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Clients' and Therapists' Views of the Therapeutic Alliance: Similarities, Differences and Relationship to Therapy Outcome

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To better understand how clients' and therapists' views of the therapeutic alliance differ and overlap, this study investigated, first, the components of the alliance that are relevant to the therapy participants; second, their relationship to post-therapy outcome; and third, the relationships between participants' alliance constructs. To identify participants' views, exploratory factor analyses were performed on clients' ($n = 176$) and therapists' ($n = 133$ observations) ratings of the Working Alliance Inventory (short form), the Helping Alliance Questionnaire and the California Psychotherapy Alliance Scales and conducted both on each measure separately and on the three measures combined. The results of the separate analyses indicated in general poor correspondence between the participant-derived components and each measure's *a priori* constructs. Results of the joint analyses suggested that clients view the alliance in terms of six basic components (Collaborative Work Relationship, Productive Work, Active Commitment, Bond, Non-disagreement on Goals/Tasks and Confident Progress), five of which were found to predict client-rated and/or therapist-rated post-therapy outcome. Results for therapists suggested four basic components (Collaborative Work Relationship, Therapist Confidence & Dedication, Client Commitment & Confidence, Client Working Ability), of which three predicted post-therapy outcome. Findings of significant, but modest to low moderate, correlations between several client and therapist joint factors suggested that despite similarities, the therapy partners' views of the alliance differ in important ways. Compared with therapists, clients appear to place greater emphasis on helpfulness, joint participation in the work of therapy and negative signs of the alliance. Implications of these findings are discussed. Copyright © 2011 John Wiley & Sons, Ltd.

Key Practitioner Message:
- Therapists should not assume that their views of the therapeutic relationship and therapeutic work are shared by their clients and are encouraged to seek the client's feedback.
- Therapists may benefit from conveying that the client's perspective on problems and relevant work is valued and that they are working with the client as a team.
- Therapists may need to explicitly address how the therapeutic work is helpful and conducive to desired changes.

Keywords: Therapeutic Alliance, Client Perspective, Therapist Perspective, Client–Therapist Convergence, Factor Analysis

The client–therapist alliance has been acknowledged as a key element of the therapeutic process and its successful outcome in numerous studies over the past three decades, across a range of treatment modalities and research settings (e.g., Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Norcross, 2002). One of the consistent findings in the alliance literature—observed across diverse treatment approaches and different methods of assessment of the alliance—is the low association between clients' and therapists' perceptions (e.g., Bachelor & Horvath, 1999; Hatcher, Barends, Hansell, & Gutfreund, 1995; Tichenor & Hill, 1989), suggesting that the therapy participants have different views of the alliance and its dimensions. A recent meta-analysis (Tryon, Blackwell, & Hammel, 2007) conducted on studies between 1985 through 2006 reported an average correlation of 0.36 between the alliance ratings of the two perspectives across 32 studies. Although this result suggests some degree of inter-perspective convergence, it also points to important differences between the therapy participants' views of the alliance. Because converging perspectives have been associated with positive outcome (e.g., Kivlighan & Shaughnessy, 1995) and divergent views on the alliance (e.g., disagreement about therapy tasks and goals) may reflect the presence of strains or an impasse in

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the relation, potentially resulting in termination or poor outcome (e.g., Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Safran, Crocker, McMain, & Murray, 1990)—a closer investigation of clients' and therapists' perceptions of the alliance and the particular aspects that are at the source of participants' differential or similar views is warranted. There is growing evidence, however, that clients' and therapists' perceptions of the alliance as assessed via widely used measures show little correspondence to the participants' own views. That is, the dimensions theorized to assess specific components of the alliance have shown little resemblance to actual empirical groupings derived from participants' ratings of the alliance (e.g., Gaston, Sabourin, Hatcher, & Hansell, 1992; Hatcher, 1999; Hatcher & Barends, 1996; Tracey and Kokotovic, 1989). To fully understand the relationships between clients' and therapists' perceptions, then, and how these may converge and differ, it seems important to take into consideration the therapy participants' own views of the alliance.

Pioneering work along these lines has been conducted by Hatcher and Barends (1996) and Hatcher (1999), who applied exploratory factor analytic methods to patients' and therapists' ratings on widely used alliance measures to better understand participants' implicit views of the alliance. In their study investigating patients' views, Hatcher and Barends (1996) factor-analysed patients' scores on three major alliance measures: the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), the California Psychotherapy Alliance Scales (CALPAS; Gaston & Marmar, unpublished manuscript, 1991) and the Penn Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986), both individually and jointly. The results of the individual analyses suggested 'extreme divergence' with the measures' conceptual models, a finding that underscores the importance of continued examination of patients' implicit views of the alliance. Results of the joint analysis of the items from the three alliance measures yielded six factors: *Confident Collaboration*, reflecting clients' sense of confidence in and commitment to therapy; *Goal and Task*, grouping mostly WAI Goal and Task-related items; *Bond*, consisting mostly of cross-measure bond-related items; *Idealized Relationship*, involving a sense of helpful collaboration as well as non-disagreement about the work of therapy; *Dedicated Patient*, reflecting aspects of clients' participation in therapy; and *Help Received*, containing HAQ helpfulness-toned items. This latter construct, together with the salient loadings of helpfulness items on the first factor, lead the authors to conclude that helpfulness is an important aspect of the patient's alliance. Furthermore, three of the factors (*Confident Collaboration*, *Idealized Relationship*, *Help Received*) were found to correlate significantly with patients' concurrent ratings of improvement.

In a second study (Hatcher, 1999), therapists' views of the alliance were examined based on their responses to the WAI and the CALPAS. Separate factor analyses of each measure indicated, for the WAI, a four-component structure that diverged from the theoretical model, and for the CALPAS, three components (*Patient Confidence and Commitment*, *Therapist Understanding and Involvement* [TUI], *Patient Working Engagement*) that showed similarities to the original four constructs. Results of the joint analysis of the two measures suggested the possible influence of method variance, as four of the observed five components were those found for the WAI, whereas the fifth contained all the CALPAS items (excepting TUI subscale items, which joined the WAI *Bond* component). To minimize this effect, the CALPAS was re-analysed together with two WAI items corresponding to those that loaded the patient *Confident Collaboration* factor identified by Hatcher and Barends (1996). The finding that these items joined the CALPAS' *Patient Confidence and Commitment* factor led the author to conclude that patients and therapists attend to the same features of the collaborative alliance. Correlations computed between the observed therapist factors, including the new factor containing the WAI items, named *Therapist Confident Collaboration*, and the client factors identified in the study conducted by Hatcher and Barends (1996) revealed, with the exception of the therapist bond-related scales, significant albeit in general modest inter-factor associations. Therapists' and patients' *Confident Collaboration* and therapists' WAI-derived *Goal and Task Disagreement* and patients' *Idealized Relationship* showed the strongest associations. Finally, all therapist scales, in particular *Therapist Confident Collaboration* and *Patient Confidence and Commitment*, were found to correlate significantly with a concurrently rated measure of patient improvement.

More recently, Clemence and collaborators (Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005) compared the therapy participants' perspectives using measures derived from the patient and therapist alliance factors identified in the studies conducted by Hatcher and Barends (1996) and Hatcher (1999). Results confirmed the generally modest level of inter-perspective convergence reported by Hatcher (1999). Of similar results were the findings that the therapist and patient *Confident Collaboration* scales showed the strongest association, whereas the therapist WAI-derived *Bond* scale (TUI was excluded) was unrelated to the patient factors studied (*Confident Collaboration*, *Goals and Tasks*, *Bond*, *Idealized Relationship*). However, unlike the results presented by Hatcher, the other therapist and patient scales were less consistently correlated at a significant level (e.g., therapists' *Goal and Task Disagreement* was unrelated to patients' *Idealized Relationship*, and *Patient Working Engagement* was unrelated to patients' *Bond* and *Goal and Tasks*). The patient scales were also found to correlate moderately to highly with concurrent ratings of perceived improvement and *Help Received* (Hatcher & Barends, 1996)—used as a measure of treatment effectiveness—with *Confident Collaboration* showing the strongest associations with both

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measures. In general, the therapist scales were only modestly associated with the two patient measures, although they correlated more strongly with therapists' ratings of *Help Received*.

Further research is needed with other samples of clients and therapists to determine more conclusively the salient features of the therapy participants' alliances. Moreover, the therapist factors identified in the study conducted by Hatcher (1999) were based on only two of the three measures used to derive the client alliance factors, thus offering a comparatively less comprehensive account of therapists' alliance perceptions, while precluding a direct comparison across perspectives of the specific aspects of the alliance captured by the HAQ items. In addition, the examination of the relations between the client and therapist factors and therapy outcome in the studies conducted by Hatcher and Barends (1996), Hatcher (1999) and Clemence et al. (2005) was based on concurrently rated measures, which are vulnerable to halo effects (ratings may be biased by initial, global judgments of the alliance).

This study sought to gain a closer understanding of how clients' and therapists' perceptions of the alliance differ and overlap, from the perspective of the participants' own definitions of the alliance. A first goal was to identify the components of the alliance that are relevant to the therapy participants, following previous work based on factor analysis of popular alliance measures (Hatcher, 1999; Hatcher & Barends, 1996). To extend this work, the factor structures underlying both clients' and therapists' ratings of the WAI, the HAQ and the CALPAS were examined. Factor analyses were performed both individually, which allowed for a comparison of participants' own groupings of scale items with theorized constructs, and jointly, to obtain a more detailed and inclusive account of clients' and therapists' views of the alliance.[1] The second goal was to examine the importance to therapeutic outcome of the cross-measure alliance constructs. Prior work was extended by using several different outcome measures, including pre–post-indices. The third goal was to investigate the relationships between participants' views of the alliance by examining the correlations between the cross-measure client and therapist constructs and, expanding on past work, the specific similarities and divergences in participants' alliance constructs.

[1]Although similar (but not necessarily identical) constructs are assessed by different alliance measures (e.g., personal attachments or bonds), unique facets of the alliance appear to be assessed by particular instruments (e.g., client commitment and working capacity, assessed with the CALPAS; perceived support and helpfulness, assessed with the HAQ). Indeed, evidence of significant heterogeneity among measures of the therapeutic alliance suggests that different measures cannot be readily substituted for one another (Horvath & Symonds, 1991).

METHOD

Participants

Participants were 94 White French–Canadian therapy dyads (involving 59 therapists), 82 additional clients whose therapists did not participate and 2 additional therapists whose clients did not participate. The clients were 125 women (mean [M] age = 34.3 years; standard deviation [SD] = 10.9) and 51 men (M age = 36.1 years; SD = 12.3), recruited on a voluntary basis from three sites (A1 and A2, two university consultation services, $n = 100$; B, private clinics, $n = 44$; and C, community [family and mental health] centres, $n = 32$) in eastern Canada. Forty-five percent were single; 34% were married or lived with a partner; and 21% were separated, divorced or widowed. Thirty-five percent held skilled or semiskilled positions, 27% were students, 28% were unemployed and 10% were professionals. The majority of clients held junior college (33%) or university diplomas (26%). Diagnoses provided by their therapists involved mostly relational, including marital problems (32%), anxiety-related disorders (30%, i.e., generalized anxiety, simple or social phobia) and personality disorders (15%); others included mood, adjustment, sexual or identity-related, and eating or substance abuse disorders. (Due to administrative slips or therapist omissions, diagnoses for 27 Site A1 clients were unavailable. However, their overall level of functioning, as determined by therapist ratings on the Global Assessment Scale [Endicott, Spitzer, Fleiss, & Cohen, 1976], was not found to differ significantly from other Site A1 clients, $p = 0.77$.)

Participating therapists (i.e., those who provided alliance and outcome ratings) were 41 White women and 20 men (M age: 34.2 years; SD = 10.6; range: 23–61 years; three therapists did not specify their age). Of these, 35 were clinical or counselling psychology practicum students, 19 others were licensed psychologists (2½–25 years of experience), 1 was a licensed social worker, 1 was a registered nurse (with 11 and 15 years of counselling experience, respectively) and 5 were screened volunteer helpers at one of the community family centres, with undergraduate university diplomas but no formal counselling training, who received weekly supervision. Self-described theoretical orientations were humanistic or humanistic–existential (45%), gestalt (14%) and psychodynamic (10%); the remaining therapists used eclectic, cognitive–behavioural, systemic or bio-energetic approaches. (The orientations of three therapists were unspecified.) Most (92%) of the therapists saw one or two clients; two others saw three clients; and three others saw four, five and six clients, respectively. To increase the number of therapist observations, the alliance ratings completed by a subset of the therapists ($n = 21$) at a later point in therapy, and involving 37 clients, were included in the data analyses. (These therapists were participants in an earlier study [Bachelor & Salamé, 2000] that involved

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different research goals and data analyses.) The final data set consisted of 176 client and 133 therapist observations.

Measures

Alliance measures

The *Working Alliance Inventory*, short form (*WAI-S*, Tracey & Kokotovic, 1989) is a 12-item seven-point Likert measure derived from the original 36-item version (Horvath & Greenberg, 1989), which assesses the three dimensions of agreement on therapeutic tasks (Tasks), agreement on goals (Goals) and development of affective bonds (Bond), with parallel forms for client and therapist (*WAI-T*). Tracey and Kokotovic (1989) reported evidence supporting the construct validity of both WAI short forms as well as high internal consistency estimates for their three subscales. Busseri and Tyler (2003) provided evidence of the interchangeability of the WAI short form and the full-scale WAI for both the client and the therapist versions.

The *Helping Alliance Questionnaire* (Alexander & Luborsky, 1986) consists of 11 items, eight of which assess perceived helpfulness and support (Type 1) and three of which assess collaboration with the therapist towards the goals of treatment (Type 2). Its therapist counterpart, the Therapist Facilitating Behavior Questionnaire (labelled *HAQ-T* in the present study), is an 11-item scale assessing the same two types of alliance. Alexander and Luborsky (1986) reported satisfactory reliability for the HAQ, and both subscales were shown to predict therapy outcome as assessed by various indices (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985).

The *California Psychotherapy Alliance Scales* (Gaston & Marmar, unpublished manuscript, 1991), patient and therapist (*CALPAS-T*) versions, comprise 24 seven-point items assessing four scales: Patient Working Capacity (PWC), reflecting the degree to which patients self-disclose and self-reflect, examine contributions to problems and make productive use of the therapist's comments; Patient Commitment (PC), reflecting the degree to which patients value treatment, are willing to make the necessary sacrifices and persevere despite doubts; Working Strategy Consensus (WSC), reflecting joint work and the degree of agreement between patients' and therapists' views about how to proceed in therapy; and TUI, reflecting the therapist's capacity to understand the patient's point of view and the commitment to help. Gaston (1991) reported satisfactory reliability for the total patient scale, as well as evidence of discriminant and convergent validity with various therapist, patient and treatment characteristics. Hatcher (1999) reported satisfactory reliabilities for the *CALPAS-T* scale.

This study used the French translations of the *CALPAS*, patient scale (Marmar & Gaston, unpublished manuscript, 1989), and of the other client and therapist scales, effected by two to three experienced bilingual clinician/researchers who worked independently and then resolved any discrepancies by comparing the translated with the original scale items to arrive at a final consensual version of the scale (Bachelor, de Grâce, & Pocreau, unpublished manuscript, 1991; Bachelor & Salamé, unpublished manuscript, 1991). These authors reported satisfactory overall reliabilities (άs range: 0.87–0.93), and evidence of divergent (independence from client sociodemographic characteristics and/or psychological problems or severity of functioning) as well as predictive validity of the French versions has also been shown (Bachelor, Laverdière, Gamache, & Bordeleau, 2007; Le Bloc'h, de Roten, Drapeau, & Despland, 2006). In addition, mean scores for the three measures in the present sample were comparable with published mean scores for the original English versions (*t*s range: 0.06–1.76, all $ps > 0.05$).[2] Total score alphas for the three scales, computed on the current client and therapist scores, were satisfactory, ranging from 0.85 to 0.90 and from 0.90 to 0.94, respectively.

Outcome measures

Four therapist-rated and four client-rated measures were used to assess outcome. Three measures were completed by both participants: the *Global Rating Scale* (GRS; Green, Gleser, Stone, & Seifert, 1975; Mintz, 1977), a single post-therapy index of the overall helpfulness of therapy on a nine-point scale; the *Post-Therapy Rating Scale* (PRS; Nichols & Beck, 1960), a four-item five-point Likert scale that assesses change in four areas (symptoms and complaints, understanding of self, feeling and outlook on life); and the *Target Complaints Method* (TC; Battle et al., 1966; Mintz & Kiesler, 1982), a list of the problems for which clients seek help, each rated on a six-point severity scale, which was completed pre-therapy (i.e., after the first session) and post-therapy. (To reduce the number of analyses, only the rating for the first problem listed was retained). Pre-therapy and post-therapy ratings were also completed by therapists on the *Global Assessment Scale* (GAS; Endicott et al., 1976), a measure of clients' overall level of functioning on a scale from 1 to 100, and by clients, on the *Psychiatric Symptom Index* (PSI; Boyer, Préville, Légaré, & Valois, 1993; Ilfeld, 1976), a 29-item four-point measure of perceived psychological distress. All of these measures have demonstrated acceptable reliability and validity as reported in the cited sources. In the current study, total score alphas were 0.86 and 0.85 (PRS, client and therapist versions, respectively) and 0.91 (PSI).

[2]For the *WAI-S*: M = 5.60 (SD = 1.01) and *WAI-T*: M = 5.43 (SD = .84) versus M = 5.87 (SD = .88) and M = 5.46 (SD = 0.76), respectively, Busseri and Tyler (2003); for the *CALPAS*: M = 5.87 (SD = 0.66) versus M = 5.96 (SD = 0.57), Gaston (1991); for the *CALPAS-T*: M = 5.40 (SD = 0.85) versus M = 5.41 (SD = 1.22), based on five scales and $n = 55$, Marmar, Gaston, Gallagher, & Thompson (1989); for the *HAQ*: M = 20.68 (SD = 7.05) versus M = 21.40 (SD = 8.00), Constantino and Smith-Hansen (2008); no published means could be found for the *Therapist Facilitating Behavior Questionnaire* (*HAQ-T*).

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Procedure

The directors of the three study sites were contacted and gave approval for the current study to be conducted in their centres. Therapists working in these sites were solicited either individually or at administrative meetings to collaborate in a study on the client–therapist relationship and recruit from one to three clients. Data were collected in two phases. In the first phase, therapists were also invited to participate, i.e., to complete the alliance and outcome measures. Interested therapists gave new clients a pre-therapy packet that contained a cover letter describing the study purpose and procedure, a consent form informing clients of the voluntary nature of the study and assuring anonymity and confidentiality of responses, a demographic sheet and the PSI and TC. The procedure instructed clients, if they chose to participate, to return the completed measures at their next session, sealed in the envelope provided. Therapists whose client(s) agreed to participate completed a pre-therapy packet that contained demographic and diagnostic forms, the GAS and the TC. Participating clients were given the three alliance measures in a sealed packet following their fifth therapy session, to return once completed in a sealed envelope at their next session. Their therapists similarly completed the three alliance measures after the fifth session. A total of 94 client–therapy dyads and 2 additional clients and therapists completed the pre-therapy and alliance measures. Two weeks following termination of therapy, clients and therapists were mailed the post-therapy measures (GRS, PRS, TC and the PSI or GAS, respectively) with pre-stamped return envelopes. Post-therapy ratings were available for 76 clients and 76 therapists. Clients attended an average of 16.6 sessions (SD = 11.98).

In the second phase of data collection, only clients' participation was solicited. Clients were given a packet containing a letter describing the project, an informed consent form, a demographic sheet and the three alliance measures (and others not used in this study), or a sealed envelope (Site A1 clients) containing an invitation to volunteer in the current study, which instructed interested clients to pick up a packet (containing the same research materials) at the receptionist's office. Additional clients were recruited via announcements posted in the waiting room at this latter site, and interested clients picked up the research packet from a research assistant at a pre-arranged meeting place at the site. Completed materials were returned directly to the receptionist's office or, in the latter case, to the research assistant. A total of 80 clients (who also participated in another study [Bachelor, Meunier, Laverdière, & Gamache, 2010] with different research goals and data analyses) completed the research materials. No outcome data were gathered. The therapists of participating clients were requested to complete an information sheet and provide diagnostic information on clients. (With regard to poster-recruited clients, this information was obtained from clinical records). These clients participated at different points in therapy (n = 1–153 sessions; M = 17.2; SD = 21.4). Their therapists were 39 women and 12 men (M age = 33.0 years; SD = 9.2), of whom most were licensed psychologists (53%) and psychology practicum students (41%) employing diverse treatment approaches. All participating clients were assured that their therapist would not see their responses. Clients were offered $10 as an incentive to participate.

Data Analyses

Principal component analysis (PCA), conducted separately on 174 clients' and on 131 therapists' ratings (due to missing values), was used to examine the underlying structures of the three alliance questionnaires individually. Principal factor analysis (PFA), one of the most frequently used methods to assess common underlying factors (Floyd & Widaman, 1995; Tabachnick & Fidell, 1989) and recommended in exploratory factor analyses (Tinsley & Tinsley, 1987), was used for the joint analyses of the three measures, performed separately on clients' and therapists' scores. Squared multiple correlations were used as the initial communality estimates. Principal component analysis was used prior to the PFA analyses to estimate the probable upperbound of the number of factors worth interpreting (Tabachnick & Fidell, 1989; Zwick & Velicer, 1986). The Measure of Sampling Adequacy (MSA) presented by Kaiser (1974), which provides an index of the amount of shared variance among the variables, was calculated to assess the suitability of the client and therapist data sets for factor analysis. (Values in the 0.90s range are considered 'marvellous', values in the 0.80s range are considered 'meritorious', whereas values below 0.50 are considered 'unacceptable'; Kaiser, 1974.) Criteria used to determine the number of factors to rotate and interpret included, in addition to the eigenvalue greater than 1.0 rule, the scree test (Cattell, 1966), the difference in eigenvalue size (the last factor retained is the one preceding a substantial difference in eigenvalue size, after successive small differences, Cureton & D'Agostino, 1983), the proportion of variance accounted for by each additional factor (using 4% as the cut-off) and factor interpretability. Both oblique (promax) and orthogonal (varimax) rotated factor solutions were examined. A factor loading of 0.38 was used as the cut-off criterion to identify factor items.

To examine the practical importance of the client and therapist alliance factors, factor scores, based on the factor score coefficient matrices from the client and therapist PFA solutions, were generated for each participant for whom outcome data were available and correlated with scores on the outcome measures. (One therapist score was identified as an outlier case and deleted from the analyses; final ns for clients were 69–74, and final ns for therapists were 70–75, due to missing data on specific measures). Residual gain scores (Lacey, in Sloane, Staples, Cristol, Yorkston, & Whipple, 1975, p. 246) were calculated for the pre–post-improvement measures (TC, GAS, PSI).

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RESULTS

Preliminary analyses indicated no significant differences between the three research sites with regard to clients' initial functioning (GAS scores) or sociodemographic characteristics, with the exception of level of education (attributable to the lower proportion of community centre clients with higher education compared with the other two study sites). Although the sample included more women, male and female clients did not differ with regard to age, level of education, marital status or GAS scores. Clients' age and sex were unrelated to either therapist-rated or client-rated alliance dimensions at the Bonferroni-adjusted alpha level of 0.004. The number of sessions attended was also unrelated to clients' and therapists' alliance ratings. In the subsample that provided outcome ratings, total number of sessions was unrelated to alliance ratings, whereas modest to low moderate correlations obtained with clients' and therapists' GRS and therapists' PRS ratings (rs = −0.25 to 0.38). Furthermore, no significant differences were observed between therapist-recruited clients (n = 139), clients who were handed an invitation to participate in the study (n = 27) and self-referred clients who responded to announcements (n = 14) with respect to pre-therapy GAS scores as well as client age, gender and marital status (Fs and χ^2s < 1.90, ps > 0.05). Client level of education was found to differ between these groups, attributable to the lower proportion of clients within the first group with higher education (most likely those from the community centres as found above). Finally, given that some therapists saw multiple clients, dependencies in both the client and therapist alliance ratings were estimated. Results indicated that pairs of clients seen by the same therapist did not produce, or receive, similar scores on the alliance measures, thus mitigating concerns that the data were non-independent.[3]

Factor Analyses of Individual Measures

Client-rated Measures

The unrestricted PCA of the *WAI-S* yielded three eigenvalues greater than unity; two to three components were suggested by the scree and the eigenvalue difference criteria. The three-component solution, which accounted for 71% of the total variance, appeared to approximate more closely the theoretical framework of the *WAI-S*. All Task and Goal items loaded on the first varimax component, with the exception of the two negative-worded Goal items (4, 10), which defined the third component. The four Bond items formed the second component (although Bond item 5 also loaded on the first component).

With regard to the *HAQ*, PCA yielded three eigenvalues greater than unity; the scree test and eigenvalue differences suggested between two and three components. In the retained three-component solution, which accounted for 67.2% of the total variance, the first orthogonal component comprised Type 1 and Type 2 items 6–10; the second orthogonal component comprised Type 1 helpfulness-toned items 1–3; and the third orthogonal component comprised Type 1 items 4 and 5, together with Type 2 item 11.

The unrestricted PCA of the *CALPAS* produced eight eigenvalues greater than unity. Possible three-component to six-component models, suggested by the scree and differences in eigenvalue size, were compared. The four-component model, accounting for 44.5% of the total variance, appeared the most interpretable and offered the closest approximation to the theorized structure of the *CALPAS*. In this model, the second, third and fourth varimax components were saliently defined by the negative-worded PC, WSC and TUI scale items, respectively, whereas the first component grouped most of these scales' positive-worded items, together with positive PWC items.

Therapist-rated Measures

The unrestricted PCA of the *WAI-T* yielded a single eigenvalue greater than unity; the scree and eigenvalue difference criteria supported the one-component model, which accounted for 55% of the total variance.

The unrestricted PCA of the *HAQ-T* produced two eigenvalues greater than unity; the scree and difference in eigenvalue criteria supported a two-component model, which accounted for 61% of the total variance. The second varimax component contained support-related Type 1 items 3, 7 and 8, and the first varimax component contained the remaining items.

Analysis of the *CALPAS-T* yielded five components with eigenvalues greater than unity; the scree and the differences in eigenvalue size suggested between two and five components. The three-component solution, which accounted for 60% of the total variance, appeared to offer the best approximation to the conceptual model. The first varimax component contained all six PC subscale items, most WSC and three PWC (4, 5, 6) items, with the other three forming the third component. The second component contained all the TUI and two WSC items (17, 18). Note that the promax-rotated client and therapist solutions proved identical or near-identical.

[3]For the subsample involving client–therapist dyads, intraclass correlations (ICCs) computed separately for clients' and therapists' ratings of the WAI, the HAQ and the CALPAS, yielded coefficients of 0.18, 0.14 and 0.33, respectively, for clients, and 0.14, −0.08 and 0.03, respectively, for therapists, all nonsignificant. For the subsample involving clients only, following Kenny and Judd (1996), the average values of the squared differences between pairs of scores that were unlinked and those that were linked (i.e., pairs of clients seen by the same therapist) were computed to determine r_d, the estimated correlation between dependent observations. Observed r_ds were as follows: 0.17 (WAI), 0.08 (HAQ) and 0.20 (CALPAS), all nonsignificant. The ICC is considered to offer a less biased estimate of interdependence when groups are unequal (Kenny & Judd, 1996), which was the case in the dyad (involving client–therapist sets ranging from 2 to 6 clients) compared with the client-only subsample (involving mostly groups of two clients).

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Cross-Measure Factor Analyses

Overview

Initial PCAs performed on the individual items from the three alliance measures combined suggested an upper-bound of 12 components (eigenvalues greater than unity) for the client, and 10 for the therapist item sets, estimates which fall in the expected range given the number of variables examined (Tabachnick & Fidell, 1989). Overall MSA values for the client-derived and therapist-derived item sets were 0.89 and 0.91, respectively, suggesting that a common factor model was appropriate for these data. The scree test suggested between three and six factors for the client-generated data and between three and five for the therapist-generated data. The proportion of variance criterion indicated an upperbound of six factors for clients and four for therapists, whereas the eigenvalue sizes showed sharp decreases after six factors for the client and four factors for the therapist data. Consequently, PFAs specifying three to six factors for clients and three and four for therapists were performed. For clients, the six-factor solution, accounting for 46% of the total item variance, and for therapists, the four-factor solution, which composed 55.1% of the total variance, appeared to offer the best interpretations of the data. Given relatively large inter-factor correlations in both these solutions ($rs = 0.45$–0.56 for the first four client factors and 0.56–0.60 for the first three therapist factors), the obliquely (promax) rotated factor solutions were retained. Both the client-generated and therapist-generated solutions were internally consistent (i.e., the factors were well defined by the variables) as indicated by the squared multiple correlations (SMCs) of the variables with each of the factors (Tabachnick & Fidell, 1989; range of SMCs for client-derived factors: 0.79–0.96; for therapist-derived factors: 0.89–0.93).

Clients' Cross-Measure Alliance Constructs and their Relationship to Therapeutic Outcome

Table 1, left column, displays the six client factors, with factor items arranged in descending order of loadings. (For comparison purposes, the therapist factors, described below, are displayed in the right column.)

The first factor, labelled *Collaborative Work Relationship*, was defined saliently by *WAI-S* Goal and Task items, joined by *CALPAS* WSC and *HAQ* Type 2 items that, together, reflect client–therapist collaboration in the work of therapy, including mutually agreed-upon therapeutic goals and tasks. These were linked with items reflecting positive therapist attributes (e.g., dedication, regard, attentiveness to client's goals), including the perceived ability to help the client. As shown in Table 2, which presents the correlations between the client and therapist factors and therapy outcome, this factor showed modest to low moderate relations to both clients' and therapists' post-therapy ratings of overall helpfulness and positive change.

The second factor, labelled *Productive Work*, contained salient *HAQ* Type 1 and other scale items reflecting gains associated with the work of therapy, in particular with respect to improved understanding and new perspectives on problems. Clients' disclosure of emotions was linked with these gains. (As negatively formulated items were reverse-scored, item content has a more positive connotation, e.g., not hold[ing] back feelings.) This factor was modestly to moderately related to client-rated helpfulness, positive change and decreased severity of complaints.

The third factor, *Active Commitment*, grouped negative-worded (reverse-scored) *CALPAS* items reflecting clients' commitment to and active participation in therapy. These co-occurred with items tapping agreement on therapeutic procedures and pertinent therapist interventions. This factor correlated modestly with therapists' post-therapy ratings of positive change.

The fourth factor, labelled *Bond*, included cross-measure bond-relevant items reflecting therapist attributes such as respect for clients' working pace, liking and empathy, combined with perceived trustworthiness. It correlated modestly with client post–therapy-rated positive change.

The fifth factor, labelled *Non-disagreement on Goals/Tasks*, contained reverse-keyed *CALPAS* WSC and *WAI-S* Goal scale items reflecting non-disagreement with the therapist regarding therapy goal and tasks. It showed modest positive relationships to both clients' and therapists' ratings of positive change and to decreased severity of complaints as rated by therapists.

The sixth factor, labelled *Confident Progress*, contained three *HAQ* items reflecting clients' confidence in therapeutic results as well as observed gains (e.g., increasingly capable of functioning without therapy). This factor was unrelated to post-therapy outcome.

Therapists' Cross-Measure Alliance Constructs and their Relationship to Therapeutic Outcome

Table 1, right column, presents the items and factor loadings in descending order for the four therapist factors, which are paired with significantly related (see next section), or conceptually similar client factors. The first factor, *Collaborative Work Relationship*, contained most cross-measure consensus-related (*WAI-T* Task and Goal, *HAQ-T* Type 2, *CALPAS-T* WSC) items, linked with *HAQ-T* Type 1 items. These describe client–therapist agreement and shared views regarding the goals and appropriate tasks or foci of therapy, together with improved client functioning and perceived helpfulness of the work. As shown in Table 2, this factor correlated modestly with all therapist-rated outcome indexes, excepting change in target complaint severity.

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Table 1. Rotated principal factor pattern matrices and loadings: client[†] and therapist[‡] samples

Item			Factor loading	Item			Factor loading
Factor 1: COLLLABORATIVE WORK RELATIONSHIP				Factor 1: COLLLABORATIVE WORK RELATIONSHIP			
WAI GOAL	6	My th and I are working towards mutually agreed upon goals.	0.99	HAQ-T T 1	5	I believe the cl has been feeling better than when he or she began.	0.76
WAI TASK	1	My th and I agree about the things I will need to do in therapy to help improve my situation.	0.92	WAI-T GOAL	11	We have established a good understanding between us of the kind of changes that would be good for my cl.	0.75
	8	We agree on what is important for me to work on.	0.91		6	We are working towards mutually agreed upon goals.	0.73
WAI GOAL	11	We have established a good understanding of the kind of changes that would be good for me.	0.89	HAQ-T T 2	10	I feel that the cl feels a growing sense of being able to do by him of herself what we do together.	0.69
CAL TUI	13	During this session, how dedicated was your th to helping you overcome your difficulties?	0.58	WAI-T TASK	1	My cl and I agree about the steps to be taken to improve his or her situation.	0.68
CAL WSC	10	Did you feel that you were working together with your th, that the two of you were joined in a struggle to overcome your problems?	0.58	HAQ-T T 2	11	I believe we have similar ideas about the nature of the cl's problems.	0.67
	16	Did you feel that your th understood what you hoped to get out of this session?	0.58	CAL-T WSC	15	The cl and I agreed about the kind of changes to make.	0.67
HAQ T 2	9	I feel I am working together with the th in a joint effort.	0.49	HAQ-T T 1	2	The cl believes that he or she is getting help from me.	0.64
WAI BOND	7	I feel that my th appreciates me.	0.48	WAI-T TASK	8	We agree on what is important for the cl to work on.	0.62
CAL WSC	19	Did the treatment you received in this session match with your ideas about what helps people in therapy?	0.47	CAL-T WSC	13	Therapy proceeded in accord with the cl's ideas of helpful change processes.	0.54
HAQ T 1	8	I feel the th wants me to achieve my goals.	0.47	WAI-T TASK	12	My cl believes the way we are working with her or his problem is correct.	0.53
CAL TUI	24	How much did your th help you gain a deeper understanding of your problems?	0.46	WAI-T GOAL	10	My cl and I have different ideas on what his or her real problems are.	0.49
WAI TASK	12	I believe the way we are working with my problem is correct.	0.44	HAQ-T T 1	8	The cl feels I understand him or her.	0.48
HAQ T 2	10	I believe we have similar ideas about the nature of my problems.	0.43	HAQ-T T 2	9	I feel that I am working together with the cl in a joint effort; we are on the same team.	0.47
WAI BOND	5	I am confident in my th's ability to help me.	0.40	HAQ-T T 1	1[§]	I believe I am helping my cl.	0.44
	9	My th and I trust one another.	0.40	CAL-T WSC	17	The cl and I agreed on salient themes.	0.42
				WAI-T TASK	2	My cl and I both feel confident about the usefulness of our current activity in therapy.	0.38
Factor 2: PRODUCTIVE WORK							
HAQ T 1	3	I have obtained some new understanding.	0.71				
	2	I believe that the treatment is helping me.	0.65				
	1	I believe that my th is helping me.	0.47				
WAI TASK	2[§]	What I am doing in therapy gives me new ways of looking at my problem.	0.47				
CAL PWC	22	Did you have the impression that you were unable to deepen your understanding of what is bothering you?	0.43				
	8	How much did you hold back your feelings during this session?	0.39				
Factor 3: ACTIVE COMMITMENT				Factor 3: CLIENT COMMITMENT AND CONFIDENCE			
CAL PC	1	Did you find yourself tempted to stop therapy when you were upset or disappointed with therapy?	0.53	CAL-T PC	8	Cl was willing to make sacrifices, i.e., time.	0.85

(Continues)

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Table 1. (Continued)

Item			Factor loading
CAL PWC	6	When important things came to mind, how often did you find yourself keeping them to yourself rather than sharing them with your th?	0.50
CAL TUI	9	Did you find your th's comments unhelpful, that is, confusing, mistaken, or not really applying to you?	0.49
CAL WSC	20	Did you feel you were working at cross purposes with your th, that you did not share the same sense of how to proceed so that you could get the help you want?	0.43
CAL PC	15	How much did you resent the time, cost or other demands of your therapy?	0.43

Factor 4: BOND

CAL TUI	2	Did you feel pressured by your th to make changes before you were ready?	0.57
WAI BOND	3	I believe my th likes me.	0.52
HAQ T 1	7	I feel the th understands me.	0.49
CAL TUI	5	Did your th's comments lead you to believe that your th placed his or her needs before yours?	0.41
HAQ T 1	6	I feel I can depend upon the th.	0.40

Factor 5: NON-DISAGREEMENT ON GOALS/TASKS

CAL WSC	14	Did you feel that you disagreed with your th about the kind of changes you would like to make in your therapy?	0.61
WAI GOAL	10	My th and I have different ideas on what my problems are.	0.60
CAL WSC	23	How much did you disagree with your th about what issues were most important to work on during this session?	0.56
CAL PC	4	Did you feel that even if you might have moments of doubt, confusion or mistrust, that overall therapy is worthwhile?	0.42
WAI GOAL	4	My th does not understand what I am trying to accomplish in therapy.	0.41

Item			Factor loading
	11	Cl participated in therapy despite painful moments.	0.76
	9	Cl viewed therapy as important.	0.74
CAL-T PWC	4	Cl experienced strong and modulated emotions.	0.69
CAL-T PC	12	Cl was committed to go through process to completion.	0.65
	10	Cl had confidence in therapy/therapist.	0.59
	7	Cl was confident that efforts will to change.	0.55
WSC	16§	The cl and I shared the same sense about how to proceed.	0.40

Factor 2: THERAPIST CONFIDENCE AND DEDICATION

CAL-T TUI	21	I felt committed to help the cl and had confidence in therapy.	0.78
WAI-T BOND	5	I am confident in my ability to help my cl.	0.74
CAL-T TUI	20	I could remain non-judgmental; regard the cl positively.	0.71
HAQ-T T 1	7	I feel I understand the cl.	0.65
CAL-T TUI	19	I was able to understand the cl's suffering and subjective world.	0.60
WAI-T BOND	7	I appreciate my cl as a person.	0.57
HAQ-T T 1	3	I believe I convey a sense of wanting my cl to achieve his or her goals.	0.56
CAL-T TUI	23	My interventions were tactful and well timed.	0.52
WAI-T GOAL	4	I have doubts about what we are trying to accomplish in therapy.	0.51
CAL-T TUI	22	At times I had difficulties keeping the cl's best interests as my chief concern.	0.50
HAQ-T T 1	6	I believe the cl will eventually work out the problems he or she came to treatment for.	0.49
CAL-T TUI	24	My interventions facilitated the cl's work on salient themes.	0.41
WAI-T BOND	9	My cl and I have built a mutual trust.	0.40

(Continues)

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Table 1. (Continued)

Item			Factor loading	Item			Factor loading
Factor 6: CONFIDENT PROGRESS							
HAQ T 1	5	I can already see that I will eventually work out the problems I came to treatment for.	0.65				
HAQ T 2	11	I feel now that I can understand myself and deal with myself on my own (that is, even if the th and I were no longer meeting for treatment appointments).	0.60				
HAQ T 1	4	I have been feeling better recently.	0.50				
				Factor 4: CLIENT WORKING ABILITY			
				CAL-T PWC	2	Client self-observed behaviours.	0.65
					3	Client explored own contribution to problems.	0.60
					1	Client self-disclosed thoughts and feelings.	0.42
					6	Client deepened exploration of salient themes.	0.41

Note:
†$n = 174$ (due to missing values).
‡$n = 131$ (due to missing values).
th = Therapist. cl = client. WAI (WAI-T) = Working Alliance Inventory (therapist version); CAL TUI (CAL-T TUI), CAL WSC (CAL-T WSC), CAL PWC (CAL-T PWC), CAL PC (CAL-T PC) = Therapist Understanding and Involvement, Working Strategy Consensus, Patient Working Capacity, Patient Commitment subscales (therapist versions) of the California Psychotherapy Alliance Scales; HAQ T 1 (HAQ-T T 1), HAQ T 2 (HAQ-T T 2) = Helping Alliance Type 1 and Type 2 (therapist versions, respectively), of the Helping Alliance Questionnaire (Therapist Facilitating Behaviors Questionnaire).
§ = item with double loadings.

Table 2. Correlations of client and therapist joint factors with therapy outcome

	GRS		PRS		TC		GAS	PSI
Factors	Cl	Th	Cl	Th	Cl	Th	Th	Cl
Client								
Collaborative work relationship	0.29*	0.30**	0.37***	0.25*	−0.20	−0.19	0.14	−0.21
Productive work	0.36**	0.21	0.44***	0.19	−0.26*	−0.15	0.16	−0.18
Active commitment	0.20	0.18	0.13	0.24*	−0.05	−0.13	0.13	−0.03
Bond	0.13	0.10	0.24*	0.15	−0.02	−0.13	−0.08	−0.06
Non-disagreement on goals/tasks	0.29*	0.24*	0.28*	0.22	−0.14	−0.26*	0.18	−0.08
Confident progress	−0.09	−0.06	0.14	−0.04	−0.05	0.06	−0.20	−0.14
Therapist								
Collaborative work relationship	0.17	0.30**	−0.00	0.23*	−0.00	0.06	0.24*	0.13
Therapist confidence and dedication	0.16	0.27*	0.06	0.24*	0.07	−0.05	0.46***	0.18
Client commitment and confidence	0.24*	0.33**	0.08	0.29**	0.07	0.02	0.33**	0.16
Client working ability	0.15	0.23	0.08	0.17	0.07	−0.09	0.21	0.06

Note: *n*s for client factors = 69–74 and for therapist factors = 70–75 due to missing values. Cl = client. Th = therapist. GRS = Global Rating Scale. PRS = Post-therapy Rating Scale. TC = Target Complaints Method. GAS = Global Assessment Scale. PSI = Psychiatric Symptom Index.
*$p < 0.05$.
**$p < 0.01$.
***$p < 0.001$.

The second factor, labelled *Therapist Confidence and Dedication*, contained most cross-measure bond-related (*CALPAS-T*-TUI, *WAI-T* Bond, *HAQ-T* Type 1) items. (Despite the lack of a significant association [see following section], this factor was paired with the client *Bond* factor given its bond-related content.) This bond-toned factor describes

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therapists' confidence in therapy and in their ability and commitment to help, together with attitudes of positive regard, empathy and support vis-à-vis their clients. It showed significant and modest to moderate correlations with all therapist ratings of outcome, excepting change in target complaint severity.

The third factor contained all *CALPAS-T* PC scale items, which generally had the highest loadings, and select PWC and WSC scale items. Together, these reflect perceived client commitment and confidence in the therapeutic endeavour, linked with client emotional involvement (expression of affect) and a shared sense of therapy tasks. This factor, labelled *Client Commitment and Confidence*, showed modest to low moderate associations with all therapist-rated outcome measures (excepting target complaint severity) and with client-rated helpfulness.

The fourth factor, named *Client Working Ability*, consisted of *CALPAS-T* PWC items defining aspects of clients' working ability in therapy, such as self-reflection. It was unrelated to outcome.

Correlations between Clients' and Therapists' Cross-Measure Alliance Constructs

As can be seen in Table 3, which presents the Pearson product-moment correlations between the client and therapist alliance factors (based on the ratings of the 94 therapy dyads; final $n = 91$, due to missing values), clients' and therapists' *Collaborative Work Relationship* factors were moderately correlated, as were clients' *Active Commitment* and therapists' *Client Commitment and Confidence*. The latter therapist factor, together with therapists' *Confidence and Dedication*, was also significantly associated with most of the other client constructs. The client *Bond* and *Confident Progress* factors were generally unrelated to the therapist factors, and therapists' *Client Working Ability* was generally unrelated to the client constructs.

The specific sources of clients' and therapists' similar and differing views, which were also investigated in order to better understand the relations between participants' views of the alliance, are reviewed in the Discussion section below.

DISCUSSION

This study adds to the scarce literature on the facets of the alliance that are meaningful to the involved therapy participants and, furthermore, sheds light on the nature of clients' and therapists' differing and convergent views of the alliance. To identify participants' views, a first goal of this study, their responses to three alliance measures (*WAI*, *CALPAS*, *HAQ*) were factor-analysed, first within and then across the three measures. In the following sections, the results from the separate factor analyses, in which the participant-derived components are compared with each measure's theorized constructs, are first discussed. The client and therapist constructs derived from the joint analyses, which provide a more inclusive and detailed portrait of the components of the alliance that are relevant to the participants, are next discussed in turn. Their impact on post-therapy-rated (versus earlier concurrently rated) outcome, which this study examined as a second goal, is also addressed in these two sections. The relations between clients' and therapists' views of the alliance, the investigation of which was this study's third goal, are then discussed. In addition to the correlational results, the similarities and differences in clients' and therapists' alliances are more specifically examined, expanding on earlier work that generally focused on the strength of the relationships

Table 3. Correlations among client and therapist alliance dimensions

	Therapist dimensions			
Client dimensions	Collaborative work relationship	Th confidence and dedication	Cl commitment and confidence	Client working ability
Collaborative work relationship	0.32**	0.23*	0.32**	0.16
Productive work	0.30**	0.32**	0.42***	0.17
Active commitment	0.25*	0.23*	0.42***	0.20
Bond	0.00	0.18	0.12	0.06
Non-disagreement on goals/ tasks	0.34**	0.21*	0.39***	0.14
Confident progress	0.00	−0.20	−0.12	−0.21*

Note: Based on data from 94 client–therapist dyads; $n = 91$ due to missing scores on some scales. Cl = client. Th = therapist.
*$p < 0.05$.
**$p < 0.01$.
***$p < 0.001$.

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between participants' constructs. The discussion concludes with implications of these findings for the assessment of the alliance and clinical practice.

Participants' versus Theoretical Alliance Constructs

The client and therapist constructs that emerged in the separate factor analyses of the alliance measures studied were generally found to show poor correspondence with each measure's theorized constructs, and they also differed among the participants. The results of the analyses performed on the *WAI-S* indicated that although a Bond component similar to the original construct was identified by clients, the original *WAI-S* Goal scale items split, with the positive-worded items joining the (all positive) Task items, whereas the negative items defined a separate component. This finding contrasts with the results presented by Tracey and Kokotovic (1989) who reported unique *WAI-S* Goal and Task factors corresponding to the original, long-form scales but is congruent with other results (Claus & Gillaspy, 2000; Guédeney, Fermanian, Curt, & Bifulco, 2005; Hatcher & Barends, 1996). Similarly, the positive-worded items of three *CALPAS* scales, PC, WSC and PWC, were found to mostly coalesce on a common component, whereas the negative-worded scale items formed in general distinct components. Taken together, these results suggest that to clients, negative scale items reflect distinct facets of the alliance and are not simply alternate formulations of positive alliance features—a finding reported earlier for other alliance measures containing negative items (e.g., Marziali, 1984). Therapists, in contrast, did not discriminate among the three original *WAI-T* scales but viewed the working alliance more globally, a finding consistent with the nonspecific, global second-order factor reported by Tracey and Kokotovic (1989). (The current exploratory procedures precluded determining whether this was a second-order factor, subsuming three first-order dimensions, or a first-order factor.) Also in contrast to clients' conceptualization of the *CALPAS-T*, that of the therapists was generally found to correspond more closely to that of the scale's authors. Similar to the findings presented by Hatcher (1999), the original Therapist Involvement and Understanding and PC scales defined separate scales (although the current commitment-related construct was broader than both the original *Patient Confidence and Commitment* construct and that of Hatcher), whereas a third factor grouped items reflecting perceived client engagement in the work of therapy (but contained only half of the original PWC items).

With regard to the *HAQ*, the findings suggest that clients distinguished among the original Type 1 items, separating helpfulness-toned from support-toned items, which they associated with Type 2 collaboration-toned items. These results are consistent with the structure of the *HAQ* reported by other researchers (De Weert-Van Oene, De Jong, Jörg, & Schrijvers, 1999; Hatcher & Barends, 1996; Hendriksen et al., 2010). Clients further distinguished, in line with Hatcher and Barends' findings, two aspects of helpfulness, which possibly reflect the helpfulness of the therapeutic work and a more global sense of improvement and confidence in outcome. Therapists similarly differentiated among the original *HAQ-T* Type 1 helpfulness-related and support-related items, although in contrast to clients, they associated helpfulness, and not support, with the Type 2 collaboration-related items. Together, these results suggest, in line with prior findings (e.g., Gaston et al., 1992; Hatcher, 1999; Hatcher & Barends, 1996; Tracey & Kokotovic, 1989), that the therapy participants, and in particular clients, construe the core components of the alliance differently than proposed by the developers of the current scales. One implication of these results is that researcher-defined versus participant-defined views of the alliance should be distinguished in theoretical and empirical studies of the alliance. Because the above client and therapist alliance constructs were mostly reproduced in the joint analyses, discussed next, they are not interpreted further.

Cross-Measure Components of Clients' Alliance and their Relationship to Outcome

The results of the joint factor analysis conducted on clients' ratings of the three alliance measures studied suggest that clients view the therapeutic alliance in terms of six basic constructs: the collaborative relationship with the therapist, the productiveness of the therapeutic work, active commitment to the therapeutic endeavour, the therapeutic bond, non-disagreement on therapy goals and tasks and, lastly, confidence in therapeutic progress.

The *Collaborative Work Relationship* construct may be construed as clients' definition of the working alliance, i.e., 'the alignment that exists for the purpose of the work' (Gelso & Carter, 1994). Clients view themselves and their therapists as partners in this alliance, working as a team engaged in a common endeavour. Agreeing on and sharing the same view (of salient issues, therapy goals and related tasks) appear to be closely intertwined with, and possibly contribute to, clients' sense of a collaborative work relationship with the therapist. Also, as suggested by the therapist-specific items loading on this factor, therapists' positive concern (e.g., dedication to help clients with their difficulties and achieve their goals) and perceived skill (ability to help, to foster understanding and to conduct relevant work) are important to, and possibly promote, clients' perceptions of collaborative work. The finding that collaboration represents a main focus of clients' alliance supports the conclusion presented by Hatcher and Barends (1996) that collaboration is the vital core of clients' views. However, compared with their salient *Confident Collaboration* factor,

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which emphasized client commitment and confidence about the helpfulness of the work, the current construct included more collaboration-related and agreement-related items (similar to their *Goal and Task* factor), highlighting clients' sense of partnership with the therapist in carrying out the goals and tasks of therapy. The finding that the *Collaborative Work Relationship* factor was predictive of several client-rated and therapist-rated outcome indices underscores the importance of a good collaborative relationship, as defined by clients, in the views of both therapy participants.

The *Productive Work* construct highlights the importance, in the view of clients, of the helpfulness or change-inducing impact of the work undertaken in therapy. Clients appear to view productive therapeutic work as specifically involving improved self-understanding and new perspectives on problems, two therapeutic impacts commonly reported by clients (e.g., Elliot, James, Reimschuessel, Cislo, & Sack, 1985; Martin & Stelmaczonek, 1988). Clients also appear to acknowledge their own efforts (i.e., willingness to disclose feelings) and not only those of the therapist, as contributing to these gains. This focus on the results of the work adds support to the conclusion presented by Hatcher and Barends (1996) that helpfulness is to be considered an important aspect of clients' appraisal of the alliance. The relevance of helpfulness to clients' conceptualization of the alliance was further supported by the delineation, in both studies, of a second helpfulness-related factor (*Confident Progress* and *Help Received*, respectively), defined by *HAQ* items and reflecting a more global appreciation of the benefits of therapy. That alliance helpfulness-toned items do not merely represent aspects of improvement is supported by studies on the alliance's relation to outcome that controlled for in-treatment improvement or involved the removal of helpfulness items (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Klein et al., 2003; Zuroff & Blatt, 2006) or again, used a broader array of outcome indexes than tapped by helpfulness items (e.g., Alexander & Luborsky, 1986). The findings, in the current study, that the *Productive Work* factor correlated only with select indices of post-therapy outcome (and correlations were moderate at best), and the *Confident Progress* factor was unrelated to outcome, further mitigate concerns of an overlap of content between helpfulness-toned items and outcome.

Clients also identified commitment to therapy as a basic facet of the alliance, a concept proposed by the authors of the *CALPAS* and reflected in their PC scale. The current *Active Commitment* factor contained, however, only the negative-valenced PC items, and it linked clients' sustained engagement in therapy with therapist and not only client contributions to the work (pertinent interventions and self-disclosure, respectively) as well as shared views—thus suggesting a broader, more interactive-toned interpretation than targeted by the original scale that taps client-specific behaviours. Although it contained only a few of the items found in the *Dedicated Patient* factor presented by Hatcher and Barends (1996) (reflecting the negative aspects of patients' participation), it was broadly similar in that it reflected counterproductive therapist interventions, as well as frustration about the work undertaken. As found by these authors, clients did not relate their perceptions of commitment to therapy outcome.

Consistent with the study results presented by Hatcher and Barends (1996), the bond, or personal attachment between client and therapist, remains a meaningful facet of the alliance in the view of clients, albeit, similar to their findings, a generally weaker predictor of outcome. Perhaps therapist-offered facilitative attitudes (which the cross-measure bond-relevant scales predominantly tap) represent a necessary pre-condition, and set the stage for, a collaborative work relationship.

Finally, clients are concerned about disagreement with the therapist regarding salient issues needing work and relevant therapeutic goals. The *Non-Disagreement on Goals and Tasks* factor is similar to the disagreement component identified by Hatcher and Barends (1996) in their *Idealized Relationship* factor, whose (reverse-keyed) items reflect more or less serious disagreement with the therapist. However, at variance with their result of a negative relationship to client-rated improvement, attributable to the disagreement items, the current factor showed, similar to the results of Clemence et al. (2005), a positive relationship to several client and therapist outcome indices, suggesting that less conflict between the therapy partners regarding therapeutic work and goals may support positive outcome. (Note that the removal of the positive-valenced items loading the current factor did not alter the direction of results.) Additional research is needed to determine the impact on outcome of goal and task disagreement among the therapy participants.

Cross-Measure Components of Therapists' Alliance and their Relationship to Outcome

The findings from the analysis performed on therapists' combined ratings of the three alliance measures studied suggest that therapists view the alliance in terms of four main components: effective collaborative work, both the therapists' and their clients' confidence in and commitment to the work and clients' working abilities. The first factor, *Collaborative Work Relationship*, which grouped most cross-measure consensus-related items, lends support to the notion of agreement on the goals and tasks of therapy as a significant component of the alliance as presented by Bordin (1979, 1994). Consistent with the findings of Hatcher et al. (1995) based on global alliance scores, therapists associated sharing similar views and agreeing with their clients on relevant work with perceived client improvement and helpfulness. This item combination also

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lends support to the proposition presented by Bordin (1994) that the identification together with the client, as well as a common understanding of pertinent therapy goals and related tasks, is in itself therapeutic, potentiating client change such as improved morale. Although a therapist collaboration factor was also identified by Hatcher (1999), it emphasized joint confidence in the usefulness of the work and patient commitment, in contrast to the current agreement-toned construct. The association of the current factor with most therapist-rated indices of post-therapy outcome suggests the importance to therapists of consensually determined views of therapeutic goals and tasks.

Therapists' perceptions also supported the theoretical notion of the bond as a core element of the alliance. The joint clustering, in the *Therapist Confidence and Dedication* factor, of virtually all cross-measure bond-relevant items (excluding helpfulness items) is in line with the result presented by Hatcher (1999) of the gathering of the *WAI* Bond and *CALPAS* TUI items on a single component and suggests that the *HAQ-T*'s support-related items are also part of the same latent construct. Consistent with the results presented by Hatcher (1999) and Clemence et al. (2005), the therapist bond construct proved to be a significant predictor of therapist-rated positive outcome.

The other two components identified by therapists, *Client Commitment and Confidence* and *Client Working Ability*, which represent predominantly client contributions to the alliance, lend support to the delineation by the authors of the *CALPAS* of scales reflecting the patient's commitment (PC) and working capacity (PWC), although these were defined somewhat differently by therapists in this study. As suggested by other-scale (PWC and WSC) items that joined the original PC items, to therapists, a committed client also shows a willingness to express emotions and shares a similar understanding of therapeutic tasks. The finding that perceived client commitment was associated with several outcome indices converges with a large body of evidence documenting the therapeutic importance of clients' engagement and active participation, particularly from the perspective of external observers and therapists (e.g., Bachelor & Horvath, 1999; Orlinsky, Grawe, & Parks, 1994; Tryon & Winograd, 2002). The item composition of the current *Client Working Ability* construct suggests that therapists distinguished among the original PWC items, differentiating those that may reflect client self-initiated work behaviours (e.g., 'Client self-observed behaviours'), from those that may involve therapist interventions (e.g., 'Client worked actively with my comments') that loaded on other factors. At variance with the significant relations reported by Hatcher (1999) and Clemence et al. (2005) between their similar *Patient Working Engagement* factor and concurrently rated progress, the current *Client Working Ability* construct did not predict outcome rated post-therapy.

Overall, the current cross-measure client and therapist constructs were generally found to be similar or broadly similar to previously identified constructs (Hatcher & Barends, 1996; Hatcher, 1999) with the main exception of participants' concept of collaboration. The current results suggest that participants viewed collaboration more in terms of a shared understanding of, and mutual efforts towards, the work of therapy rather than commitment on the part of the client and joint confidence about the usefulness and helpfulness of the work. In addition, the WAI-specific factors identified by Hatcher (1999) in his joint analysis of therapists' ratings of the WAI and the CALPAS, which were attributed to method effects, were not reproduced. The inclusion of the therapist-rated HAQ in the current joint analysis (which allowed for a comparison with how the HAQ items were organized in clients' perceptions), as well as the use of the *WAI-S*, may partly account for these differences. Although, as found by Hatcher and Barends (1996), Hatcher (1999) and Clemence et al. (2005), participants' alliance constructs were, with few exceptions, significantly associated with therapeutic outcome, two comparable constructs across studies, reflecting clients' sense of confidence in their progress and therapists' perceptions of clients' abilities to work in therapy, previously found to correlate with concurrently rated client improvement, were not related to outcome rated post-therapy. Although these differential results may be due to differences both in the constructs and the outcome measures across studies, it may be that, if appraised at the same therapy session, the perceived impact of these aspects of the alliance is reflective of the particular therapy session at the time. If replicated, the current results suggest that their importance may be viewed differently once therapy is concluded and final outcome is assessed.

The finding in this study that virtually all the observed client and therapist cross-measure constructs were predictive of one to several indexes of positive outcome supports the significance of the therapy participants' own views of the alliance and warrants their continued investigation. The finding that the observed correlations varied across rater perspective, alliance dimension and outcome index is in line with previous studies (e.g., Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998) that point to the need for a more differentiated theory of alliance–outcome interrelations.

Relationships Between Participants' Views of the Alliance

As suggested by the correlational results, clients and therapists viewed some aspects of the therapeutic alliance similarly, but their perceptions of other aspects diverged considerably. In line with prior results (Clemence et al.,

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2005; Hatcher, 1999), and notwithstanding differential emphases in the nature of constructs across studies, the therapy participants showed agreement in their perceptions of collaboration and commitment (participation), whereas their views of the therapeutic bond were unrelated. The current findings of significant relations between the therapist-perceived bond and the other client constructs, and no association between therapist' perceptions of clients' ability to work in therapy and the latter, add to the mixed findings in earlier reports and suggest the need for continued investigation of these relationships. Despite convergence on important aspects of the alliance, the finding that the inter-factor correlations were in the low moderate range at best, in line with previous results (Clemence et al., 2005; Hatcher, 1999) and the average correlation ($r = 0.36$) reported by Tryon et al. (2007) in their meta-analytic review, underscores the differing views of the therapy partners.

A closer examination of clients' and therapists' alliance constructs, including their salient ingredients, may provide insight into the specific aspects of the alliance that are viewed differently or similarly by the participants. As suggested by an inspection of the client and therapist factors and their respective item content (see Table 1), both clients and therapists identified—and shared to some extent a similar understanding of—a work-related construct viewed as important to effective therapy, *Collaborative Work Relationship*, which focused on the interactions of the therapy participants regarding appropriate therapeutic tasks and goals. However, the therapist factor emphasized client–therapist consensus while, among clients, agreeing on the work seemed to go hand in hand with a sense that the work and efforts to solve their problem(s) represent a shared endeavour, which was further linked with therapist-specific contributions (e.g., dedication, concern for clients' goals). In line with prior results (e.g., Al-Darmaki & Kivlighan, 1993; Dunkle & Friedlander, 1996; Hatcher, 1999; Horvath & Greenberg, 1989), the distinction among the goals and tasks of therapy appeared to be less relevant, both to clients and therapists, than achieving a consensual view of the work. Furthermore, although the interactive work was associated with helpfulness in both constructs, the finding of two client factors directly related to helpfulness, *Productive Work* and *Confident Progress*, suggests that clients, more than therapists, focus on the helpful aspects of the alliance.

Both therapy participants also identified alliance dimensions involving clients' commitment to therapy and shared to some extent similar views of client commitment. As reflected in the *Active Commitment* factor, clients again inter-related therapists' and their own behaviours, linking engagement (i.e., not not engaging) in therapy to both partners' contributions, including a common understanding of relevant tasks. Therapists' concept of client commitment, represented by the *Client Commitment and Confidence* factor, corresponded more closely to the *a priori CALPAS* definition of the construct, stressing client behaviours and attitudes. The finding that therapists, but not clients, identified a client-specific work component, *Client Working Ability*, similarly suggests that therapists may be more concerned with clients' contributions to the therapeutic endeavour. As suggested by the client *Non-disagreement on Goals/Tasks* factor, clients for their part may be more concerned with possible misunderstandings regarding the issues that need work and the changes that are sought.

Both clients and therapists identified a bond-related aspect of the alliance but defined the bond quite differently, as suggested by the low association between the participants' bond-relevant constructs. The client *Bond* factor focused on perceived consideration, liking and empathy, as well as a sense of trust in the therapist. Its therapist counterpart, *Therapist Confidence and Dedication*, while generally including the former affective-toned qualities, placed emphasis on therapists' commitment and confidence in the provision of help to their clients. Both constructs emphasized therapist contributions in fostering a positive relational climate.

Overall, compared with therapists, clients appear to be more concerned with the helpfulness aspects of the alliance; their (positive) work-related interactions with the therapist, i.e., collaborating and achieving a common view of relevant goals and tasks, appear to be more closely linked with therapist contributions, in particular affective-toned attitudes reflecting therapists' positive concern—attitudes that are equally central to clients' view of a positive relational climate. Finally, they are more sensitive to negative signs of the relationship, such as differing views on therapy goals or salient issues. Compared with clients, therapists place greater emphasis on client contributions to the therapeutic endeavour. Such an emphasis may reflect therapists' ideas or expectations, informed by clinical theory and training as well as professional experience, that a good therapeutic relationship involves not only joint work efforts and personal contributions but also, importantly, clients' active participation, including clients' commitment to the work of therapy as well as the ability, or willingness to disclose information about self.

Implications for Measurement and Clinical Practice

The findings reported for the client and therapist alliance constructs, if replicated, suggest that if a representative assessment of participants' alliance perceptions is sought, then therapists' perceptions can be reasonably well captured using any one of current alliance scales that assess collaboration/consensus and the bond (omitting, for the *HAQ-T*, helpfulness items 1, 2 and 4), together with scales that reflect client commitment and working capacity. As it

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includes all these dimensions, the *CALPAS* (therapist form) may offer the most practical approach to assessing therapists' alliance.

Because theoretically proposed alliance concepts, while relevant, are construed differently by clients, it might be appropriate, in order to to fully and adequately tap the range of attitudes and behaviours that underlie clients' perceptions, to consider some modification of current measures' subscales, in particular, those reflecting consensus/collaboration and commitment. Positive item content, which could include therapist-specific contributions (e.g., dedication), could be distinguished from negative content, whereas new scales could be devised that include disagreement-related and low commitment-related items and, further, specifically assess helpful aspects of the work.

From a clinical standpoint, the current findings suggest that therapists should anticipate that their views of the therapeutic alliance and the therapeutic work are not necessarily shared by their clients. Therapists are encouraged to regularly seek clients' feedback concerning perceptions and expectations regarding the relationship with the therapist, the work conducted and therapeutic progress. Because attentiveness to and acknowledgment of their own perspective on relevant problem(s) and therapeutic goals are valued by clients—and not always correctly identified by therapists (Swift & Callahan, 2009)—therapists should ensure that goals and therapeutic tasks are discussed together and mutually determined and remain vigilant for signs of tension in the relationship that could reflect a perceived lack of shared views, adjusting their responses accordingly. To facilitate a sense of confidence and trust in the therapist and therapy, it appears important to ensure that clients view the therapeutic endeavour as a team effort and that therapists' felt dedication to help the client is effectively conveyed. Therapists may need to explicitly address how the particular techniques or work strategies undertaken can be of help (e.g., foster improved self-understanding and new perspectives on problems) and are relevant to achieving desired changes. Lastly, although the client's commitment to the work is meaningful to both therapy partners, such commitment may similarly be enhanced when interventions are perceived as relevant to the client's specific situation or problem(s).

Finally, this study has limitations that should be noted, including those associated with naturalistic settings, such as nonrandom selection, predominantly female participants and differing levels of therapist experience—although level of experience, including lack of formal training, appears to be unrelated to the quality of the alliance (e.g., Dunkle & Friedlander, 1996; Kivlighan, Patton, & Foote, 1998; Strupp, & Hadley, 1979). As well, all participants were White. Although therapeutic approach does not appear to influence the alliance (e.g., Gaston, 1991; Salvio, Beutler, Wood, & Engle, 1992; Marmar et al., 1989), a sizeable proportion of the participant therapist sample subscribed to a humanistic–existential orientation. Furthermore, repeated alliance measurements by a subsample of the therapists may have introduced dependencies in the therapist data set, possibly inflating significance levels in the correlational findings. The associations both between clients' and therapists' alliance constructs, and alliance constructs and outcome, were limited to subsets of the larger study sample. As well, the number of associations examined may have contributed to spurious results. The participant constructs that emerged in this study are tied to the item content of the scales used; measures that tap other content may yield different constructs. The present results were based on self-report instruments and could reflect shared method variance. Only single assessments of the alliance were made, which may not be representative of participants' perceptions at other time points. The sample sizes for the joint factor analyses at the item level were relatively modest. However, as shown by Arrindell and van der Ende (1985), stable factor solutions can be obtained when the sample size is approximately 20 times the number of factors retained. These ratios were exceeded in the current analyses. Replication of the present findings with different ethnic groups, more experienced therapists and diverse therapeutic approaches as well as larger samples would increase confidence in the generalizability of these results to other clinical samples. Research should also examine the stability of the current client and therapist constructs, using multiple assessments over therapy. The different reference bases employed by clients and therapists in their appraisal of the alliance (e.g., Horvath, 2000) as well as participants' characteristics (e.g., attachment style, interpersonal functioning) that may affect their implicit views of the alliance remain to be explored. Research examining such variables may provide further insight into the therapy participants' differing perspectives.

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