

Therapist–Client Agreement on Helpful and Wished-For Experiences in Psychotherapy: Associations With Outcome

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Therapists and clients often have different perspectives about what is helpful and what they wish for in therapy, but it is unclear how their perspectives differ and whether their agreement have implications for therapy outcome. In a mixed-method study, 18 therapists and clients were interviewed separately after termination about their experiences and what they wished had been different about their psychotherapy. Transcripts were analyzed using consensual qualitative research. Therapists and clients agreed moderately that exploration of the therapeutic relationship, therapists' use of challenges, and therapist validation and support were helpful. In contrast, there was low agreement on wishes. Whereas clients wished that therapists had provided more structure and direction, therapists did not mention any typical wishes. Using multilevel modeling, a high level of agreement on what was helpful was associated with reductions in psychological symptoms and interpersonal problems, although no relationship was found between agreement on wishes and outcome. The findings underscore the importance of therapist–client agreement about helpful aspects of therapy for successful therapy.

Public Significance Statement

Therapist and client agreement and its association with psychotherapy outcome were studied using quantitative and qualitative methods. Therapists and clients agreed that exploration of the therapeutic relationship, therapists' challenges, and therapist validation and support were helpful. Agreement on the tasks of psychotherapy appears to be an important consideration for improving psychotherapy effectiveness.

Keywords: therapist–client agreement, helpful experiences, process and outcome, psychoanalysis/psychodynamic therapy

In *Everyday Gets a Little Closer: A Twice-Told Therapy*, Yalom and Elkin (1974) described their different views of their psychotherapy sessions. For example, although the therapist (Yalom) relished the brilliance and accuracy of his interpretations, Elkin (the client) did not typically recall such interpretations. In contrast,

Elkin often valued Yalom's supportive comments and warm compliments, but these comments did not even cross Yalom's mind when he reflected on the therapy hour. This clinical anecdote echoes an early research finding in which therapists emphasized the helpfulness of specific techniques, whereas clients valued the human characteristics of therapists (Feifel & Eells, 1963). Unfortunately, there has not been much research comparing therapist and client perspectives on helpful events in therapy and connecting these with therapy outcome. Even fewer studies examined what therapists and clients wished for more from therapy and whether agreement on the wished-for experiences is related to outcome.

Empirical Studies of Helpful and Wished-For Experiences in Psychotherapy

Several studies have examined client perceptions of helpful components of psychotherapy. For example, in his examination of volunteer clients' descriptions of helpful and nonhelpful counselor responses, Elliott (1985) found that task-based interventions (e.g., the therapist offering a new perspective) or relationship-based

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Results from this study were presented in part at the 48th International Meeting of the Society for Psychotherapy Research in Toronto, Ontario, Canada, June 21–24, 2017.

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interventions (e.g., displaying understanding) were perceived as helpful, whereas misperceiving the client and negative counselor reactions were perceived as nonhelpful. Similarly, clients have often mentioned learning a new perspective as a helpful part of therapy (e.g., Levitt, Butler, & Hill, 2006; Paulson, Truscott, & Stuart, 1999), and that feeling understood and accepted was helpful (see Timulak & Keogh, 2017, for a review).

In terms of wished-for experiences in psychotherapy, these wishes may arise from discrepancies between initial expectations and actual experience. Most research on expectations in psychotherapy looked at outcome expectation (i.e., anticipated improvement in psychotherapy). Wished-for experiences, on the other hand, may be related to the much less researched process expectation, such as expectations about treatment procedures and behaviors of therapists and clients in the therapeutic relationship (Westra, Aviram, Barnes, & Angus, 2010). Violations to process expectations is common in psychotherapy, but there are some nuances. Clients with good outcome more often experienced violations to negative expectations (i.e., pleasant surprises), whereas clients with poor outcome tended to experience violations to positive expectations (i.e., disappointments; Westra et al., 2010). Further examination of perceived disappointments in therapy is therefore important. Given that clients are generally hesitant to criticize therapy and their therapists (Rhodes, Hill, Thompson, & Elliott, 1994), reframing disappointments using growth-oriented language, such as wished-for experiences, may facilitate investigation in research.

Agreement Between Therapists and Clients About the Process of Psychotherapy

Studies on agreement in psychotherapy research have most often focused on agreement about the therapeutic relationship. For instance, therapists and clients have shown low to moderate agreement across a large number of process and relationship variables, including working alliance (Tryon, Blackwell, & Hammel, 2007), therapist empathy (Elliott, Bohart, Watson, & Murphy, 2018), and real relationship (Fuertes et al., 2007), indicating that therapists and clients likely have different perspectives about the relationship.

Researchers have less often focused on agreement between therapists and clients about other important aspects of the therapy process such as whether therapists and clients share views on what they find helpful or wish for in sessions. We could imagine that there would be less agreement about helpful and wished-for components given that by the nature of the roles in psychotherapy therapists are other-focused (trying to be helpful to another person) whereas clients are self-focused (trying to open up and work on their problems). For instance, when evaluating the working alliance, clients place greater emphasis on helpfulness, joint participation in the work of therapy, and negative signs, such as having divergent views on therapy goals or other issues than do therapists (Bachelor, 2013).

Although agreement between perspectives is interesting, perhaps more important is whether agreement between therapist and client perceptions of therapy process predict better client outcome. Again, the literature here has focused primarily on the therapeutic alliance, with several studies indicating that agreement is associated with better outcome. For instance, Marmarosh and Kivlighan

(2012) reported that when therapists and clients agreed that they have a strong alliance, sessions were smoother and clients had greater symptom reduction. Some studies have also reported that congruent perceptions of the alliance predicted lower symptom levels during treatment and at follow-up (Coyne, Constantino, Laws, Westra, & Antony, 2017; Laws et al., 2017; Zilcha-Mano, Snyder, & Silberschatz, 2017). In addition, Rubel, Bar-Kalifa, Atzil-Slonim, Schmidt, and Lutz (2018) found that agreement about the strength of bond between therapist and client predicted better treatment outcome than when therapists and clients perceived their bond differently.

In contrast, therapist–client agreement did not predict client outcome in other studies. For instance, the level of agreement between clients and therapists about the therapeutic alliance in a course of drug treatment was not related to treatment retention (Meier & Donmall, 2006). The authors suggested that the small number of treatment centers might have limited generalizability of findings, and the examination of retention as outcome might not accurately reflect the importance of therapist–client agreement about the alliance because dyads that dropped out did not have enough time to develop the therapy relationship. Nevertheless, these reasons are speculative and further research is needed to clarify what aspects of agreement are particularly important in predicting outcome.

This exclusive focus on the therapeutic alliance in the agreement to outcome literature is not surprising given that the alliance is one of the most researched psychotherapy process variable in relation to outcome (Flückiger, Del Re, Wampold, & Horvath, 2018). However, there is a distinction between how therapists and clients think about the relationship and what they find helpful or think should happen in therapy. For example, using interviews with therapist–client dyads, Banerjee and Basu (2016) documented that therapists and clients agreed that emotional unburdening through listening and acceptance of emotions through containment are helpful therapy processes. In contrast, they differed in preference for having a hierarchical therapeutic relationship (clients preferred it but not therapists), and in viewing the therapy relationship as a curative element (therapists saw it as an agent for corrective relational experience but not clients). These aspects of agreement and disagreement are not related to the alliance and thus deserve further investigation.

Another limitation is that most agreement studies used quantitative analyses that rely solely on standardized measures, constraining our understanding of the things about which therapists and clients agree or disagree (Bachelor, 2013) and neglecting content areas that might be pertinent to the outcome of therapy but for which there are no standardized measures. For instance, although therapists and clients may have highly congruent scores on the Task subscale of the Working Alliance Inventory, this high agreement does not provide any indication about what specific tasks of therapy they agree on. Conversely, therapists and clients may have regrets about a course of therapy that cannot be easily measured using existing scales and thus other methods of inquiry are needed. For example, we do not yet have a checklist that therapists and clients can complete about the ways in which therapy could be improved (i.e., wished-for experiences). We suggest that at this stage of our knowledge a qualitative approach for establishing what therapists and clients find to be helpful and

problematic with therapy might be more useful than relying on standardized measures.

In this study, our first purpose was to examine what therapists and clients thought was helpful and what they wished to have happened in their therapy. We used consensual qualitative research (CQR; Hill, 2012; Hill et al., 2005; Hill, Thompson, & Williams, 1997) to analyze posttherapy interviews conducted separately with therapists and clients so that their inner experiences about therapy could be studied in depth. We primarily chose CQR instead of other qualitative methods because it involves using multiple judges in data coding. Having multiple perspectives is especially important when one tries to understand complex phenomena, such as psychotherapy process, given that judges can discuss a variety of viewpoints and reach consensus about nuances in data (Hill, 2012).

Our second purpose was to examine the relationship between agreement between therapists' and clients' responses and therapy outcome. Although therapist–client agreement was assessed using posttherapy interviews, the interviews focused on how therapy unfolded over time. Hence, we thought it was appropriate to examine how clients changed over the course of therapy as an evaluation of outcome. Using multiple data points is also preferred to pre- and posttherapy ratings alone as they take more information into account. In addition, given that data were collected in a psychodynamically/interpersonally oriented community clinic, we examined two measures of outcome: (a) Outcome Questionnaire (Lambert et al., 1996) for changes in general psychological functioning and (b) Inventory of Interpersonal Problems (Barkham, Hardy, & Startup, 1996) for changes in interpersonal functioning.

Method

Data Set

Data were collected within a low-fee psychology department-based community clinic in the Mid-Atlantic United States with doctoral student therapists and adult clients in individual open-ended psychodynamic psychotherapy. This psychotherapy focused on the interpersonal approach in psychodynamic theory (e.g., Safran & Muran, 2000; Teyber & Teyber, 2010), but no specific treatment manual was used. The study was approved by the institutional review board where data collection took place.

Participants

Clients. Eighteen (nine women, nine men; 12 European American, three African American, two Asian American, one biracial; age $M = 29.22$ years, $SD = 9.13$) adults from the community served as clients. They had completed between 17 and 181 sessions of therapy ($M = 49.17$, $SD = 40.09$). Presenting problems reported at screening included depression, anxiety, relationship problems, meaning in life, grief and loss, and career concerns.

Therapists/interviewers. Eighteen (13 women, five men; nine European American, four Asian American, two Hispanic, two international (Chinese and Indian), one African American; age $M = 30.67$, $SD = 6.53$) counseling psychology doctoral student externs served as therapists and interviewers in this study. All therapists/interviewers had participated in at least two practicums prior to their time in the clinic and espoused a psychodynamic

orientation as a part of the requirements for joining the clinic. In addition, on the Therapist Orientation Profile Scale–Revised (Worthington & Dillon, 2003; 1 = *not at all* to 10 = *completely*) they reported strong affiliation with psychoanalytic/psychodynamic ($M = 7.48$, $SD = 1.20$) and humanistic/existential ($M = 6.48$, $SD = 1.68$) orientations, in comparison with cognitive-behavioral orientation ($M = 4.17$, $SD = 1.63$; Cohen's $d = 2.31$ and 1.40 with psychodynamic and humanistic, respectively). All therapists participated in weekly individual supervision and biweekly group supervision with experienced psychodynamic supervisors.

Judges. The judges were three doctoral-level psychologists, including a 35-year-old male, Asian International assistant professor in counseling psychology; a 42-year-old female, Latina International staff psychologist; and a 36-year-old male, European American staff psychologist. The two staff psychologists work at university counseling centers. All judges had served as therapists in the clinic, but their data were not included in this data set. The external auditor was a 69-year-old female, European American counseling psychology professor. The judges and auditor were all authors of this study.

Before engaging in data analysis, the judges discussed their biases and expectations related to the focus of the study: All believed that therapists and clients probably have different views about what they think is helpful and what they wished had happened in therapy. They also all believed that being aware of clients' expectations and hopes about the work in therapy is beneficial to therapists, and that therapists should facilitate a discussion about goals and tasks at the beginning and throughout therapy. Finally, they all believed that there would be better outcome if therapists and clients agreed about helpful and wished-for components of therapy, although they were not clear about which specific aspects were crucial. Judges mentally bracketed biases and expectations and focused on the data as completely as possible.

Measures

Demographics. Clients and therapists completed questionnaires about their age, sex, and race/ethnicity. In addition, clients provided information about their presenting concerns.

Posttherapy interview protocol. Semistructured interview protocols for therapists and clients were developed by the clinic directors and piloted on clinic therapists. The protocols were revised based on their suggestions. Importantly, these interview protocols had been developed at the beginning of the clinic as an exit interview rather than being specifically designed for this study. Thus, we used data relevant to the present study by searching through the archival data set of interviews.

Specific questions provided data for the present study. Clients were asked, "How did you feel about your therapy experience?" and "What do you wish the therapist would have done differently in your therapy?" Therapists were asked, "How did you feel about the therapy experience with [client]?" and "What were the challenges in this case or things that you would have liked to have been different?" It should be noted that follow-up probes were used in the semistructured interview so that specific experiences, such as helpful experiences, were elaborated. In addition, clients and therapists sometimes provided information relevant to the present study in response to other questions in the interviews (e.g., both

clients and therapists were asked about client struggles in interpersonal relationships, the effects of therapist immediacy, working with dreams in therapy, reasons for termination, and the impact of research; therapists were also asked about their emotional reactions and countertransference toward clients, clients' transference issues, dreams about clients, and impact of supervision).

Outcome Questionnaire–45 (OQ-45; Lambert et al., 1996).

The OQ-45 is a widely used 45-item self-report measure assessing psychological symptoms, interpersonal functioning, and social role functioning. The measure is sensitive to change and suited for repeated measurement to assess client progress in the course of therapy. Items are rated on a five-point scale from 0 to 4, with a higher score indicating greater distress. In this study, the total score was used (possible range from 0 to 180). At pretherapy, the mean client score was 79.7 ($SD = 26.4$, range = 33 to 114; $n = 17$; one client did not have pretherapy data due to a computer error). This score is comparable to the baseline score obtained from another sample of adults receiving psychotherapy in the community ($M = 78.0$, $SD = 25.7$; Lambert et al., 1996). At posttherapy, the mean client score was 64.4 ($SD = 27.7$, range = 16 to 113). Internal consistency reliability (Cronbach's α) at intake for the study sample was .94.

Inventory of Interpersonal Problems–32 (IIP-32, Barkham et al., 1996). The IIP-32 is a 32-item self-report measure of difficulties in interpersonal functioning. Specifically, 20 items relate to things that one experiences difficulty in interpersonal relationships, such as being assertive or expressing affection to another person. The remaining 12 items relate to things that one does too much, such as being overly disclosing or aggressive. Items are rated on a scale from 0 to 3, with a higher score indicating greater interpersonal problems. In this study, the average score was used (possible range from 0 to 3). At pretherapy, client mean score was 1.6 ($SD = 0.5$, range = 0.4 to 2.1; one client did not have pretherapy data due to a computer error). This score is comparable to the baseline score obtained from another sample of psychotherapy adult outpatients ($M = 1.5$, $SD = 0.7$; Barkham et al., 1996). At posttherapy, client mean score was 1.4 ($SD = 0.7$, range = 0.3 to 2.4). Internal consistency reliability (Cronbach's α) at intake in this study was .83.

Procedure

Recruitment. Therapists/interviewers were recruited via an e-mail announcement in the doctoral program in counseling psychology where the clinic was housed. To participate, students had to espouse a psychodynamic/interpersonal orientation and indicate an interest in receiving training in psychodynamic/interpersonal psychotherapy as part of the clinical externship. Therapists signed informed consent (which included information about the posttherapy interview) at the beginning of the time at the clinic and annually thereafter. Each therapist was assigned a code number to protect confidentiality (e.g., 1, 2, 3. . .).

Clients were recruited to the low-fee clinic via several methods (e.g., word of mouth, the clinic's website, online referral links, and referrals from professionals in the community). Prior to intake, telephone screening was conducted to ensure that potential clients met eligibility criteria (at least one interpersonal issue, absence of psychosis, no concurrent individual psychotherapy with another therapist, on psychotropic medication for at least 2 months if

taking it, willingness to be videotaped and to participate in research, and ability to pay the fee). Individuals who did not meet criteria were given referrals to other mental health providers in the local area, whereas those who met criteria were scheduled for an intake session. Once a client was assigned to a therapist for an intake session, they were given a code number linking them to that therapist, such that the therapist's number was followed by the client in order in which they were seen (e.g., 3001, 3002).

When clients came for the intake session, they were assessed for their willingness to engage in open-ended psychodynamic/interpersonal treatment and to participate in the research; the specific fee (\$25 to \$50) was also established. After signing informed consent (which included information about the posttherapy interview), clients completed the OQ and IIP and other measures not used in the present study (clients also signed consent forms annually throughout treatment).

Clients also completed the OQ-45 and IIP-32 after every eighth session (e.g., 8, 16, 24 . . .). Data collection was generally consistent. Because clients had between 17 and 181 sessions, the number of expected ratings ranges from three to 23 per client, with a total of 121 ratings for 18 clients. In total, 108 ratings were recorded. The missing data (10.7%) included five clients with one missed rating, one client with two missed ratings, and one client with seven missed ratings (this client had 16 out of 23 expected ratings). One possible reason for missing data was the entry of a wrong session number in the computer survey. For instance, one client had a rating after Session 9, possibly because the research assistant entered Session 8 which called up the OQ and IIP measures (this extra rating was included in the analysis). Another possible reason was that clients exited the survey before all the questionnaires were completed.

Posttherapy interview. Clients who had completed at least three sessions of psychotherapy were invited to return to the clinic for an hour-long posttherapy interview conducted by a different therapist/interviewer. The therapists for these clients were also invited for a posttherapy interview with one of the therapists/interviewers. We did not invite clients and therapists who had one or two sessions because they would not have sufficient experience to answer interview questions in depth, and it is also difficult to ask clients to return for research when they are not engaged in therapy.

Of the 200 clients who sought psychotherapy at the clinic over an 8-year period, 141 had more than three sessions and were thus eligible for this study. Of the 141 cases, posttherapy interviews were conducted with both therapist and client in 75 cases (clients did not return for the posttherapy interview in the remaining cases). Only clients with at least one outcome assessment after baseline were included (outcome was assessed after every eight sessions), which further reduced the sample to 61 clients seen by 21 therapists. To focus on client's experience with just one therapist, eight clients who transferred from a former therapist in the clinic were excluded. To control for therapist effects and focus on therapist views on their work with a single client, one client per therapist was randomly selected from the remaining 53 cases. Furthermore, three cases were excluded because they were seen by the study authors (the informed consent did not include authorization for therapists to review clients' posttherapy interviews). The final sample for this study thus consisted of 18 unique therapist–client dyads.

Most interviews took place within 2 weeks after the final session. Therapists and clients were interviewed separately so that they could speak freely, and interviews for the therapist and client within each dyad were conducted by different interviewers to minimize interviewer influence. For example, knowledge about a therapist's thoughts and feelings about a course of therapy might have led the interviewer to interview the corresponding client differently and elicit different responses. After completion of the interviews, both clients and therapists were asked to sign forms indicating how their data could be used for research.

Transcripts. Posttherapy interviews with therapists and clients were transcribed verbatim and checked for accuracy. To protect confidentiality, all identifying information was removed and the therapist–client code number was used to identify the transcript.

Qualitative data analyses. Transcripts of the interviews were analyzed using CQR (Hill, 2012; Hill et al., 1997, 2005). For the present study, the full posttherapy interview was read for context and the data relevant to the research questions were coded. Three steps of the CQR process were domains, core ideas, and cross analyses.

Four domains were first developed via consensus among the three judges based on the research questions and their reading of the interviews: (a) what therapists thought helped their client in therapy, (b) what clients thought helped them in therapy, (c) what therapists wished they had done differently in the course of therapy with their client, and (d) what clients wished had been done differently in the therapy. Judges independently read interview transcripts and assigned relevant portions of each transcript to one of the four domains. Final decisions were made via consensus after considerable discussion. No new domains emerged during the analyses.

Based on their reading of the entire interview and then more specifically the data within the domain, judges independently wrote core ideas (i.e., concise summaries) for each domain. Judges then met to discuss the core ideas and reach consensus. The auditor reviewed and provided feedback about all the consensus versions, which the primary team considered and modified via consensus.

Judges independently examined core ideas across participants within domains and constructed categories that reflected major themes. Judges then met to discuss and reach consensus on the list of categories. The auditor reviewed the list of categories and the core ideas within each category to make sure that the categories accurately represented the data. Feedback from the auditor was discussed among the judges who made changes to the categories based on consensus. The auditor reviewed the revised categories and provided additional suggestions that the judges again discussed and incorporated via consensus, until all judges and the auditor were satisfied with the cross-analysis.

Therapist–client agreement. Using the final consensus version of core ideas, judges rated the amount of agreement between the therapist and client about what was helpful as well as about what was wished for using a five-point scale (1 = *no agreement*, with a *predominant discrepancy between client and therapist perspectives*; 3 = *moderate agreement*, a *match between approximately half of the material shared by client with that shared by therapist*; 5 = *high agreement with almost complete matching or coherence between client and therapist perspectives*). Judges then

met to discuss their ratings and arrive at final ratings via consensus.

Quantitative data analysis. Because ratings on the OQ and IIP over the course of therapy were nested within clients, multi-level modeling was used to examine the relationship between therapist–client agreement and change in OQ and IIP over time. To examine change over time, we first calculated the number of days since intake when outcome measures were completed (number of days is better than using session number, given that not all clients had weekly sessions and there were some missed sessions and vacations). In the initial model, the days variable was entered as a Level 1 predictor and OQ (or IIP) scores were entered as the outcome variable (i.e., OQ and IIP in separate models). In addition, baseline symptom (i.e., OQ or IIP at intake) was entered as a Level 2 predictor. We found that baseline symptoms predicted subsequent symptom levels (OQ: coefficient = 0.88, $p < .001$; IIP: coefficient = 0.94, $p < .001$) but not the change in symptoms over time (OQ: coefficient = -0.0008 , $p = .26$; IIP: coefficient = -0.0006 , $p = .57$). As such, baseline symptom was entered as a covariate of intercept (β_{0j}) but not of slope (β_{1j}) when testing subsequent models.

In the second model, therapist–client agreement scores (of what was helpful and of what was wished for in therapy) were added as Level 2 predictors, along with OQ (or IIP) score at intake as a client-level covariate to control for baseline symptom levels. The following example shows the use of OQ as the outcome:

Level 1 Model

$$OQ_{ij} = \beta_{0j} + \beta_{1j}(Days_{ij}) + r_{ij}$$

Level 2 Model

$$\beta_{0j} = \gamma_{00} + \gamma_{01} \times (Help_j) + \gamma_{02} \times (Wish_j) + \gamma_{03} \times (BaselineOQ_j) + u_{0j}$$

$$\beta_{1j} = \gamma_{10} + \gamma_{11} \times (Help_j) + \gamma_{12} \times (Wish_j) + u_{1j}$$

Note that days was uncentered, whereas help, wish, and baseline OQ (or IIP) were grand-mean-centered, such that γ_{00} could be interpreted as the psychological functioning score and γ_{10} as the change in functioning over time (i.e., days since intake), at the beginning of therapy when baseline symptom level and the level of therapist–client agreement on what was helpful and what they wished for in therapy were average for the sample. Also, Level 2 residuals (u_{0j} and u_{1j}) were assumed to be correlated.

Results

A summary of the frequencies of categories for what participants found to be helpful and wished for is shown in Table 1. Following CQR guidelines, results are reported as “general” if they applied to 17 or 18 of the therapists or clients, “typical” if 10 to 16, and “variant” if 3 to 9. In the text, we used quotes from participants (labeled *T* for therapist and *C* for client, followed by a number from 1 to 18 representing each therapist–client pair) to illustrate the categories. Ellipses (. . .) were used when words were deleted to save space. We left out filler words like “You know” and “Mm hmm.”

Helpful Aspects of Therapy: Therapist Perspective

Therapists typically thought that exploration of the therapeutic relationship (e.g., using immediacy to talk about the relationship in

Table 1
Domains, Categories, Subcategories, and Frequencies

Domain, category, and subcategory	Frequency (n)
Helpful things in therapy	
What therapists considered helpful	
Exploring the therapeutic relationship to facilitate self-understanding	T (12)
Facilitating client's emotional expression	V (7)
Challenging client	V (6)
Facilitating termination	V (6)
Being supportive, validating, and affirming	V (5)
Using directives/active techniques	V (5)
Working on dreams	V (3)
What clients considered helpful	
Therapist being supportive, validating, and affirming	T (12)
Therapist introducing new ideas/perspective	T (11)
Exploring the therapeutic relationship to facilitate self-understanding	V (7)
Therapist challenging client	V (4)
Therapist self-disclosing	V (4)
Wishes	
What therapists wished for in therapy	
To have more time in therapy	V (8)
To engage clients differently (e.g., more present, confident)	V (7)
To have explored other content	V (7)
To have identified issues and intervened earlier	V (5)
To have explored the therapeutic relationship more	V (4)
What clients wished for in therapy	
To have more structure and direction (e.g., homework, two-chair)	T (14)
To have different settings (e.g., longer sessions, have a couch)	V (4)

Note. Therapists ($N = 18$); clients ($N = 18$). T = typical (i.e., this category occurred for 10 to 16 participants); V = variant (i.e., this category occurred for three to nine participants). Number in parentheses represents the number of participants for that subcategory.

the here and now) was helpful to facilitate client self-understanding. For example, T8 said, "That was kind of a turning point for us because we were talking about our relationship and what was happening and how it was similar to what happened in other relationships. . . . I think we had some really good work together." In addition, through discussing specific interactions that implicate both the therapist and client, clients may clarify assumptions about their therapists based on past interpersonal experiences and enhance the therapeutic relationship. For instance, T6 noted the following:

She [client] had a strong reaction to something I said about caring about her . . . she had a crush on me, and she looked it up, and it was transference. She was very apologetic. . . . "I hope this doesn't mean we can't work together." And so I talked about it to her in session, and I explored her fears. . . . I think the bit we began to do was helpful for her because I asked her what her fear was, and she said that she thought I'd be disgusted by her being attracted to me. And I was just struck by what a strong word disgusted is. I reflected that to her and I could see that that had an impact on her. I wouldn't be disgusted and I'm not. To actually be able to tell me that she's attracted to me and for us to have a conversation about it where I'm not angry at her or disgusted at her, I think that was a positive experience for her to have.

Therapists variantly reported that facilitating clients' emotional expression was helpful. To illustrate, the facilitation of client emotional expression includes helping clients articulate and experience feelings in session. T10 described this as follows:

He [client] basically said he felt nothing, but we explored some of his sensations, how it was like for him physiologically. He said he got

more irritable, so we kind of explored how those signs, those physical signs could indicate some feelings you had.

Therapists variantly reported that challenging the client was helpful, especially when challenges facilitated client engagement in therapy. For instance, T7 said the following:

I wanted to push and really make the connection like "Hey, we haven't really talked more about this since we first mentioned it. I really feel like with your history and everything we've talked about, we have to talk about it." So, we processed a lot of that loss component, but he was also excited, he felt a sense of accomplishment.

Therapists also variantly reported that facilitating termination was helpful. For example, having a planned time toward the end of the therapy to review progress and set posttherapy goals was deemed productive. T9 said the following:

She really liked this framework of looking back, looking forward, saying goodbye. . . . She remembered a lot and was also really interested in looking forward and setting new goals and gave me a lot of room to give her feedback too. . . . Whenever I gave her feedback she would sometimes avoid it or like talk about something else, so she really let that in at that point, and she talked about how helpful therapy was.

Therapists variantly reported that being supportive, validating, and affirming was helpful. For instance, T2 said the following:

She [client] was crying really, really hard. She was sobbing, kind of more than I had seen her cry before, which she didn't do very often. But there was a moment in the last session when she said slowly, sort of over a while, between breaths, she said "I'm a pretty perceptive

person and if I had felt any time that you were judging me, then I know I would've shut down. But I didn't feel that at all and I wanted to say thank you for that."

In addition, therapists variantly mentioned that using directives and active techniques was helpful. These directives include guidance for client action between sessions (e.g., homework) or in-session activities (e.g., role-play). For example, T3 said, "We did do a couple role-plays and I think he did progress even his relationship with his partner of bringing things up, maybe not so much parents, but with his partner."

Finally, therapists variantly reported that working on dreams in sessions was helpful. For example, T5 said, "Dreamwork was actually very effective in helping her to be less defensive and less cognitive about her experiences. She did tell me that she felt more relieved I think after the dream interpretation, so I feel like it's quite a productive piece of work doing dreams."

Helpful Aspects of Therapy: Client Perspective

Clients typically reported that therapists being supportive, validating, and affirming was helpful. For instance, C8 said, "He kind of assured me that like, he wouldn't judge me . . . he did appreciate when I showed him that type of stuff (a sketchbook), like kind of encouraged me to be as open as I could be." C2, who resonated with T2's support in the last session (see preceding therapist quote), said, "So I wasn't just a client, even though I was. I was a person and that she cares. I felt that a lot. She just said some things that really made me feel like she had really been listening and made me feel so positive about the work that I'd invested in therapy."

Clients also typically talked about the helpfulness of therapists offering new perspectives, including the connection between previous and current relational patterns. C3 said, "Yeah getting an idea of things that I project onto people and sort of unassuming those things. . . . It has taken it from sort of like a weird generalized teenager angstiness and turned it into a thoughtful understanding." C6 said, "[Therapist] helped me recalibrate my perspective of myself. . . . Whereas I was thinking, 'Oh, I failed again, this is all my fault, what's the point of living because I'm never really going to do anything good?' It was always in those moments in those sessions where I finally was able to see that it's not so much about fault."

Clients variantly reported that the therapist's facilitating an exploration of the therapeutic relationship, including helping clients explicitly talk about their feelings about the relationship, was helpful. For example, C5 said, "She always asked me how comfortable I am with her, how I think about our relationship together. . . . I was always honest with her, because that was the truth. She really made me feel at ease and comfortable." C7 said, "[The therapist] checked in pretty frequently about our relationship. . . . helped me become more aware of our relationship. . . . I think that was really helpful."

Clients variantly talked about the helpfulness of therapists' challenges, which were often described as something that clients needed as part of self-improvement. For instance, C11 spoke of how "[the therapist] was willing to interrupt me if she needed to clarify, which is big because I will just steam roll a conversation if I'm on a roll. So not being afraid of that." C15 welcomed her therapist challenging the truthfulness of what she said after the

client admitted to having lied in previous sessions. The client reported saying to the therapist, "That's fine. I'd actually prefer you to do that so you know I'm being genuine."

Finally, clients variantly mentioned that therapist self-disclosure was helpful, particularly helping clients to feel closer to their therapists. For instance, C16 said, "The instance of feeling closer to her was when [T's name] shared with me that she got married over the break . . . it's kind of weird because you share so much of yourself with somebody, but then almost you know very little about them . . . the fact that she shared a personal thing with me showed that obviously there's some trust there too."

Agreement Between Therapists and Clients About Helpful Aspects of Therapy

Therapists and clients both noted that exploration of the therapeutic relationship, therapist challenges, and therapist support and validation were helpful aspects of therapy. However, the frequency for the endorsement differed somewhat between groups. Using the criterion of 30% difference (Ladany, Thompson, & Hill, 2012), clients more often than therapists noted that therapist support and validation was helpful, but therapists and clients endorsed the helpfulness of therapist challenges and the exploration of the therapeutic relationship at similar frequencies.

Wished For in Therapy: Therapist Perspective

All the categories that emerged for therapists were variant. Thus, there was minimal consistency among therapists about what they wished had occurred in the therapy.

Therapists variantly reported that they would have liked to have had more sessions with their clients so that they could have delved deeper into their clients' issues or could have compensated for missed sessions. T6 said, "In the middle of working with her I had migraines, so I think I had to cancel a couple of sessions. . . . Also, she was very erratic with time early on and some sessions she'd come in like half an hour late, and she'd beat herself up over it. We talked a lot about time management and punctuality."

Another variant finding was that therapists wished they had engaged with clients differently, such as wishing they had been more present, confident, and less vocal. T7 said, "There were times when I felt like I was so preoccupied with my own stuff that I wasn't as present as I could have been with him." T13 acknowledged, "Overexplaining and talking a lot, I know that, that's my own contribution in terms of countertransference because that happens across my clients, so I know that's me."

Therapists variantly wished they had explored other content, such as drug use and body image issues, during the course of therapy. T10 said, "I don't know whether he'll be able to reduce his use, but I wish we could have done more with the drug use." T7 said, "There were things that I wish were covered a little more about his body image things, disordered eating sorts of stuff that did come up at the beginning and we talked about but that sort of faded."

Therapists also variantly wished they had identified issues and intervened earlier. T3 would have liked to have addressed client's lateness earlier, "Being late all the time was a really huge challenge, and to being able to process that more with him or bring it up earlier when it first started happening."

Finally, therapists variantly wished they had explored the therapeutic relationship more so that they had gone in greater depth to help clients increase in self-understanding. For instance, T13 said, "I would have liked a lot more time to process my relationship with him and the progress he's made." T3 noted the following:

Addressing how he comes across in our, in the room too, it would have been helpful. I feel like there's all these things that I could've done, but with the tendency to smile when he talks about everything . . . making that more aware in the room because that is a tendency and I think I would bring it up and he's like, "Oh yeah, I do that," and then it just kind of goes, fizzles out, and that's kind of how it would go from there. So maybe focusing more.

Wished For in Therapy: Client Perspective

Clients typically wished that therapists provided more structure and direction in their sessions. They wanted more structure and direction, including homework, reading, role play, breathing exercises, strategies, less ambiguity in session, and instructions on how to prepare for coming sessions. For example, as seen from the quotes, T3 wanted to intervene earlier and explore the therapeutic relationship more, but C3 desired more information and guidance about the therapy:

I really would have liked to have a sort of little pamphlet on what, what is the type of therapy they do in here called. . . . Yeah, I had to ask [the therapist] a bunch of times, she finally sent me a thing on what it is and I see that it's printed out on the table there. I mean, I am just that sort of person where I really need to understand things. That kind of makes me mad when I don't get something that I am part of, and you know, you just come in and talk and she wouldn't say anything and my idea of therapy is totally different, but reading the 3 page paper and then finding a book on the bookshop described it, I was like okay I totally get it.

Similarly, a C7 wanted more direction and said the following:

There were sometimes that I felt like [the therapist] was a little bit passive. I think that it would have been nice to have . . . someone who was more active. [The therapist] was really good and having the conversation and asking good questions, but at sometimes I wish I had gotten some instruction, what I could do to approach things differently. And [the therapist] was much more focused on guiding me toward reaching those conclusions myself, but sometimes I had doubt about if this is what I should be doing.

Clients variantly wished that therapists had approached the therapy setting differently, such as having longer sessions or having the client lie on a couch. C9 said the following:

You're finally pulling your thoughts together and it's already time to leave. So I feel like just a little longer session, maybe an hour session would definitely help. And I always imagined like if there be therapy like when you see in the movies and when you see on television that there's a couch, right? It sort of like relaxes the subject.

Agreement Between Therapists and Clients About Wishes

Therapists and clients did not seem to agree on what they wished for in therapy. Therapists more often (a difference of at least 30%) wished they had more time, engaged clients differently

(e.g., be more present), and explored other content. In contrast, clients more often (a difference of at least 30%) wished therapists had provided more structure and direction.

Agreement Ratings in Relation to Client Outcome

We also rated the level of agreement on what was helpful and what was wished for in therapy for each dyad. Following the precedent of other studies (e.g., Hill, Thompson, & Ladany, 2003), we a priori decided that 3.5 or higher would represent high agreement on the five-point (1 = *no agreement* and 5 = *complete agreement*) scale, moderate agreement would be 2.5 to 3.49, and low agreement would be 1 to 2.49. Hence, we judged that therapists and clients had moderate agreement on what helped ($M = 3.00$, $SD = 1.19$, range = 1 to 5) and low agreement on what they wished for ($M = 2.11$, $SD = 1.23$, range = 1 to 4) in therapy. The dyad-level agreement ratings echoed the extent of agreement found in the group-level qualitative analysis, where there were overlapping "helpful" but not "wished-for" categories between clients and therapists.

Table 2 presents the fixed effects of therapist–client agreement on what was helpful and what was wished for in relation to client outcome assessed throughout the course of therapy (OQ and IIP were analyzed in separate models), controlling for pretherapy client functioning. Agreement between therapist and client on what was helpful in therapy predicted change in OQ and IIP over time (i.e., slope; how quickly OQ or IIP scores change in a given time). Specifically, as agreement in what was helpful increased, there was a greater decrease in OQ (coefficient = $-.036$, $t = -3.14$, $p = .007$) and IIP scores over time (coefficient = $-.0008$, $t = -4.17$, $p < .001$). In particular, an increase of one point of agreement about what was helpful predicts an additional decrease of 0.036 points of OQ score and 0.0008 points of IIP score per day after the start of therapy. However, agreement between therapist and client on what they wished for in therapy did not predict change in OQ (coefficient = $.012$, $t = 1.26$, $p = .23$) or IIP (coefficient = $.0002$, $t = 1.29$, $p = .22$) over time. In addition, agreement in what was helpful and what was wished for in therapy did not predict the intercept (i.e., OQ or IIP scores).

Discussion

Based on posttherapy interviews with 18 doctoral student therapists and their adult community clients, we found that therapists and clients had moderate agreement about what was helpful in therapy, but little agreement about what they wished had happened in therapy. Furthermore, agreement between therapists and clients about what was helpful was related to treatment outcome, whereas agreement about what was wished for was not related to treatment outcome. Our results complement and extend the findings of existing research about therapist–client agreement related to the therapeutic alliance (e.g., Coyne et al., 2017; Laws et al., 2017; Marmarosh & Kivlighan, 2012; Zilcha-Mano et al., 2017).

Helpful Aspects of Therapy

Therapists typically and clients variantly reported that exploring the therapeutic relationship was helpful. It makes sense that therapists valued exploring the therapeutic relationship because they

Table 2
Relationship Between Therapist–Client Agreement on What Was Helpful and What Was Wished For in Therapy and Outcome

Fixed effects	OQ			IIP		
	Coefficient	<i>t</i>	<i>p</i>	Coefficient	<i>t</i>	<i>p</i>
Intercept, β_0						
Intercept, γ_{00}	75.85	29.57	<.001	1.620	20.70	<.001
Help, γ_{01}	–1.88	–.71	.49	.068	.96	.35
Wish, γ_{02}	2.56	1.19	.25	–.063	–.92	.37
Baseline symptoms, γ_{03}	.91	7.40	<.001	.94	4.74	<.001
Days slope, β_1						
Intercept, γ_{10}	–.016	–1.33	.21	–.0001	–.52	.61
Help, γ_{11}	–.036	–3.14	.007	–.0008	–4.17	<.001
Wish, γ_{12}	.012	1.26	.23	.0002	1.29	.22

Note. OQ = Outcome Questionnaire 45.2 (Lambert et al., 1996); IIP = Inventory of Interpersonal Problems (Barkham, Hardy, & Startup, 1996); *t* = coefficient/standard error; Help = therapist–client agreement on what was helpful in therapy; Wish = therapist–client agreement on what they wished for in therapy; Baseline symptoms = client OQ or IIP (in their respective model) at intake.

agreed to work in the clinic from a psychodynamic/interpersonal perspective and were supervised by experienced psychodynamic/interpersonal supervisors. Perhaps these therapists gave their clients a clear rationale for exploring the therapeutic relationship (i.e., to facilitate self-understanding), so that they too were aware of the benefits of such exploration. This convergence may reflect how clients' values tend to become more similar to therapists' values over the course of therapy (Beutler, 1979).

The majority of clients but fewer therapists noted that therapist support, validation, and affirmation was a helpful component of psychotherapy. This finding supports early studies that document the helpfulness of the “interpersonal/affective aspects” of therapy (Elliott & James, 1989, p. 456), and the therapists' “facilitative interpersonal style” (Paulson et al., 1999) and “sense of professional caring” (Levitt et al., 2006, p. 320). Indeed, in a meta-analysis of qualitative studies of client experiences in psychotherapy, the need for therapist support and validation formed the biggest cluster of client experiences (Levitt, Pomerville, & Surace, 2016). Therapists' affirmative stance also helps clients to feel truly understood and facilitates connection at a deeper level (Noyce & Simpson, 2018). In addition, being validating and supportive also reflects therapists' affiliation with the humanistic/existential orientation, in addition to the psychoanalytic/psychodynamic orientation. It is interesting that here, as in the previous literature (e.g., Feifel & Eells, 1963) more clients than therapists mentioned support/validation/affirmation as helpful. We suspect that this discrepancy is because support/validation/affirmation come more naturally to therapists and so they do not recognize them as special, whereas clients have often come from barren family settings where support is lacking and thus their presence is very notable.

Both therapists and clients variably thought that therapists' challenges were helpful in therapy. This result stands in contrast to previous investigators who reported that therapist challenges could be perceived negatively (Levitt et al., 2006). For instance, therapists who delivered overly intense and poorly received challenges were described as “pushy, annoying, and judgmental,” and people who felt “more strongly about an issue than [clients] did themselves” hindered clients coming “to their own decisions” (Levitt et al., 2006, p. 320). Perhaps therapists in the present study delivered

challenges that were sufficiently gentle and collaborative such that their clients valued them and found them to be helpful.

Clients also typically reported that therapists' offering new perspectives and connecting previous and current relational patterns was helpful. Although learning a new perspective is a commonly mentioned helpful aspect of therapy (e.g., Levitt et al., 2006; Paulson et al., 1999), connecting previous and current relational patterns might have been a unique feature of participating in psychodynamic therapy. Given that therapists were psychodynamically oriented, it is surprising that they did not likewise find this behavior to be helpful. Perhaps therapists were humble and did not want to acknowledge that they have offered new ideas and perspectives to clients. Alternatively, therapists might have attributed new ideas to clients instead of themselves as part of exploration and so did not mention them as particularly helpful.

Therapists variably considered facilitating emotional expression and facilitating termination to be helpful. These interventions may reflect therapists' psychodynamic approach to therapy, but they did not appear to leave a sufficiently deep impression on clients for them to also articulate the helpfulness of these activities in the posttherapy interview. This result perhaps illustrates therapists' prizing of therapeutic techniques (Feifel & Eells, 1963). Of course, it could be that clients were not aware of technical vocabulary that labels interventions and phases of therapy, even though they might have judged these interventions to be helpful if they had been asked in a different way.

A few clients but no therapists reported that therapist self-disclosure was helpful. This finding resonates with the literature, where clients rated therapist self-disclosures as more helpful than therapists did (Hill et al., 1988). These findings are also similar to the overall helpfulness of therapist self-disclosures in the literature (Hill, Knox, & Pinto-Coelho, 2018).

What Was Wished For in Therapy

The finding that clients typically desired more structure and direction, such as being assigned homework, role plays, and breathing exercises suggests that many of the clients were knowledgeable about the techniques used in other forms of therapy, such

as cognitive-behavioral therapy. Coincidentally, it lends evidence that the integration of cognitive-behavioral interventions in psychodynamic therapy may demonstrate responsiveness of the therapist and enhance therapy process and outcome (Gold & Stricker, 2001). Therapists therefore need to check in periodically with clients whether the open-ended nature of psychodynamic therapy may lack the level of structure and direction that clients want, and whether what clients are experiencing in therapy match their expectations. For example, compared with clients who themselves are trained mental health professionals, layperson clients prefer greater therapist directiveness and less emotionally intense sessions (Cooper, Norcross, Raymond-Barker, & Hogan, 2019). Therapists therefore need to be aware to not impose on clients their assumptions of what clients want in therapy. In addition, therapists need to present to clients a clear and acceptable rationale for their interventions (Wampold, 2015) so that clients can see the anticipated, helpful path of the therapy.

Agreement in Relation to Treatment Outcome

We found moderate agreement between therapists and clients on what was helpful in therapy (exploration of the therapeutic relationship, therapist challenges, and therapist support and validation). In contrast, there was low agreement on what therapists and clients wished had happened in therapy (i.e., no common categories). Perhaps therapists and clients can come up with many individually preferred ways of conducting/engaging in therapy, such that their overlap is small, whereas there are common factors that characterize helpful therapy experiences (Wampold, 2015). It appears that it is important for participants to agree on what happened that was helpful but agreement on what was wished for does not matter.

The significance of the relationship between therapist-client agreement on what helps in therapy and treatment outcome reflects the essence of collaboration and agreement on the tasks and goals of therapy. When therapists and clients agree on the helpful components of therapy, they can work together more effectively. Across a number of studies, collaboration, which “is an active process whereby the patient and the clinician work together to achieve treatment goals” (Tryon, Birch, & Verkuilen, 2018, p.373), is associated with positive therapy outcome. Development of clinical tools, such as the Therapy Personalisation Form, has aided therapists to learn about what clients want in therapy and then tailor sessions accordingly (Bowens & Cooper, 2012; Bowens, Johnstone, & Cooper, 2011).

Limitations and Future Directions

Data were collected from one training clinic in psychodynamic therapy, and so findings may not generalize to nontraining settings or settings that focus on other theoretical orientations (e.g., cognitive-behavioral therapy). For example, similarity in views between therapists and clients may not be as important for client outcome in therapies that have a less explicit focus on the therapeutic relationship. Also, agreement with clients might be more or less important for therapists with more clinical experience. In addition, the sample size was small for multilevel analysis, although we do need to consider it in the context of a mixed-method study where in-depth qualitative analysis of additional data would

not be feasible. We also increased the sample size at Level 1 by including multiple assessments over time (instead of just pre-post difference) in the model and used restricted maximum likelihood as our estimation method that produces less biased estimates of the variance components in small samples (Raudenbush & Bryk, 2002).

Agreement between therapists and clients was assessed only at the end of therapy through a posttherapy interview, which limits our ability to examine how agreement over the course of therapy may impact process and outcome. Furthermore, data were collected only from clients who returned for the posttherapy interview. Their experiences and responses may be different from those who have dropped out of therapy. Also, therapists were interviewed by other therapists in the clinic; the collegial relationship may have hindered truthful reporting due to social desirability concerns.

Although quantitative (e.g., Kivlighan & Shaughnessy, 1995) and qualitative (e.g., Råbu, Halvorsen, & Haavind, 2011) studies on therapist and client agreement over time had been conducted previously, future studies may include other data collection methods, such as interpersonal recall (Elliott, 1986), where therapists and clients review session recordings and describe in-the-moment thinking about what was helpful and what they wished for in therapy. Examination of how their perspectives converge or diverge over time in relation to session outcome may also provide additional insights. Using research tools, such as the Therapeutic Collaboration Coding System (Ribeiro, Ribeiro, Gonçalves, Horvath, & Stiles, 2013), can also allow in-session markers of collaboration to be systemically identified and related to treatment outcome. For example, judges can read session transcripts, consensually list a client's problems, identify the therapist's problem-specific intervention and the client's response, and categorize the exchange into different types of collaboration. Treatment outcome could be compared across cases characterized by the different types of collaboration to see which type of collaboration is conducive for treatment success. In addition, agreement may have been achieved in part through clients' ability to reflect on and mentalize therapists' intentions, which should be taken into account because reflective functioning has positive associations with working alliance development and psychotherapy outcome (Ekeblad, Falkenström, & Holmqvist, 2016).

Implications

Collaborative goal setting and discussions regarding the tasks and process of therapy appear critical to enhancing client-therapy agreement and in turn increasing the likelihood of an effective course of psychotherapy. We stress the advisability of therapists using immediacy (Hill et al., 2014, 2018) throughout therapy to establish common goals and work on ruptures that inevitably occur throughout therapy. In addition, the therapist's capacity to collaborate with clients toward an agreement on what is helpful in therapy is an important area of focus for training endeavors. Through supervision, didactic learning, and practice, therapists grow their ability to conduct such collaborative and ongoing discussions. Further, the training milieu offers therapists the ability to hone mentalization and reflection abilities over time (Ensink et al., 2013), such that they may better understand and resonate with

the interaction of their own and their clients' desires for successful therapeutic work.

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