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EMPIRICAL PAPER

“What shall we focus on?” – A thematic analysis of what characterizes cognitive-behavior therapy sessions with high or low quality of working alliance

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Abstract

Objective: Several studies have shown that the quality of the working alliance predicts symptomatic improvement session-by-session, including in cognitive-behavioral therapy (CBT). We wanted to explore what characterizes CBT sessions with high and low alliances further using qualitative analysis.

Method: Ten CBT-sessions were selected from eight patients' therapies in a larger research project on psychotherapy for patients with major depression. Five sessions were chosen from high- and five from low-alliance sessions, based on therapist- and patient-reported Working Alliance Inventory scores. Transcripts of these sessions were analyzed using thematic analysis.

Results: The analysis yielded four themes, each structured into two sub-themes: Therapist style, Person in focus, Content focus, and Therapeutic direction. In contrast to low-alliance sessions, high-alliance sessions were characterized by a more exploring as opposed to expert therapist style; a focus on the patient's thoughts, feelings, and behavior, rather than a diffuse focus or a focus on other people's actions/external events; and a sense of moving forward rather than stagnation.

Conclusion: Our qualitative analysis showed theoretically and clinically meaningful processes in CBT sessions of high- vs low working alliance. This method is a useful complement to quantitative within-patient analyses, to expand on the meaning of quantitative findings.

Keywords: major depression; working alliance; cognitive-behavioral therapy; psychotherapy; process research

Clinical or Methodological Significance of This Article We studied sessions of cognitive-behavioral therapy using qualitative analysis to explore what kinds of processes may explain the predictive effect of working alliance on next-session depressive symptoms shown in previous studies. The analysis yielded four clinically relevant themes, each containing two subthemes, that may be useful for therapists when conducting CBT with depressed patients.

Although originally a psychoanalytic construct, the most common definition of the working alliance used in psychotherapy research is Bordin's (1979) pan-theoretical one, which formulates the alliance as agreement on therapy tasks and goals, in the context of a positive emotional bond. Other authors

have used terms like “confident collaboration” (Hatcher & Barends, 2006) to better capture the process of collaboration throughout therapy work, and not just “agreement,” which seems to refer more to the initial therapy contract rather than to the more implicit process of working together in therapy.

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The importance of therapeutic collaboration has been emphasized in Cognitive Behavioral Therapy (CBT) since its inception in the form of collaborative empiricism (Beck et al., 1979). Collaborative empiricism was originally discussed as client and therapist working together to design, implement, and evaluate empirical tests of the client's maladaptive beliefs in a scientific manner. The patient's role was to provide the therapist with the "raw data" by reporting thoughts, feelings, wishes, and behaviors, while the therapist's role was to guide the patient in what data should be collected and how to use it for therapeutic purposes. Beck et al. had the view that collaborative use of CBT techniques is relationship building in and of itself, so in principle no specific techniques for fostering alliance were needed.

The similarities between the concepts of collaborative empiricism and working alliance are apparent. However, Tee and Kazantzis (2011) criticized the alliance literature based on Bordin's conceptualization of the alliance and on the items of the Working Alliance Inventory, both of which emphasize *agreement* on goals and tasks more than actual *collaborative work* which they meant is the essence of collaborative empiricism. This is probably more a problem with Bordin's definition of the alliance, which seems more apt for describing the initial establishment of the alliance than the alliance in actual therapeutic work. In the way most contemporary theorists and researchers use the term "working alliance," it is meant to be about therapeutic collaboration on treatment tasks and not just agreement (R. L. Hatcher, personal communication, April 25, 2021). Another potential point of divergence between collaborative empiricism and working alliance theory is in the concept of the emotional bond in the working alliance. Although the working alliance is sometimes equated with a generally positive relationship, this is not what was intended in Bordin's working alliance definition. In Bordin's definition, the bond is important only to the extent that it supports therapy work (Hatcher & Barends, 2006). Thus, although the concept of collaborative empiricism does not contain any reference to the importance of the emotional bond between therapist and patient, we do not see conflict.

Seen in this way, collaborative empiricism would be a specific form of working alliance, rather than something separate from it. Although the importance of working alliance for outcome in CBT is still somewhat contested (Strunk et al., 2010; Webb et al., 2012; Whelen et al., 2021), meta-analyses consistently indicate no differences in alliance-outcome correlation among various treatment methods – including CBT (e.g., Flückiger et al., 2018). If collaborative empiricism is

conceptually similar to working alliance, this might explain this finding.

A large body of research links the quality of the working alliance to psychotherapy outcome (Flückiger et al., 2018). However, less is known about the kinds of processes that constitute better or worse alliance in various treatments. Lavik et al. (2018) found 15 qualitative studies on what constitutes a good alliance in the first five sessions of treatment. Their qualitative meta-analysis showed that clients valued meeting a competent therapist, feeling understood, appreciated, and supported as a whole person, getting new strength and hope for the future, and overcoming initial fears about therapy. Therapists spoke about balancing technical interventions with warmth, showing their genuine desire to understand, supporting their clients' agency, creating a safe environment, attending to body language, and providing helpful experiences already during the first session.

All of the studies in Lavik et al. (2018) were based on client- and therapist interviews about the alliance. Since the publication of this meta-analysis, a few more qualitative studies have been published on the therapy relationship in CBT. Wilmots et al. (2020) interviewed adolescent patients with good outcome after CBT about their experiences of the therapy relationship using qualitative interviews. Results showed that the adolescents experienced a positive relationship as fostered by therapists respecting their autonomy, while also offering experiences of emotional closeness. Also, Soygüt and Gülüm (2016) studied moments of alliance ruptures in therapies of mixed orientation by showing therapists and patients segments of identified ruptures and interviewing them about their experiences of these. Their results showed that therapists often attributed ruptures to negative contributions from the patients and suggested technical solutions.

There seem to be much less research done studying sessions directly. Oddli et al. (2021) studied future-oriented actions in the first three sessions of five good-outcome cases that also reported a good working alliance, and were treated using psychodynamic, humanistic, and systemic psychotherapies. Their findings showed that therapists did not explicitly work on goals, but instead picked up subtle signs of agency from their clients to gradually facilitate a forward-driven process. Also, although not explicitly focused on working alliance, von der Lippe et al. (2019) conducted qualitative analysis of the initial two sessions of good- versus poor outcome cases treated by eclectic psychotherapists with mostly psychodynamic orientation. Their focus was on how therapists fostered a sense of agency in clients with low proactive agency. Of

note, none of these studies focused specifically on the working alliance in CBT.

In the last decade, more sophisticated quantitative designs of alliance-outcome research have gained prominence. Specifically, in response to criticisms of the correlational research that most alliance research is based on, which cannot ascertain causal direction, several authors have started to use repeated measures designs analyzed using time-lagged predictor models (e.g., Falkenström et al., 2020) to study the alliance – outcome relationship. In addition, most of these studies have also applied some form of separation of within- and between patient variances, which further strengthens causal inference since it protects against unobserved confounders that are stable over time (Falkenström et al., 2017). A meta-analysis by Flückiger et al. (2020) showed a significant effect of alliance on next-session symptoms across 20 studies, and again no significant differences between therapy models were found. One of the studies included in this meta-analysis was part of the same research project as the present study. That study showed a large effect of alliance quality on next-session symptom severity in CBT and Interpersonal Psychotherapy (IPT) (Falkenström, et al., 2016).

This finding means that when the alliance is rated unusually high for a given dyad, symptom severity is more likely to decrease in the following session, and when the alliance is rated unusually low for a given dyad, symptom severity is more likely to increase (or decrease less) to the following session. However, the statistical analysis does not provide any reason for why this happens. Thus, it is of great interest to study the characteristics of sessions in which this pattern holds; that is, sessions in which the alliance is rated unusually high and are followed by symptomatic improvement, and session in which the alliance is rated unusually low and are followed by symptomatic deterioration. A detailed study of such sessions might yield clues as to *how* the alliance is related to outcome.

Intrigued by these queries, the aim of this study was to do a follow-up of our previous quantitative study (Falkenström, et al., 2016) to explore the characteristics of therapy sessions in which the alliance was rated as particularly high – and was followed by a symptom reduction at the next session, *or* the alliance was rated particularly low – and was followed a symptom increase at the next session, using qualitative analysis. The focus of this paper was on CBT sessions provided to patients diagnosed with major depression. An exploratory, inductive qualitative approach was taken, to increase the chance of potentially unexpected findings to emerge.

Method

The present study was conducted within a broader research project entitled Cognitive and Interpersonal Psychotherapy at the Psychiatric clinic in Sundsvall (CIPPS; Ekeblad et al., 2016) which was a non-inferiority trial comparing IPT to CBT for patients with major depressive disorder (MDD). This project was approved by the Regional Ethical Board in Linköping, Sweden (2010/348-31). Within this project, therapy sessions were video recorded.

Patients

All patients had been diagnosed with MDD and had been referred to the psychiatric clinic. The inclusion criteria were age 18–65 years and a primary diagnosis of MDD. The patients had received previous depression treatment (mostly pharmacological) in primary health care, with none or only partial response. Exclusion criteria were psychosis, ongoing substance addiction, ongoing self-harm, or severe neuropsychiatric diagnosis. The patients in this study were all randomized to receive CBT treatment (the other half of the patients who were randomized received IPT treatment, but these were not included in the present study).

The 10 sessions selected for the present study included eight patients (seven women and one man), i.e., two patients appeared in both a high- and a low-alliance session. Their ages varied from 18 to 51 years, and their average score on BDI-II before therapy was 38.6 for patients in the selected high-alliance sessions and 36.0 for patients in the selected low-alliance sessions. In their last session, patients in the high-alliance session group had an average BDI-II score of 18.0 while the patients in the low-alliance session group had 19.3. On average, the high-alliance session group had a WAI-SR (patient-reported) score of 5.6 and a WAI-S (therapist-reported) of 4.8 across all their sessions. The low-alliance session group had a WAI-SR score of 5.4 and a WAI-S of 5.2.¹

Therapists

The therapists were employees at the psychiatric clinic where the treatments took place. The 10 sessions selected for the present study included six therapists (five women and one man). Two of the therapists appeared in three sessions each, and the remaining in one session each. Four therapists were in their thirties, and two were in their forties and fifties. One of the therapists was a social worker, and the remaining were psychologists. Two of the

therapists had specialist training in CBT and the rest had basic CBT training.² In addition, they received supervision by specialist CBT supervisors, and extra CBT training during the project time. The number of therapists with basic or specialist psychotherapy training was similar in high- and low-alliance sessions.

Measures

Working Alliance Inventory – Short (WAI-S; Tracey & Kokotovic, 1989). The WAI-S is a 12-item version of the original 36-item WAI. It has shown satisfactory internal consistency, high correlations with the original WAI, and prediction of therapy outcomes in the expected direction (Busseri & Tyler, 2003). The therapist-reported version was recently found to have adequate psychometric properties in a fairly large study (Hatcher et al., 2020).

Working Alliance Inventory – Short form Revised (WAI-SR; Hatcher & Gillaspay, 2006). The revised short form of the WAI is another 12-item patient-reported measure of the working alliance. Several studies have shown the validity of the Swedish version of the WAI-SR in predicting symptom change during treatment (Falkenström et al., 2016; Falkenström et al., 2013, 2014; Larsson et al., 2018).

In the present study, the therapist-reported version of the WAI-S and the patient-reported version of the WAI-SR was used. The reason for using different instruments was that although the WAI-SR is more thoroughly evaluated psychometrically, at the time the study was planned there was no psychometric evaluation of the therapist version of the WAI-SR. Both therapist and patient filled out the WAI immediately after each session.

Beck Depression Inventory-II (BDI-II; Beck & Steer, 1996). Depression symptoms were rated immediately prior to each session, using the BDI-II which is a widely used instrument to self-assess depressive symptoms. The scale consists of 21 items, each item rated from 0 to 3. The BDI-II has shown good reliability, capacity to discriminate between depressed and non-depressed subjects, and concurrent, content, and structural validity (Wang & Gorenstein, 2013).

Session Selection

For the purpose of the detailed qualitative analysis of the present study, 10 sessions were selected (from a total of 918 sessions with complete data), five from high- and five from low-alliance sessions. The

selection of sessions was done as follows: (1) the mean value of WAI-S and WAI-SR ratings was calculated into a new variable (WAI-ther/pat). (2) BDI-II and WAI-ther/pat were standardized within each patient, so that the standard deviations were equal to one for both measures within all treatments. (3) separate regression analyses within each therapy were used to determine whether the alliance significantly predicted next-session outcome in this specific therapy. This was done to increase the probability that the finding from our previous study that, on average, improved quality of the alliance predicted next-session symptom improvement was applicable to the specific treatments from which sessions were chosen. Only therapies in which WAI-ther/pat significantly predicated the BDI-II score in the following session were used. (4) From these therapies, the session with the highest respective and the lowest value on WAI-ther/pat was selected. If the selected session was the final session of the therapy, this session was replaced with the session with the second highest or lowest alliance score. If the selected high-alliance session was not followed by a decrease in depression symptoms in the following session, this session was replaced with a high alliance session that followed the general pattern of decreasing depression symptoms in the following session. Accordingly, low alliances sessions were selected when they followed the pattern of an increase in depression symptoms in the next session. In total, five high-alliance sessions and five low-alliance sessions were selected for further analysis. All the high-alliances sessions originated from the middle and later parts of the therapy (sessions 7–13), while all low alliances sessions originated from the beginning or middle parts of the therapy (sessions 1–8).

Treatment

The CBT therapists in the study used two different manuals, where one focus on cognitive interventions (Beck et al., 1979) and the other focus on behavioral change (Martell et al., 2010). Some of the therapists also used mindfulness in their treatment. The therapists made individual clinical decisions regarding what methods they used for each patient, as is a common standard in Sweden. Fourteen weekly sessions of treatment were the format used in both treatment arms. The adherence to the method was rated using the CSPRS-6 as high Ekeblad, et al. (2016).

Qualitative Analysis

The primary qualitative analyses were done by two graduate students (MD and MP) under supervision

by a researcher with extensive experience in qualitative methods (AM). Three of the researchers (MD, MP and FF) have basic training in CBT, which in Sweden consists of one and a half years of lectures and supervised therapy. Still, the allegiance of the team as a whole is mixed, with one researcher (FF) with a leaning towards psychodynamic and another (AE) towards interpersonal and psychodynamic psychotherapy.

The 10 selected video-recorded therapy sessions were analyzed following a six-step Thematic Analysis as recommended by Braun and Clarke (2006, 2013). Initially, the researchers were blinded to which sessions were in the high- or low alliance group, to ensure that they were not influenced by this information when coding the data. At a first step, the two graduate students watched all 10 selected video recordings and made short notes of thoughts that arose from watching the tapes. Thereafter they transcribed the entire sessions verbatim, including non-verbal utterances such as “um-hm,” sighs and laughter. Identifiable information, such as names of persons and locations were replaced with pseudonyms during the transcription process. In the next step, all transcripts were coded inductively by the graduate students, at first separately and then together to come up with consensual codes (Hill, 2012). Thereafter the sessions’ categorization as high or low alliance was unblinded to the researchers.

When analyzing the data, codes from sessions with high and low alliance were analyzed separately and sorted into categories to allow comparison of codes within and between the two groups of sessions. Candidate themes were discussed between all authors and revised until the final themes were established. This process also involved returning to the transcripts, re-watching parts of the sessions, and comparing with the researchers’ initial notes from watching the sessions. This movement between analytic codes and original data was important to ensure credibility in terms of that the final themes were well grounded in the data.

For example, analysing the differences between codes in a category of patient *expressing negative feeling* (like worry, frustration, or hopelessness), patient *expressing positive feelings* (like hopefulness or determination) and both therapist and patient *talking about goals*, highlighted a pattern that was later formulated as the theme *therapeutic direction*, and the sub-themes *stagnation* and *moving forward*.

Results

The results are presented in the following four different themes: *Therapist style*, *Person in focus*, *Content*

focus, and *Therapeutic direction*. Each of these themes consist of two sub-themes in which contrasts between high- and low-alliance sessions are shown. The subthemes display major patterns in the sessions and highlight the most prominent differences between the high- and low alliances sessions. However, there are also deviant examples, where sessions do not fit the major pattern, in the sense that some low-alliance sessions include some characteristics of high-alliance patterns, and vice versa.

Therapist Style

The first theme is named *Therapist style* and focuses patterns in how the therapist acts during the sessions. The theme consists of two themes: *Exploring* and *Expert Role*. An exploring therapeutic style dominated high-alliance sessions, whereas the expert role dominated low-alliance sessions.

Exploring – “What makes that difficult?”.

When the therapists employed an exploring therapeutic style, the dialogue sounded like a collaboration, in which the therapist helped the patient to identify and formulate answers to the issues in focus. The therapists seemed to strive to engage the patients in the therapeutic process. To do this, they were mirroring, summarizing, and asking questions. Generally, the therapeutic dialogue was oriented towards a deepened understanding of the issue at stake, or at a certain behavior change. In session A, the therapist explored why the patient could not go away for a planned activity. T: What do you feel would be important to focus on now? About the things that we have discussed as important to ... P: (Subdued) Perhaps getting started with things on my own. T: Mm (...) T: Yes (...) P: Sort of getting out in nature (laughter) T: Yes. What happens there? What makes that difficult? P: Well yes, I don’t know. I just don’t do it. I don’t know. I plan to do things but ... no. I just don’t do it. I just sort of am at home and then suddenly the whole day has passed. / ... / T: Ok, let’s say that you wake up on a Saturday. And hopefully maybe the weather is lovely. You have this plan. P: Yes. Either I go. Or I just lose heart and feel that there is no point and then I stay home. T: Ok. You lose heart ... P: Mm. / ... / Yes, and that I feel that I might as well just stay home. And then I stay home. T: If you were to go out anyway. P: Yeees. Could be possible. Or I go and stay only for a little while and then I leave. T: Yes. Do you think that could make a difference? If you went? P: Yeees I think so. I have tried at least, then. T: Do you think that it would feel different when you come home? P: Yes, I think so. It would

feel like I at least did something.T: Ok. And that would mean? For you?P: Yes...I would probably be less antsy at least.Through shaping a scenario, mirroring the patient's attitude, and asking follow-up questions, the therapist in this extract helped the patient to reflect, and a collaborative exploration of the situation took place. Through this work, the joint understanding of the patient's behavior was deepened, which in turn is important for a behavior change to happen. This kind of explorative approach was common in the high-alliance sessions, where the therapists collaboratively deepened the understanding of the patients' problems; how thoughts, feelings, and behavior fit together, and what the patient could do to handle the situation. These explorations further challenged negative thoughts, which appeared frequently in most sessions. Through collaborative exploration of the truth and trustworthiness of negative thoughts, the patient was helped in developing new ways of thinking.

Expert role – “The best for you would be to ...”. In contrast to the high-alliance sessions, where the explorative therapist style was frequently employed, this style was less common in low-alliance sessions. The therapist style was in these sessions rather characterized by an expert role, in which the therapist's collected information, validated the patient, and gave them advice. The therapists asked the patients specific questions, rather than promoting a collaborative exploration. These questions mostly concerned third-person behavior and course of events. When employing an expert role, the therapists frequently gave advice and presented various kinds of facts, although it was often difficult to tell whether the patients appreciated the advice or not. However, it is important to point out that the therapists continued to validate the patients' experiences and feelings to a similar degree as in the processes characterized by exploration. Session H is an example where most of the session was focused on practical problem-solving. The patient explained that she did not thrive at home and wanted to find her own appartement. The therapist asked questions about her economy, raised practical issues about living alone, and gave different sorts of advice to the situation:P: But the question is will I get the housing allowance?T: You have to change your registered address to [the other city], that is how it works.P: Yes.T: You have to move to [the other city] to this apartment/.../T: The landlords are usually quite strict about that they need to know that you have an income.P: Yes.T: So even if you write that you are interested it is not certain that you will get it.P: No.T: Because they want to know that they will get the rent, so to say.P: Yes, I

know that. That is also the thing that I just...T: Yes. You are not planning to share the apartment with that friend or yourboyfriend or?/.../T: Because I know girls your age who are in high school who live in their own apartments, for example in [the city T works in] since I work here, and they do get help from the social services.P: YesT: And financial housing aid. So they can manage but not more.P: NoT: And if they work and get some money then what happens is of course that they get less financial aid from social services if they do extra work on the side.P: Yes./.../T: The best would be if you had found a roommate. You know in a room with a small kitchen in a house, or... In this excerpt, the therapist was instructing the patient on how to get housing allowance, and how to approach the situation of renting an apartment. To this, the patient gave only monosyllabic responses. There was no collaborative exploration taking place, as the therapist advised the patient on how to act, rather than exploring this issue together with the patient.

Person in Focus

Two subthemes were constructed about the person that was mostly in focus during the session: *Focus on the patient* and *Focus on other people and external events*. In high-alliance sessions the patients tended to talk more about themselves, their thoughts, feelings, and behavior, and the therapist encouraged that – while in low-alliance sessions focus of dialogue was mainly on external circumstances and about what other persons had been doing and saying.

Focus on the patient – “I am having a hard time”. The core of the theme *Focus on the patient* is that the patients talked about themselves, and the “I” was at the center of the narrative. The patients talked about their own thoughts, feelings, and behaviors, and this was encouraged by the therapists. This is clearly seen in session E:T: How have things been, how have you been...?P: Rather hard. Things have been pretty hard with school. I have been having a hard time getting up in the morning. I feel like, it has been difficult to take the bus to school and like go there. I have like felt like the devil is on one side and an angel on the other side, like, and saying “Stay at home today, you're ok, it doesn't matter if you stay home.”T: What is that, like, you are saying that you had two. The devil on one shoulder and an angel on the other.P: Two voices who...T: Two voices...P: Two voices who are telling me what is good and. That I know that I should do it, I mean go to school, but, ah.../.../T: Is there anything else that you are thinking about that you

think you should use the time for today.P: Er ... Well this morning I actually thought. I mean the thing that, I hate talking about this. I mean like suicide, I thought a lot about that this morning.In this extract, the patient was fully focused on herself, her own thoughts, feelings, and behaviors. When the patient was invited to plan the agenda, she opened up to tell the therapist about the suicidal thoughts she had had the same morning. The patients' self-centered focus remained throughout the session. When the patients focused their narrative around themselves, as in the extract above, they were providing the therapists with valuable information about themselves. The patients were often generous in their sharing their inner life. The dialogue in session A is a good example of this:P: I mean that, I'm very aware of that, that thing, that that is the way it is. And I mean, I am not sure, right now I somehow feel that ... I am not sure, I don't want to rush ... it's like I have said before, before I have always rushed everything because, like, I want to move on somehow. But for once I have slowed down and accepted that it takes a while to get where you want. But instead, yes, like, and you have to take some time because otherwise you can't, I mean otherwise you don't get to where you want to be, you hit a wall.From this narrative, the therapist got information about the patient's desires, what feelings the patient had around them, and difficulties that were associated with achieving them. All in all, this contributed to an increased understanding and consensus. When the patients focused on themselves, as in the extracts above, this had most often been preceded by therapist questions, directed at the thoughts or feelings of the patient.

Focus on other people and external events – “She really annoyed me!”. In contrast to the high-alliance sessions, most of the low-alliance session were characterized by the fact that patients talked about people and events external to themselves. Rather than having a self-oriented focus, the topics raised were directed outwards and the narratives were dominated by talk about other people. Below follows an example from session H, where the patient described a phone call from a relative:T: You don't need to wag your tail and (laughs shortly) sort of, but also like, to not counterattack but take her seriously when she seeks contact. Say “ok, alright. When shall we be in touch?”P: But usually she just calls to complain, or yell, or there is something. Because last time I said that. Oh, but the day before when she called. Then she asked “What are you doing?” “No, we are sleeping.” Then she said, “Aha,” because I guess it was after

9.30, because I was ill, had a high fever, was in really bad shape. And then she started complaining, don't exactly remember what it was but I was very annoyed at her, but I didn't say anything. And then she continued./ ... /P: And then I said again, “Yes, but I would like to sleep now.” And then she continued to talk about something that she felt was very important, but it wasn't that important, she could have just as well taken it the next day. [...] So, then it was super annoying. And afterwards, after we hung up, I was wide awake and really super annoyed.This long narrative was a response to the therapist giving a suggestion about how to communicate in a different way with the relative. While patient's description of the phone call provided a picture of her thoughts and feelings, these were not the focus of her narrative. Instead of trying to ask follow-up questions about the patient's thoughts and feelings, the therapist seemingly chooses to be relatively quiet and thereby letting the patient spend a lot of time talking about other peoples' behavior. This is the difference from high-alliance sessions, in which the patients' thoughts, feelings, and behaviors commonly were in focus of the conversation. In contrast, the patients' detailed narratives about external events were frequent in low-alliance session, and often, but not always, where they reinforced by the therapists.

There were however also examples of low-alliance sessions where the therapist tried to shift the focus to be more oriented to the patient. In session F, when the patient was describing how her or his friends were not making contact, the therapist attempted to provide a different perspective to the patient:T: Is there a reason why they are not calling?P: There is no reason. Some of them don't even want to have any contact, “You have a boyfriend, it's impossible to talk to you.”T: Is that something they said?P: They, they behave in a completely unacceptable way.T: But ... it can be interpreted in many different ways if you don't ... If you don't, if you are not in touch with them, they might interpret that as if you ... P: That I don't give a damn, sort of.T: They think that you feel that way and then there is a lot of. They think you don't give a damn about them and you think they don't give a damn about you because they don't call. Perhaps both of you want to be in touch but nobody ... The patient was obviously upset about her or his friends' behavior. By suggesting an alternative interpretation, the therapist shifted focus to the patient's own behavior.

Content Focus

The third theme is named *Content focus* and displays patterns regarding focus in the conversations in the

session. The theme consists of two sub-themes: *Focus on problem areas* and *Absence of focus*. High-alliance sessions were to a greater extent characterized by an explicit focus as the content of the session regarded one or more explicit problem areas. In contrast, the low-alliance sessions were rather characterized by an absence of focus – it appeared as if therapist and patient had no plan for the session.

Focus on problem area – “This is what we will use this session for”. As shown previously, the high-alliance sessions were characterized by a general pattern of focusing on the inner world of the patients and their thoughts, feelings, and behaviors. This thinking-feeling-behavior focus was generally related to specific problem areas, and the greater part of the session consisted of classical cognitive and behavioral interventions. For example, in session D, there was a psychoeducation section about panic attacks, as the therapist prepared the patient for exposure:P: But the tough part is here (points to whiteboard), before it calms down, that is when one panics.T: Exactly, this is, this is the tough period, if you get past that and like come over here, then things are like rather ok. But this is where you have to fight. This is where it is hard.P: That is what I feel (points), if I stop there, then I know that I won’t panic.The psychoeducation was oriented towards the patient’s desire to function in everyday life without being hindered by annoying thoughts and feelings of panic. This was the problem area in focus. During the session, the patient and therapist were focusing on negative thoughts and ideas, and the patient talked about her fear. They were talking about how the patient could proceed to reach her goals, and what she was supposed to do to move in the right direction. The therapist appeared to have a clear plan for the session and initiated by going through the patient’s homework. Goals were discussed and possible interventions were presented to the patient and connected with her problems.

Absence of focus – “What happens in your life?”. As shown previously, the patients’ thoughts, feelings, and behaviors were often not as clearly outspoken in low-alliance sessions as in high-alliance sessions. The low-alliance sessions had more of a supportive than a therapeutic character, where the therapist validated the patient and suggested solutions to presented problems. Consequently, the focus was often rather diffuse. The therapists followed the patients’ reporting rather than guided the session and set the focus. This pattern was clear in session H, where most of the session was designated

for the patient to report what had happened since the last session, as encouraged by the therapist:T: Well, let’s see when did we last meet again? It was sometime right before Christmas. How, tell me how have you, a summary, how have you been over the holidays?To ask the patient what has happened since the last session is a common start-up in both high- and low alliance sessions. However, in session H it was notable that the report from the patient was allowed to take up almost the entire session. This had the effect that the dialogue of the session was jumping from one thing to another, as the patient raised different topics. It was not until the end of the session that the therapist raised their work towards the therapy goal.

Therapeutic Direction

The final theme is named *Therapeutic direction* and displays patterns in which the conversations engaged with directions for the future. The theme consists of two sub-themes: *Moving forward* and *Stagnation*. In high-alliance sessions, there was generally a sense of forward movement. In contrast, many low-alliance sessions were characterized by a sense of stagnation and an absence of hope.

Moving forward – “I’m taking control”. The moving forward spirit in the high-alliance sessions was visible in the goals that were expressed, and in the interventions that were presented to help the patients reach them. The patients’ goals and valued directions were fitted together in the sessions, and the patients and the therapists explored jointly how to move on. This was often leading to meaningful homework assignments. When talking about future change in behavior, most alliance sessions have in common a view where change was expected to be in the hands of the patient to achieve; there was no need for a third person to be involved. Being hopeful and believing in your own ability are themes that repeatedly appeared in these sessions. An example is found in session A:P: I mean, I don’t know because I mean, I haven’t, he hasn’t, like, been there alot this past week ... It somehow feels like, there’s been a few times that the defiant teenager has shown his face and wanted to skip for instance cleaning. I have, like, taken control anyway and done it.T: Ok.P: So, I feel like I... without too much stress, I feel like I now have things reasonably under control. I clean up every other or every three days depending. And I make the beds now, such a little thing, every morning. Pick up every evening and well, go out for a walk every day. So, I feel, right now it feels good, right now it feels like the

only thing that is missing is perhaps the more social thing, but that will come / ... / In this statement, the patient exhibited a sense of inner power and ability to act in a valued direction, despite resistance. The patient was proud of his work and seemed confident and reassured.

Stagnation – “It will never end”. Sessions where stagnation was identified were dominated by the patient’s reports about hard circumstances and relationship difficulties. The patients expressed their frustration about their situation and seemed to have lost faith in the future. External strains were common topics, and the spirit of the session was characterized by resignation and despair. One session where stagnation was clear was Session G. The patient experienced a very strenuous situation with a family member, and the session focused on handling this crisis. The therapist was supporting and tried to find solutions, but the patient expressed suffering and despair, and did not believe in improvement: P: No, that, no, I just wait for the next thing. T: What do you think then, what do you think will be the next thing? P: Well I don’t know, but something, it never calms down. T: No, it has been turbulent. / ... / P: There is always something ... a few days can go by when things are okay but then there is always something new ... so right now I just feel rather tired and worn out. P: No, it never ends, it will never end, the misery [laughter], it doesn’t feel that way. T: It feels like it will never end. P: No, it will only continue. The patient is in despair, expressing a feeling that difficulties will never end, while the therapist seems to try to be empathic and supportive while struggling to keep up hope. Still, the patient seems stuck in hopelessness. Another example was from Session F. In contrast to many other low-alliance sessions, which were characterized by an absence of focus, most of Session F was focused on concrete behavior changes, connected to the goals of the patient. The stagnation in this session was seen in the patient’s resistance to change: T: Exactly. And the goal is then perhaps that you should be able to give yourself a kick in the butt. / ... / P: Yes, I don’t really have the motivation to do that. I don’t have motivation to do much at all really. I just try to get every day to pass by. T: Yes, you will have to choose the timing yourself. P: Daytime will not work, because I have so much else to. T: But then you can just decide the day before that “Tomorrow we go for a walk.” Sometimes it is easier, because then you don’t know how hard it will feel. P: No, I don’t know. It’s going to be that you go for a walk when you see that everything else is done. T: Ok. Do you ever get everything

done? P: Noooo ... (Both laugh). No, but it was like one day when I did laundry all day. Instead of waiting for the machine to be finished in half an hour, I could have just as well gone out, but you don’t do that, want to do that. T: Because if it is always last, so that all the cleaning and laundry and cooking and everything else has to be done first, then you might never get the P: Yes, but I think that those things are still more important. At least food. To eat, have a routine. T: Mm. That is important. But maybe it can jump a little bit higher on the list of priorities. I mean that it, I mean during these weeks it can be a little bit more important ... P: Well, no, I can’t do that. I eat (inaudible words) and that’s the way it is. In this extract, the therapist tried to work with the patient’s resistance, but the aversion from the patient remained and there was no moving forward. Rather, the conversation stagnated at the patient’s image that any change would be impossible.

Discussion

A well-functioning working alliance has been shown to be related to better psychotherapy outcome in hundreds of studies, including in CBT (Flückiger et al., 2018). This has also been shown on a session-by-session level (Flückiger et al., 2020). However, there are few qualitative studies focusing on what characterizes sessions in which the working alliance is high, compared to sessions in which the working alliance is low. We used qualitative thematic analysis to study sessions with relatively high alliance, according to patient and therapist quantitative estimates, and compared those to sessions with relatively low alliance ratings. Our analysis resulted in four major themes, each including two different sub-themes.

In the high-alliance sessions, an exploring approach created a narrative where the patients focused on themselves, their feelings, thoughts, and behaviors. A sense of consensus was formed, and the patients were guided to shape their own answers. When the patient slid away from the major focus, the therapist took the lead and got the session back on track. The joint explorative approach, with the patients’ inner situations at center, resulted in a deeper content with focus on the problem area. These sessions were filled with classic cognitive and behavioral interventions, tied to the patients’ goals and what made the patient feel better in the long run. The sessions had a clear focus and a spirit of moving forward, where positive changes and a belief in the patients’ own capability were at hand.

In contrast, low-alliance sessions were characterized by therapeutic behavior of gathering information, solving problems, validating, and giving advice. The topics discussed were to a high degree external circumstances and the behavior of other people. The patients generally described strenuous circumstances and talked about difficult dialogues with family members. This focus on other people was also reinforced by the therapists' questions. All in all, the low-alliances session often lacked focus on the patient's thoughts, feelings, and behavior. The therapists were not having the same focused manner as in high-alliance sessions, and the session had a sense of being "afloat." The patients' narrative led the session and the therapists' role was more supportive than therapeutic. The patients' reporting on strenuous circumstances carried negative feelings like frustration, anxiety, and resignation. This, together with the lack of clear interventions, resulted in a session atmosphere characterized by stagnation and lack of faith in change.

The low-alliance sessions in our study can be seen as sessions characterized by alliance ruptures. Previous research on ruptures in CBT has shown that ruptures are often characterized by withdrawal from the therapeutic tasks (Aspland et al., 2008; Castonguay et al., 1996), which was obvious also in our study. When facing ruptures, CBT therapists are encouraged to, as a first step towards reparation, identify and acknowledge the rupture (Okamoto & Kazantzis, 2021). It is rather striking that there were no instances of acknowledging ruptures in any of the low-alliance sessions in our study. It may be that therapists were unaware that there was a rupture, perhaps because they were caught up in enactments of relational schemas (Safran & Muran, 2000) or had their own core beliefs activated (Okamoto & Kazantzis, 2021). Alternatively, they may have interpreted the patients' lack of engagement in the therapy tasks as part of a general depressive style.

An interesting question that arises from these results is if and how it would have been possible for therapists in low-alliance sessions to turn the session from unfocused therapy attending overly much to other people's behavior to a more focused cognitive-behavior therapy attending to the patient's own thoughts, feelings, and behavior? From the data we have, it is obviously not possible to determine this, but we may speculate that the explorative stance, together with gently but firmly refocusing on the therapeutic tasks after initial validation of concerns about strenuous external circumstances, might be the best option for not losing therapeutic momentum and risking stagnation in therapy. Also, the rupture-repair literature gives useful advice on how to handle alliance ruptures, which as noted above are

likely to have been present in most of our low-alliance sessions (Okamoto & Kazantzis, 2021; Safran & Muran, 2000).

Our finding regarding the negative influence on the alliance of the therapist taking an expert role towards the patient is reminiscent of recent qualitative findings on the importance of strengthening the patient's agency and autonomy in therapy (Oddli et al., 2021; von der Lippe et al., 2019; Wu & Levitt, 2020). Therapists taking a more exploratory role might lead the patient to take on more responsibility for their treatment. Alternatively, patients who take on passive roles in relation to their therapist might make the therapist take on more of an expert role, which in turn may reinforce the patient's passivity.

The findings of our study can in one sense be seen as validating the alliance instruments used in the study, in the sense that the qualitative analyses largely confirmed (with some exceptions) the difference between low- and high alliance sessions. Stated differently, sessions characterized as "high-alliance sessions" according to the instruments, were often characterized by themes that seem theoretically and clinically relevant for a good working alliance, such as therapist and patient working together in a focused manner using CBT-related techniques. Conversely, "low-alliance sessions" were often characterized by themes that make theoretical and clinical sense as being indicative of a poor working alliance, such as being unfocused or focused on external events or behavior of other people. Exceptions from this pattern may partly stem from the different perspectives between the within-patient definition of low/high alliance used for selecting sessions, and the between-patient perspective used when comparing sessions in the qualitative analysis (see also the limitations section below).

We may also note that strenuous external circumstances were often mentioned in the low-alliance, but less often so in the high-alliance sessions. This may be important to note since there is the possibility that the prediction of next-session symptoms from the alliance may be confounded by external events happening between sessions. However, the external circumstances shown in this study were mostly of low-intense but "chronic" nature (e.g., the patient who complained about friends who did not initiate contact), so it is unclear if such events would have profound effects on alliance ratings and on the patient's depression in a given week.

Strengths and Limitations

We think there are several strengths of our study. Most important, the study contributes to an

increased understanding of what happens in CBT sessions with unusually high or low alliance ratings. Such knowledge is useful to further understand the working mechanisms behind a well-functioning therapeutic alliance. The study is situated within a larger RCT study, with clear inclusion/exclusion criteria and a clinically fairly severe sample of patients with MDD and treatments were monitored with adequate adherence to CBT techniques/principles. Moreover, within the RCT, sessions were purposively sampled to best reflect the pattern of findings from studies on the prediction of symptoms from alliance session-by-session. The consensual method of qualitative research should also increase the trustworthiness of the coding.

Regarding limitations, we should note that the thematic analysis conducted on the transcribed data does not include non-verbal material, or even analyses of the form (as opposed to content) of verbal statements. The extensive heterogeneity of the session material was a challenge during coding, especially as the analysis was aimed at an inductive approach. The inductive approach was chosen to increase the possibility of new ideas to emerge from the data. However, some kind of combination of deductive (theory-driven) and inductive principles might be helpful to facilitate structuring of coding without *a priori* deciding which themes to look for.

Another potential limitation is the definition of high- and low alliance that we used. Since our study was an attempt to shed light on previous quantitative findings from within-patient session-by-session analyses, the definition of high vs low alliance quality that we used was relative to the level within each therapy. Thus, a session characterized as “high alliance” in one therapy may not have comparable level of alliance as a session characterized as “high alliance” in another therapy. Since the researchers only watched the chosen sessions and not the whole treatments, this generated some confusion when comparing sessions. In the initial stage of coding, the researchers were blinded to which sessions were in the high- or low alliance group, and when unblinding, the coders were in a few cases not fully clear about the characterization. This can probably be explained by the within- vs between patient definitions of high/low alliance – in that the grouping was made from a within-patient perspective, while the coders compared sessions from different patients (i.e., a between-patient perspective).

Since our sample consisted of patients with MDD, we do not know if our findings can be transferred to CBT treatment for other conditions. Finally, we should note that many of the high-alliance sessions came from late in treatment, while most of the low-alliance sessions came from the early phase. This

means that a potential confounder of our results is time in treatment, since early in treatment the alliance may not be as well-established as later in treatment. Although this may not be much of a problem with the qualitative analysis as such; that is, the analysis still points to characteristics of low- vs high-alliance sessions, it may be more of a problem of the overall session-by-session predictions of outcome from alliance. In the quantitative literature a strategy of “detrending” is sometimes used (e.g., Falkenström et al., 2020; Wang & Maxwell, 2015) to avoid the potential risk of both alliance and outcome developing linearly over time for reasons unrelated to the research question. Such a strategy might have been useful when sampling sessions to use for qualitative analysis as well, to minimize the risk that all sessions with high alliance come from the late part of treatment and all session with low alliance from the early part.

Conclusions and Recommendations for Future Research

Our findings show some clinically important characteristics of high- and low alliance sessions in CBT. High alliance sessions were characterized by therapists taking an explorative rather than expert stance, the patient focusing on her own thoughts, emotions, and behavior rather than on external circumstances, and a process characterized by focus on central CBT themes and techniques more than on unfocused “supportive” therapy elements focused on external circumstances or behavior of other people. Since these processes are linked to improvement/deterioration in symptoms to the following session, the results point to some tentative clinical recommendations. First, we believe CBT therapists should try to avoid the “expert” stance, i.e., telling the patient what to do, think, or how to behave, but rather try to generate a mutual interest in the patient’s thoughts, feelings and behavior, and then to apply CBT principles to generate a mutual understanding of these. Second, when patients experience distressing external circumstances during therapy, it is of course important to express empathy and support for these difficulties. However, at the same time, it is likely to be unproductive to set off too much time to focus on these, or to abandon the therapy focus altogether, as seems to have happened in some of the low-alliance sessions in this study. Instead, it seems important to gently but firmly refocus the patient to the therapy tasks and goals. If this is not possible, it may be better to explicitly pause therapy for some time, for instance changing focus to supportive or grief therapy until the patient is ready to focus on

the therapy tasks, rather than proceeding with an unproductive therapy process.

We believe that the method of this study may be used by other researchers interested in gaining an increased understanding of the meaning of quantitative within-patient results. Future research may use detrending when choosing sessions, to avoid the risk that most good-alliance sessions come from the late part of treatment and most bad-alliance sessions from the early part. Quantitative within-patient studies may also include measures of distressing external events happening during treatment, to enable adjusting findings for this potential confound.

Notes

- ¹ Since high- vs low alliance session was defined by the deviation from the patient's average, the average alliance across all sessions is not expected to be higher for the high- than low alliance session group and vice versa.
- ² Specialist training was defined according to the Swedish system, in which basic training involves two years of (half-time) studies and specialist training is three additional years of (half-time) studies. Training consists of didactic teaching plus supervised therapy.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

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