UNIVERSITY OF SOUTHAMPTON

FACULTY OF SOCIAL, HUMAN AND MATHEMATICAL SCIENCES

School of Psychology

An Exploration of How Therapists Judge the Quality of Their Therapeutic Relationships in Clinical Practice

by

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Thesis for the Degree of Doctor in Clinical Psychology

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ABSTRACT

FACULTY OF SOCIAL, HUMAN AND MATHEMATICAL SCIENCES
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Thesis for the degree in Doctor of Clinical Psychology

AN EXPLORATION OF HOW THERAPISTS JUDGE THE QUALITY OF THEIR THERAPEUTIC RELATIONSHIPS IN CLINICAL PRACTICE

By Carina R. Simmons

In a systematic review of the existing literature exploring how therapists measure the quality of the therapeutic relationship, twelve quantitative articles deemed relevant and to have enough scientific rigour were examined and appraised. These included observational studies, and partially-controlled or uncontrolled clinical trials, all of which differed greatly in their methodology. A number of predictors of therapists' judgments of the quality of their therapeutic relationships were identified during the narrative synthesis. These fell into three main categories: *therapist factors*, *interpersonal factors* and *client factors*. These findings are consistent with previously reported patterns relating to the links between the quality of the therapeutic relationship and specific therapist characteristics, including the impact of their views of the relationship (e.g. Zilcha-Mano et al., 2015). Results also suggested therapists and clients differ in both their views of the relationship (e.g. Hatcher et al., 1995), and the information they use to judge its quality (e.g. Bachelor, 2013). However, datasets were highly variable, and methodological weaknesses affected the extent to which conclusions could be reliably generalised. Furthermore, the largely correlational designs meant that only associations between the above factors were made. As advocated by Elvins and Green (2008), more qualitative research attempting to explain how therapists assess the quality of the therapeutic relationship is warranted.

There is an accepted evidence-based link between the quality of the therapeutic relationship and clinical outcomes. However, this is set in the context of a lack of clarity around how therapists actually measure their therapeutic relationships, and whether this differs with experience. The present study recruited 71 Trainee Clinical Psychologists across the UK, who completed an online questionnaire exploring their experiences in their therapeutic relationships. Utilising QSR NVivo 10.0 (Silver, 2014), Braun and Clarke's (2006) six-phase iterative thematic analysis process organised data into three domains: *'Conceptualising the Relationship'*, *'Managing Challenges'* and *'Measuring the Quality'*. Among the superordinate themes, Trainees discussed what makes a 'Good Relationship' and its 'Perceived Role', alongside 'Strategies' used to manage difficulties in the relationship, which generated themes of 'Open Discussion', 'Formulation', 'Reflective Practice' and 'Adapting Approaches'. Trainees also described a superordinate theme of using 'Quantitative Approaches' to measure the quality of the relationship, but tended to use more 'In-Vivo Indicators' in this judgement. Indicators included 'Attunement and Congruence', 'Client Feedback', 'Trust, Honesty and Openness', 'Motivation and Attendance', and 'Intuition, Feelings and Gut'. Conversely, some Trainees reported having no experience of therapeutic ruptures, which could reflect either a lack of clinical experience, or could point to potential insecure attachment styles among some Trainees. Implications include (i) the potential benefits of increasing and possibly standardising approaches in using both quantitative and qualitative methods of measuring the quality of therapeutic relationships on UK Clinical Psychology training programmes, and (ii) that most Trainees currently prioritise the therapeutic relationship, practice reflexively and understand and appreciate the link between the quality of their relationships and clinical outcomes.

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Academic Thesis: Declaration of Authorship

I, Carina Simmons, declare that this thesis and the work presented in it are my own, and have been generated by me as the result of my own original research.

An Exploration of How Therapists Judge the Quality of Their Therapeutic Relationships in Clinical Practice

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission.

Signed: Carina R. Simmons

Date: 9th May 2016

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I am so grateful for the support from my family and friends for their help in managing my work-life balance, and in making clinical training an invaluable experience.

List of Abbreviations

ANCOVA	Analysis of Covariance
ARM	Agnew Relationship Measure
ASQ	Attachment Style Questionnaire
BDI	Beck Depression Inventory
BPSR	Bern Post Session Reports
BSI	Brief Symptom Inventory
CALPAS	California Psychotherapy Scales
CAS	Constructivist Assumptions Scale
CASF-P	Combined Alliance Short Form Patient Version
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CSBQ	Career Sustaining Behaviour Questionnaire
DIS	Dynamic Intrapsychic Variables
DPCCQ	Development of Psychotherapists Common Core Questionnaire
DR	Dynamic Relations
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders (Fourth Revision)
DTS	Dyadic Trust Scale
EFA	Exploratory factor analysis
EPQ	Brief Eysenck Personality Questionnaire
GAS	Global Assessment Scale
GRS	Global Rating Scale
HAq	Helping Alliance Questionnaire
HAq-R	Penn Helping Alliance Questionnaire-Revised Version
HSCL-11	Hopkins Symptom Checklist Revised
IEQ	Intersession Experience Questionnaire
IIP-C	Inventory of Interpersonal Problems-Circumplex
M	Mean
MTMM	Monotrait Mulitmethod
N	Number
PBI	Parental Bonding Inventory
PCA	Principal Components Analysis
PCL	Therapist Problem Checklist
PD	Personality Disorder
PEI-R	Revised Psychotherapy Expectancy Inventory
PhD	Doctor of Philosophy
PI	Psychodynamic Interpersonal therapy

PRS	Post-Therapy Rating Scale
PSI	Psychiatric Symptom Index
PSS	Perceived Stress Scale
PSTQ	Personal Style of Therapist Questionnaire
PTSD	Post-Traumatic Stress Disorder
QAF	Quality Assessment Framework
QOL	Quality of Life Inventory
QOR	Quality of Object Relations
QQSR	Quality and Quantity of Social Relations
RCT	Randomised Controlled Trial
REBT	Rational Emotive Behaviour Therapy
RI	Relationship Inventory
SASB	Structural Analysis of Social Behaviour
SES	Session Evaluation Questionnaire
TAQ-SF	Therapist Attitudes Questionnaire-Short Form
TAU	Treatment as Usual
TC	Target Complaints Method
TIRS	Therapist Intervention Rating System
TS	Techniques List
TWIS	Therapist Work Involvement Scales
USA	United States of America
UK	United Kingdom
WAI	Working Alliance Inventory
WAI-S	Working Alliance Inventory-Short Form
WAI-T	WAI-Therapist Version
WoSCC	Web of Science Core Collection (excluding Medline)

Chapter 1 – Systematic Review of the Literature: What is Known About How Therapists Measure the Quality of the Therapeutic Relationship?

1.1 Introduction

1.1.1 Conceptualising the therapeutic relationship. The complexity inherent in isolating a robust conceptualisation of the therapeutic relationship is linked with difficulties in testing hypotheses about its impact, value and effects (Elvins & Green, 2008). The "treatment alliance" refers to the interpersonal processes between the therapist and client during therapy sessions (Elvins & Green, 2008, p.1168), which can be considered to occur independently of the treatment model applied (Green, 2006). As such, the meaning of the 'therapeutic relationship' in this review will encompass both the treatment alliance and the treatment model (for example, psychodynamic therapy), as these different terms are often used in an interchangeable fashion in clinical contexts.

The therapeutic alliance[1] was first referred to by Freud (1913/1958) during his development of psychoanalysis as a talking therapy, where he described transference[2] from the patient or client[3] to the therapist. Zetzel (1956) described the alliance as the client's ability to cope with the process of psychoanalysis, where the transference is analysed by the analyst. Its psychoanalytic roots and the need for more scientific approaches to exploring psychotherapy outcomes gave rise to a pan-theoretical model of the therapeutic alliance (Horvath, 2000). Whilst Rogers (1961) named unconditional positive regard, congruence and empathy (core conditions) experienced by the client from the therapist as defining the alliance, Greenson (1967) differentially focused on examining the relationship between the therapist and the client in the context of what both brought to their therapeutic interactions.

Bordin's (1979) model of the working alliance was drawn from the psychoanalytic and humanistic literature, where he defined the working alliance as a conscious phenomenon occurring within the therapeutic relationship (see Raue & Goldfried, 1994), that could be affected by past relationships in early stages of therapy. Bordin (1979, pp.253) proposed that the working alliance was a two-way process between the therapist and client, including *"...three features: an agreement on goals, an assignment of a task or a series of tasks, and the development of bonds*". This definition has since undergone further adaptations for specific therapies, such as Family Therapy (e.g. Palatano, 1997).

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[1] The terms 'working alliance' and 'therapeutic alliance' (see Bordin, 1979) and 'treatment alliance' (Elvins & Green, 2008) may be used interchangeably throughout this review, except where particular researchers or authors have described specific definitions, which will be explicated where applicable, and non-specific instances will be referred to as 'the alliance'.

[2] Transference can be defined as the moments of experiencing aspects of a past relationship pattern in the current context of therapy with the therapist (Hamilton, 1996).

[3] The person receiving therapy will thereafter be referred to as a 'client' to avoid: (i) pathologising participants or individuals receiving therapy, and (ii) assuming the person receiving therapy has a diagnosable mental illness.

The literature illustrates the convolutions in conceptualising the alliance, with multiple explanations cited (e.g. Horvath, 2006). Specific examples include: (i) the multiple definitions or constructs and their links with psychometric constructs (Elvins & Green, 2008), (ii) the difficulties encountered in varied empirical approaches to measuring a heterogeneous phenomenon (Elvins & Green, 2008; Horvath, Del Re, Flückiger, & Symonds, 2011), (iii) the different therapeutic paradigms and orientations of therapists (e.g. Gaston et al., 1995; Horvath, 2000; von Braun, 2013), and (iv) the variation in whether the client, therapist or observer's perspective is being captured (Horvath et al., 2011). Further discrepancies in the evidence-base may also be partly explained by the different findings around the validity and reliability of numerous instruments (Elvins & Green, 2008; Horvath & Luborsky, 1993) and the use of single and multiple measures in research studies when attempting to explore the quality of therapeutic relationships.

Measuring particular constituents of the therapeutic relationship means that other important parts of this phenomenon may be overlooked. This is problematic, given that the presence of multiple concept-specific definitions and tools available, which suggests these components could be inextricably linked. The construct validity of tools used to measure specific aspects of the therapeutic relationship and the strength of different theoretical models are somewhat constrained by this issue. A working model of the therapeutic relationship which includes the theoretically distinct components (for example, the 'working' relationship and the 'real' relationship - see Gelso, 2011), could present a more comprehensive view, and offer way forward for developing a reliable tool that measures these different features of this compound notion. This could avoid losing crucial aspects of incredibly idiosyncratic therapeutic relationships. It could also prevent reducing such a multifaceted experience to a specific component, and make future tools appropriate for diverse therapeutic models that may place differing emphasis on the therapeutic relationship.

Horvath (2000) too argues for an integrated model of the alliance, in an attempt to overcome the methodological issues in its measurement associated with the existence of numerous definitions. The varied evidence base and array of measures available for assessing arguably idiosyncratic therapeutic processes (see Bachelor, 1988) may maintain the divergence in findings in relation to psychotherapy outcomes and operational definitions (Elvins & Green, 2008).

1.1.2 The alliance and therapeutic outcomes. The relationships and processes that occur between therapists and their clients have been increasingly recognised as important in explaining changes during therapy (Bordin, 1979), clinical outcomes (Hartley & Strupp, 1983; Preibe & McCabe, 2006) and other therapeutic processes (Orlinksky, Grawe & Parks, 1994). Whilst the alliance-outcome link is widely accepted (Horvath et al., 2011), different trends have been identified, showing patterns of convergence (e.g. Elvins & Green, 2008; Horvath, 2000; Horvath & Luborsky, 1993; Horvath et al., 2011), and divergence or variability (e.g. Baldwin, Wampold & Emel, 2007; Kim, Wampold & Bolt, 2006; Ramnerö & Öst, 2007; Wampold, 2001; Zilcha-Mano

& Errázuriz, 2015). Hilensroth, Peters and Ackerman (2004) highlight the importance of researching both clients' and therapists' ratings of the alliance to develop our understanding of such discrepancies. Where most studies have focused solely on client-ratings (e.g. Stiles et al., 2004), other research has explored the views of clients and therapists (e.g. Bachelor & Salamé, 2001).

Elvins and Green (2008) provide a substantial overview of the evidence-base underpinning many tools used to measure the alliance, showing some consensus around core constituents of the alliance being examined. The authors call for more rigorous testing of these measures in order to work towards a unified understanding of this concept, and articulate a need for more qualitative research to explore the underlying mechanisms of change that are not well-understood. Further to the apparent quantitative bias in the literature, Kazdin (2008) also notes that tools used to measure the quality of the therapeutic alliance largely fail to scrutinise *how* mechanisms of change occur within the alliance.

1.1.3 Review aims. Previous reviews have focused on exploring the alliance-outcome relationship (e.g. Horvath et al., 2011) or quantitative approaches to measuring the therapeutic relationship (e.g. Elvins & Green, 2008). Despite the importance of the therapist's role in managing the therapeutic relationship, there is still little understanding of the processes explaining how therapists judge the quality of their alliance with clients. In the context of the established differences in how clients and therapists perceive the alliance (e.g. Clemence et al., 2005; Meier & Donmall, 2006), this is particularly problematic.

Therefore, informed by PRISMA Guidelines (Moher et al., 2009, see Appendix A), this systematic review of the literature aimed to evaluate the extent to which existing studies have attempted to explain how therapists judge their therapeutic relationships, in order to address the question: *How do therapists judge the quality of their therapeutic relationships with their clients in clinical practice*?

1.2 Methodology

1.2.1 Identifying the literature.

1.2.1.1 Inclusion criteria. Articles were included in the review process if they had data describing how therapists measure the quality of their therapeutic alliances in human samples. Further inclusion criteria included articles being published in peer-reviewed journals in order to ensure high quality research was reviewed, and articles had to have been published in English in order for them to be read and reviewed.

In order to be included in this review, studies had to include only adult samples, to avoid confounding the synthesis of findings owing to: (i) different skill sets being used to work therapeutically with child and adult populations due to cognitive differences (Elvins & Green, 2008), and (ii) the lack of cohesion in how the alliance with children is measured (see Faw, Hogue, Johnson, Diamond & Liddle, 2005).

1.2.1.2 Exclusion criteria. The following types of articles were deemed to be outside the scope of this review: (a) case studies, due to generalisability issues, (b) psychometric validation studies, because of the lack of explanatory power in answering the review question, and (c) book chapters, meeting abstracts, conference proceedings, review articles, panel reviews, or commentaries, as these would not necessarily focus on a particular study in-depth.

Unpublished articles, such as dissertations, were not included in order to ensure only rigorously reviewed work was included, and papers that were not published in English were also excluded as it was not possible to review articles in a foreign language. Articles published before 1990 were not reviewed, as one of the aims of the review was to look at trends in the research in discrete time period, over which the majority of the literature published in this field had emerged. Articles with *'supervision'* in the title were excluded, as preliminary searches suggested their focus would be on their supervisory relationships rather than their therapeutic alliances, and would therefore not be relevant to the research question. Further articles were excluded if they focused on:

i. Non-psychological therapies, as the focus or aims of therapy are markedly different from psychological therapies;
ii. The observer's or client's ratings of the therapeutic alliance, as these did not describe how therapists measured their therapeutic alliances, and
iii. Samples which were too specific in terms of presenting difficulties, such as bereavement, or phenomena such as sexual attraction in the therapeutic relationship, due to the difficulties generalising findings.

1.2.1.3 Location of literature. Preliminary searches were performed using the search terms '*therapeutic relationship', 'therapeutic alliance'* and *'working alliance'* using PsychINFO, a bibliographic database, to examine predominant keywords. Secondly, keywords were used to narrow down a broad search.

Three main bibliographic databases, namely PsychINFO, Medline and the Web of Science Core Collection (excluding Medline; WoSCC) were used to conduct electronic searches to interrogate the evidence-base published between January 1990 and November 2015, in order to review seminal research developments and trends in the preceding 25 years. Abstracts were initially screened and full-text articles were sought where articles were thought to be relevant to determine whether they were eligible for inclusion. Secondly, reference lists of full-text articles were examined to identify any relevant articles, which were sourced through either the University of Southampton library facilities or via correspondence with authors.

The following search procedure was used initially on PsychINFO and then on Medline, following removal of duplicates. This was repeated with WoSCC, where research areas were restricted to (i) psychology, (ii) psychiatry and (iii) behavioural sciences, and duplicates were again removed. Primary search terms that had to feature in article titles were entered into the

bibliographic database search engines and included *therapeutic relationship* or *therapeutic alliance* or *working alliance* to accommodate the multiple terms and definitions existing within the literature, but excluded *supervision* to avoid confounding the primary phenomena being explored. Secondary search terms that also had to feature in article titles included *therapist* or *therapist characteristics* or *psychotherapeutic processes* or *clinical practice* or *measure** or *judg** or *qualit** or *perspective**[4]. This secondary search was combined with the primary search in order to specify the area of interest within the broad field of therapeutic relationships (see Appendix B).

1.2.2 Search results. Results are illustrated graphically in Figure 1 (pp.22). This shows that after initial exclusion criteria were applied, the PsychINFO search retrieved 138 articles and the Medline search retrieved 5 articles, after 44 duplicates and 58 unsuitable studies were excluded. The WoSCC search retrieved 15 articles, after excluding 522 unsuitable and 41 duplicate articles. Including a further 18 articles identified through reference lists, a total of 176 full-text articles were retrieved and screened.

Applying exclusion criteria removed 164 articles in total. This left 12 articles that met all the inclusion criteria, of which 8 were retrieved from PsychINFO. Medline and WoSCC both yielded 1 article each, and 2 were sourced from the reference lists.

[4] '*' refers to truncation of search terms in order to include multiple forms of that word, for example, *judge, judges, judgment* and *judging*.

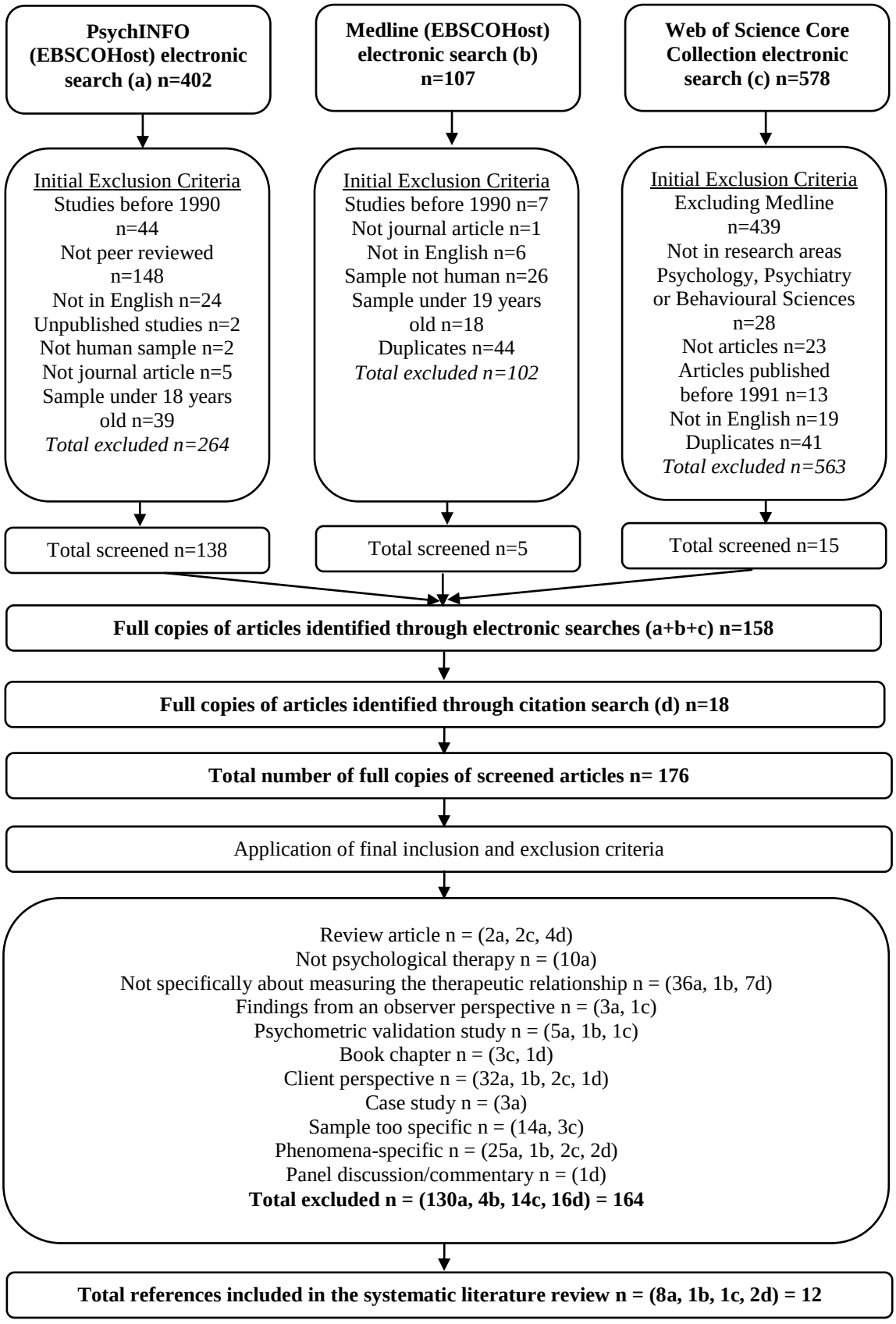

Figure 1. Systematic literature review flowchart.

1.2.3 Quality appraisal. There were two broad categories of studies included in this review, namely observational studies and experimental studies. The observational studies included

postal and online questionnaire batteries. The experimental designs involved clinical trials - one of which was randomised, some of which were partially-controlled or uncontrolled and some of which were naturalistic.

Utilising standardised approaches to assessing the quality of the studies in terms of their design and methodology was necessary, to examine the strength of data, implications and conclusions. However, observational and experimental studies required different quality assessment frameworks to assess the extent to which each study met criteria for its subtype. To examine the quality of experimental studies, the Quantitative Quality Checklist (QQC; Downs & Black, 1998; see Appendix C) was used, as its criteria encompassed the scope of the studies reviewed most thoroughly, it was straightforward to use, and it offered clear scoring criteria. The STROBE Guidelines (von Elm et al., 2008; see Appendix D) were used to explore the quality of observational studies. Differentially, this is a set of guidance around good practice in conducting and reporting such studies, rather than a quality assessment tool, per se (da Costa, Cevallos, Altman, Rutjes & Egger, 2011). Reviewing the quality assessment tools for observational studies revealed a dearth of comprehensive quality assessment tools available in this area. In particular, STROBE Guidelines were selected as its criteria covered the features of the observational studies in this review most inclusively, compared to other available measures.

Collectively, both the QQC and the STROBE Guidelines were selected as they each had the capacity to review the majority of study attributes: this factor was prioritised in order to ensure the process of quality assessment was rigorous, transparent and to support the appropriate dissemination of research findings. However, it is challenging to combine a quality assessment tool (QQC) with a set of recommendations (STROBE Checklist), particularly as the latter does not have a scoring system. As such, higher scores obtained by studies were understood to be indicative of having higher quality, although it was not possible to apply cut-off scores.

This process provided an overview of the strengths and limitations associated with each study[5], and overall scores were offered (see Table 1). This quality assessment process suggested that studies varied widely on criteria across the two frameworks used. For example, whilst some studies articulated limitations and ethical considerations, other studies had vague rationales underpinning statistical analyses and procedures followed, or employed complex reporting styles. This inevitably impacted on quality scores, as the extent to research could be replicated and considered representative of the implications described was varied and therefore, somewhat limited.

[5] Further details of quality assessment scoring can be found for both observational and experimental studies in Appendices E and F, respectively.

Table 1.

Studies included in the review.

Study design	Aim(s)	Sample(s)	Interventions / measures	Analysis	Findings	QAF score
Al-Darmaki and Kivlighan (1993) Observational uncontrolled cross-sectional survey.	To examine the relationship between congruence in client-therapist expectations and the alliance.	Therapists (n=25): 9 male; age range 23-50, including trainee psychologists, qualified psychologists, and counsellors. Clients (n=25): 18 female; age range 18-30; university students.	Client-therapist dyads in an American university counselling service completed a questionnaire pack after the third session of therapy, which included the Revised Psychotherapy Expectancy Inventory (PEI-R; Berzins, 1971); Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The therapeutic orientation and the duration of the therapeutic contract were not described.	Correlations for demographic variables, alliance ratings and expectancy ratings and on congruence. Multiple regressions for alliance ratings, expectancy and congruence as predictors.	Therapists' and clients' alliance ratings were significantly related to their own alliance expectations. Congruent alliance expectations were significantly related to most aspects of alliance ratings.	19/33

Study design	Aim(s)	Sample(s)	Interventions / measures	Analysis	Findings	QAF score
Bachelor (2013) Observational uncontrolled cross-sectional survey.	To explore how clients' and therapists' views of the alliance differ and overlap.	94 therapy dyads engaged in a variety of therapies were recruited. Therapists (n=59):41 female; including trainee psychologists, psychologists, a social worker, a nurse, and family clinic volunteers. Clients: n=184 (125 female). Diagnoses included anxiety disorders, PD relational difficulties and 'other' disorders.	In a Canadian university, clinic and community setting, data were collected in two phases: (1) questionnaires were completed pre-therapy, after 5 sessions and 2 weeks post-termination, and (2) questionnaires were completed at different times and therapists provided diagnostic information. Questionnaires included the WAI-Short Form (WAI-SF; Tracey & Kokotovic, 1989); Helping Alliance Questionniare (HAq; Alexander & Luborksy, 1986); California Psychotherapy Scales (CALPAS; Gaston & Marmar, 1991); Global Rating Scale (GRS; Green, Gleser, Stone & Seifert, 1975); Post-Therapy Rating Scale (PRS; Nichols & Beck, 1960); Target Complaints Method (TC, Battle et al., 1966); Global Assessment Scale (GAS; Endicott et al., 1976); Psychiatric Symptom Index (PSI; Boyer, Préville, Légaré & Valois, 1993)	Principle components analyses (PCAs) were conducted on 174 clients' and 131 therapists' data due to missing items and to assess underlying factors and identify relevant factors. Exploratory factor analyses (EFAs) assessed the alliance measures separately. Factor scores from clients and therapists were correlated with scores on outcome measures.	Therapists were seen to view the alliance in terms of 4 components, namely collaborative work, therapist confidence and dedication, client commitment and confidence and client working ability, of which 3 predicted post-therapy outcome. Although there were some similarities between therapist and client views, there were also important differences.	22/33

Study design	Aim(s)	Sample(s)	Interventions / measures	Analysis	Findings	QAF score
Black, Hardy, Turpin and Parry (2005) Observational uncontrolled cross-sectional survey.	To explore the relationship between therapists' reported therapeutic orientation and style of attachment with both problems in therapy and alliance.	Therapists (n=491): 70% female; including psychotherapists, nurses, psychologists, social workers, psychiatrists and counsellors. Orientations: psychodynamic; CBT, cognitive analytical (CAT), integrative, eclectic and humanistic.	Postal questionnaires were sent to 1,400 psychotherapists identified on registers of accredited therapists in the United Kingdom to measure attachment behaviours, the WA and problems in therapy. Questionnaires included the Attachment Style Questionnaire (ASQ; Feeny, Noller & Hanrahan, 1994); Agnew Relationship Measure (ARM; Agnew-Davies, Stiles, Hardy, Barkham & Shapiro, 1998), Therapist Problem Checklist (PCL; Shroder, 1999), and Brief Eysenck Personality Questionnaire (EPQ; Eysenck & Eysenck, 1969).	Correlations explored relationships between attachment styles and both alliance and PCL scores. ANCOVAs tested for differences in alliance and PCL scores between orientation groups. Multiple regressions explored factors explaining the variance in alliance scores.	Therapists with secure attachments reported significantly more positive alliances, and therapists with anxious attachment styles reported significantly weaker alliance scores and more problems in therapy. Both attachment style and orientation significantly predicted alliance scores.	22/33

Study design	Aim(s)	Sample(s)	Interventions / measures	Analysis	Findings	QAF score
Hartmann, Joos, Orlinsky and Zeeck (2015) Non-randomised uncontrolled clinical trial.	To explore the divergence between clients' and therapists' views on the quality of alliance from the client's perspective, and the relationship with therapist work involvement and therapist session process experience.	Therapists (n=26). Outpatient therapist sample: 37% trainees, 84% female. Day clinic therapist sample: 60% Trainees, 40% female. Clients (n=98): 50% in a day clinic (mean age 49.2, 53% female), 50% from an outpatient clinic (mean age: 40.7; 72.3% female).	In America, day clinic treatment took place over 9 months through twice-weekly sessions of individual, group, art and body therapies, a relaxation session and nurse/doctor contact; outpatient clinic treatment involved twice-weekly individual therapy sessions. All therapies were grounded in psychodynamic approaches. Session and intersession processes were measured weekly, and other measures every third session. Measures included the Helping Alliance Questionnaire (HAq; Alexander & Luborsky, 1986); Session Evaluation Questionnaire (SES; Stiles, 1980); Therapist Work Involvement Scales (TWIS, from the DPCCQ; Orlinsky et al., 1999), and Intersession Experience Questionnaire (IEQ; Orlinsky & Gellar; 1993).	A scatter plot and linear regressions were computed for clients' and therapists' perceptions of clients' alliance scores. Further regression analyses explored potential predictors of divergence in alliance ratings. Surface models explored non-linear relations between variables.	Therapist case-wise work involvement was found to be significantly related to therapist and client divergence in views of the alliance. Therapists reporting they were experiencing a "distressed practice" work involvement pattern appeared to be the most significant predictor of therapist-client divergence in views of the alliance.	15/27

Study design	Aim(s)	Sample(s)	Interventions / measures	Analysis	Findings	QAF score
Hatcher, Barends, Hansell and Gutfreund (1995) Observational uncontrolled cross-sectional postal survey.	To use a nested design with confirmatory factor analysis to explore the general factors and effects of client and therapist reports on three alliance measures.	Therapists (n=38): 24 female; including predoctoral and postdoctoral interns and senior staff. Client sample (n=144): 99 female; aged 18-66.	Clients were engaged in once-, twice- or thrice-weekly psychodynamic therapy (range: 2-274 sessions) in an American university psychology clinic. Therapists and clients completed questionnaire packs comprising the Penn Helping Alliance Questionnaire-Revised (HAQ-R; based on Alexander & Luborsky, 1986), WAI (Horvath & Greenberg, 1986), CALPAS (Gaston & Marmar, 1991), and Quality of Life Inventory (QOL; Mayman, 1990).	A correlation matrix was computed for both therapist and client versions of the three alliance measures. A three factor model (patient, therapist and shared view factors) explored how these factors accounted for variance across the alliance measures.	A shared-view factor was most represented by the HAQ and least represented by the WAI. Unique factors and therapists' views were best represented by the WAI. Using multiple measures to accurately assess the alliance is indicated.	17/33
Heinonen, Lindfors, Härkänen, Virtala, Jääskeläinen and Knekt (2014) Partially-controlled longitudinal clinical trial.	To investigate the impact of therapist characteristics on the quality of the alliance as rated by therapists and clients, this differed between long-term and short-term therapies.	Therapists (n=70): included psychologists, psychiatrists and other disciplines. Clients (n=333), outpatients, aged 20-45; 24.8% male; diagnoses included longstanding mood or anxiety disorder.	In a Finnish clinical trial, were randomly assigned to (i) solution-focused therapy (n=97; 12 sessions), (ii) psychodynamic therapy (short-term: n=101, 20 sessions; long term: n=128, 2-3 times weekly for 3 years) or (iii) psychoanalysis (self-selected, 4 times weekly for 5 years). Therapists completed the DPCCQ (Orlinsky et al., 1999) and both parties completed the WAI (Horvath & Greenberg, 1989).	Regression analyses explored the impact therapist factors, length of therapy, the interaction between the length of therapy and therapist factors and confounds on alliance ratings at session 3 and after 7 months.	Therapists' quality of life predicted their alliance ratings but not client alliance ratings. Engaging, encouraging relational styles improved patient ratings of the alliance in short-term therapies only.	19/27

Study design	Aim(s)	Sample(s)	Interventions / measures	Analysis	Findings	QAF score
Hersoug, Høglend, Monsen and Havik (2001) Uncontrolled non-randomised naturalistic experiment.	To explore therapists' personal and professional variables based on therapist self-evaluation as predictors of the quality of the WA in psychotherapy.	Therapists (n=59): 51% female; mean age: 43.6, including clinical psychologists, psychiatrists, social workers, nurses. Clients (n=270): mean age: 33.7; 67% female; diagnoses included social phobia, dysthymia, depression, generalised anxiety and other anxiety disorders.	A naturalistic multisite study in Norway involved 7 sites with 15 outpatient clinics. 6 sites offered open-ended therapy, and 1 site offered up to 40 sessions. Treatments were either treatment as usual (TAU; non-specified) or therapy with a non-manualised psychodynamic orientation. Questionnaires completed included the DPCCQ (Orlinsky et al., 1999); Inventory of Interpersonal Problems-Circumplex (IIP-C; Alden, Wiggins & Pincus, 1990); Structural Analysis of Social Behaviour (SASB; Benjamin, 1974), Parental Bonding Inventory (PBI; Parker, Tupling & Brown, 1979) and Value Survey (Rokeach, 1973).	Univariate analyses and multivariate analyses were run on professional variables, interpersonal problems, past relationships and value similarity, all using Bonferroni adjustments. A hierarchical multiple regression analysis was built to examine the predictors further.	There was divergence in clients' and therapists' ratings of the alliance. Where therapist experience, training, skill and progress in their role as therapists were significantly related to therapist-rated alliance. Interpersonal relationships were significantly related to both therapist- and client-rated alliance.	20/33
Hersoug, Monsen, Havik and Høglend (2002) Design identical to that in Hersoug, Høglend, Monsen and Havik (2001, see above).	Aim: the study aimed to predict the quality of the WA in psychotherapy using patient pre-treatment variables as predictors.	Sample was the same used in the study by Hersoug et al., (2001, see above).	Design and measures were the same used in the study by Hersoug et al., (2001, see above).	Univariate and multivariate analyses of each predictor with Bonferroni adjustments were run. A hierarchical multiple regression analysis examined diagnosis, current relationship, past relationship and intrapsychic variables as predictor variables.	Early alliance quality is better predicted than later alliance quality, and although variables associated with clients' diagnoses did not predict alliance ratings, both the quality of past and current relationships is associated with alliance ratings.	20/33

Study design	Aim(s)	Sample(s)	Interventions / measures	Analysis	Findings	QAF score
Kivlighan, Marmarosh and Hilsenroth (2014) Observational uncontrolled cross-sectional survey.	To develop knowledge about the impact of a moderated actor-partner independence model on the alliance, session evaluation and outcomes.	Therapists (n=29): 14 male; 3rd/4th year clinical psychology Trainees. Clients (n=74): receiving individual psychodynamic psychotherapy.	In an American outpatient clinic, psychological evaluations preceded once or twice-weekly sessions of short-term psychodynamic psychotherapy. Clients filled out the BSI (Derogatis & Spencer, 1993) prior to and after therapy, and client and therapist ratings of the SEQ (Stiles, 1980) were completed every 3rd or 4th treatment session. Clients completed the Combined Alliance Short Form Patient Version (CASF-P; Hatcher & Barends, 1996) and therapists completed the WAI (WAI; Horvath & Greenberg, 1989).	Path analysis in a structural equation modelling framework computed the actor-partner independence model effect. All variables were mean-centred before interaction terms were created. This was to explore actor effects and partner effects.	Therapists' alliance ratings were significantly related to their ratings of session depth and positivity, and associated strong alliances with positive post-session emotions. Therapist-rated alliance was also related to session smoothness.	11/27
Lee, Neimeyer and Rice (2013) Observational uncontrolled cross-sectional survey.	To explore epistemic approaches as predictor of therapists' interventions use, therapeutic style and alliance ratings.	Therapists (n=1,151): 733 female; mean age: 45.09; models used included rational emotive (REBT), Gestalt, CBT, integrative, psychodynamic, interpersonal, humanistic, constructivist and existential approaches.	An online survey was sent to 15,918 American therapists through their professional bodies. The final sample size was 1,151 therapists, and included the Therapist Attitudes Questionnaire -Short Form (TAQ-SF; Neimeyer & Morton, 1997); Constructivist Assumptions Scale (CAS; Berzonsky, 1994); Techniques List (TS; Hollis, 1995); Personal Style of Therapist Questionnaire (PSTQ; Fernandez-Alvarez, Garcia, Bianco & Santoma, 2003), and WAI-SF (Tracey & Kokotovic, 1989).	Multiple regressions explored a number of hypotheses about therapist epistemology predicting therapy style, the quality of the alliance according to therapists' ratings and therapists' selection of specific therapeutic interventions.	Differences in therapists' epistemic assumptions did predict differences in their personal style. Epistemic style was also seen to predict the bond subscale of the WAI, and therapist use of specific interventions.	20/33

Study design	Aim(s)	Sample(s)	Interventions / measures	Analysis	Findings	QAF score
Peschken and Johnson (1997) Observational uncontrolled cross-sectional survey.	To examine if therapist trust in their clients, therapists' experience and use of the core conditions in therapy are associated with clients' trust in therapists.	Therapists (n=17): 10 male; mean age: 47. Orientations: eclectic, systemic; psychodynamic and CBT. Clients (n=48); mean age: 39; outpatients.	Therapists recruited by professional listings in Canada were asked to recruit their clients to partake in the study. The 48 consenting dyads completed postal questionnaire packs. Clients had attended a median of 25 sessions at the time of data collection. The questionnaire pack contained the following measures: the BSI (Derogatis & Spencer, 1993); Relationship Inventory (RI; Barrett-Lennard, 1962), and Dyadic Trust Scale (DTS: Larzele & Huston, 1980).	Correlations were run between therapists' and clients' trust and alliance scores; therapist and client ratings of facilitative attitudes/conditions respectively, and client-rated symptoms with clients' and therapists' trust and alliance scores.	Positive correlations were found between (i) therapist trust in clients and therapist ratings of facilitative conditions, and (ii) clients' ratings trust in therapists and clients' ratings of therapists' facilitative attitudes.	15/33

1.3 Literature Review

1.3.1 Overview. The studies selected for this review ranged widely in their methodology, designs, populations, research foci and rationale. Their heterogeneity (for example, including both trainee and qualified therapists from a range of professional backgrounds, across and within studies) represents the diverse evidence base in the broader field of research into the therapeutic alliance. This also emphasises the lacuna of studies specifically addressing how therapists judge the quality of the alliance. Of the twelve studies included, some compared multiple measures of the alliance (n=3), and others either used only the Working Alliance Inventory (Horvath & Greenberg, 1986/1989; n=5) or other singular alliance measures (n=4). Whilst some studies focused solely on therapists' views (n=2), the remaining studies explored therapists' and clients' views, of which 6 also explored therapeutic outcomes. Additional foci included the impact of attachment style, trust, expectations, therapist orientation and epistemology, quality of object relations and other client and therapist variables.

1.3.2 Narrative synthesis. The reviewed studies yielded a vast pool of data; however, only some findings were pertinent to the review question. Therefore, only data concerning how therapists judge the quality of the alliance will be discussed. This review is organised by the most salient patterns that were found to be significantly associated with therapists' judgment of the quality of the alliance: firstly, therapist factors; secondly, interpersonal factors and thirdly, client factors.

1.3.2.1 Therapist factors. A number of studies described an array of factors predominantly attributable to therapists, which were seen to be significantly related to their assessment of the quality of the alliance. These included a diverse range of therapists' personal and professional characteristics or traits.

In an American online survey involving 1151 qualified therapists, Lee et al., (2013) explored the impact of epistemic approaches on the quality of therapist-rated alliance using the WAI-S (Tracey & Kokotovic, 1989), looking at therapists' attitudes, constructivist assumptions, personal therapist style and general therapeutic techniques. Techniques were grouped into cognitive-behavioural and constructivist frameworks by independent raters, and confirmatory factor analysis assessed the extent to which techniques were most consistently identified as belonging to either paradigm. Correlational analyses revealed that rational epistemologies were not significantly correlated with any of the WAI-S subscales; yet constructivist epistemology was significantly correlated with all three subscales of the WAI-S. Furthermore, constructivist epistemology was found to be positively correlated with the Task and Bond subscales of the WAI-S, the latter of which had the strongest correlation. This indicated that constructivist therapists may place more emphasis on therapeutic activities and the working alliance than rationalist therapists when judging the quality of the alliance. Both constructivist and rationalist epistemologies were positively correlated with the Goals subscale on the WAI-S, suggesting therapists of both

epistemologies place similar emphasis on agreed therapeutic aims when assessing the quality of the alliance. This indicates that therapists' epistemic approaches are significantly related to how they judge different components of Bordin's (1979) three constituents of the alliance, as examined by the WAI-S. Specifically, different epistemic approaches do appear to differentiate the importance ascribed to these areas of the alliance. Whilst these findings can arguably be generalised to therapists using many different theoretical models due to the large therapist sample using many different approaches, these findings are limited to the constructs measured by the WAI-S. Additionally, the differences seen in epistemic approaches were compromised by the subjectivity inherent with the process of grouping techniques prior to statistical analysis, and should be interpreted tentatively.

Other studies also explored how therapists' therapeutic orientations impact on their ratings of the quality of the alliance, using contrasting methodologies. In a British postal survey of 491 accredited psychotherapists who used a variety of theoretical approaches, Black et al., (2005) explored the relationship between therapist attachment styles, therapist personality factors, problems experienced in therapy and self-reported quality of the alliance using a modified version of the Agnew Relationship Measure (ARM; Agnew-Davies, 1998).When therapist personality factors were controlled for, anxious attachment scores were negatively correlated with alliance scores, compared to secure attachment scores which were positively correlated with alliance scores. Furthermore, analyses of covariance (ANCOVAs) revealed that when gender was controlled for by being entered as a covariate (where there were proportionately more males than females who identified CBT as their therapeutic orientation), therapeutic orientation had a significant effect on alliance scores. More specifically, this suggested that irrespective of therapist gender, psychodynamic-interpersonal (PI) therapists reported poorer alliances compared to humanistic, cognitive-behavioural (CBT) and cognitive-analytical (CAT)/integrative therapists. Multiple regression analyses confirmed that attachment styles and therapeutic orientations significantly predicted the quality of the alliance and problems in therapy.

Small but significant independent effects of both therapeutic orientation and attachment style on the quality of the alliance suggested that both these factors play an important role in informing how therapists judge the quality of their therapeutic relationships, perhaps through drawing on knowledge associated with their theoretical paradigms and past relationship experiences. The effect size could have been compromised by the varied professional backgrounds of the psychotherapists, and the modifications made to the ARM might have affected its construct validity and reliability. As participants had many years of clinical experience, the above inferences are only generalisable to experienced therapists.

Maintaining a focus on therapists' backgrounds, Hersoug et al., (2001) examined therapist experience and the quality of the therapeutic relationship in a naturalistic study from the Norwegian Multisite Project on Process and Outcome of Psychotherapy (NMSPOP), among 270

clients and 59 therapists from different professional backgrounds. Symptoms, current relationships, past relationships, intrapsychic variables and the alliance were measured (the latter using the WAI; Horvath & Greenberg, 1989) at sessions 12 and 20, and then every 20 sessions thereafter. Therapist professional and personal variables were also measured. Correlational analyses showed that therapists tended to rate the alliance less favourably than clients. Although univariate and multivariate analyses showed that some therapist personal and professional variables did not consistently predict the quality of the alliance, therapist self-reported skill (early on and later in therapy), progress (early in therapy) and training (later in therapy) were significantly positively correlated with therapist-rated WAI scores. Therapist skill was the strongest predictor. This suggested that some therapist personal and professional characteristics had a marked, yet limited impact on their judgment of the quality of the alliance.

There was also an unexpected negative relationship between the amount of therapist professional experience and therapist-rated alliance early in therapy, which indicated that less-experienced therapists rated their alliances as stronger than more experienced therapists. Perhaps experienced therapists were reluctant to rate the alliance favourably in early stages of therapy. However, it is difficult to take these implications on face value, as (i) the therapist and client samples were highly heterogeneous and uncontrolled, (ii) the details of the treatment-as-usual (TAU) were not made available, and (iii) there were no adherence checks for therapist interventions. These issues affected the reliability of findings, and the ease with which the study could be replicated. Whilst strengths included no artificial manipulations and non-manualised treatments being potentially more ecologically valid, the WAI was introduced late in the process for therapists. Therefore, the inferences made about the relationships between the quality of the alliance and both therapist skill and training are only representative of later stages of therapy.

Further exploring the impact of therapist characteristics on the alliance (assessed using the WAI, Horvath & Greenberg, 1989), Heinonen et al., (2014) recruited 333 clients in Finland with anxiety and/or depression to one of four treatments, who were seen by one of 70 experienced, qualified therapists. These comprised short-term solution-focused or psychodynamic therapy, or long-term psychodynamic therapy or psychoanalysis. Data were collected after 3 sessions, and 7 months post-therapy. Numerous therapist characteristics were found to predict early therapist-rated alliance, with fewer characteristics found to predict therapist ratings at follow-up. Similarly to findings by Hersoug et al., (2001), therapist skill predicted early therapist-rated WAI scores. Additionally, higher therapist self-confidence, work enjoyment and positive self-experiences in their personal lives were positively correlated with their ratings of the alliance. Therapist self-rated basic relational skills and efficacious relational manner were also found to predict early therapist-rated WAI scores, particularly in short-term therapies. Therapists' invested relational manner, moderate healing involvement, constructive coping, more experiences of flow, and fewer experiences of (i) anxiety, (ii) boredom and (iii) frequent difficulties also significantly predicted

better therapist-rated WAI scores early on in both long-term and short-term therapies. This suggested that confidence, work enjoyment, perceived competence and a less-dominant relationship style could play important roles in how therapists judge the quality of the therapeutic relationship, alongside therapists' intrapsychic experiences during therapy sessions.

In contrast to Hersoug et al., (2001), this study examined the alliance between different long-term and short-term therapies. Therefore, conclusions about the extent to which therapist factors can explain how therapists judge the quality of the alliance from these studies cannot easily be compared. Furthermore, Heinonen et al., (2014) specify that their data could have been clouded by the different therapeutic models being used across the short- and long-term therapies. The authors also alluded to the possibility of therapist characteristics being related to each other. As such, these findings generalisable to the modes of therapy specified, delivered by experienced therapists to clients with anxiety and/or depression.

Differentially, when exploring the impact of therapists' work involvement in relation to both therapists' perceptions of clients' views of the alliance (using the HaQ; Alexander & Luborsky, 1986), Hartmann et al., (2015) recruited 26 therapists in Germany with various levels of experience, who were working psychodynamically with 98 clients. Clients received treatment in either an outpatient clinic, where they were seen no more than thrice-weekly, or a day clinic, involving twice-weekly individual, group, art and body therapy and contact with clinic staff over a period of 9 months. Data were gathered from 10 sessions from the middle-phases of both outpatient and day clinic therapist-client dyads with up to 12 points of measurement.

Correlational analyses showed that when therapists rated the alliance based on their perception of their clients' views, they significantly underestimated the alliance when clients' actual ratings were high, and significantly overestimated the alliance when clients' actual ratings were low. Compared to client-rated alliance, therapists experiencing high levels of stressful involvement significantly underestimated client-perceived alliances. Therapists who reported experiencing healing involvement significantly overestimated client-perceived alliance. This suggested that therapists' judgments of clients' views of the alliance were skewed significantly in the opposite direction to client-rated alliance. Additionally, therapists' experiences of their own work as either healing or stressful appeared to have contributed to overestimating or underestimating clients' views, respectively.

However, this does not explain what the therapists' own views of the alliance might be, and potential mediating factors can only be applied to therapists' judgments of their clients' views of the alliance. The authors also assumed the clients' views to be true representations of the quality of the alliance, and further explained that a proportion of the variance among the observed divergences could have been due to *"regression to the mean"* (Hartmann et al., 2015, pp.415). Therefore, the findings may not reliably portray a true divergence in views, particularly as the study was uncontrolled, and therapy formats varied between settings. Both the limited statistical power

associated with the exploratory nesting of 98 therapies in 26 therapists during analysis, and the software used for computing the data being unable to account for the nested structure, further constrained the reliability of these findings.

In considering the role of therapist expectations on their alliance ratings, Al-Damarki and Kivlighan (1993) recruited 25 therapeutic dyads in an American university counselling centre (including therapists who were qualified and in-training), to explore both their expectations and judgement of the quality of the alliance. The alliance was measured using the WAI (Horvath & Greenberg, 1989) and all participants completed questionnaires after their third therapy session. Multiple regression analyses revealed that congruence was found between clients' and therapists' ratings on the Goals subtest of the WAI, and no other significant congruence was observed between other WAI subtests. Broadly, this suggested that clients and therapists judge most aspects of the alliance in different ways, excluding agreement on therapeutic goals. As clients' expectations of the relationship were unrelated to therapists' WAI scores, this suggested that therapists may not base their judgment of the alliance on information gathered about clients' expectations for the alliance. However, therapists' expectations of the relationship were seen to significantly correlate with all aspects of therapist WAI scores. Furthermore, therapists rated the alliance as stronger, when (i) therapists had higher expectations of clients' self-disclosure during therapy sessions, and (ii) clients and therapists agreed about the level of self-disclosure.

When therapists predicted the quality of the alliance, the results suggested that congruence between therapist and client expectations of the relationship may be more important than which member of the dyad has higher or lower expectations for the relationship. Furthermore, clients and therapists appeared to arrive at their judgments based on different information. Therapists' perceptions of, and agreement with clients about client-self disclosure also seemed to impact on their judgment of the alliance. Whilst these results only represented therapists' views early in therapy, they can be cautiously generalised to both in-training and qualified therapists, given the small sample size. Furthermore, it was not made clear whether therapists had seen clients' ratings before, or whether clients and therapists were aware of each other's expectations, reducing the transparency of this trend. An indication of this study is that early in therapy, if a therapist has lower expectations about therapy, this could adversely impact on the judgment and possibly the strength of the alliance, which could in turn compromise the quality of therapy.

The following studies were seen to examine the extent to which the most commonly-used measures of the alliance were able to capture how both therapists and clients view the alliance, to establish trends of convergence and/or divergence in views, to add to the current understanding of how therapists assess the quality of the alliance. Hatcher et al., (1995) explored the views of 38 American therapists, who were seeing more than one client in ongoing treatment on a once-, twice- or thrice-weekly basis. The authors used the Revised Penn Helping Alliance Questionnaire (HAq-R; based on Alexander & Luborsky, 1986; Luborsky, Crits-Christoph, Alexander, Margolis, &

Cohen, 1983), Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and California Psychotherapy Alliance Scale (CALPAS; Marmar & Gaston, 1988) to measure therapists' judgement of the quality of the alliance. A monotrait multimethod (MTMM) was used to establish the convergent validity of these measures, to illustrate the extent to which clients and therapists had shared views or whether their individual views differed (unique variance). The MTMM incorporated the views of therapists who had more than one client, using a nested design, which removed the 'typical' impact of a therapist on the alliance, allowing analysis at group and individual levels.

The amount of variance accounted for by individual and shared-view factors suggested that therapists' views appeared to differ from clients' views, which indicates that therapists might draw conclusions about their views of the relationship based primarily on their own views. In particular, whilst shared views were demonstrated by clients' and therapists' scores across the three measures, unique variance of clients' or therapists' views showed that the HAq-R yielded the strongest shared views, and the WAI showed the weakest shared views. This suggested that the HAq-R might be more suitable for measuring the shared view of clients and therapists, given its strong shared-view correlations, whereas the WAI (which appeared to be most representative of the views held by therapists alone) may be more suitable for use with therapist-only samples. While all three measures were grounded in Bordin's (1979) model of the working alliance, the findings implied that clients and therapists differ in how they judge the quality of the alliance.

However, the authors emphasised the possibility of the different phrasing of questions across measures contributing to the variance accounted for by shared-view and unique factors. Further difficulties with reliably generalising these conclusions were inextricably linked with the small sample size of mostly female American therapists, and the lack of information available in the results section about the scores obtained on the measures. Nonetheless, an important indication is the need for more exploration of theories underpinning the structure of measures of the alliance on more heterogeneous samples of therapists, and the authors advocated a multi-measure approach to exploring the quality of the alliance.

Bachelor (2013) followed up the work of Hatcher et al., (1995) in a Canadian study measuring 176 therapists' and 133 clients' ratings of the WAI, the CALPAS and the HAq-II (Luborsky et al., 1996) in conjunction with various outcome measures, among three sites in community mental health or university counselling settings. Exploratory factor analyses (EFAs) assessed data for each measure separately and combined across the three sites, and principal components analyses (PCAs) were conducted separately on clients' and therapists' data to explore the underlying structure of the three alliance questionnaires. Rotated principal factor pattern matrices for therapist samples suggested that therapists view the alliance in terms of four main components, namely the collaborative work relationship, therapist confidence and dedication, client commitment and confidence, and client working ability. Therapist confidence and dedication

contained the most bond-related items across the measures, and was significantly correlated with all therapist outcome ratings. Therapists did not appear to significantly discriminate between the three WAI scales, and instead took a more global view of the alliance, supporting the findings of Tracey and Kokotovic (1989). Similarly to Hatcher et al., (1995), Bachelor (2013) found that therapists associated perceived client improvement and helpfulness with agreement on therapeutic tasks and sharing similar views, based on global alliance scores.

This implied that therapists' views can be captured using a measure that explores: (i) collaboration/agreement over goals, (ii) the bond, (iii) client commitment, and (iv) client working ability, providing clients' views on the alliance are also explored. The strength of these conclusions was somewhat constrained by methodological limitations, including the missing data described in the PCAs, the non-randomised design associated with naturalistic studies, the effects of participants completing repeated measures, and differing levels of therapist experience. However, the clinical indication for seeking both therapy participants' views in order to gain a representative picture of the quality of the alliance is important, as this emphasises that therapists' and clients' views may involve making use of the same information in qualitatively different ways. This could lead to different overall ratings of the alliance.

1.3.2.2 Interpersonal factors. In this review, interpersonal factors are understood to be aspects of the two-way relationship between the client and therapist that are not easily or necessarily tied to either client or therapist alone.

In a Canadian study of 48 therapist-client dyads in settings including private practice, universities or health clinics, Peschken and Johnson (1997) explored the views of 17 therapists, working with between 1 and 6 clients each and 48 clients. Therapists' orientations included psychodynamic, eclectic, systemic and cognitive-behavioural approaches. Both therapists and clients completed the Dyadic Trust Scale (DTS; Larzelere & Huston, 1980) and the Relationship Inventory (RI, Barrett-Lennard, 1962). Clients also completed the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1993) to assess their psychological functioning. Correlational analyses revealed that therapists' ratings of facilitative attitudes did not correlate with clients' ratings of facilitative conditions. Furthermore, therapists' trust in their clients did not correlate with clients' trust in their therapists. This suggested that clients and therapists experienced the relationship differently due to their perceptions of the therapeutic conditions, which might have impacted on their alliance ratings. Therapists' trust in their clients also appeared to be significantly related to both their experience of providing facilitative attitudes, and with their ratings of positive and unconditional regard for their clients. This was particularly important, as therapist-rated positive and unconditional regard on the RI was seen to significantly positively correlate with trust on the DTS, which indicated the extent to which therapists trusted their clients impacted on how they assessed the quality of the alliance.

The pattern of within- but not between-rater correlations of parallel measures may point

towards a degree of rater-bias. It may also be indicative of reliability issues associated with the specific measures used, particularly as the DTS is a modified version of a social psychology measure, which might have lacked construct validity. Furthermore, the RI therapist and client forms were seen to have unrelated items measuring the same variable, the sample size was relatively small, and the time-point at which questionnaires were completed was unreported. These factors markedly limit the extent to which these findings can be reliably generalised, for example, to early or later stages of therapy. However, this highlighted the need for more research in this area, given the potential impact of interpersonal factors in therapists' judgement of the quality of the alliance.

Differentially, Joyce and Piper (1998) conducted a study exploring the views of therapist-client dyads in America over a three-year period, focusing on therapy expectations, quality of object relations[6] (QOR), symptomology and therapy outcomes. Clients from a psychiatric walk-in clinic were matched in terms of gender and age, and were then randomly assigned to immediate or delayed therapy with one of eight project therapists. The final sample included 64 clients, balanced on QOR, treatment condition and therapist. Clients had a mix of mood, anxiety and personality disorders, and received up to 20 sessions of weekly manualised psychodynamic therapy (see Malan, 1976; Strupp & Binder, 1984). The alliance was rated using six 7-point scales, four of which were rated immediately after sessions, and two were rated retrospectively about collaboration and helpfulness (see Luborsky, 1984) after sessions 7, 14 and 20.

Hierarchical multiple regression analyses showed that the higher therapists' expectations were for a therapy session, the less likely sessions would meet those expectations. Therapist-rated alliance was seen to be significantly related to expectancy of usefulness rated immediately after sessions, and expectancy of session comfort was seen to be significantly associated with therapists' reflective alliance scores, rather than with their ratings immediately after sessions. This suggested that the more therapists expected the sessions to be (i) useful in the here-and-now and (ii) comfortable after a period of time, the more likely they were to rate the alliance favourably. Therapists' expectation and experience scores were also more discrepant with clients' more favourable scores, suggesting that therapists' experiences of therapy were less positive than their clients' experiences. As confirmation of client expectancies was seen to be positively correlated with therapists' alliance ratings, this suggested that therapists may take into account unspecified signifiers of clients' expectations being met, when they measured the quality of the alliance.

The difficulties with taking these findings at face value include the complexity of the analyses used, exacerbated by the use of unspecified measures, which may only be applicable to therapists practicing manualised psychodynamic time-limited therapy. The authors also

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[6] 'Object relations' refers to one's ability to relate to others and situations in their adult life, which is informed by early developmental experiences, and is based on object relations theory (see Greenberg & Mitchell, 1983).

acknowledged the development of a more succinct clinical interview since the study took place, which suggested their clinical interviews might not have been the most efficient approach. Whilst there were some controls in sampling methods, the lack of control and/or comparison groups reduced the extent to which these findings can be considered to be specific to the treatment model.

In further exploring therapists' expectations in the aforementioned study by Hartmann et al., (2015), statistical analyses showed that therapists significantly underestimated their clients' perceptions of alliance when clients viewed the alliance favourably, particularly when therapists reported higher levels of stressful involvement. They also significantly overestimated clients' views of the alliance when clients' rated the alliance as weaker, especially when therapists reported more healing involvement. Assuming the clients' views to be representative, this suggested that therapists' views differed markedly from those of their clients. Whilst this study points to the importance of therapists' assessment of their work involvement and stress, it also points to the difficulties therapists may experience in attempting to judge their clients' views, suggesting their experiences of the interpersonal interactions in sessions could be markedly different.

Notably, this study presents therapists' judgement of clients' views of the alliance and does not provide insight into their own views of the alliance per se, and its generalisability is limited to the modes of therapy specified. It is, however, possible that therapists' views of their clients' perspectives could inform how therapists' assess the quality of the alliance. Yet, the reliability of these findings was compromised by previously highlighted statistical issues, including confounding variables being present, statistical models reducing statistical power, and analytic software used being potentially unsuitable for the analyses employed.

In an extension of an American study by Peasale, Hilensroth and Owen (2012), Kivlighan, Marmarosh and Hilensroth (2014) recruited 74 clients engaged in open-ended psychodynamic therapy on a once or twice-weekly basis with 29 Trainee Clinical Psychologists[7]. Symptoms, experiences of sessions and the alliance were measured, the latter of which was captured using the client version of the Combined Alliance Short Form (CASF-P; Hatcher & Barends, 1996) and the therapist version of the WAI (WAI-T; Horvath & Greenberg, 1989). Actor-partner (therapist-actor and client-actor) effects were analysed, using path analysis within a structural equation modelling framework. This showed that therapists' alliance ratings were positively correlated with session smoothness and positivity. Additionally, therapist-actor effects (associations between therapists' session evaluations and therapists' alliance ratings) were seen to be significantly related to ratings of both session smoothness and positivity. A degree of divergence was seen between therapists' and clients' views, where their alliance ratings were significantly associated with session smoothness and session depth, respectively. There was also some convergence, where both clients and therapists' alliance ratings were associated with session positivity. This suggested that the

[7] Trainee Clinical Psychologists will hereon in be referred to as Trainees.

extent to which the therapist experienced the session as running smoothly and being a positive experience impacted on how they judged the quality of the alliance.

This implied that therapists appear to use different aspects of the interpersonal experiences in sessions to inform their views on the quality of the alliance. However, these conclusions should be drawn cautiously, as variability in the number of treatment sessions could account for the variability in clients' outcomes. Furthermore, the model fit statistics were not reported due to the Actor-Partner Independence Model (APIM; see Cook & Kenny, 2005) being saturated. Additionally, all variables were mean-centred prior to interaction terms being created during analysis, and therapists were not modelled in the main analysis because therapist variance was significant in only one rating of the SEQ (Stiles, 1980). Therefore, further research is needed to substantiate the statistical power underpinning these findings.

1.3.2.3 Client factors. In this section, factors specifically related to clients or client attributes that appear to be related to how therapists judge the quality of the alliance will be discussed.

In the aforementioned study by Hersoug et al., (2001), the authors also explored how clients' personal variables, such as interpersonal difficulties, introjects, past relationships and values were associated with therapist alliance-ratings. Interpersonal problems and introjects were negatively correlated with the therapist-rated alliance both early and later on in therapy, but this was unsubstantiated in the multivariate analyses. In both univariate and multivariate analyses, whilst therapist and client value similarity were found to be unrelated to therapist-rated alliance, clients' past relationships were positively correlated with therapist alliance ratings. This suggested that therapists were more likely to rate the alliance unfavourably with clients who had more interpersonal problems and higher introject scores.

Using the same study design, sample and measures as Hersoug et al., (2001), Hersoug et al., (2002) explored client diagnoses and client object relationship data in relation to alliance scores after 3 and 12 therapy sessions. The low-moderate correlations between clients' and therapists' alliance ratings suggested that clients and therapists view the alliance differently, where therapists rated the alliance more negatively than clients, particularly during earlier stages of therapy. The only predictor significantly associated with client- and therapist-rated alliance was the 'cold' dimension of the IIPC, which were negatively correlated. In both univariate and multivariate analyses, therapists tended to rate the quality of the alliance as better when the client had higher dynamic intrapsychic variables (DIS) scores. Therapists also rated the alliance more favourably when clients had better global functioning and fewer symptoms. This suggested that therapists perceived their relationships as stronger with clients who were higher-functioning, had more insight, higher tolerance for emotions, better problem-solving abilities and who were more psychologically healthy. This also indicated that, not only did clients' diagnoses impact on this process, but how clients coped and managed their mental health also appeared to play an important

role in how therapists assessed the quality of their relationships.

However, the conclusions drawn from the studies by both Hersoug et al., (2001) and Hersoug et al., (2002) should be drawn tentatively, as these findings did not account for therapist factors that might have been involved in making judgements about the quality of the alliance. Additionally, with the exception of the 'cold' dimension of the IIPC, different predictors were seen to be significantly related to clients' alliance ratings, suggesting again that clients and therapists judged the quality of the alliance in different ways. Methodological issues also constrained the generalisability and reliability of these results, due to the naturalistic design having few controls, the higher attrition rates with the alliance ratings, the lack of adherence checks for therapist interventions and the sample being heterogeneous. Therefore, it is difficult to know how applicable these findings are to therapists working with more specific clinical populations.

In another previously reported study, Bachelor's (2013) exploration of therapists' and clients' views of the alliance using the WAI (Horvath & Greenberg, 1989), HAqII (Luborsky et al., 1996) and CALPAS (Marmar & Gaston, 1988) showed that some therapist and client factors were significantly correlated. These included the collaborative work relationship (therapist factor) being correlated with active commitment (client factor). Therapists also appeared to associate sharing similar views and agreeing with clients with their perception of client improvement and perceived helpfulness. Client commitment and confidence, and client working ability were significantly related to therapist-rated alliance. This highlighted the importance of therapists' perceptions of clients' contributions to therapeutic encounters. It also suggested that despite the limitations of the study design and generalisability, awareness of these factors is important, as they could determine how therapists perceive the alliance, which could subsequently impact on the quality of therapy.

1.3.3 Summary of findings. A number of therapist factors were significantly positively correlated to with therapists' alliance ratings. These included therapist self-rated confidence and dedication, therapists having shared views with their clients, therapist-perceived client improvement (Bachelor, 2013; Hersoug et al., 2001); therapists expecting more client self-disclosure (Al-Damarki & Kivlighan, 1993), and therapists experiencing less stressful involvement in therapy provision (Hartmann et al., 2015). Additionally, therapists perceiving themselves as more competent (Heinonen et al., 2014; Hersoug et al., 2001), and therapists enjoying their work and engaging in a less-dominant relationship style (Heinonen et al., 2014) were also positively correlated with therapist-rated alliance. Lastly, therapists having secure attachment styles (Black et al., 2005); constructivist epistemologies (Lee et al., 2013), and more therapist training (Hersoug et al., 2001) also predicted stronger therapist-rated alliances.

Some interpersonal factors were also significantly associated with therapists' assessments of their alliances. Having more trust in clients and the presence of facilitative therapeutic conditions (Peschken & Johnson, 1997) , having lower expectations for the therapeutic alliance and encounters (Joyce & Piper, 1998), having positive experiences of work involvement (Hartmann et

al., 2015), and perceiving increased session smoothness and positivity (Kivlighan et al., 2014) were significantly positively correlated with stronger alliances.

A number of client factors were also positively associated with therapists perceiving better alliances, namely the client having fewer interpersonal problems and lower introject scores (Hersoug et al., 2001), the client having more insight, higher tolerance for emotions, better problem-solving abilities and global functioning and fewer symptoms (Hersoug et al., 2002), and clients having increased levels of perceived commitment, confidence and working ability (Bachelor, 2013).

Similarly to Zilcha-Mano et al., (2015), this review identified trends of therapists rating the alliance less positively than their clients, and therapists and clients using different approaches to rating the alliance and client factors (such as symptom presentation) impacting on therapists' ratings of the alliance. As therapists' alliance ratings were associated with clinical outcomes, Zilcha-Mano et al., (2015) suggest that it is imperative for therapists to identify therapeutic ruptures. This echoes earlier research, where many therapist attributes and techniques have been shown to predict the quality of the alliance (e.g. Accurso & Garland, 2015; Ackerman & Hilensroth, 2001, 2003; Crits-Christoph, Barber & Kurcias, 1993; Ligiéro & Gelso, 2002; Merten, 2005; Nissen-Lie, Havik, Høglend, Monsen & Rønnestad, 2013; Norcross & Hill, 2004).

A number of studies that recruited and measured the views of both therapists and clients also concluded that based on the data gathered, clients and therapists appear to either (i) use different sources of information, or (ii) perceive the same information differently when making an assessment about the strength of the therapeutic relationship (for example, Al-Damarki & Kivlighan, 1993; Hatcher et al., 1995; Hersoug et al., 2002; Kivlighan et al., 2014). Whilst this review did not have the capacity to review clients' views due to the constraints of directly answering the research question posed, this last notion is important when considering how therapists assess the quality of the therapeutic relationship. This is particularly pertinent when considering how to measure therapists' and clients' views concurrently. Different approaches may be needed to accurately capture and represent these views when attempting to build a comprehensive view of the quality of idiosyncratic therapeutic relationships.

1.4 Discussion

The majority of reviewed studies appeared to focus on therapist characteristics, leading to *1.3.2.1 Therapist factors* being a disproportionately larger section than either *1.3.2.2 Interpersonal factors* or *1.3.2.3 Client factors*. This was an interesting observation, as there have been previous reports of a bias in the existing literature focusing predominantly on the impact of client factors views of the alliance (e.g. Satterfield & Lyddon, 1995; Mallinckrodt, 1991). This suggests that despite a lack of coherence in research foci, perhaps this trend is linked with the nature of the search process during this review. Alternatively, it could point to the prominence of client factors in how therapists measure the therapeutic relationship, as this still was a clearly demarked narrative

within the literature focusing on therapists' perspectives.

The lack of focus on therapist attachment styles or traits[8] among the included studies was notable, given the importance and impact of experiences of early relationships on future relationships (Bowlby, 1988; Collins, 1996), and in particular, on the development of the therapeutic alliance (see Orlinsky, Grawe & Parks, 1994, and Roth & Fonagy, 1996). Whilst the alliance can depend on the client's attachment style and what they bring to the therapeutic encounter (Horvath, 1994; Luborsky, 1994), Beutler (1997) emphasises the need for an equal research focus on therapists' attachment styles. This is of particular relevance, as client attachment styles have been found to be associated with the responses of therapists during pivotal moments in therapeutic encounters (Hardy et al., 1999).

However, this trend in the review is partly due to a number of studies on therapist attachment being retrieved during the literature searches, but only one article by Black et al., (2005) being included, as the other articles did not describe how therapists measured their therapeutic relationships and were therefore deemed not relevant. Furthermore, there is a distinct lack of theoretical clarity: whilst most studies using psychometric tools favoured the WAI compared to other established measures, some studies adapted measures and did not specify how they conceptualised or defined the therapeutic alliance. Moreover, the findings about how the therapeutic alliance was measured did not point to one particular theory (e.g. Bordin, 1979) or coherent definition (e.g. Elvins & Green, 2008), and most studies appeared to be atheoretical.

Many difficulties were encountered in reliably and consistently reporting patterns in the data due to methodological limitations associated with individual study designs. Inevitably, the studies constituted a highly variable data set. Some studies had an overly technical focus, particularly with regard to philosophical or epistemic positions and statistical techniques, compromising the extent to which findings could be) readily understood and easily replicated. Some studies favoured subjective writing styles, others had linguistic or formatting errors, and some had omitted data or particulars of the study design. Whilst some statistical analyses were clearly planned and grounded in evidence-based hypotheses, some analytic approaches seemed data-driven, and others featured speculative discussions about potential meanings of findings not grounded in the evidence-base, clouding the actual data.

Additionally, during the quality assessment process, both observational and experimental studies had scores that ranged by 7 and 8 points, respectively. This suggested there was a notable amount of variation in the quality of studies included, but cut-off scores were not used as the STROBE Guidelines was not a formal quality assessment tool. Furthermore, challenges were encountered in scoring studies due to the high variation in reporting clarity, transparency and style.

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[8] Bowlby's (1988) attachment theory describes the extent to which an individual's pattern of interacting with or relating to others can be seen as insecure, secure, ambivalent or avoidant (see Black et al., 2005).

Therefore, some studies obtained lower scores as it was not possible to determine the presence or absence of a particular quality criterion, suggesting the study's reporting style was of lower quality, when compared other studies with similar scores where it had been possible to ascertain if all quality criteria had been met. As such, it is important to acknowledge the range in quality of the included studies, which may affect the extent to which conclusions can be reliably drawn and confidently generalised.

1.4.1 Review limitations. There are an inherent number of limitations within this review. Firstly, whilst all reported results were statistically significant at a minimum level of .05, each level of statistical significance was not referred to in the review. This is because power calculations or standardised effect sizes were often unreported or unclear, and some studies inconsistently made use of Bonferroni corrections where low statistical power was identified (see Nakagawa, 2004). It is therefore difficult to determine the extent to which the data support the claims made by the research, thereby making the strength of clinical and research implications questionable.

Secondly, the reviewed articles were limited to those published in English in order for them to be read and understood. Therefore, this review contains elements of (i) dissemination bias as it includes only articles published in English, and (ii) publication bias[9], as it only includes published peer-reviewed studies with significant findings, where studies with significant findings are more likely to be published (see Song, Hooper & Loke, 2013). Despite these biases being non-intentional, they do mean that the literature included in this systematic review may be markedly different from, or unrepresentative of the literature in this area that does not meet the above criteria. They were also constrained by the timeframe within which the search was performed, where further studies could have emerged between when the search was performed and when this review was written. Thirdly, the retrieved literature is specific to the search terms used, which might have been overly inclusive of articles referring to conceptually distinct phenomena, yet bounded to those explicitly referring to these terms in the article titles. For these reasons, this review is not exhaustive.

Fourth, there are difficulties in directly generalising the overall themes among the findings into clinical practice. This is owing to the pool of naturalistic, partially controlled and survey research. The latter meant that therapists' reflections on their clinical work had taken place outside the study, therefore limiting the extrapolation of these findings. Attempting to compare a variety of alliance measures - some of which have been adapted - also amplifies the issues with construct validity underlying the studies' findings. There are inevitable biases and difficulties in comparing studies involving therapists providing psychotherapeutic interventions to consenting clients, due to the range of treatment lengths, therapeutic modalities, clinical populations, settings, therapist

[9] Song, Hooper and Loke (2013, pp.71) explain publication bias as occurring *"...when results of published studies are systematically different from results of unpublished studies"*.

backgrounds and psychometric tools used to capture elements of the treatment process and the alliance. Most populations recruited also largely excluded clients with severe psychiatric difficulties such as organic disorders, psychosis and addictions.

Furthermore, in this review, there appeared some sampling biases. For example, some study samples were of qualified professionals (n=7), and many studies included different types of therapists, such as psychiatrists, social workers, nurses, psychotherapists and psychologists. Other studies included a mix of qualified and in-training therapists (n=4), and one sample was of trainee clinical psychologists exclusively. Therapist samples appeared to be predominantly female, where percentages of male therapists ranged from 16% to 58%. Furthermore, most samples that reported therapist ethnicity (n=3) showed that the vast majority of therapists were Caucasian (ranging from 84%-97%).Three studies did not include client samples, and 10 studies reported only some client demographics. Trends among the described client samples included being: (i) largely Caucasian (n=3); (ii) predominantly female (n=10), and (iii) educated in college and/or university (n=5). Clients with organic conditions, substance use disorders, learning disabilities and psychotic disorders were excluded. Lastly, some studies recruited therapists working with clients in university settings (n=6), which could indicate a socioeconomic bias in the findings, given that university samples may consist of students from economically advantaged background due to universities often charging costly tuition fees. This presents significant challenges when attempting to generalise findings.

Fifth, the articles reviewed were entirely quantitative; therefore, this review cannot account for qualitative data on how therapists measure their alliances (e.g. Hill, Nutt-Williams, Heaton, Thompson & Rhodes, 1996; Jones, 2013; Kothari, Hardy & Rowse, 2010). This is because only the quantitative articles were relevant and had sufficient scientific rigour to be included in this review. Additional biases attributable to reviewing solely quantitative studies include utilising differing effect sizes and moderators (see Horvath et al., 2011); encountering multiple methodological confounds (see Elvins & Green, 2008); the *"halo effect"*[10] (Horvath et al., 2011, pp.14), and correlations being the predominant method of statistical analyses, making inferences of causality largely impossible.

1.4.2 Implications for future research. Although there are a number of limitations associated with this review, the findings both within and across studies have a number of important implications for future research. The quantitative bias in the literature measuring the quality of the alliance - possibly compounded by the many alliance measures available - emphasises the strong need for more qualitative research. This notion is advocated by Elvins and Green (2008),

[10] The *"halo effect"* (Horvath et al., 2011, pp.14) refers to the methodological issue in alliance-outcome research, where the therapeutic alliance data and clinical outcome data are both sourced from the same individual, which may falsely increase the strength of the association between the therapeutic alliance and the clinical outcome.

particularly as the evidence base does not appear to coherently explain *how* therapists measure the alliance. Qualitative exploration may allow examination of (i) issues at both the micro- and macro-levels, (ii) go beyond articulating the quality of the alliance in quantitative ways, and (iii) explain how therapists assess this phenomenon without relying on psychometric measures. Whilst more qualitative research is needed, further quantitative research in this field is also warranted due to issues with the sensitivity of psychometric measures, and the possible interactions between techniques, client engagement and alliance in relation to outcome (Hill, 2005). Alternative quantitative approaches measuring the alliance may benefit from having clearly defined stages of therapy, alongside different types of therapy outcomes (Hill, 2005). These could include clients' and therapists' perspectives on clinical outcomes, as well as looking at symptoms, distress, quality of life and other subjective measures (Hill, 2005).

Considering the findings being based on both qualified and unqualified heterogeneous samples, it is important to add to the literature on therapists at different levels of training, particularly as Stein and Lambert (1995) found a trend in their meta-analysis suggesting that therapists in outpatient settings who have more training had lower dropout levels from treatment and better clinical outcomes, compared to therapists with less training. If good alliances are associated with better clinical outcomes, and outcomes are positively correlated with therapist training, then it is especially important to explore how therapists with less training measure the alliance, as this could be an important factor in determining clinical outcomes. Furthermore, this may have implications for developing therapist training, as this is the easiest way to improve the alliance outside of focusing on promoting client motivation (see Hill, 2005).

1.4.3 Conclusions. The weight of findings from the vast range of past research is somewhat hindered by both the complexities associated with the multiple definitions of the alliance. The multitude of measures available makes drawing inferences more complex, as these may not be measure or describe the same phenomena. This is further compounded by the diverse and largely uncontrolled research exploring heterogeneous groups of therapists' views on the quality of their therapeutic relationships. Furthermore, as randomised controlled trials (RCTs) are difficult to conduct in psychotherapy outcome research, there is no straightforward solution to overcome the methodological limitations described. Lastly, in the studies reviewed, it is not possible to establish cause and effect owing to corrrelational designs employed, and there is a distinct lack of conceptual cohesion in the literature around both defining and measuring the quality of the therapeutic alliance.

Whilst some research has shown disagreement between therapists' and clients' alliance ratings (e.g. Fitzpatrick, Iwakabe & Stalikas, 2005; Heinonen et al., 2014; Meier & Donmall, 2006), a fairly consistent pattern of therapists assessing the alliance less favourably has been established (e.g. Clemence et al., 2005; Ogrodnuczuk, Piper, Joyce & McCullum, 2000; Zilcha-Mano et al., 2015). Patterns of divergence established could represent the minutiae of differences

within and between therapist-client dyads, secondary to therapeutic idiosyncrasies or particulars of study designs. Patterns of convergence could highlight important factors to explore further, to examine whether future research supports these findings, and the non-specific alliance factors shared by most therapeutic modalities.

Whilst observational or survey research is advantageous in being able to capture pictures of therapists' overall therapeutic alliance, drawing strong generalisable conclusions confidently and reliably can be problematic, as they do not portray idiosyncratic therapeutic alliances, which can be highly heterogeneous. In experimental studies, the essence of clinical work in action can be captured to an extent, and the nature of individual therapeutic alliances can be exemplified, However, this can be constrained by whose view is captured (e.g. the therapist, the client or the rater/observer), meaning that it is challenging to obtain a fully representative picture of the quality of the alliance. Both types of research designs are further complicated by the plethora of psychometric and qualitative approaches to measuring the quality of the alliance, making reliable and valid comparisons almost impossible. As such, the picture of how therapists understand the quality of their therapeutic relationships has many inconsistencies and a distinct lack of clarity.

For these reasons, this systematic review of the literature provides a platform for future research into: (i) how therapists judge the quality of the alliance; (ii) how trainee therapists assess the alliance in clinical practice, and (iii) exploring this phenomenon qualitatively. This may avoid limiting findings to objective tools that could be measuring different constructs, and might allow some insight into the fascinating processes that occur when therapists are reflecting on and assessing their therapeutic relationships.

Chapter 2 – Empirical Paper: A Qualitative Exploration of How Trainee Clinical Psychologists Judge the Quality of Therapeutic Relationships in Clinical Practice in the UK

2.1 Introduction

2.1.1 Background. The concept of the therapeutic relationship is both complex and dependent on the robustness of its definition (Elvins & Green, 2008). Whilst the interpersonal processes occurring between the therapist and client during therapy sessions have been referred to as the therapeutic alliance (Kozart, 1996), the *"treatment alliance"* (Elvins & Green, 2008, pp.1168) or the working alliance (Raue & Goldfried, 1994). However, each author offers a different distinction. Kozart (1996) explains that the therapeutic alliance occurs independently of therapeutic goals, and Elvins and Green (2008) state that the treatment alliance exists independently of the therapeutic model being applied. Raue and Goldfried (1994) further articulate the working alliance as occurring in the wider context of the therapeutic relationship.

The therapeutic relationship may be considered to contain both the therapeutic model being used and the therapeutic alliance - that is, the interpersonal processes that occur during sessions which are unrelated to therapeutic goals. It is therefore difficult to use these terms interchangeably. As such, the use of the term 'therapeutic relationship' throughout this paper will be used to encompass both of these phenomena.

2.1.2 Evolution of the 'therapeutic relationship'. Sigmund Freud was first to refer to the therapeutic alliance within talking therapies (Baldwin, Wampold & Imel, 2007), when describing the process of transference[11] from the client to the therapist during therapeutic encounters (Freud, 1912/1958; Priebe & McCabe, 2006). Thus, the roots of the concept of the therapeutic alliance are grounded in psychoanalytic thinking (Horvath & Luborsky, 1993). Zetzel (1956) later explicated that the therapeutic alliance was determined by the client's capacity to cope with the transference being analysed during psychoanalysis. Differentially, Rogers (1957) felt the client's experience of core conditions from the therapist – unconditional positive regard, congruence and empathy, both defined and determined the therapeutic alliance in humanistic therapy.

A further difference in understanding the concept of the therapeutic alliance was Greenson's (1965) notion of the alliance being what the client and the therapist brought to the interaction. Bridging the gap between psychoanalytic foundations and humanistic traditions, Bordin (1979) specified that, unlike Freud's concept, the working alliance was a phenomenon positioned within the therapeutic relationship that was primarily conscious, given the capacity for clients' past relationships to affect the therapeutic relationship early on in therapy. Like Greenson (1965), Bordin (1979) felt the therapeutic alliance was a two-way process between the therapist

[11] Transference can be defined as *"...the phenomenon whereby we unconsciously transfer feelings and attitudes from a person or situation in the past on to a person or situation in the present,"* (Hughes & Kerr, 2000, pp. 58).

and client. In particular, Bordin (1979) identified three key features, namely agreeing on therapeutic goals, assignment of therapeutic tasks and building a therapeutic bond.

The above definitions are not exhaustive of those currently available, given various adaptations for different therapeutic models, for example, in cognitive therapy (e.g. Raue & Goldfried, 1994) and humanistic-existential fields (Stevens, 1996). It is clear from the literature that a singular definition does not exist and conceptualising the therapeutic relationship is inherently complex (Norcross, 2001). This may be associated with the different therapeutic models and schools of thought available (Gaston et al., 1995; Horvath, 2000; Strupp, 2001; von Braun, 2013).

Although it is difficult to compare heterogeneous studies exploring the therapeutic relationship (see Stiles, Shapiro & Elliot, 1986), Kozart (1996) explains that the quantitative literature using psychometric measures suggest that the therapeutic alliance may be better understood as the unique intertwined experience between the client and therapist occurring autonomously, rather than tied to therapy goals. Perhaps most clearly, Henry, Schacht and Strupp (1990, pp.768) state that:

"Stripped of technical jargon, psychotherapy may be seen in one context as simply a structured relationship between two people".

2.1.3 The relationship-outcome link. The processes and experiences that are understood to occur between therapists and their clients have been increasingly credited with facilitating change that takes place in therapy (Bordin, 1979) and improving clinical outcomes (see Krupnick et al., 1996; Priebe & McCabe, 2006). It is known that aspects of a good therapeutic relationship include the therapist being flexible, honest, respectful, trustworthy, engaged, warm, and confident (see Ackerman & Hilensroth, 2003; Lambert & Barley, 2001). Whilst research has explored both therapeutic techniques and interpersonal variables that might contribute to this link, Hilensroth, Peters and Ackerman (2004) emphasise the need to look at both therapist and client perspectives on the quality of the therapeutic relationship to further develop the understanding of this phenomenon.

Most literature exploring both clients' and therapists' views point to a pattern of therapists rating the quality of the therapeutic relationship less favourably than their clients (e.g. Fitzpatrick et al., 2005; Heinonen et al., 2014). Therapists' ratings of the therapeutic relationship have also been shown to be significant predictors of clients' outcomes (Baldwin, Wampold & Imel, 2007; Zilcha-Mano et al., 2015). Additionally, Zilcha-Mano et al., (2015) found both that therapists' ratings of the therapeutic relationship was affected by clients' symptom severity, and their respective ratings appeared to measure different aspects of the therapeutic relationship, substantiating earlier findings by Horvath et al., (2011). Whilst most studies point to an association between the therapeutic relationship and clients' clinical outcomes (e.g. Ardito & Rabellino, 2011), few studies have been able to consistently explain (i) *why* this happens and (ii) the mechanism of

action underlying change and improvement in client wellbeing as a result of having a good therapeutic relationship with the therapist (Kazdin, 2008; Latchford, 2010).

2.1.4 The associations between therapist training and outcomes. A meta-analysis of therapy outcome studies showed that varying outcome studies were linked with a moderate effect size in favour of therapists who had more training, and that therapists who had more training experienced fewer clients discontinuing therapy in outpatient settings (Stein & Lambert, 1995). This has also been observed in trainee therapist populations (e.g. Kolb, Beutler, Davis, Crago & Shanfield, 1985), and refuted by a more recent study, which found no difference in therapist effectiveness measured by clients' clinical outcomes in a comparison of Trainee Clinical Psychologists[12] and qualified clinical psychologists (Buckley, Newman, Kellett & Beail, 2006).

Other studies have established an association between trainee therapists' skills and the quality of their therapeutic alliances (e.g. Crits-Christoph et al., 1993; Grace, Kivlighan & Kunce, 1995; Mallinckrodt & Nelson, 1991; Safran & McMain, 1990; Weiden & Harvens, 1994). However, therapist experience was not found to be consistently positively associated with therapeutic goals, bond and task assignment within Bordin's (1979) model of the working alliance (Mallinckrodt & Nelson, 1991).

2.1.5 Issues in the evidence-base. There are a number of possible explanations for the disparity in the literature, including multiple definitions of the therapeutic relationship being tied to a variety of psychometric measures purporting to measure the therapeutic relationship (Elvins & Green, 2008); the discrepancies in research methodologies exploring this phenomenon, and the variation in perspectives measured e.g. the therapist or the client (Horvath et al., 2011). For example, some studies account for both therapist and client perspectives (e.g. Bachelor & Salamé, 2001), whereas others focus only on clients' ratings of the therapeutic relationship (e.g. Stiles et al., 2004). Furthermore, the use of single or multiple measures and the inherent differences in reliability and validity of different instruments may also contribute to some of the divergence in the literature (Elvins & Green, 2008).

There are additional biases in the research: firstly in favour of quantitative measures of the therapeutic relationship, as these might measure different aspects of the same construct or completely different constructs depending on the psychometric tool used. Secondly, research findings from therapist-client dyads might be impacted by the *"halo-effect"* (Horvath et al., 2011, pp.11). Thirdly, the evidence-base focuses predominantly on samples of qualified therapists (e.g. Hersoug et al., 2001, 2002), and shows some discrepancies in the few studies including Trainees, meaning less is understood about the therapeutic relationships of trainee therapists. As Bennett-Levy (2006, pp.58) states,

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[12] Trainee Clinical Psychologists will hereon in be referred to as Trainees. Other lowercase references to trainees refer to trainee practitioners of other disciplines, for example, trainee psychotherapists.

"Clearly the training of psychotherapists is an important issue, because the value of psychotherapy research and new practices is limited if its product is being ineffectively disseminated by psychotherapy trainers."

These issues mean there are difficulties with reliably inferring that the evidence-base accurately represents both clients' and therapists' views of the therapeutic relationship, and in the capacity of researchers to draw conclusions about both convergence and divergence in both parties' views. Furthermore, there are difficulties in comparing studies that measure distinct aspects of the therapeutic relationship, for example, the working alliance referring to the work-related features of the relationship and the real relationship pointing to the personal relationship aspects (see Gelso, 2011).

2.1.6 The present study. Research into conceptualising and measuring the therapeutic relationship that explores beyond common relationship difficulties is needed, to (i) identify ways in which the quality of therapeutic relationships can be improved and (ii) increase the likelihood of positive clinical outcomes for clients (Kozart, 1996). Elvins and Green (2008) emphasise the need for different approaches to explicate what mechanisms are involved in the treatment alliance, and suggest that qualitative approaches may facilitate the development of ideas around how these mechanisms work. Furthermore, many studies that have explored the therapeutic relationship have used measures that do not explain how clinicians understand or measure the quality of the therapeutic relationship without using psychometric measures (see Kazdin, 2008). The present study was designed to attempt to research this area qualitatively, to provide an alternative approach to explaining how therapists measure the quality of their therapeutic relationships, in a unique population.

Trainees were selected for the sample for the following reasons. Firstly, only research involving American Trainees was retrieved in this field, where training programmes differ substantially from training in the United Kingdom (UK; see Kivlighan et al., 2014 and Kurcias, 2000); thus pointing to a marked gap in the literature, particularly in the UK. Secondly, findings could also potentially identify useful approaches for developing competencies in Clinical Psychology training programmes in the UK, when Trainees are learning about the therapeutic relationship (see Latchford, 2010). This is particularly important, given the links between therapeutic relationships and clinical outcomes (Lambert & Barley, 2001) and the diverse theoretical and contextual approaches endorsed by UK course centres (see Buckman & Barker, 2010).

2.1.7 Aims. Upon embarking on this project, the researcher did not aim to construct a new model of the therapeutic relationship or alliance. Rather, the main research aim was to explore how Trainees understand, make use of and measure the quality of the therapeutic relationship alone, irrespective of outcome, and contribute to the sparse literature in this field. The secondary aim was to explore any common themes and subthemes that could paint a picture of the salient aspects of

how therapeutic relationships are understood, managed and measured, to develop the current understanding of these phenomena in this population.

A third aim was to consider how this information could be used to support the continuous development of training programmes in Clinical Psychology in the UK in their efforts to help Trainees build their competencies in managing their therapeutic relationships in clinical practice, to continue contributing towards improved clinical outcomes, as advocated by Summers and Barber (2003). A final aim is for the data gathered in this study to support future research into the conceptualisation and measurement of the therapeutic relationship, especially given the established link with clinical outcomes.

2.1.8 Research questions. The main question being posed by this research project was: *how do Trainees understand the therapeutic relationship*? A second research question was: *how do Trainees measure the quality of their therapeutic relationships in clinical practice?*

2.2 Method

2.2.1 Research design. This research project qualitatively explored how Trainees - with at least six months' experience on a Clinical Psychology training programme in the UK - understood, measured the quality of and managed therapeutic relationships with their clients in their clinical practice. Qualitative analysis was selected to support the examination of participants' attitudes, behaviours, thoughts and beliefs in the context of their reported experiences (Patton, 2002).

2.2.2 Ethical approval. Ethical approval was sought from and granted by the University of Southampton (see Appendix G; ERGO Study ID number: 12850), confirming that the research complied with the ethical and research governance principles endorsed by the University of Southampton and by the British Psychological Society (2010). Informed consent was sought, no deception was used, participants were able to withdraw at any time, participants were provided with a debriefing sheet, and all data was anonymised to preserve participants' confidentiality.

Data was gathered from participants using iSurvey, a secure encrypted online survey generation and research tool run by iSolutions[13], preventing third party interception and protecting the anonymity and confidentiality of participants. Electronic data was stored on university password-protected computers and hard copies of data were stored in a locked filing cabinet. All documents were password-protected on secure university computers and all data will be destroyed within five years of the research being completed.

2.2.3 Recruitment. Following the confirmation of ethical approval from the University of Southampton's Ethics Committee for this research project, the iSurvey website was set to 'live' to enable data collection following participation.

The programme directors of all course centres running Doctorates in Clinical Psychology in the UK (n=30) were emailed a standardised email, including confirmation of ethical approval

[13] iSolutions is the University of Southampton's Information Technology Service.

and a request for their dissemination of a self-selecting standardised recruitment email to Trainees from all three years of their Clinical Psychology training programmes (see Appendix H). A response rate of 10-20% was assumed (see Deutskens, De Ruyter, Wetzels & House, 2004).

The recruitment email included information about offering all participants the opportunity to opt into a prize draw, where eight participants would be drawn at random to win a £50 Amazon voucher each[14]. Participants also had the opportunity to supply their email address if they wished to receive a summary of the research at the end of the project. The website remained live for 4 months after the initial recruitment emails were sent, to allow participants sufficient time to participate, and to avoid keeping the website live unnecessarily, when no more participants were completing the survey.

For course centres who did not reply initially (n=7), up to two further follow-up emails identical to the initial email were sent after 1 and 2 months, from the date of the first email, respectively. Some course centres granted permission immediately (n=18); others referred it to internal ethics committees (n=2); 7 course centres did not reply to initial or follow up emails, and 3 course centres declined participation either without specifying a reason (n=1) or due to only circulating internal university research (n=2). In total, 20 course centres took part in the research (see Appendix L), of which one course centre chose to print a poster of the recruitment email rather than circulating it, and 10 course centres did not participate (33.33%). Therefore, the overall course centre response rate was 66.67%.

A total of 71 participants took part in the survey, of which 57 (80.28%) were complete and the remaining 14 (19.72%) were incomplete. The decision was made to include the data, as the questions completed contained of qualitative information which would have been unethical to discount, and excluding these participants would have taken away their voices despite them contributing to the research data (see Braun & Clarke, 2006).

2.2.4 Participants. The sampling method was purposive, as inclusion criteria meant that all participants had to be on a registered NHS-funded Doctorate in Clinical Psychology in the UK with a minimum of 6 months' clinical experience on their training programmes. The latter inclusion criteria was applied to allow participants to reflect on their clinical work as the questionnaire schedule was focused on their clinical experience, and the researcher was aware that not all Trainees would be commencing training with a clinically-orientated background. For example, some participants may have had only research experience prior to their clinical training. However, it is acknowledged that this may affect how participants reflect on their clinical experience as they may only have 6 months' of clinical practice to consider, which may be markedly different from other participants who may have many years' experience of offering

[14] Eight Trainees were randomly selected using a number generator website (www.psychicscience.org), which was witnessed by the researcher's research supervisor, and the Trainees were emailed electronic Amazon vouchers immediately after the prize draw took place in July 2016.

psychological therapies. However, this decision was made in order to gain an accurate representation of a diverse cohort, and to avoid excluding participants in their first year, who may have a lot of clinical experience. No other exclusion criteria were applied. As 20 course centres took part, the maximum number of potential respondents was 1,195[15]. The sample of 71 participants meant that the overall response rate from participating course centres was 5.94%.

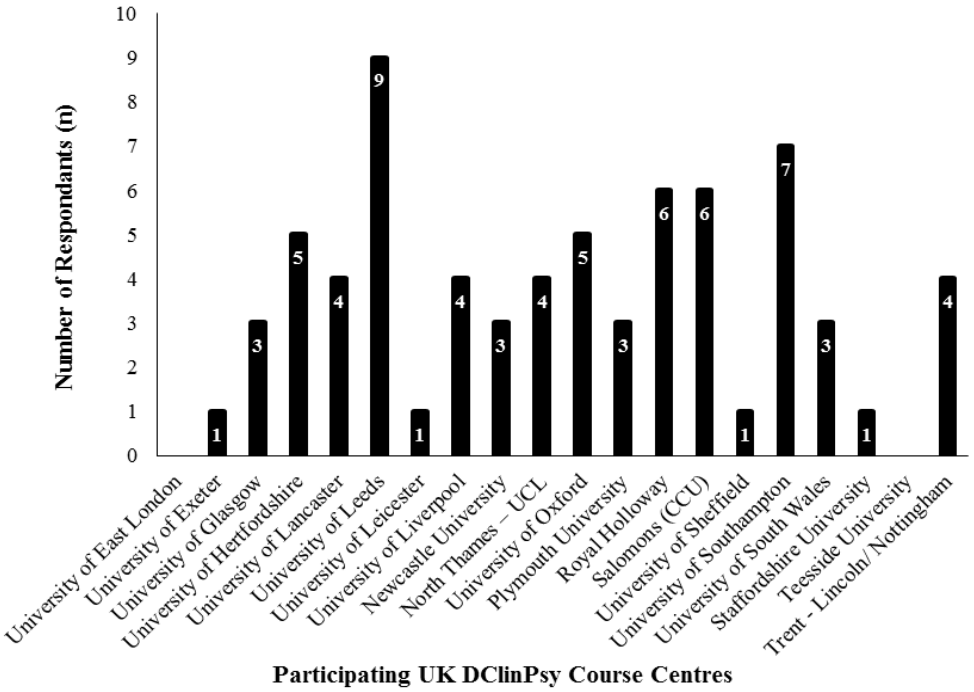

Figure 2. Participating course centre response rates.

Of the total sample (n=71), demographic information was available for 70 participants and the following data therefore represents these participants. The sample was 88.57% female (n=62), aged between 23 and 45 years old (mean = 29.47; median = 28.5; sample standard deviation [SD] = 3.79; sample standard variance [SV] $s^2 = 14.37$; population SD, $\sigma = 3.76$; population SV, $\sigma^2=14.16$). Participants described 13 different ethnicities, of which 90% identified themselves as 'White', with 54 participants identifying as British or part-British, including 'White Scottish' (n=1), 'White Other' (n=1), 'White Mixed' (n=1), White Irish (n=3), White British (n=49), White (n=5) and British (n=3). Other identified participant ethnicities included White European (n=2), White British French (n=1), Mixed White Asian (n=1), Greek (n=1), Chinese (n=1), and British Greek Cypriot (n=1). In terms of their academic year of clinical training, 30% of participants were in their first year, 31.43% were in their second year and 38.57% were in their third year. Figure 3 (below) illustrates the total amount of responses from respondents for each question in the iSurvey questionnaire, showing a trend of fewer respondents over the course of the questionnaire.

[15] Trainee numbers were sourced from the Clearing House for Postgraduate Courses in Clinical Psychology (2014).

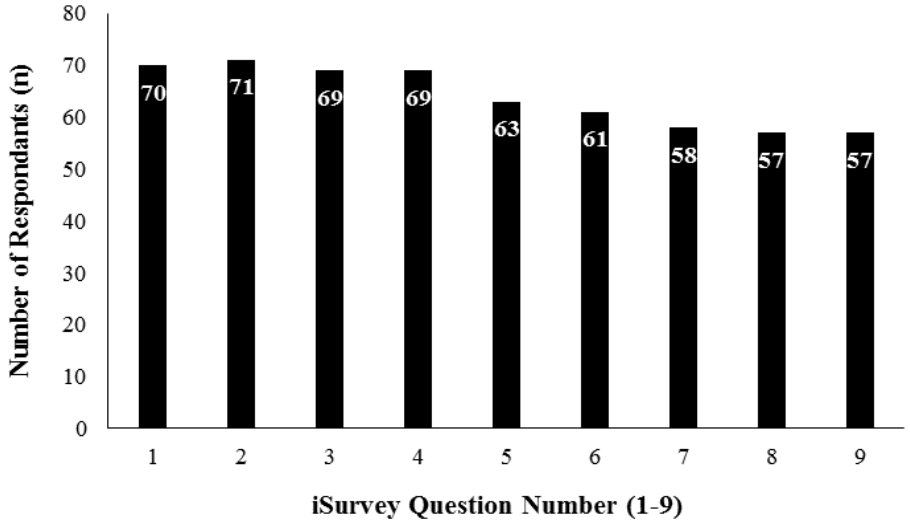

Figure 3. Response rates for iSurvey questions.

2.2.5 Measures and research tools. A semi-structured open-ended online questionnaire schedule was orientated using Kvale's (1996) criteria for conducting qualitative interviews. The questionnaire schedule included demographic questions, followed by more detailed questions about how Trainees conceptualised, worked with and assessed the quality of their therapeutic relationships with their clients (see Appendix J). iSurvey is a survey generation and research tool for disseminating online questionnaires, which was selected for this project due to its high level of security and encryption, and because of the ease of access for participants.

QSR NVivo 10.0[16] was selected for analysing the data to reduce the possibility of errors associated with manual coding, and increase the flexibility and accuracy given the large sample size (see Burnard, Gill, Stewart, Treasure & Chadwick, 2008; Walsh, 2003). Using NVivo also allowed the triangulation of research findings through adding a quantitative dimension - for example, numerical counts of coded items supporting themes and subthemes, to the qualitative data (see Silver, 2014). NVivo was chosen over other packages as it was able to determine minimum text units in advance of the main analysis. It was also compatible with the way data was gathered from iSurvey: it was imported via Microsoft Word and easily coded on screen, where stripes applied to coding could illuminate where codes had been used (see Silver & Lewins, 2014). NVivo also allowed the researcher's reflexive diary (see Reinharz, 1997, and Appendix N for a reflexive diary extract), analytic memos and analytic notes to be linked with relevant data items or extracts.

2.2.6 Procedure. After granting permission for the research to take place at individual course centres, course directors, research directors or administrative staff disseminated the recruitment email to Trainees, containing a secure encrypted website link to direct them to the online questionnaire (https://www.isurvey.soton.ac.uk/13538) and a password to access the

[16] QSR NVivo 10.0 will hereon in be referred to as NVivo.

questionnaire. This was to ensure that only participants who were approached were able to participate, and to protect their data. They were then shown a Participant Information Sheet and Consent Form (Appendix I), and if they opted in, they were required to use the password and tick a box to indicate their informed consent.

Participants were then asked five demographic questions, followed nine open-ended questions about how they understood and measured the therapeutic relationship in their clinical practice (see Appendix J). Each section required participants to save their answers in order to proceed to the next section. Finally, they had the opportunity to opt into the prize draw. This information was collected separately from questionnaire answers to maintain confidentiality and anonymity. Participants then viewed a Debriefing Sheet (Appendix K).

2.2.7 Analytic approach and epistemology. Thematic analysis is a theoretically flexible qualitative analytic method, used to identify and report themes or patterns that emerge from qualitative data (see Braun & Clarke, 2006). It is a contextualist method, positioned between constructionist and essentialist paradigms (Braun & Clarke, 2006). Thematic analysis organises data in a minimal way, preserving both the richness and depth of the meaning within the data (Braun & Clarke, 2006; Lowenthal, Lee, MacLeod, Cook & Goldblatt, 2003). Boyaztis (1998) explains that thematic analysis actually goes beyond this level of organisation by interpreting different components of the field being explored. Thematic analysis is designed to portray a specific essence or nature of a particular population's views and experiences, particularly among populations whose views currently unknown (Braun & Clarke, 2006). In this study, how Trainees understand and measure the quality of their therapeutic relationships was explored through their reported attitudes, views and experiences (Elliot, Fischer & Rennie, 1999; Lowenthal et al., 2003).

The researcher took a critical-realist standpoint (see Ponterotto, 2005; Willig, 1999), where participants' responses were understood to be informed by broader social contexts, without losing focus on the data or the boundaries of differing realities (Braun & Clarke, 2006). This perspective also allowed data to be analysed in a relatively straightforward way, as the largely one-directional relationship between language, meaning and experiences in the data facilitated theorising about underlying meanings, motives and experiences to take place (Braun & Clarke, 2006).

2.2.8 Analytic method. The data were imported from iSurvey to Microsoft Excel in nine separate databases for each question asked, which were all formatted and converted into nine headed Microsoft Word documents. Each participant was given an anonymous code indicating their course centre, year group, ethnicity, age and gender in the headings for their responses, before these documents were imported into NVivo as 'Sources'. This approach was designed to facilitate exploring the data within each participant's responses (vertically) and across different questions asked (horizontally). Participants' demographic data were also coded to ensure each heading linked correctly with participants' responses. This also indicated where participants had not responded to a particular question, and facilitated searching within and across datasets with an awareness of

participant demographics provided by the anonymised participant codes.

Due to varying views as to how best to conduct thematic analysis (Attride-Stirling, 2001), the method used in this research was grounded in Braun and Clarke's (2006) six phases[17], and adapted for use in NVivo:

1. Reading and re-reading the datasets initially familiarised the researcher with the data. Certain features in NVivo facilitated this process, including conducting word frequency counts to generate word clouds. This produced a picture of the most frequently occurring five-letter words (to exclude shorter words such as 'the', 'and' and 'that') in the most commonly occurring 100 words across the nine datasets, including stemmed words (see Figure 4). The higher the frequency, the larger the text (see Silver & Lewins, 2014).

Figure 4. NVivo word cloud.

2. Descriptive initial codes were generated from the data referring to basic segments of raw data. NVivo facilitated a systematic and inductive approach to initial codes generated through displaying each code with counts of data segments that constituted

[17] Please note the following terms specified by Braun and Clarke (2006) will be used to define different aspects of the data distinctions between terminology: (1) Data corpus – all data collected for the research project e.g. transcripts, reflective diaries and memos; (2) Data set – all data collected for a particular type of analysis e.g. transcripts; (3) Data item – each piece of data that together constitute the data set or data corpus, and (4) Data extract - individual coded segment of data identified within and taken from a data item.

each code. A cross-tabulation of codes against each other enabled examination of the data to test for duplicated data extracts appearing in more than one code, which facilitated the development of ideas about inclusion and exclusion criteria for each code.

3. Attention was refocused at the broader level of themes rather than codes, and sorting the codes into potential themes through starting to analyse the codes and develop an initial thematic map. Using NVivo allowed flexibility in how these codes could potentially be organised and reorganised under themes that fitted within domains, and this enabled the development of an initial thematic map.
4. After the initial themes were reviewed, two levels of reviewing took place. Level 1 reviewing involved examining the coded data extracts and whether the themes and subthemes formed a coherent pattern. NVivo was used to combine codes where there was no differentiation, and tests for duplicated data extracts were run again. Level 2 reviewing involved focusing on the validity of the individual themes in relation to the entire dataset, where codes with few data segments were removed, alongside other codes that did not tell a clear story in relation to the theme and domain.
5. A final thematic map of the data was created, and then defined, and further refined for the themes to be presented for analysis, where codes that did not have a strong narrative or did not appear salient to the overall picture were removed (see Miles & Huberman, 1994). A coding manual using Boyaztis' (1988) guidance about code creation was developed. The researcher's supervisor viewed the data set, the coding manual and thematic map twice, to verify the themes and patterns identified, and to increase inter-rater reliability.
6. A report was then produced to convey the merit and validity of the findings, aiming to be concise, non-repetitive and compelling, where extracts were embedded within the analytic narrative, to support arguments in relation to research questions (see Miles & Huberman, 1994).

The above process illustrates the inductive nature analysis in the context of the iterative nature of thematic analysis (see Frith & Gleeson, 2004). Datasets were conducted inclusively, to allow the data to inform the structure of the analysis (Patton, 2002), and avoid fitting data to pre-existing theories. It is important to explicate that semantic themes were identified during the analytic process (Braun & Clarke, 2006): explicit or surface meanings were used to avoid going beyond participants' answers, remain true to the data, and allow the data to speak for itself (Braun & Clarke, 2006). The themes aimed to be descriptive, whilst illustrating patterns in semantic content, summarised by over-arching themes (Braun & Clarke, 2006). This iterative process is represented diagrammatically below (see Figure 5), where the rationale for choosing this analysis was to explore a less-well understood field of research (Joffe, 2012).

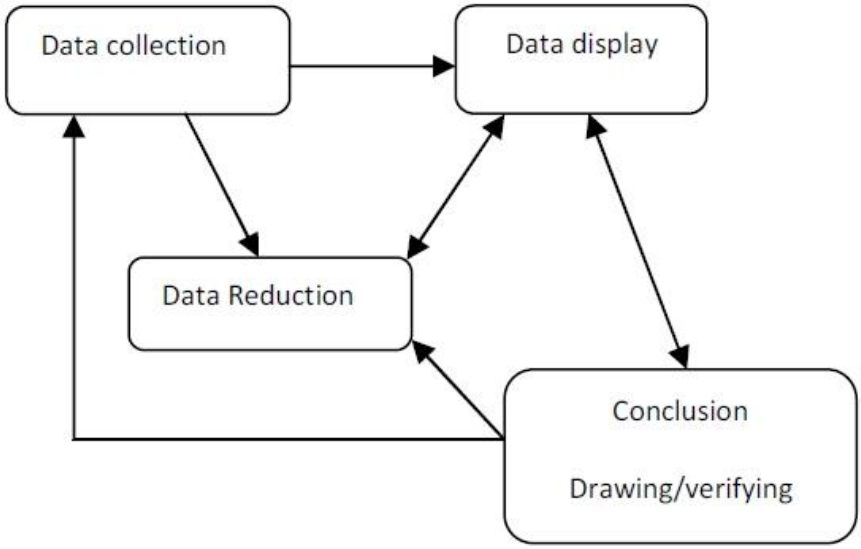

Figure 5. Interactive model of the thematic analysis process (Miles and Huberman, 1994, pp.12).

As represented in Figure 5, the analytic process is dynamic and iterative when working towards clear, reliable and elucidatory understanding that aim to answer defined research questions (Miles & Huberman, 1994).

2.2.9 Reflexivity. The researcher's role impacted on the research process throughout, including designing the study and questionnaire schedule, analysing the data, and reporting the findings. This was captured through the researcher maintaining a reflexive diary (Reinharz, 1997). However, the researcher did not merely represent participants' views (Braun & Clarke, 2006; Fine, 1992). Collecting data online added an interesting dimension to the researcher's role, as qualitative research often involves interviews or focus groups (e.g. Wilkinson, Joffe & Yardley, 2004), where reality could be co-constructed through the interaction between the researcher and participant (Willig, 1999). The researcher understood the importance of acknowledging their role in the research process (see Braun & Clarke, 2006; Willig, 2001), to avoid passively accounting for emergent themes (see Taylor & Ussher, 2001).

It was important to acknowledge the researcher's background in Counselling Psychology, where their experience of training was that the therapeutic relationship was always at the forefront, irrespective of the therapeutic model being utilised. This experience played an important part in influencing the researcher's choice of research area, owing to researcher's more recent training in Clinical Psychology having a contrasting focus, where the therapeutic model is focused on more predominantly than the therapeutic relationship. The researcher was keen to explore where the importance of the therapeutic relationship was placed among a diverse cohort of Trainees from across the UK. Of note, the researcher's preferred therapeutic model being of psychoanalytic thinking impacted on the qualitative interest in this field, as the researcher aimed to capture the essence of Trainees' intrapsychic experiences in clinical practice, and how non-observable phenomena might shape and inform Trainees' views and experiences.

Furthermore, given that the Counselling Psychology training the researcher experienced early in their career was initially grounded in person-centred therapy (see Rogers, 1957, 1961), the researcher's views were inevitably influenced by their experience of aiming to provide and maintain facilitative therapeutic conditions, and in their beliefs around therapists striving to be congruent. The researcher was therefore mindful of avoiding searching for similar views, attributes and experiences in clinical practice, as they were aware of the heterogeneity in Trainees' backgrounds and personal therapeutic styles. Whilst the researcher's experience of attending to therapeutic ruptures in clinical practice was perceived as largely positive and beneficial, and the researcher was aware that other Trainees' may have had more difficult experiences in this context. However, there are inextricable biases in the researcher's analytic approach and findings, associated with their interpretation of recurring or pertinent themes and their relationship to other themes. As such, the picture built from the data could have been very different if another person had been conducting the analysis.

The researcher's personal context as a Trainee themselves also meant they were aware of the pressures potentially experienced by other Trainees, where Trainees are constantly assessed in their academic, research and clinical roles. Whilst the researcher's physical absence when the participants were completing the survey may have provided a more neutral context for their participation, the researcher was conscious of the potential for Trainees to be mindful of how they were perceived through their responses to survey questions.

It is possible that there could have been an element of demand characteristics or social desirability shaping Trainees' responses (see Cherry, Byrne & Mitchell, 1976), irrespective of their confidentiality being maintained through both data collection and analytic strategies, as participants may have held concerns about judgement of their clinical practice. Additionally, using a computer and answering questions in their own time may have allowed participants to construct their answers carefully and possibly have edited their responses, meaning that interviews or focus groups with the researcher present may have generated markedly different data (see Appendix M for an exemplar participant transcript).

2.3 Results

2.3.1 Theme development. Initially, the four domains contained between two and three overarching themes, where each theme contained between three and five subthemes, producing a total of 43 subthemes. During the extensive review process, both independently and with the researcher's supervisor, themes were dropped if they were found to be: (i) difficult to define, (ii) repetitive or overlapping with other themes, (iii) lacking in terms of the supporting data extracts, (iv) not adding to the overall picture of how Trainees understand and measure their therapeutic relationships, and (v) representing data coded inclusively where a story was being told outside the bounds of the research questions.

A few themes and one domain were removed from the thematic map due to their meeting

the aforementioned criteria, particularly criteria (iv) and (v). However, because they contained interesting data items, they will be described in the Discussion section. This left the following domains, namely *'Conceptualising the Relationship'*, *'Managing Challenges'* and *'Measuring the Quality'*, which collectively constituted the overall thematic map (see Figure 6).

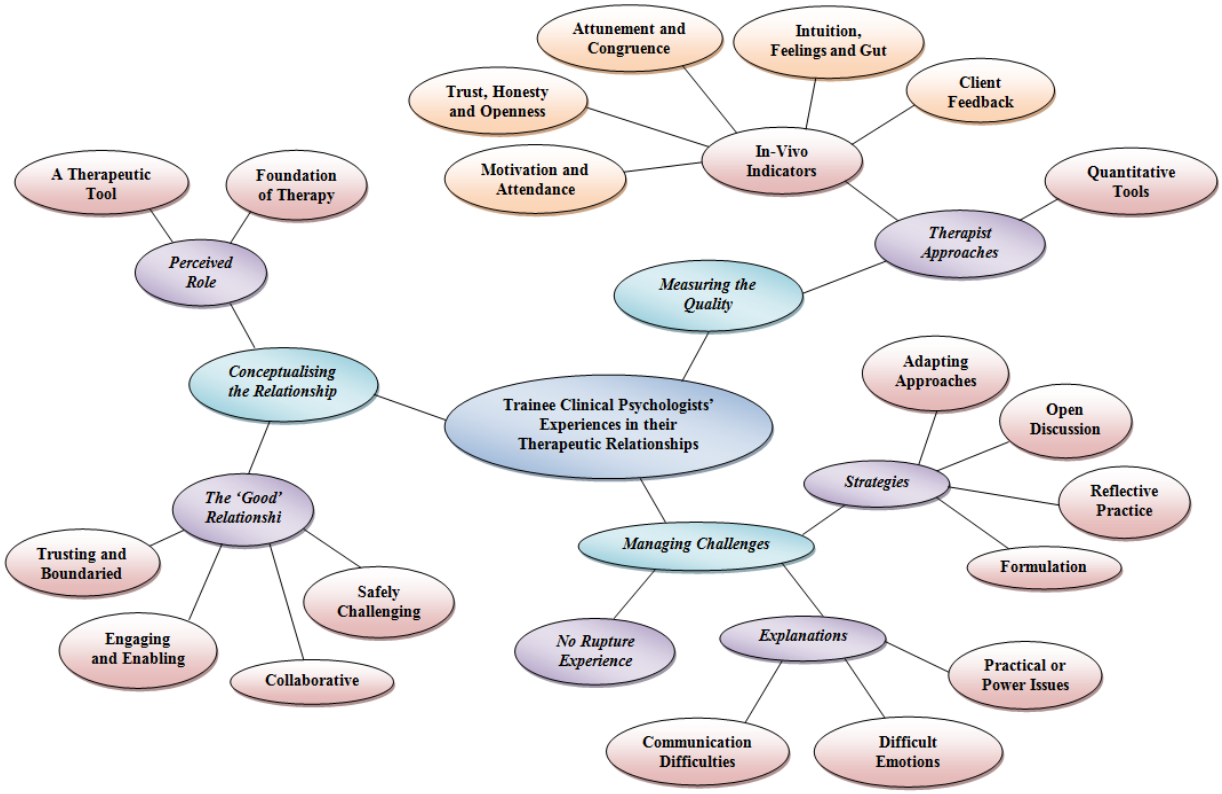

Figure 6. Final thematic map.

Figure 6 shows that Trainees' predominant stories were organised around how they conceptualised, responded to challenges within and approached measuring the quality of their therapeutic relationships, which appeared to be somewhat related to the structure and content of the questionnaire schedule, where participants were first asked about their understanding of the therapeutic relationship, then about their experiences of therapeutic rupture and their experiences of measuring the quality of the therapeutic relationship.

It is possible the researcher's Clinical Psychology training in third-wave cognitive-behavioural therapies, such as Acceptance and Commitment Therapy (see Hayes, Strosahl & Wilson, 1999) and Dialectical Behaviour Therapy (see Linehan, 1987, 1993a, 1993b) may have further influenced how the themes were organised. These are both proactive therapies, that typically make use of the therapeutic relationship as a tool in therapy itself, and view the therapist's and client's contributions as important in collaborative encounters. The researcher's previous training in psychoanalytic approaches may have also impacted on the weight placed on the amount

of subthemes in the indicators used to measure the therapeutic relationship, as a lot of emphasis is placed on transference and countertransference in psychoanalytic thinking (see Loewald, 1986).

The number of sources and references used to support each theme and subtheme are documented in Table 2, below:

Table 2.

Data supporting thematic analysis.

Domains, Superordinate Themes, Themes and Subthemes	**Sources (datasets)**	**References (data extracts)**
Conceptualising the relationship		
Perceived role		
A therapeutic tool	3	18
Foundation of therapy	3	55
The good relationship		
Safely challenging	4	23
Trusting and boundaried	4	45
Managing challenges		
No rupture experience	3	29
Explanations		
Communication difficulties	4	23
Difficult emotions evoked	3	27
Practical or power issues	4	50
Strategies		
Adapting approaches	3	18
Formulation	3	29
Open discussion	4	53
Reflective practice	9	51
Measuring the quality		
Therapist approaches		
Quantitative tools	3	21
In-vivo indicators		
Attunement and congruence	2	35
Client feedback	2	28
Honesty, trust and openness	2	35
Intuition, feelings and gut	3	29
Motivation and attendance	6	33

Table 2 shows that the majority of themes are supported by evidence sourced from two to four, and up to all nine datasets, showing that the data extracts featured in Trainees' responses to more than question. With a minimum of 18 and a maximum of 55 data extracts supporting each theme or subtheme, this suggests each component of the thematic map is well-supported (see Coding Manual in Appendix O).

2.3.2 'Conceptualising the Relationship'. The first domain that developed during analysis was how Trainees described their understanding of the therapeutic relationship. Trainees' stories appeared to be broadly organised into two predominant superordinate themes, namely 'Perceived Role', which contained two themes, and 'The Good Relationship', which contained four themes. These themes emerged from multiple occurrences of Trainees describing how important

the therapeutic relationship was to them, and their descriptions of what a good therapeutic relationship might look like.

2.3.2.1 'Perceived Role'. This superordinate theme referred to a range of comments around the purpose, function and degree of importance ascribed to the therapeutic relationship.

For example, *'A Therapeutic Tool'* emerged as a theme, following a clear pattern of Trainees describing how the therapeutic relationship itself was used in therapy, as an important component of or catalyst within the overall therapeutic process. One Trainee explained:

"The relationship itself can be used therapeutically, and with a "good" therapeutic relationship the client can feel safe enough to use the relationship to notice current ways of relating to others and can try out new things."

This statement directly references the therapeutic relationship as a tool that facilitates therapeutic development, including enhanced client insight or improved interpersonal skills. This quote also illustrates the containing nature of the therapeutic relationship in supporting clients in therapy, positioning the relationship as a part of the overall process. This collectively suggests there are many ways in which the therapeutic relationship can promote change within the overall therapeutic process.

Differentially, *'Foundation of Therapy'* emerged from other Trainees' descriptions of feeling the therapeutic relationship is at the forefront, heart or centre of therapeutic practice. One Trainee explained this in terms of engagement:

"Very important, it is everything to do with engagement and is what will keep your client in therapy. If you aren't able to build a relationship then you don't have a foundation for therapy."

This appears to ascribe the responsibility of building the relationship to the therapist, whilst pairing this sentiment with a statement of importance in it being the roots of therapy. This also suggests the importance of the therapeutic relationship spans across therapeutic orientations, modalities and approaches. This theme shows a different upholding of the therapeutic relationship and its position in relation to the therapeutic model.

2.3.2.2 'The 'Good' Relationship'. This superordinate theme emerged from many Trainees describing markers of conditions they considered to be necessary for a strong or positive therapeutic relationship.

A key theme was '*Safely Challenging'*, which arose from Trainees' frequent references to their need to be able to challenge their client within the parameters of the individual therapeutic relationship:

"Over time I have learnt to see that within a strong therapeutic relationship the therapist can tactfully challenge the client and this can be a very beneficial aspect to the therapy process."

Here, it is clear that being pragmatic and tentative is paramount when challenging clients, so as not to push beyond the bounds of the therapeutic relationship, so that the client can be encouraged to move forwards at a safe pace, such that the challenge is not detrimental to the client

or the relationship. Being able to challenge clients safely is positioned as both important in facilitating therapeutic tasks and as a signifier that the relationship is strong, and can contain the challenge.

Another crucial theme was *'Trusting and Boundaried',* which captured Trainees' references to the need for clear boundaries or parameters in the therapeutic relationship, alongside trust:

"A sense of safety and trust that leads to openness. A relationship that is boundaried, warm and caring. A relationship with an ending."

This quote elucidates the need for both boundaries within the therapeutic relationship, and boundaries around the length of the therapeutic process, suggesting the benefits of openness around such boundaries. The Trainee indicates in this instance that this is built on warmth and trust, where other Trainees echoed these sentiments quite consistently in their narratives around the common features of strong therapeutic relationships.

2.3.3 'Managing Challenges'. In Trainees' stories about how they managed challenges, difficulties and ruptures in their therapeutic relationships, the three main superordinate themes identified were 'No Rupture Experience', 'Explanations' and 'Strategies' where the latter two both contained four themes.

2.3.3.1 'Explanations'. When recounting difficulties they had experienced in their therapeutic relationships, Trainees appeared to seek to explain why these difficulties had occurred, as part of their sense-making process.

One of the most cited explanations was *'Communication Difficulties',* a theme that encapsulated a wide range of different types of communication issues, barriers, blocks and obstacles. For example:

"Miscommunication/misunderstanding of therapeutic goals and expectations - we had a 'nice' relationship but not one based on good understanding and therefore therapy got stuck."

In this instance, the Trainee notes that lacking a shared understanding around both parties' expectations and the goals agreed in therapy caused difficulties in the relationship, suggesting that whilst they were able to work together and relate to each other in a kind way, that perhaps this maintained the sense of being "stuck". Other Trainees described communication issues relating to clients' difficulties using verbal communication and their difficulties understanding their clients' communication, articulating how communication breakdowns manifest as therapeutic blocks in the therapeutic relationship.

Another frequently cited cause of issues in the therapeutic relationship was *'Difficult Emotions Evoked',* which transpired following a pattern where Trainees described issues in the therapeutic relationship as arising in response to either the client or Trainee experiencing challenging emotions. One Trainee recalled:

"I have sometimes found it challenging to form therapeutic relationships with personality disordered clients, as I can experience negative countertransference in response to their challenging behaviour, which they then pick up on."

This highlights a commonly described experience among many Trainees who reported having difficult feelings in response to their clients. In this case, this quote points to a specific and heterogeneous client group (who have personality disorder diagnoses), where the Trainee specifies negative feelings as a block, further exacerbated by the client being aware of these feelings. Other Trainees described similar difficulties around issues with 'liking' their clients or experiencing other negative emotions in response to the client or therapeutic material being processed.

Another explanation was *'Practical or Power Issues',* a theme which was far broader in the range of practical and power issues captured. *'Power Issues'* included a variety of difficulties such as clients being hesitant about Trainees' statuses, having more than one client in the room and needing to break confidentiality to manage risk issues. One Trainee recounted:

"This was particularly challenging in family work where you are managing multiple relationships and often family members can be quite invested in getting you 'on side'."

This quote points to issues around how to work with more than one person and negotiating multiple relationships in therapeutic interactions. It also further highlights the challenges associated with multiple individuals with different agendas or intentions, and suggests that despite the clinical need for seeing families together, for example, this can adversely impact on the therapeutic relationship with the client referred for psychological therapy. *'Practical Issues'* covered factors such as session time constraints, service limitations and a lack of resources. For example, a Trainee recalled time constraints as a difficulty in the therapeutic relationship:

"When I've needed to quickly build a therapeutic relationship for example when I was working as a Psychological Wellbeing Practitioner and only had 30 minutes per session."

In this example, the limits imposed by the length of the session are highlighted, whose impact manifested in the pressure to build a relationship with clients quickly which can compromise or have an effect on the quality of the therapeutic relationship. The indication here seems to be that time pressures in these circumstances were not experienced as beneficial to developing or managing the therapeutic relationship.

2.3.3.2 'Strategies'. This superordinate theme refers to the strategies Trainees used when describing how they managed or attended to ruptures within their therapeutic relationships, which contained four themes.

One of the first themes to emerge from this superordinate theme was *'Adapting Approaches',* which captures how Trainees described changing or adjusting their approaches in order to overcome difficulties in the therapeutic relationship. In one example, a Trainee reflects*:*

"Eventually we overcame the problem through art. Although she struggled hugely to verbalise or show the distress she described, her artwork was incredibly emotive. Through her art we found a

way to connect together to her emotional experiences, and she has ended up being the client I remember the most, and feel made the most positive progress through therapy."

Here, the Trainee talks candidly about the mode in which they delivered therapy being the main aspect of what was changed, to better accommodate the client's needs, by facilitating communication through nonverbal means. This illustrates the importance of flexibility in therapeutic approaches, going beyond the therapeutic model. Other Trainees spoke of examples of how their approach had transformed, such as slowing the pace of sessions, extending the session or therapeutic contract length and matching their body language or verbal communication to suit the client's perceived needs or actual requests.

A predominant theme that also emerged was *'Formulation',* where many Trainees recalled how they would draw upon the formulation or reformulate the client's difficulties, in order to facilitate their understanding of their client so they could overcome or manage issues within the therapeutic relationship. For example:

"A client I had did not know why I would like her or be warm to her. I recognised this was part of her internal working model and therefore was unable to take it too personally. It meant that I tried to match where she was at so as not to make her feel too uncomfortable."

This quote shows how the Trainee utilises their knowledge of how the client thinks, feels and behaves with them is secondary to the client's early experiences to inform their understanding and how this could be contributing to difficulties in the therapeutic relationship, enabling the Trainee to tailor therapy accordingly to meet the client's needs. A number of Trainees described a very similar process of drawing on understanding why the client was behaving or experiencing things in a certain way, in order to either (i) inform appropriate interventions or (ii) deepen empathy for the client. This clearly shows the use of formulation or reformulation as a commonly used and helpful technique for managing therapeutic blocks or ruptures.

Many Trainees also described another strategy, which led to the development of *'Open Discussion'* as a theme. In this instance, the importance of naming and processing issues within the relationship was brought to the foreground, for example:

"It's also about being honest in a way that is helpful to the client, acknowledging if you make a mistake and setting a space for therapy in which mistakes, misunderstandings and reconciliations are part of the work."

This quote succinctly shows how an important feature of openly discussing issues in the therapeutic relationship is honesty. The Trainee in the above example also describes the process of owning mistakes made in therapy, and points to the normality of processing difficulties within therapeutic work, whilst highlighting the need for dedicated time to discuss such issues.

Nearly all Trainees talked about practicing reflexively in response to different questions on the questionnaire, which prompted the development of the theme '*Reflective Practice'*, particularly as most Trainees portrayed it as a method of managing issues within their therapeutic relationship.

One Trainee stated:

"Reflecting outside of therapy and in supervision allows you to consider your relationship with a client, including any transference or difficult feelings, reflecting on whether the relationship feels like it is aiding change."

It is important to note the multiple dimensions of reflective practice mentioned by Trainees, for example, reflecting in supervision, on one's own, in sessions with clients, with multidisciplinary professionals, with peers, in lectures, in clinical training environments, and in personal therapy. Therefore, the above quote captures just two dimensions of a non-exhaustive list of ways in which using reflective practice aids management of issues in therapeutic encounters. Common to nearly all statements about reflective practice as a strategy was having time to think about processes in-the-moment, to allow Trainees to decide whether or not to attend to such issues inside or outside of sessions.

2.3.3.3 'No Rupture Experience'. A theme that did not follow the same patterns as the aforementioned themes but did fit within this particular domain was *'No Rupture Experience'*. This developed through some Trainees' repeated references to either not having ruptures, or not having experience of having to manage ruptures within their therapeutic relationships, for example:

"I understand the definition of rupture - but I can't say I have ever encountered anything in my personal therapy experience that could be classified as this."

This quote shows that despite being aware of what it means to have a rupture in the therapeutic relationship, the Trainee confirms they have not experienced any ruptures in any therapeutic relationships they have had – a sentiment echoed by a number of Trainees. None of the data extracts gave any information around explaining the absence of experiences of ruptures in the therapeutic relationship. As this appears to be an anomaly given the rest of the picture portraying how Trainees explain and manage difficulties in their therapeutic relationships, it is possible that this may reflect a range of attachment styles or characteristics of Trainees in this sample and will be discussed in more depth in *2.4 Discussion*.

2.3.4 'Measuring the Quality'. Trainees also spoke at length about how they determined the strength and quality of their therapeutic relationships, which led to the formation of the superordinate theme, *'Therapist Approaches'*, containing two themes - namely *'Quantitative Tools'* and *'In-Vivo Indicators'*, the latter of which included five subthemes.

2.3.4.1 'Quantitative Tools'. This theme emerged following the frequent references Trainees made to a variety of psychometric tools used to assess the quality of the therapeutic relationship in clinical practice, for example:

"Sometimes I use measures at the end of the session to check how the client has found the session and how they perceive the therapeutic relationship to be."

This Trainee refers to unnamed measures that explore both the quality of the session and the quality of the relationship from the client's perspective. Of note, some Trainees referred to

specific measures exploring the therapeutic relationship (for example, the Working Alliance Inventory; Horvath & Greenberg, 1986), whilst others referred to general outcome measures monitoring the client's symptoms (e.g. the CORE-OM; Barkham et al., 1998). Some Trainees commented on using quantitative measures alone, whilst others referred to using them in conjunction with qualitative feedback from clients. A few Trainees also described the limitations associated with using psychometric tools designed to measure the therapeutic relationship.

2.3.4.2 'In-Vivo Indicators'. This theme arose from the variety of signifiers Trainees reported experiencing during sessions that gave them a sense of the quality of the therapeutic relationship, from their perspective or from the client's perspective.

The subtheme *'Attunement and Congruence'* encapsulated Trainees' descriptions of feeling a sense of being attuned to their client and both the client and therapist being honest and true to themselves. One Trainee stated:

"Another thing I think that makes a good relationship different is that the therapist is attuned to the client. I don't think that means that you always get it right, but that you can pick up when you've got it wrong and attend to that."

The Trainee alludes to the importance of understanding the processes occurring within the therapeutic interactions, and being aware of the client's needs. The Trainee also captures the importance of a sense of 'realness', where in a good therapeutic relationship, using an imperfect or ineffective intervention will not necessarily cause irreparable damage, as long as the therapist notices any disparity and addresses this appropriately. Therefore, being able to attend to and manage such difficulties can be a sign of a good therapeutic relationship.

As mentioned previously, many Trainees described using qualitative feedback as a way of measuring the quality of the therapeutic relationship. *'Client Feedback'* emerged as a subtheme as many Trainees described asking their client for their feedback on both therapeutic progress and the quality of the therapeutic relationship, for example:

"I do ask clients for feedback. I read recently how the difference between an average and really good therapist is asking for client feedback regularly and using this constantly to improve."

This Trainee explains that they ask clients for feedback about their experience of therapy openly and suggests that such dialogue should be common-place. The indication is that where some clients may not be able to offer spontaneous feedback about how they are finding therapy, the therapist is well-placed to do so. Furthermore, making this a routine part of therapy discussions could be important in enabling the client to feel comfortable in sharing their views. The Trainee suggests that being amenable to feedback promotes good practice as it offers a way to develop therapy to better meet the clients' needs. Additionally, other Trainees described receiving spontaneous feedback, with some explaining that the client being able to give honest feedback was a good sign in itself as well as using the content of the feedback to measure the quality of the therapeutic relationship. However, clients may tell therapists what they think the therapist wants to

hear in order to be seen as socially desirable (Cherry et al., 1976), which may mean that feedback sought by therapists may be biased or unrepresentative of the quality of the therapeutic relationship. Whilst not detracting from the potential truth in sought feedback, and from spontaneous feedback offered by clients, this does point to a need for therapists using more than one approach to measuring the quality of the therapeutic relationship, to gain a fuller picture of clients' views and experiences.

Trainees also described more general qualities that they felt showed the therapeutic relationship was strong. The subtheme *'Honesty, Trust and Openness'* is captured below:

"One that is open and transparent and the therapist does not lie or withhold the information is essential."

The Trainee's use of the word "essential" stresses the importance of these qualities: of being able to be honest and open in order to promote and maintain trust within the relationship. This suggests that without these qualities, the therapeutic relationship could suffer, and their absence may be a sign of a poorer therapeutic relationship.

Many Trainees described less tangible intrapsychic experiences as markers of a good therapeutic relationship. The subtheme *'Intuition, Feelings and Gut'* arose from the multitude of descriptions of gut reaction as a way of knowing how strong the relationship was, for example, one Trainee succinctly states:

"I think I rely on gut reaction."

Another Trainee explains they use different inner feelings to gain a sense of whether they feel the therapeutic relationship is good, for example:

"I would also draw on intuition and introspection - thinking about how I feel when I'm with a client to evaluate the quality of the relationship, as well as thinking about how the therapy is going in general."

This suggests that other subjective experiences, namely intuition and introspection, are also used in the complex process of judging the quality of the therapeutic relationship in clinical practice.

Lastly, most Trainees talked about the different ways in which clients demonstrate their motivation and references the pattern of attendance as signs of the quality of the therapeutic relationship, giving rise to the subtheme *'Motivation and Attendance'.* One Trainee states:

"They are motivated to come to sessions and work with the therapist (and the work is 50:50, as opposed to the therapist taking on too much of the responsibility if the client is reluctant to open up). The good therapeutic relationship is collaborative. A poor therapeutic relationship is one in which the client does not feel safe and supported, does not feel they are making progress and is not motivated to come to sessions."

Thus, observable signs from the client, along with the extent to which they demonstrate engagement in both session participation and undertaking therapeutic tasks, can be taken to signify the quality of the therapeutic relationship.

2.4 Discussion

This study aimed to explore how Trainees understand and conceptualise the therapeutic relationship, and how they measure the quality of their therapeutic relationships in clinical practice. These research questions emerged following examination of the literature, which showed a dearth of (i) qualitative research in this field (see Elvins & Green, 2008), (ii) studies exploring the therapist's perspective (see Stiles et al., 2004) and (iii) research into the macro-level of processes during therapeutic interactions (Lepper & Mergenthaler, 2007).

2.4.1 Summary of themes. The final thematic map illustrated that three domains were established, namely *'Conceptualising the Relationship', 'Managing Challenges'* and *'Measuring the Quality'*.

'Conceptualising the Relationship' constituted patterns of Trainees' narratives that gave rise to the development of two main superordinate themes. *Perceived Role*, containing the themes the *'Foundation of Therapy'* and *'A Therapeutic Tool'*, suggested Trainees broadly felt the therapeutic relationship is pivotal, but differed in their views of the extent to which it is a therapeutic tool, or as the scaffolding upholding multiple therapeutic models. Irrespective of their differences in where the therapeutic relationship is positioned, most Trainees passionately described how important the therapeutic relationship was to them and to their clients. *'The Good Relationship'* emerged from how Trainees talked about what a good therapeutic relationship looked like for them, and named qualities that were organised into the two themes *'Trusting and Boundaried'* and *'Safely Challenging'*. These subthemes captured the importance of having both a sense of trust and knowing the parameters of the therapeutic relationship, and being able to support clients in processing and overcoming difficult experiences through appropriately selected therapeutic tasks, respectively.

'Managing Challenges' encapsulated how Trainees deal with difficulties within the therapeutic relationship and contained superordinate themes *'No Rupture Experience', 'Explanations'* and *'Strategies'*. Explanations captured how Trainees made sense of why difficulties had occurred, and included the themes *'Practical or Power Issues', 'Difficult Emotions Evoked*' and *'Communication Difficulties'*. Most often, Trainees reported that issues arose related to (i) the variety of demands associated with their role or practical aspects of service delivery, (ii) communications problems either experienced by the client or between the client and Trainee, or (iii) the difficult emotional experiences that can occur for either or both parties in therapeutic encounters. It is known that attachment styles developed in early relationships have a significant impact on how humans respond to and manage their future interpersonal relationships (Bowlby, 1988; Collins, 1996), and this has been observed in how therapists build the therapeutic alliance

(see Orlinsky, Grawe & Parks, 1994, and Roth & Fonagy, 1996). As such, the apparent willingness of most Trainees' to consider threats to or difficulties within their therapeutic relationships could be indicative of having a secure attachment style (see Rozov, 2001).

'No Rupture Experience' was positioned as a theme in its own right, as it contained statements from Trainees whose responses indicated that they had not had therapeutic ruptures in their clinical experience, or had no experience of attending to ruptures in clinical practice. This was considered to be conceptually distinct from Trainees who described how they understood and managed difficulties in their therapeutic encounters. It is possible that Trainees' responses indicating they have had no experience of ruptures or of attending to ruptures may be linked with a lack of clinical experience. For example, if some Trainees had only had 6 months' clinical experience since becoming a Trainee (if they came from a predominantly research or academic background prior to training), they may not yet be accustomed to or competent in detecting therapeutic ruptures or difficulties within the therapeutic relationship. First-year Trainees may not have had teaching specifically around the therapeutic relationship by the time they partook in this research, and therefore may not be aware of what therapeutic ruptures might look like in clinical practice. It is difficult to speculate on this, as the amount of clinical experience Trainees had prior to becoming a Trainee was not quantified in the survey, owing to it being a qualitative exploration.

However, this could also point to a different issue. It is known that 30-35% of the population have insecure attachments (National Institute of Clinical Excellence [NICE], 2015). Furthermore, many psychotherapists have experienced adverse childhood experiences in their caregiving relationships which have the potential to cause insecure attachment styles (e.g. Fussell & Bonney, 1990). It is therefore likely that some Trainees who participated in this research may have insecure attachment styles. If Trainees had avoidant, ambivalent or disorganised attachments styles (all indicative of having an insecure attachment), threats to the relationship could have been experienced by the Trainee as rejecting, and such threats may have therefore been minimised, denied or avoided (see Andrew, 2004; Bucheim & Kachele, 2003; Rozov, 2001; Rubino, Barker, Roth & Fearon, 2000). The difficulties Trainees may have had in processing such issues could have made them less aware of these issues altogether, or might have led them to refute the presence of any difficulties, due to the distress it might have caused them to acknowledge, reflect on and attend to such difficulties.

'Measuring the Quality' transpired from Trainees' stories about how they were able to draw conclusions about the quality of their therapeutic relationships forming one superordinate theme *'Therapist Approaches'*, which generated two themes. These themes did not broadly illustrate exclusive approaches to how Trainees measure the quality of the therapeutic relationship, as some Trainees used psychometric tools alone (*'Quantitative Tools'*), others used these in conjunction with in-session qualitative approaches (*'In-Vivo Indicators'*), and some only used these qualitative approaches. More specifically, *'In-Vivo Indicators'* included the subthemes

'Trust, Honesty and Openness', 'Motivation and Attendance', 'Intuition, Feelings and Gut', 'Attunement and Congruence' and *'Client Feedback'*. These included two observable phenomena – namely client attendance and feedback, alongside intrapsychic experiences. Of note, non-observable phenomena do appear to dominate this theme, which could be influenced by the researcher's therapeutic style of attending to intrapsychic experiences in reflective practice, shaped by both psychoanalytic thinking and third-wave cognitive behavioural therapies. It could also be a genuine reflection of Trainees' approaches to measuring the therapeutic relationship quality, influenced by the popularity of training in third-wave approaches across many course centres in the UK, given their inclusion in NICE guidance for a variety of mental health problems, such as Dialectical Behaviour Therapy for women with Borderline Personality Disorder who are engaging in self-harming behaviours (NICE, 2009). It may also indicate that a number of Trainees' have secure-enough attachment styles in being able to consider the implications of overt, subtle and non-observable or intrapsychic processes during therapy sessions.

2.4.2 Excluded data. In the process of defining the final themes, a domain (namely, *'Building the Therapeutic Relationship'*), a few superordinate themes and some additional themes (e.g. *'Poorer Outcomes'*) were excluded for one or more of the following reasons. These were excluded if firstly, they confirmed what is already well-known among the literature around therapists' personal and professional approaches to building and maintaining therapeutic relationships, such as offering validation, being empathic and genuine and having unconditional positive regard for clients (e.g. Norcross & Wampold, 2011a). A second reason for exclusion was if they did not explicate anything about how the therapeutic relationship is understood or measured by Trainees, and thirdly, if there were too few quotes to reliably support the theme or subtheme.

It is important to note the presence of this data, as whilst it did not contribute to answering the research questions, it is still clinically relevant. Trainees appear to be using personal styles and professional approaches that broadly fit with recommended and evidence-based approaches to building and managing therapeutic relationships in clinical practice (e.g. Norcross & Hill, 2004; Norcross & Wampold, 2011a). This suggests that these qualities and approaches are crucial in managing therapeutic relationships, irrespective of Clinical Psychology, and potentially other branches of psychotherapy training.

Of further interest were the stories Trainees told about dilemmas they encountered in measuring the therapeutic relationship, for example, not being allowed to use quantitative measures on a placement (n=1). Other Trainees also raised issues with quantitative measures being potentially reductionist (n=3), and subjective, given the multiple definitions of the therapeutic relationship currently in existence (n=5). Both of these difficulties have been previously described in reviews of the literature (e.g. Elvins & Green, 2008).

2.4.3 Evidence base of themes. The thematic analysis confirmed that many Trainees in the present study experienced a variety of challenges in knowing how to measure the quality of the

therapeutic relationship. From a pluralistic standpoint, Omer (2000, pp.201) states *"there is no universally correct therapeutic attitude and no set way to deal with troubled relationships"*, which could partly explain the continued lack of consensus around this issue.

This analysis echoed some conclusions drawn by Elvins and Green (2008), where emergent themes suggested that: (i) there are many of ways of approaching how the therapeutic relationship is measured - including qualitative and quantitative methods, and (ii) there is a lack of consensus over whether a singular or combined approach is best. In a retrospective study involving 10 Trainees in America and 3 supervisors, Kurcias (1999) interviewed participants at different time points in their training and focused on how Trainees conceptualise and work with the therapeutic alliance at these time points, using an unspecified qualitative analytic approach. The data suggested that, over time, conceptualisations of the therapeutic alliance increased in complexity, and that the therapeutic alliance became more of a focal point. Participants also felt that being more confident, comfortable and skilled in discussing the therapeutic relationship with clients and being able to identify and attend to therapeutic ruptures were important in developing skills in managing their therapeutic relationships. Of note, Kurcias (1999) uses the terms 'alliance' and 'relationship' interchangeably, making it challenging to ascertain which theoretical concept is being endorsed. However, whilst Kurcias' (1999) findings may be related to Trainees' development over time, which contrasts with the cross-sectional design of the present study, there are similarities between the findings. For example, in both studies, the therapeutic relationship is thought of as complex and important, openness in discussing issues in the alliance was identified as a strategy, and reflective practice seemed to be pertinent in identifying threats to the therapeutic relationship.

Interestingly, in another study involving American Trainees (n=29), Kivlighan et al (2014) found that therapists' views of the alliance were significantly associated with their perceptions of session smoothness and positivity, suggesting that if therapeutic encounters are perceived in a favourable light without too many difficulties, Trainees felt the quality of the alliance was better. This was not overly related to the findings in the present study, as Trainees in the present study reported that being able to identify and manage ruptures signified that they had good therapeutic relationships, rather than the absence of difficulties. The use of the phrase 'alliance' in Kivlighan et al.'s (2014) study may mean the authors were measuring and describing a theoretically distinct concept, and it is therefore difficult to compare the findings of Kivlighan et al. (2014) with the present study.

The different ways in which Trainees in the present study explained difficulties in the therapeutic relationship has also been highlighted in earlier studies (e.g. *'Communication Issues'* captured problems in developing or maintaining a shared understanding between the therapist and client, which has previously been shown to lead to ruptures in the therapeutic relationship, for example, Rhodes, Hill, Thompson and Elliot (1994). Furthermore, themes describing Trainees' approaches to managing such difficulties have been endorsed in the evidence base, for example,

'Adapting Approaches' captured an essence of how Trainees tailor therapy to individual clients, which has been widely endorsed in the literature (e.g. Norcross & Wampold, 2011b). Lastly, some of the descriptions of how Trainees felt they were able to judge the quality of their therapeutic relationships have been described in previous studies, such as *'Attunement and Congruence'* (see Norcross & Lambert, 2011) and *'Client Feedback'* (see Norcross & Wampold, 2011a).

2.4.4 Strengths and weaknesses. A strength of this study was the large sample size (n=71, including incomplete respondents), which gave rise to the use of NVivo to support analysis both across and within the datasets (see Silver, 2014; Silver & Lewins, 2014). A benefit of having a large sample of Trainees from across the UK means that it is possible to consider the findings as largely representative of the cohort of Trainees across the three years of doctoral training. Although the majority of the sample identified as White (90%), and 89% were female, this illustrates the current demographics of Trainees in the UK (e.g. British Psychological Society, 2004; Scior, Gray, Halsey & Roth, 2007).

The term ‘therapeutic relationship’ was used to inclusively capture the overall therapeutic relationship commonly referred to in clinical practice, as well as the therapeutic or working alliance, more commonly referred to in the literature. This was to promote inclusivity. However, it could also assume commonality in the term ‘therapeutic relationship’. A word count showed that the term ‘therapeutic relationship’ was used most frequently (n=219), and there were far fewer references to the ‘alliance’, ‘therapeutic alliance’, ‘working alliance’ or ‘therapeutic frame’. It is therefore possible that Trainees were responding to the terminology used in the online questionnaire, or that their language directly indicated how they refer to the interpersonal processes that occur between themselves and their clients. However, this study was unable to ascertain the reasons underlying Trainees' choices in terminology, or whether they were in fact referring to a different concept.

A benefit of conducting online research, where Trainees completed anonymous questionnaires in their own time, is the lack of researcher impact on the Trainee during their participation. Conversely, the lack of interaction between the researcher and participants may have detracted from the capacity of the researcher to know the minutiae of Trainees’ interpersonal processes when completing questionnaires, and may also have meant that their responses were subject to the effects of social desirability or demand characteristics. The data that might have been generated through focus groups or interviews might have been markedly different, as it would have been co-constructed with the researcher, and would have perhaps been less 'edited', and therefore, be more representative of attitudes, opinions and beliefs.

Furthermore, the questionnaire schedule could have been more developed, had a focus group been conducted with Trainees, to explore (i) whether more or less questions would be suitable, and (ii) whether the questions used were as pertinent to the research questions as possible. However, using an online survey was an ethically sound approach, given the opt-in procedure, and

the absence of an imposed time-limit to participate or complete the questionnaire (British Psychological Society, 2010). Additionally, employing NVivo to analyse the data allowed triangulation through utilising quantitative approaches to capturing the frequencies or the presence or absence of data items in the data corpus (see Bryman, 2006). This enhanced the validity of the findings, through being able to demonstrate numerically to what extent patterns were emerging within and across Trainees' narratives (see Campbell & Fiske, 1959).

2.4.5 Training and clinical implications. It is acknowledged that there are multiple similarities with some of the established findings about how qualified therapists and Trainees understand and judge the strength of their therapeutic relationships. The need to be able to assess the links between Trainees' knowledge and clinical practice is clear, given the importance of (i) reflective practice in Continuing Professional Development (CPD), and (ii) the range of competencies in clinical training – such as maintaining both professional and therapeutic relationships (Knight, 2011; Laidlaw & Gillanders, 2011; Nel, Pezzolesi & Stott, 2012). The findings from this research offer some unique insight into how Trainees make sense of and judge the quality of their therapeutic relationships during their Clinical Psychology training.

An important trend in the research suggests disparity among Trainees in their use of quantitative measures when assessing the quality of their therapeutic relationships with their clients. Whilst some Trainees described using specified and unspecified measures of either clients' outcomes or of the therapeutic relationship (n=21), one Trainee described not being allowed to use psychometric tools to measure the therapeutic relationship on a placement, and some alluded to being avoidant of or averse to using measures (n=5). Other Trainees (n=34) favoured relying on their emotions, reflective practice and supervision, asking for client feedback and noting both attendance rates and levels of engagement as indicators of the quality of the therapeutic relationship. The lack of consensus in approaches, compounded by stories told by Trainees reporting no experience of difficulties in the therapeutic relationship may point to a need for more teaching on Clinical Psychology training programmes about the macro-level processes in the therapeutic relationship (see Lepper & Mergenthaler, 2007). It may also highlight a need for training to promote the different ways Trainees can engage with and develop their reflective practice skills (see Binks, Jones & Knight, 2013), as this disparity could be indicative of difficulties translating academic knowledge into clinical practice (see Keville et al., 2013).

Trainees also emphasised the importance of being able to review the quality of the relationship with their clients when they reflected on the potential for therapeutic relationships to model healthier ways of both relating to others (n=5), and internalising positive experiences (n=7) for their clients. The gains clients could make from these experiences might contribute towards their clinical outcome, which further strengthens the rationale for Trainees being competent in measuring the quality of their therapeutic relationships. Clinical Psychology training programmes could benefit from teaching Trainees about the different quantitative measures available to them, to

complement or supplement their reflective practice skills, particularly around seeking client feedback. By promoting a degree of standardisation in this field (see Latchford, 2010), this could enhance how Trainees use their clinical judgment to measure their therapeutic relationships and in turn, positively impact on clients' clinical outcomes. In addition to supporting Trainees' learning on different ways of measuring the therapeutic relationship, it may also be of use to include information about the potential impact of attachment styles on therapists' reflexivity and stance during therapy, and information on how to appropriately process this in reflective supervision sessions. It may also be pertinent for some course centres to support Trainees to engage in personal therapy if Trainees feel they wish to confidentially and safely explore their attachment styles in more depth, particularly as research suggests that adult attachment patterns can be changed or adapted through helping individuals to adjust their internal working models (see Hopkins, 2006).

2.4.6 Research implications. Disseminating this will help to make this information accessible to a variety of clinicians in all stages of their career, and continue to promote an understanding of the importance of the therapeutic relationship for CPD and clients' clinical outcomes. This research could also be used to support the development of a quantitative measure of Entrustable Professional Activities (EPAs; Ten Cate, 2013), to specify tasks or responsibilities given to Trainees that aid assessment of the links between skills and practice (Steketee, Lee, Moran & Rogers, 2013).

Potentially, use of such EPAs could benefit Trainees in developing their clinical skills and experience, and thus improve both the quality of care provided and clients' clinical outcomes (Kazdin, 2008; Newnham & Page, 2009), and Gallichan and Mitchell (2008) call for a more formal standardised way of assessing in-vivo clinical competencies. However, Tweed, Graber and Wang (2010) point out that current methods of assessing clinical competencies in Clinical Psychology training include multiple formats, such supervision, observation, formulation and in-vivo assessments, where standardisation may be inconsistent. In their exploration of the reliability and validity of the Clinical Skills Assessment Rating Form (CSARF), Tweed et al. (2010) found that the CSARF had acceptable internal consistency and a 5-domain structure rather than the suggested 7 domains, and further exploration of the inter-rater reliability was warranted. Of note, the CSARF was the only formalised quantitative tool retrieved from the literature that was found to be specific to rating the competencies of Trainees. Challenges of using quantitative tools could include a queries around how sensitive and specific these tools are to (i) diverse and idiosyncratic therapeutic styles and (ii) differing therapeutic models that might require unique skill-sets and contrasting therapist approaches[18]. Arguably, such tools might miss less overt or observable therapeutic skills

[18] For example, cognitive-behavioural therapists tend to be quite proactive in therapy as this approach is very collaborative, whereas in psychoanalytic therapies, the therapist might be more neutral and less proactive in their therapeutic encounters.

and are based on supervisor ratings, which may not be consistent across placements in the UK. In particular, the CSARF does not explore reflective skills or skills as a supervisee.

Nevertheless, it is a standardised approach to bridging the gap between theory and practice, and to offering Trainees constructive feedback based on their clinical work so they can improve their practice. It may also support Trainees in their self-monitoring of their clinical practice. Having an accessible tool could also promote more frequent observation by supervisors, enhancing the transparency of Trainees' clinical work, and providing Clinical Psychology training programmes with a method of monitoring skill development over time - providing ratings were conducted fairly regularly. This could further support courses in selecting placements that are particularly well-suited to helping individual Trainees to build on their strengths and attend to their development needs. This could also enhance university-placement links and assist communication between academic staff, placement staff and Trainees. It is possible that a more comprehensive tool might include model-specific competency rating scales, alongside a rating scales for generic clinical skills whilst Trainees are on placements, including reflective practice skills, working relationships with other members of staff, leadership behaviours, and use of supervision.

Further research could explore Trainees' experiences of judging the quality of the therapeutic relationship through comparing observer feedback with Trainees' subjective experiences, which would fit well with general models of placement supervision endorsed by Clinical Psychology training programmes (see Latchford, 2010, and O'Donovan, Halford & Walters, 2011). Additionally, comparing views of Trainee-client dyads at different time-points during therapy could investigate patterns of convergence and divergence in participants' views on the quality of the therapeutic relationship over time. It could also explore Trainees' experiences of translating knowledge into clinical practice, which could yield further recommendations for supporting Trainees' CPD on Clinical Psychology training programmes.

Additionally, whilst having personal therapy is mandatory on some psychotherapy training courses, this is not a requirement in Clinical Psychology training, and more research could explore the different attachment styles of Trainees in relation to how they measure the quality of their therapeutic relationships. This may provide important information about whether personal therapy should be a training requirement on Clinical Psychology training courses, to help support Trainees in building and maintaining their therapeutic relationships in clinical practice.

2.4.7 Conclusions. This study's thematic analysis of Trainees' responses to an online questionnaire raises a number of important indications. Firstly, Trainees shared common views about the therapeutic relationship being paramount in their clinical practice. They frequently described the importance of being able to support their clients through their pacing of challenges in therapy and offering containment through boundaries and fostering trust.

The analysis revealed that Trainees were able to articulate a number of reasons underpinning difficulties in the therapeutic relationship, such as communication problems and

dealing with negative emotions, and tended to overcome or address these issues through open discussion, reflective practice, formulation and tailoring therapy to the client. Trainees also reported using both quantitative and qualitative approaches to measuring the quality of the therapeutic relationship, the latter of which included their own intrapsychic experiences, and client feedback, attendance and motivation. An apparent anomaly was that some Trainees reported having had no difficulties in their therapeutic relationships. This may have been associated with the amount of clinical practice Trainees had experienced, or have been associated with their particular attachment style or attachment attributes (see Black et al., 2005). More research is needed into how therapists' attachment styles could affect the quality of the therapeutic relationship and how the quality of the therapeutic relationship is assessed by therapists - particularly in Trainees, who are a somewhat under-researched population in this particular field around the therapeutic relationship.

Whilst there were some methodological considerations, such as the inclusive use of the term 'therapeutic relationship', this research approach offered an alternative and unique insight into some of the macro-level processes Trainees experienced during therapeutic encounters. The findings suggest that it is important to conduct more qualitative research to further explore this phenomenon (see Hatcher & Barends, 2006), and to explore the diverse approaches to measuring the quality of the therapeutic relationship.

Further teaching and training around how Trainees understand and measure their therapeutic relationships may be of benefit across Clinical Psychology training courses in the UK, and a standardised approach to exploring how Trainees translate their knowledge into clinical practice could facilitate this process. Teaching and training around therapists' attachment styles and their impact in therapeutic encounters might also improve how Trainees' attend to and manage their therapeutic relationships in clinical practice. The results are encouraging in suggesting that most Trainees prioritise the therapeutic relationship, engage in reflective practice and understand the links between their therapeutic relationships and clients' clinical outcomes.

Chapter 3 – References

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Chapter 4 – Appendices

Appendix A: PRISMA Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	

Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2 for each meta-analysis.)	
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	
Synthesis of results	21	Present the main results of the review. If meta-analyses are done, include for each, confidence intervals and measures of consistency.	
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	

Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	

Sourced from: http://www.prisma-statement.org/PRISMAStatement/Checklist.aspx

From: Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G., & The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med 6*(6): e1000097.

Appendix B: Inclusion and Exclusion criteria

Inclusion Criteria:

- Papers written in English.
- Papers published in peer-reviewed journals.
- Papers published between 1990 and 2015.
- Research using only human samples.
- Research using only adult samples.
- Papers including the following two combined searches in the title of articles: S1 [*therapist characteristics* or *therapist* or *psychotherapeutic processes* or *clinical practice* or *perspective** or *measure** or *judg** or *qualit**] and S2 [*therapeutic relationship* or *therapeutic alliance* or *working alliance*].

Exclusion Criteria:

- Papers not written in English.
- Papers published prior to 1990.
- Review papers, book chapters, unpublished articles, dissertations, meeting abstracts, conference proceedings, and panel discussions/commentaries.
- Articles with the search term *supervision* in article titles.
- Psychometric validation studies.
- Case studies.
- Studies with samples that were too specific e.g. only clients with substance use disorders.
- Studies that were not specifically looking at how therapists measured the quality of therapeutic relationships
- Studies whose findings were from only clients' and/or observers' perspectives
- Studies using non-psychological therapies e.g. looking at therapeutic relationships between case managers or key workers and their clients.
- Studies whose findings were specific to a particular phenomenon e.g. bereavement.

Key:-

* = Truncated search for different versions of words

S1 = Search 1

S2 = Search 2

Appendix C: Downs and Black (1998) Quantitative Quality Checklist

No.	Criteria	Y	N	UTD
1	Is the hypothesis/aim/objective of the study clearly described? Must be explicit (Y/N)			
2	Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no. ALL primary outcomes should be described for YES (Y/N)			
3	Are the characteristics of the patients included in the study clearly described? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given. Single case studies must state source of patient (Y/N)			
4	Are the interventions of interest clearly described? Treatments and placebo (where relevant) that are to be compared should be clearly described (Y/N)			
5	Are the distributions of principal confounders in each group of subjects to be compared clearly described? A list of principal confounders is provided. YES = age, severity (Y/N)			
6	Are the main findings of the study clearly described? Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions (Y/N)			
7	Does the study provide estimates of the random variability in the data for the main outcomes? In non-normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported (Y/N)			
8	Have all important adverse events that may be a consequence of the intervention been reported? This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events (COMPLICATIONS BUT NOT AN INCREASE IN PAIN) (Y/N)			
9	Have the characteristics of patients lost to follow-up been described? If not explicit = NO. RETROSPECTIVE – if not described = UTD; if not explicit re: numbers agreeing to participate = NO. Needs to be >85% (Y/N)			
10	Have actual probability values been reported (e.g. 0.035 rather than 1 group and blinding not explicitly stated (Y/N/U)			
11	Were the subjects asked to participate in the study representative of the entire population from which they were recruited? The study must identify the source population for patients and describe how the patients were selected (Y/N/U)			
12	Were those subjects who were prepared to participate representative of the entire population from which they were recruited? The proportion of those asked who agreed should be stated (Y/N/U)			
13	Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive? For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. Must state type of hospital and country for YES (Y/N/U)			
14	Was an attempt made to blind study subjects to the intervention they have received? For studies where the patients would have no way of			

	knowing which intervention they received, this should be answered yes. Retrospective, single group = NO; UTD if > 1 group and blinding not explicitly stated (Y/N/U)			
15	Was an attempt made to blind those measuring the main outcomes of the intervention? Must be explicit (Y/N/U)			
16	If any of the results of the study were based on "data dredging", was this made clear? Any analyses that had not been planned at the outset of the study should be clearly indicated. Retrospective = NO. Prospective = YES (Y/N/U)			
17	In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls? Where follow-up was the same for all study patients the answer should yes. Studies where differences in follow-up are ignored should be answered no. Acceptable range 1 year follow up = 1 month each way; 2 years follow up = 2 months; 3 years follow up = 3months.....10years follow up = 10 months (Y/N/U)			
18	Were the statistical tests used to assess the main outcomes appropriate? The statistical techniques used must be appropriate to the data. If no tests done, but would have been appropriate to do = NO (Y/N/U)			
19	Was compliance with the intervention/s reliable? Where there was non-compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. Surgical studies will be YES unless procedure not completed (Y/N/U)			
20	Were the main outcome measures used accurate (valid and reliable)? Where outcome measures are clearly (Y/N/U)			
21	Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population? Patients for all comparison groups should be selected from the same hospital. The question should be answered UTD for cohort and case control studies where there is no information concerning the source of patients (Y/N/U)			
22	Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same time? For a study which does not specify the time period over which patients were recruited, the question should be answered as UTD. Surgical studies must be 10 years then NO (Y/N/U)			
23	Were study subjects randomised to intervention groups? Studies which state that subjects were randomised should be answered yes except where method of randomisation would not ensure random allocation (Y/N/U)			
24	Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable? All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no (Y/N/U)			
25	Was there adequate adjustment for confounding in the analyses from which the main findings were drawn? In non-randomised studies if the effect of the main confounders was not investigated or no adjustment was made in the final analyses the question should be answered as no. If no significant difference between groups shown then YES (Y/N/U)			
26	Were losses of patients to follow-up taken into account? If the numbers of patients lost to follow-up are not reported = unable to determine.			
27	Did the study have sufficient power to detect a clinically important			

	effect where the probability value for a difference being due to chance <5% Sample sizes have been calculated to detect a difference of x% and y%? 1-5 n1–n2 = 1; C n3–n4 = 2; D n5–n6 = 3; E n7–n8 = 4; F n8+ = 5	

Key:-

Y = Yes (score of 1)

N = No (score of 0)

UTD = Unable to Determine (score of 0)

Notes:

Whilst Downs and Black (1998) do not overtly reference this tool for use in public health practices, they do explicate that this checklist could be applied to a research study involving an intervention in the healthcare domain, and is therefore appropriate for use in this review. This tool can be used to assess the quality of quantitative research articles and synthesise the findings for professionals working in public healthcare.

The checklist contains 10 items measuring the overall quality of the study, 3 items measuring external validity and generalisability, 7 items measuring study bias in the intervention(s) and outcome measure(s); 6 items measuring confounding and selection bias from sampling or group assignment, and 1 item measuring the power of the study to ascertain whether findings are due to chance.

Downs and Black (1998) describe assessing face, content and criterion validity by comparing the total scores of the tool with another tool used only for randomised controlled trials, yielding a high correlation (r=.90), meaning it was valid. Reliability testing was complete, showing high internal consistency for all subscales (Cronbach alpha >.69) excluding the external validity subscale (Cronbach alpha = .54), thought to be associated with raters' lack of healthcare experience. There was also high test-retest reliability for all subscales (r = .69-.90), with a low correlation score for external validity (r = -.37).

Appendix D: STROBE Checklist for Observational Studies

Area	**Item No**	**Recommendation**
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background/ rationale	2	Explain the scientific background and rationale for the investigation being reported
Objectives	3	State specific objectives, including any pre-specified hypotheses
Methods		
Study design	4	Present key elements of study design early in the paper
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	6	(*a*) *Cohort study*—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up *Case-control study*—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls *Cross-sectional study*—Give the eligibility criteria, and the sources and methods of selection of participants
		(*b*) *Cohort study*—For matched studies, give matching criteria and number of exposed and unexposed *Case-control study*—For matched studies, give matching criteria and the number of controls per case
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	9	Describe any efforts to address potential sources of bias
Study size	10	Explain how the study size was arrived at
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding
		(*b*) Describe any methods used to examine subgroups and interactions
		(*c*) Explain how missing data were addressed
		(*d*) *Cohort study*—If applicable, explain how loss to follow-up was addressed *Case-control study*—If applicable, explain how matching of cases and controls was addressed *Cross-sectional study*—If applicable, describe analytical methods taking account of sampling strategy
		(*e*) Describe any sensitivity analyses
Results		
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed
		(b) Give reasons for non-participation at each stage
		(c) Consider use of a flow diagram
Descriptive	14*	(a) Give characteristics of study participants (eg demographic, clinical,

data		social) and information on exposures and potential confounders
		(b) Indicate number of participants with missing data for each variable of interest
		(c) *Cohort study*—Summarise follow-up time (eg, average and total amount)
Outcome data	15*	*Cohort study*—Report numbers of outcome events or summary measures over time
		Case-control study—Report numbers in each exposure category, or summary measures of exposure
		Cross-sectional study—Report numbers of outcome events or summary measures
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included
		(*b*) Report category boundaries when continuous variables were categorized
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses
Discussion		
Key results	18	Summarise key results with reference to study objectives
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	21	Discuss the generalisability (external validity) of the study results
Other information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based

*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

Retrieved from: http://www.strobe-statement.org/index.php?id=strobe-publications (see von Elm, E., Altman, D.G., Egger, M., Pocock, S.J., Gøtzsche, P.C., Vandenbroucke, J.P. & STROBE Initiative, 2008).

Notes:

An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

Appendix E: Quality Assessment Frameworks Scoring for Observational Studies.

Study / Criteria	Al-Darmaki & Kivlighan (1993)	Bachelor (2013)	Black, Hardy, Turpin & Parry (2005)	Hatcher, Barends, Hansell & Gutfreund (1995)	Hersoug, Høglend, Monsen, & Havik (2001)	Hersoug, Monsen, Havik & Høglend (2002)	Lee, Neimeyer & Rice (2013)	Peschken & Johnson (1997)
1. Title / abstract	1	1	1	1	1	1	1	1
2. Introduction - background	1	1	1	1	1	1	1	1
3. Objectives	1	1	1	1	1	1	1	0
4. Method - study design	1	1	1	1	1	1	0	1
5. Setting	1	1	1	1	1	1	1	1
6. Participants	0	0	1	0	1	1	0	1
7. Variables	1	1	1	1	1	1	1	0
8. Data sources	1	1	1	1	1	1	1	1
9. Bias	1	1	0	1	0	0	1	0
10. Study size	1	1	1	0	1	1	1	1
11. Quantitative variables	1	1	1	1	1	1	1	1
12. Statistical methods	2	2	2	2	1	1	2	1
13. Results - participant data	0	2	1	0	1	1	1	0
14. Descriptive statistics	1	1	1	0	1	1	1	1
15. Outcome data	1	1	1	1	1	1	1	1
16. Main results	2	1	1	1	1	1	1	0
17. Other analyses	1	1	1	1	0	0	1	0
18. Discussion - key results	1	1	1	1	1	1	1	1
19. Limitations	1	1	1	0	1	1	1	1
20. Interpretation	1	1	1	1	1	1	1	1
21. Generalisability	0	1	1	1	1	1	1	0
22. Funding	0	0	1	1	1	1	0	1
Total Score	**19/33**	**22/33**	**22/33**	**17/33**	**20/33**	**20/33**	**20/33**	**15/33**

Key:
U = Unable to determine 1 = Yes 0 = No - = Not applicable

Appendix F: Quality Assessment Frameworks Scoring for Experimental Studies.

Study / Criteria	Hartmann, Joos, Orlinsky & Zeeck (2015)	Heinonen, Lindfors, Härkänen, Virtala, Jääskeläinen & Knekt (2014)	Joyce & Piper (1998)	Kivlighan, Marmarosh & Hilsenroth (2014)
1. Hypothesis / aim / objectives	1	1	1	1
2. Main outcomes to be measured	1	1	1	1
3. Participant demographics	1	1	1	0
4. Interventions described	1	1	1	0
5. Principal confounders mentioned	0	1	0	0
6. Main findings reported	1	1	1	1
7. Random variability discussed	1	1	1	1
8. Adverse effects noted	0	0	0	0
9. Participant attrition mentioned	0	0	-	0
10. Probability values reported	1	1	1	1
11. Representative sample recruited	1	1	1	1
12. Representative sample participated	1	1	1	0
13. Ecologically valid setting	1	1	0	0
14. Extent of study blinding - interventions	0	0	U	0
15. Extent of study blinding - data analysis	0	0	U	0
16. 'Data dredging'	1	1	U	1
17. Consistency in follow-ups	0	1	U	U
18. Appropriate statistical tests	1	1	1	1
19. Compliance with intervention reliability	U	0	U	U
20. Validity of outcome measures	1	1	1	1
21. Participants in different interventions from same population	-	1	1	-
22. Participants recruited in same time frame	1	1	1	-
23. Randomisation of participants	0	0	1	0
24. Concealed randomisation	0	0	0	-
25. Adjustments for confounds	1	1	1	0
26. Participant losses accounted for	0	0	U	0
27. Sufficient statistical power	U	1	U	U
Total Score	**15/27**	**19/27**	**15/27**	**11/27**

Key:
U = Unable to determine 1 = Yes 0 = No - = Not applicable

Appendix G: Ethical Approval from the University of Southampton

E ERGO
10/02/2015 21:31

Your Ethics Submission (Ethics ID:12850) has been reviewed and approved
To: Simmons C.

Submission Number: 12850
Submission Name: DClinPsy Thesis: A qualitative exploration of how British trainee clinical psychologists judge the quality of therapeutic relationships in clinical practice.
This is email is to let you know your submission was approved by the Ethics Committee.

Comments
None
Click here to view your submission

ERGO : Ethics and Research Governance Online
http://www.ergo.soton.ac.uk

DO NOT REPLY TO THIS EMAIL

Appendix H: Recruitment Email to UK Doctorate in Clinical Psychology Course Directors

Dear .....(Course Director),

I am a 2nd year Trainee Clinical Psychologist currently undertaking my doctoral research at the University of Southampton's Doctorate in Clinical Psychology. I am emailing to request your permission to approach all Trainee Clinical Psychologists across the three years on your programme.

The title of my research is "A Qualitative Exploration of How British Trainee Clinical Psychologists' Judge the Quality of Therapeutic Relationships in Clinical Practice". This project is being supervised by Dr Kate Willoughby and Dr George Johnson at the University of Southampton.

This research has been granted ethical approval by the University of Southampton (ERGO Study ID number: 12850). I have attached confirmation of ethical approval to this email, and I have included my recruitment email below. I was wondering if you would circulate this email to the Trainees on your programme?

If you wish to speak to me further prior to this recruitment email being distributed, or if you need any further information, please do not hesitate to contact me on [left blank for confidentiality purposes].

Thank you in advance for considering my request.

Yours sincerely,

Carina Simmons
Trainee Clinical Psychologist
University of Southampton / Taunton and Somerset NHS Foundation Trust

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Dear Trainees,

I am a Trainee Clinical Psychologist currently in the second year of the Doctorate in Clinical Psychology at the University of Southampton. I am emailing to offer you the opportunity to participate in my research investigating how Trainees understand and measure the therapeutic relationship in their clinical practice.

The title of my research is "A Qualitative Exploration of How British Trainee Clinical Psychologists' Judge the Quality of Therapeutic Relationships in Clinical Practice". This project is supervised by Drs Kate Willoughby and George Johnson at the University of Southampton, and has been granted ethical approval by the University of Southampton (ERGO Study ID number: 12850).

To participate:

- You must be a Trainee Clinical Psychologist with at least six months' experience of training, as questions ask you to think about your clinical practice.
- The secure, encrypted questionnaire is available at: https://www.isurvey.soton.ac.uk/13538
- The password required to enter the questionnaire is: [left blank for confidentiality purposes]
- Please feel free to write as much as you want on the questionnaire.
- You will have the chance to win one of eight £50 Amazon vouchers!

All participation is entirely voluntary and anonymous. You can withdraw at any time during data collection by contacting me on [left blank for confidentiality purposes] and your confidentiality will be maintained at all times. Please email me if you wish to receive a copy of the summary of the results (anticipated September 2016).

I hope to contribute to the growing body of literature on conceptualising and measuring the therapeutic relationship, and develop recommendations to add to current methods of assessment of clinical skills in Clinical Psychology training programmes.

Thank you very much for your time and consideration.

Yours sincerely,

Carina Simmons
Trainee Clinical Psychologist
University of Southampton / Taunton and Somerset NHS Foundation Trust

Appendix I: Participant Information Sheet and Consent Form

Title of the research: Qualitative Exploration of British Trainee Clinical Psychologists' Lived Experiences of Judging the Quality of Therapeutic Relationships in Clinical Practice.
Researcher name: Carina Simmons, Trainee Clinical Psychologist, University of Southampton.
ERGO Study ID number: 12850

I am requesting your participation in a study regarding how you understand and judge the quality of the therapeutic relationships you have with your clients. This will involve taking part in an online semi-structured open-ended questionnaire lasting less than 1 hour.

You will be asked a number of questions and given the opportunity to answer these questions in your own time, at your convenience, by writing your responses in the boxes below the questions. Your responses can be as long as you wish, you are encouraged to give as much detail as possible.

Responses will be transcribed and later analysed. Personal information will not be released to or viewed by anyone other than researchers involved in this project. Results of this study will not include your name or any other identifying characteristics.

A potential outcome is to make recommendations with regard to developing clinical psychology training programme initiatives to improve the teaching on the therapeutic relationship and how Trainees are assessed in their clinical practice.

It is important that your answers do not contain any information identifying clients, colleagues or clinical settings including NHS Trusts or sites.

By continuing past this page, you are confirming the following statement of consent

- I have read and understood the information about this study.
- I voluntarily agree to take part in this research project and agree for my data to be used for the purpose of this study.
- I understand I may withdraw during data collection without my legal rights being affected.
- I also understand that data collected as part of this research will be kept confidential and that published results will maintain that confidentiality.
- I understand that if I have any questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I may contact the chair of the Ethics Committee, Psychology, University of Southampton, SO17 1BJ, UK. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk.

If you would like to enter the random prize draw to win one of eight £50 Amazon vouchers, you will be asked at the end of the questionnaire to enter a valid contact email address that you will have access to until after October 2016. Your decision about whether to enter does not affect your participation. You will be notified by email after October 2016 if you have won a voucher.

A password is required to access this survey. Please enter password below:

.....

☐ Please tick (check) this box to indicate that you consent to taking part in this survey.

Appendix J: Questionnaire Schedule

Section 1. Demographics

- Question 1. What is your gender?
- Question 2. How old are you?
- Question 3. What is your ethnicity?
- Question 4. Where are you currently undertaking your Doctorate in Clinical Psychology?
- Question 5. What year of Clinical Psychology training are you currently in?

Section 2. How You Understand the Therapeutic Relationship

- Question 1. What do you do to help to build the therapeutic relationship with a client? What factors do you feel are important?
- Question 2. How would you define or characterise the term 'therapeutic relationship'? What does this mean for you?
- Question 3. If your understanding of the therapeutic relationship has changed over time, can you explain how this has changed and what influenced this?
- Question 4. How important do you feel the therapeutic relationship is to therapy? Can you describe examples of where you have felt the therapeutic relationship has been particularly important and why?

Section 3. How You Measure the Therapeutic Relationship

- Question 1. What makes a good therapeutic relationship different from a poor therapeutic relationship?
- Question 2. How do you measure the quality of the therapeutic relationships you have with clients?
- Question 3. Can you give examples of the challenges you have encountered in building a therapeutic relationship? How have you overcome these challenges?
- Question 4. Can you describe a time when a client has not felt the same way about the therapeutic relationship as you, and how you made sense of this discrepancy?
- Question 5. If applicable, can you describe a time when you have attended to ruptures in the therapeutic relationship with a client?

Section 4: Your chance to enter the £50 Amazon voucher prize draw

- Question 1. If you would like to enter the random prize draw to win one of eight £50 Amazon vouchers, please provide a valid contact email address that you will have access to until after October 2016 in the box below.

Appendix K: Debriefing Sheet

Title of Research: A Qualitative Exploration of How British Trainee Clinical Psychologists Judge the Quality of Therapeutic Relationships in Clinical Practice
Researcher name: Carina Simmons, Trainee Clinical Psychologist, University of Southampton
ERGO Study ID number: 12850

The aim of this research was to investigate how Trainee Clinical Psychologists understand and measure the quality of their therapeutic relationships in clinical practice. As this study uses qualitative methodology, it is unknown what themes will emerge from the interviews of participants until analysis has taken place.

Knowing more about how you understand and measure the therapeutic relationship in clinical practice will help develop a wider understanding of how the therapeutic relationship is understood.

Results of this study will not include your name or any other identifying characteristics. This research did not use deception. If you feel you need support after having participated in this study, if may be of use to contact your clinical tutor, your University Counselling Service, your GP or alternatively, the Samaritans on 08457 90 90 90.

You may choose to receive a copy of the summary of research findings once the study has been completed, if you wish, by contacting the researcher on the details provided below.

Furthermore, if you chose to enter the random prize draw to win one of eight £50 Amazon vouchers by entering a valid contact email address that you will have access to until after October 2016, you will be notified by email if you have won one of these vouchers after October 2016.

If you have any further questions please contact Carina Simmons (Trainee Clinical Psychologist and Lead Researcher) via email on [left blank for confidentiality purposes]

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the chair of the Ethics Committee, Psychology, University of Southampton, SO17 1BJ, UK. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk.

Thank you for your participation in this research.

Appendix L: Recruitment Process and Participation Data

Universities / Course Centres	Took part	Further ethics process	Declined (D) / no reply (NR)	2015 intake	2014 intake	2013 intake	Total intake	Responses (response rate)
Bangor	No	-	D	11	11	11	33	0
Bath	No	-	NR	14	17	17	48	0
Birmingham	No	-	NR	17	17	25	59	0
Coventry and Warwick	No	-	NR	10	10	15	35	0
East Anglia	No	-	NR	22	16	15	53	0
East London	Yes	No	-	31	31	31	93	0
Edinburgh	No	-	NR	29	30	28	87	0
Essex	No	-	D	11	10	10	31	0
Exeter	Yes	No	-	15	14	15	44	1 (2.27%)
Glasgow	Yes	No	-	24	25	23	72	3 (4.17%)
Hertfordshire	Yes	No	-	15	16	15	46	5 (10.87%)
Institute of Psychiatry	No	-	NR	21	21	21	63	0
Lancaster	Yes	No	-	24	24	24	72	4 (5.56%)
Leeds	Yes	Yes	-	16	16	16	48	9 (18.75%)
Leicester	Yes	No	-	12	12	13	37	1 (2.70%)
Liverpool	Yes	No	-	24	24	24	72	4 (5.56%)
Manchester	No	-	NR	24	24	25	73	0
Newcastle	Yes	No	-	14	14	14	42	3 (7.14%)
North Thames – University College London	Yes	No	-	42	42	42	126	4 (3.20%)
Oxford	Yes	Yes	-	17	15	15	47	5 (10.64%)
Plymouth	Yes	No	-	13	12	13	38	3 (7.89%)
Royal Holloway	Yes	No	-	29	29	29	87	6 (6.90%)
Salomons (Canterbury Christchurch University)	Yes	No	-	33	33	33	99	6 (6.06%)
Sheffield	Yes	No	-	18	18	18	54	1 (1.85%)
Southampton	Yes	No	-	13	13	13	39	7 (17.95%)
South Wales	Yes	No	-	16	15	14	45	3 (6.67%)
Staffordshire	Yes	No	-	15	15	15	45	1 (2.22%)
Surrey	No	-	D	31	29	29	89	0
Teesside	Yes	No	-	14	14	14	42	0 (0%)
Trent - Lincoln/ Nottingham	Yes	No	-	16	16	17	49	4 (8.16%)
Totals	**20**	**2**	**10**	**591**	**583**	**592**	**1,766**	**70 (100%)**

Appendix M: Anonymised Exemplar Participant Transcript

1. ***What do you do to help to build the therapeutic relationship with a client? What factors do you feel are important?***

   It sounds very basic but I think the basic skills really help. Really listening and clarifying what I have heard, focusing on feelings and trying to understand, having a curious stance, wanting to know the reality for them, asking for their opinion and feedback, explaining the process and why I am doing or asking the things I am, being open and honest not afraid to get things wrong and talk openly. Being human with people I suppose not treating people as if they have a problem or as if there is something wrong with them, I am yet to work with anyone where there experience and response doesn't make sense. I name things happening in the room and reflect on how things are going inviting a space for honesty and exploration. Despite doing these things I am also aware that sometimes this isn't enough and I am by no means perfect I aim for good enough and use supervision to unpick things that have come up or explore barriers to compassion and empathy.

2. ***How would you define or characterise the term 'therapeutic relationship'? What does this mean for you?***

   I think it is trying to capture the feelings in the room when working with someone. Therapy can feel awful and can feel judging and threatening. The therapeutic alliance for me is how much a person can be who they are in the room and this is enabled by the relationship between them and the therapist. It is my role to be consistent and open enough to assist this relationship and dispel stigma, worry and fear in the way I speak respond and react in the room and to do all this as naturally as possible, basically using myself and my way of being as the main therapeutic tool.

3. ***If your understanding of the therapeutic relationship has changed over time, can you explain how this has changed and what influenced this?***

   I have been a researcher historically and therapeutic alliance was something we measured and it always seemed odd that it was the therapist notion off how well therapy was going that seemed to determine therapeutic alliance although I have also used service user self report measures alongside therapist self report measures. Over time and with more clinical experience I believe it is much more complex than this the therapeutic relationship is fluid and changes and can be difficult to explain in words. I really think that it is the people we work with who are the best judge of the therapeutic relationship however if it is a strong alliance there should be parallels between the therapist and service user's perspective.

4. ***How important do you feel the therapeutic relationship is to therapy? Can you describe examples of where you have felt the therapeutic relationship has been particularly important and why?***

   I think it is the most important aspect of therapy. I don't believe the model used or anything else has any comparison to therapeutic alliance. With every person I have worked with it has been our shared understanding, honesty, validation and the relationship in the room that has enabled acceptance and change. Without this aspect I think the person could feel some benefit but I'm not confident it would be very valuable and could perhaps be more damaging than helpful. This puts a lot of pressure on us as individuals which is why supervision and looking after ourselves is important it is what happens between the therapist and the persons that is important not individual factors that we bring with us

5. ***What makes a good therapeutic relationship different from a poor therapeutic relationship?*** For example: when using CBT for PTSD It was understanding a particular persons belief about memory and masculinity that made a difference more so than the reliving work, which a textbook may have emphasised. Another person (using CBT) completed all the diaries and expressed how good therapy was and allowing this to be explored and allowing criticism changed everything, rather than accepting this good feedback as fact. Using CAT it was

listening to and making sense of individual experience and talking about the power imbalance in our relationship openly that enabled a meaningful understanding this took time and really listening to what the person said and how they were in the room. I am currently working psychodynamically and this allows more focus on the relationship and again sometimes its boundaries are not human enough to allow a good therapeutic alliance which is a challenge. The complex cases (for want of a better term) I currently work with have very emotional and difficult things they want to talk about and without a good therapeutic alliance they would never be spoken in the room, our relationship in therapy has enabled them to talk about thoughts that have terrified them and contradictions to what perhaps is perceived as good or 'normal' to share things they are deeply ashamed of and how they feel about therapy and me as a therapist. Once this has happened, once someone has for example expressed the fear that they are "mad" a "bad mother" or that they are dissatisfied with the person they idolise or hate themselves and want take their own life. When they can connect these thoughts and experiences to feelings and we can understand this together, the conversation becomes real and therapeutic alliance is active (if that makes sense).

6. ***How do you measure the quality of the therapeutic relationships you have with clients?***

   A good therapeutic relationship is a relationship where two or more people can be who they are safely and without prejudice. It is an honest collaboration without a need for perfection, it is paced and meaningful focusing on feelings and thoughts (of both parties) and grounds thoughts and feelings to concrete observations and experience. A poor therapeutic relationship has a one sided agenda and ignores everything that doesn't fit in a pre-determined structure, it denies a person's reality and right to make bad choices, it denies any fault with the therapy or the therapist and it has no consistency or clear boundaries or a clear ending to allow the person room for autonomy. It is over/under involvement and based upon systemic targets that ignore the person.

7. ***Can you give examples of the challenges you have encountered in building a therapeutic relationship? How have you overcome these challenges?***

   In sessions it is measured by feedback and through an open dialogue; however this is not good enough, if people are doing better on any outcome measures the therapeutic alliance is definitely a dominant factor in this. I have used measures specific to therapeutic alliance but they are not all encompassing. It's tricky, because I don't think I should be judging this for my own therapy. I'm biased and I certainly should not be asking because this biases a person's response. General feedback to the service is useful and described changes that have improved a person's well-being and their life also provides information, but can this be attributed to the therapeutic alliance? I'm unsure. Sometimes if someone turns up consistently this also provides information, it is often idiosyncratic and this is the problem. I think there really needs to be a better way of measuring therapeutic alliance but I don't have the answers. I just work with the tools I have or the service provides, and maintain an open dialogue about therapy itself with the people I work with (by no means a good way of measuring it but keeps it in mind).

8. ***Can you describe a time when you have had a sense that a client has not felt the same way about the therapeutic relationship as you, and how you understood this discrepancy?***

   I have had many challenges to it. There have been times I have just dreaded sessions with a particular individual or I have been talked at for an hour and leave sessions feeling confused and overwhelmed, or not knowing what is going on. I have had sessions where I have to focus on risk and safeguarding and I always do this openly and explain the process and reasons as I go but this does impact on it anyway. I have attended meetings and worked with families and couples where everyone has a different focus and forming a therapeutic alliance with a system is really difficult. I have worked with sex offenders and perpetrators of violence where I morally disagree with their actions and it is a challenge to separate that from our relationship. I often feel pulled into caring too much and wanting to do more than is helpful. In all these cases I have used supervision, I have reflected on these experiences and how it has made me

feel to make sense of the barriers, formulated my own stuff to enable me to become unstuck or develop an understanding. I don't think it is simple to develop a good therapeutic alliance; there's no way to guarantee it will happen, so always being aware and being psychologically present when working with people seems very important.

9. ***If applicable, can you describe a time when you have attended to ruptures in the therapeutic relationship with a client?***

   I often feel a discrepancy at some point in therapy often at the start or mid-way I consider this good because we are two (or a group) of different people and we haven't developed a relationship or there are different expectations that haven't necessarily been voiced. Therapy is a strange situation and it often takes time to develop a relationship so I would be suspicious if I ever felt I was therapeutically aligned with a person throughout and sometimes it is the ruptures or changes in the alliance that provide most important information and allow for a greater shared understanding, Clients indicate this in what they say how they are and behave. Sometimes, I am surprised by something or simply don't understand these times are salient and important and I am yet to work with someone where this hasn't occurred. I have so many examples. I have noticed a change in someone in a session their interpersonal responses body language, sometimes I name it, sometimes it's more appropriate to wonder if perhaps something has changed or if they are angry, sad, frustrated etc. I have had people not come to sessions and to explore that with understanding. There are times when a person has been angry at me or hidden things because they want me to consider them in a positive light. Sometimes I haven't heard things correctly, made a mistake or made an assumption. I try to explore expectation at the beginning and can address the fact that I am not perfect and can make mistakes in an attempt to introduce an open dialogue but this isn't always enough and the relationship is worked on throughout therapy. I have had to alert safeguarding teams and shared this before during and after with clients, and this has often resulted in a rupture, which has been explored always listening to their perspective and being open and honest about my thoughts and intentions.

Appendix N: Reflexive Diary Extract

The researcher approached the research process with assumptions about the terms 'therapeutic relationship', the 'therapeutic alliance' and the 'working alliance', where it was felt that these could be somewhat interchangeable terms. Through reviewing the literature, the researcher discovered that the therapeutic alliance and working alliance are widely considered to be phenomena occurring within the broader context of the therapeutic relationship. As the researcher is a Trainee themselves, the researcher was aware that not all other Trainees will have done research into the historical concepts and evolution of the terms. The researcher was also aware of the impact of being on different training courses, which will inevitably place different levels of importance on the concept and use of the therapeutic relationship in clinical practice.

The researcher therefore made the decision to refer to the therapeutic relationship throughout the project, in order to capture information that might go beyond capturing the therapeutic alliance or working alliance, and explore other aspects of the therapeutic relationship that might still be elusive or less established. The researcher was also aware of their background in counselling psychology and their experience in prioritising, processing and attending to issues within the therapeutic relationship in clinical practice.

The researcher also felt it could be important to avoid assuming that, for those Trainees who have a clear idea about how they understand the concept of the therapeutic relationship, they would base this on a specific model, such as Bordin's (1979) definition of the working alliance. Furthermore, the researcher did not want to inadvertently reduce possible factors or constituents of the therapeutic alliance and wider therapeutic relationship to those related to research models. This was in order to allow the richness of the data to emerge and possibly add to pre-existing understandings of the therapeutic alliance and therapeutic relationship, or perhaps pave the pathway to future research exploring newer or wider models of these concepts.

The researcher spent time reflecting on their responses to the answers provided by participants and was aware of the presence of a number of Trainees reporting that they did not have any experience of ruptures or difficulties within their therapeutic relationships with their clients. The researcher wondered whether, just by being in an interaction with someone where both roles are acknowledged, surely Trainees are actively managing and attending to actual or perceived ruptures by responding appropriately in order to gain a desired response (for example, a reduction in distress) and/or positive feedback (such as gratitude) or reassurance? Perhaps Trainees only recognise the difficult-to-resolve, anxiety-provoking or unresolvable ruptures that may start a negative feedback loop as actual ruptures.

If this is the case, the researcher pondered over whether Trainees could be overlooking subtle ruptures they are constantly managing, because they have become so primed to expecting increased distress among our clients. The researcher also wondered what it might mean if Trainees, and therapists in general, ever have ruptures? An observation that instigated this level of thought was that some Trainees reported an absence of ruptures but also referred to self-monitoring and observing their clients' verbal responses and non-verbal behaviours. The researcher considered whether those who had reported "Not applicable" to questions regarding their experiences of ruptures could really mean there had been no actual ruptures, or whether these Trainees were unable to perceive ruptures, or whether they were underestimating the work they are actually doing. By constantly responding to clients' needs in sensitive and flexible ways, are Trainees not managing ruptures that they might otherwise experience if they endorsed a more inflexible, rigid, insensitive and prescriptive approach? It is clear that more research was, and is still needed to further explore this phenomenon.

Appendix O: Coding Manual

NAME	DESCRIPTIONS	CODED TEXT
Measuring Quality	Definition: Trainees' most commonly reported approaches to measuring the therapeutic relationships they have with their clients, along with indicators of both good and bad therapeutic relationships, detailing both qualitative and quantitative approaches.	
Therapist Approaches	Definition: Trainees' accounts of their different methods of understanding how they measure the therapeutic relationship and the issues encountered in standardising this process, including their reflections on their own emotions and instincts, their use of quantitative measures, feedback received from clients and their own reflective practice.	
Quantitative Tools 3 sources 21 references	Definition: Trainees' descriptions of the psychometric measures they use. NB: this includes the following numerical counts: including general outcome measures (n=2), nonspecific measures (n=6), the CALPAS (n=1), the HAT (n=2), the ORS (n=2), the SOS (n=1), the SRS (n=10 refs from 3 sources), the WAI (n=4) and the TCS (n=1). Inclusion criteria: statements confirming that Trainees make use of quantitative/ psychometric measures in response to questions about how they measure the quality of their therapeutic relationships. Exclusion criteria: statements that do not contain direct references to Trainees using quantitative/psychometric measures to assess the quality of the therapeutic	<Internals\\ISurvey Responses\\Question 1 Responses> - § 1 reference coded [0.51% Coverage] Reference 1 - 0.51% Coverage: I also use a session rating scale to monitor the alliance and bring any changes in score into the room for discussion with the client. <Internals\\ISurvey Responses\\Question 3 Responses> - § 1 reference coded [1.03% Coverage] Reference 1 - 1.03% Coverage: Being aware of research that the relationship is the most important factor in therapeutic outcomes helps me feel confident that its quality time well spent, just to focus on the relationship. Now I use the Session Rating Scale to monitor therapeutic relationship. <Internals\\ISurvey Responses\\Question 6 Responses> - § 19 references coded [12.02% Coverage] Reference 1 - 0.18% Coverage: Using measures such as WAI. Reference 2 - 0.86% Coverage: I think more formal measures like the Outcome rating scale can be useful at times but if I'm honest I rarely use formal measures. Reference 3 - 0.16% Coverage: Session outcome scales. Reference 4 - 0.58% Coverage: I have used measures specific to therapeutic alliance but they are not all encompassing. Reference 5 - 0.59% Coverage: I use the session rating scale and sometimes I use the Helpful Aspects of Therapy scale.

	relationships with their clients or references to alternative approaches such as gut instinct.	Reference 6 - 0.79% Coverage: Sometimes. I haven't had many therapy cases yet but have done in the past using Helpful Aspects of Therapy Scale (HATS). Reference 7 - 0.60% Coverage: I tend to use the session rating scale each session as a measure of therapeutic alliance. Reference 8 - 0.30% Coverage: Sessional measures e.g. Session Rating Scale. Reference 9 - 0.45% Coverage: Measures such as the SRS (Session Rating Scale). Monitoring outcome. Reference 10 - 0.45% Coverage: I use the sessions rating scale and therapeutic competency scales. Reference 11 - 0.32% Coverage: I use the Session Rating Scale where appropriate Reference 12 - 0.89% Coverage: Formally through a post-assessment questionnaire completed by the client, which asks about how comfortable they felt with the therapist. Reference 13 - 1.47% Coverage: I also make use of the Session Rating Scale (SRS) (I think it's by Miller & Duncan, 2000?). It provides four scales for the client to fill out and the therapeutic relationship can therefore be charted as sessions continue. Reference 14 - 0.25% Coverage: Session Rating Scale and ORS measures, Reference 15 - 0.98% Coverage: As a general rule I don't specific psychometrics (although have used the Working Alliance Inventory on some occasions to evaluate this more formally. Reference 16 - 0.82% Coverage: Practically with written measures of the session quality and therapeutic relationship (i.e. collect feedback and review this). Reference 17 - 1.11% Coverage: Currently this is not something I do, but prior to training when working in an IAPT service we handed out patient evaluation sheets which included a question on this. Reference 18 - 1.02% Coverage: Sometimes I use measures at the end of the session to check how the client has found the session and how they perceive the therapeutic relationship to be.

		Reference 19 - 0.20% Coverage: Quantitatively I use the CALPAS.
In-Vivo Indicators	Definition: Trainees' most commonly reported signs, signifiers or indicators of the quality of their therapeutic relationships, based on a multitude of client and therapist factors, such as attunement or a shared understanding, congruence, honesty and openness and trust, and the client's perceived levels of motivation and actual attendance.	
Motivation and Attendance *6 sources* *33 references*	Definition: Trainees' accounts of their perceptions of their clients having good levels of motivation and attendance of therapy sessions as signs of having a good therapeutic relationship. Inclusion criteria: Trainees' descriptions of perceiving either good attendance, motivation and engagement being indicative of having a good therapeutic relationship, or perceiving poor attendance, motivation and engagement as signifying having a bad therapeutic relationship. Exclusion criteria: Trainees' descriptions of other observable or non-observable phenomena outside of engagement, attendance and motivation as signs of either a good or poor therapeutic relationship.	<Internals\\ISurvey Responses\\Question 1 Responses> - § 1 reference coded [0.17% Coverage] Reference 1 - 0.17% Coverage: The client's motivation to engage in therapy. <Internals\\ISurvey Responses\\Question 5 Responses> - § 7 references coded [7.40% Coverage] Reference 1 - 0.81% Coverage: What the client thinks of the relationship! If they think it's poor, then it is and this will show in their engagement with you e.g. DNAs. Reference 2 - 0.81% Coverage: When the client does not want to engage, gives short answers, finds it difficult to explore or think beyond what they have shared with us. Reference 3 - 2.49% Coverage: They are motivated to come to sessions and work with the therapist (and the work is 50:50, as opposed to the therapist taking on too much of the responsibility if the client is reluctant to open up). The good therapeutic relationship is collaborative. A poor therapeutic relationship is one in which the client does not feel safe and supported, does not feel they are making progress and is not motivated to come to sessions. Reference 4 - 0.45% Coverage: A bad therapeutic relationship forces the client to close down or disengage. Reference 5 - 0.53% Coverage: Clearly them turning up to therapy is a good indicator that things aren't going terribly. Reference 6 - 1.40% Coverage: In a poor therapeutic relationship I imagine the client would be much less 'up for' trying out new things, such as behavioural experiments. The client may also be less open with the therapist, perhaps because they don't trust them as much. Reference 7 - 0.91% Coverage: The extent to which the client engages in the session, turns up to the session on time, completes any homework task, takes ownership of their

		difficulties. <Internals\\ISurvey Responses\\Question 6 Responses> - § 19 references coded [15.36% Coverage] Reference 1 - 0.95% Coverage: I think a good but simple test is just whether they attend or not, if you have engaged them and built a good rapport then they come to sessions. Reference 2 - 1.73% Coverage: Generally by whether they keep coming back the therapy, whether they report they get anything out of it, by asking them for feedback, gauging their interest/engagement levels in sessions (are they yawning a lot and if so, is it because I'm getting it all wrong!) Reference 3 - 1.01% Coverage: I might also look for signs such as DNAs, to see if there are potential problems which need to be addressed or explored in the therapeutic relationship. Reference 4 - 0.29% Coverage: By their engagement and motivation to share. Reference 5 - 0.99% Coverage: Can manifest in observable phenomena e.g. clients requesting to reschedule so I can be present at MDT meetings, client punctuality and amount of DNAs. Reference 6 - 0.34% Coverage: I gauge from their reaction and engagement with me. Reference 7 - 2.27% Coverage: I think this is a very difficult question to answer and I think I simply measure the quality of the therapeutic relationship by their level of engagement in both the sessions and in the interventions outside of the sessions and ask them to let me know if they don't feel comfortable or if they are experiencing any problems in the relationship. Reference 8 - 0.72% Coverage: In rapport, re-attendance at sessions, and asking directly for feedback on how they are finding the process. Reference 9 - 0.61% Coverage: Based on their reactions to me and what I say, and on how well they engage with the process. Reference 10 - 0.22% Coverage: I pay attention to DNAs, lateness. Reference 11 - 0.95% Coverage: Whether they come to sessions/how they explain

		cancellations/DNAs. A "sense" of whether they like me - same as with any other human interaction! Reference 12 - 0.67% Coverage: Their commitment to the sessions, do they come on time, do they do homework, are they open and honest. Reference 13 - 0.84% Coverage: I think clinically is probably most relevant - whether clients will engage with you and keep coming back, despite any barriers. Reference 14 - 0.92% Coverage: Disengagement can sometimes be a marker of relationship, although it is always important to consider potential other factors for the client. Reference 15 - 0.30% Coverage: Quantitatively by CORE and attendance rates. Reference 16 - 0.34% Coverage: Whether they engage with the work/ attend sessions. Reference 17 - 0.41% Coverage: By their engagement with me and whether they attend sessions. Reference 18 - 0.94% Coverage: by how I perceive the client's engagement, the extent to which they complete their homework and take an active role in their treatment/support. Reference 19 - 0.87% Coverage: I think we can sometimes see the quality of the relationship in the amount of sessions attended, level of information divulged etc. <Internals\\ISurvey Responses\\Question 7 Responses> - § 3 references coded [0.42% Coverage] Reference 1 - 0.05% Coverage: Clients DNAing Reference 2 - 0.24% Coverage: Clients consistently not showing up to appointments from the start. Reference 3 - 0.13% Coverage: Difficulty attending early sessions. <Internals\\ISurvey Responses\\Question 8 Responses> - § 2 references coded [1.53% Coverage] Reference 1 - 1.10% Coverage: Other times I've felt as though a session went really well and then the client never came back again. It is hard to know what that might mean for

		your relationship when they don't give any feedback about why they didn't return. Reference 2 - 0.43% Coverage: In one example, I thought the sessions were going well and then they stopped attending. <Internals\\ISurvey Responses\\Question 9 Responses> - § 1 reference coded [0.43% Coverage] Reference 1 - 0.43% Coverage: An example that comes to mind is a client was disengaging near the end of a session.
Intuition, Feelings and Gut *3 sources* *29 references*	Description: Trainees' descriptions of their own feelings elicited during and between sessions by their therapeutic interactions with the clients as used to inform them of the apparent quality of the therapeutic relationship, often but not always referred to as intuition or gut instinct. Inclusion criteria: Trainees' references to less tangible, difficult to define or their largely intrapsychic experiences that act as indicators of the quality of the therapeutic relationship, namely around gut instinct, specific emotions and intuition. Exclusion criteria: Statements that do not contain references to either specific emotions, intuition or gut instinct as signs of indicating the quality of the therapeutic relationship.	<Internals\\ISurvey Responses\\Question 5 Responses> - § 4 references coded [3.88% Coverage] Reference 1 - 1.71% Coverage: The feeling you get from the session. You feel a connection with the other person. You don't get that all the time. Doesn't mean to say you can't help those people, but in my experience the connection is very valuable. I think it enables/empowers clients to take risks in opening up or not. Reference 2 - 0.53% Coverage: A subjective feeling that progress is being made, or that individual sessions feel useful. Reference 3 - 0.67% Coverage: It's hard to express in words. There's an intangible connection between individuals when you know it’s going well. Reference 4 - 0.97% Coverage: It also impacts on how I feel in the session, how fluid/smooth I can transition from one part of the session to the next, and my timekeeping throughout the session. <Internals\\ISurvey Responses\\Question 6 Responses> - § 24 references coded [16.82% Coverage] Reference 1 - 0.43% Coverage: Do I as the therapist feel like I can share information and ideas? Reference 2 - 0.41% Coverage: Do I feel like I'm doing all the work or not able to do my job? Reference 3 - 1.26% Coverage: I think it is something you can sense, you can tell if the client feels safe/comfortable. It might also be obvious in how you feel about the client and

		what type of emotions they elicit in you. Reference 4 - 1.20% Coverage: Also the level to which I feel I can challenge them and that this feels ok - not too threatening to our alliance such that they become unmanageably distressed or just don't come back. Reference 5 - 0.70% Coverage: Just by the sense I get of how well connected I felt to them, and how comfortable I felt in the sessions. Reference 6 - 0.61% Coverage: Largely in implicit ways - more about the 'feel' of the relationship than an objective fact. Reference 7 - 0.25% Coverage: I suppose it's often just a feeling. Reference 8 - 1.78% Coverage: I rely primarily on my own feelings about how the client is responding to me, and what they say and do (e.g. being late for sessions or missing sessions can be a big sign something is wrong- or feeling like the client is 'resisting' or you're doing too much of the work). Reference 9 - 0.72% Coverage: I think it’s intuitive, you can feel it in the session and you can feel it after you have left the session. Reference 10 - 0.85% Coverage: I am slightly adverse to paper based measurement. I good therapist can intuitively tell whether the relationship is good or bad! Reference 11 - 0.30% Coverage: I would say gut instinct - whatever that is! Reference 12 - 0.41% Coverage: No specific way of measuring - more to do with a felt sense. Reference 13 - 0.21% Coverage: I think I rely on gut reaction. Reference 14 - 0.30% Coverage: ...My reactions to the process of therapy. Reference 15 - 0.26% Coverage: Through my subjective experience of it. Reference 16 - 0.22% Coverage: How comfortable I feel with them. Reference 17 - 1.42% Coverage: However, I would also draw on intuition and introspection- thinking about how I feel when I'm with a client to evaluate the quality of the relationship, as well as thinking about how the therapy is going in general.

		Reference 18 - 0.66% Coverage: I measure them subjectively through my experiences of sessions, how the client reacts, ruptures etc. Reference 19 - 0.64% Coverage: Sometimes its non-verbal e.g. a feeling you have as therapist (e.g. the feeling of pure empathy). Reference 20 - 0.45% Coverage: You have a gut feeling that you are getting on well with the client. Reference 21 - 0.53% Coverage: I also try to be aware of my feelings towards he client (counter-transference). Reference 22 - 1.39% Coverage: I'm not sure I know! I think I probably just go on instinct. Actually I think I know when I have a good therapeutic relationship with someone because I feel confident about seeing them and in what they're doing. Reference 23 - 1.72% Coverage: As soon as I start to feel nervous before a session, or even sense that my own barriers are up in some way because I don't feel quite right (I guess that's the instinct bit!) then I would make the presumption that there is something lacking in the relationship Reference 24 - 0.09% Coverage: Gut feeling. <Internals\\ISurvey Responses\\Question 8 Responses> - § 1 reference coded [0.65% Coverage] Reference 1 - 0.65% Coverage: I think normally if the relationship isn't going well you both know or it's hidden I don't think there's often much of a discrepancy
Honesty, Trust and Openness *2 sources* *35 references*	Definition: Trainees' accounts of the extent to which both they and their clients feel able to be open, honest and perceive there to be trust between them as indicators of having a good therapeutic relationship. Inclusion criteria: Trainees' references to experiencing a mutual	<Internals\\ISurvey Responses\\Question 5 Responses> - § 27 references coded [20.19% Coverage] Reference 1 - 0.62% Coverage: One that is open and transparent and the therapist does not lie or withhold the information is essential. Reference 2 - 1.53% Coverage: Fostering an atmosphere in which your client could share negative feelings without fear of judgement or rejection. I guess your client feels understood, able to participate in the process and encouraged to express themselves honestly without fear of judgement.

	degree of honesty, trust, safety, respect/being non-judgmental and openness, or their perception of either the presence or absence of their own or their clients' experiences of these qualities, which they take as signs of the quality of the therapeutic relationship. Exclusion criteria: Statements that do not contain direct or indirect to experiences of trust, openness, honesty or safety on the part of the trainee and/or the client, in relation to how the trainee gets a sense of the quality of the therapeutic relationship.	Reference 3 - 1.55% Coverage: I think a good relationship results in better outcomes for both the therapist and patient. It differs in terms of how helpful the therapy may feel to the client, and how understood they may feel. I think it aids formulation by allowing the client to be more open. Reference 4 - 0.79% Coverage: In a good relationship the client will feel able to speak freely and give honest feedback. They will be empowered to direct the work. Reference 5 - 0.30% Coverage: Transparency, collaboration, honesty and openness. Reference 6 - 1.62% Coverage: I think a good therapeutic relationship is one in which the client feels safe, they can open up to you, they engage not just on a surface level but really engage in the work that you are doing and it needs to be a collaborative relationship where you are both contributing. Reference 7 - 0.60% Coverage: In a good therapeutic relationship, the client feels safe to bring up everything they want to explore. Reference 8 - 0.53% Coverage: In a good one both parties will feel safe and comfortable enough to be open and honest. Reference 9 - 0.73% Coverage: A good therapeutic relationship is a relationship where two or more people can be who they are safely and without prejudice. Reference 10 - 0.60% Coverage: Both the client and the therapist feel they can be open and honest in a good therapeutic relationship. Reference 11 - 0.52% Coverage: The environment feels safe and containing, sensitive issues can be raised and explored. Reference 12 - 0.53% Coverage: Trust, openness, understanding, humour, a shared language, mutual respect/positive regard. Reference 13 - 0.68% Coverage: Trust, warmth, and the ability to say the unsayable and raise difficulties and reactions encountered within therapy. Reference 14 - 0.33% Coverage: Trust, honesty and openness. Feeling cared for and safe. Reference 15 - 0.57% Coverage: Openness and willingness of therapist to connect and meet client according to client's interests.

		Reference 16 - 0.67% Coverage: The ability to openly discuss the therapeutic relationship. Confidence and trust in the clinician from the client. Reference 17 - 1.11% Coverage: Good is when therapists feel comfortable to raise issues with timing, engagement etc and bad is when people are potentially being seen for a long period of time without issues being raised. Reference 18 - 0.56% Coverage: Warmth, unconditional positive regard, honesty, trust, openness - good therapeutic relationship. Reference 19 - 1.44% Coverage: I think that when people slowly start to tell you more and more as the relationship develops. That differs from people who are a little unboundaried and tell all from the start. That for me is an indicator of trust essential to the relationship. Reference 20 - 1.31% Coverage: A good therapeutic relationship is one where there is trust and respect between the two parties and where when ruptures happen, they can be explored, understood and repaired. One where the client feels heard and understood. Reference 21 - 0.05% Coverage: Honesty. Reference 22 - 0.40% Coverage: Being open-minded to people's different experiences, and not judging. Reference 23 - 0.16% Coverage: Trust, engagement, empathy. Reference 24 - 0.74% Coverage: Good - feels safe, engages in sessions, opens up, appropriate boundaries, whereas a poorer one may make these things harder. Reference 25 - 1.35% Coverage: One where both the patient and therapist feel able to challenge one another, where the patient feels able to discuss any thoughts/behaviours that have made them feel ashamed and which they have previously not been able to discuss. Reference 26 - 0.62% Coverage: Everything! The extent to which the client is happy to talk in the session, to share their story with you. Reference 27 - 0.28% Coverage: Openness, respect, therapeutic gain and willing. <Internals\\ISurvey Responses\\Question 6 Responses> - § 8 references coded [8.86%

		Coverage] Reference 1 - 1.74% Coverage: I think their gradual ability to open up to you and feel comfortable in the room with you is a good indication and how well you progress with the work, if the work isn't going well I would be trying to come back to the relationship and use that to understand why. Reference 2 - 0.86% Coverage: I think that if a client feels able to speak honestly then that is a good indicator, and spans some quite different presentations. Reference 3 - 0.27% Coverage: Also how comfortable they appear with me. Reference 4 - 0.36% Coverage: Whether they feel able to trust you and open up to you. Reference 5 - 1.72% Coverage: Informally through continuously assessing the quality of the interaction in the room, by monitoring eye contact, use of humour, how well the conversation/session flows, whether changes are implemented and how open the client is to giving and receiving feedback. Reference 6 - 1.20% Coverage: Also, client's being open and honest with me suggests they feel safe to do so. Being able to become frustrated/angry/upset in sessions and work through it with me as their therapist. Reference 7 - 1.94% Coverage: Being able to challenge clients in a supportive way can be a good indicator. If the relationship is not there, this will be more difficult, potentially with the client being much more defensive to challenges, or feeling that they are personal as opposed to challenging them to face difficulties. Reference 8 - 0.77% Coverage: For example if they seem more relaxed and able to share more information then I feel we have a stronger relationship.
Client Feedback *2 sources* *28 references*	Description: Trainees' descriptions of how they use client feedback in order to gain a sense of either their overt or covert views of the quality of the therapeutic relationship, when trying to ascertain the quality of their therapeutic relationships with their	<Internals\\ISurvey Responses\\Question 3 Responses> - § 1 reference coded [1.21% Coverage] Reference 1 - 1.21% Coverage: The therapeutic relationship is fluid and changes and can be difficult to explain in words. I really think that it is the people we work with who are the best judge of the therapeutic relationship however if it is a strong alliance there should be parallels between the therapist and service user's perspective. <Internals\\ISurvey Responses\\Question 6 Responses> - § 27 references coded [14.81%

	clients. Inclusion criteria: Trainees' references to their actively seeking or making use of client feedback as a method of assessing the quality of the therapeutic relationship. Exclusion criteria: Statements that do not contain direct references to making use of client feedback when Trainees are in the process of trying to ascertain the quality of the therapeutic relationship.	Coverage] Reference 1 - 0.45% Coverage: Gaining feedback from the client and other involved professionals. Reference 2 - 1.24% Coverage: I do ask clients for feedback. I read recently how the difference between an average and really good therapist is asking for client feedback regularly and using this constantly to improve. Reference 3 - 0.89% Coverage: I suppose it is something I encourage discussion about regularly throughout therapy, particularly if there seems to be difficulties. Reference 4 - 0.86% Coverage: I find it easier to have more direct conversations in it when using approaches like CAT that lend themselves to it being built-in. Reference 5 - 0.43% Coverage: I also openly ask them about it if it appears to be in difficulty. Reference 6 - 0.80% Coverage: Against what they felt their goals were at the beginning and where they were in their journey in relation to the goals. Reference 7 - 0.70% Coverage: I will check out how the client is experiencing me, e.g. "how did you feel when I asked you that question?" Reference 8 - 0.95% Coverage: Through verbal feedback at the end of each session how they found the session and collaborate changes to the direction of therapy if necessary. Reference 9 - 0.74% Coverage: By reading the verbal and non-verbal signals & by regularly checking things out more explicitly with the client. Reference 10 - 0.44% Coverage: In sessions it is measured by feedback and through an open dialogue Reference 11 - 0.21% Coverage: Try to discuss with the client. Reference 12 - 0.52% Coverage: I ask people how they have experienced the sessions. What they will take away. Reference 13 - 0.43% Coverage: I have discussions with clients about how they find the sessions.

		Reference 14 - 0.22% Coverage: Qualitative feedback from client. Reference 15 - 0.14% Coverage: Talk to them about it. Reference 16 - 0.18% Coverage: Asking for direct feedback. Reference 17 - 0.17% Coverage: I also ask patients. Reference 18 - 0.28% Coverage: At the moment, I discuss it with patients. Reference 19 - 1.78% Coverage: I try to check in with clients intermittently and ask how they are finding the therapy and me as a therapist. If they say they feel well supported, understood or something along those line I would usually take this as an indicator that we have a relatively good rapport. Reference 20 - 0.60% Coverage: Checking in with the client how they feel things are going, if they feel they can be open. Reference 21 - 0.19% Coverage: Verbal feedback from clients. Reference 22 - 0.11% Coverage: Gaining feedback. Reference 23 - 0.26% Coverage: How helpful the work has been to them. Reference 24 - 0.89% Coverage: Otherwise just asking them at the end of therapy about what they thought. Reference 25 - 0.48% Coverage: I usually ask my clients how things are going after the 2nd/3rd session. Reference 26 - 0.38% Coverage: Verbal feedback about usefulness of sessions from client. Reference 27 - 0.44% Coverage: More frequently I try to enable the client to speak about it.
Attunement and Congruence *2 sources*	Description: Trainees' descriptions of or allusions to their level of attunement or congruence with their clients or having a shared or mutual understanding as signs of having a	<Internals\\ISurvey Responses\\Question 5 Responses> - § 33 references coded [34.60% Coverage] Reference 1 - 0.59% Coverage: I think the therapist being themselves, being genuine, owning their own stuff and knowing themselves.

35 references	good therapeutic relationship with their clients. Inclusion criteria: Trainees' direct or indirect descriptions of or references to the extent to which they feel congruent, attuned, connected and have a shared understanding with their client as markers of the quality of their therapeutic relationships, which they use when exploring how strong, or positive the therapeutic relationship is. Exclusion criteria: Statements about how Trainees assess the quality of their therapeutic relationship, that do not directly or indirectly refer to processes around being attuned, congruent, connected and/or having a shared understanding with their clients.	Reference 2 - 1.29% Coverage: I guess a bad therapeutic relationship would be characterised by avoiding or neglecting a lot of things that are important to the client, being dogmatic and judgemental (even if you only convey this tacitly by accident). Reference 3 - 0.98% Coverage: I guess the client would feel judged, misunderstood, 'told-off' or even just as though they bore their therapist and that their therapist has no real interest in them. Reference 4 - 1.29% Coverage: For me, a poor relationship would be the opposite of what I outlined to be a good therapeutic relationship e.g. the client does not feel they can be open and trust you, the client does not feel part of the process etc. Reference 5 - 0.66% Coverage: I think a good therapeutic relationship is one where the client and therapist are on the same page - congruent. Reference 6 - 1.11% Coverage: A poor therapeutic relationship would be one where both client and therapist have different agendas. The therapist might pursue their agenda without much thought to where the client is at. Reference 7 - 1.40% Coverage: Another thing I think that makes a good relationship different is that the therapist is attuned to the client. I don't think that means that you always get it right, but that you can pick up when you've got it wrong and attend to that. Reference 8 - 0.75% Coverage: In a poor relationship I think the therapist usually ends up talking too much and the client is either passive or oppositional. Reference 9 - 0.51% Coverage: Authenticity on both sides, understanding and really hearing what the client is saying. Reference 10 - 0.98% Coverage: When it doesn't feel too directive- like you are telling the patient what to do, and when there feels like there is a mutual understanding and empathy of each other. Reference 11 - 0.97% Coverage: A bad therapeutic relationship is characterised by the therapist imposing their own interpretations on the person and ruptures occur that are never addressed. Reference 12 - 0.76% Coverage: In a good therapeutic relationship there will be a good understanding from both parties about the needs of each person involved.

		Reference 13 - 0.61% Coverage: Good relationships are collaborative and open, bad ones may be directive, authoritarian or collusive. Reference 14 - 3.78% Coverage: It is an honest collaboration without a need for perfection, it is paced and meaningful focusing on feelings and thoughts (of both parties) and grounds thoughts and feelings to concrete observations and experience. A poor therapeutic relationship has a one sided agenda and ignores everything that doesn't fit in a pre-determined structure, it denies a person's reality and right to make bad choices, it denies any fault with the therapy or the therapist and it has no consistency or clear boundaries or a clear ending to allow the person room for autonomy. It is over/under involvement and based upon systemic targets that ignore the person. Reference 15 - 1.03% Coverage: It has to come from both of you. The client has to be open to wanting to engage with you at some point and you have to want to put the work in to be able to engage with them. Reference 16 - 0.69% Coverage: A poor relationship could be characterised by both therapist and client feeling unable to name barriers to progress. Reference 17 - 0.62% Coverage: Client feels safe enough to be honest, you work towards a shared understanding, therapy is more effective. Reference 18 - 1.58% Coverage: As a concrete example, I find being able to laugh at the same things - or find the same things humorous - as being an indicator of a good therapeutic relationship. Poor therapeutic relationship will be demonstrated by a lack of honesty from either patient or therapist. Reference 19 - 2.54% Coverage: I think there can be lots of different kinds of therapeutic relationship - but ultimately if the client feels uncomfortable with the therapist, or vice versa (not just transiently as transference occurs or people step into certain reciprocal roles, but more permanently due to feelings of lack of safety, lack of empathy etc.), it's likely the therapy won't be helpful and I'd say at this point the therapeutic relationship is poor. Reference 20 - 0.45% Coverage: The shared understanding of the role and responsibilities of both parties. Reference 21 - 0.29% Coverage: Therapist insight. Attunement. A shared agenda.

		Reference 22 - 0.33% Coverage: Agreement on tasks, goals, and a strong affective bond. Reference 23 - 1.50% Coverage: Having experiences of positive emotions with the other person (being able to joke, laugh, feel calm etc.). Being (and being able to be) honest with the client about difficulties in therapy/the therapeutic relationship; not just being 'nice' all the time. Reference 24 - 0.61% Coverage: GENUINENESS. I really don't think you can "fake" warmth and empathy and unconditional positive regard. Reference 25 - 0.42% Coverage: Cold, judgmental, didactic, superior - bad therapeutic relationship. Reference 26 - 1.59% Coverage: For me it is about the flow of information back and forth between the individuals. If it is stilted and one sided I struggle. If it is relaxed yet challenging. I think being able to repair ruptures successfully is also a really positive indicator of a good relationship. Reference 27 - 1.29% Coverage: A poor therapeutic relationship involves some sort of dissonance in the relationship, whereby the therapist is failing to pick up on something or to understand something correctly, and/or the client doesn't trust them? Reference 28 - 0.96% Coverage: A bad therapeutic relationship is likely to develop if you present as the expert on everything and dictate actions rather than work collaboratively with the client. Reference 29 - 0.17% Coverage: Being attuned to your client! Reference 30 - 0.74% Coverage: Having a clear working alliance – i.e. having an agreement on the goals of therapy. Minimizing any perceived power imbalances. Reference 31 - 1.93% Coverage: The amount of trust and rapport you have with your client. Therapy is very difficult, and only within an environment in which you have confidence and a genuine connection with the therapist, would you be able to disclose intimate and personal difficulties which many have predisposed/perpetuated your psychological difficulties. Reference 32 - 1.60% Coverage: A lack of rapport, leading to no sense of connection. I think that this means the client can't trust you and doesn't feel safe to be honest. If they

		can't be completely open I think it must feel to the client that the work you're doing is fully true to their experiences Reference 33 - 0.58% Coverage: Connecting on an individual level with a client vs. not connecting or not seeing them as a human! <Internals\\ISurvey Responses\\Question 6 Responses> - § 2 references coded [1.77% Coverage] Reference 1 - 0.92% Coverage: By the degree to which I feel connected, and I believe my clients feel safe with me and able to be themselves (whatever form that may take). Reference 2 - 0.85% Coverage: How much each person, Client and Therapist, can name difficulties within the relationship and work through them. Authenticity.
Managing Challenges	Definition: Trainees' responses around how they experience and manage difficulties in their therapeutic relationships with their clients, particularly with reference to whether they experience difficulties,what kind of blocks can cause difficulties, how Trainees explain such difficulties occurring and the types of approaches Trainees use to overcome and manage these difficulties.	
No Rupture Experience 3 sources 29 references	Definition: Trainees' reports of either not experiencing ruptures in their therapeutic encounters or having no experience of managing/attending to ruptures in their therapeutic encounters. Inclusion criteria: Trainees' references to not having had difficulties in therapeutic relationships, thinking they have not had issues in therapeutic relationships, not being able to think of examples of difficulties in the therapeutic relationship, responding with 'not applicable' (N/A), or no experience in managing difficulties in	<Internals\\ISurvey Responses\\Question 7 Responses> - § 1 reference coded [0.41% Coverage] Reference 1 - 0.41% Coverage: I wouldn't say I have ever had a poor therapeutic with any client so far - only some that were better than others. <Internals\\ISurvey Responses\\Question 8 Responses> - § 10 references coded [2.68% Coverage] Reference 1 - 0.21% Coverage: I don't think this has ever been the case. Reference 2 - 0.20% Coverage: Can't think of one at the minute, sorry. Reference 3 - 0.02% Coverage: No Reference 4 - 0.22% Coverage: I can't think of an example of this sorry. Reference 5 - 0.25% Coverage: I can't say I have, it's always felt more mutual. Reference 6 - 0.01% Coverage: N/A Reference 7 - 0.39% Coverage: I don't think I've had this experience yet, or at least I'm

	their therapeutic relationships. Exclusion criteria: Any trainee's statement of experiencing difficulties in the therapeutic relationship.	not aware of this. Reference 8 - 0.79% Coverage: Not really. In my limited experience whenever I have felt that I have a good relationship with a client I have generally felt that the client feels the same way. Reference 9 - 0.36% Coverage: No, not sure this has happened as I am always careful with expectations. Reference 10 - 0.22% Coverage: I can't think of an example at the moment. <Internals\\ISurvey Responses\\Question 9 Responses> - § 18 references coded [4.43% Coverage] Reference 1 - 0.03% Coverage: N/A Reference 2 - 0.14% Coverage: This also hasn't happened. Reference 3 - 0.02% Coverage: N/A Reference 4 - 0.03% Coverage: N/A Reference 5 - 0.02% Coverage: N/A Reference 6 - 0.03% Coverage: N/A Reference 7 - 0.03% Coverage: N/A Reference 8 - 0.11% Coverage: Not really applicable. Reference 9 - 1.64% Coverage: I understand the definition of rupture - but I can't say I have ever encountered anything in my personal therapy experience that could be classified as this. The idea of a rupture suggests there is a place we need to get to together - I'm not sure if that is always the case, just ground that can be explored together. Reference 10 - 0.14% Coverage: Not currently applicable. Reference 11 - 0.75% Coverage: Haven't experienced this yet. Only have clinical experience with children so far so I imagine my experience might be different in adult services. Reference 12 - 0.30% Coverage: I don't feel that I have any experience of this really.

		Reference 13 - 0.03% Coverage: N/A Reference 14 - 0.02% Coverage: N/A Reference 15 - 0.54% Coverage: I don't think I've ever had any ruptures as such (but perhaps I misunderstand what is meant by ruptures!). Reference 16 - 0.09% Coverage: Not applicable. Reference 17 - 0.27% Coverage: I don't think I've had any major ruptures in therapy; Reference 18 - 0.27% Coverage: I can't think of any time this has happened either.
Strategies	Definition: Trainees' most commonly-described strategies or approaches for managing difficulties or discord in the therapeutic relationship.	
Reflective Practice 9 sources 51 references	Definition: Trainees' descriptions of how they have used reflective practice both during sessions and during supervision to reflect on, process, attend to, recognise and/or manage ruptures as a way of addressing difficulties in therapeutic encounters. Inclusion criteria: Statements about, references to or examples of Trainees' use of reflective practice when they are experiencing difficulties in the therapeutic relationship, as a way of understanding or resolving such difficulties. Exclusion criteria: Statements that do not directly or indirectly describe or name using reflective practice as a	<Internals\\ISurvey Responses\\Question 1 Responses> - § 5 references coded [3.88% Coverage] Reference 1 - 1.46% Coverage: Also really gently noticing certain dynamics, for example if you feel as though the person is struggling with whether they can trust you, I think that can be important to pick up on and validate. I think that's the most important thing really, having had my own therapy, it's feeling that your therapist takes you seriously so I try to keep that very much in mind with my own clients. Reference 2 - 0.71% Coverage: Another thing that I think is important is that you attend to how you feel in the room with the client. I think if you ignore this, it can be harder to build a therapeutic relationship. Reference 3 - 0.45% Coverage: Be aware of power issues and try to address these, try to be reflexive/self aware, transference and C/T are important, Reference 4 - 0.87% Coverage: Despite doing these things I am also aware that sometimes this isn't enough and I am by no means perfect I aim for good enough and use supervision to unpick things that have come up or explore barriers to compassion and empathy. Reference 5 - 0.39% Coverage: I use supervision to gain a better understanding of the clients difficulties as so be more sympathetic. <Internals\\ISurvey Responses\\Question 2 Responses> - § 3 references coded [3.40%

	management strategy when Trainees are making sense of or working through difficulties in their therapeutic relationships with their clients.	Coverage] Reference 1 - 1.23% Coverage: I think it's always about looking at yourself too and being mindful of how you would feel in their shoes but also how you could be re-enacting harmful dynamics if you don't pay attention to your own responses to the therapy and your part in their story. Reference 2 - 1.56% Coverage: That's why I think it's important to attend to your own feelings about the client and think about how that can impact on the building of the relationship. But you also have to think about their stuff and how that impacts on the relationship. So you're having to hold your mind and their mind in mind, if that makes sense. Reference 3 - 0.61% Coverage: There is something of a scrutiny that the therapist puts on the relationship itself. Talking is always more than just talking. <Internals\\ISurvey Responses\\Question 3 Responses> - § 16 references coded [17.89% Coverage] Reference 1 - 1.87% Coverage: Before I probably thought training would teach me the 'magic secret' of the therapeutic relationship and now I realise it's quite a nebulous thing than you need to keep working at to understand it with each person you meet. I've always been influenced by psychodynamic ideas but having come to training I'm more aware of how dynamics may be played out in therapeutic relationships and how you can harness this as part of the learning experience for the client (if you do it well!) Reference 2 - 1.45% Coverage: Once I stopped relentlessly pursing my own agenda and focused on engaging the client, I became more aware of the process of building the therapeutic relationship. I think it's something you have to work at and attend to over the course of therapy. So if something happens, like a rupture, you need to attend to that and repair it, otherwise the relationship will suffer. Reference 3 - 1.33% Coverage: The main thing that has influenced this has probably just been increasing experience with different client groups and settings - the therapeutic relationship is important wherever you're working. I also had a really good supervisor in CAMHS who saw it as central and really got me to think about the therapeutic relationship in my practice.

		Reference 4 - 1.27% Coverage: Including my experience prior to training, i think my understanding of the therapeutic relationship has changed. This has partly been a result of working in different services, so for instance in a forensic service it felt the therapeutic relationship had to be much more clear cut and developed within a narrower set of rules. Reference 5 - 1.16% Coverage: I think my understanding of the therapeutic relationship over time has changed because of my own clinical experience, so learning from what has been helpful and what has been unhelpful in building the therapeutic relationship and the effect this has had on the client's engagement in the treatment. Reference 6 - 1.00% Coverage: Now I am able to make more use of the therapeutic relationship and can concentrate more on this. I feel this was also influenced by a change in supervision (in IAPT - case management compared to now- more reflective with space to discuss the relationship.) Reference 7 - 1.03% Coverage: There is a collaborative aspect and often very genuine affection for clients, but I think I'm now much more able to talk about these relationships in supervision to be more aware of the process issues and what information the relationship can add to the formulation. Reference 8 - 0.70% Coverage: I think I have an increased understanding about how ruptures in the relationship can be helpfully used in therapy and can ultimately strengthen the relationship if handled well. Reference 9 - 0.86% Coverage: I think as I have progressed through training I have developed a more compassionate approach, and also become more aware of potential barriers to developing a therapeutic relationship and how to TRY and overcome them. Reference 10 - 1.29% Coverage: It is not about empathically listening and trying to guide the client only where I think it is right for them to go. I think this less realist position has been shaped by learning on my course - through constructionist lectures and extra philosophical reading I've done, as well as through discussions with supervisors and lecturers Reference 11 - 1.98% Coverage: It used to be case that I felt I had no skills but I could make someone feel heard. Then I learned a bunch of skills and for a while forgot to focus on the shared humanity. Then I had this moment with a patient with whom I'd been focusing on skills and he disengaged. Eventually he came back after a few DNA'd

		sessions and said: "To be honest, you're just a bit cold". That bowled me over as it had always been the one thing I could rely on: building relationships! So I went back to making that the priority. Reference 12 - 0.40% Coverage: I feel more consciously aware of the therapeutic relationship 'processes' now in-session with clients. Reference 13 - 0.90% Coverage: I think I have developed a more thorough understanding of the therapeutic relationship through experiences of having to develop it and through being prompted on the course to think critically about what it is and how to foster it. Reference 14 - 0.70% Coverage: I am more attentive to ruptures, and have become more aware about power imbalances that may affect the client's behaviour despite my best efforts to minimise power differentials. Reference 15 - 0.70% Coverage: I think as my training has progressed I have realized that ruptures and repairs in the alliance can be key to building a stronger relationship (and can be a vehicle for change). Reference 16 - 1.25% Coverage: I guess maybe in the past I thought that having a good relationship was a benefit for the therapy, but that these two processes were more separated. I'm now coming to realise that the nature and qualities within that relationship can be used to influence what happens in the therapy part of my interactions with clients. <Internals\\ISurvey Responses\\Question 4 Responses> - § 2 references coded [1.13% Coverage] Reference 1 - 0.66% Coverage: This puts a lot of pressure on us as individuals which is why supervision and looking after ourselves is important it is what happens between the therapist and the persons that is important not individual factors that we bring with us. Reference 2 - 0.47% Coverage: I would suggest that it is more important or at least requires more attention when working with clients whom I perceive to have very different beliefs/values to my own. <Internals\\ISurvey Responses\\Question 5 Responses> - § 5 references coded [6.50% Coverage] Reference 1 - 1.34% Coverage: I think that involves reflexivity in yourself, the ability to

		reconcile misunderstandings and differences, facing up to difficulties or breaks in the therapeutic relationship (and encouraging learning from them for both of you). Reference 2 - 1.65% Coverage: What also makes good relationships different from bad ones is shaped by the institution the therapy takes place in. If the therapist is well supported with access to supervision and adequate training, the relationship is has more support to flourish and to withstand testing times. Reference 3 - 1.83% Coverage: A mindfulness of the relationship itself, and of the therapist's emotional reaction to the client and the things they say and do and the ways they do them. Using the countertransference and transference for the benefit of the client, in formulation, in building empathy and understanding, and in the work itself. Reference 4 - 1.51% Coverage: The difference is through (1) the ability to be aware of own beliefs and moral judgement, and not let them hinder one's ability to listen with respect and empathy; (2) aware of transference and counter transference (could be facilitated through supervision) Reference 5 - 0.18% Coverage: Good reflective supervision. <Internals\\ISurvey Responses\\Question 6 Responses> - § 6 references coded [3.87% Coverage] Reference 1 - 1.51% Coverage: Reflecting outside of therapy and in supervision allows you to consider your relationship with a client, including any transference or difficult feelings, reflecting on whether the relationship feels like it is aiding change. Reference 2 - 0.15% Coverage: Discuss in supervision. Reference 3 - 0.59% Coverage: Reflecting in supervision and getting formal feedback from clients at the end of therapy. Reference 4 - 0.13% Coverage: Reflective practice. Reference 5 - 0.48% Coverage: Supervision sessions in which the therapeutic relationship is discussed. Reference 6 - 1.00% Coverage: I use my clinical judgement more than anything, and supervision to discuss challenges with connecting with people or entanglements in the

		relationship. <Internals\\ISurvey Responses\\Question 7 Responses> - § 10 references coded [6.39% Coverage] Reference 1 - 0.58% Coverage: When working with a woman who was critical and rejecting, I used supervision to remind me of the formulation which allowed me to take a more empathic point of view. Reference 2 - 0.99% Coverage: I think also finding there are many similarities between yourself and the client can be challenging you can fall into over relating and making assumptions about what how they feel or think etc and trying to notice that and take it to supervision can help you keep check on that. Reference 3 - 0.81% Coverage: I think the best way to overcome this is to reflect in a supervisor about what both the therapist and client is bringing to the session and where the lack of cohesion is. This can then help you to identify what needs to change. Reference 4 - 0.42% Coverage: Good supervision where I feel able to be honest about exactly how I feel about a client has been immeasurably helpful. Reference 5 - 0.26% Coverage: I have overcome this through good supervision (including peer supervision). Reference 6 - 0.83% Coverage: I think I try to remember who the client is and what it is they need. Supervision is a great place to reflect on this stuff and notice the directions you're being pulled in to allow you to manage things more consciously in the room. Reference 7 - 0.80% Coverage: In all these cases I have used supervision, I have reflected on these experiences and how it has made me feel to make sense of the barriers, formulated my own stuff to enable me to become unstuck or develop an understanding. Reference 8 - 1.11% Coverage: Reflected on this in supervision and went back over goals with the client - did some "wondering" and managed to unpick where the misunderstandings had taken place. So far I haven't had a client I don't like - I've been told it's bound to happen at some point so I'm interested to see what challenges arise then! Reference 9 - 0.24% Coverage: I also try to use supervision to explore process issues in therapy.

		Reference 10 - 0.35% Coverage: I have used supervision and personal therapy to help me be aware and to be able to cope with this. <Internals\\ISurvey Responses\\Question 8 Responses> - § 2 references coded [2.29% Coverage] Reference 1 - 1.58% Coverage: I reflected on my approach yet felt that we had become "stuck" rather than moving forward. I discussed this sense of "stuckness" with the client and she would refer to other agencies involved with her not "doing enough", "not caring" and "not helping". I considered if this was how she felt with my input. However she said not. Reference 2 - 0.71% Coverage: After reflection in supervision and considering her formulation again, I viewed that part of her fears of abandonment related to therapy sessions. <Internals\\ISurvey Responses\\Question 9 Responses> - § 2 references coded [2.56% Coverage] Reference 1 - 0.75% Coverage: When a client started to DNA to the point that work was very sporadic, I took it to supervision and a plan was agreed for me to try to engage them. Reference 2 - 1.80% Coverage: Attending to ruptures in the relationship with a client is something that occurs on a regular basis, as ruptures to my mind occur in every type of therapy, ranging from small to irreparable. Although I can't describe a specific example, I try to monitor my own internal experience, and take a step back from the relationship to observe what is going on.
Open Discussion 4 sources 53 references	Definition: Trainees' naming of or descriptions of either being open and honest and/or naming issues with a client largely to overcome difficulties, whether or not these are framed or conceptualised as ruptures within the therapeutic relationship, with a common aim being to improve the therapeutic relationship with	<Internals\\ISurvey Responses\\Question 2 Responses> - § 1 reference coded [1.05% Coverage] Reference 1 - 1.05% Coverage: It's also about being honest in a way that is helpful to the client, acknowledging if you make a mistake and setting a space for therapy in which mistakes, misunderstandings and reconciliations are part of the work. <Internals\\ISurvey Responses\\Question 7 Responses> - § 18 references coded [10.41% Coverage] Reference 1 - 0.69% Coverage: I think remaining respectful and curious about the client's

	varying degrees of success. Inclusion criteria: Trainees' statements about naming difficulties or having open honest discussions as a management strategy to process, attend to or resolve issues when difficulties are being experienced in their therapeutic relationships with their clients. Exclusion criteria: Statements that do not directly or indirectly specify naming difficulties or discussing difficulties openly with clients as a way of managing difficulties in therapeutic relationships.	experiences can be helpful but also to be interested and name differences with the client, explore them without becoming defensive. Reference 2 - 0.45% Coverage: I think just trying to be as open about this as possible in an effort to reassure that you do actually know what you are doing. Reference 3 - 0.74% Coverage: I have stuck with it and addressed these concerns, exploring the meaning behind them, rather than passing the case to a more senior colleague. Through doing this, the therapeutic relationship has developed. Reference 4 - 0.65% Coverage: Trying to be open about this and think about what might be happening can help, but again paradoxically, this requires a good relationship so that someone can feel safe to discuss it. Reference 5 - 0.40% Coverage: Again explicit conversations about what might be happening, and clarity around boundaries can be helpful here. Reference 6 - 0.50% Coverage: I generally dealt with this by being as upfront and honest as possible and by giving them as much time as they needed to learn to trust me. Reference 7 - 0.44% Coverage: I spoke with the client about feeling sometimes invited to either battle with her or admire her while being admired by her. Reference 8 - 0.53% Coverage: I have managed this by being aware of the patient's vulnerabilities and defences, and allowing them to set the pace of establishing the relationship. Reference 9 - 0.22% Coverage: This was overcome by addressing it explicitly (open & honest). Reference 10 - 0.20% Coverage: Discussed this with clients in an open and honest way. Reference 11 - 0.39% Coverage: We discussed this openly and talked about what he might want to get from sessions, considering he was there. Reference 12 - 1.25% Coverage: I have attempted to overcome these challenges by being as open and transparent as I can, both about my thinking, my role, and perhaps most importantly when I am unsure of something or can't give the definitive answer that I am being asked for. This for me is extremely important, and maintaining a stance of

		respectful curiosity helps me a lot in this. Reference 13 - 0.50% Coverage: I believe these challenges were addressed (as best as possible!) by being open with the client about what information I was sharing and why. Reference 14 - 0.42% Coverage: Again, openness and honesty, along with reflection regarding the situation helped to open the way to effective therapy. Reference 15 - 0.96% Coverage: We identified these patterns and highlighted them gently when he got into them. I feel this helped him see how he was doing this in a lot of his relationships and through showing I wasn't going to judge him for this or be angry with him we were able to work through it. Reference 16 - 0.66% Coverage: I worked with a lady and as part of the work a risk assessment was required in relation to gaining access to her children again. This was discussed openly with her and she engaged well. Reference 17 - 0.79% Coverage: She returned for a session following a therapeutic letter being sent to her and we were able to discuss her feelings about the report. She had taken some time to reflect on this and worked through the difficulties with me. Reference 18 - 0.63% Coverage: I have overcome these differences by naming the differences and exploring them, by finding mutual interests/areas of commonality and by being myself- being genuine in the room. <Internals\\ISurvey Responses\\Question 8 Responses> - § 6 references coded [5.06% Coverage] Reference 1 - 0.44% Coverage: We talked about how honesty was needed in the relationship for therapy to be able to work. Reference 2 - 1.50% Coverage: When I get a sense that a client is only "complying", I would be honest in my feedback during the session and say what I think in order to check if this is so. This usually creates an opportunity for client to feel that I am modelling honesty and give them a sense of agency, allowing collaboration in therapy. Reference 3 - 1.00% Coverage: Part of me thought the parent must have been angry towards me personally but I did not feel my therapeutic relationship had been affected in any way as I was not afraid to be honest with how I was feeling.

		Reference 4 - 0.61% Coverage: It was only after he returned from his 5 week break and we openly discussed this that I was able to understand this more fully. Reference 5 - 0.62% Coverage: We spoke about it but decided that it was best for her to work with my supervisor and work through this with her if necessary. Reference 6 - 0.89% Coverage: When I feel this could be the case, I have discussed therapeutic endings as early as possible and outlined the difference between building friendships and a therapeutic relationship. <Internals\\ISurvey Responses\\Question 9 Responses> - § 28 references coded [32.12% Coverage] Reference 1 - 0.52% Coverage: I frequently raise this issue with clients as I find naming it normally enables us to work though it. Reference 2 - 1.31% Coverage: I tried to name it and think about what that felt like for them and help them express their anger about the me and the situation but as it was nearing the end of my placement I don't think they could allow themselves to fully feel some of the anger and hurt Reference 3 - 1.86% Coverage: In this case I offered the client another therapist but also explained to them that I was young but I had a set of skills which I could use to support them in their recovery and no one could ever fully understand their position because no one could ever walk in their shoes. Thankfully, the client took this well and engaged very well in the sessions thereafter. Reference 4 - 1.04% Coverage: I explained the rationale for why I 'steer' her, but from then on made sure to always check in with her to make sure we had covered everything she wanted to bring up, which helped to repair the alliance. Reference 5 - 1.34% Coverage: I dealt with this by encouraging exploration of these issues and by continuing to offer sessions and a planned ending. It did not end in a way that felt satisfactory for me, but it was positive that the client was able to express her anger and disappointment. Reference 6 - 1.30% Coverage: I have so many examples. I have noticed a change in someone in a session their interpersonal responses body language, sometimes I name it, sometimes it’s more appropriate to wonder if perhaps something has changed or if they

		are angry sad frustrated etc. Reference 7 - 1.65% Coverage: Sometimes I haven't heard things correctly, made a mistake or made an assumption. I try to explore expectation at the beginning and can address the fact that I am not perfect and can make mistakes in an attempt to introduce an open dialogue but this isn't always enough and the relationship is worked on throughout therapy. Reference 8 - 1.31% Coverage: I have had to alert safeguarding teams and shared this before during and after with clients and this has often resulted in a rupture which has been explored always listening to their perspective and being open and honest about my thoughts and intentions. Reference 9 - 1.27% Coverage: I have spoken very frankly and honestly about how I am experiencing the sessions. I have done it through therapeutic letter and in person. I have therefore wondered with the client what is going on and if there is anything I can do to change it. Reference 10 - 1.25% Coverage: I have discussed with a client her feelings about me having to break her confidentiality to deal with a risk issue. I found that acknowledging her feelings and encouraging her to voice them helped us to strengthen the relationship after this. Reference 11 - 0.51% Coverage: I was able to repair our alliance by "naming" that I could tell she was angry and normalising that. Reference 12 - 0.46% Coverage: I have openly brought up how the client feels about their relationship with me regularly. Reference 13 - 0.80% Coverage: I do my best to acknowledge the role that I may have played in the rupture, and attempt to explore the client's experience and clarify any misunderstandings. Reference 14 - 0.88% Coverage: Once worked through though, it often has led to a stronger relationship, and can challenge some long held client beliefs regarding conflict and interactions with the other. Reference 15 - 1.10% Coverage: I think being a young therapist it's quite easy for younger clients to think therapy means another friend to share things with so I have had

		conversations about things that are appropriate/inappropriate to therapy. Reference 16 - 1.11% Coverage: I had a client who would tell me quite openly, prompted by the SRS, if he e.g. felt angry because I'd pushed too hard etc. He'd throw these comments out there and expect to move on, but I'd focus on it and discuss it. Reference 17 - 0.78% Coverage: Once a client got offended by the way I asked questions. She was able to tell me on the phone and we spoke about it and were able to heal the rupture. Reference 18 - 1.39% Coverage: I am currently going through a rupture, I am jointly working with another trainee and the client told me she didn't like my colleague (this is quite a standard interpersonal relating style problem she has) and we had to discuss this with the colleague which was difficult Reference 19 - 1.58% Coverage: I validated her feeling angry, and explained exactly what had happened, along with my rationale for doing so, then invited her to comment. I think by having an open discussion and showing that I understood why she was angry and wasn't afraid of her emotion the therapeutic relationship was partially mended. Reference 20 - 0.72% Coverage: In the following session I spent time exploring what had happened and explained my frustrations and apologised if I had been pushing too hard. Reference 21 - 1.35% Coverage: Rather than challenge this rupture and ask him to put his homework away, we discussed his homework, why he felt he wanted to do it etc. and reflected on the process. By being open-minded and observing the situation the rupture was repaired before the session ended. Reference 22 - 1.72% Coverage: I think ruptures are often a healthy part of the process, as it can be necessary sometimes to gently challenge clients: I have managed this by explaining my rationale, continuing to validate the client and facilitating their self-efficacy by prompting them to tell me how they feel and when they feel too pressured or challenged etc. Reference 23 - 0.87% Coverage: We discussed and identified these patterns and were able to gradually overcome them so he could access his feelings and for him to trust that I wouldn't judge him for them Reference 24 - 0.91% Coverage: I have had session rating scales reveal difficulties in the

		therapeutic relationship. At these times the measures have provided a way of talking about and repairing difficulties. Reference 25 - 0.84% Coverage: Where I've noticed myself falling into a trap or getting stuck, I've been learning to bring it up with the client and being open about how I've been feeling stuck. Reference 26 - 1.72% Coverage: I have at times asked clients about the relationship, how they felt about it, what they would like to see more or less of in the things that I say or do. I think it's important to remember that the relationship is a two-way process and sometimes clients need to be given permission/ supported to assert themselves in the relationship. Reference 27 - 1.71% Coverage: At this point I was able to switch the conversation from content to process so she could explain why she was so often silent, despite my clarifying questions and asking them again and probing. This meant we could discuss the pros and cons of being silent for her low mood, and she decided she wanted change so she wanted to talk to me. Reference 28 - 0.83% Coverage: These sessions were initially difficult but they were facilitated by having a gentle open discussion about what went wrong and my apologising for my role in it.
Formulation 3 sources 29 references	Definition: Trainees' descriptions of times when they have referred back to or reformulated the formulation, in order to understand their own or the clients' process, as a way of developing their understanding in order to inform treatment and/or develop empathy and foster engagement. Inclusion criteria: Trainees' references to or examples of when they have thought about the client's	<Internals\\ISurvey Responses\\Question 7 Responses> - § 7 references coded [5.80% Coverage] Reference 1 - 1.34% Coverage: I have overcome these challenges for example with those who are reluctant to come to therapy, I have recognised their reluctance and been empathic and understood their reluctance and have been transparent with the way I work in therapy and given them the choice as to whether they would like to give therapy a go or not and very much make them feel in control of the sessions. Reference 2 - 0.57% Coverage: These are many - defences, negative views of psychology, sense of hopelessness. Mainly defences though which I try to overcome using dynamic therapy approaches. Reference 3 - 0.62% Coverage: I think that perhaps me being consistently there for her, not reacting angrily or rejecting her when she was angry with me was a very different

	formulation - in terms of their role, the client's role and/or the trainee's and client's roles together - as a management strategy to help them understand the client and/or resolve difficulties in the therapeutic relationship. Exclusion criteria: Statements about Trainees managing difficulties in the therapeutic relationship that do not specifically refer to understanding their own or their client's roles in the therapeutic relationship in the context of the overall or specific aspects of the client's formulation.	type of relationship for her. Reference 4 - 1.05% Coverage: This took a long time to resolve but essentially came about through trying to understand how their experiences had led to them feeling they have to lie or perform which made me feel quite deeply for them and feel much better connected. Essentially finding empathy from somewhere was the solution. Reference 5 - 1.08% Coverage: It turned out she had moved from working in a factory, had no previous experience of working with this client group whether personally or occupationally and was essentially speaking from a position of ignorance rather than bigotry. This allowed me to reframe her language as amoral rather than immoral. Reference 6 - 0.67% Coverage: Her fears around rejection and abandonment had been triggered and by me remaining consistent in offering her sessions and working through these concerns it enabled her to continue our work. Reference 7 - 0.47% Coverage: I think in these situations I have tried to focus on their problem and how it has developed as a way of feeling warmth toward them. <Internals\\ISurvey Responses\\Question 8 Responses> - § 16 references coded [18.90% Coverage] Reference 1 - 1.32% Coverage: A client I had did not know why I would like her or be warm to her. I recognised this was part of her internal working model and therefore was unable to take it too personally. It meant that I tried to match where she was at so as not to make her feel too uncomfortable. Reference 2 - 0.45% Coverage: I understood the discrepancy within the formulation, and it was useful to talk it through. Reference 3 - 0.90% Coverage: I believe my feelings of being stuck were perhaps a projection of the client's experience onto me, and that actually he was still gaining from being able to talk through his difficulties. Reference 4 - 1.01% Coverage: I had a client recently who had a very disrupted attachment with her daughter, causing her significant guilt, and I think was attempting to repair this by treating me as a child/granddaughter in our sessions. Reference 5 - 1.48% Coverage: For example I have a client who experiences only ever

		being in competition in relationships and this means therapy can become a competition and this means we have to highlight that, and remain mindful of this way of interpersonally relating to people. It's about awareness and not trying to change that. Reference 6 - 0.59% Coverage: I think often this is to do with people who have never experienced someone being compassionate and thoughtful towards them. Reference 7 - 1.56% Coverage: Therapy is a strange situation and it often takes time to develop a relationship so I would be suspicious if I ever felt I was therapeutically aligned with a person throughout and sometimes it is the ruptures or changes in the alliance that provide most important information and allow for a greater shared understanding. Reference 8 - 0.72% Coverage: I have seen this as her needing time to be able to open up to me, so I need to adjust the pace of the sessions and the way I am to accommodate this. Reference 9 - 0.60% Coverage: I wonder if there is something about transference, or about seeing in the client something which reminds you of someone else Reference 10 - 0.40% Coverage: Understood in terms of client's level of social isolation and need for validation. Reference 11 - 1.87% Coverage: I understood this discrepancy by examining my own internal process, and realising that what I thought was the client buying into the goals and task of therapy was actually appeasement on his behalf, telling me what he thought I wanted to hear, which turned out to be a longstanding strategy of his in order to avoid conflict and experiencing difficult feelings such as loss or rejection. Reference 12 - 1.57% Coverage: At the end of an extended assessment, he expressed that it had been useful to have a 'mother figure' as he does not have any female role models in his life. I realised that in my efforts to provide answers to some of his queries, I had come across as someone who solves his problems for him, which is not what I had intended! Reference 13 - 2.38% Coverage: There have been times when completing assessments with clients where I have felt us to have a good therapeutic relationship - I have respected the client through pacing, explanation of materials, reflected the difficulty or ease of sub-tests, provided supportive statements etc. however the client's evaluation was that he hated the assessment process. I understood this through his negative experience of school and assessments there and that this seemed like an additional pressure for him.

		Reference 14 - 1.83% Coverage: Her view was that if she was "better" then she would not longer need input from services. If this was the case, she would feel alone and so rather than being alone, she focused on what the services weren't doing to provoke people to do more for her. It appeared that to some degree, some of her complaints or motivation were in response to not wanted to be discarded by services. Reference 15 - 0.92% Coverage: I had felt that what I saw as her lack of engagement was a due to, in part, an ineffective therapeutic relationship and it may have also been seen in the context of her fears of abandonment. Reference 16 - 1.29% Coverage: There was a time I thought a client did not like me, and did not like working with me. It turned out this was not the case. Reflecting on this I realised that this was how he related to people he liked, which explained why he had very few meaningful relationships. <Internals\\ISurvey Responses\\Question 9 Responses> - § 6 references coded [9.60% Coverage] Reference 1 - 1.68% Coverage: I was working with a gentleman who was very anxious and avoidant and we were able to capture this as one of his patterns in his reformulation map, this was really helpful as it gave me permission to draw attention to processes between us in a less threatening way, I could point out when we were becoming drawn into his patterns. Reference 2 - 0.68% Coverage: My understanding is that she needed to control the therapy and myself and that she might not have been ready for doing anything else. Reference 3 - 0.64% Coverage: There are times when a person has been angry at me or hidden things because they want me to consider them in a positive light. Reference 4 - 2.07% Coverage: For me ruptures are again about attending to where the client is really coming from. Realising that maybe you as a therapist have lost your direction, or have forgotten that the client is the focus of therapy, and repairing a rupture can be about purposefully trying to get back alongside the client, back with them, back to seeing things through their eyes so you can work together for a common purpose. Reference 5 - 0.64% Coverage: We'd try to work out why he was feeling that way and how it fits with the formulation as well as what I could do differently.

		Reference 6 - 3.89% Coverage: I remained on the ward to allow him the space to come back for any part of his session that remained. He didn't but for the following session he attended (although as stated by him "purposely late" to "pay you back").As we had done a CAT formulation diagram in earlier sessions I was able to use this to encourage him to talk through what had happened in the previous session. He also apologised for the verbal outburst on the ward and it was acknowledged that his actions had been an expression of his views that I was using my "power" as staff against his "patient" status and humiliating him. It was also to acknowledge that his outburst was in retaliation to "humiliate" me and that he was surprised that I didn't shout back at him on the ward.
Adapting Approaches 3 sources 18 references	Definition: Trainees' descriptions of recognising the need for and implementing change in order to meeting the client's needs in an alternative way - perhaps by adjusting therapeutic modalities or language or tasks or adapting the interpersonal style, in order overcome or avoid ruptures and facilitate a better relationship between the trainee and client. Inclusion criteria: Trainees' descriptions of different ways in which they have adapted or developed their approaches in therapy, including but not limited to adjusting body language, verbal communication, therapeutic approaches, holistic approaches, the speed and pace of sessions, session contact and session arrangements in order to accommodate clients, as a way of managing difficulties, either	<Internals\\ISurvey Responses\\Question 7 Responses> - § 15 references coded [11.28% Coverage] Reference 1 - 1.63% Coverage: I was lucky to be able to drop in and see them for 15 minutes at a time if needed as I was working in a prison so did not have the practical limitations of work in the community. This approach worked in the majority of cases and I had feedback that not "hiding behind" professional/psychological language was particularly valuable in helping the clients to believe I was really interested in their experience and not just writing a report for the parole board. Reference 2 - 0.62% Coverage: In some instances this has involved not "doing any psychology" for several sessions, and simply having a cup of tea and a chat to allow the person to become more comfortable. Reference 3 - 1.00% Coverage: We encouraged him to think of different situations and how he felt in those and whether he felt able to tackle new ways of living - this was deemed more positive because it was more concrete. A lot of the work was about finding the language that suited him and not the clinicians. Reference 4 - 0.80% Coverage: Have overcome this by changing goalposts of expectations for therapeutic relationship e.g. realising that you don’t have to "like" your client and that it can take time to find a way to make the therapeutic relationship work. Reference 5 - 0.55% Coverage: To overcome this I will try to bring in the quieter person and draw attention to any differences in goals to encourage exploration and negotiation of this. Reference 6 - 1.29% Coverage: Eventually we overcame the problem through art.

	pre-emptive and/or responsive strategies. <u>Exclusion criteria</u>: Statements that do not directly or indirectly refer to or describe adapting or developing an aspect of therapy as a way of managing difficulties in the therapeutic relationship, in order to support or accommodate the client.	Although she struggled hugely to verbalise or show the distress she described, her artwork was incredibly emotive. Through her art we found a way to connect together to her emotional experiences, and she has ended up being the client I remember the most, and feel made the most positive progress through therapy. Reference 7 - 0.92% Coverage: Trying to focus too hard on "doing therapy right", and skills acquisition got in the way at the start of training. That's better now that I feel more confident in my skills but also more justified in choosing to spend energy on initial relationship building. Reference 8 - 0.35% Coverage: I adapted my style and looked at him less and allowed more silences rather than filling it so much. Reference 9 - 0.64% Coverage: I have managed this in the past by finding out a bit about someone's background and their preferences, as well trying to remain responsive to how they appear to be relating to me. Reference 10 - 0.40% Coverage: I have overcome this by ensuring that I am still present in the same way in session and providing a stable base. Reference 11 - 0.52% Coverage: It can take different amounts of time and techniques to engage people but it is important to work within their own zone of proximal development. Reference 12 - 1.12% Coverage: By encouraging her not to do the same with me, she felt accepted for the first time and was able to create a bond that is helping her change the way she relates to others i.e. empowering her in the therapeutic relationship to act in a different way than usually, even though this might mean criticising my work. Reference 13 - 0.53% Coverage: When I noticed this happening, with the help of supervision, I was able to be a bit less directive with them and allow them to take the lead more. Reference 14 - 0.41% Coverage: When this has happened I have played a game or done an ice breaker (admittedly more so during my CAMHS placement!) Reference 15 - 0.52% Coverage: Where I have, it has tended to be when I've been enabled to be more accommodating and slow paced in my approach, or employed creative techniques.

		<Internals\\ISurvey Responses\\Question 8 Responses> - § 1 reference coded [0.52% Coverage] Reference 1 - 0.52% Coverage: I had to look at progression in a different way from other placements and evaluate the sessions differently. <Internals\\ISurvey Responses\\Question 9 Responses> - § 2 references coded [2.31% Coverage] Reference 1 - 1.20% Coverage: In the past I have directly questioned the animosity of clients, but this has not worked too well as they have become more defensive. These days I tend to gently explore defences, keep pushing if it seems safe, but backing off if not. Reference 2 - 1.11% Coverage: We were able to agree a plan for me to be late (infrequently) but purposely to some sessions in order to then discuss the feelings which arose each time in the session, and he attended rather than DNA'd the sessions.
Explanations	Definition: How Trainees have made sense of or explained how and why differences, difficulties and ruptures have occurred within their therapeutic relationships, if at all, including how they have explained when such difficulties have not occurred within their clinical experience.	
Practical or Power Issues 4 sources 50 references	Definition: Trainees' descriptions of the constraints imposed by service limitations, risks, referral types and power/boundary issues when trying to manage their therapeutic relationships with clients, which have been perceived as therapeutic blocks. Inclusion criteria: Trainees' references to a range of difficulties associated with (i) their own, service or modality limitations/constraints, (ii) events outside their control, (iii) risk issues, (iv) power imbalances, (v) referral issues and (vi) clients' past	<Internals\\ISurvey Responses\\Question 4 Responses> - § 1 reference coded [0.57% Coverage] Reference 1 - 0.57% Coverage: I am currently working psychodynamically and this allows more focus on the relationship and again sometimes its boundaries are not human enough to allow a good therapeutic alliance which is a challenge. <Internals\\ISurvey Responses\\Question 7 Responses> - § 25 references coded [12.95% Coverage] Reference 1 - 0.42% Coverage: I recognised that it related to me feeling bullied in a previous relationship and was more boundaried with the client. Reference 2 - 0.30% Coverage: When clients have been unsure of my competence in relation to the "trainee status". Reference 3 - 0.70% Coverage: Having to take time off yourself for sickness etc can impact on your ability to 'be there' for your clients, especially if it's only in early stages.

	experiences of therapy, that are cited as a way of understanding why clients and/or Trainees may have been experiencing difficulties in the therapeutic relationship. Exclusion criteria: Trainees' descriptions of events as described above but not in reference to explaining how difficulties can arise in therapeutic relationships, or other reasons for difficulties in the therapeutic relationship that are not linked to such power or practical issues.	Sometimes you can't overcome these challenges. Reference 4 - 0.44% Coverage: When I haven't been the psychologist that the client expected to see e.g. too young or inexperienced (i.e. not qualified). Reference 5 - 0.06% Coverage: Power imbalances. Reference 6 - 0.60% Coverage: When I've needed to quickly build a therapeutic relationship for example when I was working as a Psychological Wellbeing Practitioner and only had 30 minutes per session. Reference 7 - 0.27% Coverage: When the client has been very unwell and not ready to engage in therapy. Reference 8 - 0.25% Coverage: When a child/adolescent gets referred for therapy from other parties. Reference 9 - 0.24% Coverage: When they had poor experience with therapists/mental health staff. Reference 10 - 0.60% Coverage: This was particularly challenging in family work where you are managing multiple relationships and often family members can be quite invested in getting you 'on side'. Reference 11 - 0.61% Coverage: I have had sessions where I have to focus on risk and safeguarding and I always do this openly and explain the process and reasons as I go but this does impact on it anyway. Reference 12 - 0.60% Coverage: I have attended meetings and worked with families and couples where everyone has a different focus and forming a therapeutic alliance with a system is really difficult. Reference 13 - 0.64% Coverage: Difficulties have arisen when balancing the needs of parents/carers in the session as well as the client's. This can be particularly problematic when their agendas are different. Reference 14 - 0.54% Coverage: When a service user has previously been let down by services or regularly in relationships, generally takes longer to build a therapeutic relationship.

		Reference 15 - 1.12% Coverage: One example is of a client who had a diagnosis of personality difficulties who would present very differently on a weekly basis. Some weeks it felt as though we had a good alliance and other times she would not attend, attend late, appear disinterested or claim to have forgotten what we have previously worked on. Reference 16 - 0.26% Coverage: Someone who didn't want to come to sessions but had to for a court case. Reference 17 - 0.89% Coverage: This can often be compounded by their experience of mental health services. The challenge has often been to establish a trusting relationship, negotiating the boundaries of the relationship without the individual feeling rejected, or not listened to. Reference 18 - 0.39% Coverage: Someone who has been very unwell and in a current crisis as mood has been so changing from session to session. Reference 19 - 0.97% Coverage: It is particularly difficult when working with a number of other professionals as well as a client. I have found it tricky to balance a need to share information with other professionals because of a duty of care, against the need for a very mistrustful client to trust me. Reference 20 - 0.45% Coverage: There have also been times where the client did not want to come to therapy, but was obliged to (by law, by parental figures). Reference 21 - 0.53% Coverage: I currently work with a young lady who has learnt all her life to do everything to please others. This was re-enacted in the therapeutic relationship. Reference 22 - 0.38% Coverage: With a few clients I have found myself being too directive, which was (understandably) met with resistance. Reference 23 - 0.66% Coverage: Differences in SOCIAL GRACES I feel can impede relationships. For example working with an older gentleman from a working class background, a young child of school age or a BAEM client. Reference 24 - 0.74% Coverage: I think it easy in these situations to get drawn in to trying to prove that you're 'the good guy' and in the past I have perhaps been guilty of

		having weak boundaries and giving too much to the relationship. Reference 25 - 0.30% Coverage: Forced to attend (superficial consent). I have not always overcome these challenges. <Internals\\ISurvey Responses\\Question 8 Responses> - § 11 references coded [8.89% Coverage] Reference 1 - 0.73% Coverage: When my client was a trainee counsellor himself. Differences in power, and an understandable reluctance of hers to be the client and not the therapist. Reference 2 - 1.28% Coverage: Sometimes you bend over backwards to accommodate a client - really work hard on being open, plan sessions in detail and so on. However the relationship is terrible - combative, accusatory etc. this is best explained as transference and projective identification. Reference 3 - 0.41% Coverage: I have worked with clients in the past who have wanted a more informal 'friendship'. Reference 4 - 0.73% Coverage: In another example, I thought we had a very professional understanding and she then asked for my home number and whether we could meet outside of work. Reference 5 - 0.44% Coverage: When a client has perceived the therapeutic relationship as being more like a friendship. Reference 6 - 0.65% Coverage: When working with a 9 year old with learning disabilities - the child saw me as more of a friend/mother figure and someone who was fun. Reference 7 - 1.07% Coverage: They resented having to do "work" with me. The work was around relationships but rather than doing what I had planned we spent time talking about how I was different from a mum/friend and why she found it hard when I left. Reference 8 - 1.12% Coverage: I guess I'd also been a bit intimidated by him as he kept making comments about being seen by a Trainee, so I wanted to come across as super professional so that he would trust me, but that actually just caused him to feel unheard. Reference 9 - 0.70% Coverage: One lady struggled to talk to me because she felt I was too young and inexperienced, and having met me with my supervisor, preferred to see

		her. Reference 10 - 1.00% Coverage: Occasionally clients have struggled with the boundaries of therapeutic relationships and may try to ask personal questions (I guess because it's a difficult sort of relationship to what they are used to?) Reference 11 - 0.77% Coverage: Sometimes it can feel like the client is starting to view you as a friend and that they are disappointed when you do not wish to continue contact after therapy. <Internals\\ISurvey Responses\\Question 9 Responses> - § 13 references coded [12.58% Coverage] Reference 1 - 0.68% Coverage: Through discussing in depth the reason why I had to take a certain action (around a serious risk concern) which then caused a rupture. Reference 2 - 0.68% Coverage: A client would repeatedly cancel sessions and while on the phone attempt to speak to me at length about how she was feeling hopeless. Reference 3 - 1.45% Coverage: I had to put boundaries in place around that and she said that I was heartless and a bitch. The client threatened litigation unless I agreed to do phone counselling with her. I addressed his in a series of letters and phone calls and eventually the client agreed to attend a session. Reference 4 - 1.08% Coverage: Risk situations - having to break confidentiality around suicidal ideation and involving the crisis team. Unfortunately due to the timing of this (end of placement), the relationship was not able to be repaired. Reference 5 - 0.60% Coverage: Having to refer a client's parents to social services made the work subsequently difficult as they felt misunderstood. Reference 6 - 0.73% Coverage: I once had a client who didn't want to see me because on our first meeting they felt I was too young to understand what they were experiencing. Reference 7 - 0.87% Coverage: Recently at a therapy review, a client said that she felt I was 'steering' the sessions and she did not feel she always got a chance to say everything she wanted to say. Reference 8 - 0.62% Coverage: I had a client who reacted very angrily to the news that I

		was leaving the service for a new role & they felt abandoned. Reference 9 - 0.48% Coverage: I was forced to cancel two appointments in a row with a client who was very distressed by this. Reference 10 - 1.15% Coverage: Yes - a client came into a session angry as she thought that I had contacted another professional organisation without letting her know. She wanted to know why she should continue therapy with someone who could not be trusted. Reference 11 - 0.66% Coverage: On an adult placement with a defensive client who put up many barriers in the relationship which prevented work from progressing. Reference 12 - 2.73% Coverage: Also when working with a male client who was particularly mistrustful of women, I was late to a session on one occasion. We had developed a reasonably good therapeutic relationship over quite some time (consisting of me turning up each week and staying on the inpatient ward for the session time whether he attended or not) - he was considered by the team to engage in lots of testing behaviours. At the time when I arrived to the ward late, he became verbally abusive and went to his side-room without the opportunity to discuss this. Reference 13 - 0.85% Coverage: When working in IAPT prior to training, a patient was very upset that I had had to break confidentiality and share some information relating to their child's safety.
Difficult Emotions Evoked 3 sources 27 references	Definition: Examples or descriptions of when difficult or negative emotions have been experienced during therapeutic processes or interactions, either about clients or about therapists, that therapists perceive to be a barrier to their therapeutic work. Inclusion criteria: Trainees' descriptions of or allusions to their own or their clients' experiences of	<Internals\\ISurvey Responses\\Question 7 Responses> - § 17 references coded [10.34% Coverage] Reference 1 - 0.50% Coverage: Clients with histories of abuse finding it harder when the relationship is more established, which paradoxically means closeness is aversive. Reference 2 - 0.25% Coverage: A major challenge is when a client is difficult to like/connect with. Reference 3 - 0.59% Coverage: In working with a narcissistic client who idealised and denigrated me I found it difficult to build a relationship that felt authentic while also being collaborative. Reference 4 - 0.69% Coverage: When a young man found it difficult to share his experiences, thinking very literally and not allowing himself to explore beyond that,

	difficult emotions as a way of understanding why they might be experiencing difficulties in the therapeutic relationship, either about each other or about things or people external to the therapeutic relationship. Exclusion criteria: Statements not directly referencing difficult emotions for clients and/or Trainees as a way of understanding how and why difficulties may be experienced in the therapeutic relationship.	preferring to say 'i don't know', rather than try and think. Reference 5 - 0.82% Coverage: I have sometimes found it challenging to form therapeutic relationships with personality disordered clients, as I can experience negative countertransference in response to their challenging behaviour, which they then pick up on. Reference 6 - 0.82% Coverage: I have had many challenges to it. There have been times I have just dreaded sessions with a particular individual or I have been talked at for an hour and leave sessions feeling confused and overwhelmed or knowing what is going on. Reference 7 - 0.60% Coverage: I have worked with sex offenders and perpetrators of violence where I morally disagree with their actions and it is a challenge to separate that from our relationship. Reference 8 - 0.55% Coverage: Where you find the client difficult to engage because you may not initially find them easy to talk to or where you feel that you almost don’t "like" them. Reference 9 - 0.90% Coverage: I have worked with one person where I struggled to get anywhere. I didn’t like the client very much, I found him invasive of my space and intimidating. On a level, I didn’t allow myself to like him because I was scared of him. This affected the rapport. Reference 10 - 0.52% Coverage: People who I see as very accomplished or high achieving in particular areas can feel intimidating and hinder the process of relationship building. Reference 11 - 0.37% Coverage: Sometimes there are patient factors that make the therapeutic relationship harder (e.g. paranoia, fear). Reference 12 - 0.50% Coverage: Being burnt out makes it hard to be accessible to the patient and if you just "go through the motions" you don't get that genuine connection. Reference 13 - 0.83% Coverage: Sometimes it is harder - when you perhaps don't like your client too much - but someone recently said to me that that is because you have not yet completely understood your client's vulnerability and that's certainly stayed with me. Reference 14 - 0.71% Coverage: I have struggled to empathise with an individual I felt to

		be essentially lying in their therapy. I struggled to connect with someone when I felt it was a performance rather than genuine experiences. Reference 15 - 0.07% Coverage: Mistrust of clients. Reference 16 - 0.79% Coverage: I guess this most often occurs with people who have a diagnosis of a personality disorder. Those people that are very untrusting and don't believe you are even interested in them let alone want to work positively with them. Reference 17 - 0.81% Coverage: I think it can also be difficult to build a therapeutic relationship with people whom I don't naturally warm to. It would be unnatural, I think, to like every single person you come across in life and this applies to therapy too. <Internals\\ISurvey Responses\\Question 8 Responses> - § 8 references coded [7.78% Coverage] Reference 1 - 0.82% Coverage: I think sometimes I've wanted to help a client so much that I've ignored possible rifts in our relationship in trying to pursue (what I thought was) a helpful solution. Reference 2 - 0.78% Coverage: When the relationship seems to be developing, some clients, especially those who have been let down by supposed caregivers in the past, can become overwhelmed. Reference 3 - 1.11% Coverage: I worked with a gentleman with OCD who was very difficult to work with as he seemed ambivalent about therapy. While he attended sessions, I felt we had difficulty connecting and that he wasn't able to be completely open with me. Reference 4 - 1.49% Coverage: However, I felt that in this context she would not trust me sufficiently to be fully open as she would try to protect me from her more difficult thoughts, feelings and experiences and my approval had become too important. I also felt frustrated and like my personal boundaries were being challenged by this. Reference 5 - 0.80% Coverage: Similarly, people can react very strongly against this and really struggle to experience care. I think it can feel uncomfortable or even intrusive in these cases. Reference 6 - 0.65% Coverage: I think when transference and countertransference was ignored, times when my feelings of frustration mirrored others in their lives.

		Reference 7 - 1.09% Coverage: There was a client who was very engaged in therapy that I found really tricky - I later understood this discrepancy as relating to some of my personal experiences which made it more challenging for me to work with this client. Reference 8 - 1.04% Coverage: I worked with a lady who I found difficult to empathise with at times. I found myself reflecting on our sessions and considered that I would become quite frustrated with what I considered to be a lack of motivation. <Internals\\ISurvey Responses\\Question 9 Responses> - § 2 references coded [1.76% Coverage] Reference 1 - 1.38% Coverage: I had been working with a client who was struggling with motivation in doing some behavioural activation work. I had become increasingly frustrated and became more challenging in the session than my client could manage leading to the premature termination of the session. Reference 2 - 0.38% Coverage: After a difficult session where my client reported he would never return.
Communication Issues 4 sources 23 references	Definition: Trainees' descriptions of the different types of communication difficulties and clients' therapy preconceptions they have experienced, associated with both general communication issues such as misunderstandings, and more significant communication issues associated with certain diagnoses or difficulties (e.g. selective mutism, social communication disorders and learning disabilities). Inclusion criteria: Trainees' descriptions of or references to issues in therapeutic rapport in terms of either understanding or empathising	<Internals\\ISurvey Responses\\Question 4 Responses> - § 2 references coded [1.33% Coverage] Reference 1 - 0.56% Coverage: I think often when the work gets stuck or isn't as helpful it is because we have not built a strong enough rapport yet or because there's been a rupture and I haven't noticed or repaired it very well. Reference 2 - 0.77% Coverage: In these cases my experience is that it has been, for a variety of reasons, difficult to build an initial therapeutic relationship and a working alliance. That is a poor relationship where attempts at repair have been unsuccessful has, in part, potentially led to drop out. <Internals\\ISurvey Responses\\Question 7 Responses> - § 9 references coded [5.68% Coverage] Reference 1 - 0.32% Coverage: I worked with an 18 year old selective mute and it was hard to feel a connection with her. Reference 2 - 0.74% Coverage: I think sometimes there is a sense that they might feel like you cannot understand them, because you are in a professional role and they have a sense

	with their clients, or in being understood by their clients, which has led to difficulties in the therapeutic relationship. Exclusion criteria: Statements without citing communication issues or difficulties in understanding clients or being understood by clients as a source of difficulties in the therapeutic relationship.	of you being constantly happy with your life at the moment. Reference 3 - 0.63% Coverage: I find quiet and reserved people most difficult to build a therapeutic relationship with. I have looked for specific advice on how to help with sessions and this has helped. Reference 4 - 0.82% Coverage: I struggled a lot with my first ever client as a trainee. It was a young woman who I just could not connect with. She showed little emotion, and little connectedness to her inner experience. I found it hard to get in her shoes. Reference 5 - 0.63% Coverage: Miscommunication/misunderstanding of therapeutic goals and expectations - we had a 'nice' relationship but not one based on good understanding and therefore therapy got stuck. Reference 6 - 1.13% Coverage: I had a socially anxious client who I was trying to display warmth and compassion to by using eye contact and saying how difficult things must have been for him, but actually the eye contact was making him feel more uncomfortable and shame was a big issue, so saying how difficult it must have been made him feel worse. Reference 7 - 0.92% Coverage: Working with individuals with limited communication (e.g. A learning disability) can make this slightly harder but I think we can still use our basic interpersonal skills to help build relationships (e.g. Eye contact, validation, reflection, listening etc.) Reference 8 - 0.42% Coverage: I have also found it hard to build a therapeutic relationship when patients have not been forthcoming with information. Reference 9 - 0.07% Coverage: Difficulty talking. <Internals\\ISurvey Responses\\Question 8 Responses> - § 11 references coded [13.84% Coverage] Reference 1 - 2.26% Coverage: I worked with one young man who was extremely anxious, he had a learning disability and had been told to come to sessions by a psychiatrist and to 'use them well' i think this caused him a lot of anxiety, confusion and pressure and as much as i tried to explore that and offered reassurance and acknowledge his dilemmas with coming it was very difficult to get past his preconceptions of therapy

		and the way it had been set up for him outside of our relationship. Reference 2 - 1.93% Coverage: I tend to be very soft-spoken and tentative, and I have had some feedback previously that I also look very young for my age. I think this isn't always the sort of personality/profile people are looking for in their therapist. I think some people feel reassured by someone with more maturity or a more direct approach - and in a way it's good that they thought "you're not the right therapist for me". Reference 3 - 1.09% Coverage: The client felt that I was not getting how they really felt which was true because they weren't being open with me and expected that if I was any good at my job, that I would just be able to mind read what was troubling them. Reference 4 - 0.89% Coverage: A client thought we had a good relationship that was "positive" while I felt that he was striving to please me, and I didn't believe him that he was doing his out of session work etc. Reference 5 - 1.30% Coverage: I recently received an email from a client in which she said she was doubting our work together and the model I was using, which surprised me as I thought we had a warm rapport and she had previously said that she looked forward to our sessions and found them helpful. Reference 6 - 1.22% Coverage: I once had a client who had different ideas about why we were meeting despite many conversations about it. He often spent much of the session going off topic and discussing other irrelevant things, and he was often inappropriate and struggled socially. Reference 7 - 0.97% Coverage: I had a sense that he thought it was a good therapeutic relationship however I felt it was not, due to his difficulties with communication and the differences in our understanding of the relationship. Reference 8 - 0.81% Coverage: Sometimes I am surprised by something or simply don’t understand these times are salient and important and I am yet to work with someone where this hasn’t occurred. Reference 9 - 0.85% Coverage: Not being seen as a therapist - someone got the impression I was an undergraduate student, even though I explained my trainee role. Future sessions did become more therapeutic. Reference 10 - 1.60% Coverage: I think there are often discrepancies within client and

		therapist opinions on the therapeutic relationship. For example, with one client I thought we had a strong therapeutic relationship, however he did not feel contained within the relationship, which resulted in him taking a short notice 5 week break in the middle of therapy. Reference 11 - 0.93% Coverage: This could be due to me feeling a bit out of my depth initially in this area and the diagnosis of autism for the client which meant that she wasn't able to communicate her feelings very well. <Internals\\ISurvey Responses\\Question 9 Responses> - § 1 reference coded [0.86% Coverage] Reference 1 - 0.86% Coverage: There have been times where I tried to suggest 'homework' to clients, but it was evident from their body language and facial expressions they were not happy about this.
Conceptualising the Relationship	Definition: The most commonly reported and dominant themes that Trainees used to describe how they conceptualise and understand the concept of the therapeutic relationship, particularly how they conceptualise a 'good' therapeutic relationship, the role of the therapeutic relationship and how their experience has informed their views of the therapeutic relationship.	
The 'Good' Relationship	Definition: Trainees' characterisations of features or aspects of the therapeutic relationship they feel are important in defining it as a therapeutic relationship.	
Trusting and Boundaried 4 sources 45 references	Definition: Trainees' descriptions of the importance of having trust, safety and boundaries when defining the therapeutic relationship, indicating a necessary presence for the creation of safety or a 'safe base' for the client, alongside appropriate therapeutic boundaries. Inclusion criteria: Trainees' references to having trust and/or having boundaries as ideal conditions to ensure the therapeutic relationship	<Internals\\ISurvey Responses\\Question 2 Responses> - § 24 references coded [17.74% Coverage] Reference 1 - 0.65% Coverage: A sense of safety and trust that leads to openness. A relationship that is boundaried, warm and caring. A relationship with an ending. Reference 2 - 0.42% Coverage: A therapeutic relationship is a safe, open, non-judging, relationship with boundaries. Reference 3 - 0.90% Coverage: It means mutual respect between client and practitioner where the client feels safe and knows the limitations and boundaries of the relationship, but in a way that they feel okay about. Reference 4 - 0.33% Coverage: It means the rapport and trust you build up with a client over time. Reference 5 - 0.94% Coverage: Ideally it should be based on trust and clarity, and without

	is good, with specific references to having trust, safety, containment and/or boundaries. Exclusion criteria: Statements that describe qualities of having a good therapeutic relationship that do not directly or indirectly trust, safety, containment and/or boundaries.	too much of a power gradient in either direction. It should foster an environment where people feel safe to discuss personal matters. Reference 6 - 0.56% Coverage: A relationship where a client feels safe and confident to tell the therapist their genuine experience of the world. Reference 7 - 0.93% Coverage: This is distinguished partly by issues of confidentiality and boundaries influenced by professional considerations. For me it is a working relationship; it has a function and is time limited. Reference 8 - 1.07% Coverage: This for me means a relationship that is professional, it is boundaried for the sake of the client and the therapist and it is dynamic so it builds over time and at times it can also be ruptured and need to be repaired. Reference 9 - 0.59% Coverage: A therapeutic relationship is something that evolves over time and withstands ruptures and offers safety and containment, Reference 10 - 0.77% Coverage: For me it means the extent to which the therapist and client 'get' each other. I think if it works well, the client feels cared for, contained and not judged. Reference 11 - 0.91% Coverage: It's developing a relationship with someone, where they feel like they can open up to you. It's a place where you feel like you can be honest and where they feel like they can trust you. Reference 12 - 0.72% Coverage: I think it describes the feelings between client and therapist, including how far the client feels able to trust and feel safe in the relationship. Reference 13 - 0.94% Coverage: It means the relationship you have while in therapy. It is a two way thing but to me it primarily means how the client trusts you and how comfortable they feel in sharing information with you. Reference 14 - 0.99% Coverage: It means a safe and trusting relationship, where the client feels they can openly discuss their struggles, without feeling judged or labelled, where they can share the moments when life is really tough. Reference 15 - 1.00% Coverage: If I was to define it succinctly it would be the moment that someone begins to disclose things that seem meaningful and relevant to them is the moment you feel that you have built a therapeutic relationship.

		Reference 16 - 0.62% Coverage: A 'therapeutic relationship' is characterised by trust and support, which facilitates honesty and collaboration within therapy. Reference 17 - 0.97% Coverage: An honest relationship where the client can be truly open about how they feel and know that the therapist won't judge them and that the therapist truly wants to help the client to support themselves. Reference 18 - 0.59% Coverage: A positive working relationship in which the client develops trust in you as their therapist to work through difficulties. Reference 19 - 0.27% Coverage: A safe space for exploration of struggles and distress. Reference 20 - 0.99% Coverage: It relates to the human bond developed under defined boundaries, but being a bond between two humans nevertheless that aims to help one of the two parties recover from his/her psychological difficulties. Reference 21 - 0.59% Coverage: A relationship with a client whereby they feel safe and able to open up to you, which will hopefully facilitate change. Reference 22 - 0.81% Coverage: It also says something to me about the client feeling able to share things that they may not feel able to share with others, while knowing they won't be rebuked for it. Reference 23 - 0.73% Coverage: The professional relationship between a therapist and client that allows for reflection, education, deconstruction of thoughts and behavioural change. Reference 24 - 0.46% Coverage: To me, it means a mutual development of trust, safety, healthy/ helpful boundaries and empathy. <Internals\\ISurvey Responses\\Question 3 Responses> - § 4 references coded [3.12% Coverage] Reference 1 - 1.20% Coverage: I think I now put more emphasis on the trust between the client and therapist whereas in the past I felt more comfortable if I thought the client liked me. I don't think a client has to like you (some just won't like you) to trust you and to know that you will treat them with respect and without judgement. Reference 2 - 0.75% Coverage: I think i have started to think about how there are commonalities to the therapeutic relationship which I would hope to achieve with all

		clients, for instance having positive regard and trust. Reference 3 - 0.70% Coverage: Since commencing training my awareness of the importance of boundaries in relationships and discussion honestly about difficulties in the therapeutic relationship has been enhanced. Reference 4 - 0.46% Coverage: I have become much more concerned with providing an attachment base and offering a secure and safe space for clients. <Internals\\ISurvey Responses\\Question 4 Responses> - § 15 references coded [9.32% Coverage] Reference 1 - 0.65% Coverage: Gaining trust from the client means they can make use of the sessions better. For people with damaged relationships in earlier childhood I hope that the therapeutic relationship can be internalised to form a warm kind internal voice. Reference 2 - 0.88% Coverage: I think in particular, when I've worked with clients who have been told (explicitly and implicitly) all their lives that they are worthless you won't get anywhere without putting in some ground work to earn their trust and to show them you have something to offer them that is different to what they might expect. Reference 3 - 0.22% Coverage: To get to the heart of a client's problems they need to be able to trust you. Reference 4 - 0.36% Coverage: I think it is key as without it the client may find it difficult to trust in you as a therapist, and feel that it is ok to share. Reference 5 - 0.78% Coverage: If you can help them to feel safe and respected I believe this is reparative itself. I have similarly found this with forensic populations. Also people with long term difficulties have seemed to benefit substantially from modelling a clear positive relationship with boundaries. Reference 6 - 0.70% Coverage: I believe that the therapeutic relationship was essential thereto build the willingness and trust for the client to take the brave step he needed to take in telling me the content of what his voices were saying to him, and the content of his paranoia. Reference 7 - 0.89% Coverage: Although not the only factor, but it is a very important factor to start facilitating therapy. Particularly in cases where clients have trust issues e.g.

		due to abuse, in people with trauma. E.g. If clients have trust issues, they are unlikely to start providing information to facilitate formulation and treatment plan. Reference 8 - 0.72% Coverage: In both cases, they needed that trust in our relationship to feel safe enough to be completely open and start exploring things that were incredibly difficult for them (they were both above 40 and had been having these experiences for lengthy period of time) Reference 9 - 0.71% Coverage: I don't think you can work effectively without it. We are asking very sensitive questions, so to feel like you can open up would mean that you have to be safe in the knowledge that what you are saying isn't going to be judged or taken in the wrong way. Reference 10 - 0.16% Coverage: It may also allow someone to feel safe for disclosures. Reference 11 - 0.33% Coverage: It can help when trying to facilitate change to do so within a safe, secure and boundaried therapeutic relationship. Reference 12 - 0.93% Coverage: I think the therapeutic relationship is extremely important - not only because all the evidence says so, but also because you can do great therapy, but if people don't feel safe with you and don't trust you, they will not show their vulnerabilities - people will not take on board anything the therapist says if they don't trust you. Reference 13 - 0.76% Coverage: By allowing the clients the space to explore alternative narratives to the dominant story I gained their trust and respect and this propelled the relationship along positively, and helped the therapy be effective as they felt able to explore these stories with me safely. Reference 14 - 0.60% Coverage: I felt the relationship was important on a recent LD placement where a client was able to discuss issues at home which led to a safeguarding referral, without a good relationship I doubt she would have told me this Reference 15 - 0.63% Coverage: I have found it particularly important to help clients to face difficult memories, develop the trust to take part in ERP or experiments, and to talk about things they experience as shameful or disgusting about themselves. <Internals\\ISurvey Responses\\Question 5 Responses> - § 2 references coded [1.63%

		Coverage] Reference 1 - 0.63% Coverage: A good therapeutic relationship has trust. There is a mutual respect. It maintains professional boundaries. Reference 2 - 1.00% Coverage: A never-ending therapeutic relationship is not necessarily positive if the client becomes dependent on the therapist and does not experience a positive ending to therapy.
Safely Challenging 4 sources 23 references	Definition: Trainees' descriptions of the importance of having the capacity to challenge clients in a safe and appropriate way in good therapeutic relationships, either as a sign of a good relationship or in order to build or continue building a good therapeutic relationship with their clients. Inclusion criteria: Trainees' references to being able to appropriately or safely challenge their clients in therapy in order to facilitate the client's recovery as necessary in order to have good therapeutic relationships with their clients, or acknowledging a good therapeutic relationship being able to support challenges in therapy. Exclusion criteria: Statements that do not directly or indirectly refer to the ability to challenge or cope with challenges in the therapeutic	<Internals\\ISurvey Responses\\Question 2 Responses> - § 9 references coded [6.49% Coverage] Reference 1 - 0.34% Coverage: A relationship that will challenge both and that both will learn from. Reference 2 - 0.37% Coverage: It is containing but also has the potential to be challenging when necessary. Reference 3 - 0.97% Coverage: Lastly, I think taking risks and being assertive are important to the therapeutic relationship too, there's no point blindly validating everything someone says - that wouldn't bring about any change. Reference 4 - 1.23% Coverage: A relationship unique to therapy, that when effective, allows the client to feel both comfortable describing and exploring their difficulties, whilst also being adequately challenged by the therapist in ways that they may not be able to achieve alone. Reference 5 - 0.82% Coverage: In a good therapeutic relationship the therapist also feels able to suggest ideas knowing the client will be able to reject them if they don't want to work in that way. Reference 6 - 0.90% Coverage: I also think it means that the client feels they are being held in mind and that they are respected. I think it's the glue that holds clients together when therapy is more challenging. Reference 7 - 0.42% Coverage: Also making the client feel safe enough to talk about their experiences/difficulties. Reference 8 - 0.30% Coverage: Strength of the relationship to manage challenging

	relationship in the context of understanding what it is to have a good therapeutic relationship.	content. Reference 9 - 1.14% Coverage: I would say that it is a relationship in which a client and therapist are able to mutually interpret and express dynamics that may be occurring and also expressing perspectives of different events that have occurred in a client's life <Internals\\ISurvey Responses\\Question 3 Responses> - § 5 references coded [6.38% Coverage] Reference 1 - 1.09% Coverage: I have also learnt that there are other ways of helping other than just being kind, being more assertive or challenging at times can help the work progress or show you are more attuned to your client, they may react better to a direct approach or they may need to be challenged. Reference 2 - 0.98% Coverage: I think especially as an assistant I saw the therapeutic relationship as the service-user 'liking' me. Now I perceive it more as a relationship that allows the service-user to explore change in a way that feels safe and suits their interpersonal style. Reference 3 - 1.72% Coverage: Perhaps when very inexperienced I saw the therapeutic relationship as one where I had to ensure the client liked me; even if this meant ignoring things pertinent to the therapy (i.e. consistently turning up late to therapy, not doing homework etc). Over time I have learnt to see that within a strong therapeutic relationship the therapist can tactfully challenge the client and this can be a very beneficial aspect to the therapy process. Reference 4 - 1.54% Coverage: I used to think that a 'good' therapeutic relationship was all about empathy and making someone feel good, safe, or comfortable. However, I am starting to think that it is more complicated than this. For example a good therapeutic relationship might involve a therapist who challenges a client, and is perhaps not particularly liked by them, but mobilises them to make changes in their life. Reference 5 - 1.05% Coverage: I have also learned that it's not about being the person to "fix" clients problems. A good therapeutic relationship is one in which you can supportively challenge the client, explore the difficulties and enable them to work through these. Not to solve problems for them. <Internals\\ISurvey Responses\\Question 4 Responses> - § 7 references coded [6.24%

		Coverage] Reference 1 - 0.61% Coverage: But for decent therapy, the relationship is important, especially if you are going to ask someone to challenge their ideas/ face their fears in some way, otherwise they are not likely to feel safe and contained to do so. Reference 2 - 1.95% Coverage: I think it's essential and however skilled you may be in delivering a model of therapy, a client will not engage if the relationship does not adequately develop. Some examples from my clinical practice: being able to challenge anorexic cognitions in ED clients. The therapeutic relationship allows you to work together as a team against the anorexia, and being able to comment on behaviours that the client may feel defensive about such as compulsions in OCD - the relationship has allowed me to introduce things in a slightly humorous way as I have learned from the client that this may feel less threatening and a good starting point from which to start to understand and challenge behaviours. Reference 3 - 0.67% Coverage: For me a good therapeutic relationship has been particularly important when needing to confront, challenge or explore a sensitive subject without forcing the client to disengage (i.e. exploring motivation for change or secondary gains etc.) Reference 4 - 0.97% Coverage: The stronger the relationship, the easier it is to probe and challenge. I have felt it has been particularly important when it has been absent - by that I mean it has been easy to see that a patient has DNA'd because they have no reason to come back (perhaps after an initial session, when the relationship has not been established effectively). Reference 5 - 0.54% Coverage: The therapeutic relationship and people feeling alongside you really helps them take risks, e.g. in behavioural experiments, or when trying something new, or when you're gently challenging them. Reference 6 - 0.54% Coverage: I think it is important though to conceptualise it not simply as a supportive relationship but one that is strong enough to allow you to challenge the client when it is appropriate to do so. Reference 7 - 0.96% Coverage: I have recently worked with a client with very difficult obsessional thoughts. Part of therapy has been for him to confront these and actively engage with them. On a number of occasions I have had a very strong sense that the only

		reason he has felt able to do some of the things we have agreed is because we have a really strong relationship. <Internals\\ISurvey Responses\\Question 5 Responses> - § 2 references coded [1.59% Coverage] Reference 1 - 0.76% Coverage: Good therapeutic relationship is when its safe enough for the person to ask questions and not feel judged and allows exploration Reference 2 - 0.83% Coverage: Creating a safe environment is also crucial and promoting independence of the client to continue their progress following the therapist input.
Engaging and Enabling 4 sources 43 references	Definition: Trainees' references to the importance of being able to engage/connect with and enable their clients within their therapeutic relationships with them, with this being a sign of a good, helpful and facilitative therapeutic relationship that may work towards recovery, improvement or a reduction in distress/symptomology. Inclusion criteria: Trainees' descriptions of or allusions to how a good therapeutic relationship is characterised by engagement and/or having a connection with their clients which can have an enabling effect in therapeutic encounters. Exclusion criteria: Statements that do not directly or indirectly describe the enabling or the	<Internals\\ISurvey Responses\\Question 1 Responses> - § 1 reference coded [0.38% Coverage] Reference 1 - 0.38% Coverage: I think that "human connection" is the most important thing. I guess nonverbal language contributes. <Internals\\ISurvey Responses\\Question 2 Responses> - § 28 references coded [22.23% Coverage] Reference 1 - 0.87% Coverage: For me, the therapeutic relationship is the human connection that occurs and which can make the work feel really rewarding. I work hard to achieve a good therapeutic relationship. Reference 2 - 0.70% Coverage: For me it means the relationship between myself and the client that allows them to feel they are able to open up to me about their difficulties. Reference 3 - 0.58% Coverage: Building up and maintaining a rapport that enables the client to feel that they can explore and reflect in a safe space. Reference 4 - 0.33% Coverage: The connection, understanding and trust between you and the client. Reference 5 - 1.23% Coverage: To me it means the relationship between me and the service user in the room and how we make that relationship mutually helpful and empathic and get to some sort of an understanding on what is going on for them, without making them feel judged in anyway. Reference 6 - 0.50% Coverage: A helpful and supportive relationship. A relationship

	engagement/connection aspects of a good therapeutic relationship.	which promotes positive psychological well-being. Reference 7 - 0.16% Coverage: Engagement to facilitate therapy. Reference 8 - 1.46% Coverage: I think it is trying to capture the feelings in the room when working with someone. Therapy can feel awful and can feel judging and threatening. The therapeutic alliance for me is how much a person can be who they are in the room and this is enabled by the relationship between them and the therapist. Reference 9 - 0.98% Coverage: Having a healthy and positive working relationship with the client that enables them to discuss things openly in therapy. Fostering a relationship that allows the client to get the best out of therapy. Reference 10 - 0.28% Coverage: Working together in therapy in a trusting and helpful way. Reference 11 - 0.87% Coverage: It means having a relationship with the person that allows them to trust you enough to engage with therapy - i.e. without it a person will not be able to engage with the process. Reference 12 - 1.16% Coverage: A process of engagement and building up trust and collaboration with an individual. It means getting to know what works and doesn't work in a session and how clients/SUs are likely to respond to particular ideas or ways of communicating. Reference 13 - 0.59% Coverage: It is the human connection between two individuals in a therapy, where one is a therapist and the other receiving therapy. Reference 14 - 1.30% Coverage: To me, it means the part of therapy that is human, and sets it apart from reading about strategies, for example. It is what makes people have confidence in the therapy and sets a pace that is unique to the individual so that they have a positive experience of therapy. Reference 15 - 0.71% Coverage: I think it encompasses body language and emotional reactions to interpersonal processes in the therapy room, both within the client and therapist. Reference 16 - 0.66% Coverage: The relationship you build between two people to enable trust, honesty and openness and encourage a piece of work whatever that might be.

		Reference 17 - 0.77% Coverage: It means the bond that we have throughout therapy that allows patients to talk to us and move with us to change something that they deem important to change. Reference 18 - 0.42% Coverage: Having a working relationship with clients that promotes psychological growth/change. Reference 19 - 0.52% Coverage: Relationship between two people (if individual therapy), with the aim of therapeutic benefit to the client. Reference 20 - 0.47% Coverage: The part of a relationship between therapist and client which influences the progress of therapy. Reference 21 - 0.72% Coverage: The human bond, the feeling of along-sided-ness. It's the reason I do the job! The most satisfying and most important part of working with someone. Reference 22 - 1.22% Coverage: The element or component of therapy which is about the relationship between the client and the therapist. It could be about communication or understanding between the two people, or more generally how one person impacts how the other feels or behaves. Reference 23 - 1.86% Coverage: Therapeutic relationship for me refers to a relationship between a therapist and client with the aim of enabling some sort of positive outcome. You can refer the constituents of therapeutic relationships involving the alliance, transference/counter-transference etc but for me it is simply about enabling another individual so that their life is less distressing and more satisfying. Reference 24 - 0.54% Coverage: A positive alliance built between the client and their therapist as a result of the therapeutic work undertaken. Reference 25 - 1.68% Coverage: I would term it as the emotional connectivity between psychologist and client. For me, this would mean (in a good therapeutic relationship) that both parties have understood and respected each other’s roles, and feel safe and secure enough together to commit to an ongoing journey, hopefully towards a clients increased sense of self-discovery. Reference 26 - 0.61% Coverage: The alliance an individual in a supporting/caring/therapeutic role develops with the person or persons seeking their

		support. Reference 27 - 0.52% Coverage: The relationship between therapist and client - how the therapist feels when with the client and vice versa. Reference 28 - 0.51% Coverage: The rapport that exists between client and therapist upon which trust and therapeutic gains are developed. <Internals\\ISurvey Responses\\Question 3 Responses> - § 5 references coded [3.13% Coverage] Reference 1 - 0.27% Coverage: Client feeling more comfortable to talk about issues and to reflect. Reference 2 - 0.53% Coverage: However, if anything, this has only served to confirm how important I think it is to invest time at the start by getting a connection. Reference 3 - 1.06% Coverage: I think sometimes you get a moment, often when you have been empathising with what they are saying, where the relationship clicks. I also think with some people it takes quite a bit of time to develop and sometimes takes you saying one thing right to make that difference. Reference 4 - 0.74% Coverage: I used to want to deny this, but now I accept this is ok – it's ok that the client shapes me just as much as I shape them! I think also I'm less realist about everything than I used to be! Reference 5 - 0.54% Coverage: I think it has moved from being a very one way relationship with the therapist in an 'expert' position to a much more collaborative stance. <Internals\\ISurvey Responses\\Question 4 Responses> - § 9 references coded [6.89% Coverage] Reference 1 - 0.73% Coverage: I think in cases such as clients with OCD when you are asking them as their therapist to engage in ESRP, you need to have a good therapeutic relationship in order for them to engage in this especially challenging intervention otherwise the client may disengage. Reference 2 - 1.32% Coverage: The complex cases (for want of a better term) I currently work with have very emotional and difficult things they want to talk about and without a good therapeutic alliance they would never be spoken in the room, our relationship in

		therapy has enabled them to talk about thoughts that have terrified them and contradictions to what perhaps is perceived as good or 'normal' to share things they are deeply ashamed of and how they feel about therapy and me as a therapist. Reference 3 - 0.53% Coverage: When they can connect these thoughts and experiences to feelings and we can understand this together, the conversation becomes real and therapeutic alliance is active (if that makes sense). Reference 4 - 0.45% Coverage: It is also helpful when a person becomes 'stuck' in therapy. A good bond with the therapist can help keep them engaged where they may have otherwise disengaged. Reference 5 - 0.34% Coverage: Once a therapeutic relationship is established, a service user will feel more able to engage in the process of therapy. Reference 6 - 0.99% Coverage: Today for example was the last session of a family piece of work I've been doing. The relationship was key. The family let me in to their world and together we created a formulation that enabled the client and their family to move forward. Without the relationship, there would be no movement, no "letting me in", no shared understanding of the problem. Reference 7 - 1.30% Coverage: For me it is especially important for individuals who have bounced around the system and have not gained any satisfactory outcomes. Those difficult to reach individuals. It also plays an important part with individuals who have a lot of contextual difficulties that won't change such as physical disabilities. Some of their distress may change but some may not. Being the person that doesn't give up on someone when they have experienced that frequently in the past. Reference 8 - 0.64% Coverage: The therapeutic relationship has been important to me when having to give clients 'bad' news, when liaising between clients and wider services, and facilitating deeper thought in people that have otherwise been reluctant to do so. Reference 9 - 0.59% Coverage: You need to build a relationship with your clients to help them engage in therapy. I think this is particularly important when working with individuals who have had difficult past experiences of relationships.
Collaborative	Definition: Trainees' descriptions of the ways in which they have	<Internals\\ISurvey Responses\\Question 2 Responses> - § 9 references coded [4.66% Coverage]

3 sources 21 references	recognised the need for shared responsibility in therapeutic relationships or the need to work collaboratively with clients, to manage both power and foster agency in order to facilitate therapeutic interventions. Inclusion criteria: Trainees' references to or descriptions of the importance of a two-way, collaborative relationship that acknowledges the role of the trainee and the client in good therapeutic relationships. Exclusion criteria: Statements that do not describe the two-way nature of the relationship when understanding what a good therapeutic relationship might look like, without directly or indirectly specifying the collaborative or mutual or shared way of working with clients.	Reference 1 - 0.49% Coverage: Having a relationship with the person where you are working together to gain a shared understanding. Reference 2 - 0.43% Coverage: I think it is a mutually respectful relationship which can help foster positive change. Reference 3 - 0.36% Coverage: The relationship between client and therapist, and how they work together. Reference 4 - 0.21% Coverage: Being able to work with someone effectively. Reference 5 - 0.83% Coverage: For me it generally means the extent to which the client and myself are working collaboratively and successfully together, and the quality of the emotional bond between us. Reference 6 - 0.46% Coverage: I think it is the way I relate to my client and how we both feel about each other in session. Reference 7 - 0.59% Coverage: The process of interacting between the therapist and the client, the building of a professional, supportive relationship. Reference 8 - 0.58% Coverage: Being able to empathise with clients and for them to feel understood and that they are working towards an agreed goal. Reference 9 - 0.71% Coverage: To me it means a collaborative and respectful relationship between therapist and another e.g. client that allows for a successful working alliance. <Internals\\ISurvey Responses\\Question 3 Responses> - § 8 references coded [7.59% Coverage] Reference 1 - 1.64% Coverage: I think I used to think that I had to be a lot more active in the therapeutic relationship, give advice, find solutions, problem solve for clients and always be nice and soft however I think through training and working in different models and with different supervisors I have learnt that it is important to support clients in finding their own solutions and to not take all the responsibility for the work that happens. Reference 2 - 0.53% Coverage: Just general experience has guided the knowledge that building the relationship is very interpersonal and not something I can do alone. Reference 3 - 0.64% Coverage: Influential factors include: collaboration, both client and

		therapist provide feedback (and reflection) after each session, time, understanding and respect, empathy. Reference 4 - 0.64% Coverage: The therapeutic relationship to me is now about sharing a story, coming to ideas together, forming a relationship with the client out of which great things can come. Reference 5 - 0.48% Coverage: I increasingly feel the need for me to be a present and active agent in this process, to be myself and to bring myself. Reference 6 - 0.63% Coverage: Over time I have learnt that the therapeutic relationship is built mutually not just by the therapist alone. It requires an investment of effort from the client. Reference 7 - 1.18% Coverage: I have come to realise that the therapeutic relationship is ideally a place where you can work collaboratively with a client. Previously, I thought of it as simply a comfortable relationship which allowed knowledge to transfer from therapist to client. I now realise it is much more complex than that. Reference 8 - 1.86% Coverage: What has changed is the belief that the client has to be the one who sometimes initiates and makes the change. The therapist sometimes has to take a step back rather than do all the work or offer lots of remedies as this is of no use if the client doesn't want to help themselves. This has been influenced through completing training, I always thought it was down to me whether changes were made or not and now I realise stepping back helps the client to take a step forward. <Internals\\ISurvey Responses\\Question 4 Responses> - § 4 references coded [3.01% Coverage] Reference 1 - 0.92% Coverage: With every person I have worked with it has been our shared understanding, honesty, validation and the relationship in the room that has enabled acceptance and change. Without this aspect I think the person could feel some benefit but I'm not confident it would be very valuable and could perhaps be more damaging than helpful. Reference 2 - 0.54% Coverage: ...but also needed to feel empowered enough that the change wasn't all coming from me so that when our sessions ended they were able to continue the progress they had made during our sessions.

		Reference 3 - 0.35% Coverage: It has been really important mostly when I've felt it has not been a 'good' relationship and we have both had to work at it. Reference 4 - 1.20% Coverage: This was particularly important with a young man whom I worked with, that for years had not told anyone that he felt responsible for the divorce of his parents. I can only imagine carrying this heavy burden for as long as he had, and he told me that telling me felt like a huge weight off his shoulders. If I didn't have a good therapeutic relationship with him, I have no doubt that he would have continued to carry that burden.
Perceived Role	Definition: Trainees' descriptions of any changes or developments in how the therapeutic relationship is understood and used, and their perception of its weight in their therapeutic encounters with their clients as a result of their past academic, clinical and/or research experience(s).	
The Foundation of Therapy 3 sources 55 references	Definition: Trainees' descriptions of or references to the therapeutic relationship being at the heart, core or centre, of therapeutic processes and/or outcomes, where they describe or allude to the relationship being the foundation upon which therapy is built or refer to it being the most important factor in conducting therapy. Inclusion criteria: Trainees' references to the therapeutic relationship being central to different therapeutic modalities, or the key/pivotal/most important factor in therapy, over and above other factors such as therapeutic approaches or technical skills.	<Internals\\ISurvey Responses\\Question 2 Responses> - § 10 references coded [6.51% Coverage] Reference 1 - 0.55% Coverage: The therapeutic relationship to me means the key to any helpful work, it is the foundations of any model you use. Reference 2 - 1.11% Coverage: The two-way relationship which is at the very heart of the work that we do as a clinical psychologist. It doesn't matter what model you are working in, if the therapeutic relationship is lacking, then change is unlikely to occur. Reference 3 - 0.47% Coverage: For me, the therapeutic relationship is the basis of any therapy or psychological intervention. Reference 4 - 0.19% Coverage: It's the basis for all interventions. Reference 5 - 0.34% Coverage: I see the relationship as the main determinant of therapeutic outcome. Reference 6 - 0.46% Coverage: I think it is the most important thing we've got. It can change hugely from patient to patient. Reference 7 - 1.01% Coverage: It's important to me, possibly the most important aspect of the work. If I have a good therapeutic relationship, I feel I can help the client work towards change and make a positive difference to their life. Reference 8 - 1.03% Coverage: I think it is almost the most important therapeutic factor

	Exclusion criteria: Any statements suggesting that the therapeutic relationship is intertwined with therapeutic interventions.	because you can have the best CBT skills and knowledge but unless you can help your client feel they can share with you, no progress is going to be made. Reference 9 - 1.08% Coverage: To me I believe that the therapeutic relationship is the most important foundation to begin any therapy and the strength of the therapeutic relationship can be a big predictor of how well a person engages and use therapy. Reference 10 - 0.26% Coverage: Without this, therapeutic work would be impossible. <Internals\\ISurvey Responses\\Question 3 Responses> - § 11 references coded [8.62% Coverage] Reference 1 - 1.52% Coverage: Maybe at the beginning of training I thought the theory/technique of the model I was working in was more important than I do now. Now, I place the therapeutic relationship over and above the therapy technique. Just having someone listen attentively to you, be present, help you make sense of and contain your feelings can be hugely beneficial, aside from any technique we use as psychologists. Reference 2 - 0.74% Coverage: Over the course of training, I think I've (hopefully!) started to understand more about the therapeutic relationship. Now I see it as really central to therapy, whatever model you're using. Reference 3 - 0.64% Coverage: I think I rate its importance more highly in relation to other components of therapy as time goes by - it seems more important than modality-specific competencies. Reference 4 - 0.75% Coverage: My understanding of what the therapeutic relationship hasn't changed, but I now place more importance on the relationship as being the minimum necessary foundation for any model of intervention. Reference 5 - 0.98% Coverage: It has changed to become a more pivotal influence in how i work with my clients - the therapeutic alliance is imperative and the model is secondary rather than the other way around and has been evidenced as providing positive outcomes for the clients. Reference 6 - 0.31% Coverage: If that relationship isn’t there then I think it is hard to do any work together. Reference 7 - 0.33% Coverage: Overtime I have appreciated its importance and its

		centrality to successful therapy. Reference 8 - 0.63% Coverage: I now understand that it really probably is one of the most important things and that we have to try as hard as possible to retain good therapeutic relationships. Reference 9 - 0.98% Coverage: It is the foundation that therapy is built on, my understanding of this hasn't changed but my respect for it has and I fear that services like IAPT have it totally wrong by forgoing the therapeutic relationship and putting pressure on session numbers. Reference 10 - 0.97% Coverage: During my first clinical training placement I appreciated how vital it is to spend time building the relationship in preparation for therapy, particularly when working with patients with personality disorders and chronic relationship difficulties. Reference 11 - 0.75% Coverage: I feel that all this knowledge needs to be supplemented and underpinned by first building a good rapport and relationship with the patient in order to make the therapy meaningful and workable. <Internals\\ISurvey Responses\\Question 4 Responses> - § 34 references coded [17.89% Coverage] Reference 1 - 0.46% Coverage: I think the therapeutic relationship is crucial and is always important, I can't think of a client I have worked with where the relationship hasn't been important. Reference 2 - 0.64% Coverage: Ultimately, all the research suggests that models etc are not in any way as important as having a therapeutic relationship - the simple elements like being heard, validated, understood and accepted can bring about so much change. Reference 3 - 0.42% Coverage: It's very important; it's the number one factor for successful outcome in therapy. It is particularly important for clients who feel judged or ashamed Reference 4 - 0.91% Coverage: It is the most important part of the therapy to me. Particularly when working with clients that have been hard to engage or when there is a pressing need to engage that person in services at that particular time (e.g. there is a significant risk concern or you feel a person may not engage again with services in the

		future). Reference 5 - 0.19% Coverage: I think it's absolutely central to therapy, whatever model you use. Reference 6 - 0.34% Coverage: Crucial - research has consistently suggested that it is the most important factor that influences the outcome of therapy. Reference 7 - 0.33% Coverage: I think it is crucial and it would be impossible to conduct therapy in the absence of a good therapeutic relationship. Reference 8 - 0.47% Coverage: It is the foundation of therapy. Working with complex cases in a forensic environment, establishing a therapeutic relationship is in itself a therapeutic intervention. Reference 9 - 0.35% Coverage: I think it's probably the most important factor in therapy. Without it, you can't do much else, for me it's the foundation. Reference 10 - 1.62% Coverage: I believe the therapeutic relationship is the single most important factor in therapy which can decide it is a success or failure. If you don't have a good therapeutic relationship with your client they may disengage, they may not open up to you because they don't feel safe enough to, they may feel the need to test the resiliency of you and the relationship if they don't feel it's secure and ultimately if the therapeutic relationship is not strong enough the client may not feel confident enough to engage in difficult interventions which may really challenge them emotionally. Reference 11 - 0.52% Coverage: I think the therapeutic relationship is vital. I don't think I could name examples of when it has been particularly important, as it's always the most important thing with every client. Reference 12 - 0.26% Coverage: I feel it is extremely important, and that it is very difficult to do good therapy without it. Reference 13 - 0.34% Coverage: I believe it is central and believe there is large evidence base to confirm this. It’s important all the time, every time. Reference 14 - 0.35% Coverage: Extremely important. I don't think therapy would be completely successful/effective without a good therapeutic relationship. Reference 15 - 0.40% Coverage: I think it is the most important aspect of therapy. I don’t

		believe the model used or anything else has any comparison to therapeutic alliance. Reference 16 - 0.23% Coverage: I think the therapeutic relationship is very important to the outcome of therapy. Reference 17 - 0.67% Coverage: I feel it is incredibly important. Without it, this work would just be a 'job' and that makes me feel sad. There are hundreds of examples I can think of where therapy has only got off the ground because of the therapeutic relationship. Reference 18 - 0.20% Coverage: I think that the relationship is the most important element to therapy. Reference 19 - 0.32% Coverage: I think it is essential. Without a therapeutic relationship, I think what can be achieved in therapy is limited. Reference 20 - 0.11% Coverage: I feel it is key to successful therapy. Reference 21 - 0.79% Coverage: Therapeutic relationship is very important to therapy. The foundations on which everything else is built. Need to establish therapeutic relationship is particularly important when working with persons detained under the MHA who may not be ready to undertake psychological therapy. Reference 22 - 0.60% Coverage: The therapeutic relationship is crucial to therapy (accounts for roughly 30% of outcome). The therapeutic relationship has been particularly important when working with clients who have experienced trauma or abuse. Reference 23 - 0.66% Coverage: I think it is very important and pivotal for the success of therapy. I worked with a client with an enduring eating disorder, she was honest, willing to try behavioural experiments and engaged with therapy and I think that made it work. Reference 24 - 0.68% Coverage: I think it's huge. I have had patients tell me that it was the only reason they got better or were willing to take risks. I also think it helps keep me motivated, which means the therapy I deliver is probably more tailored and more effective. Reference 25 - 0.53% Coverage: Very important, it is everything to do with engagement and is what will keep your client in therapy. If you aren't able to build a relationship then you don't have a foundation for therapy. Reference 26 - 0.40% Coverage: I can't imagine a situation where the therapeutic

		relationship isn't important to be honest and is in my opinion the biggest part of our work. Reference 27 - 0.32% Coverage: I believe it is the key factor in facilitating change, and is necessary to allow any techniques or models to work. Reference 28 - 0.76% Coverage: It is the most important aspect of therapy. This is because it provides the vehicle for changing how the client relates to others and views relationships in general. I consider this the most important aspect of therapy because problems usually originate in relationships. Reference 29 - 0.55% Coverage: I've come to see it as extremely important, because without it, I could be making the best suggestions in the world but the client won't have warmed to me so my suggestions may fall on deaf ears. Reference 30 - 0.99% Coverage: I think it is the most important aspect of therapy. Examples include clients that have been abused and have difficulties trusting others. By focusing on building a relationship before beginning any therapeutic work the client has felt safe and secure in disclosing difficult experiences and emotions. They have also felt contained when distress arises. Reference 31 - 0.95% Coverage: Sometimes I have found that it is the therapeutic relationship that has facilitated the most change as opposed to the specific therapy techniques! Counselling skills like being held with unconditional positive regard, being listened to, being asked questions in a curious manner has helped people come to terms with difficult life events. Reference 32 - 0.24% Coverage: The therapeutic relationship (in my opinion) is the most important factor in therapy. Reference 33 - 0.70% Coverage: I have also found that for a majority of my clients, they have not retained a lot of what we had spoken about. But they have remembered who I was, that I was there for them, that I cared and was interested in what they had to say and how they felt. Reference 34 - 0.61% Coverage: I'd have to go with Rogers on this... I think it is the single most important aspect of the therapeutic process. Without it, nether the client nor the therapist can be 'genuine' and without this progress cannot be made.

A Therapeutic Tool 3 sources 18 references	Definition: Trainees' descriptions of the therapeutic relationship being used as a therapeutic tool or as part of an intervention in their clinical practice with clients to facilitate therapeutic processes and/or improve clinical outcomes. Inclusion criteria: Trainees' statements about their use of the therapeutic relationship as a tool in the therapeutic process, or references to the therapeutic relationship being embedded in or a constituent part of the overall therapeutic process. Exclusion criteria: Trainees' references to the therapeutic relationship being central to or separate from the other parts of the overall therapeutic process.	<Internals\\ISurvey Responses\\Question 2 Responses> - § 5 references coded [5.26% Coverage] Reference 1 - 1.26% Coverage: I guess I see the therapeutic relationship as completely intertwined with the intervention itself. I think the relationship changes as the work does, from assessment stages to ending - and it accounts for a lot of the implicit learning the client experiences. Reference 2 - 0.77% Coverage: I think the therapeutic relationship itself can be therapeutic, that is almost an intervention at times to help the person achieve understanding and change. Reference 3 - 1.09% Coverage: The relationship itself can be used therapeutically, and with a "good" therapeutic relationship the client can feel safe enough to use the relationship to notice current ways of relating to others and can try out new things. Reference 4 - 1.34% Coverage: It is my role to be consistent and open enough to assist this relationship and dispel stigma, worry and fear in the way I speak respond and react in the room and to do all this as naturally as possible, basically using myself and my way of being as the main therapeutic tool. Reference 5 - 0.81% Coverage: One uses this relationship to facilitate the process of therapy. The characteristics of this relationship will impact and shape the course and consequences of therapy. <Internals\\ISurvey Responses\\Question 3 Responses> - § 1 reference coded [0.51% Coverage] Reference 1 - 0.51% Coverage: I became more aware of the impact of the therapeutic relationship and its potential to be therapeutic in itself across approaches. <Internals\\ISurvey Responses\\Question 4 Responses> - § 12 references coded [9.30% Coverage] Reference 1 - 0.29% Coverage: I think the therapeutic relationship is intertwined with the theoretical/intervention side of therapy. Reference 2 - 1.04% Coverage: I believe that the therapeutic relationship is an essential element of "successful" therapy, because without it the client has no reason to feel safe

		enough, or trusting enough to speak about things which might bring them shame and discomfort or might make them feel vulnerable or humiliated, and avoidance of these things can lead to a tokenistic, shallow sort of therapy. Reference 3 - 1.00% Coverage: When I have been working with parents where we have been talking about attachment issues, I have had to rely on my therapeutic rapport with the client to be able to talk to them about parenting skills. This is a sensitive area and it could have lead to the client becoming defensive, the therapeutic relationship allowed understanding on both of our parts. Reference 4 - 0.18% Coverage: I believe the relationship is one of the most important elements. Reference 5 - 1.82% Coverage: Fundamental. Provides framework to identify patterns that are playing out, to name these and to try and do something different. For example one man I was working with had a pattern of hearing rejection. He heard something I said as rejecting and was driven to leave. The strength of our relationship, his respect for me and hope for the future offered him the strength to try something different. We were able to name and explore this pattern and consider alternative explanations. He came back and completed the work. We were also able to offer a different ending for him, he frequently gave up therapy prior to the end but with me he stuck it out. Reference 6 - 0.64% Coverage: In working with clients I have found it much easier to introduce ideas that clients may feel uncomfortable with when the therapeutic relationship is good - without this honesty I don't think therapy would be at all effective. Reference 7 - 0.81% Coverage: I am aware that the literature base states that it is the biggest indicator for change for the client, and as such, I feel that it is highly important to efficacious therapy. An example of this would be with clients who perhaps have not been given the space to reflect and be heard before. Reference 8 - 0.64% Coverage: I think it's extremely important, if you are able to be honest with each other I feel you can make more progress and highlight when either of you may be feeling stuck or discuss any emotion that may help therapy to move forward. Reference 9 - 0.76% Coverage: I think the therapeutic relationship was key here because despite his self-described paranoia and mistrust around mental health and legal services, he found himself wanting to talk through this with me (even though I was seen as part of

		this "corrupt" system he feared). Reference 10 - 0.88% Coverage: I think a good therapeutic relationship is a 'common factor' in therapy. I believe it can account for a high proportion of change during therapy. However, I don't think the relationship by itself is necessarily sufficient to bring about change and I am a believer in the 'contextual model of therapy' (see Wampold). Reference 11 - 0.82% Coverage: Vital - but you also need some therapy skills! In order to engage clients and for them to feel you are competent. It's useful for example when clients are not ready for change but contact you at a later date when they are ready for change - they know you can support them when they are ready. Reference 12 - 0.42% Coverage: I feel the therapeutic relationship is crucial to therapy and is likely the reason that an array of techniques and approaches are useful and effective.

Key:-

CAPITALS	Colum titles
Bold	Domains
Bold Italic	Superordinate Themes;
Normal	Themes
Italic	Subthemes