The Therapist's Experience of the (non-) Establishment of Therapeutic Alliance in Couple Therapy

Helen Creagh

A dissertation submitted to

Auckland University of Technology

in partial fulfilment of the requirements of the degree of

Master of Psychotherapy

2019

Department of Psychotherapy

School of Public Health and Psychosocial Studies

Abstract

This dissertation concerns the therapist's experience of the establishment, or non-establishment, of therapeutic alliance in couple therapy.

There is strong evidence that the therapeutic alliance has a significant impact on the outcomes of couple therapy. Although there is a considerable literature on therapeutic alliance in individual therapies, far fewer endeavours have been made in the realm of couple research.

Even though the workings of the alliance within a therapeutic triad attract attention in published research, results have been contradictory and confusing. There is very little research which involves the therapist as subject or makes use of qualitative methodologies to answer key questions. There remains a lack of clarity about the definition of therapeutic alliance in couple therapy and about the importance of imbalance in the therapeutic triad.

This research investigates experiences of registered psychodynamic therapists in the (non-) establishment of therapeutic alliance with couples. The methodology used is Interpretative Phenomenological Analysis (IPA). Five personal interviews conducted with experienced couple psychotherapists provide the data.

Key research findings include that therapists actively seek the establishment of an alliance with couples and that the formation of an alliance is not a given. Imbalance in therapeutic alliance is common to the endeavour of couple therapy, particularly at the outset. Using a combination of therapeutic process and stance, therapists aim to deliver containment, equity, and both emotional and experiential safety to their couple clients. Challenges to alliance formation with couples include client factors, therapist factors and process errors.

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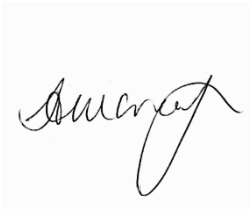
Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university of other institution of higher learning.



Helen Creagh

8 December 2019

Acknowledgements

Ethics approval for this research was granted on 3 May 2019, approval number 19/117. My thanks to David Parker for editorial assistance.

I would like to thank my supervisor Garjana Kosanke for her dedication, intelligence, thoughtfulness and kindness. I am also grateful to my clinical supervisor, Dr. Stephen Appel, for his revisions and teaching me how to work with couples.

To Cindy who has given me so much encouragement and applied the last ounces of her patience, thank you.

To Cindy, Joseph, Frances, Adrienne, Christine and David, who have taught me how to be in relationship, thank you.

To Lesley Brokenshire who helped me to break through the resistance and find motivation, thank you.

To Lize Straus, I would never have got here if it had not been for your faith in me and diligence as my therapist, thank you.

I am truly indebted to the couple therapists who participated in this research, thank you.

Finally, to the couples I have worked with and will work with, thank you for letting me share a part of your journey. Your courage is inspiring.

“Relationship is the first condition of being human.”

(Petruska Clarkson, 1990, p. 148)

CHAPTER 1. INTRODUCTION

In this chapter I introduce myself and the background to my research, I provide a summary of the research process and I outline the structure of this dissertation.

1.1 Why Couples?

It was always my intention to work as a couple therapist. With a tempestuous childhood, lived as a soothing go-between and negotiator for my parents, I imagined making better use of a pre-existing skill set. A skill set that, in the practice, I have found not to be much help; fortifying fierce countertransference experiences. Fortunately, I also have an intellectual fascination with couple therapy and I still recognise and can engage with a part of me that wishes to fulfil, as an adult therapist, a childhood expectation-cum-fantasy that I could make a difference.

I found myself at the end of my clinical training in individual psychotherapy wondering what I would do to provide myself with the necessary skills to undertake this work. It seemed obvious that working in a therapeutic triad, within and on relational dynamics in action, could not be something that one just did. It certainly was not something that I believed I could just do. Among other things, the decision to write a dissertation about couple therapy was intended to help me in my journey towards competence as a couple therapist. It made sense to me that, if I had questions, then others in my position would too. Thus, I hoped this research might contribute something to the broader community of couple psychotherapists.

1.2 A Therapeutic Alliance or a Countertransference Storm?

I began, under expert supervision and a pile of reading, to work with a very small number of couples in private practice. I found myself in a whirlwind of countertransference; fear, guilt, anxiety all played their part as well as a heightened sense of responsibility. These couples encroached on my sleeping, my dreaming and my waking. I had a strong sense of myself as not only less than good enough, but a bad therapist. As I began, the difficulty of establishing a working, therapeutic relationship with two people and the mess between them escalated that whirlwind into a tornado. It was not a giant leap, therefore, to wonder about the formation of the therapeutic relationship in couple therapy, or to think about what it was like for others working in the field.

My initial review of the literature, fully discussed in Chapter 2, revealed strong evidence that the therapeutic alliance has a significant impact on the outcomes of couple therapy (Friedlander, Escudero, Welmers-van de Poll, & Heatherington, 2018; R. Porter & Ketring, 2011; Rober, 2015). Nevertheless, a great deal is unknown about how this alliance is built and maintained through the therapy process with couples. This reflects the fact that, in couple therapy there is considerably less available research about the nature and impact of the therapeutic alliance than for individual therapy (Horvath, Symonds, & Tapia, 2010). Furthermore, a review of what information is available indicates some contradictory findings, so that Horvath et al. (2010) wonder whether the research is "asking the question the right way" (p. 216). As an experienced qualitative researcher in my former profession, I am familiar with an approach to research whereby the formation of the right questions for a survey depends on a foundation of qualitative exploration of the language and experience of the intended research subjects. As I sought out qualitative research, the absence of papers was striking. As a beginning therapist, seeking the expertise of others in the field, I also found a dearth of information about the therapist's experience of alliance formation with couples. This set the foundation for my question: what is the experience of therapists in establishing or not establishing a therapeutic alliance with couples?

1.3 Qualitative Research

I have always been fascinated by the nature of experience; this interest founded both my first and second career choices. I have been a specialist qualitative researcher, working in the social research sphere, for almost three decades. I have been impatient to undertake a dissertation where I could marry my research background with an academic question in service of my new occupation as a psychotherapist. There was never a question for me that I would use a qualitative methodology involving interviews for my dissertation, despite the additional requirements of ethics approval and time needed to gather primary data. This may appear to be misaligned with the academic process of developing a research question and, subsequently, a suitable methodology to explore the question. The sequence of question then methodology is also how we work in commercial research. Nevertheless, it was and has always been in my heart to engage in research that brings me face to face with people; to explore their experience through direct relationship. In my professional research career, I directed those projects where research questions necessitated qualitative approaches. For this dissertation I intentionally sought to bring together my identity as a researcher and as a beginning therapist. That meant I was looking for a question that could be addressed with a

primary, qualitative research approach. To me, this reflects something of the intentionality described by Crotty (1998), which he defines as the 'reaching out towards' of a research enquiry. He says that the subject and the object of research, while always distinguishable, are also, always united.

My background in social research has provided both challenge and opportunity in the preparation of this dissertation. As an academic process it has necessitated that I pay conscious attention to my own ideas about knowledge and meaning and explore some of the theory that underlies the practical application of methods and generation of findings. If anything, this investigation of my own assumptions has strengthened my identity as a researcher.

1.4 Interpretative Phenomenological Analysis (IPA)

The choice to use IPA to undertake this research was natural to my understanding of the power of the subjective experience and how meaning can be made of that experience. As a beginning couple therapist, I wanted to engage with the experience of other practitioners. As a researcher, I wanted to employ a methodology that would favour an exploration of the experience of individual participants, to draw together the themes and understandings arising from these experiences and to make use of a personal interview format to gather data.

The philosophical underpinnings of IPA combine phenomenology, hermeneutics and idiography (J. A. Smith, Flowers, & Larkin, 2009). IPA research is embedded in the notion that our experiences and understandings are constituted in relationship – to others, to objects, to time, culture and place – and this has great resonance for me. A hermeneutic interpretation of data promotes the examination of parts in relation to whole and supports the possibility of layering, both in process, and in findings. This is suited to my own enjoyment of the world at face value and in its deeper meanings and resonances. The IPA inquiry is the researcher's attempt to understand the participant's experience. The researcher's endeavours to capture this experience are acknowledged, so that IPA gives me, as the researcher, permission to be visible.

The existential philosopher Jean-Paul Sartre has been quoted to observe that we, humans, are forever engaged in the process of becoming (J. A. Smith et al., 2009). This idea is implicit to IPA, whereby the research itself is evolutionary. This, exactly, matches my wish to continue, through the research, along the path of becoming a couple therapist. I hope that others might also find meaning from the findings on their

journey as therapists. In Chapter 3, the methodology and method are more fully discussed.

1.5 Summary of Research Process

Five face-to-face interviews with experienced couple therapists were conducted between June and August 2019. Participants were selected at random. All participants were registered with the Psychotherapists Board of Aotearoa New Zealand (PBANZ), advertised themselves as couple therapists, had been in practice at least three years post-qualification, and worked in Auckland.

After ethics approval was granted (Appendix A), participants were sent an email inviting them to take part in the research; a participant information sheet was attached (these documents can be found in Appendix B). Participants were informed of their rights and entitlements as research subjects, including the right to withdraw, and consent forms were signed (see Appendix B). A semi-structured questionnaire was used to guide the interviews, without precluding the opportunity to explore and discuss anything that arose in the course of the interview (Appendix B). In Chapter 3, the participant sample and interview process are fully detailed.

Interviews were fully transcribed for analysis. Each case was considered individually before common themes were identified and developed. The analysis and findings are presented in Chapters 4 and 5.

1.6 Terminology and Context

A range of terms for the alliance between therapist and client have been used in the literature; these include ‘working alliance’, ‘helping alliance’ and ‘therapeutic alliance’. I use the term ‘therapeutic alliance’ or ‘alliance’ throughout for consistency; nevertheless, this is not intended to exclude other ways of naming the phenomenon that is the subject of this research. As the research and my reading progressed, the definition of therapeutic alliance with couples became increasingly central to addressing my research question and sub-question. For this reason, I do not offer a definition of therapeutic alliance with couples in this introduction.

There is a lack of research which pertains to experiences and definition of alliance with couples, compared to individual therapy. In my literature review, I found research that looked at the therapeutic alliance in what is called marital and family therapy (MFT), even though couples today are often not married. In these papers, couples are

included as a subset of family therapy, often referred to as conjoint therapy. I use this term in place of couple therapy where the research which I am describing cannot be accurately reduced to referring to couples.

There are professional therapists who have trained, usually overseas, specifically and primarily as conjoint therapists. This research is based in a New Zealand context where the pathway to becoming a couple psychotherapist might be to train as an individual psychotherapist and then to get professional supervision from a couple therapist and undertake additional private training(s) for which registration as a mental health professional is generally a pre-requisite (for example, Emotionally Focused Therapy, Imago Therapy and Gottman method trainings among others, are available in New Zealand). I use the term 'couple therapists' throughout this dissertation for ease and brevity. However, a more accurate description might be 'therapists who work with couples'. None of the therapists included in this research worked exclusively with couples, all were primarily trained in psychotherapy with individuals. I also use the term 'therapist' to refer to psychotherapists with training in psychodynamic psychotherapy.

This research is specific to psychotherapy with couples in Aotearoa, New Zealand. I am a Pākehā-identified researcher and the therapists participating do not include tangata whenua. Findings should in no way be interpreted as reflective of the experience of therapists working in other ethnic and cultural contexts either here or abroad.

Like most research in the sphere of couple therapy, this dissertation concerns couple therapists' experiences with heterosexual couples (unless the therapists have otherwise specified).

1.7 Chapter Summary

In this chapter I have provided background to myself as a researcher and therapist, and to the journey that seeded my interest in understanding the experience of couple therapists in establishing a therapeutic alliance. I have briefly described some of the questions that arose as part of my preliminary investigation of the literature on this subject and I have outlined the ways in which I came to choose a methodology. A précis of the research process is also provided. I concluded the chapter with clarification of the terminology used and the context for this dissertation.

CHAPTER 2. LITERATURE REVIEW

2.1 Introduction

In this chapter I review the literature on the therapeutic alliance in couple therapy, with a view to locating my research question in the context of existing knowledge and to set the scene for data analysis and interpretation. An initial search of the literature on the therapeutic alliance in couple therapy was undertaken using the AUT library search function. Searches included (variations of) the following terms: therapeutic, working, alliance, psych*, psychodynamic, couple, therap*, experience and outcome(s). Further searches were undertaken on the PEP (Psychoanalytic Electronic Publishing) website and ProQuest Dissertations and Theses Global. Throughout my reading, relevant citations from papers were noted and a number of these are also included in this review.

This chapter illustrates the significance of the therapeutic alliance in couple therapy, finding that there are different ways in which the definition of this alliance can be constructed, and that definition of alliance in conjoint therapies is of current interest to academics in the sphere. A relatively poor understanding of how the therapeutic alliance is established in couple therapy, a lack of qualitative research approaches and the relative lack of focus on the therapist as the research subject are all discussed.

2.2 The Influence of the Therapeutic Alliance in Couple Therapy

The therapeutic alliance has been proven to have a significant impact on the outcomes of couple therapy (Friedlander et al., 2018; Knerr et al., 2011; Martin, Garske, & Davis, 2000; R. Porter & Ketring, 2011; Rober, 2015) and also in reducing dropout rates from therapy (Swift & Greenberg, 2015). Bartle-Haring et al. (2012) make a direct comparison of alliance formation in individual and couple therapy. Although they say further research is needed, their findings point to the therapeutic alliance with couples, compared to individuals, as more complex and more significant to therapy outcome. Horvath et al. (2010) also see that the therapeutic alliance in couple therapy is more central than in individual therapy, describing variations in the alliance as both focus and process in the work.

Research shows few couple therapists are wedded to a given modality and that elements of the therapeutic relationship, including alliance, are a more important influence on outcomes than the underlying theoretical orientation or modality of

practice (Friedlander et al., 2018; W. K. Halford, Pepping, & Petch, 2016). The consistent findings on the influence of the therapeutic alliance seem to have driven much research aiming to better understand how the therapeutic alliance works (see, for example, Glebova et al. (2011); T. C. Halford, Owen, Duncan, Anker, and Sparks (2016); L. N. Johnson, Ketring, and Espino (2019); Knerr et al. (2011)).

While the significance of the therapeutic alliance in couple therapy is recognised (Friedlander et al., 2018; Horvath et al., 2010), there is much less published research in the sphere of conjoint therapy than exists for individual therapy (Escudero, 2016; Knerr & Bartle-Haring, 2010). Reasons for this may include the relatively nascent development of theory and research in the field of couple therapy (Horvath et al., 2010). In addition, the difficulties and limitations imposed by the complexities of research and therapy with couples are pointed out by Horvath et al. (2010) and Knerr and Bartle-Haring (2010). In examining these complexities, Rober (2015) refers to couple and family therapies as “multi-actor dialogues” (p. 115). It seems that “each person’s individual alliance with the therapist can influence the others, thereby impacting therapeutic outcomes” (R. Porter & Ketring, 2011, p. 211). Horvath et al. (2010) refer to this as the complex web of relationships.

In spite of, or perhaps because of, the importance of therapeutic alliance in successful conjoint therapy, my review of the literature has found a number of significant gaps, including in how the therapeutic alliance is defined, a bias towards using clients as research subjects, the methods adopted, and understanding of how the splits in the therapeutic alliance influence the therapy.

2.3 Gap One: Definition(s), What is the Therapeutic Alliance?

The definition of therapeutic alliance is particularly relevant at this moment in time, as researchers and writers come to terms with differences between couple and individual therapy and attempt to identify more accurate and consistent forms of measurement (Bartle-Haring et al., 2012; Friedlander et al., 2018; L. N. Johnson et al., 2019). A criticism of much of the existing research has been the reliance on Bordin’s (1979) definition (outlined below) which was developed in the context of individual therapy (Hilsenroth, Peters, & Ackerman, 2004; Horvath, 2018; Martin et al., 2000). These critics assert that couple therapists, and therapy, ought to focus on both the client system and the individual within (Lebow, 2014b). The client system refers to the relationship between the couple, mentioned elsewhere in this dissertation as the ‘couple as client’. The complexities of relationship in a therapy triad and implications for the measurement of therapeutic alliance are clear.

As my reading in this sphere deepened, it became clear that various definitions of therapeutic alliance address quite different aspects of therapy and relationship.

Firstly, and most predominant in the literature and research, Edward Bordin (1979) developed a pan-theoretical definition of therapeutic alliance, i.e., a definition that is relevant to therapies regardless of modality. His definition involves three constructs in the therapy: (1) developing an emotional bond, (2) agreement on the tasks of treatment, and (3) shared vision of goals and outcomes.

A second way of thinking about defining therapeutic alliance is based on elements of the therapist's way of being with the client or clients, or therapeutic stance. Carl Rogers (1957) identifies the necessary conditions for therapeutic change including accurate empathy, unconditional positive regard and congruence from the therapist. Therapists' ways of being are included in discussions of definitions of therapeutic alliance by Swift and Greenberg (2015), Clarkson (2003), and L. N. Johnson and Wright (2002), among others. Clarkson (1990, 2003), for example, has devoted considerable attention to the therapeutic relationship and sees it as a kind of kinship which, in various guises, places the therapist in lieu of, for example, a cousin or godparent.

A third way of talking about the therapeutic alliance is to describe its function in the therapy, a means by which the therapy occurs. Clarkson (1990) also defines the therapeutic alliance as a function in therapy, saying: "This working alliance is represented by the client's or patient's willingness to engage in the psychotherapeutic relationship even when they, at some archaic level, may no longer wish to do so" (p. 150).

These three ways of defining the therapeutic alliance do little to provide clarity on which to found research about couple therapy. Nevertheless, they point to some essential variations in how researchers and writers conceive of therapeutic alliance. The core concepts of (1) Bordin's (1979) constructs, (2) therapist stance and (3) function, will be returned to in the analysis presented in Chapter 4.

It appears there is agreement among many, if not all, contributors in the field that the therapeutic alliance is a common factor in both couple and individual therapy (Clarkson, 2003; Fife, D'Aniello, Scott, & Sullivan, 2019; Karam, Blow, Sprenkle, & Davis, 2015; Lebow, 2014a; Sprenkle & Blow, 2004). A common factor refers to an element of therapy which plays a part in therapy process, regardless of the model used by, or theoretical orientation of, the practitioner (Blow et al., 2009; Blow, Sprenkle, & Davis, 2007; Horvath, 2018; Rober, 2015). As a common factor, the therapeutic alliance may meet all three aspects of definition described above: therapeutic construct (Bordin, 1979a), stance (Rogers, 1957) and function (Clarkson, 1990, 2003).

There are many gaps and some contradictory findings in research about the therapeutic alliance in conjoint therapy. For this reason, and given other developments in the field, there have been some efforts to re-define the alliance to better fit a multi-relationship system (L. N. Johnson & Wright, 2002). Some of the work of William Pinsof has been to develop a definition of therapeutic alliance relevant for family therapy (of which couple therapy is considered a sub-set). His definition is:

> the clinically relevant part of the relationship between the therapist and patient systems...consist[ing] of those aspect of the relationship between and within the therapist and patient systems that pertain to their capacity to mutually invest in and collaborate on the tasks and goals of the therapy. (Pinsof, 1995, p. 61)

L. N. Johnson and Wright (2002) point out that Pinsof's definition relies broadly on Bordin's three constructs but adds an interpersonal element, referring to the alliances within a family system and/or sub-system, i.e., a group of clients.

Most recently, L. N. Johnson et al. (2019) have made a case for using attachment theory (Bowlby & Holmes, 2005) as an improvement to Bordin's (1979) definition and as the basis for the measurement of alliance between couple clients and their therapists. They provide evidence that their attachment-based definition and alliance measurement tool (the Attachment Based Alliance Questionnaire, ABAQ) offers the potential for greater clarity, accuracy and theoretical validity in research findings. The authors cite research that demonstrates a relationship between attachment constructs and the therapeutic alliance and argue that attachment theory has a more robust evidential foundation than Bordin's (1979) three constructs. The authors do not, however, directly suggest an alternative definition of alliance but focus on the process of the development and testing of the ABAQ.

Friedlander, Escudero, and Heatherington (2006) devote attention to both definition and measurement of the therapeutic alliance in conjoint therapy. They designed an empirical model of measurement called the System for Observing Family Alliances (SOFTA). In defining the therapeutic alliance, their view is that in conjoint therapy as well as individual therapy, the base factors of therapeutic alliance are the same: using Bordin's (1979) framework of agreement on the goals and tasks of therapy and the establishment of emotional bonds. They identified two additional elements, included in the SOFTA, which are: (1) safety within the therapeutic system, and (2) a shared sense of purpose with other family members (in the couple case, a shared sense of purpose with the spouse). This is explained as follows:

> Since clients are seen conjointly in therapy with other family members, a strong alliance in this treatment modality requires a within-system agreement on the problems, goals, and value of therapy, which can only be accomplished if

> partners or family members feel comfortable speaking openly with one another in the therapy context. (Escudero & Friedlander, 2017, p. 6)

As mentioned above, there is criticism of a de-facto reliance on Bordin's (1979) definition of alliance which is the foundation of the standardised alliance measures in couple therapy and on which much of the measurement research in the sphere is based (L. N. Johnson et al., 2019). Krause, Altimir, and Horvath (2011) undertook a qualitative investigation of client and therapist reflections on the therapeutic alliance, recognising that variance in the concept of alliance, and the ways this had translated into standardised measures of alliance, may underlie some of the variations in research findings. "In practice, we have a set of overlapping de-facto definitions based on the instruments used to assess the alliance" (Krause et al., 2011, p. 267). While their focus was alliance in individual therapy, an interesting finding was that both clients and therapists focused much more on the emotional and bonding elements of their relationship than on agreement on tasks and goals.

2.4 Gap Two: Insufficient Qualitative Research

As a professional researcher, I have undertaken qualitative research in the social and services sectors. It has been striking to find how much of the research on therapeutic alliance in couple therapy is quantitative, and the extent to which a positivist stance has been adopted. The great majority of what I found made use of measurement tools and statistical analyses in attempts to deconstruct how the therapeutic alliance works in couple therapy. For example, T. C. Halford et al. (2016) look at pre-therapy relationship adjustment, gender and therapeutic alliance. Knerr and Bartle-Haring (2010) focus on differentiation and stress and their influence on marital satisfaction over the course of therapy and Knerr et al. (2011) assess the impacts of age, differentiation, prior stress and depression. Knobloch-Fedders, Pinsof, and Mann (2004) research marital distress, individual symptomology and family-of-origin issues, and their relationship with the therapeutic alliance over time. R. Porter and Ketring (2011) investigate client stage of change, symptom distress and alliance formation. Glebova et al. (2011) consider changes in alliance and changes in couple relationship satisfaction.

Findings that contradict those from other research and/or findings which are contrary to what has been hypothesized or expected at the outset are common to these research efforts.

In their review of measurement research and discussion of how attachment theory might be a useful alternative to Bordin's (1979) constructs, L. N. Johnson et al. (2019)

report evidence that client respondents find it hard to distinguish between what Bordin has identified as the goals and tasks of therapy when responding to standard alliance measurement questionnaires. They suggest that the goal and task constructs are overlapping and that this overlap in definition may be an underlying cause of the discrepancies in research findings.

The limited quantitative research with a focus on therapist variables is plagued by similar problems. Kubricht (2018) evaluated couple therapist behaviours and their influence on the therapeutic alliance. Finding no correlation between behaviours and alliance formation, he wonders whether there may have been a problem in the data capture. Bartle-Haring et al. (2012) find no significant relationship between either therapist experience or sex and patterns of alliance formation. Bartle-Haring, Shannon, Bowers, and Holowacz (2016) look at therapist differentiation levels (as a proxy for therapist personality). They recommend their findings are interpreted with caution as, counter to their hypothesis, lower levels of therapist differentiation were found to be statistically correlated with better alliance scores, at least in some cases.

In my experience, we cannot measure what we have not clearly defined and at least somewhat understood. Similar comments have been made by L. N. Johnson and Wright (2002), who called for more qualitative research to both to better understand Bordin's (1979) constructs of therapeutic alliance and the process of therapeutic alliance in conjoint therapy, to develop concepts and models. Others have called for more qualitative research in the sphere (Blow et al., 2009; W. K. Halford et al., 2016; Oka & Whiting, 2013), not only because research findings have been contradictory but also because it has been observed that what has been found in conjoint therapy research has not been relevant to the audience of practitioners; there is a gap between findings and practice.

It seems that qualitative research may be necessary not only to support a better understanding of how to define therapeutic alliance for couples, but also to deliver greater relevance and utility of studies aiming to measure therapeutic alliance.

2.5 Gap Three: Lack of Focus on Therapists as Research Subjects

> Therapeutic alliance is created by therapists and clients joining together, co-creating a partnership and collaboration that aims to fulfil the tasks and goals of therapy. As such, the alliance is the shared awareness and reality of the client and therapist. (Timmins, 2011, p. 39)

Bartle-Haring et al. (2016), Glasgow (2017) and Blow et al. (2007) acknowledge that there has been very little attention to the therapist's perspective in either conjoint or individual therapy research. This is despite evidence that therapist effects are considerably more significant in therapy outcomes than, for example, differences between models or specific interventions (Kim, Wampold, & Bolt, 2006). Blow et al. (2007) add that the therapist, as a person who may deliver any therapeutic model, is highly significant to outcomes.

2.6 What Do We Know About the Therapeutic Alliance in Couple Therapy?

As mentioned at the beginning of this chapter, the therapeutic alliance is a strong predictor of successful outcomes in couple therapy (Friedlander et al., 2018). Symonds and Horvath (2004) find that the strength of the allegiance between the couple is also strongly correlated to outcomes. This makes intuitive sense; the more 'together' couple may be more successful in therapy. Those couples with lower levels of stress at the beginning of therapy may form alliances more quickly than others (Glebova et al., 2011). Rober (2015) says that, in couple therapy, the pair present as a 'we' but, as dialogue begins, they become two distinct subjectivities. This relationship between what happens to individuals as part of a couple and what happens in their relationship in therapy is an important distinction. For example, R. Porter and Ketring (2011) point out the potential problems if one of the couple is a customer and the other a visitor: "The customer, often the initiator of therapy, may be invested in the process, whereas the visitor may have been dragged to therapy" (p. 203). At the extremes, alliance formation is going to be challenging if one of the pair is determined to leave the relationship and the other desperate to stay (Glebova et al., 2011).

It is therefore not too surprising that goal establishment has been identified as potentially much slower in couple than in individual therapy (Bartle-Haring et al., 2012); the therapy often involves conflict in the relationship and initial motivations of each partner may be at variance (Rober, 2015). This implies the necessity of forming alliances early in the therapy, and that these alliances are likely to be based more on the emotional, interpersonal bond elements in the absence of agreed goals, as per Krause et al. (2011), described above. When clients perceive aspects of the therapist that are human and relatable, they are more inclined to form alliances quickly (Timmins, 2011).

A sense of collusion between the therapist and one of the couple, or an imbalanced alliance whereby one of the pair feels well bonded and the other does not, is considered to be detrimental to retention rates and therapeutic outcomes (Friedlander et al., 2018; Horvath et al., 2010). The implications of split alliances are discussed more fully below.

Blow et al. (2009) identified a couple in an effective therapy, and then retrospectively used data collected during the therapy to see how successful therapeutic change occurs. They evaluated the therapist, therapeutic alliance, extra-therapeutic occurrences, the therapy and the couple. Their findings on the importance and application of the therapeutic alliance are included in Table 1, below. These conclusions also include elements of all three 'types' of definition of alliance identified above: Bordin's (1979) therapeutic constructs, therapist stance (Rogers 1957) and therapy function (Clarkson, 1990, 2003).

Table 1

Team Conclusions Concerning Therapeutic Alliance Factors (Blow et al., 2009, p. 361)

"A sound therapeutic alliance affords the therapist the opportunity to take risks with clients and to get away with the risks if they do not work out.
Mistakes and missed opportunities can be used to therapeutic advantage.
Agreement on goals of the alliance is not always possible in multi-problem couples, and this is made up by other qualities such as assurance and understanding. In this regard, the therapist ideally needs initially to be aligned most strongly with the individuals who are most able to keep the clients engaged in therapy and the process moving forward, without compromising the effectiveness of the therapy.
Therapist ratings of the alliance that are higher than those of the client may indicate a mismatch in the therapeutic alliance involving a lack of awareness, on the part of the therapist, of the strength of the alliance. This may lead to client dropout or dissatisfaction.
Clients appear to be able to be more authentic as treatment progresses and are able to evaluate therapy more realistically.
The relationship clients share with the therapist may, in some cases, mirror the relationship they are experiencing with each other."

There is also neuroscientific research which considers various aspects of the physiology of alliance in couple therapy. Links between the physiological states of participants in therapy have been established (Timmons, Margolin, & Saxbe, 2015; Tourunen et al., 2019) and neurological patterns associated with the state of alliance identified (Stratford, Lal, & Meara, 2009). However, a full review of the neuroscientific evidence is beyond the scope of this dissertation.

2.7 What Do We Know About the Therapists' Experience of Couple Therapy?

Research findings have moved the role of the marital and family therapist from someone who delivers a 'successful' model (Sprenkle & Blow, 2004) to someone who, by their way of being in relationship, is an essential part of the therapy; a common factor (Blow et al., 2007; Lebow, 2014a).

As mentioned above, there has been some attention to attachment theory (Bowlby & Holmes, 2005) and its potential relevance to the definition of alliance for couple therapy. Attachment theory is a foundation of Emotionally Focused Therapy (EFT), a couple therapy model developed by Dr. Sue Johnson (S. M. Johnson, 2011). Yusof and Carpenter (2016) find that securely attached therapists have greater capacity to build a therapeutic alliance and conclude that, in training and practice, therapists might aim to develop more secure attachment styles, for example through addressing their own family of origin experiences. There is also evidence that a therapist's understanding of the couple's attachment styles is an invaluable aid to formation of the therapeutic alliance (Del Valle, 2015).

Although their focus is on individual therapies, Krause et al. (2011) find some interesting similarities in the ways in which therapists and clients reflect on the alliance, but differences in where the emphasis is placed. The over-riding themes of both client and therapist conceptions of alliance are identified as: affective reciprocity and emotional expressions; acceptance, trust and understanding; and expertise, commitment and collaboration. However, therapists were found to give more emphasis to the commitment and collaboration of clients. The researchers also found that alliance for clients is an implicit experience, whereas for therapists it is an explicit element of therapy, actively sought and seen as a tool for change and progress in the work.

Reading these papers, I have had very little sense of connection with the therapist as a person, or therapists as a group. The paper by Blow et al. (2009) is an exception, in which the group of therapists conducting the analysis and the therapist in the case study are clearly represented. For example, they write the following of themselves and their process:

> Our team had diversity including varying levels of experience. We viewed tapes independently and as a group. We established ground rules for analysis that would allow for the open discussion of new ideas…, we were able to clear up points of dispute or confusion. (Blow et al., 2009, p. 359)

The findings of this study clearly portray the therapist, her role and experience, hence these were quoted included in the section above.

Some authors of doctoral theses have also engaged directly and in depth with couple therapists as the subjects of their research (MacCormack, 1998; Schaafsma, 2006; A. G. Smith, 2008). The therapist's encounter with a couple is described as a feeling one, whereby feelings may be used both as a source of information and in service of the therapy, based on the reflexive capacities of the therapist (MacCormack, 1998). Self-attunement can be used to both understand and guide the therapy process. Therapists may refer to this as an emotional knowing.

MacCormack (1998) also finds that therapists and clients enter an emotional realm together, establishing a kind of feeling consensus in the work, and that the emotional balance of power largely lies with the therapist, who might foster a particular emotional context while eliciting emotions from clients.

In their research with couple therapists, both A. G. Smith (2008) and Schaafsma (2006) look at the personal qualities of effective or master therapists. Both studies find the significance of the therapeutic alliance to therapists, both as a construct and a function of therapy. Both also find that couple therapists describe the nature of the therapeutic alliance as unique in couple therapy. Many relationship-building qualities in therapists were said to influence the therapeutic alliance, including empathy, respect and humour. The capacity to tolerate conflict and high levels of affect were other qualities that therapists believed they brought to couple therapy, as well as the capacity to promote autonomy for each client in their own individual decision making, and as a couple.

2.8 Gap Four: What is the Significance of Splits in the Therapeutic Alliance with Couples?

When I began to investigate alliance formation in couple therapy, it was evident from my own experience that there are challenges in developing a therapeutic alliance with two individuals at the same time when those two individuals may both have significant individual challenges and are in conflict. This topic gets considerable attention in the literature and there have been conflicting perspectives and research findings. It seems that the complexities of alliance in couple therapies may be central to the issues of definition and measurement of the therapeutic alliance, as summarised below.

Probably the most common and conflicting findings in the research concern variations in alliance formation within the therapeutic triad. There are three participants in couple

therapy and the impact of variance in alliance between the three has implications for therapy outcomes. There is evidence that splits in the alliance can cause dropout (Friedlander et al., 2018) and that maintaining the alliance supports the course of couple therapy (Swift & Greenberg, 2015).

Each alliance influences the others (Friedlander et al., 2018; R. Porter & Ketring, 2011). Lebow (2014b) points out the need for couple (and family) therapy to focus on both the system and the individual within. Once the alliance with each partner in the pair is balanced, meaning that a therapeutic alliance has been established with each individual in the pair, therapy outcomes may be more favourable (Friedlander et al., 2018). Nevertheless, this does not mean that, for each of the participants, the strength of alliance is necessarily the same, particularly from the outset (Horvath et al., 2010). The therapist who attends to the more reluctant or disengaged client in the pair is likely to successfully navigate alliance building (Blow et al., 2009; Rober, 2015).

In their research, Schaafsma (2006) and A. G. Smith (2008) find that maintaining a good balance in alliance with each of the individuals in the couple is something that therapists are mindful of and work towards as therapists. In each case, there are examples of how therapists consciously work towards building an alliance with an individual who, as part of a couple, may have a more challenging presentation, for instance, is highly defended.

There are those that see these divisions in alliance as something to be avoided (Garfield, 2004), while others see potential opportunities which, when addressed effectively, may further the progress of treatment (Blow et al., 2009); and there is also a view that fluctuations in the alliance, and attendance to them, are inherent to the process of couple therapy (Horvath et al., 2010). Horvath et al. (2010) say there might have been a common assumption that splits in the alliance or variance in the alliance over time have negative outcomes in conjoint therapy. However, they also submit that these variations may be better constructed as part of the therapy and that addressing discrepancies or ruptures in the alliance may provide opportunities to take the therapy forward by demonstrating and enacting new ways of being in relationship. As Blow et al. (2009) point out, the therapy relationship may mirror aspects of the couple relationship and this provides an opportunity to learn new ways of relating.

2.9 Summary: What Does the Research Tell Us About the Therapist's Experience of the Therapeutic Alliance in Couple Therapy?

In this chapter I have found there are several gaps in the literature regarding the therapist's experience of the formation of therapeutic alliance with couples. There appears to be agreement that the definition of the therapeutic alliance, and therefore the implications of alliance in couple therapy, is still in development. Some assert that use of the same definition for individual and couple therapy is not adequate. My interpretation from the literature is that elements of therapeutic stance (Rogers 1957), the constructs defined by Bordin (1979) and the function of therapy (Clarkson, 1990, 2003) are encompassed within various existing definitions. Those working towards evolving a definition of alliance particular to conjoint therapies consider elements of the family or couple system in their thinking (L. N. Johnson et al., 2019; Pinsof, 1995), and also the notion of safety in the therapy (Friedlander et al., 2006)

The relatively infrequent use of qualitative research approaches, despite calls for these, and the relative lack of studies in which the therapist is the primary focus of investigation are the second and third gaps identified.

The fourth gap concerns the divergence of opinion and conflicting research findings about the nature and role of splits or imbalances in the therapeutic alliance. Although the research regarding the allegiance of the couple to each other seems consistently to correlate with positive therapy outcomes, there remain challenges in our understanding of relationship dynamics in conjoint therapy.

2.10 Research Implications and Research Question

This review of the literature has been broad because even the foundations of defining therapeutic alliance in couple therapy appear at question, because my interest in a deeper understanding of the therapist's experience is only loosely met in what is available, and because there are still questions about how therapeutic alliance works within a therapy triangle. My understanding of the complexities around the definition of therapeutic alliance with couples evolved through my research process; like others, at the outset of my reading and thinking I believed that Bordin's (1979) definition, so widely referred to in the research, would be suitable for my exploration of alliance with couple therapists. It was only as I undertook my interviews and read more extensively that the question of definition and its centrality became clear.

My research question was conceived based on the second and third gaps identified in this chapter; these gaps were identified from my initial review of research. The question is a broad one: what is the experience of therapists in establishing or not establishing a therapeutic alliance with couples? Given the various ideas about splits in alliance described as gap four, I also aim to address a sub-question: what is the therapist's experience of imbalance in establishing alliance with couples? The methodology supporting the exploration of my research question and sub-question is detailed in the following chapter.

CHAPTER 3. METHODOLOGY AND METHOD

3.1 Introduction: A Qualitative Research Approach

In this chapter, I outline the epistemology, theoretical perspective, methodology and method of my research, as summarised in Table 2, below. The first part of the chapter describes why a qualitative research approach, and particularly Interpretative Phenomenological Analysis (IPA) is suited to address my research question – what is the experience of therapists in establishing or not establishing a therapeutic alliance with couples? – and my sub-question – what is the therapist's experience of imbalance in establishing alliance with couples? The constructionist and interpretivist underpinnings of IPA are briefly described, and significant historical contributions from philosophers are summarised. The second part of the chapter describes how the sample of participants for this research was constructed and the processes of recruitment and interviews are also described. The chapter concludes with a description of the analysis process.

Table 2

Overview of Theoretical Underpinning and Methodology

Epistemology	Constructionist
Theoretical Perspective	Interpretivist
Methodology	Interpretative Phenomenological Analysis (IPA)
Method	Personal Interviews (IPA research design)

There has been much debate about qualitative and quantitative approaches to research and their suitability or otherwise for application to studies in the sphere of psychotherapy (Ponterotto, 2005; J. A. Smith, 2004; Williams & Morrow, 2014). Ponterotto (2005) points out that both qualitative and quantitative research approaches have scientific merit. Both require the collection, analysis and interpretation of data and are, therefore, empirical.

Merriam and Tisdell (2016) also indicate that making use of a qualitative approach should reflect both the best fit for the question and for the world view and skills of the researcher. As a researcher, I believe in the value of quantitative and qualitative methodologies, based on both their suitability to whatever is the question at hand and also as methodologies which can be applied within various epistemological and theoretical frameworks (Grant & Giddings, 2014). I have chosen a qualitative

methodology, IPA, to address my research question. This choice is supported by numerous other IPA studies in the sphere of health psychology (Howitt, 2016; Shaw, Burton, Xuereb, Gibson, & Lane, 2014), including those that focus on the experiences of practitioners in psychotherapy (Keenberg, 2015; Kleiman, 2018; J. Porter, Hulbert-Williams, & Chadwick, 2014).

Developed during the 1990s in the UK, IPA was born from a desire to find ways of better understanding the subjective experience of patients in a psychology setting (Eatough & Smith, 2017; Merriam & Tisdell, 2016; J. A. Smith, 2011; J. A. Smith et al., 2009). IPA arose as a qualitative methodology in health research at a time when there was a movement away from a cause-and-effect (positivist) bio-medical model and increasing validity ascribed to the notion of illness as constructed (Brocki & Wearden, 2006). IPA therefore sits within a constructionist epistemology (Eatough & Smith, 2017; J. A. Smith et al., 2009).

To achieve validity in qualitative research, Merriam and Tisdell (2016) identify four criteria: “the focus is on process, understanding, and meaning; the researcher is the primary instrument of data collection and analysis; the process is inductive; and the product is richly descriptive” (p. 15). Williams and Morrow (2014) also set out several parameters of trustworthiness in qualitative research, including clear grounding of studies within a research paradigm or paradigms, integrity of the data (including adequacy and dependability), balance between reflexivity and subjectivity, and clear communication of findings. IPA has been effectively used by many academic researchers and offers the opportunity to meet high standards of qualitative research quality (Brocki & Wearden, 2006; J. A. Smith, 2011), as is detailed in the remainder of this chapter.

In thinking about the experience of couple therapists as they form (or do not form) therapeutic alliances, it is apparent to me that IPA offers the opportunity to explore their experience(s) within a research paradigm designed to honour their subjectivity and reflect on my own, in a research framework particular to a health psychology setting.

3.2 Epistemology

The research takes a constructionist approach, as described by Crotty (1998). My research question concerns an experience or experiences that take place in relationship; the therapist’s experience in establishing therapeutic alliance with couples. That experience is constructed of the complex relationships in a therapeutic triad. Participants in the research were asked to reflect on their experience of not one, but

many, therapeutic relationships. The way in which they responded to the question of their experience was, therefore, formed from their thinking about these relationships.

As Williams and Morrow (2014) point out, trustworthy qualitative research must be grounded in a research paradigm or paradigms. Constructionism provides a way of thinking about knowledge, founded on the idea that our understanding of things, for example, objects, people and processes, is relational (Crotty, 1998; Eatough & Smith, 2017; Grant & Giddings, 2014; J. A. Smith et al., 2009). In contrast, a positivist epistemology would favour the notion of discovery and may see the truth as an 'absolute', which exists independently of (human) consciousness (Crotty, 1998; Grant & Giddings, 2014; Grbich, 2007; Merriam & Tisdell, 2016). Rather than pursuing 'a truth', constructionism frames meaning as made through human interaction (and non-interaction) with the world.

A constructionist paradigm means that, as the researcher, I take a part in constructing meaning from responses. In this dissertation I reflect not only on the transcribed data but also on my engagement with each participant; how it felt to be with them and what they might have been communicating non-verbally. I also bring my experience of training in couple therapy and working together with couples. In the analysis, I relate my experience to what I hear from participating practitioners. These interpretations are particular to my subjective experience. As I explore and write about what it is like to establish a therapeutic alliance when working with couples, I also imagine readers of this research constructing their own understandings based on the engagement of their own experience with the research findings.

3.3 Theoretical Perspective: Interpretivism and its Application in IPA

Interpretivism takes the theoretical stance that meaning is interpreted, as opposed to explained (Crotty, 1998). Interpretivist approaches have generally been associated with the social, as opposed to the natural, sciences (Grant & Giddings, 2014; Merriam & Tisdell, 2016).

IPA involves the researcher in understanding the experience of research subjects which are "unique to the person's embodied and situated relationship to the world" (J. A. Smith et al., 2009, p. 21). The researcher, or interpreter, is guided by IPA's bringing together of idiography, hermeneutics and phenomenology (Eatough & Smith, 2017; J. A. Smith, 2004; J. A. Smith & Eatough, 2012; J. A. Smith et al., 2009). The way in which data is interpreted reflects that IPA is phenomenological, through its focus on

understanding human experience; it is idiographic because the significance of the individual account is primary, as is a focus on 'the particular'; it is hermeneutic through both its concern with interpretation of the individual's experience and recognition of the subjectivity of the researcher as the vessel through which interpretation is made. This is often referred to as the 'double hermeneutic' (Brocki & Wearden, 2006; Eatough & Smith, 2017; Shaw et al., 2014; J. A. Smith et al., 2009).

An overview of each of these foundations of IPA is given below, followed by a brief comment on their application in the IPA methodology.

Idiography

In IPA, the significance of the individual account is primary, as is a focus on 'the particular'. I, as the researcher, maintain contact with and draw significance from the depth of individual experience. Idiography focuses on the specific and favours maintaining connection with the individual case (Eatough & Smith, 2017). The methodology makes use of biographical and/or narrative material (Shaw et al., 2014). The use of small, homogenous samples, such as the sample drawn in this research, is common to IPA (J. A. Smith, 2011).

Phenomenology

Phenomenology is a philosophy of study that concerns itself with understanding the experience of being human (Eatough & Smith, 2017; Grant & Giddings, 2014; J. A. Smith et al., 2009). A phenomenological approach supports undertaking qualitative research which is focused on meaning, inductive and richly descriptive (Merriam & Tisdell, 2016). The significance of phenomenology to psychology and its related professions lies in the way in which we evaluate and understand lived experience; how it is to be human. J. A. Smith et al. (2009) summarise the influences of five phenomenological philosophers on the development of IPA and these are briefly described below.

> Edmond Husserl's (1859-1938) work established that human experience should be studied in the way that it happens, and in its own context. Husserl's phenomenology involves stepping aside from our day-to-day ways of being in order to separate ourselves from our assumptions to allow reflexivity. The process of reduction is a fundamental in Husserl's view, whereby the superfluous material, such as the researcher's preconceptions, are stripped back, allowing the particular nature of an experience to be examined (Eatough & Smith, 2017). In reflecting on the substance of life and our responses to it, we are being phenomenological.

Martin Heidegger (1884-1976) was a student of Husserl. His contribution to phenomenology was to locate the human experience in terms of objects, relationships and language. Human capacity for making meaning, for Heidegger (1962), was inter-subjective, always in relationship to another; and existential, being located temporally. Thus, Heidegger identified the significance of the interpretation of people's meaning-making activities to phenomenology. This is specifically relevant in the application of phenomenology to psychology.

Maurice Merleau-Ponty (1908-1961), like Heidegger, was interested in contextualising phenomenology. However, the direction he took was to focus on how the human experience is embodied. The experience of the other can never be fully shared, because that experience is housed in their own embodied place in the world. While the subject's experience of themselves can never, therefore, be fully understood, neither can the fact of their embodiment be overlooked (J. A. Smith et al., 2009).

Jean Paul Sartre (1905-1980) focused on the nature of humanity as 'becoming', adding the notion of the unfolding nature of experience, as people undertake their 'projects'. Sartre explored how relationships shape experience, the necessary difference made to a project by the being there or not being there of an individual or individuals (J. A. Smith et al., 2009).

Amedeo Giorgi (1931-) is credited with being one of the first psychologists to develop a structured phenomenological approach to research. As a follower of Husserl, Giorgi set out to describe the 'general' experience of a phenomenon through gaining an understanding of individual experiences of it (Howitt, 2016).

IPA treats research participants as experts in the phenomenon of the inquiry (J. A. Smith et al., 2009). "IPA aims to grasp the texture and qualities of an experience as it is lived by an experiencing subject" (Eatough & Smith, 2017, p. 3). The subjectivity of experience is 'phenomenal'; there is no 'reality' that exists without the connectedness of individuals to their worlds. The therapists participating in this research are experts in the experience of therapeutic alliance formation. The research aims to capture something of the substance and essence of their experience of the phenomenon of alliance formation in conjoint therapy.

Hermeneutics

As a psychotherapist, I regard the hermeneutic element of IPA as a natural fit both to the question and to my analytic engagement with the material generated within interviews. I attempt to make meaning of the participant trying to make meaning of their

own experience; this is the double hermeneutic (Eatough & Smith, 2017; Shaw et al., 2014; J. A. Smith et al., 2009). There is a dialogue between the participant's account of their experience and my interpretation of it, as the analyst.

Hermeneutics is the theory of interpretation (Grant & Giddings, 2014; Sandage, Cook, Hill, Strawn, & Reimer, 2008; Shaw et al., 2014; J. A. Smith & Eatough, 2012). Sandage et al. (2008) provide a brief history of hermeneutics and credit Friedrich Schleiermacher (1768-1834) with the emergence of the hermeneutic circle. The hermeneutic circle, in simple terms, conceptualises the relationship of 'parts' and 'whole' in interpretation; that the parts are integral to the whole and the whole is integral to the parts. In reference to interpretation of text, therefore, we cannot interpret the single sentence without consideration of the entire text, and vice versa. Schleiermacher also conceived of the significance of the hermeneutic circle in relation both to a text and to the psychology of the interpreter (J. A. Smith et al., 2009).

Willian Dilthey (1833-1911) extended hermeneutics into the realms of human behaviour and culture, exploring the notion that individuals experience the world through an interpretive lens. Heidegger (1962) took this idea further than a single dimensional method of interpretation, to the phenomenological interpretation of the person who interprets the data. Heidegger, and his student Gadamer (1900-2002), highlighted the idea that the experience of life is, at its foundation, interpretive and dialogical. Gadamer (1960/2013) proposed two arcs within the hermeneutic circle, one of projection and one of reflection. We, as researchers, project our pre-conceptions and understandings into an investigation and, as we interpret, may reflect on and alter these projections. As Yanchar (2015) states, "there is no showing up of phenomena in social inquiry independent of researchers' prior familiarity and practices within an historical setting" (p.115).

The hermeneutic element of IPA delivers some of the elements of research quality defined by Williams and Morrow (2014) and Merriam and Tisdell (2016); specifically, a balance of reflexivity and subjectivity, and a focus on process, understanding and meaning. A part of this takes place through a non-linear engagement with the data. The relationship between the whole and the parts of both a participant's experience and my own relationship with the data is dynamic. The analysis is not step by step but, rather, layered and iterative (J. A. Smith et al., 2009). J. A. Smith et al. (2009) encourage a creative approach to data interpretation. The researcher can move back and forth in the analysis, to make meaning, rather than moving in a linear progression from point A to point B. The (non-linear) way in which I have navigated analysis in this research is described below. The invitation to find my own ways to connect with the experiences

told by each participant allows me to access many aspects of myself, my experience and expertise, intellect and reflexivity.

3.4 Methodology and Method: Applying IPA to my Research

Interviews are the most common method used for IPA research, although other methods such as journals and focus groups have been known (Shaw et al., 2014; J. A. Smith & Eatough, 2012). I am using interviews as the means to gather my data, not only because they are common to IPA, but because a face-to-face discussion with couple therapists in a familiar, comfortable setting might encourage deep and reflective exploration of experience. A focus group, while possible, might not have allowed space for personal reflection and the accommodation of difference, nor for sharing individual case material. I reflect further on the choice of personal interviews in Chapter 5.

A semi-structured question schedule has been developed (Appendix B). This schedule provides a guide to the interview, rather than something to be strictly adhered to. As J. A. Smith et al. (2009) point out, the capacity to vary the content of the interview allows full participant expression of their experience and the capacity to uncover novel material. While this approach has the advantage of close attunement to the experience of each participant, in some cases it can also compromise the capacity to make comparison between cases, as exactly the same questions have not been asked (Knox & Burkard, 2014). To mitigate this, as far as possible I attempted to cover the same subject matter with each participant, even though the specific questions varied in each case.

Five interviews were completed. There were two interviews where time constraints meant there were some limits to the information covered. Details of sample selection, recruitment, the interview process and analysis are provided below.

Sample Specification and Exclusions

IPA studies have been known to include anything from one to scores of participants (Brocki & Wearden, 2006; J. A. Smith, 2011). Small, homogenous samples are recommended to provide the richest data and to retain IPA's idiographic intent (Shaw et al., 2014). IPA, like many qualitative research methods, makes use of purposeful sampling to gather data from those who have had a specific experience relevant to the research question (Merriam & Tisdell, 2016; J. A. Smith et al., 2009). In this study, there is intentionality about the kinds of psychotherapists to be included as participants.

Only private practitioners have been included in the sample, which has also targeted registered psychotherapists who are working with couples and have been practicing for at least three years post-qualification.

Working with private practitioners allows exploration of the individual practitioner's freedom, for example, to choose their own working style, modality, range or type of clients and conditions for practice; to establish their own therapeutic frame. My interest is to understand the participating therapists' experience of the therapeutic alliance in the context of these choices. Therefore, public sector organisations and agencies working with couples were determined to be out of scope for this research. This excluded, for example, the possibility of too much variance between accounts of participants facing, for example, potential limitations to the number of sessions allowed for therapy, restrictions in the client choice of therapist and the possibility of an organisationally determined therapeutic modality. While these circumstances might also reveal some interesting data about the therapeutic relationship in therapy with couples, that may form the basis of a separate study.

I also excluded a small number of practitioners with whom I have an existing personal or professional relationship.

Sample Selection

Although I discussed with my supervisor the possibility of advertising for participants, I decided to directly contact couple psychotherapists based on a random selection process. This process avoided any potential response bias that might be associated with 'self-selection', for example, attracting only participants who see themselves as 'suitable candidates' for the research. Directly contacting prospective participants also gave me greater control over the time period during which my fieldwork could be undertaken. The first interview invitations were issued on May 28, 2019 (Appendix B), and interviews took place between June 12 and August 7, 2019.

To find potential participants I searched the internet using the terms couple, therapy, therapist, psychotherapy and Auckland. This search generated several websites and/or webpages for individual therapists and private therapy organisations. From these, a sample of 47 potential participants was drawn. Each of these was either advertised as registered with PBANZ, or the PBANZ public register was checked to ensure current registration. Each prospective participant advertised that they work with couples and, as far as possible, participants were screened to ensure they had been working in the field for three years or more post-qualification. This information was verified by prospective participants during the recruitment process.

I decided to include both male and female participants, determining to interview at least two male psychotherapists. Although I considered the benefits of including either only male or female psychotherapists, for example to anchor the data gathered into a narrower perspective, I was more interested to capture both male and female perspectives. In a project of this size, participation of male or female therapists in any combination could make little difference to the findings; however, including both men and women seemed, to me, a more equitable approach to sample construction.

The sample set was divided into male (14) and female (33) therapists.[1] Contact information was entered to an Excel spreadsheet. To select participants, a random number was generated for each sample item, using the Excel programme. Numbers were then sorted from lowest to highest and the first three therapists in each list, male and female, were sent invitations to participate in the study. Randomisation was essential. This minimised any potential bias I might have had in a selection process, for example, based on the search information I had been exposed to, the location or reputation of the practitioner.

Prospective participants were sent an invitation by e-mail and a participant information form was attached to the email (Appendix B). The opportunity to ask questions and to contact me or my supervisor was clearly expressed, as was the voluntary nature of the study. The email invitation stated the process by which participants' names had been selected. Prospective participants were asked to confirm they were in scope for the research (registered with PBANZ, working with couples, three years post-qualification). Participants were asked to allow up to 90 minutes for the interview.

To maximise the chances that each of the psychotherapists originally chosen at random to participate could be included in the research, those who did not respond were sent a follow-up message one week after the original invitation was sent. When a therapist chosen for participation refused or was not available for the interview, they were replaced with the next prospective participant in the list and the process was repeated until completion.

Ultimately five interviews were generated from eight invitations. The three who did not participate included one who did not respond and two who said they did not have time to be interviewed.

[1] Therapist gender was inferred from advertised material. In most cases, therapists were referred to in the third person in their advertising.

A suitable time and place were arranged with those who agreed to be interviewed and they were sent consent forms (Appendix B) to review before the interview, when these were signed.

Sample Description

Table 3, below, shows the key characteristics of the psychotherapists who participated. All participants were registered with PBANZ. All participants worked with both couple and individual clients.

Table 3

Sample Description

Participant	Gender	Years in Practice	Years Working with Couples	Modality
1	Female	12	10	Predominantly Gottman method (and other influences)
2	Female	13	9	Eclectic
3	Female	16	12	Eclectic
4	Male	19	10	Predominantly Emotionally Focused Therapy (and other influences)
5	Male	25	25	Eclectic

Data Gathering

Interviews took place at the participant's home or workplace, and in one case the interview took place at a community facility in a hired room. Interviews lasted between 55 and 80 minutes. The interviews were recorded on my mobile phone using specialist Rev software. The interviews were submitted to REV for automated transcription. This meant that no confidentiality agreements had to be signed with human transcribers; it was also very fast and cost effective.

REV makes clear that data is transferred and held securely, through its statement on its website: "All customer files are encrypted both at rest and in transit. Communications between you and Rev servers are encrypted via industry best-practices (HTTPS and Transport Layer Security 1.2). TLS is also supported for encryption of emails" (Rev, n.d., para.1).

The accuracy of automated transcripts, however, required that I listen to each interview, correct errors and fill in missing parts of the data. Although this was time consuming, this listening became a useful part of the analysis process. Full transcripts were produced for analysis and these were the main data source. Each participant was

sent an email approximately two weeks after the interview, asking for any further comments or feedback. While all replied, little supplementary information was provided.

Reflecting on my own process was also part of the data gathering. During interviews I was mindful of my own countertransference responses to participants and this reflective process continued into my analysis of the data, in exploration and consideration of the 'projective hermeneutic arc' (Sandage et al., 2008).

Data Analysis

The process of analysis is an integral part of the IPA method. J. A. Smith (2011) and Shaw et al. (2014) note that a description of the analysis process within a method section is a sign of quality in IPA studies. Although the concepts underpinning analysis are inherent to the epistemology and theoretical framework outlined earlier, it is worth briefly specifying what this means for an IPA analysis, as this makes sense of the process I employed.

Merriam and Tisdell (2016) point out that all qualitative research should be inductive, that is, the aim is to build concepts and understandings from the data (rather than deductive, whereby an hypothesis might be either proven or eliminated). Analysis processes in IPA are not prescribed (J. A. Smith et al., 2009). This allows scope for the researcher to make use of their own creativity and to explore themselves in relationship to the data in a fluid manner. Nevertheless, there are elements to an analysis which make it an IPA study. The process should be iterative, that is, there are steps to the analysis, but these need not be sequential; analysis can move back and forward. It should also be immersive, allowing exploration of the layers of meaning in the data. The process being immersive means spending time with each account and using different means to think about and explore what has been said. The analysis should be reflexive, allowing for consideration of the subjectivity of the researcher and the influence of that on the interpretation of the experience of the participant(s). The process should also first attend to the case, to draw meaning from the individual participant's experience; and, secondly, permit the commonalities and divergences between cases to be considered (Eatough & Smith, 2017).

Table 4, below, shows the elements of the analysis process I have undertaken, based on a list of strategies provided by J. A. Smith et al. (2009).

Table 4

Elements of Analysis

Strategy	Process(es)
Close analysis of each participant's account	Listening to each interview. Notes on my countertransference experiences. Reading each interview, initial noting.
Identification of emergent patterns	Patterns within each case. Patterns between cases.
Analytic dialogue between myself as the researcher and the data, including reflexivity.	Reflection on my own assumptions, knowledge and understandings, beginnings of interpretation.
Development of analytic frameworks	Developing themes from codes, contextualising these and thinking about relationships between them (see below).
Collaboration and consolidation of findings	Consultation with my supervisor, discussion of findings.
Writing	Development of a cogent account of the research findings, including transparency of process and direct evidence from interview text.

Analysis began with transcription of the interviews. Although the automated REV software transcribed much of what was said, each interview had to be listened to and the automatic transcript corrected through close listening. Once each interview was transcribed, I read and re-read the interviews, making notes and highlighting particular comments or words. I reflected on my experiences and the interview content and noted my thoughts and ideas.

I then took sections of each transcript where certain subject matter was addressed (for example, definition, challenges to establishing alliance and so on) and used the copy and paste tool in Microsoft Word to bring together much of the data pertinent to a specific question, gap or topic. From this I drew the content of and evidence for my initial drafting of findings on that subject. As this process was repeated, additional layers of information were retrieved, so that, for example, while thinking about therapists' experiences of challenges to building alliance, I might come across material relevant to definition. This would lead to a review or editing of findings in the definition section, and so on, for each of the sections. This process facilitated rigour in assessing

the data, the capacity to conceptualise links between what might appear to be disparate subject material, and depth in both description and interpretation of findings.

The analysis includes both the direct responses of therapists to interview questions and my interpretation, and what might be inferred from comments at any points in our discussions together.

The following images provide some evidence of my process of analysis. Notes about themes and ideas from each individual interview were written into an exercise book. Frameworks were developed by mapping some of the core concepts and material from the interviews together. Some of this work was undertaken using large pieces of paper and marker pens.

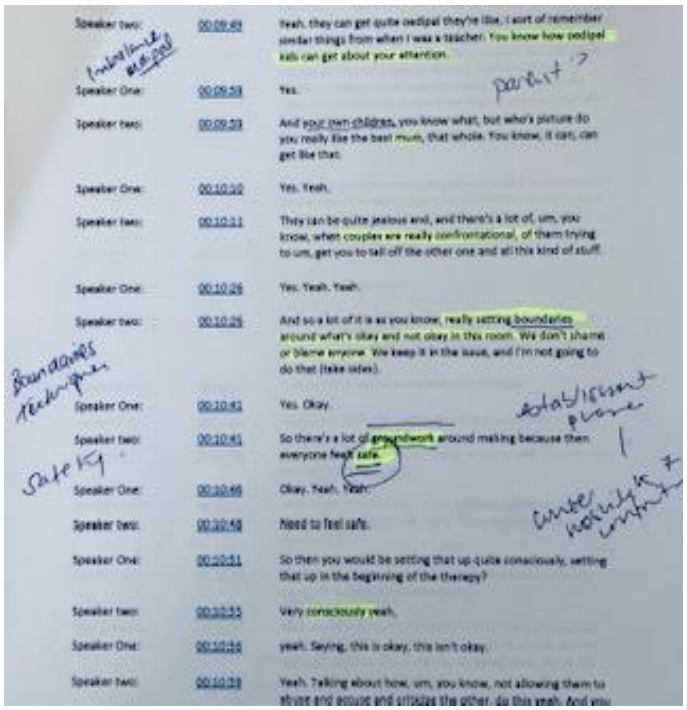


Figure 1. Example of Marked Up Transcript.

Figure 2. Analysis Images.

3.5 Chapter Summary

This chapter outlines the argument for the use of IPA as a suitable approach for my research. IPA is founded on the principles of constructionism and interpretivism, philosophical approaches to making meaning of experience which have long and rich histories in the sphere of social research. IPA allows me to make use of a small, homogenous sample of five experienced therapists who are based in Auckland, have the same basic training in psychotherapy and work with couples. IPA also allows me to be a visible presence in the research process, where my subjectivity is a visible element of the process through which meaning is made and which also honours and engages with the individual experience of each participant. IPA supports me in engaging with the material of the data in an iterative and immersive manner. Having set out the methodology and method and demonstrated their congruence with the research question, the analysis and findings are set out in the following chapter.

CHAPTER 4. FINDINGS

4.1 Introduction

This chapter presents my analysis of five interviews with therapists about their experiences of establishment of therapeutic alliance with couples. A full description of the method of analysis has been given in Chapter 3.

This chapter provides information about how therapists' experience and perspectives might contribute to a broader understanding of the definition of the therapeutic alliance with couples, as outlined in the literature review. It also describes how therapists aim to establish the working alliance, the challenges they face and their own experience of the therapeutic alliance with clients. The chapter finishes with a short section on the ways in which therapists experience and manage imbalances in the therapeutic alliance with couples.

Organisation of Findings

Gaps in the research on therapeutic alliance with couples were identified in Chapter 2. This research was designed to address those gaps by placing therapists as the subjects of research, understanding their experience of alliance formation (or non-formation) with couples and focusing somewhat on the dynamics and implications of an imbalanced alliance in the therapeutic triad. The findings are structured to address these gaps.

What emerged during the process, however, was the centrality of the question of the definition of therapeutic alliance in couple therapy. At the outset, the interview schedule included a discussion of the definition with participants, primarily with the view to establishing a platform on which to balance and reference the remainder of the interview. However, as my reading and the interviews progressed, I found the data I had gathered relevant to another gap in current thinking about the therapeutic alliance with couples: how should the alliance be defined? Accordingly, I have included an analysis of these findings.

Write Up

In the main, the data, quotations, have been included without substantial edits. However, in some cases, for sense, clarifying words have been included in brackets. The use of the ellipsis (three dots, …), signifies that the quotation has been abridged to include only what is relevant to the point made.

In my analysis I have chosen not to identify individual respondents, for example, attributing to quotations or creating pseudonyms. I do not refer to the number of

respondents who may have directly or indirectly referenced a theme. Nevertheless, to demonstrate the balance of couple therapists' voices in the analysis, the number of quotes taken from each participant are 25, 24, 19, 19 and 9.

I have used this approach, firstly, to maximise the confidentiality of my respondents, who work within a relatively small professional sphere. Secondly, this way of writing also honours a constructionist approach to the material at hand and the hermeneutic underpinnings of IPA. Undertaking a single, semi-structured interview with each of five therapists allowed me to access and engage with parts of their experience. In my analysis and interpretation, I have taken the view that each individual interview holds a part of a much broader range of experience among the community of couple therapists. Thirdly, my specific experience with each participant has been co-constructed; a different researcher may reflect differently on their experiences with participants, a different researcher may or may not gain a sense of a working connection with participants. Furthermore, each of the participants might, or might not, resonate with the experiences described by other therapists. To attribute any aspect of the therapists' experience as belonging only to a single individual or to all individuals would be a mis-representation.

One of my hopes is that therapists reading this research might have the opportunity to reflect on their experiences of alliance formation with couples; I hope to achieve this by presenting my material as an overall picture, to which each participant contributes a valuable part.

Interpretation

In Chapter 3 I have outlined the process of my analysis. In this chapter I have developed some frameworks to describe the findings. The frameworks are intended to clarify meaning, not to separate concepts. This reflects that the experiences of therapists establishing a therapeutic alliance with couples is one in which the parts cannot readily be separated from the whole; the elements are strongly bound together.

4.2 Definition of the Therapeutic Alliance with Couples

At the outset of each interview, it was my intention to discuss the definition of therapeutic alliance to establish a foundation for the remainder of what was covered in the interview, concerning the therapist's experience. Participants were asked for their own definition of the therapeutic alliance and then definitions offered by Bordin (1979) and Clarkson (2003) were read to them (these definitions had also been provided in the information sheet prior to the interview, provided in Appendix B).

At the time of interviews, it was not yet clear to me that the definition of therapeutic alliance with couples was such a significant question; my own understanding emerged as part of the process of undertaking the interviews and my further investigation of the literature. In attempting to discover what was the couple therapist's experience of establishing the therapeutic alliance, it became clear that there was uncertainty among practitioners, as in the literature, about the definition. Some of the reasons for this have been described in the literature review. The first part of my description of findings attends to issues around the definition of the therapeutic alliance in couple therapy.

One Size Does Not Fit All in Couple Therapy

Therapists are clear and consistent that a therapeutic alliance is necessary to achieving an outcome in couple therapy; without an alliance there could be no therapy. Nevertheless, in general, participants do not find defining the alliance easy, and some resisted engaging with the definitions provided in the interview or dismissed them. It was also clear that, from the therapists' perspectives, the concept cannot be reduced to a characteristic example, or generalised to simple concepts. There are two elements to this.

Firstly, couple therapists had not always reflected on their experiences of therapeutic alliance prior to the interview (even though they were provided materials detailing the subject of the interview and some definitions of alliance – see Appendix B). To some extent, the material of the interviews was, therefore, unprocessed or what could be called top-of-mind. More is said about the implications of this for further research in Chapter 5.

Secondly, therapists commented that their experience of alliance formation cannot be described as typical but that it varies depending on circumstances, most particularly the presentation of each of the clients and their desired outcomes for themselves as a couple, which might be uncertain or different for each individual of the pair:

> "There are no rules and scripts to this. You have to look really carefully at every individual situation and try to sort of be in tune, with two."
>
> "…you're trying to put a wide-ranging thing into a few words."
>
> "Well look, honestly, there's so many variations on a theme in this couples work, I mean it's just, it is, it is fascinating."

These interviews were open-ended and exploratory; I observed, as therapists began to reflect, a reluctance to commit to a concrete definition of therapeutic alliance. I also observed the authentic voice of knowledgeable therapists pointing out that their

experiences of establishing the therapeutic alliance with couples vary case by case and, therefore, cannot be simply or neatly packaged.

Fit with Other Definitions of the Therapeutic Alliance

As I analysed the data, key themes arose which provided inroads into a way of thinking about the therapeutic alliance with couples. A useful and suitable way of organising the substance of the interviews, acknowledging that one size does not fit all in couple therapy, was to classify the data according to the three 'types' of definition emerging from the literature review in Chapter 2. For example, the following quotes, thematically deconstructed in Table 5, below, demonstrate elements of Bordin's (1979) three constructs (emotional bond, agreed tasks and goals of therapy), therapeutic stance (for example, Rogers, 1957) and the function of alliance in therapy (for example, Clarkson, 2003):

> "I use the [metaphor] of a guide, I liked the one about a mountain guide and a sherpa, so I'm helping them to find their way."

> "The alliance is our kind of goodwill and understanding of, together, you know, how, how are we going to work together and um, it's just that important vehicle where we feel connected and seen by the other in order to move forward with, with what's really vulnerable and difficult work. And feeling on side and with, you know, well, yeah, alongside."

Table 5

Example of Research Themes and Fit with Definitions of the Therapeutic Alliance with Couples taken from the Literature

Element of Definition	Themes from quotes above
Emotional bond (Bordin)	Goodwill Feeling on side with Feel connected, feel seen Provide a secure base Build rapport and trust
Tasks (Bordin)	How are we going to work together
Goals (Bordin)	Helping them find their way What the issues are
Therapeutic Stance (e.g., Rogers)	Guide, sherpa
Function in the Therapy (e.g., Clarkson, 2003)	Important vehicle in order to move forward

Throughout the interviews, participants exemplified each of these elements of definition as part of their experience of and working towards establishing the therapeutic alliance with couples, described more fully below.

In my analysis, the concepts of therapist stance and function could be clearly identified through and in relation to the therapists' experiences. The material of tasks and goals, however, was less clear and more complex. The concepts of tasks and goals, therefore, are captured in what therapists have said that links their process in therapy to the establishment of the therapeutic alliance.

4.3 Therapists' Experience of Establishment of the Therapeutic Alliance

Function of Therapeutic Alliance

Participants consistently referred to the function of the therapeutic alliance as allowing the work of therapy to be done and they acknowledge that without the alliance there could be no therapy. Therapists spoke of the co-creation of the alliance between the three individuals concerned; a therapeutic alliance cannot be formed unless all three participants are willing and capable. One participant said the formation of an alliance cannot be considered a given:

> "So, it's [the therapeutic alliance] never a given, and I think it relies very much on all of you. Uh, if people are not at this point, able to, you know, pitch in and take it all on, there, there's nothing really very much you can do to establish it. Like, um, but usually if, if they feel safe, if they feel heard and if they feel seen, um, yeah, then I, then I think you can move ahead."

The therapeutic alliance is described as the vehicle by which the work, requiring client's vulnerability, self-scrutiny and willingness to change, could progress. One participant said that "Without that [alliance] you cannot have growth". The function of the therapeutic alliance also includes sustaining the work through difficult periods (emotional vulnerability, conflict), allowing the therapist the capacity to challenge or confront a client or clients as part of the work, or providing a context within which clients can be honest or reveal secrets essential to progression in the couple therapy.

Working Alliance and Therapeutic Alliance

Therapists may distinguish the working alliance from the therapeutic alliance, in that the working alliance establishes the frame and conditions necessary for the work of therapy to take place, while the therapeutic alliance holds something of the continuous function of therapy and endures for the length of treatment. I believe this may be a

useful distinction to incorporate into conceptualising alliance in couple therapy. Nevertheless, in my analysis I make use of the term therapeutic alliance as encompassing all elements of the concept.

Pre-Therapy

A participant commented that the therapeutic alliance begins before the first meeting with a couple:

> "First of all, the working alliance starts before I see them because they hear about me, so they have read an article of mine that I've written or they've, um, they've heard from friends or family, you know, so they already kind of have this, this guy's a professional, you know, we can, we can trust him."

Participants noted that couple's expectations, conscious and unconscious, come into play even before they enter the room, including their willingness to invest time and money in the process. Inherent to this is the therapist's reputation and how they have invited prospective clients including through published articles, as mentioned above, but also advertising, networking and word-of-mouth connections through which referrals may be made.

Therapists' Alliance Aims: Safety, Equity, Containment

From the analysis of the couple therapists' experiences of initial and early meetings, over-arching themes about the development of therapeutic alliance have been derived. The evidence underpinning these themes is detailed below and, as elsewhere in this research, the concepts are not mutually exclusive.

The themes include, firstly, creating emotional safety and safety in the experience of therapy; and secondly, providing a sense of equality for each of the partners – that is, that each of them would, for example, feel seen and heard and neither would feel judged. The third over-arching theme is providing containment, for example, therapists referred to the alliance as a secure base for the work.

> "It's about, what we are agreeing to work on, what the issues are, what needs to be worked on. But it's also about building rapport and trust and, you know, like a bit of a secure base for the work. Um, I think it includes the boundaries of the work, the timeframes, the payment, all that stuff."

The next few sections look at how safety, equality and containment are delivered through different parts of the therapeutic alliance, the therapist's stance and their process in the establishment stage of couple therapy. Based on the interviews and literature, I understand therapeutic stance as the therapists' ways of being; I define this as a combination of who and how we are in meeting a couple as clients. Process refers to both the what and how elements of therapy.

Delivering Safety, Equity and Containment through Therapeutic Stance

Therapists aim to emotionally attune to their clients, both in the here and now of the session(s) and towards historical material, both of each individual and of the couple. Therapists used a variety of adjectives describing their way of being with clients when establishing a therapeutic alliance. These include: warm, reassuring, parental, empathic, understanding and non-judging. More than one respondent referred to the concept of being authentic, genuine, grounded or "in my integrity". Also, they described adopting a stance that would help, in the first session, to de-escalate anxiety:

> "I often say, it is a bit like coming to the dentist coming to see me."

Theoretical terms were used including humanistic, providing a temporary attachment figure and providing a secure base for the work.

> "So, one concept that can simplify that is, we become a temporary attachment figure. So, we become a good father, mother who's able to hold them and to sooth them."

Participants talked about the significance of managing their own emotional regulation as a means of influencing the emotional states of their clients. An awareness of the physiology of anxiety highlighted the importance of the capacity to self-regulate, providing containment in the form of emotional levelling. The link was made between the therapist's own physiological states and the capacity to do the work of couple therapy:

> "We know each other's nervous systems affect each other and um, that's what happens. Yeah. That I am, hopefully, well aware of what I'm experiencing and using that as really important information about what is going on, with each [person]."

Table 6, below, provides a framework for understanding the ways in which containment, equality and safety may be delivered by therapists, as a part of the means to establish working alliance. As mentioned above, the framework is not intended to indicate exclusivity between concepts but demonstrate the themes and ideas underpinning each of the overarching themes that have been identified.

Table 6

Therapist Stance and Alliance Formation

Overarching Themes	Safety	Fairness and Equity	Containment
Pertaining to…	Emotional Experiential	Each individual and the couple	Individuals and their relationship. Anxiety Conflict
Elements of therapist stance	Warmth Empathy Reassurance Calm Trust Non-judgement Authenticity Integrity	Transparency Non-partisan Curiosity Space for both	Understanding Leadership Willing to intervene Capacity to self-regulate Reflexivity Executive function to lead and to hold or control the tension

Safety

The following quotes demonstrate therapists' capacity for creating safety in couple therapy:

> "Because the work that we do is, we're asking people to be totally vulnerable and truthful. And that, that's hard and, you can't do that if you feel unsafe and [to help them feel safe] you have to really be watching your own mind and not be critical and just keep your empathy really alive and to be walking with that other person."

> "I'm welcoming, I'm kind of warm and … that's kind of my way of being."

> "I've got a lot of empathy and compassion and understanding, but it can be fairly confrontational so ... it's tough and tender if you like, I use those terms."

> "There's a huge parental, loving warm-hearted, fatherly um, side that comes up."

Equity

Balance is an important aim of therapists and is discussed in detail in section 4.5, below. The following quote is an example:

> "I think being empathic, being curious, being warm, um, helping them to feel like each one's been heard. You know that it is kind of the feeling equal, equal kind of playing field. One's not getting privilege over the other."

Containment

The therapist's leadership, guidance and structure in the therapy, and taking responsibility for what happens in the room, are important elements of therapists' stance in establishing the alliance. I also gained a sense of this in the way therapists engaged with me. I had an impression of gentle authority, assertiveness, experience and expertise. The following quotes demonstrate how therapists deliver containment:

> "Therapists that I respect have a very strong presence in the room, which I think enables them to do that [intervene in the therapy]. So, I think it's a combination of their own groundedness, a confidence in the approach they're using, um, and a confidence that it's actually okay to assert in the therapy rather than just following. I think that was a difficulty I had from before [I did couple training], I was much more of a follower and non-intervening. "

> "I'm thinking about, so what, what keeps me in that relationship [with a difficult couple]? Part of it is professional. Professional, … and I have a responsibility."

> "So, I think the central first thing in the therapist is to be able to control the tension in the room."

This capacity of containment is achieved, in part, through the ability to keep oneself separate and or to stay grounded. The ability to tolerate the conflict that might be in the room is also a skill that supports the containment of couples.

> "If I, if I'm not kind of, stopping them getting conflicted. I don't get very upset by that, you know, I would like to, but I just feel like that's not, that's not my job. If they, if they decided to keep on fighting, I'll do everything I can. I just don't get over, over involved, over identified with it. Yeah. So that's a really good skill to have."

Delivering Safety, Equity and Containment: Process as a Construct and Function of Alliance

In the interviews, couple therapists made clear links between creating a sense of safety, equality and containment and their therapy process.

Some of the process at the beginning of therapy can be thought of in terms of 'how we are going to work together' and 'what will happen in the course of the work'. This has

an element of Bordin's (1979) definition of the tasks and goals of therapy. Therapists did not use the word tasks in talking about the therapeutic alliance but describe ways of communicating the process or structure of therapy to clients. Goals were referred to but there are a range of these: goals of the couple for their relationship, goals of the therapy and of the therapist; these things may not necessarily align. More is said on this subject at the end of this section.

Process, as I intend it, is also broader than goals and tasks, because it is something enacted between the three people in the room; process might therefore be both a construct and a function of therapy. The quote below provides an example of how process can provide a vehicle for therapeutic change.

> "What I like to do is get couples to deal with each other, not me. Right. So, they'll often talk to me like they have to kind of convince me of this or that point of view. I say, tell him, tell her, you know? And so often one thing that might happen is that the couple gets more at ease with addressing each other face to face looking at each other. So that will change the dynamic away from me as the expert back to them as the experts in their own relationship."

Consistent with the notion that couple therapy could not be one-size-fits-all, therapist assessment and alliance establishment processes vary. For example, a therapist might meet the couple first and then hold an individual session with each, before meeting them again as a couple. A therapist might take an individual history of each and create a version of a genogram. A therapist might have a specific set of questions they ask or cover histories in a specific way. Attendance to the therapist's fees, cancellation policies, the frequency, place and timing of meetings were also mentioned as important parts of the process of working alliance formation, as was the significance of confidentiality.

> "I'll say stuff like, um, there's two things from my end I just need to tell you before we start. One is that I have a three-day cancellation policy. If you don't give me three days, and I explain it quite carefully, notice I charge you. Yeah. And, um, then I say this is totally confidential. This, what we say in here, it doesn't leave the room unless, you know it's a certain condition for it. That's extreme. It's never happened."

> "They come in and then they, um, they will, um, yeah, they'll sit down and I'll, ask them a whole five minutes' worth of questions, just to make them feel at ease and to kind of let them not feel, they have to rush straight into, you know, 'This is the problem'."

Making the process transparent is directly linked to creating a sense of safety, equality and containment. It is not the content of the process that appears as essential; it is more that there is a transparent process, communicated with clients.

> “Another thing I would say is actually explaining the process. Lots, so it appears people get what you're doing.”

Making clear what will happen in the therapy includes such things as psychoeducation, teaching the pair tools for improved communication or addressing the (unhelpful) process of communication between the couple, to reveal underlying primary emotions.

> “There's quite a lot of input and knowledge giving and, there's even, even some didactic, you know, use of the whiteboard.”

Safety, containment and equality are delivered by therapists in the processes for how sessions would proceed and how the couple and therapist would communicate with each other, as demonstrated in the following quotes:

> “And so, a lot of it is … really setting boundaries around what's okay and not okay in this room. We don't shame or blame anyone. We keep it in the issue, and I'm not going to do that [take sides].”

> “I often hear myself saying and sometimes, you know, we get these spiels that kind of come out after a while. Um, I talk about this sort of a three-pronged approach for me, which is one of them as um, kind of what's happening now that the second one is there's some history in there and we'll talk about it. And then, um, I mean I've got a sort of a few tools that might be helpful and how to talk with one another and communicate. So, I talk about that, those sort of three angles that I come from. So that sometimes is quite containing.”

Another process used by therapists to build and maintain the therapeutic alliance is asking for feedback from the couple. Therapists believed this helps to insure they are attuned with the clients’ experience:

> “And then I say at the end [of the first session], ‘I'm gonna ask you what you can take away and I'll ask you that in most sessions, not every session, but most sessions, what do you take away today, so that I know that you're going away with, with something. Or if you don't take anything away, I want you to tell me.’ You know, so I kind of establish that, we have the same goals.”

> “‘Cause I asked them, you know, we had probably ten minutes at the end and I said, ‘How are we, how are we going you know, how are we going? How are we going? Um, what's it like, you know, is there anything, any feedback you want to give?’”

The goals of couple therapy

In my analysis I noted that the goals therapists’ mention in the interviews include the couple’s goals for their relationship, the therapist’s goals and/or the more generalised goals of the therapy. Couples attending therapy are often not sure about their future together or what the outcome of the therapy may be.

The frequently discrepant goals of the couple in therapy and uncertainty of outcomes can be influential in how therapists might set about their process and forming alliances.

> “It depends, you know, what things are like when they come and what it is they want out of the couples work. Whether they are really wanting the relationship to work or has one of them reached a tipping point and um, they really don't want it and then, how do we go forward with that? How do I give them the space to work through that?”

Some therapists hold an understanding that, while a person is in the room, no matter how reluctant they appear, there is part of them that wants to participate in the therapy, and a therapist might work to engage that part of them in the service of the therapy and the relationship.

> “One take on that is that just, the person's in the room part of them is presumably willing to look at whether there's the potential to find a connection and so I'm prepared to work with them as long as they turn up. Um, and I also like the parts, concepts or language there, so I'll often say to the person, you know, ‘Clearly, um, you know, you've said if it wasn't for the children, you probably would have been out of here some time ago. … So, clearly part of you has, you know, has felt very fed up and ready to leave and there is another part that's, you know, still here and still working on it.’ And so, you're kind of acknowledging the, the two parts in the person.”

Couples’ relationship goals could influence therapist process, for example, whether or not the therapist would refer both or either client elsewhere for individual therapy or undertake single sessions with each of the couple.

Some therapists have in mind their own goals for a couple’s work. Some say their role is, if possible, to build the strength of the relationship between the couple. Alternatively, one therapist commented on the opportunity for each of the individuals’ personal development:

> “My goal of couples therapy is for each of them to know themselves, to know themselves enough and to be doing, learning a little bit of that and in front of each other.”

> “The main goal is to get them to stop hurting each other so they can stop hurting the kids too.”

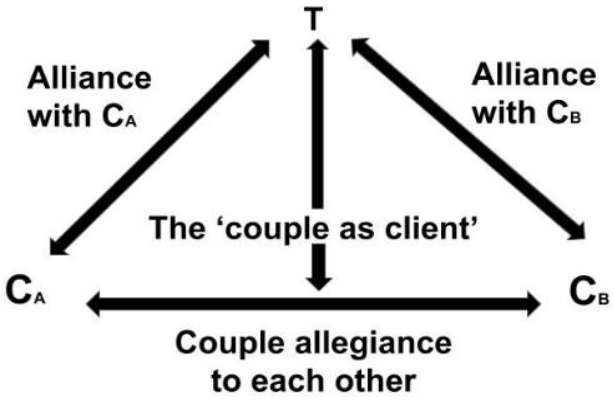
Holding hope for couples is also a goal for some therapists. The following quote demonstrates a way in which this can be translated into a process, with the broad goal of building understanding of the situation, rather than focusing on a relationship goal:

> “Your clients need to leave with hope. Some hope. Yes. I often do that and if I see the love, I often comment on the love … I don't [offer] false hope, false hope. I certainly say, okay, this is what we need to do. This is what's, this is

what we're going to do. And by doing, I'm generally meaning we need to start looking at yourselves. We need to understand what's happening here."

4.4 Dynamics in the Therapeutic Triad

Based on the literature I had read, I prepared a diagram, shown in Figure 3, below, for inclusion in my interviews with couple therapists. The diagram was introduced towards the end of the interview.



T = Therapist C_A = Client A in couple C_B = Client B in couple

Figure 3. The Therapeutic Alliance in Couple Therapy.

Therapists' responses to the diagram included that it was simplistic. There was wariness, as there was in defining therapeutic alliance, about trying to fit a complex concept into a basic form. In two cases, participants did not have much to say about the diagram. However, responses included that the diagram fairly represents the nature of alliances in the therapy, acknowledging that the therapist engages in a relationship both with the individuals and the relationship between the couple.

> "Yeah, it's simple [the diagram], but it's, yeah, sure. Yeah. You know what I mean? It's very simple. It's, um, you, you, you want to establish an alliance with both."

> "Um, it is very simple. Yeah quite diagrammatic and simple. I think it's pretty impossible to put [alliance] into something like this."

Therapists described three significant ideas in relation to the diagram regarding the dynamics of therapy with couples.

Firstly, they remarked that the dynamics between the couple may be experienced in some way by the therapist or felt by the therapist in their alliance with each of the individuals of the couple. A therapist described how, for example, her initial response to

one of the individuals may later be understood as information about the couple's relationship:

> "Because what happens here, I think this person [the therapist] here has a sense of all fields too. … And what happens here [between the couple] will happen here [between the therapist and both individuals] to subtle, to degrees. … And I think you're right, there is a client a and a client b. Then there is the couple, there's definitely all of that. 'Cause what's cut off and what am I left having to hold. Um, and where does it come from? Who's not feeling it?"

Secondly, there was the idea that the alliance between the couple may not exist at the beginning of the therapy or exist only weakly, but that this is the therapist's goal, aiming to help that alliance strengthen:

> "I guess, you know, that's part of the objective of the exercise is to help their (the couple's) allegiance to each other to become stronger. … And for them to have stronger alliance."

As that relationship strengthens, so can the bond between the therapist and the couple relationship. Once this strengthening is achieved, this might ultimately be experienced by the therapist as a sense of becoming excluded from the couple's relationship, becoming more of an on-looker:

> "But as this, as they do the work. It's this one [therapist to client a] and this one [therapist to client b]. I mean in the beginning there isn't a this one, there isn't, there isn't this one [allegiance between client a and client b]. So, hard to do that one [therapist to couple as client]."

> "Thinking of that, um, couple of that have sort of changed quite fast. That's exactly it you know. Before, there was nothing going on between them. Now I almost feel like the intruder."

Thirdly, it was stated that the way in which the therapist models an alliance formation with each of the individuals will have an influence on the capacity of the couple to strengthen relationship between themselves:

> "I guess how the therapist models that [individual alliance] with each of them can no doubt influence, and hopefully help them absorb something of that themselves as a couple."

4.5 Challenges to Establishment of the Working Alliance

Participants identified factors that create challenges to the formation of a therapeutic alliance. Certain personality types, they said, can be more challenging. These were referred to in a range of ways, including people with tenuous commitment to the couple

therapy, those unable to take responsibility for their part in the relationship conflict, those unable to relinquish control to the therapist, those with limited or absent capacity for empathy and those lacking emotional maturity. Therapists also used terminology such as avoidant and disorganised attachment styles and narcissistic personality to describe some aspects of these client presentations. In these cases, therapists said that the formation of an alliance can be very difficult, or, in some cases, it did not happen.

> “As a therapist, working with dismissive avoidant people is extremely difficult because that's what they do. Yeah. It's, you know, I guess the hardest people to work with.”

> “So just the guy stomped out. Yeah. He was very keen on things on, on, uh, being the director, on being the one who decided how this thing was going to go. He didn't like this idea that, um, I sat there and said, ‘Well, with couples it's always something coming from both sides.’ He didn't like that at all. He did not like even a suggestion that he may have a part of it.”

This was also the situation if the pair of clients were unable to settle and remained escalated and combative.

> “When you work with couples, there can be a mountain of blaming and shaming, that, you know, that's what you're battling with when they come in. And while that is there, I don't think the alliance is going to work very well.”

There was disagreement about how alcoholism might be handled. One therapist would work with alcoholics given they were currently in treatment or willing to participate in treatment, while other therapists were more inclined to say that they would not work with alcoholics (unless they were post-treatment and not using alcohol).

> “Yeah, I mean, I'll recommend rehab and all the things. Yeah. Um, but as long as they're committed to the therapy and to the, doing other stuff like that, maybe they're going to CADS as well as me or whatever. Fine.”

> “Alcoholism's the other one that's a real interferer of alliance. If somebody has, their alliance is with alcohol, not with us, not with us.”

The presence of a secret that would or could not be revealed in the therapy was seen to be a barrier to establishing therapeutic alliance. One participant gave the example of one of the clients in the couple having a long-term secret affair, while another example was the non-disclosure of a history of sexual abuse.

Imbalance in the Therapeutic Alliance

The significance of fairness and equity as a contributor to a therapeutic alliance with a couple has already been described. Imbalance is, therefore, of considerable concern to therapists who work with couples.

Interviews revealed a wide range of types of imbalance observed and managed by therapists in their work. They include an imbalance in their initial feelings towards each of the members of a couple, an imbalance in the therapy goals for each individual of the couple (described above), an imbalance in the propensity of each individual to participate in therapy, and an imbalance in the therapist's actual or perceived attention to one of the individuals in the couple.

> "So, I think balance is really important … because the risk is of seeing one person's side more than the other, isn't it? So, I'm sure we all have done that and can do that if we're not careful."

Therapist's alignment

It is a familiar experience for therapists to feel greater alignment to one or other of the partners at the beginning of couple therapy. Therapists might refer to a feeling of having more in common with one person, or a sense that they could 'be friends' with one more easily than the other, or a strong identification with or against a client's circumstances.

> "'Specially if it's, say a woman who's pregnant or a young mother. As a woman, I find it quite hard not to feel more towards that one."

> "Therapeutic alliance [is] more challenging with some people. I think so. And it's a challenge to get that alliance ... knowing this [person] is a harder one, but yeah, let's go for it. This is the job. This is the work. As a teacher [like I was], it's your job to love all of them, not pick and choose."

> "Sometimes I'll feel alliance with the person, maybe with um, the underdog, but I will often be conscious of that … and then I'll try and even it up as much as I can."

Therapists made use of their reflexivity when aiming to balance their responses to each client in the couple:

> "The kind of thing that triggers me is the alcoholic, I had an alcoholic father. Um, so that, you know, and I'm also can be very, um, critical about alcoholic speak. Their self-justifying and stuff like that. That will be a time when, but then I need to notice it in myself and go back to, well, why is that person? Like, why are they an alcoholic? What's underneath that?"

Therapists were also aware that feelings towards individuals can change during the therapy, and that both their initial reactions and the change can be an important source of information, including about the dynamics between the couple themselves.

> "I feel much more aligned with you [client 1], not really so sure about you [client 2]. But then, the more I engage with them, I am going to say, 'Geez, I can see why I didn't want to like you for a moment there, or for that time I didn't like you very much'. Um, and, and that's quite interesting information. Again, I don't know. I don't think it's all about them or all about me. I think there's weights and I don't know where the beginnings and the ends are."

Equity

Therapists referred to the importance of creating a sense of fairness for each partner, a kind of level playing field. Awareness of imbalances inclines therapists to work towards mitigation. This includes working harder with: the partner they found it harder to align with, the less-engaged individual of the couple, and/or the individual who was more likely to want to leave the relationship.

> "I find myself working hard, to try and understand the one that is more ambivalent. The one that's more ambivalent, the one that is more wanting to leave, Because, it's fairly simple to understand the one that wants to stay. Uh, and the one that wants to leave is often, uh, you know, grappling with, big stuff is leading them to that position. And so, if that can be understood and expressed, then there's at least the potential of mutual understanding increasing and therefore connection increasing."

> "For example, the person this morning (*indicates one end of the couch*) I could really feel, resonate, get where this person was at. Um, we have backgrounds that are much more similar, with this woman, um, … so the guy I was finding quite an enigma so, um, so it was very easy to side with her and so I was therefore intentionally throwing my time and energy into, trying to get him more on board. And of course, the advantage was too, that because I had a good rapport with her. Um, she could see I was doing that and that was, you know, she, she was good with that."

Perceived and actual imbalance

Therapists talked about perceived and actual imbalance in the alliance between each individual and the therapist. A perceived imbalance can be very threatening to the alliance. Some individuals can be very 'jealous' of attention.

> "I think it needs to be talked about in the room, you know brought as one of the issues that they need to be brave enough to bring in. Usually it'll be the other one that will say, well they said that you paid all the attention to me. But I know that I'm very careful not to, but there are some people who if you pay any attention to one, they feel, they feel abandoned. Those that are perhaps very, very young emotionally."

The way in which couples can behave like competitive siblings was noted by therapists, and the invitation to take sides or collude with one or other of the pair is familiar territory to them. They make sure to resist this invitation, maintaining a sense of equality:

> "I think sometimes as couples we can be like siblings. So, it kind of feels very 'little' and very sort of, um, competitive and but, I have to keep, I suppose that that emotional bond was strong enough for me to be able to say, 'Come on you two what's the story, somebody is not telling me the truth here. What's, what's, what's the deal?'"

> "And I had to really, be a, a stern mother in there with them. So, I didn't have, you know, I had to say, you know, 'cause they would argue and argue and argue and it would be, they'd be sort of screaming and, I'd have to say 'Stop, Stop.'"

Therapists sometimes have to face the expectation from the person in the couple who has been betrayed that the therapist would take their side.

> "I think it's quite hard. Um, with that, um, for the one who's been cheated on to see me not totally siding with them and just, I can side with the fact that, um, yep, this was a rotten thing to do and you are feeling very abandoned, rejected, and all of that, But, you know, let's look at why this might have happened and where we want to move on from there and that can be hard. They really want you to be just as cross as they are."

Personality style

Therapists particularly notice when the attachment styles of each partner conflict, leading to imbalances in the couple relationship; therapists are familiar with couples where one has avoidant and the other an ambivalent attachment style, or where one of the partners is a hyper-activated pursuer and the other a withdrawer. Variance in individual levels of emotional maturity between partners was also mentioned.

Dealing with imbalances

Imbalances can be dealt with in the therapy. As mentioned above, therapists work hard to create and maintain balance with each of the individuals of the couple. In one case, the 'necessity' of sometimes needing to focus on one of the individuals in the pair was managed through having established an alliance with the other person during an individual session at the beginning of the therapy.

> "It's just a single session with each one. Yeah. So that's mostly on the face of it, information gathering. Um, but it does it enable that person to speak in a way that's uncensored because they're not concerned about how their partner is going to take what they say. And so, they often able to be more frank, than they have been together. Um, and so I think it does help then, you know, if the going

> gets hard or I'm working with one person, um, taking more time with one person, that the other one's got a basic sense of, you know, we've, we've talked and that I am on their side as well."

In other circumstances, scrupulous attention might be given to exactly how much time each of the partners would be the focus of each session. Arranging for individual sessions with one or both during the therapy and/or for on-going individual therapy for one or both partners are other strategies used to deal with imbalances.

Early Termination and Rupture

Participants find it difficult to really know what might have resulted in early termination or non-return to therapy. In many cases, the reasons are unknown:

> "Part of the difficulty is, how much feedback do you get [about terminations]? Because I suspect a couple that is not happy probably just leaves and doesn't say anything. Actually, you never know when that's happened."

> "None of us do [retain all clients]. So, there we go. Right. Yeah. People leave, people don't turn up, they will get distracted, you know, all these sorts of things, they just don't like, you know, they don't like us. For some reason you, they might, I might remind him of his dad who beat him up."

A participant had contacted some non-returning couples for feedback. However, even the therapist was not sure of the reliability of what he was told, and what might have been said to 'save his feelings'.

Therapists are generally aware that certain types of client are more likely to trigger emotions relevant to their personal history. In many cases, this awareness is used to inform themselves about the case at hand. Feelings they might notice in these circumstances included dislike, discomfort, failure of empathy, intrusive critical thoughts and judgements. With experience, therapists commented that they have become more attuned both to their blind spots and to the information that might be derived from these feelings:

> "I always felt I was wearing all the wrong clothes and I just looked like something the cat had dragged in and, mmm … just so, I mean, I, I, yeah, it's a familiar [feeling]. You know, like, I know who I'm with when I start to feel that in particular."

> "I think watching my own blind spots is really important. Having [a supervisor] is really important for me just to keep, the balancing and, my own therapy group. Uh, you know, all of that's really important. Maintaining, um, my own blind spots. Not maintaining them, but un-blinding."

Some therapists make use of therapy and supervision to process these responses and allow themselves the opportunity to develop therapeutic alliances. Other therapists may

not use these resources and supports, and this may pose a barrier to alliance formation.

Participants described occasional situations when one or other of the couple have abruptly left the therapy room, or where couples did not return after a significant rupture. These terminations were attributed to both therapist characteristics and client characteristics, often the combination of the two. Therapists generally take responsibility for their mistakes and the fact that these can sometimes result in early termination. Some terminations occurred when therapists found themselves responding to, rather than containing, their negative countertransference responses.

> "… people who replicate one of my parents. Um, I certainly found myself having difficulty being patient with. … Yeah, my tolerance for that personality um, was very challenged, I probably lost quite a few couples that way."

> "He became extremely abusive to her [in the session] and I found myself saying something that I shouldn't have said is, "Shut the fuck up." Something like that. You know, I got angry with it. Yeah. I didn't hold my, demeanour, but I just got angry and um, after lots of times saying to him, you know, 'Can, you know, can you, can you, um, can, can, … can you just calm down and talk to her with respect, in a respectful way?' And he just fired up and it'd be extremely abusive. Anyway, um, after that session, he didn't come back."

Therapists also described terminations to the therapeutic alliance caused by misjudgements about the therapy. Generally, they said they were going too fast, too soon in the therapy. Being confronting with a client without having first established rapport may also lead to termination.

> "My own, um, that's my own, um, countertransference, if you want to call it that, getting evoked you know, I kind of, yeah. I got, I get onto things straight away, so deal with them [too quickly]."

> "Well I have certainly had the odd situation not for some years now, where one of them has got up and walked out. But that's usually been when basically I'd be too, um, pushy with one of them and not gone slowly enough with that individual."

> "There was a couple who, I had seen the man beforehand and there was an issue that was getting in between them and then she came and, I definitely didn't establish an alliance with her because I said something that totally enraged her. So, they never came back."

Therapists' experience of unexpected terminations of couple therapy varies considerably. The quote below demonstrates how deeply this can be felt as a loss of confidence:

> “Losing the alliance, or them thinking, you know, what perhaps I feel might be going on for them. It's like ‘She, she doesn't know what she's talking about. She's useless. What are we even doing here?’ That is quite, um, that threatens my sense of, um, what's the word? … threatens my sense of, uh, I don't want to say potency. It's not quite that strong. My sense of confidence. Um, probably my sense of self actually in that moment.”

Alternatively, therapists may see this as ‘just the way things are in therapy’:

> “I do get people sometimes come and say, and I'm sure, look, when I say this, my clients, I'm sure the failures of mine go to other therapists and say I went to that [therapist’s own name] and he's no good, right. That will happen and people come to me and they say that too you know. So, it goes both ways.”

A therapist perceived that couple clients are inclined to terminate after they start to feel a little bit better and, consequently, felt that it is difficult to really achieve significant change and long-term therapy with couples. Interestingly, this therapist had less couple-specific training and did not apply a process or therapeutic strategy with couples, opting for something more fluid. The relative frequency of terminations referred to raises questions about whether a therapeutic alliance was sufficiently established in these cases.

> “I do find the couples, it's hard for them to commit to therapy and they do want a quick fix and, you know, there's a lot of pressure. I feel unconscious pressure as a therapist to do a lot. And um, also, as soon as they feel the tiny, I'm talking generally here. As soon as they feel just a little bit better or they think something's improved, they, they quite often will stop coming. … I think I do find with couples it's hard to really do any real deeper change because they often want to go, you know, they won't, they don’t want to stay, in the therapy.”

Difficult countertransference responses can create barriers to establishment of alliance, some of which is described above. More is detailed in the following section.

4.6 Therapists' Experiences of Self

Some parts of the therapist's experience of self have already been detailed in this chapter. What is detailed below are those experiences that have not been described above.

Becoming a Couple Therapist

As mentioned in the method section, the participants in this research are all graduates of the AUT psychotherapy programme, which focuses on training for individual therapies. Each of the therapists subsequently included couple work as part of their private practice. This group of therapists came into couple work seemingly more by chance than intention. As private practitioners, their couple clients had presented themselves and asked for appointments. Some participants mentioned a sense that becoming a couple therapist was a kind of natural progression.

> "I was being asked to work with couples by couples. Um, a lot. I saw it as an interesting challenge."

> "I didn't have couples at first, but they just started coming. Well, I was in private practice. I mean, I worked in an agency and I might've seen the odd couple there. It doesn't stand out in my mind though. But when I started in private practice, I got a phone call to see a couple and I thought, 'Right, well, this is it. Either I'm going to do it or I'm not going to do it.' So, I thought, 'Well, I'll do it.'"

The idea that the therapist had to face into some personal challenges, including fear, is also a part of how participants reflected on their journey into couple therapy. Some of these challenges had been addressed through training and supervision, and other challenges of the work had eased as experience in working with couples increased.

> "I didn't start off seeing couples initially. I was scared of couples. … Um, I think my own history that my parents divorced. I think there was a bit of just [low] confidence ... maybe. You haven't done it at AUT [either]."

> "So, I have certainly looked around [at lots of training]. Yeah. The fact that I was looking at some of the approaches probably tells you that I was feeling somewhat lost and, and not confident and yeah, finding couples difficult."

> "I had to work very, very closely with my supervisor as I said because I wasn't confident about that couples work in the beginning. But, um, I did find that really cool and um, I ended up doing the Gottman courses, both of them. So, level one and level two."

Reflexivity

Self-awareness and the capacity to reflect are characteristics referred to and/or demonstrated by therapists which support them in navigating and building working

alliances with couples; their capacity to reflect on their own process was inherent to their ways of responding to the questions and pondering on their own experience of establishing alliance with couples:

> "You have to really be watching your own mind and not be critical and just keep your empathy really alive and to be walking with that other person."

> "We just know that, you know, what we feel. As I said in the beginning, I work so much with how I'm feeling, and try and understand it."

> "I think the main thing is, with a lot of this stuff, is to notice it then, be able to keep it in mind to see how that unfolds and what it might mean."

> "… to influence the atmosphere of the room and to harness the fact that, you know, the fact they are so bloody desperate yeah, and to create a calm. Yeah. Stan Tatkin says that the ability of the couple therapist depends entirely upon his or her ability to stay in that calm, central kind of presence themselves, and I think he is right."

A participant described sometimes not taking couple clients, depending on her emotional state at the time:

> "[Sometimes] I decline to see couples because I don't feel in that space where I want to see couples. So, I'm very much go by how I am feeling."

Felt Sense of Alliance Formation

Participants referred to their awareness of the feeling in the room or their own personal feelings as a gauge of the state of therapeutic alliance:

> "I think [alliance], um, definitely comes from the right side of the brain."

> "I think [alliance is], how can you, how, how relatable is it in the room?"

> "I know when there's an emotional bond. I don't form one with everybody and I can tell that too. And, and maybe they're the ones that don't, and I, I don't gel. You know, and that happens sometimes, occasionally."

Another measure of the quality of therapeutic alliance could be the degree to which the therapist could challenge or confront the client(s) or the degree to which they could be playful.

> "That really Winnicottian idea of playful. It's, I think a big part of the way I form an alliance. You know, and as you go along, we get our own jokes, you know, our own references, to things. And then they will start to pick that up and banter with it. And that, that can make a huge difference, you know."

Countertransference

Much of the positive countertransference material is covered in the section on therapeutic stance above and includes the many feelings and experiences described there, for example, parental feelings, warmth, compassion and empathy and holding hope.

As mentioned above, reflexivity is an element of the couple therapist's way of being which helps to deliver the qualities of safety, equity and containment. When a therapist has a difficult countertransference response at the outset of therapy, the evidence indicates they are likely to consider their reaction in relation to their own personal history and psychic material:

> "[Experience of] a fairly difficult parent, for me, so when I, when one person in a couple is behaving in that way. That comes across as totally unreasonable. My judgemental slide comes up and I feel like telling them to fuck off. Yeah. So, I have to be really, try to be aware of that."

> "My Father is quite narcissistic and, I'm sort of a bit nervous about sort of deferring with them, with the men in these hetero couples."

Therapists saw their role as to maintain their demeanour and/or tolerate their difficult responses to clients, even when they were very uncomfortable.

> "Very rarely would I look away. It's what I do. It's 50 minutes, it's an hour, an hour. Afterward, sometimes I feel like I want to scrape that shit off my back."

> "[When a couple does not stay together] that's excruciating. Yeah. So, I definitely feel that. So, some couple sessions I go out, sweating and exhausted."

Therapists can be aware of both the conscious and unconscious implications of their difficult countertransference responses and their potential to impact on the therapeutic alliance:

> "It's noticing it in yourself. When I am thinking, 'Oh, huh, you know, your poor wife!'. When I start feeling that, I am sure something breaks, you know. Because, I think unconscious speaks to other unconscious way louder. And I think the alliance has also got a strong unconscious part of it, as well as whatever I'm saying or doing."

In some cases, therapists acknowledged that their countertransference responses could result in poor alliance formation, rupture or even premature termination of the therapy, as described in section 4.5, above:

> “Because I know early on in this work, if I found a critical thought coming into my head, and especially about the man being male, ‘Oh God what an arse,’ or something like that in my head, um, it's like big scissors descended out of the sky and went snip, with my relationship with them.”

> “My tolerance for that [narcissistic] personality, um, was very challenged. I probably lost quite a few couples that way.”

Therapists valued the information that is provided to them via their countertransference responses.

> “That [negative countertransference] often happens. But I, I um, I, I always think what, what's your problem [own name]? With that. I like what's, what, what is it, what is it about you that's judging them? But then I might get some useful information.”

The types of information that might be gained were in sensing what might not be spoken between the couple, a certain dynamic or character style.

A therapist talked about guarding her own sense of physical safety; although this was not something she remembered in her experience with couples, she was clear that if she felt physically unsafe, she would refer clients elsewhere.

Personal Relationship, Therapy and Couple Therapy

Some therapists commented that having participated in their own couple therapy, and/or personal therapy is useful input to their approach to working with couples in the capacity to know how it felt to be on the other side of the alliance. Making use of personal experience in relationship(s) was also influential:

> “I draw a lot on, on my own experience with my clients. I don't, it's not like my experience equals their experience, but that's sort of like, ‘Yeah, I have got a sense of something of that.’”

> “Being together in a house and doing all the jobs are necessary, but they're not necessarily relational. You know? Yeah. And we all know that from past relationships. So, I'm using personal experience.”

One participant talked about using attachment information in the therapy with a couple. Revealing that their own attachment style was anxious and their partner’s ambivalent, the therapist said that the clients’ styles were the same, and that, although this is a difficult and often failing combination, a successful relationship (such as the therapist’s) could be achieved. The therapist was unsure about how this might impact on the couple; however, ultimately the outcome was that the client couple increased their commitment to their relationship. The therapist also reflected that the quality of the

therapeutic alliance with this couple allowed taking a self-disclosure ‘risk’ in the therapy, which meant the therapist’s own vulnerability was visible to the clients.

4.7 Summary

In this chapter, I described how therapists experience the establishment of the therapeutic alliance with couples. I have detailed how the information provided by therapists might contribute to a better understanding of the definition of therapeutic alliance with couples. How therapists establish alliance and their experience of challenges to and early termination of therapy have been described, as have the therapists’ experience of imbalances in alliance with couples. In the next chapter, I discuss the implications of the data and link this back to the literature reviewed in Chapter 2.

CHAPTER 5. DISCUSSION

5.1 Research Intent

In this research, I set out to explore the therapist's experience of the establishment or non-establishment of the therapeutic alliance with couples. I had identified a gap in qualitative research, there was little exploring the therapist's understandings and perspectives. Much of the published research focuses on measurement and statistical analysis, and much is based on the experiences of the couple. I addressed this gap through adopting IPA as a methodology and undertaking five in-depth interviews with experienced therapists who work with couples. My initial question was: what is the experience of therapists in establishing or not establishing a therapeutic alliance with couples? Given the various ideas about splits in alliance described as gap four, I also aimed to address a sub-question: what is the therapist's experience of imbalance in establishing alliance with couples?

5.2 Definition of Therapeutic Alliance with Couples

Along the way, it became evident there was not a clear definition of therapeutic alliance in couple therapy that could be agreed on by writers and researchers in the sphere, and nor was there an agreed definition among the research participants. In some ways, this put a spanner in the works, as therapists' experiences and interview content could not be tethered to a consistent concept of alliance. Nevertheless, this also delivered some interesting data and gave me the opportunity to reflect on how the participating therapists' ideas about alliance might provide input to thinking about the definition of alliance in couple therapy. My findings support those of Friedlander et al. (2006), Krause et al. (2011) and L. N. Johnson et al. (2019), in that the therapeutic alliance in couple therapy is not the same as in individual therapy, although there may be overlaps. It seems the dynamics between three people and the therapeutic focus on the couple's relationship, which is often in crisis, necessitate a different way of conceiving of therapeutic alliance in work with couples.

In the literature, I found definitions of therapeutic alliance for individual therapies included Bordin's (1979a) three constructs, agreement on tasks and goals and establishment of an emotional bond. I also noticed definitions that incorporated elements of the therapist's stance (Rogers, 1957) and the function (Clarkson, 1990, 2003) or work of therapy itself. My findings support the relevance of all these elements in the work of establishing an alliance with a couple; all of them could be further evaluated. However, as per Rober (2015), agreement on goals seems less of an initial

focus for couple therapists; the outcomes for the relationship are often uncertain at the commencement of therapy. Goals for the therapy process, however, may be a focus.

Couple therapists participating in this research actively work to establish alliance with their clients. Balance in the relationship between the therapist and each of the participating individuals is part of what therapists believe to be fundamental to creating the right environment for the work of therapy; more is said below.

The therapists interviewed had a common training background as individual therapists, but their journeys had led them through different trainings as couple therapists. The data indicate that the alliance is a common factor of couple therapy (as per Fife et al. (2019); Karam et al. (2015) and Lebow (2014a)); establishing alliance is necessary to the work of therapy regardless of theoretical orientation or model. Nevertheless, delivering a process provides containment for a couple. Process might be based on theory, models and/or the practitioner's bringing together of various sources of knowledge and experience of couple therapy. This research finds containment substantially contributes to establishing alliance, and more is said on this point below.

5.3 Therapists' Experience of Establishing Therapeutic Alliance with Couples and Challenges to Forming Alliance.

The gap I initially intended to address in this research was the therapist's experience of establishing or not establishing therapeutic alliance with couples.

Providing emotional and experiential safety, containment and equity to couples in therapy are primary elements of the therapists' experience of establishing alliance with couples. The choice to add safety to the alliance measures included in the SOFTA (Friedlander et al., 2006) is therefore supported in this research.

Therapists achieve safety, equity and containment through a combination of therapeutic stance and therapy process. While the term process includes elements of Bordin's (1979a) tasks and goals, it is broader, in that it involves the active engagement between the three participants of couple therapy in what can be narrowly referred to as tasks but might more accurately be termed engagements. Although therapists have their own processes, and different training and approaches to couple therapy, the sense of structure provided by a transparent process is demonstrated to provide containment, safety and equity for the couple. There is also the suggestion from the data that lack of process may also correlate with early termination, with

possible implications for deficits in alliance establishment. Therapists also said that, particularly at the outset of their work with couples, they sought means of safety and containment for themselves in this work through training, supervision, their own experiences in relationship and personal therapy.

In line with MacCormack's (1998) findings, therapists in this research engage emotionally with their couple clients, and this is demonstrated in a range of positive countertransference responses. Therapists also commented on their capacity to set the emotional context which will facilitate the clients' safe explorations of their underlying emotional states.

As per Blow et al. (2009), external factors are acknowledged to have an influence on alliance formation. Therapists also mentioned unconscious material and secrets between the couple as potential challenges. Active addiction is sometimes seen as counter to establishing alliance.

Similar to the findings of A. G. Smith (2008) and Schaafsma (2006), the formation of an alliance is not seen as a given by therapists in this research, but actively established as it is suggested to be important in couple therapy by R. Porter and Ketring (2011). Therapists observed that going too quickly in therapy and challenging clients without the safety of an established alliance potentially leads to rupture and early termination, as is indicated by Escudero and Friedlander (2017). Challenges to the formation of an alliance also include specific presentations, both in respect of the presenting issues of the couple and personality types, and the ways in which these might trigger the therapist's personal material. Therapists find that clients with a tenuous commitment to therapy, a lack of capacity to relinquish control to the therapist and refusal to take responsibility for their part in relationship difficulties were particularly challenging to alliance formation. They have a range of ways of addressing these difficulties.

This research finds that the therapists' experiences of self in working with couples can be profound, and sometimes very difficult, and that, in general, therapists use reflexivity, therapy and supervision to engage with these experiences to the benefit of the therapy; this includes deepening their understanding of what might be happening for the couple and interpreting their experiences as valuable information. Therapists commented that their capacity to be with, contain and manage the conflict between the couple is a core skill and that emotional self-regulation is central to this, referencing scientific evidence, for example, that their own physiological calmness promotes calmness in clients.

5.4 Therapists' Experiences of Imbalances in Alliance

A gap in understanding about alliance with couples that fascinated me from the start of this project concerns imbalance in the relationship triangle.

Therapists experience imbalances as the ordinary work of alliance establishment with couples. Therapists notice imbalance between the couple, and imbalance in their personal responses to both individuals in the couple. Imbalances can be potentially challenging to forming alliance but are generally experienced as familiar territory in couple work; as something to be navigated. This finding aligns with the views of Horvath et al. (2010). As per Blow et al. (2009) and Rober (2015), the therapists in this research consciously work to engage the more ambivalent individual in the couple, or the one with whom they feel less immediate personal alignment. This may also be the individual more likely to influence whether the couple stays in therapy. Therapists also note that their personal sense of alliance may change over time, and that this may signify an important part of the work of the therapy. Therapists distinguish between actual and perceived imbalances, aware that couples can behave like competitive siblings. Therapists act to establish the perception of equity in these circumstances, as well as interpreting this dynamic as valuable information for the therapy.

5.5 Relationship Dynamics in Couple Therapy

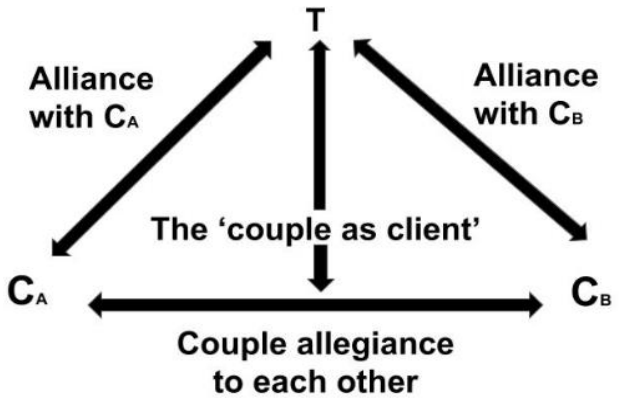


Figure 3. The Therapeutic Alliance in Couple Therapy (reproduced from section 4.4 to facilitate the discussion).

Despite some under-enthusiasm from participants, their overall responses indicated that Figure 3, reproduced above, holds representational value, as, although simple, it encompasses all the dynamics of alliance formation in working with couples. Consequently, couple therapists must be prepared to be in receipt of considerably

more information in couple therapy than in a one-on-one context, and this may result in complex countertransference responses. Because of the multiple dynamics, this has the potential to be overwhelming. If therapists can reflect on the possible sources of countertransference and how their own psychic material plays a part, this diagram provides a framework whereby these experiences might be located and thought about, to the benefit of the therapy.

The weaknesses of Figure 3 lie in its static portrayal; the use of an equilateral triangle and solid lines which give the appearance of something fixed. Based on the participants' descriptions, capturing the therapist's experience of establishing (and working with) alliance in the couple therapy journey needs something more dynamic. The imbalance(s) that can occur at the outset of therapy, the balance sought by therapists to do the work of therapy and the sense of exclusion from the couple relationship the therapist may feel at the end of the therapy might be better represented by a triangle that changes shape as the therapy progresses, and the thinning and thickening of bonds between the participants over time. In practice, these dynamics are not linear; there may be many variations in the shape of the relationship triangles through the therapy.

This research indicates that each alliance has the potential to rupture couple therapy and/or move it forward. The workings of the various alliances are therefore pivotal in the therapy process. This reinforces the significance of therapeutic alliance as a function of therapy (as described in Clarkson 1990, 2003).

5.6 Therapists as Research Subjects

Another gap in the literature is addressed by this research in that the therapist, rather than the couple, is the research subject. A focus on therapists as research subjects when trying to understand therapeutic alliance formation with couples proves valuable. Therapists contribute perspective on what it is like to build alliance with a couple that those couples who are clients in therapy cannot. Therapists understand the need for equity and the issues associated with variance of goals that clients may be less attuned to, because they are working from their own, singular and individual perspective and are typically *in* conflict. This variance in goals or imbalance at the onset of the therapy, it seems, is held or mitigated in the therapists' attention to both stance and process. Stance and process contain the ambiguity and conflict which, although they may be internalised in the dynamics of individual therapies, are often externalised in the dynamics of couple therapies and potentially stand in the way of progression in the therapy from the outset. This research demonstrates that therapists' deliver safety,

equity and containment for both individuals in the couple through their stance and process. This containment of their differences, rather than a focus on common goals, contributes substantially to building alliance with couples.

5.7 Implications for Training and Practice

This research supports the notion of distinguishing the experiences of couple and individual therapists, and the ways they establish therapeutic alliance.

Table 7, below, provides a summary of Do's and Don'ts which may assist training and beginning couple therapists in navigating their early experiences with couple clients. Given the limits of this research, the table is intended as a starting point on which others might build.

Table 7

The Do's and Don'ts of Establishing Therapeutic Alliance in Couple Therapy

Do	Don't
Actively work to establish alliance as a primary task of therapy.	Expect to establish alliance with all couples. Those presentations that are most challenging to work with in individual therapies may be unable to form therapeutic alliance as part of a couple where the dynamics are significantly more complex. If they are willing, refer these clients to individual therapy.
Think about how your stance in the therapy enacts the qualities of safety, equity and containment. Work to establish a sense of emotional and experiential safety for clients.	Expect the therapeutic alliance in a couple therapy to be or feel like the alliance you form with clients in individual therapy.
Be willing to explore the goals of the therapy (rather than the relationship) with clients, including what they might gain individually.	Focus too much on the goals of the couple relationship, unless this is clear at the outset.
Make use of the imbalances in the alliance in couple work to deepen your understanding of the dynamics in the triad.	Imagine that there will be a relatively stable balance in the relationships in the therapeutic triad. The shapes of the therapeutic triangle vary over time in couple therapy and this is normal to the process. At the end of the therapy you, as the therapist, may feel a sense of exclusion.

Do	Don't
Be aware of your own level of emotional regulation, aiming to maintain your emotional equilibrium.	Be surprised that you may experience some deep and difficult emotional responses, including considerable self-doubt. One way of interpreting this countertransference might be to see it as a reflection of the uncertainty in the couple relationship.
Expect to experience strong countertransference responses. Knowledge of your own material and the ability to interpret your countertransference will underpin your capacity to interpret the relationship dynamics in the triad.	Undertake the work of couple therapy without professional supervision and/or personal therapy. Expert couple therapists continue to use these resources to maintain their effectiveness and equilibrium in couple work.
Adopt a process to facilitate both the sense of containment for the couple, and a structure which contains the therapy. This will also provide containment for you in your role as therapist and improve your capacity to tolerate conflict in the work, as much as it helps to contain the conflict between the couple.	Take a rigid approach to couple therapy. One size does not fit all. Even with a good underlying process, be prepared to adapt to circumstances.
Feel confident that engaging with the more ambivalent participant in couple therapy, or the one you feel less natural affiliation to, is an accepted strategy and that a priority on establishing alliance with this individual may have a positive impact on retention.	Take on too many couple clients early in your work as a therapist. The skill set and challenges are different and need time to develop.

5.8 Study Strengths

The strengths of this study include the application of a qualitative method and in-depth, personal engagement with a relatively homogenous group of therapists. As well as providing some useful information about the couple therapist's experience of establishing alliance, the research has provided some stimulating ideas about the potential for a redefinition of therapeutic alliance which is specific to couple therapy. The analysis is founded on a thorough review of the literature, and many of the findings resonate with the ideas of other writers and researchers in the sphere.

5.9 Study Limitations

Although it was not my intention at the outset, this research to some extent skims the surface of wide-ranging issues and questions about the establishment of therapeutic alliance with couples. The sample is specific to a New Zealand Pākehā context and findings cannot be generalised to the numerous other cultures and populations represented in Aotearoa New Zealand or abroad.

This research did not investigate alliance formation and variance in couples presenting for therapy; discussions were generalised and can be assumed to refer to neuro-typical, Pākehā, heterosexual couples, even though some of the therapists had worked with same-sex couples, with individuals or couples who are not neuro-typical and with couples where one or other were tangata whenua, tauiwi (immigrants) or from other kinds of minority groups in New Zealand. From what was said in this research, there was an indication that therapists may feel more comfortable in their experience of alliance with couples or individuals in couples with whom they feel a connection, and this was sometimes equated with a sense of 'sameness'. There is plenty of opportunity for further research to understand the nuances of alliance formation and the significance of difference in the therapeutic triad.

While the project produced useful data, my engagement with the therapists was limited by what could be captured in a single interview, lasting a little more than an hour. I found a great deal of value in the data of these interviews, including that participants appeared to be processing their experiences and ideas at the time, rather than reporting on prior reflections. However, meetings with them caused me to wonder what else I might have discovered had I adopted a different approach. This is discussed below.

5.10 Implications for Further Research

The possibilities for further research in this sphere are numerous. I believe, given the findings, that there is good reason to continue to work with therapists as research subjects and to adopt qualitative research approaches in future. The definition and the establishment of therapeutic alliance are complex, whether in individual or conjoint therapies. The opportunity is to deepen our understanding of the concepts and the interplay between the concepts, rather than to solely focus on separating and measuring variables that cannot easily be distinguished or delineated. Qualitative research with both therapists and clients will be important. Researchers should be mindful that clients' experiences are specific and individual and the concepts around

therapeutic alliance complex and diverse. Therapists provide a rich source of expertise and knowledge based on their daily experience of all aspects of therapeutic alliance and there remains a great deal to learn from them. Careful attention to homogeneity in samples, large or small, and particularly when clients are research subjects, will be key to the quality of the findings in future research. When there are so many variables to consider, limiting variance in sample populations where possible seems sensible.

This research provides interesting and relevant data. Yet, if I undertook this study again, I would focus on definition as a primary aim. Until we can really capture and conceptualise therapeutic alliance for couple therapy, research on its experience in the therapy may be somewhat hobbled.

If I were to design this research again, having the benefit of hindsight, I would undertake individual interviews and also aim to capture more of the therapist's on-going reflections. This might provide the opportunity to deepen an understanding of the establishment of therapeutic alliance (or a definition of alliance) in couple therapy. The analysis would benefit from the therapist's deeper reflections over time. To achieve this, I would undertake an initial interview with therapists, ask them to diarise their thoughts and experiences over a week or ten days, and then conduct a follow-up interview.

5.11 Concluding Thoughts

Writing this dissertation has been an important part of my journey as a couple therapist. There have been moments where I doubted my capacities to work with couples, and times when my desire to work with couples has waned. Individual therapy can be messy, and with couples that messiness is manifold. However, through perseverance arises clarity. I have wrapped my head around some challenging concepts in this research and I have met couple therapists who, between them, have provided the collegial reassurance, guidance and expertise that have helped me to know what to expect in establishing couple therapy and how to navigate the therapy course. I hope it might be the same for readers.

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Appendices

Appendix A: Ethics Approval Letter

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

14 May 2019

Garjana Kosanke
Faculty of Health and Environmental Sciences

Dear Garjana

Ethics Application: 19/117 **The couple therapists' experience of establishment or non-establishment of the therapeutic alliance**

I wish to advise you that the Auckland University of Technology Ethics Committee (AUTEC) has **approved** your ethics application at its meeting of 29 April 2019.

This approval is for three years, expiring 29 April 2022.

Non-Standard Conditions of Approval

1. The Applicant must store the data, not the primary researcher;
2. If interviews are to occur in private residences, please prepare a Researcher Safety Protocol in advance;
3. In the Information Sheet please make it clear that the therapists should discuss the particulars of client in way that will not reveal their identity

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/research/researchethics.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/researchethics.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: ;helencreagh@outlook.com

Appendix B: Tools

a) Question Schedule

Final Question Schedule:

Explain to participant:
This interview contains five parts. The first part is to get some background information about you and your work with couples. The second part is about the definition of therapeutic alliance. Thirdly, I am going to ask you about what challenges you face and what enablers you experience in establishing a therapeutic alliance with couples and I will ask if you have a case material to elaborate on these. Then I am going to show you a diagram and ask you for your thoughts about this as a way of representing the therapeutic alliance and finally ask you about your experience of imbalance in the therapeutic alliance.

1. Background/warmup

Information about the practitioner

- Length of time in practice
- How long working with couples
- Why started working with couples
- Theoretical orientation (if any)
- Training
- Models (if any)
- Assessment process (if any)
- Any other information they would like to add

2. Definition of Therapeutic Alliance

In the information sheet you were provided a definition of the term therapeutic alliance. How do you understand the term therapeutic alliance for therapy with couples?

Show the definition developed by Bordin:

Bordin (1979a) defines the therapeutic alliance as having three elements; developing an emotional bond, agreement on the tasks of treatment, and shared vision of goals and outcomes.

What are your perspectives on this definition when working with couples?

Petruska Clarkson (2003) sees the therapeutic alliance as:

The working alliance is the part of the client-psychotherapist relationship that enables the client and the therapist to work together even when either or both of them do not want to

Ensure as far as possible, a clear understanding of the therapist's definition of therapeutic alliance with couples for use in the remainder of the interview.

3. Establishment and non-establishment of the Therapeutic Alliance

What is your experience of establishing a therapeutic alliance with couples, for instance what enables the alliance to form?

- Probe, if necessary, to cover elements of the agreed definition, for example emotional bond, tasks of therapy and goals of treatment.
- Ask for an example from clinical practice (remind the participant not to reveal identities).

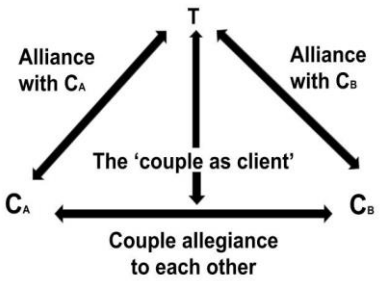
What is your experience of *not* establishing a therapeutic alliance with couples, for example, what are the challenges to forming an alliance?

- Probe, if necessary, to cover elements of the agreed definition, for example emotional bond, tasks of therapy and goals of treatment.
- Ask for an example from clinical practice (remind the participant not to reveal identities)

4. The Therapeutic Alliance Diagram

Show the following diagram:

Figure One: The Therapeutic Alliance in Couple Therapy



T = Therapist C_A = Client A in couple C_B = Client B in couple

What are your reflections on this way of representing the therapeutic alliance when working with couples?

5. Imbalances in the Therapeutic Alliance

How would you define an imbalance in the therapeutic alliance when working with couples? (If necessary offer the following definition – When the therapeutic alliance on one or more of the axes within the triad is out of proportion and/or alignment with the other axes.)

Referring to Figure One and considering each of the axes of alliance: What has been your experience of imbalance in establishing the therapeutic alliance with couples (if suitable, ask for case material).

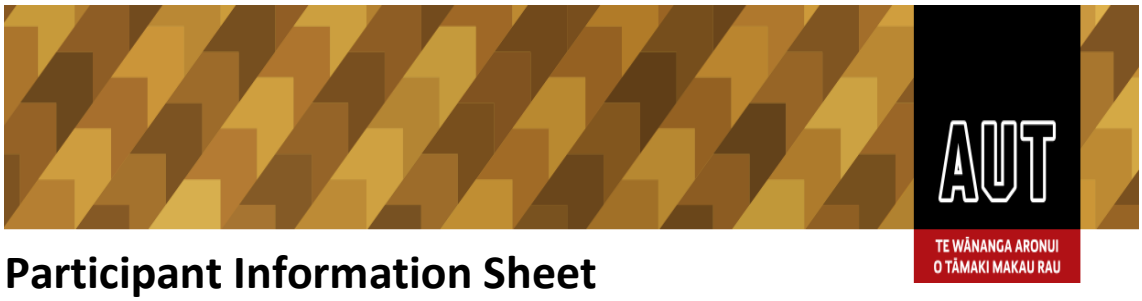
- What has been your experience of restoring or repairing the balance?
- What has been your experience of failing to restore the balance?
- What have been the implications of this for outcomes in the therapy?

Final Comments

Is there any part of your experience of therapeutic alliance as a couple therapist that has not been covered, but which you would like to comment on?
Are there any questions you would like to ask me about the research?

Thanks and closing.

b) Participant Information Sheet



Participant Information Sheet

Date Information Sheet Produced:

28 May 2019

Project Title

Couple Therapists' Experience of Establishment or Non-establishment of the Therapeutic Alliance

An Invitation

Kia Ora,

My name is Helen, I am a psychotherapist and I would appreciate your participation in a research interview exploring your experiences of the therapeutic alliance when working with couples. The interview takes up to 90 minutes and would be conducted at a time and place convenient for you.

What is the purpose of this research?

The research will be used to expand our knowledge of the therapeutic alliance when working with couples, as there is relatively little available information, particularly from the perspective of the therapist's experience. The research will allow me to complete a dissertation in partial fulfilment of the requirements of a Master of Psychotherapy degree. The findings may also be used for other academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You have been invited to take part in this research based on information published on the internet, which had identified that you are registered with PBANZ and currently working as a couple therapist.

How do I agree to participate in this research?

You may respond to me by email, at helencreagh@outlook.com to express interest in participating or to ask me any questions before you decide. I will ask you to confirm that you meet the criteria for participation, including that you are trained in psychodynamic therapy, have been in practice for at least 3 years, are registered with PBANZ and work with couples.

Once this has been established, you will be sent a copy of the consent form, and a hard copy will be provided for you to sign at the time of the interview.

Your participation in this research is voluntary (it is your choice) and whether you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

First, we will arrange a time and a place, that suits you, for us to meet. Before the interview begins you will have the chance to ask questions and to sign the consent form. We will discuss your rights as a participant, including the right to withdraw from the research and/or not to answer any question

and that you can stop the interview at any time. Then, with your agreement, I will ask you a series of questions about your experience of establishment of therapeutic alliance with couples, including asking for examples from your practice and ultimately on your experience of imbalance in the therapeutic alliance. A week or two after the interview I will recontact you to ask you for any further thoughts you have on the topic, and to offer the chance for questions.

We may refer to the following definition of the therapeutic alliance, and you will have the opportunity to use your own definition or to make clarifications to definitions as part of the interview.

Bordin (1979b) defines the therapeutic alliance as having three elements; developing an emotional bond, agreement on the tasks of treatment, and shared vision of goals and outcomes.

The interview will be recorded and then analysed using Interpretive Phenomenological Analysis (IPA). You will have the opportunity to review the transcript of your interview before it is analysed and to receive a summary of findings at the end of the research.

What are the benefits?

The research will be used to complete a dissertation towards completion of a Master of Psychotherapy degree. The information gathered is expected to make a contribution to the psychotherapy community in understanding of the therapeutic alliance in couple therapy

For you, there may not be much benefit, although it will be an opportunity to reflect on and contribute your experiences of the therapeutic alliance in working with couples.

How will my privacy be protected?

The information you provide will be recorded. During the interview, you will be asked to reflect on your own experiences with illustrations from your own case material. You will be asked to speak about cases only in ways that do not identify individuals concerned.

In the process of transcription, any identifying information will be removed. Only the researcher and supervisor will know who the research respondents are. No identifying information will be included in the analysis or the write up of the research. Nevertheless, the psychotherapy community is small and there is a possibility that verbatim material included in the dissertation, even though it is not attributed to you directly, could be identified by someone who knows you very well. For this reason, you will have the opportunity to review and edit the interview transcript before it is included in the analysis.

What are the discomforts and risks?

I anticipate very little possibility of discomfort or risk.

During the interview I will be asking you to provide illustrations from to your own case material.

There is also the small possibility that you may find your response to the interview raises concerns around your practice or personal experience.

How will these discomforts and risks be alleviated?

I will be asking you to speak about your cases in a way that is non-identifying and serves only to illuminate your experiences in practice.

You have the right to stop the interview, to refuse to answer any question or questions or to withdraw from the study.

You will have the contact information for both me and my supervisor, if you have any need to discuss any aspect of the research.

What are the costs of participating in this research?

The research will require up to 90 minutes of your time.

The researcher acknowledges that the participant's time is valuable and that this represents an opportunity cost when considered against the income that would ordinarily be generated in clinical practice.

What opportunity do I have to consider this invitation?

I would appreciate your response within two weeks of receiving this invitation.

Will I receive feedback on the results of this research?

Yes, if you would like to receive a summary of findings, this will be provided.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Garjana Kosanke, Lecturer, Department of Psychotherapy, AUT, garjana.kosanke@aut.ac.nz

09 921 9999 Ext 8010

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Helen Creagh,
Student ID 14869590
helencreagh@outlook.com
021 542 798

Project Supervisor Contact Details:

Garjana Kosanke
garjana.kosanke@aut.ac.nz
09 921 9999 Ext 8010

Approved by the Auckland University of Technology Ethics Committee on May 3, 2019, AUTEC Reference number 19/117

c) Consent Form

Consent Form

Project title: The Couple Therapists' Experience of Establishment or Non-establishment of the Therapeutic Alliance

Project Supervisor: ***Garjana Kosanke***

Researcher: ***Helen Creagh***

By signing this form, you agree:

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 08/04/2019.
- ○ I meet the eligibility criteria set out in that information sheet.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I will be contacted by the primary researcher in the two weeks after my interview and given the opportunity to provide any supplementary feedback or clarifications on the questions I will be asked.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study, or from answering any question included in the study, at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○
- ○ I wish to review the transcript of my interview before it is submitted for analysis (please tick one):

  Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

……..

……..

……..

……..

Date:

Approved by the Auckland University of Technology Ethics Committee on May 3, 2019, AUTEC Reference number 19/117

Note: The Participant should retain a copy of this form.

d) Email Invitation

Dear (Name of Therapist),

My name is Helen Creagh. I am a psychotherapist in private practice at Hobsonville, and am preparing a dissertation this year, to complete my Master of Psychotherapy. I would like to know if you would be willing to participate in my research, which is about the experiences of psychotherapists in establishing and maintaining a therapeutic alliance with couples. The *attached* information sheet provides more detail including contact information for my supervisor, Garjana Kosanke.

I found your contact information online and your name was randomly selected from a full list of couple therapists who, to the best of my ability, I have matched with the criteria for this research. I am looking for

- registered psychotherapists,
- who currently work with couples, and
- who have been practicing psychotherapy for at least three years post qualification.

Interviews last 60 to 90 minutes and would take place at a time and location convenient to you.

I would really appreciate it if you would respond to this email and let me know

- whether you **do or do not** meet the criteria for participating,
- whether you **would or would not** be willing to participate,
- whether you would like further information before making a decision about participating.

Thank you so much. I look forward to hearing from you.

Helen Creagh

Mobile: 021 XXX XXX