

Practitioner Report

Early Psychotherapy Processes: An Examination of Client and Trainee Clinician Perspective Convergence

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Convergence in the therapist–client dyad has been hypothesized to play an important role in the development of the therapeutic relationship and in successful therapy outcomes. Further, understanding the client’s views and opinions of treatment has been identified as a critical skill for therapists in training to learn in order to reach professional competency in conducting psychotherapy. This study assessed convergence for 151 trainee therapist–client dyads on the identification of goals and tasks of treatment and on ratings of the therapeutic relationship, effectiveness of therapy and the client’s current coping ability with life stressors. Results indicated that trainee therapists’ and clients’ ratings were significantly correlated; however, trainee therapists were more negative in their ratings of the relationship and progress of treatment and matched their clients’ goals for treatment only 31.1% of the time. Training and practice implications are discussed. Copyright © 2009 John Wiley & Sons, Ltd.

INTRODUCTION

Convergence, defined as a two-way event where discrepancies in judgements, perspectives, beliefs and even behaviours are lessened (Pepinsky & Karst, 1964), is a phenomenon that has been found to occur in a number of different relationships between persons (or groups of persons), ranging from conformity in social groups (Asch, 1952; Sherif, 1936) to synchrony between parents and children (Wahler & Dumas, 1989). As early

as the 1960s, the phenomenon of perspective convergence between therapists and clients has been hypothesized as an important factor in psychotherapy. At that time, Pepinsky and Karst postulated that the level of convergence may be a dependent event that serves as a precursor to other therapeutic consequences, such as therapy ‘success’ or client ‘improvement’.

The importance of client–therapist agreement or perspective convergence in therapy has also been hypothesized to play a role in other therapeutic variables that have been linked to positive therapy outcomes, viz. the therapeutic alliance. Gaston, Goldfried, Greenberg, Horvath, Raue, and Watson (1995), in a comprehensive review of the topic, indicated that convergence between

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the client and therapist is one of the key components of alliance. In a more recent review of the construct of alliance, Hovarth and Bedi (2002) indicated that although there is no universally accepted definition of the concept, most conceptualizations include an emphasis on collaboration and consensus. Especially pertinent to the topic of convergence, Bordin (1976, 1994) defined the therapeutic working alliance as including an agreement between the client and therapist on both the goals and tasks of therapy.

Findings on Client–Therapist Convergence

Although convergence between the client and therapist has been hypothesized as an important factor in the development of the therapeutic alliance and in successful therapy outcomes, empirical studies have indicated that convergence does not always occur. One area that has received attention in relation to the topic of client–therapist convergence is in the causal explanations of the client's presenting problems. For example, Long (2001) had 24 client–therapist dyads complete a measure assessing causal attributions (situational or personal), after the third session of therapy. The results of this study indicated that there was a significant disagreement between clients and therapists in their perceptions of the personal control that clients had over their problems. Long further found that the level of agreement in this area was significantly related to early therapy change, with greater client–therapist convergence being associated with more effective perceived therapy outcomes. Similar results have been reported by other studies examining convergence in this area (Claiborn, Ward, & Strong, 1981; Tracey, 1988).

Another area that has received attention in relation to the topic of client–therapist convergence is in the recall and interpretation of session events. Examining convergence in interpretations, Fuller and Hill (1985) compared therapist and helpee perceptions of the therapist's actions. In this study, therapists and helpees observed a video recording of a previous session and separately identified what they perceived the therapist's intentions to have been during that session. Results from this study indicated that the therapist–helpee dyads only matched interpretations 37% of the time. In a more recent study examining convergence for recall of important session events, Cummings, Martin, Hallberg, and Slemon (1992) asked both clients and therapists from 10 dyads to identify the most important event after the conclusion of each session. Of the 81 ses-

sions in which ratings took place, the client and therapist reported events matched only 34% of the time. Similarly low levels of convergence between clients and therapists have consistently been found in other studies also examining the recall and interpretation of session events (Cummings, Hallberg, Slemon, & Martin, 1992; Dill-Standiford, Stiles, & Rorer, 1988; Kivlighan & Arthur, 2000; Martin & Stelmaczek, 1988).

The therapeutic alliance has received the most attention in the literature with regards to the issue of convergence between the client and therapist. For example, Fitzpatrick, Iwakabe and Stalikas (2005) recently had 48 client–therapist dyads separately complete the Working Alliance Inventory (Horvath & Greenberg, 1986) after every second or third session. Results from this study indicated that client and therapist ratings of the alliance were significantly divergent, that the divergence was greater for ratings of goal and task agreement and that the level of divergence did not change over the course of therapy. Numerous other studies examining client–therapist convergence for ratings of the alliance have reported comparable results (see Bachelor & Salame, 2000; Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005; Hilsenroth, Peters, & Ackerman, 2004; Ogrodniczuk, Piper, Joyce, & McCallum, 2000).

In summarizing the alliance convergence literature, Tryon, Blackwell, and Hammel (2007) conducted a meta-analysis of 53 studies comparing client and therapist ratings of the therapeutic alliance. Averaging across variables such as the client's level of disturbance, the length of therapy, the type of measures used, the therapists' experience and the type of therapy, it was found that client and therapist alliance ratings were only moderately correlated ($r = 0.36$). Tryon et al. further found that on average, client ratings were seen to be significantly higher than therapist ratings on this factor ($d = 0.63$). Tryon et al. concluded that more research is needed in order to better understand why convergence/divergence between clients and therapists occurs, and suggested that both quantitative and qualitative methods should be used (p. 639).

Aim of the Current Study

Although the topic of client–therapist convergence has received much attention since the time Pepinsky and Karst (1964) hypothesized its role in producing successful outcomes in psychotherapy, there are still a number of gaps or shortcomings in the available literature. For example, studies examining

convergence on ratings of the therapeutic alliance have compared alignment for both the goals and tasks of therapy. However, these comparisons have only been made by looking at subjective ratings of goal and task agreement or by comparing checklists of goals to determine agreement. It would also be useful to know if clients and therapists were able to qualitatively identify the same target goals for therapy or the same tasks that have been most helpful in therapy. If clients and therapists were working towards qualitatively different things or if the therapist was using tasks that the client did not perceive to be helpful, then the therapeutic alliance would likely suffer and the client may be at greater risk to drop out prematurely from treatment (Reis & Brown, 1999).

Another gap in the convergence literature relates to the factors that have yet to be studied. Convergence for variables yet to be studied, such as how effective therapy is perceived to be or how the client is coping in life, may also affect the course and outcome of therapy. For example, if a therapist underestimates the effectiveness of therapy or the client's coping ability, that therapist may continue to work on issues that have already been resolved, not yet perceiving that the client feels it is time to move on to new things. The reverse could also be true: if a therapist feels that the client is doing great and that therapy has been extremely effective, the therapist may move on, or suggest termination before the client is ready.

A final gap in the literature relates to the attention that has been given to convergence in a training setting. Recently, understanding the client's opinions and views of what is occurring in therapy has been emphasized as an important skill for trainee therapists to learn in order to achieve an entry level of competency for professional practice (Kaslow, 2004; Spruill, Rozensky, Stigall, Vasquez, Bingham, & Olvey, 2004). Although Tryon et al. (2007) included a handful of studies using trainee therapists, further exploration of understanding the strengths and weaknesses of trainees in the area of perspective convergence is needed, given the recent competency movement. For example, trainees may show to be convergent with their clients when it comes to one aspect of treatment, but not when it comes to another. Such knowledge would be helpful to supervisors in knowing what areas need further attention in helping develop competency in trainees.

Given the previous research examining client-therapist convergence, this study aimed to expand the current findings by (1) examining convergence

for the therapeutic alliance by studying whether a qualitative match occurs for stated therapeutic goals and tasks; (2) examining convergence for perspectives of therapy variables that have yet to be studied (i.e., the effectiveness of treatment and the client's current coping ability); and (3) examine convergence in a training setting to further identify areas of convergence strengths and weaknesses for trainee therapists. Given the findings generally indicating greater divergence between client and therapist ratings on previously studied factors (see Tryon et al., 2007), it was hypothesized that this study would find similar discrepancies.

METHOD

Participants

Archival data from 151 clients seen for therapy at a Midwestern University-based training clinic were used in this study. The average age of this client population was 28.63 (standard deviation [SD] = 9.59), ranging from 18 to 62 years. These clients were largely female (62.3%) and of Caucasian ethnicity (90.4%). Other ethnicities included in this sample were Native American (4.4%), African American (2.2%) and other (3%). The mean of the Beck Depression Inventory-II (Beck, Steer, & Brown, 1996) scores for this sample at intake was 21.73 (SD = 12.29) and the mean of the Beck Anxiety Inventory (Beck & Steer, 1993) scores at intake was 15.37 (SD = 11.75). The majority of these clients were given a diagnosis of a mood- or an anxiety-based disorder at intake. The average number of sessions attended by this group was 18.13 (SD = 17.83), ranging from 3 to 88 sessions. As routine practice in this clinic, all clients were treated in accordance with the American Psychological Association's (APA) 'Ethical principles of psychologists and code of conduct' (APA, 2002), and the archival study was conducted in compliance with the University's Institutional Review Board.

Therapists

The therapists in this study were 64 trainees working with the described clients and were all doctoral students enrolled in a clinical psychology scientist-practitioner Ph.D. programme at the same Midwestern University. The average number of clients seen by each therapist was 2.36, ranging from 1 to 8 clients. Demographic characteristics of enrolled students in this programme reveal an average age of 26.57 years (SD = 5.53), with the

majority of students being female (63%), Caucasian (70.4%) and having entered the programme with a bachelors' degree (87.5%). Other ethnicities included in this sample were Native American (11.1%), Hispanic (11.1%) and other (7.4%). In general, this specific doctorate programme emphasizes the development of knowledge and skills in clinical theory, assessment and treatment procedures, and offers specialized tracks in the areas of clinical child, clinical health and adult clinical psychology. The programme's theoretical orientation can be described as cognitive-behavioural, and all of the trainee therapists were highly encouraged by supervisors to use cognitive-behavioural principles when working with clients. Further, as part of the programme's emphasis on an evidence-based model to clinical care, trainee therapists were also strongly encouraged to understand and work towards client-identified goals throughout treatment. To that end, clinic policy required that goals be documented in all client files prior to the third session of psychotherapy. Students in this programme typically begin their practicum training at the University-based training clinic by conducting semi-structured intake interviews during their first year and initiating intervention services following coursework in psychopathology, assessment and psychotherapy (usually at the end of this

first year). All students seeing clients at the clinic received weekly supervision by a member of the clinical faculty.

Measures

Clients' Ratings of Treatment

This questionnaire was created by the programme's Clinical Training Committee as a face valid feedback survey. Three domains of interest were included in the creation of this measure: the therapeutic relationship, the client's current coping ability and the effectiveness of treatment. Items pertaining to the therapeutic relationship included one item of the overall relationship rated on a 9-point Likert-type scale, one item instructing clients to qualitatively report two target goals for treatment and one item instructing clients to qualitatively report the tasks that have thus far been most helpful in treatment. Five items rated on a 9-point Likert-type scale were included pertaining to the client's current coping ability (with life, work, school, romantic relationships and family relationships) yielding an average coping ability score. One final item was also included, asking clients to provide a subjective rating of how effective therapy has been. The measure can be viewed in Table 1. Using this study's sample of clients, the

Table 1. Client evaluation of treatment questionnaire

How do you feel about your relationship with your therapist right now?										
Very negative	1	2	3	4	5	6	7	8	9	Very positive
Overall, how well are you coping with life right now?										
Not at all	1	2	3	4	5	6	7	8	9	Very well
How well are you coping with your work or employment status right now?										
Not at all	1	2	3	4	5	6	7	8	9	Very well
How well are you coping with your educational status right now?										
Not at all	1	2	3	4	5	6	7	8	9	Very well
If you are married or in a continuous romantic relationship, how well are you coping with the relationship right now?										
Not at all	1	2	3	4	5	6	7	8	9	Very well
How well are you coping with your family relationships right now?										
Not at all	1	2	3	4	5	6	7	8	9	Very well
Identify the two most important problems you are working on right now in therapy:										
Most important problem:	_____									
Second most important problem:	_____									
Overall, how helpful do you feel therapy has been for you so far?:										
Not at all	1	2	3	4	5	6	7	8	9	Very well
Please describe what you feel has been most helpful to you in therapy:	_____									

The therapist measure was identical except that where the client measure asks about 'you', the therapist measure asks about 'your client'.

measure is shown to have an overall high internal consistency (Cronbach's alpha = 0.84), as well as high internal consistency for the five items composing the overall coping ability score (Cronbach's alpha = 0.85).

Therapists' rating of treatment

Trainee therapists were separately asked to complete a parallel measure, differing from the client form only in that it directed the therapist to complete the measure for their client. Using this study's sample of trainee therapists, the therapist measure is shown to also have an overall high internal consistency (Cronbach's alpha = 0.88) and a high internal consistency for items composing the coping ability average score (Cronbach's alpha = 0.88).

Procedures

Clients and therapists were asked to complete their respective measures during or directly after the third session. The third session was selected as the assessment time in order to (1) include as many clients as possible prior to termination and (2) to allow an adequate number of sessions for therapists to set treatment goals and identify a treatment plan with their clients (at the clinic used in this study, it was policy to have goals set and a treatment plan identified by no later than the completion of the third session). Additionally, the selection of the third session matches other previously conducted studies of convergence (see Long, 2001).

Two trained graduate students independently coded the target complaints and the most helpful part of therapy questions to determine therapist–client match. These two students had been previously trained in coding procedures on a separate data set with review of their work by the second author. In this study, the coders were asked to look at the responses separately for each dyad to see whether the responses were qualitatively the same or different. The coders were asked to pay attention to both the words used and the meaning of the response. For example, the coders were instructed that a response by the client that a target of treatment was 'issues with stepmom and dad' would qualitatively be the same as a response by the therapist that a target goal of treatment was 'family discord'. The targets were coded as to whether neither of the therapist's responses matched the client's responses (coded 0), at least one of the therapist's responses matched at least one of the client's responses (coded 1) or both of the therapist's responses matched

both of the client's responses (coded 2). Order of the target responses was not taken into account. The coders showed a high level of agreement on this variable, as indicated by a significant intraclass correlation coefficient of 0.94 ($p < 0.001$). The most helpful part of therapy was coded as to whether or not the therapist's response and client's response were the same (1 = same and 0 = not the same). Again, there was a high level of agreement in the coding of this variable, as indicated by a significant kappa value ($\kappa = 0.91, p < 0.001$). For items in which there was a discrepancy, the coders met and discussed those items and came to a consensus.

RESULTS

The first research question was to examine convergence for the therapeutic alliance by examining whether a qualitative match occurred within the therapist–client dyads in terms of stated goals and tasks. For the goals of treatment, the therapist–client dyads matched on both target goals 31.1% ($n = 47$) of the time, matched on only one of the target goals 56.3% ($n = 85$) of the time and did not match on either of the target goals 12.6% ($n = 19$) of the time. For the tasks of treatment, the therapist–client dyads matched for the most helpful task thus far used in treatment in only 46.4% of the cases. Also pertaining to convergence for the therapeutic alliance, the therapist–client dyads were compared for the general rating of the therapeutic relationship. Client and therapist ratings of the general therapeutic relationship were observed to be significantly correlated ($r = 0.33, p < 0.01$). A paired samples *t*-test found that therapists' ratings were significantly lower than clients' ratings (see Table 2 for results), showing a 'small' effect by conventional standards (Cohen, 1988). As indicated in Table 3, therapists rated the relationship lower than their clients in 48.9% of the cases, occurring greater than what would be expected by chance alone ($\chi^2 [2, n = 139] = 21.95, p < 0.001$).

The second research question pertained to examining convergence in the therapist–client dyad for ratings of therapy factors that have yet to be studied; specifically, ratings of the effectiveness of treatment and ratings of the client's current coping ability with life stressors. Significant correlations were again observed between therapist and client ratings of the treatment's effectiveness ($r = 0.31, p < 0.01$) and the client's current ability to cope with life stressors ($r = 0.69, p < 0.001$). Paired samples *t*-tests indicated that therapists' ratings

Table 2. Paired samples *t*-test comparisons of therapist ratings and client ratings

	<i>n</i>	Therapist rating		Client rating		<i>t</i> statistic	Effect size <i>d</i>
		Mean	SD	Mean	SD		
Relationship	139	7.53	1.13	8.01	1.16	4.34*	0.42
Client coping	151	6.07	1.59	6.17	1.72	0.91	
Effectiveness	141	6.13	1.49	7.09	1.65	6.09*	0.61

**p* < 0.001.

Unequal values of *n* are due to some therapists or clients failing to complete the full measure.

SD = standard deviation.

Table 3. Direction of therapist/client dyad ratings of the relationship, effectiveness and coping

Variable	Frequency (%)	χ^2 value
Relationship (<i>n</i> = 139)		
Therapist rated higher	23 (14.5%)	21.95*
Ratings agreed	48 (34.5%)	
Client rated higher	68 (48.9%)	
Effectiveness (<i>n</i> = 141)		
Therapist rated higher	24 (17.0%)	49.12*
Ratings agreed	31 (22.0%)	
Client rated higher	86 (61.0%)	
Client coping ability (<i>n</i> = 151)		
Therapist rated higher	47 (31.1%)	2.27
Ratings agreed	59 (39.1%)	
Client rated higher	45 (29.8%)	

**p* < 0.001.

Unequal values of *n* are due to some therapists or clients failing to complete the full measure.

were significantly lower than clients' ratings on the effectiveness of treatment (a 'medium' effect was observed), but not on the client's current coping ability (see Table 2 for results). As indicated in Table 3, therapists rated the effectiveness of treatment lower than their clients in 61% of cases ($\chi^2 [2, n = 141] = 49.12, p < 0.001$), but only rated their clients' coping ability lower in 29.8% of cases ($\chi^2 [2, n = 151] = 2.27, p > 0.05$).

The third research question was to compare levels of convergence across variables for the therapist–client dyads in order to determine convergence strengths and weakness for these trainee therapists. This question was addressed by comparing the observed therapist–client correlations for the three continuous variables according to the methods described by Howell (2002) for comparing correlations. Results of these comparisons indicated that the therapist–client dyads showed a significantly higher correlation in ratings of the client's coping ability than ratings of the relationship ($z = 4.24, p < 0.001$) or ratings of the effectiveness of treatment ($z = 4.47, p < 0.001$). Observed correlations in the

therapist–client dyads did not differ significantly between ratings of the relationship and effectiveness of treatment ($z = 0.18, p > 0.05$).

DISCUSSION

The purpose of this study was to examine the convergence between trainee therapists and their clients regarding the ongoing course of treatment. First, convergence for factors related to the therapeutic alliance was examined. In terms of therapist–client match for the goals and tasks of treatment, this study found that in only 31.1% of the cases did the therapist and client match both goals, and in 12.6% of the cases, the therapist and client did not match on either of the identified goals for treatment. Additionally, therapists and clients matched in terms of the helpful tasks for treatment in less than half of the cases. In terms of a general rating of the relationship, it was observed that the therapists' ratings were moderately correlated with their clients' rating; however, the therapists' ratings were observed to be significantly lower.

The observed low levels of convergence found in this study match the results from previous studies examining levels of convergence for ratings of the therapeutic alliance (Clemence et al., 2005; Fitzpatrick et al., 2005; Tryon et al., 2007).

Consensus, collaboration and agreement, especially when it comes to the goals and tasks of therapy, have repeatedly been emphasized as key aspects of the therapeutic alliance (Bordin, 1976, 1994; Gaston et al., 1995; Hovarth & Bedi, 2002; Lambert & Ogles, 2004; Tryon & Winograd, 2002). This study found that for trainee therapists and their clients, consensus on the goals and tasks of treatment does not always occur. For example, one client indicated that her goal for treatment was to learn to cope with her recent divorce and loss of contact with her son because of restricted visitation rights. On the other hand, that client's trainee therapist reported that the goal for treatment was to help the client overcome symptoms of post-traumatic stress disorder related to a car accident. As a second example, one client reported that the most helpful task for therapy was just 'unloading on my therapist'. In contrast, the trainee therapist felt that 'planning daily schedules' was the most helpful task for that client. Therapists and clients who are working towards qualitatively different things or who are expecting different tasks to be used in therapy are both likely to experience frustration with the relationship, and if convergence does not occur, clients from such dyads may be at greater risk to prematurely terminate from treatment (Reis & Brown, 1999).

A mixed pattern was observed for convergence on the ratings of the effectiveness of treatment and ratings of the client's current coping ability with life stressors. A moderate correlation was found between this study's trainee therapists and their clients for ratings of the effectiveness of treatment; however, therapists again, on average, rated the effectiveness of treatment lower than their clients. In this sample, a significantly stronger correlation was found between trainee therapists' and their clients' ratings for the current coping ability of the client. Given the significant difference, this area of convergence may be a relative strength for therapists in training.

In view of the growing interest in a competency-based approach for the training of future clinicians (Kaslow, 2004; Kaslow et al., 2007; Rubin et al., 2007) and the results of this study, some further training implications can be made. It has been suggested that a competency-based approach to training should focus less on a set curriculum and more on the teaching of the skills and abilities that

are deemed necessary for clinical practice (Kaslow et al., 2007). In this study, the trainee therapists showed a deficiency in skills relating to identifying their clients' goals and tasks of treatment and converging with their client in ratings of the relationship and the effectiveness of treatment. Based on these results, it can be surmised that trainee therapists may be adequately gathering information from their client (demonstrated by the accuracy of judgements of the client's current coping abilities); however, they may not be effectively discussing on an ongoing basis the client's preferences related to the treatment (demonstrated by the failure to identify all of the client's goals or preferred tasks) or the client's opinions concerning the effectiveness of the interventions (demonstrated by the underestimating of the client's opinions of the therapeutic relationship and the helpfulness of therapy). Teaching a shared decision-making approach may be one method used to address this competency and to help training therapists learn the necessary skills and abilities related to understanding the views and opinions of their clients (Adams & Drake, 2006; Charles, Gafni, & Whelan, 1997; Ford, Schofield, & Hope, 2003).

The purpose of this study was to measure trainee therapists' understanding of their clients' opinions of therapy. A limitation of this study was that only trainee therapists were used, thus not allowing direct comparisons to be made to more experienced therapists. It may be possible that experienced clinicians are more accurate in their judgements, as was concluded by Tryon et al. (2007) from a sample of non-substance abusing studies comparing ratings of the therapeutic relationship. Further research comparing convergence across levels of therapist experience is needed. A second limitation with the use of a training setting is that the sample of clients seen at a university-based clinic may be somewhat limited in terms of demographics and level of disturbance. Convergence in therapist-client dyads may be different in settings with more diverse client populations (in terms of ethnicity, diagnosis and symptom severity). Thus, while the present study carries important training implications, research in other treatment settings would be beneficial for the purpose of extending the practice implications to other settings where trainees may also provide interventions (e.g., outlying practicum or internship settings).

A limitation of this study can also be found in the measure used and the time of administration. This questionnaire was created by the Clinical Training Committee of the programme as a face valid

measure of the client's evaluation of treatment and has previously been used on an individual training basis only. The measure shows high internal consistency; however, other psychometric properties of this measure have yet to be obtained. In addition, one may question the appropriate time to measure convergence in the therapist–client dyad. By measuring convergence too early in the course of treatment, one may underestimate the actual convergence in the therapeutic relationship by not allowing adequate time for the therapist to gather information about the client. On the other hand, by measuring convergence too late in the course of treatment, one may overestimate the actual convergence due to a failure to include dyads where the client has already prematurely terminated from treatment. Consistent with other studies of convergence (Long, 2001), this study used the third session in an attempt to minimize both problems. However, studies of convergence for the therapeutic alliance (see Tryon et al., 2007) and other therapy factors (e.g., Kivlighan & Arthur, 2000) have found convergence to improve over time. Thus, future research is needed to examine the role of measurement time in greater detail for the factors looked at in this study.

In conclusion, convergence has been emphasized as an important factor in the development of the therapeutic relationship and in successful treatment outcomes. However, in this sample, convergence concerning the stated goals of treatment and the appropriate tasks for treatment, as well as ratings of other process related factors did not always occur. Given the recent competency movement, teaching trainee therapists skills related to understanding their clients' opinions and views of therapy may be necessary. Further research examining the effect of training on convergence is recommended.

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