qualities that contact with their research phenomenon has related. These qualities have the capacity to filter, skew, shape, block, transform, construe, and misconstrue what transpires from the outset of a research project to its culmination in a written statement” (p.18).

The researcher saw different subjective I's engaged in the process of the research project. They were: “Ph.D. student in counselor education and supervision I”, “Family Therapist I”, “Supervisor I”, “Teaching assistant I”, “Italian I”.

The “Ph.D. student in counselor education and supervision I” could have influenced the way the researcher perceived the importance of Master students'

developments in the therapeutic alliance with their first clients. Since the researcher assumed she had more clinical and educational experience, she could have seen trainees' experiences from her professional lenses and not from their personal lenses.

The "Family Therapist I" played a relevant role in the researcher's perception of the therapeutic alliance in this specific field of counseling. It could be interesting to look at the same constructs (therapeutic alliance and clients feedback) even in other areas of counseling, but her professional experience in family counseling had been influenced the purpose of the research.

The "Teaching Assistant I" could have played a competitive role with the "Researcher I". For this study, the researcher was not a Teaching Assistant for students anymore. For those who had the researcher as instructor in the past, and for the researcher having them as students in the past, this could have made confusion. The researcher could have assessed students' development as instructor instead of collecting the data and interpreting them for the scope of the research.

Finally, the "Italian I" could have created a distance between the researcher and the participants because of cultural and language differences. Researcher might have misunderstood some experiences or include cultural biases in students' improvements.

3.2.2 Monitoring Subjectivity

For the ultimate goal of enhancing the quality and rigor of this qualitative research, the researcher intended to monitor the impact of the subjectivity and positionality by using these strategies: member checks, peer review/examination (Merriam et al. 2002), and personal ongoing reflexivity (Peshkin, 1988). All of those strategies addressed the researcher's biases and personal interpretation and they allowed

the researcher to be aware and understand the influence of those aspects in the conclusions of the study.

First of all, the researcher took data and interpretations from interviews back to the participants and asked them if they were plausible.

Secondly, she had a constant discussion with her advisor and with colleagues regarding the process of this study. The researcher deeply examined emerging findings and tentative interpretations.

Finally, she did a critical self-examination regarding her assumptions, biases, theoretical orientation, and personal relationship to the study by keeping an ongoing reflection journal from the beginning to the end of the research process.

The researcher was aware of the impossibility of eliminating the influence of the subjectivity and positionality, but she would like to be as neutral as she could for the validity of the research.

3.3 INSTRUMENTS

Since the focus of the research is on the development of the therapeutic alliance of 2nd year MCFC students over the length of their practicum students incorporating clients' feedback, the researcher used semi structured interviews for collecting students' interpretation regarding their experience.

3.3.1 Interviews

The questions of these semi-structured interviews generally explored the process of building the therapeutic alliance from practicum students over the length of the semester. Questions were formulated after a review of the quantitative items of The Working Alliance Inventory-Short Revised (WAI-SR) (Munder, Wilmers, Leonhart,

Linster, Bartm, 2010). This is a recently refined measure of the therapeutic alliance that assesses three key aspects of the therapeutic alliance offered by Bordin (1979): (a) agreement on the tasks of therapy, (b) agreement on the goals of therapy and (c) development of an affective bond.

Interview questions:

1. How do you define the therapeutic alliance in counseling?
2. In the therapeutic alliance with your clients, describe your experience about establishing goals of treatments.
3. In the therapeutic alliance with your clients, describe your experience on collaborating around therapeutic tasks.
4. In the therapeutic alliance with your clients, describe your experience on developing the emotional bond.
5. How does the absence of mutual therapeutic goals impact your counseling?
6. How does the absence of mutual agreement of therapeutic tasks impact your counseling?
7. How does the absence of mutual emotional bond impact your counseling?
8. What have you experienced about the use of the Client Feedback Note form in your practicum (clinical and supervision hours)?
9. How does the use of the Client Feedback Note form in your practicum experience (clinical and supervision hours) impact the development of an intentional therapeutic alliance with your clients?

3.3.2 Client Feedback Note Form

The Client Feedback Note (Haber, Carlson, & Braga, 2014) form is the intervention of choice and is composed by four open questions the client is asked to fill out at the end of each therapeutic session:

- my (client) feelings/thoughts about the therapeutic session,
- what I (the client) learned,
- what I (the client) did not like,
- what I (the client) wish would have happened.

The power of this qualitative form is that it allows to collect different aspects of the therapeutic relationship according to the clients' perspective. Feelings (positive and negative), thoughts, learning, dislikes, and wishes are explored and clients could provide complete and interesting feedbacks regarding the alliance with beginning therapists.

This intervention of choice could be related to problems in the rigor of this research design. The Client Feedback Form is a new client feedback form that has never been tested in previous research. From its use in clinical settings, it is clear that the form is helpful for receiving meaningful feedback from clients and improving the quality of the treatment efficacy, but from the research field there is no evidence that this instrument is valid.

3.4 CONTEXT FOR THE STUDY

The selection strategies the researcher followed for choosing the site/location for the study were perspective/worldview based, geography/activity focused and time based (Patton, 2002).

First of all, from the perspective strategy, people in the site shared the common experience as practicum graduate students in Family Counseling. For the purpose of this study, it was relevant that students were practicing as beginning counselors and receiving individual supervision.

Also, from the geography/activity focused strategy, the location was geographically sited at University of South Carolina, Counselor Education Department which meets CACREP standards. Since the goal of this study is educationally related, it was important to focus on an educational environment and on an accredited counseling program. According to the literature, clients' feedback have been usually obtained from adult clients, so my focus is on the Marriage and Family Counseling program at USC.

Moreover, according to the time based strategy, this site was related to the time and events. For the collection of relevant data, students had to be enrolled in a program that required the practicum and supervision experience over the length of one semester.

For all of those reasons, which are mostly oriented to the goal and the purpose of this study, data were collected during the midterm and the last week of the Fall semester 2013 to 2nd year Ed.S. practicum students in Marriage, Couples and Family Counseling (MCFC) at University of South Carolina, Columbia, SC. This University is one of the few colleges with a MCFC Master CACREP accredited counseling program. The researcher assumed that all students were from the southeastern U.S.

3.5 PARTICIPANTS

The sample of participants consist of 6 Ed.S 2nd year counseling students registered for the practicum in Marriage, Couples, and Family Counseling (MCFC) track. Students were contacted via their university e-mail provided by the counselor education

program. For what concerns the sample size, it was in line with the minimum number of participants suggested by the authors who provided methodological guidelines according to the phenomenological approach. Creswell (1998) suggested the range between 5 to 25 participants; Morse (1994) stated that it is necessary a minimum of 6 participants.

The researcher presented the research to students at the beginning of their practicum in Fall semester 2013 in order to ask them if they wanted to participate to the study.

Also, students' supervisors were informed about this research, since students were going to be supervised on the development of the therapeutic alliance skills by reviewing and discussing about clients' feedback. Moreover, students who agreed to use the Client Feedback Note (Haber, Carlson, & Braga, 2014) form during the therapeutic process and in supervision, needed to review the form in supervision assisted by their individual supervisors.

3.5.1 Measures for ethical protection

Institutional Review Board

Before starting this study, an application was submitted to the Institutional Review Board (IRB) at the University of South Carolina. The research did not start until the IRB approved the protocol of this research. The IRB process assured that measures of the research ethically protected clients.

Risks and Benefits

Since interviews transcripts were anonymous, this study did not have risks for participants. Participants voluntarily decided to participate or not to the study and the researcher did not share information with supervisors, so there was no impact on

students' grades at the end of the practicum/supervision. Also, to students it was asked to share with their clients that the Client Feedback Note form was anonymous.

Thanks to the possibility for students to provide their points of view during interviews allowed students to strengthen their counseling skills, in particular their awareness regarding the ability to build and maintain a therapeutic alliance with clients. Also, the Client Feedback Note form provided students the possibility to receive direct feedbacks from their clients and discuss them in supervision to improve more their skills according to the clients' responses.

Protection of Participants

The identities of students involved in the study remained anonymous in the discussion of results as well as in future publications or professional presentations. Participants was provided with informed consent which explained the right to participate voluntarily and the right to withdraw the research at any time. The consent form explained the purpose of the study so the researcher made sure that participants understood the nature of the research and its risks and benefits. Students were encouraged to ask questions if something was not clear and the researcher explained them the right to obtain a copy of the results of this research. Signatures from both researcher and participants were documented on the consent form agreeing to the research parameters.

3.5.2 Criteria for selecting participants

The sampling strategies the researcher followed were related to purpose sampling (Patton, 2002). In particular, the sampling was typical case sampling, criterion sampling and theory-based sampling.

First of all, the sample illustrated the typical practicum and supervision experience of 2nd year Ed.S. MCFC counselor students at USC regarding their perceptions of their development of the therapeutic alliance with clients. It was a typical sample, since the experience of the students was related to the specific program they attended and the way it was structured/organized.

Secondly, the sample met a specific criteria related to the common experience of those students as all 2nd year Ed.S. MCFC counselor students at USC. This assured the level of expertise of those students at the end of their Master program and at the same time at the beginning of their practicum clinical experience.

Finally, according to the literature, there is a huge need to obtain data from students regarding how they explore clients' feedback in supervision to increase their therapeutic alliance with their first clients. The theoretical constructs of this study (therapeutic alliance, clients' feedback, practicum experience) were in line with the choice of 2nd year Ed.S. MCFC counselor students at USC because they are important for their improvement of practicum skills as counselors.

3.6 DATA COLLECTION

Students' self-report data about their first clinical experiences with their clients were collected at the end of the Fall semester 2013 to focus on students' development on the therapeutic alliance over the entire practicum experience.

One-to-one interviews were conducted by the researcher with each students and they were audio recorded. The researcher loaded the interview on to a laptop and she transcribed each of them. Once the researcher listened the interviews, she checked their

accuracy and she transcribed them on a Word document, she started the coding process and she identified the common themes.

3.7 DATA ANALYSES

The process of data analyses consisted of audio taping each interview, transcribing and coding them. To look for common and specific themes, the researcher coded transcribed interviews with the line by line method.

The researcher followed the process suggested by Donalack and Soldwich (2004) and Moustakas (1994) according to the phenomenological approach. First of all, data were analyzed highlighting relevant sentences that provide an understanding of how the participants experience the phenomenon. From the description of what the participants experienced, the researcher wrote a description of the essence of the phenomenon noticing themes as the saturation point was met, which means when elements from the individual interviews began repeating.

In order to strengthen the validity of the research, the researcher asked participants to read their transcribed interviews for checking the accuracy of their experiences reported by the researcher. This method is suggested by Merriam et al. (2002) in consideration of the internal validity, reliability, external validity or generalizability of qualitative research.

Finally, the researcher used peer review to insure triangulation of the data. She asked to three doctoral students who had completed the qualitative research course to provide feedback about themes emerged from transcribed interviews.

3.8 CONCLUSION

There are no qualitative research on self-reports of counselor education practicum students about their development of clinical skills, in particular relational skills with first clients. In particular, from the literature review, the absence of qualitative instrument to collect clients' feedbacks regarding the therapeutic process with beginning therapists is evident. Also, even if the supervision is considered important for supporting practicum students in their first experiences as counselors, there are few studies on this training process.

This chapter presents the main methodological aspect of a qualitative research which addresses this huge empirical need in the counselor education and supervision field. The chapter describes the phenomenology as qualitative research paradigm considered effective for the goal of the study. It also addresses the role of the researcher as well as the context of the study, which will be the University of South Carolina (CACREP standards) and the participants, who will be 2nd year counseling students in marriage and family track. Measures of ethical protection for participants will be in line with the IRB requirements. Research methods will be semi-structured interviews provided at the end of the semester. Questions that will be asked to students will be in accordance to the research paradigm. Data will be analyzed using triangulation methodology which will include developing themes via coding, member checking, peer review and keeping a journal during the entire research process.

In chapter four, the findings and details concerning the codes and themes will be discussed. In chapter five, practical and theoretical implications for this research study will be presented.

CHAPTER 4

FINDINGS

The purpose of this chapter is to present the data gathering procedures, sample demographics, data tracking methodology, themes discovered, and the validation of those themes. Data gathering procedures will describe the process by which the data were generated, gathered, and recorded by the researcher. Sample demographics will present the characteristics of the participants of this study. Data tracking methodology will focus on the coding process used by the researcher to analyze the interviews. The following session will discuss patterns, relationships, and themes discovered. Finally, the researcher will present the procedures used to assure the accuracy of the data obtained.

4.1 SAMPLE DEMOGRAPHICS

The sample of participants in this study was composed of six Ed.S. students in their second year of the marriage, couples, and family program at University of South Carolina. The ages of the participants ranged from twenty-three to fifty-four. There were two males and four females. All of the participants were Caucasian. Four students (two male, 2 female) were doing their practicum at a family counseling center, having adults, children, teenagers, families, and couples as clients. The other two participants (2 female) were doing their practicum at the counseling center of the University of South Carolina, serving primarily college students and adults. Students reported that at the time of the interviews they completed an average of 300 hours of their practicum and an average of

120 hours of supervision. Four participants were using the Client Feedback Form for 75% of their clinical service and supervision, and the other two participants stated that they were using the Client Feedback Form for less than 25% of their practicum and supervision hours.

4.2 DATA GATHERING PROCEDURES

The researcher obtained a list of the emails of Ed.S. second year students enrolled in the marriage, couples, and family counseling (MCFC) program from the counselor education department where the study took place. There were six students enrolled and all of them were invited to participate to the research. The email sent to them briefly presented the research and it encouraged students to ask questions regarding the study before agreeing to be volunteers. All students agreed and the researcher made appointments for face-to-face interviews. Three students were interviewed at their practicum site. The other three interviews took place at the researcher's office. Before starting the interviews, the researcher shared the goals of the study in detail, and collected the informed consent forms and participants' demographics.

4.3 DATA TRACKING METHODOLOGY

The researcher analyzed the six interviews using the line-by-line method. Each transcript related to the questions of the interviews was examined by looking for the main categories which described the essential meaning of participants' experience. The researcher compared all responses to identify patterns and extracted relevant statements. An excel spread sheet with all the main categories and themes was kept so that tracking of themes would be easily recorded in one source. The researcher enlisted three peer-reviewers. They were three doctoral students whom had already completed the course on

qualitative research. One student was enrolled in the counselor education program, another one was enrolled in the educational foundation and enquiry program with specialization in educational research and measurements, and the last one was enrolled in the educational psychology program. These peer-reviewers assisted the researcher in checking both the transcripts and the analyses for assuring the accuracy of the data. Peer-reviewers helped the researcher to define some themes as well as to find new themes. The themes that were identified closely paralleled to all the peer reviewers and the professional literature as well. Therefore, the researcher created themes with the professional literature in mind.

4.4 THEMES DISCOVERED

The research question of the study was: How do second year Ed.S. students enrolled in Marriage Couples and Family Counseling (MCFC) program reflect on the evolution of the therapeutic alliance over the length of the practicum experience?

Participants that took part of this study shared their experiences regarding the development of the therapeutic alliance with their first clients by answering the questions that the researcher posed to them.

Through the analyses of the answers, three main categories were revealed:

1. Participants' positive experiences in the development of a therapeutic alliance with their first clients;
2. Participants' negative experiences in the development of a therapeutic alliance with their first clients;
3. Relationship between the collection of clients' feedback and the development of a therapeutic alliance.

Five themes were related to these categories:

- a. Bond, which is considered as a personal attachment between clients and therapist;
- b. Tasks, which refer to all the behaviors and cognitions involved in the counseling session for achieving the outcomes;
- c. Goals, which are considered as desired outcomes that are the target of the counseling intervention;
- d. Spirit of Collaboration, which refers to the willingness of both counselor and client to work together in consultation;
- e. Theories and Techniques, which are both the theoretical approach and the techniques that the counselor applies during the treatment with clients.

At the end of this section, differences among participants in factors related to the therapeutic alliance will be discussed.

4.4.1 Positive Therapeutic Alliance

Most of the participants shared their positive experiences in the development of the therapeutic alliance with their first clients. They considered a therapeutic process to be successful when it involved a strong emotional bond with clients, an agreement between counselor and clients on tasks and goals, a good spirit of collaboration to achieve the therapeutic goals, and the ability of the counselor to apply the right theories and techniques in the work with clients. A summary of the findings related to the positive experience of the therapeutic alliance are presented in Table 4.1.

Table 4.1 - Positive Therapeutic Alliance

| BOND | TASKS | GOALS | SPIRIT OF COLLABORATION | THEORIES AND TECHNIQUES |
|---|--|--|--|--|
| Emotional attachment Trust Self-disclosure Confidence Counselor's personal investment | Follow clients' desires Make recommendations Clients' responsibilities Counselor as "facilitator" Clients' empowerment | Counselor as a "guide" Counselor as a "meaning provider" Clients' responsibilities Thinking process | Collaborative involvement Team work Clients-Counselor mutual understanding | Counselor's personal approach Counselor's capabilities Counselor's level of preparation Counselor's level of experience Counselor's communication skills |

Bond

The first theme discovered was that therapeutic alliance involved the relational bond with clients.

Student #1 commented:

Therapeutic alliance is very similar to rapport for me. Understanding between myself, the counselor, and the client or clients. ... Understanding that I am there for their best interests. ... It is essential and I think it is sort of what everything else is built upon. Without it I do not, I cannot see how there would be effective counseling. ... I mean get to know someone, share emotionally ... share a laugh or make them laugh or just find some sort of common bond or I guess in regards to emotion find common drive maybe or a common fear or something that makes me excited. I can't pretend to know exactly what they are going through but at least I am trying to ... hopefully they can see the effort that I am trying to it beside them as we are looking at our problems together.

In relation to the development of the therapeutic alliance, the same student added:

(the therapeutic alliance) is essential and that's not immediate. I have tried to focus a lot on particularly at first but also try to continue to cultivate each session.

Student #2 stressed the emotional aspect of the therapeutic alliance:

(it is) the relationship between the client and the counselor, like how comfortable they might feel, maybe not comfortable, because some of the stuff is uncomfortable, but free from being judged, supported I guess.

Focusing on the quality of the therapeutic alliance, this student said:

I feel like when it's good it tends to just like feel more like a conversation that you have like in everyday life. ...it just like it felt natural, it felt like we were just having a conversation, like it just flowed better and I feel like you both can feel that ... you see someone in the first 10 seconds, you kind of think like, yeah I'm going to like them or not and I feel like it's that a lot of the time for them and for me probably I guess too. ... (you feel that) it is going to work. ... and then there is a lot of stuff you can do, like how do I express concern, empathy/sympathy. ... I think it's kind of a strange relationship because like I know so much about them, they don't know as much about me, but it is a very emotional relationship but it's almost one sided. Not really I guess, just they don't have that content about like the person they're talking to but I have that content about them.

Participant #3 pointed out the difference between what he considered “therapeutic alliance” and what he considered as “relational alliance”. According to this student, the therapeutic alliance is based on theories and techniques that the counselor applies in the therapeutic session. Whereas the relational alliance is more related to the bond between the counselor and the client:

A relational alliance would have more to do with does the client feel comfortable with you, have you established rapport, is there trust, are you able to discuss pretty much anything you need to in the professional setting.

The development of a therapeutic alliance of this student was strongly connected to the use of self-disclosure with the goal of building trust with clients:

My approach is to build trust through humor and self-disclosure at a reasonable level. I try to make them as comfortable as possible by finding things in common. Something that they can identify with personally and I try to use humor in some wise low level of self-disclosure to initiate that. ... I try to establish rapport and trust ... use humor and so identification with things in common¹.

According to student #4, the therapeutic alliance was related to the transparency in the feelings the therapist has with clients:

... I sort of feel an attachment like that: "I really want to help you, but I'm not going to like do the work for you", like kind of, "I want to help you help yourself" sort of attitude towards my clients so I'm sure that probably comes across. ... I get pretty attached pretty quickly to most of my clients.

¹ Participant #3 provided the following example: "I have had three experiences in the last 2 weeks where young people that I believed that I had established rapport and trust with, all three in different circumstances completely shut down, under different conversations, but sat in their chair and bowed their head and just stopped talking and when I would say "hey, hey did we touch a nerve, did I hurt your feelings, are you angry, are you sad?" No response. One was 7, one was 12, and one is 17. One was a boy and two girls and I went back and watched the tape. One of them was clearly, she did not want to talk about her family in the genogram, she's had a very unfortunate background, disadvantaged and lots of neglect and abandonment, but she wasn't able to separate, at 12, she wasn't able to separate her not wanting to talk about it from our being able to talk about why she didn't want to talk about it. I said, "I won't try to convince you to talk about it, I hear that you don't want to and we won't but will you talk about why?" And she couldn't understand that and so didn't speak for about 10 min so that was really awkward. The 7 year old, I don't know if he struggles with OCD, but we were printing, he wanted to print some things on his own genogram, and he didn't like the way I printed, he said "my writing was too curly" and so I tried very hard to print and he got angry and shut down and he was completely unreasonable of course, but at a 7 year old level I was astounded that he did not respond. The 17 year old didn't want to be there and I had asked her one too many questions to get her talking and she just stopped. So those three examples have surprised me when I think I have established an emotional connection, well I know I have, the next week you might say something totally random and it, that, those three shutdowns have been a big surprise to me".

Students #5 expressed the importance of being related to clients to be an effective counselor:

I am working hard to relate with my clients and they can see when you are really interested to them and you are trying to explore that to make sure you understand. I think that clients appreciate that.

Likewise, student #6 provided a definition of the therapeutic alliance related to the personal investment with clients:

(the therapeutic alliance) is the relationship you build with your clients. ...it's building trust and confidence. ... it's talking on an emotional level versus chit-chat that you would do with a normal person. ... it is building rapport, just following them at their place, making them feel comfortable, trying to enter in their world. ... you get invested when you like your clients, you want the best for them and it's really rewarding to see them move forward in a positive direction.

Tasks

The second theme related to the therapeutic alliance regarded the agreement between the counselor and the client on the tasks.

Student #1 explained as it follows the way she worked on tasks with clients:

I try to get them to use their own words, what those tasks are to meet the goals. I go in to each session with an idea of a couple of tasks. ...short term tasks that can be, or steps that can be taken. But I try to not just give it to them but more so here is an idea and have them sort of tailor it for their own personal use. ... the empowerment is sort of what I think is critical to the therapeutic alliance ... I try to empower them to begin to make steps on their own.

Even according to student #2 it was important to define tasks based on clients' desires:

I feel like a lot of the time, well sometimes they will like think of stuff on their own, like "I would like to do this," or "I would like to try this little thing to change," but then also a lot of the time I feel like they don't so then if I kind of provide some suggestions for like ways they can do this or with things you can try out. They can say, "yeah, I want to do that," or they don't want to do that and then sometimes I just have ones that are like geniuses and they're like, and they like google treatment and they're like "I want to try this" and you're like "Ok, sure." ... I probably have an idea of what I would like to do but I also want to check in with them and see what they're thinking and also to think what I'm, my idea is completely off base or like not helpful for them, like work with that too².

Student #4 stressed the responsibility of clients to express what they would like to work on in the counseling sessions:

I really try to like make it clear that like I'm here to facilitate their achievement of their goals and help them with that so I am very open about my thoughts, beliefs, ideas, feeling that they are the ones who do the work. I hated having it said that I'm like, "there's not anything that I could say to you in here that's going to magically change your life, so we need to figure out what you can do and how you can do it and what's going to work for you".

In the development of the therapeutic alliance with clients, student #5 explained the positivity of working together on weekly assignments:

² Participant #2 provided the following example: "I had like five clients today and I know it happened today like I was like "let's try this" and they were like "ok, could I do this too?" and I was like "yeah, yeah you can if you want to try that." Shoot I can't remember...I think I put one of my female anxiety clients, I think I gave her I think it was like a self-talk worksheet and then she was also...we were done at the end, and she was like "should I try and confront my roommate about how I feel too?" And I was like, "If you want to," I was like "yeah that's fine we can say that's an optional one." So it's like that, it was like I had something for her and they she was like "what about this, what do you think about that" and I was like "yeah if you want to do that, that can be something we work on too."

I do not have problems giving clients assignments ... they do some homework and we have made productive progress in session as a result of doing assignment like that. ... I let them consider some options, I have an idea and then we might get into how we could document what their week looks like, or what would be ways that we could understand what happened with their thoughts in the prior week and bring that into session.

Finally, student #6 briefly commented on the agreement of tasks with clients:

... just talking with them, making recommendation, seeing what fits, what feel right to them. It's a lot of that.

Goals

Participants expressed in different ways how they developed the ability to work on the therapeutic goals with their first clients.

Student #1 shared how she involved clients in the establishment of the goals of treatment:

I do find myself sort of guiding them towards what I think the goals should be sometimes...not sure if that's good or bad yet, but it is sort get them know what fits best or fulfillment for them so I try to use their own words as much as possible... I try to use their own words because my thought is that they must be willing to make changes on their own. ... I talk about the goal, I share in terms of giving them feedback on what I hear and then maybe reframe the goal. ... I think the most powerful way is to reframe their problem into a goal. ...It's something that we are doing together instead of let's fix what's wrong with you type thing.

Likewise, student #2 expressed the importance of empower and support clients in define what they would like to work on during the counseling process:

I feel like sometimes, most of the time they know but I feel like it's more general like "I just want to feel better" and you have to kind of say "well how would we know if you feel better like what would that look like?" and then sometimes they don't know, I think they're just like "I'm upset and I feel awful and like something needs to be different, I'm not sure what." It's definitely easier for me when they clearly know what their goals are because I can't say what their goals are. Sometimes I feel like they just have to learn through it like when you want it to be different, like what that look would like if we were successful at the end, that kind of thing. Yeah, but I don't want to set goals for them.

In a similar way, student #3 explained the process by which she establish goals with clients and engaged clients during the development of sessions:

Usually we try to get a sense of what they want from the counseling experience like in the first session. So they come in and tell us like, "oh my problem is this" and I ask them generally like, "so what do you think we can accomplish in counseling? How can counseling help you with this? Or I may ask them like, "what...how do you hope your life will be different or more successful?" So, but usually they change a little bit over time. Sometimes I find that it's easy to get lost in like storytelling, stuff like that, and so I find that I'm not maybe super smooth, but I find that sometimes I just like "ok, I know this was relevant but I'm just not sure how, can you help me explain what we're talking about now helps accomplish your goals?" Which, then I might repeat them, like whatever they picked, whatever we had talked about were our goals, and they'll be like "I don't know if I really want that," and I'll be like, "awesome, let's figure out what we do want to do with this so that we can make it be helpful for you".

Student #5 defined the therapeutic alliance focusing on the counselor's responsibility to define a treatment plan based on clients' expressed needs:

The therapeutic alliance is letting the client develop goals for therapy and looking at their symptoms and tying in their symptoms with their goals and coming up with a treatment plan.

The same student also shared that her ability to work on clients' goals was still a work in progress:

I am still learning how to establish goals with clients. I do ask them about their goals, like how do they hope to be different in like six months, and they tell me that then we work together on their symptoms...to develop like matching my theory with their goals. So it's still in progress I guess.

Finally, student #6 exposed her experience related to working on goals with non-voluntary clients:

It's good thing to ask the clients, fairly early in the beginning because it helps them to think about why they are there and what they want to get out of the counseling. So my experience with it it's been very positive. It is not always etched in stone, rarely actually. You start off one way and then things turns it. I think it's good, I think it makes them think about why they are there. ...sometimes they do not really know what their goal is, but certainly if they come in with a goal we go to that direction. I do not have a goal that the client would not have. At least I certainly would not push it. It might be in the background of what I'm thinking, but if they're not on that page, I'm not going to force them in that direction. ... If they're acting like they don't want to be there, because we get some...a lot of mandated clients, if they have no problems and they don't want to be here, I'll try to do something with that and find something we can do for the next hour, but I'm certainly not going to force them.

Spirit of Collaboration

According to the most of participants, a good spirit of collaboration from the clients increased the quality of the counseling sessions.

Student #1 expressed the importance of involve clients in defining their counseling expectations:

I ask them initial...make sure to ask them in their own words why it is that they are here and then what it is, what their expectations for treatment are... and from those questions I establish some goals for treatment on my own... so yeah, I try to do the collaborative involvement with the goals.

Likewise, participant #2 shared the relevance of clients and counselor working together to define counseling goals:

So sometimes I'm like "Oh, I can't tell you what your goal is," but I can help them kind of figure it out.

Participant #4 pointed out that in her experience the therapeutic is also related to the collaboration between counselor and clients on defining and solving problems together:

I feel the therapeutic alliance is like the way that my clients and I see ourselves as like collaborators like a team sort of working together to help problems. The alliance is the way that they see that I have an ability to help them and I see that they have ability to help themselves and try to draw that out for them a little bit. So like, we see things that we like need from each other and use that to like tackle problems.

Finally, for student #5 the therapeutic alliance is strongly based on clients and counselor mutual understanding:

To me the therapeutic alliance is about understanding kind of both sides (client and counselor). If you are on the right path and the client is making progress then I definitely want to hear that. And if there are thing that need to be adjusted I want the client to feel like they can express that, like I do not like this or I do like this, and so we are working together to give them the best care that we can.

Theories and Techniques

When beginning counselors felt capable in the use of counseling theories and techniques, they looked their counseling experiences positively.

Participant #2 considered counseling techniques as important factors involved in the therapeutic alliance:

There is a lot of stuff you can do, like how do I express concern, empathy/sympathy, stuff like that.

For student #3, the level of the counselor experience has an impact on the quality of the counseling sessions:

The therapeutic alliance I would think has to do with your work as a trained therapist, employing therapeutic techniques and theories, where you could plainly see and show results.

According to the same student, a therapeutic alliance can be considered positive when:

It is unconditionally good and successful ... when I see the fruit of a therapy.

Likewise, student #4 expressed the importance of clients to consider the counselor as capable to help them:

The alliance is the way that they see that I have an ability to help them.

She also added that her approach was helpful for her clients:

My personality, like my sort of approach is pretty casual, or like way that I sort of approach the counseling experience to my clients, or presented to them, is kind of casual and I feel like that helps make people more comfortable. I just try, I try to be genuine, just try to be myself, and I think that that eases things a little bit.

According to student #5, the therapeutic alliance was positive when she was able to see improvements in clients' symptoms. That was strongly related to the level of her preparation as counselor:

The more knowledge I get about what is really impacting college students today, then the better alliances I'm able to build with the client.

Finally, participant #6 expressed some technical aspects of the counseling skills that were involved in positive experience with clients:

(the therapeutic alliance is positive) if the client is making eye contact, feeling comfortable to answer to questions.

4.4.2 Negative Therapeutic Alliance

Some participants shared their challenges in developing the therapeutic alliance with their first clients. They shared that in some cases it was difficult establishing an emotional bond with clients as well as working together on tasks and goals. Students also expressed the negative impact of a lack of spirit of collaboration from some clients as well as counselor's difficulties in the application of theories and techniques that can really help clients in session. A summary of the findings related to the positive experience of the therapeutic alliance are presented in Table 4.2.

Table 4.2 - Negative Therapeutic Alliance

| BOND | TASKS | GOALS | SPIRIT OF COLLABORATION | THEORIES AND TECHNIQUES |
|--|---|--|---|--|
| Personal conversation Superficial relationship Counselor's frustration Counselor's irritation Lack of respect Disconnection Counselor's disappointment | Disagreements Misunderstandings Absence of collaboration One-sided willingness Counselors' frustration Lack of "team work" | Goals forced/imposed One-sided interests Counselor's frustration | Clients' absence of expectations One-sided intervention Disagreements | Need of supervision Counselor's frustration Counselor's lack of experience Disagreement on counselor's approach |

Bond

For some participants having an emotional bond with clients was challenging. They revealed thoughts and feelings with the researcher as it is presented below.

According to student #1, the use of self-disclosure technique was relevant in counseling sessions. However, sometimes he was afraid that the relationship was not anymore professional but too personal:

... The therapeutic alliance is good when I am honest with who I am and where I am, however I was conscious of not giving them more information than they would need because I feel like that could have damaged the alliance if it became more of a personal conversation. ... when a therapeutic alliance became too personal ... that would be negative, when it gets too into it personally. ... I think part of a therapeutic alliance is to not cross the line to where it's becoming so personal that it's making it more a personal relationship, I don't think it's healthy

The same student shared his feelings and what he did to “repair” a negative therapeutic alliance:

(when there is not an emotional bond) there is frustration, it's really a challenge ... we have to start back over.

Student #2 revealed more a consequence of the absence of an emotional bond with clients;

I feel like even if they come in and they are not very emotional it tends to get to something emotional, so I feel like if there is not an emotional bond you can't do that much and so you can stay very surface. ... It would like leave out the whole part of the issue. ...I think that's like at least partly me because that's probably like how I'm viewing the problem so that's how I am going to sort of like probably push them to look at it a little bit.

Frustration was what characterized the experience of student #3. He expressed the difficulties of working with minors who are not aware of being involved in a counseling process with a professional:

I respect them as people, they respect me as an adult but it's ... it's hard at times to respect them as client and for them to respect me as therapist. I feel more like a friend, an adult, a mentor. ... And so that's a negative aspect of it. ... I feel more like a mentor or a big brother or a babysitter.

For student #4, the lack of connection with clients deeply influenced the quality of the counseling process:

... The clients that I feel like maybe I don't like as much or don't enjoy the sessions as much are the ones that are harder for me and I know that. ... the reason that I don't like working with this person or like I get frustrated when I work with this person is because I don't feel like I know what I'm doing or I don't feel like I'm being helpful.

Therefore, when the relationship with some clients was negative, she tried to start over by sharing with them her feelings:

When they feel stuck I feel kind of stuck sometimes and I feel frustrated with that. ... I've gotten more comfortable lately just sort of talking about their relationship that my clients and I have, like discussing it with them³.

Supervision was what student #5 considered relevant for working with challenging clients. According to this student, elaborating personal reactions to difficult situations with clients was a way to face the negativity:

Progress is hampered, you're not able to continue to walk forward the way you had planned to. ... I definitively feel more disconnected with the client. I've had that a few times. And it's a challenge. I have to kind of keep myself in check and I am irritated by what the client is bringing to me. I keep my feelings about that in check. ... That is frustrating, you really need the other person's buy in, willingness, participation to have any kind of success.

Finally, student #6 expressed the importance of the emotional connection with clients. For her, the relational bond is a requirement for being in counseling:

... It is disappointing when you seem them sliding back. .. It is kind of hard to sit in a room with someone who is looking to build that therapeutic alliance with you and you with them and not feel some kind of emotional bond. I just feel like I have to be emotionally involved. It's not like I don't get more attached to some of them than others but for me there has to be some emotional involvement otherwise I might as well just not be in the room. They (clients) don't seem to not have had an emotional connection. I feel like if

³ Participant #4 provided the following example: "For example, today I had a client and I felt like I was in a cranky mood where I felt like I was a little bit frustrated with this person and I said right out, "I feel a little bit prickly, is that coming across to you? How do you think that that's impacting the work that we're doing today?" and I feel like that kind of transparency really helps just being open with my clients and being transparent about you know, "I'm experiencing this, are you experiencing that?"

they're going to sit there and tell you all this emotional stuff, they have to have some kind of an emotional bond with you.

Tasks

Participants also shared their difficulties in relation of the absence of an agreement with clients on tasks. They also added some of their reactions to those situations.

Considering important working together on clients' problems, student #2 described clients' feelings in situations where counselor and client does not agree on tasks:

I think it's harder to get stuff done, like when two people are in a rowboat and they're rowing different directions. You're not, you're going to go in circles. ... I feel like I would just feel like I really don't understand them and like I'm not like on the same side as them. ... I feel like I want them to feel like I'm on their side even if we're disagreeing. If we just flat out are like trying to go different directions I don't feel like they, I feel like they'll be like "what's my therapist doing?" Like on the other team kind of thing.

Frustration was the feeling expressed by student #3, when he explained the difficult experience regarding the development of alliance with kids. According to this student, there was not collaboration most of the time with his clients as is described below:

I have to remind them each week what my goals are as if they're new to them each time and I have to show them again like a teacher sort of a lesson plan, I have to say "today in our time together I intend for us to talk about these things, for these purposes," and then at the beginning of the next session I have to sort of recap and say "if you remember last week we talked about these things and my hope was that you would begin to feel this way" and they

just sort of nod. So the collaboration is just keeping them willing to be with me on an emotional level they're. It's really one sided, there is no collaboration except to bring them along with me in my goal setting.

Student #4 shared what she did in situations where a therapeutic alliance needed to be recovered from difficulties due to a lack of agree on tasks:

Sometimes I feel frustrated but what I try to do with this person is get a better understanding of how they see their problem and come to a mutual agreement of like the source of the problem, like if I think ok the reason, or I just try to explain the reasoning behind it, so like "the reason that I'm asking you these questions is..." because I'll be talking about something, trying to get a picture and this person will say, "can we stop talking about this, I want to work on, I want to work on" And I'm like "Ok, well the reason that I was doing this is because I think that ... what do you think?" And generally that person is pretty amenable like "oh, ok so I see where you're going with that, either I don't think that that's relevant or yes, let's pursue that.

Finally, student #6 explained how the absence of common tasks impacted the therapeutic alliance with clients according to her experience:

It impacts just by which direction I would go and how I would proceed. I mean, I'm not going to force them. I'm not going to tell them what I think that they need. You know, so it definitely changes my direction because now I feel like I have to step back maybe two steps and see where they want to go versus just being one step behind and trying to...or a half step behind and trying to lead them.

Goals

Some students experienced a negative therapeutic alliance with clients in terms of a mutual agreement on counseling goals.

Below is what student #1 said about a negative therapeutic alliance in terms of goals:

(It is negative when) I force my own goals onto them.

Working with children seemed very challenging for student #3. He considered so difficult defining goals with his clients and engaging them in the counseling process:

My experience has been, again because of their age, they don't have any concept of goals, I've had to say to each one, this is your hour each week, you are required to do this and I am required to do this so we're here together and there are some things I would like to accomplish with you for your own good. ... I think again developmentally, they don't need a purposed centered reason for everything ... most of these children just it's the next thing they do in the day and they don't ask so when I ask "what would you like," "what goals" they don't know so I'll have to say well here's my goal and they say, "ok", but if we reach it or don't reach it they won't know unless I remind them. So I guess the answer is I feel very one sided in this goal setting because even if you try to include them they don't really care, they just know they have to be there for the hour.

Finally, student #4 shared her frustration due to the absence of collaboration on goals with client with whom she had trouble in establishing a positive therapeutic alliance:

I tend to feel a little bit frustrated⁴. I wanted to help them do what they wanted to do but my actual goal was like you need to stop doing all this stuff

⁴ Participant #4 provided the following example: "like a person who came in very, very, very, very stressed and anxious, with panic attacks, and this person was doing five hundred things, working, you know, five hundred hours a week in seemed like, not taking any time for themselves and I rec...it took me about two sessions to recognize that this person's goal was to cope with their stress and feel less anxious and my goal, my perception of my goal was that I wanted to help them do what they wanted to do but my actual goal was like you need to stop doing all this stuff cause it's killing you. And it took me a little while, it took me a

because it's killing you. And it took me a little while, it took me a couple sessions to realize like the reason that I'm having trouble sort of connecting with this person⁵. ... If their ideals are such that this is necessary and they believe that, if I have to sacrifice myself to achieve these goals then I just have to do it.

Spirit of Collaboration

According to some participants, a lack of collaboration from some resistant clients impacted the counseling experiences negatively.

Student #1 expressed a consequence of the absence of a collaboration on tasks with clients:

The client has walked away with no really knowing what to do next. ...They can walked away without knowing what's something they can do to work on it between now and the next time. ...so I think that's leave them lost. ... They are not sure on what to expect.

Student #2 explained her experience when she had difficulties in working on goals with resistant clients:

I do tend to feel like “if that's your goal that's your goal” and “I'm not going to set your goal for you”. But I do kind of struggle sometimes. “You need to

couple sessions to realize like the reason that I'm having trouble sort of connecting with this person is because I'm not, we're not even at the same thing. So once I got that out of my head, it became a lot easier”.

⁵ Participant #4, in relation to the previous example, added: “This person also came from a different cultural background from me and that probably also played into it as well. So the individual importance not being as significant as the, the larger goals, so once I was kind of able to be like no, this is so important to this person, there's nothing that I can say or do that's going to make this person believe that it's more important to do these self-care activities or to like take something out then to manage the stress. So that, it was my error and once I realized like what my error was it was pretty easy to be like, ok well she wants this, let's do this”.

work on this” ... “This is clearly very like disruptive for you” and they don't see it that way. So I guess I tend to like go ahead and focus on what they want to focus on. ... Like I feel like you need to take a minute and see like what's going on, like let's figure it out, let's be on the same page. I think you can kind of get it back on track and fix it. I think you can, it's harder but you can.

For participant #3 it was not possible to define an alliance with his clients due to an absence of a collaboration with his clients:

It's not an alliance as far as a team. I'm not helping them do anything, I'm sort of doing it, they're maybe doing it with me but it's completely involuntary and I'm sort of telling them this is what's going to happen in this hour, this is how I hope you'll feel, this is where I think we'll get too. I don't want to say it's lonely, but you do wonder...I'm not worried about misleading them or doing something wrong. I just...wonder how much of it I'm in by myself, and when I begin to feel like a babysitter at times I do ask myself what am I doing, doing this, I'm sure it's good work and I'm sure it's helpful to the children just to have an adult showing interest but beyond that I'm not always sure.

Theories and Techniques

When counselors considered themselves not sufficiently prepared in the use of counseling theories and techniques, they felt that the counseling sessions were not good enough to help their clients.

Student #2 expressed the importance of supervision when she felt lost during counseling sessions with clients:

I sometimes can like tell that it's not so good and I'm not sure why and I've definitely talked to supervisors about that⁶.

⁶ Participant #2 provided the following example: “I had one girl in particular where it's just like it was not working and I was just trying to like kind of shift it but it wasn't happening and then sometimes like I can

According to participant #3, the lack of ability to implement some techniques and the few opportunities to practice as therapist were both negatively impacted his experiences with clients:

(I feel a) sense of frustration for lack of theories and preparation to work with the specific kind of client (kids). Since I'm not having the capability to work with adults I'm wondering how much I'm really getting to practice what I have learned so I'm actually looking now at my internship hours at trying to work with older kids or adults and it's late in the game to be making a change, but I'm considering that still.

Student #5 clearly expressed that a therapeutic alliance was “negative” due to her lack of preparation in working with clients as well as her lack of flexibility to use different theories:

My lack of experience in the theories and techniques. ...when a client does not agree with an approach or doesn't understand an approach.

Finally, student #6 shared that clients’ negative reactions to her were strongly related to her capability to be in session as effective counselor:

If they look like they are not interested, do not want to be there. I do work with adolescents, so I have seen that. When they are kind of glazed over, that's when I know that I'm talking too much or something.

4.4.3 Clients’ Feedback and Therapeutic Alliance

Participants often explained that the use of the Client Feedback Form was helpful in the development of the therapeutic alliance with their clients. In particular, giving the opportunity to clients for sharing feelings and thoughts about the session increased the

tell it's good and I'm not completely sure why like I don't really know how to explain why, how I could tell it was good, it just like it felt natural, it felt like we were just having a conversation, like it just flowed better and I feel like you both can feel that, I don't know”.

quality of the emotional bond and the agreement on tasks and goals. Also, the use of the Client Feedback Form helped beginning counselors to increase the quality of the collaboration with clients. Finally, reviewing during supervision hours what clients' expressed in the form increased the counselors' theoretical and technical capabilities. A summary of the findings related to the positive experience of the therapeutic alliance are presented in Table 4.3.

Table 4.3 - Clients' Feedback and Therapeutic Alliance

| BOND | TASKS | GOALS | SPIRIT OF COLLABORATION | THEORIES AND TECHNIQUES |
|--|---|--|--|---|
| Connection with family members Counselor's level of confidence increased Clients' empowerment Counselor's sense of evaluation | Symmetrical decisions Collection of clients' suggestions Definition of topics to be addressed | Guide for future sessions Counselor's effectiveness improved Supervision guide | Supervision support Supervision suggestions | Supervision as a "guide" Counselor's development Counselor's efficacy |

Bond

According to most of the participants, the use of the Client Feedback Form helped them in strengthening the relationship with clients.

Student #1 said that the form helped to build a relational bond with all members in family therapy as well as to feel more comfortable during the counseling process:

In some ways (the form) helps for the connection we can establish with a family member (who write something in the form), to make a connection with that person later, I can use that information that might be introducing to the

other parent. More sessions helps, more exposure, more familiarity. It makes things a little less awkwardness, a little less new and more familiar...that is going to help. ... I am more comfortable now ... I'm just sort of trusting the process

Likewise, student #6 focused on the importance of using the form, especially in supervision, for increasing the level of confidence as counselor and to bond with clients:

Feedback is part of the development of the alliance with my clients in general. I think with confidence comes a better ability to build an alliance and experience is just the only way to get this confidence built up. (Collecting feedback) is part of bonding with them (clients) and letting them be heard for what they liked or did not like

According to student #3, the use of the Client Feedback Form helped in both “giving a voice” to clients and helping the counselor to reflect on the quality of the counseling sessions. These two aspects increased the alliance with clients:

I am interested in what they think so that part is helpful. ... So, I think I do that in sort of a questioning way, by saying here's what happened, here's what I said, here's what they said, and here's how I think they were left, the impression they were left with, or the feeling they were left with. ... And I think they appreciate getting to have some voice...so in that sense it's positive, because they feel like they have a voice.

Finally, student #4 considered the form a way for the client to have more “power” in the relationship with the therapist by evaluating the counselor’s work:

I think that having a client feedback form does have an impact on the development of the alliance. It puts, it puts another factor in it, so at that point ... that evaluation sort of becomes a third ear in the room. Because if, if clients are having to evaluate their therapist that puts, it changes the relationship and puts them in a certain, it puts them in a certain position of, I

don't want to say position of power because that's not exactly right but it gives them a certain amount of power over the therapist or might give them the perception of having a certain amount of power.

Tasks

According to the participants, collecting clients' feedback was helpful to figuring out what to do with clients and this seemed really helpful for the development of a therapeutic alliance with clients.

Student #1 explained that the use of the form in family therapy was a way to know what clients learned from the session and to define topics to be addressed in the following sessions:

... It's useful in that, in the family setting sometimes one family member may or may not be comfortable saying something to the family but they are comfortable writing it on paper and so sometimes you have someone say something pretty profound that wasn't said during the session. ...I keep the form in my clinical notes ...it is the sense of what they learn, it helps to give an idea of what they learned. ...it's oftentimes what they learned was " I learned something about another family member" so it gives some insight as to what their relationship look like, ... if there is something that they learned today that seems really simple than that there is a disconnect there. So I can use that for maybe next time as a factor of their relationship that we can ask about or address if that's something that's missing.

Student #2 said that collecting clients' feedback was a way to make the relationship between clients and the counselor more symmetrical. So it made the clients aware that homework and tasks were related to their desires and not only counselor's decisions:

The form kind of made the relationship feel more equal, like helped them feel like they had a say in it. I think a lot of people do feel like ok I'm going to do whatever my therapist says today, so I think the form kind of helps like they have a little more power in the relationship. It can help them feeling like they just have more input in their relationship.

Likewise, student #4 shared that the form helped in collecting suggestions on what to do during counseling sessions:

That's helpful, it helps me know like what I can do better when people write specific things so I can do something about it, I can implement that. If somebody says something like, "I wish..." like, last year somebody said, "I wish my brother was here." So we invited the brother and he came in and it was really helpful, so that was really, really good.

Goals

Students shared their positive experience on the use of the Client Feedback Form in supervision for discussing the goals of the counseling sessions.

Student #1 commented the use of clients' feedback in the following way:

... It works well and it's helpful ...we get information. I use it (in supervision) as a way to sort of gauge where they are in the process ... talk about next steps or goals of treatment, part of the treatment plan⁷.

Likewise, student #2 expressed that the form was considered in her supervision experience as a guide for preparing the future sessions and improve her effectiveness with clients:

⁷ If someone says they really liked a part about, "I got to hear the dad talk a lot more than usual", you know then we can, maybe try to make sure, to each time to give that person an opportunity to do something. Anything that, anything we can take from it that we can bring in to try to say, particular paper, since we're doing experiential, anything we can do to try to make what happens in the session different from their exchanges at home.

I had a couple of men take that opportunity to kind of like say something they maybe didn't want to say or like were scared and they were like I'll just write it on the paper and run away⁸. So I guess I think for some people I guess it gives a space to kind of bring something up without bringing it up, especially if they're kind of like sheepish about it. ... Because even if they're like not saying much it's still just gives them a chance to say, "yeah I liked this, this is good for me," or like "I...this wasn't really helpful to me" or like "I wanted to do more of that." Like it just gives a space to kind of have input into like their own counseling and, which I think is a great reason for them... I guess it could kind of help prepare for the next time like "oh you need to kind learn more about this" or like "we need to address whatever"... It helps guide what do I need to talk about this week with my supervisor.

The importance of using the form in supervision especially in difficult moments with clients was expressed even from student #5:

I feel like once I've developed a little bit of rapport with the client and we met a few times I do not mind checking and ask you know "Do you feel what we have been working on has been beneficial for you?" I do like checking with my clients and they do seem appreciate as well. I use the form for feedback with my supervisor if I feel I am stuck with a particular family. And I really like feedback, weather is good or bad and so I appreciate whatever feedback we can get from families. ... (in supervision) we use the form as a check in for the next week, we reexamine a few things (of the session) and we come up with solutions collaboratively. It (the form) helps to align with the sessions goals.

⁸ Participant #2 provided the following example: "Like one mom wanted to talk about she didn't say a word about it to us but then she, on the form she gave it to us and then like left and it said she wanted to like address how her drug use had impacted her children. We hadn't talked about that yet at all and like she, and when we would say "what do you want to talk about" or "what do we want to get to today" it would not come up. And then even when they came back she still didn't say anything, so then we were like ok it's on the feedback form like you said you wanted to talk about this and then she said, "yeah we should talk about that," but she didn't want to like bring it up herself".

Spirit of Collaboration

For some students, reviewing what clients' expressed in the form helped them to collaborate better with clients in the following sessions.

Student #4 shared that the form had been helpful for her in supervision for reflecting on the quality for the relationship with the client and the emotions involved:

... So if somebody's evaluating you in that kind of way, you know what does that mean for you as a therapist, like what does that mean for me as a client of this therapist that is being evaluated. I have to tell all my clients at the beginning of sessions that they're being video-taped and every client has to sign a video recording form, but the way that I phrase that is not like, you know, I'm being evaluated and their going to judge me on how well I do with you, I very clearly tell them like "this is so I can get some help and get some resources" and so that that sort of frames me as the therapist, as a person who will go anywhere that I can to get help on my client rather than somebody who people are watching to make sure that I'm doing a good job. Even though that's totally accurate, but I want my clients to feel like I'm a professional who can help them and not like a student who's kind of fumbling along, even if I feel that way sometimes. ... I think the most important thing for me has been to focus more on what's happening with the relationship with the client, in the session with the client. And to talk to them about that. Because I think initially I wasn't really doing that and I don't think it was causing any problems that I want to call a bunch of attention to that, but I think that bringing, like bringing into the room is, or making it apparent is helpful. I think that it, it lets the client know that I'm really, I mean paying close attention⁹. ... I try to really make sure that people know that I want them

⁹ Participant #4 provided the following examples: "like if I see that their body language is very closed and I comment on, "I see that you, you seem like you might be a little uncomfortable" or "how are you feeling" and what is it, "how does it feel to talk about, you know, your social anxiety this way" and you know, "I know that we just met" to like, if I have a perception and a person seems uncomfortable, I'm like you know "I know that sometimes it can be uncomfortable to talk with somebody that you just met about problems that are really significant for you, so how, how are doing with that right now? I'm seeing that you seem a little bit closed?" So like "what...are you doing ok?" People cried, people cried at first, I was like oh no

to correct me if they think that I'm wrong. Like if I'm saying something and I'm not getting it right or I'm reflecting something back to them and I'm not, it's not accurate, I really want them to tell me. ... My supervisors have really helped me, particularly when I feel frustrated with clients which is not as infrequent as I would like it to be. They really help me understand where that frustration comes from and how to use that in a session. ... It can be super useful and so getting that from supervision was great and I feel like that's helped me a lot.

Focusing on the importance of the collaboration between counselor and clients, student #5 expressed that knowing thoughts and feelings of clients gave ideas on what to implement for the best treatment of clients' problems:

To me the therapeutic alliance is about understanding kind of both sides (client and counselor). If you are on the right path and the client is making progress then I definitely want to hear that. And if there are things that need to be adjusted I want the client to feel like they can express that, like I do not like this or I do like this, and so we are working together to give them the best care that we can.

Theories and Techniques

When participants reviewed with supervisors what happen in sessions with clients and which impressions the clients had, their effectiveness as counselor seemed increasing.

Participant #2 said that the content of the form was helpful for defining with the supervisor what to improve in session:

"just feel better, sorry" but I'm much more comfortable now, like you know, you know, "so you're tearing up a little bit, do you want to tell me what that's about?" Just like being more, yeah being more ok with like, yeah there is going to be feelings in here, this is counseling, that's what we do, we bring all our feelings here and we dump them on the table and try to sort them out".

I guess it could kind of help prepare for the next time like “oh you need to kind learn more about this or like we need to address whatever” ... it helps guide what do I need to talk about this week with my supervisor.

The same student added how much the supervision helped her in feeling more confident about the use of some techniques:

I think supervision helped me be less like scared in trying things and you can like just even like talking about something with a person makes it seem less scary. ...I think I am so new, like my scope of like things related to counseling is so small, I feel like that's kind of how you kind of open it up like oh I might try that and stuff like that.

Finally, in a way similar to the previous participants, student #6 stressed how much the form was helpful in supervision for her development as counselor and to define what to do in the following sessions:

I'm always surprised by the answers, good or bad on there. I'm surprised by what the clients get out of the sessions sometimes, I use them with my supervisors and the clients. The supervisors can kind of guide me in what to do next session. With the clients, I might come back in next sessions and say "I noticed on your form you would like to do this ...". I use the form in family therapy and I address each comment individually. It's for my personal development as counselor. Just to know if I'm on track or what the family like about the session and guide my behavior about the session. ... And using that, learning from that to help be better in session or more effective in session next time.

4.4.4 Differences among participants on factors related to the development of Therapeutic Alliance

The researcher analyzed the data to see if any difference arose attributed to the age, the gender, the level of experience and the type of clients. Participants mentioned

some factors related to the development of the therapeutic alliance. These factors seemed affecting their experiences with first clients.

First of all, according to the participants, age, gender, and cultural factors impacted the quality of the therapeutic alliance. Student #1 said:

All sort of age and cultural factors are involved in how I will approach some things. I guess also the factor being. ... I feel just as effective connecting with younger adolescent, I found easier to connect with, to establish what seems like a therapeutic alliance.

Likewise, student #2 commented:

I'm pretty close in age to most of my clients, we, I have a lot of experiences in common with them so I'm, I'm sure that that helps a lot. My personality, like my sort of approach is pretty casual, or like way that I sort of approach the counseling experience to my clients, or presented to them, is kind of casual and I feel like that helps make people more comfortable. I just try, I try to be genuine, just try to be myself, and I think that that eases things a little bit.

Interestingly, student #5 combined the influence of age, gender and type of clients:

Maybe my age (and gender) maybe the client sees me as their mother, which can be a good or bad thing, depending on the client...with a college student there is an age difference so from my side there could be a lack of knowledge about what is cool to connect with the client. ...so it seems that the more knowledge I get about what is really impacting college students today, then the better alliances I'm able to build with the client.

The same student added the impact of the level of her experience in the development of the therapeutic alliance with her clients:

... My lack of experience in the theories and techniques. ...when a client does not agree with an approach or doesn't understand an approach and I lack in the flexibility of using other theories. ... I think the therapeutic alliance is getting better through the experience.

Finally, student #3 expressed the importance of the knowledge about theories and techniques as well as the capability to work with a specific population:

Sense of frustration for lack of theories and preparation to work with the specific kind of client (kids). Since I'm not having the capability to work with adults I'm wondering how much I'm really getting to practice what I have learned so I'm actually looking now at my internship hours at trying to work with older kids or adults and it's late in the game to be making a change, but I'm considering that still.

4.5 VALIDATION OF THEMES

To assure the accuracy of data, the researcher used triangulation. This procedure included: member checking, peer review, and keeping a journal during the entire research process to document the role of the researcher with personal feelings and thoughts.

4.5.1 Member Checking

The researcher took notes during the interview process and reviewed the responses with the interviewers before ending each interviews. The transcripts were also e-mailed to each participants requesting they read the content of the interview and check if it accurately reflected their experience. Each participant affirmed that answers accurately reflected their responses immediately after the interview, however only four participants replied to the e-mailed transcript saying that it accurately represented their positions. Two students never replied to the researcher's email.

4.5.2 Peer Review

The researcher used multiple peer reviewers to assure the validity of the coding. The fresh and detached perspective that peers brought enabled the researcher to develop a greater explanation of the findings.

One reviewer was a fellow doctoral candidate in the counselor education program, another fellow doctoral candidate was enrolled in the educational foundation and enquiry program with specialization in educational research and measurements, and the last one was enrolled in the educational psychology program.

The researcher e-mailed to the peer reviewers the excel spread sheet with the categories, themes and the selected statements which were considered essential to describe participants' experiences. One peer reviewer agreed with all the analyses made by the researcher. Another peer reviewer suggested to clearly define the categories that the researcher found. The third peer reviewer found two new themes, which were "spirit of collaboration" and "theories and techniques". The researcher agreed with these two new themes and included them in the findings.

To the peer reviewers it was also asked to see any differences among participants' answers due to participants' gender and age. After an analytical analysis based on a comparison between males' responses and females' responses, and between professional of age under 30 and professional of age up 30, both the researcher and the peer reviewers agreed on the fact that gender and age did not affect participants' answers.

4.5.3 Researcher's Journal and Role

In addition to the outside scrutiny discussed above, the researcher evaluated the process of the research as it developed. The researcher's reflective commentary was

devoted to the effectiveness of the techniques that had been employed as well as to record the researcher's initial impressions of each data collection session, patterns appearing to emerge in the data collected and theories generated. After each interview, the researcher recorded in a journal the first impressions, feelings, thoughts, and experiences related to the process of the research. This was very helpful for keeping track of eventual bias and personal interests as it was presented in chapter three. The researcher had the impression that the "dual role" researcher/instructor did not help to create a comfortable relationship with the participants at the beginning of the study during the interviews. However, face to face interviews helped to stress the important implications of the study for the participants' development as counselors as well as for future students. For this reason, in some occasions, participants provided more information than they were requested by the questions of the interviews.

4.6 SUMMARY

The findings of this study reveal that the development of the therapeutic alliance with clients is relevant for being an effective counselor. According to the participants, the success of clients' treatment is strongly related to the therapeutic alliance and the factors related to it. Beginning counselors had positive experiences when a good relational bond, and tasks and goal agreement were established. They also expressed a positivity when they felt that they were collaboratively working with clients on their needs, as well as when they consider themselves able to apply the right theoretical and technical approach with clients.

When there is a lack of emotional bond or an absence of agreement on tasks and goals, students feel frustrated and the quality of counseling is deeply affected by this

negativity. Students also expressed the negative impact on counseling sessions when they experienced a lack of a sense collaboration from some clients. There also is a negative impact on counseling sessions when the beginning counselor feel not adequately prepared on the use of theories and techniques in counseling.

Students appreciate the collection of clients' feedback to improve their work with clients in terms of emotional bond, and agreement and collaboration on tasks and goals. Also, the review of the Client Feedback Form note in supervision sessions seems increasing counselors' capability to choose and apply the right theory and techniques with clients.

The factors age, gender, level of experience and type of clients seem to strongly affect the development of the therapeutic alliance with clients.

Counselor education programs must be intentional when supporting the development of the therapeutic alliance between counselors-in-training and their first clients.

In chapter five, findings will be discussed in depth in relation to the literature. In addition, researcher reflections, implications for counselor education programs, limits of this research, and suggestions for future researches will be proposed.

CHAPTER 5

IMPLICATIONS

The findings of this study show that the therapeutic alliance and the factors related to it are essential for the effectiveness of the counseling intervention. Participants shared both their positive and negative experiences related to the development of the therapeutic alliance with their first clients. According to counselors-in-training, a positive therapeutic alliance is qualified by a strong emotional bond, an agreement on both the goals and the tasks necessary to achieve the goals, a good spirit of collaboration over the therapeutic treatment, a solid knowledge of counseling theories, and the ability to use the techniques related to theories. On the contrary, a negative therapeutic alliance is characterized by difficulties in building and maintaining an emotional bond with clients, a disagreement on the therapeutic plan and the tasks associated, and a non-cooperative attitude and a lack of knowledge of counseling theories and techniques. Also, students shared that the collection of clients' feedback during the counseling sessions and the discussion of this feedback in supervision sessions was a way to help them grow in their efficacy as counselors.

The purpose of this chapter is to discuss the findings and how they relate to the professional literature presented in chapter two, in particular the Common Factors Psychotherapy, the Working Alliance Theory and the Client Feedback Informed Treatment approaches. The researcher will also address assumptions of the study as well as its scope and limitations. In addition, implications for counselor education programs,

professional supervision and professional practice will be examined. Researcher's thoughts of the current research process and suggestions for future researches will be presented.

5.1 DISCUSSION OF THEMES

Previous studies on Common Factors Psychotherapy, Working Alliance Theory and Feedback Informed Treatment have addressed the role of the therapeutic alliance in counseling and training as well as the role of collecting clients' feedback to improve the effectiveness of counseling interventions. Most of the themes mentioned in these studies were concepts that continued to emerge from participants of the current research project. There are also new themes provided by counselors-in-training. In the following section, the three theoretical approaches will be discussed along with comparing similarities and differences between this study and those discussed in chapter two.

5.5.1 Common Factors Psychotherapy

Greencavage and Norcross (1990) made a systematic review of 50 publications to discern commonalities among proposed therapeutic common factors. Across all categories, the single most frequent commonality is the development of a collaborative therapeutic alliance. According to these authors, this emphasis reflects the often asserted notion that techniques are inextricably embedded within the relationship. This is supported even from the findings of the current research. All participants from different family therapy theoretical approaches revealed that the therapeutic alliance is important for the efficacy of the counseling intervention and theories and techniques are considered fundamental components of the therapeutic alliance. One student defined the therapeutic alliance as "essential" for the clinical setting, another one said that he was working hard

to improve his therapeutic alliance since he noticed that being in a strong emotional bond with clients helped the clients feel supported and understood in their conditions. As concerns theories and techniques, most of the participants shared that when they felt themselves capable in the use of both theoretical and technical aspects, then the quality of the counseling experience was positive. All participants pointed out that the more training they got, the more efficacious were their interventions.

In reviewing the four factor model (extra-therapeutic change factors, common factors, technique factors, and expectancy factors) proposed by Lambert (1992), Miller et al. (1997) found that therapists' theoretical orientations and therapeutic methods account for 15% of symptom improvements. Moreover, Thomas (2006) analyzed the client's and therapist's perceptions about the degree to which each of four common factors in therapy (client's hope and expectations, client's extratherapeutic factors, theories and techniques of the therapist, therapeutic relationship) contribute to change in the therapeutic process. Among the common factors, the rank order for therapists in the common factors was (1) therapeutic relationship, (2) client's hope and expectations, (3) client's extra-therapeutic factors, and (4) model/techniques of therapist. Miller et al. (1997) and Thomas (2006) collected their data from professional therapists. The results that the authors obtained seem in contradiction with the results of the current research project, maybe because participants were counselors-in-training. In fact, students shared that the knowledge of theories and techniques is an important factor for the quality of the therapeutic alliance with clients and therefore for their improvements in the counseling intervention. For one student, theories and techniques were so important that he thought of the therapeutic alliance as the ability to use the counseling knowledge and the ability to apply it.

Frustration was the general feeling that emerged from the experiences of counselors-in-training when they considered themselves not sufficiently trained in helping clients. In these cases, students shared that the supervision sessions were a good opportunity for reviewing their lack of knowledge and subsequently, to improve in this area.

The review from DeFife and Hilsenroth (2011) showed that fostering realistic and positive expectancies, role preparation for treatment, and collaborative goal setting are three core psychotherapeutic factors that influence the early psychotherapy process and are empirically linked with subsequent treatment outcomes. For Tschacher, Junghan, and Pfmamatter (2014), patient engagement, affective experiencing and therapeutic alliance were connected with therapeutic outcomes. The agreement on goals along with the emotional aspects pointed out by these recent studies are considered important also by the participants of this study. In particular, one student said that there is therapeutic alliance when the counselor and the clients work together on clients' problems. Another student said that without a collaborative involvement on goals, it is not possible to have a positive counseling experience. The emotional connection with clients is considered a requirement for being in counseling according to another student. For this student, if there is not an "attachment" between the counselor and the clients, the counseling session is senseless.

Recently, Fife, Whiting, Bradford, and Davis (2014) proposed an interesting model of common factors. Authors discussed their model in pyramid format, with techniques on top, the therapeutic alliance in the middle, and the therapist way of being as the foundation. According to this meta-model, there is a relationship not just between the therapeutic alliance and techniques, but also between these two common factors and a

therapist's way of being, which is considered as foundational to all the aspects of an effective therapy. According to the experiences of the participants of the current research, there is a strong relationship between therapeutic alliance, theories and techniques and the self of the therapist too. Most of the participants shared that the use of the self-disclosure was an important technique that helped them make their clients comfortable. For example, one student said that using humor and identification was a way to start her relationship with clients. In another case, the student expressed that sometimes the therapeutic alliance was negatively affected by the counselor's negative feelings towards a specific client and his or her story. In these situations, according to the student the supervision sessions were a good resource to work on transference and countertransference dynamics.

5.5.2 Working Alliance Theory

The main theoretical framework of the current research study is Bordin's theory on working alliance. In his 1979 paper, Bordin suggested that collaborative work involves three essential components: goal agreement, task agreement, and bond. Goal agreement involves the parties having a shared understanding of the goals for change. Task agreement entails them to have a shared understanding of and confidence in the activities that will accomplish these goals. Bond consists of an emotional attachment between the parties that arises through their work together. Bordin (1980, 1994) later explained that strains in the alliance would likely occur when patients in psychotherapy were given therapeutic tasks that activated the problematic behaviors that had brought them to treatment. He argued that these moments posed challenges for agreement on tasks and goals as well as the quality of the bond. Preserving the working alliance

requires working to repair these inevitable strains. According to Bordin's theory, the goal agreement, task agreement, and bond components of a collaborative interaction uniquely contribute to the quality of the working alliance. The findings of the current research confirmed that the main components of the therapeutic alliance are the emotional bond and the agreement on tasks and goals. For what concerns the bond, all participants of the current research did not share only the emotional aspect of the relationship with clients (with a focus on support, trust, confidence), but also the counselor's interest to understand the clients' world and the mutual interest between the counselor and the clients to explore clients' problems together. When it was asked to the students to focus on their negative experiences of therapeutic alliance, most of them answered that the absence of an emotional bond with clients generated frustration for the counselor and this challenged the progress of the therapeutic process because it was not possible to explore problems in depth. For what concerns the agreement on tasks, the participants shared not only the mutual understanding of activities that accomplish the goals, but also the collaboration for achieving the goals and the importance of empowering clients' activities. Once again, the absence of an agreement on tasks generated frustration in counselors. For the goal agreement, the participants confirmed Bordin's theory on the importance of having a shared understanding of the goals, but they also added the importance of a clarifications of clients' own goals and a mutual collaboration on their definition. Negative experiences on the goal agreement focused on the counselors' tendency of defining one-sided goals.

Participants' experiences of the development of the therapeutic alliance over their practicum led the researcher to consider not just the emotional bond and the agreement on

tasks and goals, but also other two other factors: the collaboration between counselor and clients and the counselor's knowledge of theories and techniques. The effectiveness of collaboration was just implicitly recognized by Bordin. Looking at the most recent publications on the therapeutic alliance construct, therapeutic collaboration is defined as a central avenue to healing, problem solving, and better alliance (Gergen and Gergen, 2007; Suggese, 2005; Tryon & Winograd, 2001; Norcross & Wampold, 2011).

Friedlander, Escudero, and Heartherington (2006), reporting on the therapeutic alliance within couple and family therapy, linked collaboration to increased engagement with the family. In this current research, it seemed that the collaboration played an important role in determining the quality of the therapeutic alliance. Two students reported that the therapeutic alliance is strongly based on how the counselor and the clients perceived each other as collaborators and part of a team that works as a system on clients' problems.

Other two students focused on the importance of a collaborative involvement on counseling goals. As Bordin (1979) mentioned, different types of collaborations would emphasize or place demands on different components. Even in this study, participants referred to difficulties on the collaboration on tasks and goals when it was asked them to report their negative experiences on the working alliance. According to participants, resistant clients affected the quality of the relationship and the frustration that came from this kind of experiences was the main reason for asking a help in supervision sessions.

For what concerns the factor "theories and techniques", it was considered a huge factor for all counselors in training. In fact, for all participants, clients' improvements were strongly related to the level of preparation of the counselor and the ability to use communications skills in an intentional an effective way. According to participants, the

lack of experience on theories and techniques, the disagreement between the counselor and clients on the counselor approach, and the counselor's lack of flexibility on the use of different theories and techniques impacted negatively the quality of the therapeutic alliance and the counseling sessions.

The empirical literature also seems to indicate that alliance quality correlates positively with some clients' characteristics and behaviors (e.g., psychological mindedness, expectation for change, quality of object relations) and negatively with others (e.g., avoidance, interpersonal difficulties, depressogenic cognitions) (Constantino et al., 2002). Furthermore, research suggests that certain therapist characteristics and behaviors are positively associated with quality alliances (e.g., warmth, flexibility, accurate interpretation) (Ackerman & Hilsenroth, 2003). According to Spruill, Rosensky, Stigall, Vasquez, Bingham, and De Vaney Olvey (2004), the development of a therapeutic alliance or relationship is based on the interpersonal and communication skills of the clinician, coupled with client variables. For Geller and Greenberg (2012) the therapeutic presence deeply affects the quality of the therapeutic relationship. This presence is composed by "the availability and openness to all aspects of the client's experience, openness to one's own experience in being with the client, and the capacity to respond to the client from this experience" (p. 72). According to participants of the current research, the "self of the therapist" plays an important role in the therapeutic alliance. One student explicitly pointed out that the personality of the counselor, the way that the counselor approaches the counseling experience affects the quality of the therapeutic alliance. For most of participants, it was necessary to be trained in the use of communication skills in counseling, especially the self- disclosure technique, for being

effective in using the self of the counselor in the most effective way in counseling sessions. Another participant said that the “self of the clients” is determinant, too. In particular, not just the personality of the clients, but also the type of symptoms that clients brought to therapy were affecting the therapeutic alliance. For example, according to a student, it was not easy to work on therapeutic goals with clients with anxiety, as well as it was difficult to develop a relationship with depressive clients. The counselor’s level of preparation on theories and techniques and the level of therapeutic experience along with cultural factors, age and gender are all important aspects that other previous studies did not focus on and participants of this study pointed out. For connecting effectively with clients, according to three students it is important to be in the same “life stage” and have common experiences. Also, according to two students, the more experiences the counselor has collected, the more are the abilities to build and maintain a working alliance with clients.

According to the literature review, because the alliance is arguably the most robust predictor of change and growth for the client (Martin, Garske, & Davis, 2000), there is a need not only of exploring the factors that make the alliance successful or not, but also of having a better understanding of how the therapeutic alliance develops during the course of treatment (Horvath & Luborsky, 1993) and the role of the alliance training (Constantino, Morrison, MacEwan, & Boswell, 2013) specifically designed to foster the alliance and to address alliance ruptures (Costonguay et al., 2006; Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005; Safran et al., 2002; Whipple et al., 2003). For Holloway and Neufeldt (1995) the trainee’s experience in supervision is crucial to development of skills in assessment and intervention. For Häuser & Hays

(2010), while theory and research emphasized the importance of therapeutic presence, there have been few studies of how a counselor can cultivate therapeutic presence and integrate it into the therapeutic relationship. For the participants of the current research, the development of relationship skills is a foundational component of the acquisition of effective intervention skills. One student said that the therapeutic alliance was essential but not something immediate. This student focused a lot on the therapeutic alliance at the beginning of the practicum, but he also said that through the supervision sessions he was continuing to cultivate the necessary relational skills for becoming a fully competent clinician. Most of the participants expressed that they felt more competent at the end of their practicum experience compared to the beginning because of the support they received by their supervisors. The results of this study confirmed that a training on the alliance is important and possible in supervision particularly. One student said that the supervision was helpful for discussing about how to provide the best intervention to resistant clients. Other two students shared that the supervision sessions supported the knowledge of theories and techniques useful for the practice. Finally, three students pointed out that the supervisory relationship was necessary for facing the frequent frustration that came from negative experiences of therapeutic alliances with some clients.

Recent empirical researches on the power of the supervision for fostering therapeutic alliance skills were designed by Crits-Christoph, Gibbons, Narducci, Schamberger, Gallop (2006), Bambling, King, Raue, Schweitzer, and Lambert (2006) and Carpenter, Escudero, and Rivett (2008). Crits-Christoph, et al. (2006) constructed a treatment model that focused on therapist actions that might help foster the alliance. This

treatment approach (alliance-fostering therapy) was developed to be used with patients who have a diagnosis of major depressive disorder (MDD). The primary outcome of the study was an examination of changes in alliance scores from before to during and after training in the alliance-fostering treatment model. Secondary outcomes examined changes in patient outcomes as a function of receiving training in alliance-fostering therapy. The study assessed alliances formed by five psychotherapists relatively inexperienced PhD or PsyD with 1 or 3 years postdegree experience. The specific techniques used to enhance the alliance were organized according Bordin's theory (1979). The therapeutic alliance was measured using two self-report scales: the California Psychotherapy Alliance Scale, patient version (CALPAS) (Gaston, 1991) and the Helping Alliance Questionnaire (HAq-II) (Luborsky et al., 1996). Both the CALPAS and HAq-II were administered at the end of every treatment session during all three (before, during, and after training) phases of the study. A statistically significant difference between therapists in the improvement in their alliances was found for the Working Capacity scale of the CALPAS but not for the other alliance scales. Another study which focuses on clinical supervision is from Bambling et al. (2006). This study evaluated the impact of clinical supervision on client working alliance and symptom reduction in the brief treatment of major depression. To assess the working alliance, the Working Alliance Inventory was used. Before beginning treatment, therapists received one supervision session for brief training in the working alliance supervision approach and in specific characteristics of each case. The results of this study provided qualified support that supervision that focuses on working alliance can influence client perception of alliance and enhance treatment outcomes. A pilot study of Carpenter et al. (2008) tried to assess

the effectiveness of training family therapy students in their acquisition of conceptual, observational, and executive skills relating specifically to the therapeutic alliance. The authors used the System for Observation Family Therapy Alliances (SOFTA) model (Friedlander et al., 2006a) and a workshop consisting of the observation and the analysis of a sample short of videotaped segments of simulated therapy sessions illustrating segments of simulated positive and negative alliance behavioral indicators. Supervisors used the same SOFTA to give specific feedback to the student on their therapeutic alliance behaviors. The limitations of these three studies were addressed in the current research project. First of all, the researcher decided to choose as participants of the research not post-doctoral therapists, as it was designed by Crits-Christoph et al. (2006), but graduate students enrolled in their first practicum, which means inexperienced therapists. This was really important to detect training effects on the development of the therapeutic alliance. At the time of the collection of data, students were doing their practicum in family therapy with clients with different diagnosis, and not just MDD diagnosis as it was in the study designed by Crits-Christoph et al. (2006) and Bambling et al. (2006). In this way, the researcher collected data from students who were doing their practicum experiences with a variety of clients. Secondly, the therapeutic alliance was not measured by self-report scales, as it was chosen by Crits-Christoph et al. (2006) and Bambling et al. (2006), but it was asked to use the Client Feedback Note form in both clinical and supervisions setting to see if the collection of clients' feedback by the use of this qualitative form supported students' training. The use of a qualitative form as intervention of choice and the use of semi-structured interviews allowed the researcher to collect the meaning of participants' personal experiences. In addition, counselors'

development was tested by supervisors. Finally, the researcher of the current study did not request supervisors to train students on the working alliance theory, as it was in the study by Bambling et al. (2006) or to use simulated therapy sessions on positive or negative alliance behaviors, as it was implemented by Carpenter et al. (2008). The absence of any kind of training on the therapeutic alliance allowed students not to be influenced in their answers during the interviews. Despite the methodological differences between the previous studies and the current research, the results of the current research confirmed what was found before. According to the participants, supervision sessions were considered helpful for the development of the therapeutic alliance. In particular, supervisors supported the students in emotional difficulties related to building and maintaining a positive therapeutic alliance with resistant clients, as well as for strengthening the knowledge of theories and techniques useful for working effectively with first clients. What is new compared to previous studies is the use of clients' feedback as additional instrument used in supervision for increasing the counselors' awareness of the quality of the therapeutic alliance. The power of clients' feedback in training will be discussed in the following paragraph.

5.5.3 Feedback Informed Treatment

Recent studies have documented significant improvements in both retention in and outcome from treatment when therapists have access to formal, real-time feedback from clients regarding the process and outcome of therapy (Duncan & Miller, 2000; Duncan, Miller, & Sparks, 2004). Participants of the current research project often expressed that by collecting client feedback about what seems to be working and more importantly what is not working, their responsiveness to clients improved. In particular,

students explained that the use of the Client Feedback Form was helpful in the development of the therapeutic alliance with their clients. Giving the clients an opportunity for sharing feelings and thoughts about the session increased the quality of the emotional bond with clients and the agreement on tasks and goals. Also, the use of the Client Feedback Form helped beginning counselors to increase the quality of the collaboration with clients. Finally, reviewing during supervision hours what clients' expressed in the form increased the counselors' theoretical and technical capabilities. One student said that client feedback gave clients some "power" in the relationship, since they have the opportunity to evaluate the counseling session. Another student added that this kind of evaluation from clients helped the therapist get some resources and improve the quality of the therapeutic process. Another student said that the clients' feedback is useful for the counselor development because when they are reviewed in supervision they support the counselor in guiding the intervention of the following sessions.

According to the comprehensive meta-analyses by Sapyta, Riemer, & Bickman (2005), a key element of effective feedback is bringing into the recipient's awareness the discrepancy between what is thought by the therapist and what is the reality of counseling perceived by the clients, thereby prompting corrective action. This research supported the conclusion that feedback in clinical practice improves patient outcomes. This is supported also by the result of this research, in fact participants expressed that by adjusting their interventions based on clients' feedback, they and the clients work together as a team for the best care the clients can get from the counseling sessions. One participant said that by giving "a voice" to the perceptions of clients, this increases the quality of the bond with them. In particular, according to this student, it is important in supervision to compare

and work on the counselor's feelings and impressions on the session and the clients' feelings and impressions on the session. Another participant shared that the information obtained from clients were useful in supervision to review the counseling process and readdress the treatment plan. This was found even by Lambert and Shimokawa (2011). Authors found that helping the therapist become aware of negative change helps the therapist to become aware of the possible need to adjust treatment, alter or addresses problematic aspects of the treatment as appropriate (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment). This was confirmed by participants of the current research project. In most cases, students shared that clients' feedback was used as a "guide" for the therapist, since they helped to adjust the intervention and make the therapist more reflective on the quality of the intervention. An important difference between the results of this current research and the previous is that students expressed their difficulties in discussing clients' feedback in the counseling sessions with clients. Most of participants said that they feel comfortable in using clients' feedback in supervision but they would like to feel more competent in the use of clients' feedback as resource in the therapeutic encounter (for example discussing with clients about what they wrote in the Client Feedback Note form).

For Riemer and Bickman (Riemer & Bickman, 2004; Riemer, Rosof-Williams, & Bickman, 2005), feedback should have certain characteristics which are beneficial for clinicians. Feedback should be committed to the goal of improving therapist's performance, the feedback source should be credible, and feedback should be immediate, frequent, systematic, cognitively simple, unambiguous, and provides clinicians with concrete suggestions of how to improve. It is also important for the information to add

something to the therapist's view of patient well-being and future actions. A recent trend in clinical practice involves regularly monitoring and tracking client treatment response with standardized scales throughout the course of treatment and then providing clinicians with this information. The need for quick, practical and ongoing feedback measures, led to the development of the Outcome Rating Scale (ORS) (Miller & Duncan, 2001) and Session Rating Scale (SRS) (Johnson, Miller, & Duncan, 2000). Shaw and Murray (2014) argued that quantitative data obtained with scales like the SRS limit clients' responses in a few questions and analog ratings. Also, Aveline (2006) asked for qualitative investigations of what happens in sessions where such feedback is applied. In the current research project, the researcher tried to fill the gap in the literature using the Client Feedback Form as a research instrument. This is a new qualitative client feedback form that students used in both clinical and supervision sessions. Participants shared that the form was helpful for their development of counselors because of specific characteristics of the form. First of all, according to students, the information obtained by the use of the form (clients' learning, likes, dislikes, and wishes) increased their confidence as counselors. One student said that giving to clients the opportunity to express themselves about the counseling session allowed for the development of an alliance with clients. Another student shared that the content of the form informed both the beginning counselor and the supervisor about the reality perceived by the client giving the possibility to review the quality of the intervention. In two cases, participants highlighted that clients' feedback made clients in a more powerful position in the relationship with the counselor, since clients evaluated the intervention and the counselor could work on what the clients expressed in the form. In line with the results of previous studies, most of

participants shared that an ongoing collection of clients' feedback provided relevant material for the supervision sessions. In particular, students experienced that a deep discussion about what clients wrote in the Client Feedback Form helped them to develop a stronger therapeutic alliance with clients and improve the effectiveness of their interventions.

Reese, Usher, Bowman, Norsworthy, Halstead, Rowlands, and Chisholm's (2009) also investigated the use of continuous client outcome data in psychotherapy supervision. According to the results of their research, the relationship between counselor self-efficacy and outcome is stronger for trainees in the feedback condition than for those in the no-feedback condition. Authors pointed out that, although the use of client feedback data has been proffered to be of value in the supervisory process, there is no a large body of research to support this contention. Haber, Carlson, and Braga (2014) expressed the need for a systematic research on the use of this new methodology in both clinical and supervision settings. The current research attempts to address this lack of research about collecting clients' feedback and providing them to supervisors for use within supervision. The question of whether supervisory training is beneficial is answered by the current research project. According to counselors-in-training, the revision of clients' feedback in supervision was helpful to strengthening counseling interventions. In particular, participants reported that clients' feedback supported the development of the therapeutic alliance with clients. One student said that supervisor's suggestions based on the content of the Client Feedback Note form filled out by client helped to bond with clients because clients' voices obtain more value. Another participant shared that what clients expressed in the form was used to review counseling tasks and take decision on clients' desires.

Most of participants said that clients' feedback was used in supervision to guide future counseling sessions. Also a student reported that the form was used as a tool for looking at what needed to be adjusted in a collaborative manner between the counselor, the clients, and the supervisor. Finally, two students said that the form informed the supervision about eventual lack of knowledge of useful techniques that might help the counselor in an effective counseling intervention.

Focusing on the use of clients' feedback in the supervision setting, Worthen and Lambert (2007) argued that it is time for therapists and supervisors to incorporate outcome monitoring and brief client assessments into ongoing counseling supervision. They require clients to fill out a weekly outcome measure, the Outcome Questionnaire-45 (OQ-45) (Lambert, 2004) that assesses symptoms, interpersonal problems, social role functioning, and well-being. According to these authors, the use of progress feedback in supervision provides at least five important contributions to training and treatment. First, it provides a source of standardized performance feedback that is critical for training purposes. Second, the authors believe it is important to have an independent source of information that identifies clients that will provide a focus for supervision where the attention is most needed. Third, feedback from clients provides information supervisors may have unintentionally overlooked or underemphasized. Fourth, the use of clients' feedbacks may enhance counselors' treatment efficacy by identifying problematic domains that may hinder progress (e.g., therapeutic alliance, motivation for therapy, social support, etc.) and point towards potential interventions. Fifth, the use of additional information beyond counselors' own clinical intuition may provide another window on therapy. The contribution that clients' feedback provides to both counselors' training and

counseling treatment was founded even in this research. The importance of knowing clients' experiences through the use of the Client Feedback Note form was clearly expressed by one student who considered the form as an evaluation on the therapist work made by clients. This student looked at this evaluation as a "third ear in the room". For another participant, it was really helpful to analyze the form with the supervisor and being supported by the supervisor in the frustration that frequently came from her relationships with clients. The use of the form in supervision was recalled by a third counselor in training who reported that the supervisor supported the analyses of cases with an examination of the form, a discussion of the stage of the counseling intervention, a decision on future goals, and eventually solutions on problems raised in the counseling session. Moreover, for the other two participants, the form was used as a way to compare and contrast what happened in the session from the counselor's perspective and what was perceived by the client. A student pointed out that the form strengthened the therapeutic alliance with clients because through the form the counselor was able to know if he was on the right path with the client and in supervision there was a possibility to figure out adjustments needed in therapy.

The literature review did not reveal any research on the Feedback Informed Treatment in family therapy with the contribution of a qualitative methodology. The findings of this research project provide important information to this professional field. According to a participant, the Client Feedback Form helped to develop a therapeutic alliance with all the members of the family system because the information obtained with the form were used by the counselor to introduce a family member to another one. Another student said that what clients expressed in the form was used as suggestion for

the following actions of the counselor in the future counseling sessions. Another participant noticed that often the form gave a voice to family members who were less talkative in session and in these cases the notes provided important information on the family relationships as well as on what each member learned in the counseling session. Three students expressed their experiences focusing on the use of the form in both family therapy and supervision sessions. In one case, the student said that the form was useful especially when the counselor was having difficulties in the relationship with family members. In the second and in the third cases, the students said that the content of the form was used by the supervisor for guiding the counselors' intervention and increasing its effectiveness by providing both theoretical and practical suggestions.

5.2 ASSUMPTIONS, SCOPE, AND LIMITATIONS

5.2.1 Assumptions

In designing this study, there were four assumptions. First of all, it was assumed that the therapeutic alliance is a critical factor in the therapeutic training of beginning counselors. A large body of research has found the therapeutic alliance to be a strong predictor of successful counseling (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Orlinsky, Ronnestad, & Willutzki, 2004; Wampold, 2001). Studies supported that the alliance between counselor and client is one of the best indicators of successful counseling outcomes in a variety of contexts (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Shaw and Murray, 2014). According to Bedi, Davis, and Arvay (2005), considering the importance of a positive therapeutic alliance between counselors and clients to a successful treatment, "it is incumbent upon counselor educator to provide trainees with a comprehensive understanding of the construct of the alliance

and the necessary skills to build and maintain effective alliances with their clients” (p. 72). This assumption was founded even in the experiences that participants shared during the interviews. All students expressed that the quality of therapeutic alliance was strongly related to the effectiveness of their counseling intervention. A negative therapeutic alliance was generally characterized by a profound emotional bond with clients, an agreement on both the goals and the tasks necessary to achieve the goals, a good spirit of collaboration over the therapeutic treatment, a solid knowledge of counseling theories, and the ability to use the techniques related to theories. On the contrary, a negative therapeutic alliance was characterized by difficulties in building and maintaining an emotional bond with clients, a disagreement on the therapeutic plan and the tasks associated, and a non-cooperative attitude and a lack of knowledge of counseling theories and techniques. Moreover, students shared that the supervision sessions were helpful for strengthening the alliance with clients. In supervision, students had the opportunity to discuss and review critical cases and work on factors that impacted negatively on the development of a good therapeutic alliance with first clients.

Secondly, it was assumed that collecting and analyzing clients’ feedback for training purposes is important. The American Psychological Association Commission on Accreditation (2011) requires that the monitoring of treatment outcomes be a part of the training process. For Grossl, Reese, Norsworthy, and Hopkins (2014), “having a better understanding of how the process influences trainee development is critical to clinical supervision and training” (p. 2). This assumption was founded even in the data obtained from counselors-in-training. In particular, students shared that it was helpful going through the comments that clients wrote on the Client Feedback Note form. Thanks to the

collection of clients' feedback, supervisors had the opportunity to know about what happened in the clinical session from the clients' perspectives and compare and contrast this with the counselors' perceptions. According to students, the review of clients' feedback in supervision supported the development of the therapeutic alliance with clients and increased the students' awareness of the quality of the counseling intervention.

Moreover, it was assumed that the participants of this study had achieved a solid theoretical and technical knowledge about the counseling profession and students were opened to discuss their improvements about the therapeutic alliance with their first clients during their supervision sessions. This assumption was partially founded by collecting the results this research. Students were open to report their experiences about the development of the therapeutic alliance with their first clients during the practicum. However, from what some students shared, it seemed that in some cases there was a lack of theoretical and technical knowledge that impacted negatively the quality of the therapeutic alliance and therefore the efficacy of the counseling intervention.

A final assumption was that students were supervised by competent supervisors who took into account the importance of students' development of therapeutic alliance during their practicum. At the beginning of the study, the researcher met students' supervisors and it seemed that they were experienced enough to support students' learning. About the goal of the supervision process, supervisors gave value to students' development of the therapeutic alliance with their first clients. According to the experiences collected from the participants, most of the supervisors used clients' feedback as a way to be informed on the quality of the therapeutic alliance.

5.2.2 Scope

The scope of this study involved students from a public university (University of South Carolina) in the CACREP accredited counselor education program. The University was located in the Southeastern area of the United States. While the scope of this research only extended to one University in the Southeast, counselor educators and supervisors could nonetheless be able to extrapolate from the data and make implications for counselor education and supervision programs in other areas. In fact, both the researcher and the peer-reviewers did not find any cultural-biases in participants' responses.

5.2.3 Limitations

A limitation brought to this research study was that the researcher had biases toward the role of the therapeutic alliance development in family therapy and the use of clients' feedback in training.

As it was stated in chapter three, different subjective I's were engaged in the process of the research project. The "Ph.D. student in counselor education and supervision I" might have influenced the way the researcher perceived the importance of Master students' developments in the therapeutic alliance with their first clients. Also, the "Family Therapist I" played a relevant role in the researcher's perception of the therapeutic alliance in this specific field of counseling. Moreover, the "Teaching Assistant I" might have played a competitive role with the "Researcher I". For most of the participants, the researcher was their instructor in the past and the researcher noticed that some students perceived the interview as a way to assess their development as counselors. Finally, even if the researcher's "Italian I" seemed not to create distance between the researcher and the participants, cultural differences might have interfered

with the analyses of the content of the interviews and in the exploration of students' experiences. For the ultimate goal of enhancing the quality and rigor of this qualitative research, the researcher monitored the impact of my subjectivity and positionality by using these strategies: member checks, peer review/examination (Merriam et al. 2002), and personal ongoing reflexivity (Peshkin, 1988).

Limitations of this study did not only involve researcher's biases but even some aspects of the qualitative methodology.

First of all, the sample was limited in size and diversity. The sample of this study was composed of six second year Ed.S. practicum students in Marriage, Couples and Family Counseling (MCFC) program at University of South Carolina. The number of participants was at the limit of the minimum amount of people necessary for conducting a phenomenological research project. Creswell (1998) suggested the range between five to twenty-five participants and Morse (1994) stated that it is necessary a minimum of six participants. Also, students were all enrolled at the University of South Carolina and this is another restriction for what concerns the peculiarity of the sample. Moreover, the focus of the study was just on the practicum experience of counseling practicum students, who can be considered beginning therapists. Results of this research might be different from professionals trained at other Universities, from other programs, and at different levels of expertise.

Another limitation is the issue related to self-reported data. The researcher asked participants if they used the client feedback form note in their practicum and how often. Participants reported that they used client feedback data in supervision but in some cases it was unclear if they collected clients' feedback constantly during the entire semester.

Moreover, the researcher evaluated only one semester of data with practicum students who were interviewed at the end of their practicum experience. Perhaps after another semester of practicum, participants would have been able to implement the client feedback note more efficiently or effectively.

Finally, participants were supervised by different supervisors. It is possible that some aspects of the supervision process, including supervisor style, supervision alliance, supervisor theoretical approach, and supervisor interventions, might have affected the supervision and consequently the development of the therapeutic alliance between beginning counselors and their first clients.

5.3 SIGNIFICANCE OF THE STUDY

5.3.1 Generation of New Knowledge

In chapter two it was pointed out that there is a lack of a common description of therapeutic alliance among authors. The first important implication of this study regards the definition of factors that qualifies the therapeutic alliance construct. According to the participants of this research project, not only the emotional bond and the agreement between counselors and clients on tasks and goals define the therapeutic alliance (Bordin, 1976), but also the spirit of collaboration and the theories and techniques used by therapists have an influence on the quality of the therapeutic alliance. The clinical development of beginning therapists should be promoted with a consideration of all of these aspects.

Also, findings suggest that the therapeutic alliance could be monitored by the use of clients' feedback in supervision. This is another important result of this research that few other past studies pointed out. The knowledge generated by the use of the Client

Feedback Form in supervision settings was considered useful according to the participants of the study for fostering and maintaining a good quality of the therapeutic alliance with their clients. Clinicians should be encouraged to use quality measures of the clients' feedback, such as the Client Feedback Form note, because clients' voices might help them to know about the quality of the relationship with clients.

5.3.2 Professional Applications

The findings of this study are important not just because they provide new knowledge on the construct "therapeutic alliance" and the use of clients' feedback in supervision, but also because they bring powerful suggestions that could be useful for academic purposes.

Implications for Counselor Education Programs

This research project was able to identify factors that are related to the therapeutic alliance according to beginning therapists.

Counselor education programs would do well in preparing students by having them study and explore the components of the therapeutic alliance. First of all, in courses that prepare students in using specific communication skills in counseling, students should work on techniques that allow them to learn how to relate with clients during the therapeutic process as well as how to establish goals and define tasks. Also, the researcher suggests to focus on the counselors'-in-training personal abilities to relate to people and help students being more aware of these abilities and on their impact in the counseling sessions with future clients. Secondly, for what concern theories and techniques, students should be trained more on different counseling approaches and the different techniques implied in each approach. In particular, in courses that teach

different family therapy approaches, students should learn the main concepts as well as examine the models, have the opportunity to study the unique therapeutic relationship prescribed by each model, and have the opportunity to implement the specific techniques advocated by each specific theory. Lastly, in relation to the self of the therapist, which is the last component of the therapeutic alliance discovered in this research, students should be trained to work on the awareness of the different characteristics that allow a therapist to use self as an effective tool in the counseling process. Books and materials prepared for teaching communication skills in counseling should have a specific session dedicated to the self of the therapist and the role it plays in counseling.

Gehart and McCollum (2008) described the self of the therapist as a “therapeutic presence”, “an attitude or stance toward present experience that the therapist brings to the moment-to-moment therapeutic encounter” (p. 178). They considered therapeutic presence to be more of a state of being rather than of doing. Yet most training programs focus on teaching students skills, which might be thought of as doing rather than being. The importance of the factor “being” should be considered more in the assessment of future counselors at the beginning of their program of studies. When it is necessary to evaluate students before they start their graduate studies in counseling, it is important that faculty members focus on the “self of the student” and the personal relational skills as important background for being a future good counselor. Also, learning fundamental counseling skills is essential, however graduate training programs in counseling seem to be lacking in more implicit aspects of the therapeutic relationship. It could be useful to support students’ learning with the adoption of a protocol that focuses on the factors of the therapeutic relationship found in this research. For example, in the communication

skills in counseling course, an evaluation form on the quality of the therapeutic relationship should be used by counselor educators to evaluate students' videotapes. This form should include the following sections: emotional bond, agreement on tasks and goals, spirit of collaboration, theories and techniques.

Another implication for counselor education programs would be the knowledge of the Client Feedback Note form as a tool for empowering the quality of counseling sessions. In theoretical classes, students should learn the importance of collecting clients' feedback in therapy and start to explore this methodology becoming more familiar with it and ready to use it in their practicum experience.

Implications for Professional Supervision

From the experiences shared by the participants of this research, it seems relevant to support beginning therapists in the development of a positive therapeutic alliance with their first clients. According to Gard and Lewis (2008), "because of the multiple demands placed on beginning therapists and their supervisors, the therapeutic relationship is often neglected during supervision, often with problematic results" (p.39). As it is stated by Dryden (2008), it is important that counselors feel professionally and personally supported in the demanding work of being a counselor, so that their input to the alliance is more likely to foster a good outcome. For example, in individual counseling sessions as well as in group counseling sessions, supervisors should spend time on how trainees establish a therapeutic alliance with clients and how trainees maintain a good quality of this alliance with clients. Supervision sessions should be more focused on the development of an understanding of the interpersonal dynamics occurring during the therapy. Also, an analyses of students' reports regarding their therapeutic alliance during

the entire therapeutic process as well as a consideration of clients' narratives help beginning therapists to better understand what specific aspects of the therapeutic process clients consider most helpful, leading therapists to more effective interactions with clients. Recently, Swift, Rousmaniere, Whipple, Dexter, Callahan, and Wrape (2014) discussed three strategies for integrating clients' feedback into the supervisory process: training students to obtain and use objective client feedback, using specific client data to inform discussions of clients, and identifying patterns of outcomes across clients to facilitate supervisee development. The analyses of clients' feedback in supervision may help the supervisor make an interpersonal assessment of the trainee's relational abilities. At the same time, supervisees could increase their use of self during therapeutic process by using clients' feedback, by a discussion about this feedback in supervision and by the incorporation of the supervisor's suggestions in the following counseling sessions.

Implications for Professional Practice

Both the literature and the findings of this research highlight that the therapeutic relationship is at the crux of successful counseling intervention. Although the counseling relationship is the most potent therapeutic factor, it has been found that counselors are not as accurate as they believe at understanding client perspectives of empathy and the relationship (Greenberg et al., 2001; Orlinsky et al., 1994).

Especially for students who are starting a career as counselors, it is relevant to be aware of the importance of fostering and maintaining a working alliance with their clients. Johnson and Ketring (2006) said that if the therapeutic alliance is influential on therapy outcomes, "therapy training needs to focus on the skills necessary to reach the level of alliance needed of change" (p.346). Beginning therapists, in their practicum

experience, should have the opportunity to work on the different components of the therapeutic alliance and be evaluated on them. Trainees, especially at the beginning of their professional experience as therapists, are expected to apply different skills. Most of them retain technical skills, while others are related to interpersonal aspects and the use of self in the therapeutic sessions. The beginning therapists should be required to pay attention to a variety of dimensions of the therapeutic context, such as the content of what the person is saying, the affect associated with that content, diagnostic issues, and any reactions the therapist is having to the client. Also, in line with the results of this study that show the importance for students to know deeply theories and techniques for a good counseling intervention, it is important that supervisors support students in their development as counselors helping them being aware that the factor “counselor being” is the primary element for relating with clients and the frustration for not knowing all counseling theories and techniques is a normal development stage for counselors-in-training. Moreover, it seems important that students start to be exposed to clients’ feedback from the beginning of their practical experience as therapists. They should learn that the integration of client feedback not only honors the ethical mandate of monitor counselor effectiveness (American Counseling Association, 2005; American Mental Health Counselor Association, 2010) but also helps to elevate the client’s voice in relation to the direction and effectiveness of the counseling experience.

There are also professional implications for more experienced therapists. It is relevant that they constantly keep in their mind that the therapeutic alliance is a primary component in the therapeutic process and clients’ feedback gives a contribution to the empowerment of their counseling intervention. For both beginning therapists and more

experienced therapists, intentional peer interactions and discussions to what qualifies as positive or as negative therapeutic alliance should be fostered.

5.3.3 Social Change

Lastly, social change is another consequence related to the significance of this study. It is recommended for counselors in training and professionals to consider important not just the knowledge of theories and the correct application of techniques, but even the quality of the emotional bond with clients, the mutual agreement on goals and tasks and the spirit of collaboration. It is important that counselors are aware of the quality of their therapeutic alliance with clients and they discuss about it in the context of supervision regardless if it takes place in an academic environment or in a counseling agency. Both beginning therapists and more experienced therapists should take the advantage of supervision hours for working on improving their therapeutic alliance with their clients. Working on the quality of the therapeutic alliance, professionals ensure a good quality of the intervention with their clients.

Also, as it is stated above, it is ethical to monitor the efficacy of the counseling intervention and the collection of clients' feedback could be a way to do this. Giving clients the opportunity to express their feelings, thoughts, and desires about the counseling session will empower them. According to the experiences shared by the participants of this study, the Client Feedback Form could be used as a qualitative measure of the therapeutic alliance when the content of the form is discussed in supervision. Monthly, supervisors should give to each student the opportunity to present a case study as an example of a positive experience of therapeutic alliance and another case study as an example of a negative experience of therapeutic alliance. After the

presentation, supervisors should open a group discussion in which students share their thoughts and this might help them improve their therapeutic alliance with clients.

5.4 SUGGESTIONS FOR FUTURE STUDIES

Though the limits to this research have already been dealt with, there remain recommendations for future studies that this research did not address.

First of all, this study could be replicate with an incentive (for example a monetary incentive) to see if more beginning counselors wish to participate. This study had four females and two male participants from the same University. More participant from different universities and different programs (for example school counseling programs) would increase the diversity of the population and allow the collection of more information regarding students' development of the therapeutic alliance.

Secondly, it would helpful to ask participants to bring and share the clients' feedback note forms filled out by their clients. This would provide more data as well as allow the triangulation using multiple sources of information. In this way, it would be interesting to compare and contrast the development of the therapeutic alliance from the beginning counselors' perspective vs. their clients' perspective.

Also, it could be interesting to analyze if the supervision alliance between beginning counselors and their supervisors might have an impact on the development of the therapeutic alliance of beginning counselors with their first clients. It might be possible that the more strong and helpful the supervision alliance the more effective the therapeutic alliance.

A last recommendation for research could be to collect more long-term data. Interviewing students at the end of their first year practicum and at the end of their

second year practicum might allow the opportunity to see if the development of the therapeutic alliance with clients increases or not along with the increased experience of counselors using the Client Feedback Note form.

5.5 RESEARCHER REFLECTIONS

Exploring graduate students' experience of the therapeutic alliance was fascinating to the researcher. The researcher found that counselors-in-training were very articulate in discussing the development of the therapeutic alliance over the practicum experience. Most of the students were able to share many personal examples of both negative and positive experiences of therapeutic alliance with their first clients. The researcher expected to hear students' responses, since there was little previous research on this topic. This expectation was satisfied by a wealth of data provided by participants, which could be used to strengthen the pedagogical component of the development of graduate students' therapeutic alliance throughout counselor education programs.

The experiences shared by participants were eye opening with regard to how the development of the therapeutic alliance can be strengthened by the collection of clients' feedback in the practice of counseling as well as in supervision. From the findings of this study it is clear that seeking client feedback helps in understanding the client's subjective experience and promoting client empowerment. Because the client perspective is central to a strong alliance, client feedback must be sought routinely in counseling and supervision. The use of clients' feedback should be systematically integrated in counselor education and supervision programs as a way to learn that clients' perspectives on the quality of the counseling sessions matter on the students' development of counseling skills.

Finally, students provided useful information on positive and negative aspects as well as suggestions about the use of the Client Feedback Note form. Students shared the power of this form but they also expressed their desire to know more how to implement the form in different clinical settings with different clients (adults, children, families, groups). Even if the information obtained on the form was not specifically examined since they did not concern the main focus of the current research project, the researcher found that they were very useful for future research studies as new data on this form that has yet to be tested.

5.6 SUMMARY

The purpose of this chapter was to articulate the implications of the data collected in chapter four and its connection to the literature found in chapter two. The researcher paid attention to each piece of professional literature that was utilized to support this study. In particular, previous studies on therapeutic alliance and the use of clients' feedback from the Common Factor Psychotherapy, the Working Alliance Theory and the Client Informed Treatment approach were discussed looking for similarities and differences from previous studies. Also, the researcher presented what the current research added to the literature. Assumptions, limitations, scope, and delimitations were also addressed. Implications for counselor education programs, supervision, and professional practice were also presented including a focus on the new knowledge generated with this study and the social change offered by the results obtained with this research. The researcher provided also suggestions for future research, and researcher reflections collected during all steps of the research.

The rationale of this study was to explore graduate students' experience on the development of the therapeutic alliance during their practicum. This study also attempted to understand the impact of clients' feedback used in both clinical and supervision sessions on the development of students' therapeutic alliance. As it has been stated before, the significance of this study aims to generate new knowledge on the therapeutic alliance and clients' feedback constructs to assist counselor educators in pedagogy and professionals in practice. Furthermore, information from this study will also assist supervisors in using the Client Feedback Note form as a new instrument to collect clients' feedback.

The importance in preparing competent counselors aware of both the relational factors involved in the working alliance with clients and the importance of feedback provided by counselors must occur within counselor education programs. This also sounds as an ethical imperative for counselors in training and professionals. In conclusion, this study provides important data for encouraging a deep preparation on relational skills in counseling and an effective way to integrate clients' feedback in educational and professional settings.

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APPENDIX A – MCFC PRACTICUM APPLICATION

1. Name: _____ USC ID: _____

Address:

Street City State Zip

Email (Home): (Work/Campus):

Phone (Home): (Work): (Cell):

2. For which semester are you applying? Semester: _____ Year: _____

3. Please attach a photocopy of your grade report(s).

Core Classes Sem/Year Grade

EDCE 510 Introduction to Counseling _____

EDCE 600 Communication Skills in Counseling _____

EDCE 700 Cross-Cultural Counseling _____

EDCE 702 Counselor as Consultant _____

EDCE 706 Individual Appraisal Laboratory _____

EDCE 710 Professional, Ethical, and Legal Issues _____

EDCE 720 Theories of Counseling _____

EDCE 722 Group Procedures in Counseling _____

MCFC Specialization Sem/Year Grade

EDCE 503 Family Guidance _____

EDCE 711 Advanced Family Guidance _____

EDCE 716 Leaders in Counselor Education _____

EDCE 716 Leaders in Counselor Education _____

EDCE 716 Leaders in Counselor Education _____

Psycho-Diagnostics Sem/Year Grade

RHAB 757 Psychopathology for Counselors OR _____

RHAB 758 Classification & Assessment of Mental Disorders _____

4. Advisor Approval:

Advisor Signature Date

For office use only:

Date Received: _____ Date Reviewed: _____

APPENDIX B – INVITATION LETTER

Dear _____,

My name is Cristina Braga. I am a doctoral candidate in the Counselor Education and Supervision Department at the University of South Carolina. I am conducting a research study as part of the requirements of my doctoral degree in Counselor Education and Supervision, and I would like to invite you to participate.

I am studying the master students' experience regarding the development of the therapeutic alliance with first clients over the length of the practicum experience. If you decide to participate, you will be asked to meet with me for an interview about your practicum experience. In particular, you will be asked questions about your experience of the therapeutic alliance with your clients. The meeting will be on a mutually agree upon time and place, and should last about 45 minutes. The interview will be audio taped so that I can accurately reflect on what is discussed. The tapes will only be reviewed by members of the research team who will transcribe and analyze them. They will then be destroyed.

Participation is confidential. Study information will be kept in a secure location at the University of South Carolina. The results of the study may be published or presented at professional meetings, but your identity will not be revealed. Participation is anonymous, which means that no one (not even the research team) will know what your answers are. So, please do not write your name or other identifying information on any of the study materials.

Taking part in the study is your decision. You do not have to be in this study if you do not want to. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering. Participation, non-participation or withdrawal will not affect your grades in any way. If you begin the study and later

decide to withdraw, there are other research credit opportunities available to satisfy your research requirement.

We will be happy to answer any questions you have about the study. You may contact me at 803-629-2559, braga2@email.sc.edu or my faculty advisor, Dr. Joshua M. Gold (803-777-1936, josgold@mailbox.sc.edu) if you have study related questions or problems. If you have any questions about your rights as a research participant, you may contact the Office of Research Compliance at the University of South Carolina at 803-777-7095.

Thank you for your consideration. I will contact you by email to see whether you are willing to participate.

With kind regards,

Cristina Braga, MS Psychology

Doctoral Student
Counselor Education and Supervision
140 Wardlaw, Greene st., 29208 Columbia, SC
803-629-2559
braga2@email.sc.edu

APPENDIX C – DEMOGRAPHIC FORM

Gender:

Age:

Ethnicity:

Name of the place you did your practicum experience:

Name of the place you did your internship:

Service typology (school counseling, individual counseling, family counseling):

Clients typology (adults, children, teenagers, families, couples):

Amount of practicum hours:

Amount of internship hours:

Amount of supervision hours:

Use of the Client Feedback Form note with your clients in both practicum and internship:

Use of the Client Feedback Form note with in supervision: