# EVALUATING THERAPEUTIC RELATIONSHIP FROM THE PERSPECTIVE OF CLIENT AND THERAPIST

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# EVALUATING THERAPEUTIC RELATIONSHIP FROM THE PERSPECTIVE OF CLIENT AND THERAPIST

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*To those who make me feel like I belong.*

## DECLARATION OF ORIGINALITY

I hereby declare that I am the sole author of this thesis and that this is the true copy of my thesis, including the final revisions, approved by my thesis committee. All data and information have been obtained, produced, and presented in accordance with the rules of research ethics and principles of academic honesty. As required by these rules, to the best of my knowledge I have acknowledged ideas, thoughts, and any copyrighted material in accordance with the standard referencing rules. I certify that any part of this thesis has not been submitted for a degree or diploma in another educational institution.

Mehmet Bora Gerin

## ABSTRACT

The therapeutic alliance is among the most critical aspects of therapy, which brings about change and a positive outcome. The literature regarding therapeutic alliance is mainly focused on individual sessions; therefore, the alliance in couples therapy is investigated less in comparison. This study examined the trajectory of therapeutic alliance in the initial phase of couples therapy conducted in two Turkish university clinics. The observer version of the System for Observing Family Therapy Alliances (SOFTA-o) provided a medium for interpreting the video recordings from those two clinics. Four dimensions of SOFTA (Engagement, Emotional Connection, Safety, and Shared Sense of Purpose) were focused on in the study. A General Linear Model was used to understand the pattern of the therapeutic relationship with the effect of role and session being investigated. Bivariate correlations showed associations between client and therapist dimensions of Engagement and Emotional Connection, whereas the Safety dimension showed weaker patterns.



***Keywords***: Therapeutic alliance, couples therapy, softa

# ÖZET

Terapötik ittifak, değişim ve olumlu sonuçlar getiren terapinin en önemli unsurlarından biridir. Terapötik ittifaka ilişkin literatür çoğunlukla bireysel seanslar düşünülerek yapıldığından, çift terapisinde ittifak daha az araştırılmıştır. Bu çalışma, iki Türk üniversite kliniğinde yürütülen çift terapisinin başlangıç aşamasında terapötik ittifakın seyrini incelemiştir. Aile Terapisi İttifaklarını Gözlemleme Sistemi'nin (SOFTA-o) gözlemci versiyonu, bu iki klinikten gelen video kayıtlarını yorumlamak için bir ortam sağlamıştır. Çalışmada SOFTA'nın dört boyutu (Katılım, Duygusal Bağlantı, Güvenlik ve Paylaşılan Amaç Duygusu) odaklanmıştır. İncelenen rol ve seansın etkisiyle terapötik ilişkinin örüntüsünü anlamak için Genel Doğrusal Model kullanılmıştır. İki değişkenli korelasyonlar, danışan ve terapist boyutları olan Katılım ve Duygusal Bağlantı arasında ilişki gösterirken, Güvenlik boyutu daha zayıf örüntüler göstermiştir.



***Anahtar Kelimeler***: Terapötik ittifak, çift terapisi, softa

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# 1. INTRODUCTION

The therapeutic relationship is generally defined as the alliance between clients and therapists within the context of therapy (Flückinger et al., 2018). It encompasses several aspects that have been investigated. These include shared expectations about what therapy will achieve, agreements on tasks or responsibilities that each person will undertake, and the emotional connection that develops between the therapist and client. In accordance, therapeutic alliance is particularly important, as it supports and strengthens the work done in the other areas (Bordin, 1979). In other words, the therapeutic alliance is a crucial component of the therapy process, significantly impacting the outcome. Therefore, it is grouped under the term “common factors," meaning that the therapeutic alliance is independent of the modality or perspective therapists use (Flückinger et al., 2018). It was suggested that therapists’ characteristics, such as being genuine and empathetic, help build an alliance, and these aspects of the therapists help clients to perceive them as confident and trustworthy (Tilden et al., 2021).

## 1.1 Therapeutic Alliance

Alliance is a common and fundamental element of the psychotherapy process, which predicts the outcome of both individual therapy and couple therapy (Flückinger et al., 2018; Norcross & Lambert, 2018). According to Horvath and Symonds (1991), therapeutic alliance in the earlier sessions of the therapy process was more meaningful in predicting positive outcomes. Namely, the alliance established between the third and the fifth sessions predicted the outcome compared to the later sessions of the therapy process.

On the other hand, misinterpretations and breaches in alliance can influence the process and outcome of the therapy (Escudero et al., 2012). Additionally, it was found

that in cases where this breach in the alliance is identified and addressed through collaboration with the clients, the outcome of the process appears to be even more favorable (Eubanks et al., 2018). However, since both clients and therapists are parties to the therapeutic alliance, both can experience a rupture in the alliance. Unfortunately, the issue with alliance may not be realized by either of the parties and lead to harm in the relationship within the therapy system or even dropping out of therapy altogether (Harmon et al., 2007). Therefore, it is essential for therapists to investigate alliance with their clients and to pay attention to whether their relationship is harmed in any way (Tilden, 2017).

Conceptualizing and investigating the therapeutic alliance as having different aspects, which include the therapist and client as individuals who interact with each other, may provide a clearer picture (Flückinger et al., 2018). This idea is quite natural because the alliance between a therapist and a couple is a human interaction at its core. Therefore, studying the alliance between them should include their emotional connection, the environment they create together, and the social interactions that occur during the process (Horvath, 2017). Moreover, the alliance is not built solely on verbal understanding and agreement on the tasks or goals of therapy, but also has foundations in the attunement between the therapist and the client, the trust they build with each other, and the safety the client can feel while communicating with the therapist. These elements are not created solely by the therapist; rather, both parties participate in building this therapeutic environment together. This environment, in turn, helps clients to be open with their emotions and thoughts (Friedlander et al., 2005).

Another component of therapeutic alliance is that it is a fluid and dynamic construct that differs from session to session. These shifts develop in response to the

emotional dynamics in the room, the way people interact, and how each person interprets the session (Safran & Muran, 2000). Research has shown that even seemingly minor moments, such as a brief exchange of eye contact, can help sustain or restore the alliance when it falters (Tschacher & Meier, 2020). For this reason, the therapeutic alliance is best understood as a multifaceted system with several layers and interconnected elements. Examining it in this way can provide the most detailed and clear picture possible of the therapeutic alliance (Horvath & Greenberg, 1989).

The literature suggests that the therapeutic relationship is related to culture. For instance, culturally shaped concepts such as social beliefs and perceptions regarding mental health and help-seeking can influence how clients express their emotions and how they share vulnerable information within the therapy process. In return, the perception of therapy varies across cultures. (Al-Krenawi, 2019; Topkaya et al., 2017). Furthermore, since nonverbal cues are an important component of understanding the social exchange in therapy, cultural norms regarding how to express them may influence both clients' and therapists' behaviors and their perceptions regarding the relationship between them (Friedlander et al., 2006; Escudero et al., 2008).

### 1.2 Therapeutic Alliance in Couple Therapy

Most therapeutic alliance literature has focused on the alliance in individual therapy. However, Pinsof and Catherall (1986) brought a new interpretation and expanded the alliance into a more "systemic" manner. This new perspective makes interpreting the therapeutic alliance in a couple therapy setting easier, as a systemic approach is essential for couple therapy. Escudero (2016) states that alliance in a couple therapy setting is more complex than in an individual setting. For instance, therapeutic alliance in couple therapy consists of the alliance between the therapist and each client,

the alliance between the clients, and the alliance between the system (within-system) and the therapist. Therefore, for couples therapy, there are more contexts in which therapeutic alliance may be influenced. For example, therapists must keep track of clients individually and their "within-system" alliance (Garfield, 2004). In some cases, one or more components can be impaired throughout the process. Partners can perceive their alliances with the therapist differently, which may affect their motivation to continue the process, or their within-system alliance may lead them to disagree on specific process components or harm their emotional relationship (Friedlander et al., 2016).

Symonds and Horvath (2004) state that in couples therapy, the alliance only affects the result when the clients have the same perception of it. "Split alliances," in which the therapist keeps an alliance with one of the clients, can result from alliance impairments in couples therapy. In cases where the alliance is more split, the outcomes are poorer in comparison (Friedlander et al., 2018; Pinsof, 1995). Therefore, therapeutic alliance plays a complex role in couples therapy, and awareness of it may be crucial to ensure an excellent outcome. Additionally, Knobloch-Fedders et al. (2007) found that the therapeutic alliance was related to marital symptoms; however, it was not found to be related to the individual problems that the partners experienced. According to Tilden et al. (2021), the alliance between the partners as individuals, as well as their perception of the alliance as a couple, predicted influencing decreasing individual symptoms such as anxiety or depression. This finding suggests that, in addition to considering the couple as an entity, therapists should also consider that clients form an alliance with the therapist individually.

Like the alliance in general, earlier sessions were also more helpful in predicting outcomes for couples therapy. Namely, at the end of the third session, the alliance

between the therapy components predicted the process results (Johnson & Talitman, 1997). This is in relation to the fact that the therapeutic alliance in couple therapy may change throughout sessions, rather than remaining stable once it is established (Friedlander et al., 2006). Additionally, it has been suggested that the early development of an alliance is crucial for couples therapy (Halford et al., 2016). Furthermore, it is believed that clients' relationship improvement will be simpler in the early phases of couples therapy if they form an alliance with their therapist both individually and as a couple (Tilden et al., 2021). In this situation, the client-therapist interaction is also very important since it serves as an example of a positive relationship for the couple (Escudero et al., 2012).

Since the therapeutic relationship is influenced by cultural factors, as stated above, it is essential to consider the Turkish context in couples therapy. According to Gürmen's study (2025) about investigating couples therapy in a Turkish context, most couples in initiated therapy voluntarily, and 53% had prior therapy experience. 28% of the couples perceived the presenting problem to be their partner's instead of a shared problem. Communication problems were the most prevalent issue, with 37%, followed by frequent conflict and trust issues. Along with this information, Türkiye's status as a non-WEIRD country and its in-between nature regarding individualism and collectivism create a unique picture of therapeutic alliance in couples therapy (Gürmen & Kılıç, 2022).

### *1.2.1 Between-System Alliances*

A between-system alliance is a type of therapeutic alliance between each individual partner and the therapist (Pinsof, 1994). Knobloch-Fedders and colleagues (2007) found that partners' individual alliances with the therapist predicted improvement

regarding marital distress. Therefore, it was argued that each partner's alliance with the therapist plays a role in couples therapy regarding change.

Symonds and Horvath (2004) demonstrated that when partners shared similar views on the strength of their alliance with the therapist, and the male partners' alliance was strong, the alliance-outcome relationship was the strongest. Additionally, in the same study, they argued that to ensure that clients in couples therapy feel connected with their therapist, the therapist must balance each partner's between-system alliance as well as their alliance as a couple (Symonds & Horvath, 2004).

### *1.2.2 Within-System Alliances*

According to Anderson and Johnson (2010), within-system alliance can be described as a type of therapeutic relationship that occurs between family members or a couple. In other words, it is the team that the clients form with each other in the therapy context, and it entails the idea of "we are together in therapy". In the same study, it was found that this type of alliance is a stronger predictor of early improvement compared to the other types of within-session alliance (Anderson & Johnson, 2010). In this light, it can be inferred that within-system alliances play a crucial role in establishing change.

Within-system alliance entails shared goals, tasks, and a sense of collaboration between clients (Heatherington et al., 2019). This dynamic can be related to the spirit of being a team, as stated above. Moreover, it was found that the stronger the within-system alliance, the better the outcomes of family therapy. Additionally, a stronger within-system alliance predicted a better outcome than just having each client have a relationship with the therapist individually (Heatherington et al., 2019).

A within-system alliance differs from a between-system alliance mainly in several areas. They are the unit of focus, clinical implications, measurement differences, and the focus of intervention.

As discussed by Anderson and Johnson (2010), a between-system alliance is the alliance formed between one of the partners and the therapist. This alliance can differ between partners since it is an individual relationship. It is primarily the therapist-client relationship, and in a couples therapy context, two different between-system alliances can be talked about. However, a within-system alliance refers to the relationship formed between partners regarding the process of therapy. It considers the partners as a subsystem of their own, and it is dependent on the relationship of the couple. This type of alliance is not present in individual settings; therefore, it is one of the unique aspects of couple and family therapy.

Research showed that within-system alliance predicted relational distress at the fourth session more strongly than the between-system alliance. Hence, within-system alliances may play a more significant role than between-system alliances when it comes to predicting outcomes in couples therapy (Anderson & Johnson, 2010). Furthermore, a positive relationship between each spouse and the therapist is not sufficient in couples therapy. When it comes to the therapy itself, partners ought to be able to agree. The therapeutic process may be hampered when couples have a strong relationship with the therapist but disagree on the objectives or course of treatment within their subsystem.

On one hand, between-system alliance can be measured by assessing each client's perception of the therapist, and on the other, within-system alliance is usually measured by items that require perception of each other as well, for example, Anderson & Johnson

(2010) used partner reports, such as “we are comfortable with what the therapist is doing,” “we share goals for the therapy,” etc.

When the partners in couple therapy do not share a similar level of alliance with each other, the issue lies in the within-system alliance. For such cases, the therapist should be helping the couple find a shared sense of purpose, clarify what they’re working toward together, and strengthen their agreement. The goal is to move them from two separate individuals to a team working together. In contrast, when the problem is with the between-system alliance, the therapist’s attention needs to turn toward rebuilding that person’s therapeutic relationship. Anderson and Johnson (2010) emphasize that effective couple therapy requires sensitivity to both levels: helping partners unite with each other while maintaining strong, trusting bonds with the therapist.

### *1.2.3 Split Alliances*

A split alliance occurs when the strength of the alliance between the therapist and the clients differs from one partner to another, in other words, when one client feels that the therapist is more aligned with them than with the other partner. It was argued that this difference can be clinically risky (Pinsof & Catherall, 1986). Even though it may pose a challenge to the therapy process, Heatherington and Friedlander (1990) found that split-alliances occurred frequently, and it is not a rare situation.

One of the threats that split alliances may cause is hindering the process of change. Symonds and Horvath (2004) found that the outcome of couples therapy was better when each partner’s alliance with their therapist was comparable and strong. On the contrary, when split-alliances take place, the results are worse. It was also highlighted that partners in couples therapy may attempt to take the therapist's side, which may lead to the

formation of a split alliance, hindering their shared sense of therapeutic alliance (Symonds & Horvath, 2004).

### 1.3 Perception of Therapeutic Alliance

The therapeutic alliance has a particularly complex structure in couple therapy, as it involves multiple, overlapping relationships between the therapist and each partner, as well as the couple as a unit. Because several people participate in the therapeutic process, each person naturally develops their own understanding of how the relationship is progressing. Research has long shown that clients and therapists do not always perceive their working relationship in the same way (Bedi et al., 2005). These differing perspectives can shape how each partner experiences and evaluates the therapy. Importantly, clients' views of the alliance tend to be more strongly linked to how therapy eventually turns out than therapists' own ratings (Norcross & Lambert, 2018). In other words, therapists may at times misread the quality of the relationship, whereas clients usually have a clearer sense of how the process feels to them. Another pattern that has emerged in the literature is that clients often experience the alliance as something steady, while therapists and outside observers are more likely to notice shifts and fluctuations across sessions (Martin et al., 2000). These perceptual differences are likely to influence both the progression and the outcomes of therapy (Glebova et al., 2011).

### 1.4 Measuring Alliance in Couples Therapy

Early alliance measures, such as the Working Alliance Inventory (Horvath & Greenberg, 1989), were created with individual therapy in mind. Therefore, they focus on the therapist-client dyadic relationship. However, in couples therapy, measures should investigate the alliance among multiple clients, as there are more combinations of alliance

compared to a singular therapist-client dyad (Friedlander et al., 2006). Systemic approaches, such as SOFTA, solve this issue by measuring the therapeutic alliance in a systemic manner (Friedlander et al., 2006).

### *1.4.1 System for Observing Family Therapy Alliances (SOFTA; Friedlander, Escudero, & Heatherington, 2006)*

SOFTA was developed by Friedlander, Escudero, and Heatherington in 2006. The system's main objective is to measure therapeutic alliance in couple and family therapy contexts, which differs from the already established individual therapy contexts. According to the authors (Friedlander et al., 2006), one of the primary motivations for developing such a system was to assess multiple therapeutic alliances in systemic therapy. Namely, they are the alliances emerging between therapist-client, client-client, and client-therapist subsystems (Friedlander et al., 2006).

SOFTA was conceptually related to Bordin's (1979) model of "the working alliance," which views therapeutic alliance as consisting of task, goals, and bond that is shared between the client and the therapist. Yet, SOFTA expanded this individual setting to include multi-person systems, such as couples and families. It is also designed to capture several nonverbal or subtle cues related to the therapeutic alliance, such as interactions, behaviors, and emotional qualities present in a multi-client setting (Friedlander et al., 2006).

Friedlander and colleagues (2006) developed the SOFTA-o version, which is based on observational ratings. This version is used by trained coders/raters who observe and code verbal and non-verbal alliance cues in recorded sessions. Since it includes not only verbal but also nonverbal indicators, this version allows for detailed coding of the therapeutic alliance at both individual and systemic sessions (Friedlander et al., 2006).

There are four core dimensions that are investigated in SOFTA, which are "Engagement in the Therapeutic Process, Emotional Connection with the Therapist, Safety within the Therapeutic System, and Shared Sense of Purpose within the Family" (Friedlander et al., 2006). According to Friedlander and colleagues (2006), the "Engagement in the Therapeutic Process" dimension refers to active participation, being open, and being engaged in therapy tasks and topics. "Emotional Connection with the Therapist" explores the warmth and the affective bond that develops between each family member and the therapist. "Safety within the Therapeutic System" examines whether clients feel protected and experience non-judgmental acceptance, which in turn fosters an environment where open expression of emotions and thoughts is possible. Finally, the "Shared Sense of Purpose within the Family" dimension is related to the family's or the couple's agreement and collaboration about therapy's goals, meanings, and desired outcomes.

Friedlander and colleagues (2006) argued that several key features of SOFTA-o make it a suitable tool for analyzing therapeutic alliances in couples and family therapy. Firstly, it can capture nonverbal behaviors such as gestures, tone shifts in voice, eye contact, and turn-taking between clients. It also allows for multi-session coding, which enables following the pattern of development of alliance across several sessions. Since SOFTA-o is relying on observers to rate recorded sessions, it emphasizes observer reliability by implementing double-coding procedures. Finally, it was also used in research (Escudero et al., 2015) to assess the therapeutic relationship by investigating whether ruptures occurred in therapy and whether therapists or clients tried to repair them, as well as the general development of within and between system alliances, and to track the therapeutic alliance's gradual change throughout sessions.

One of the interesting aspects of SOFTA is the dynamics and interactions of dimensions within the theoretical framework. In the SOFTA Manual, the Shared Sense of Purpose dimension is described as the team spirit of the clients (Friedlander et al., 2006). Accordingly, other dimensions (Engagement, Emotional Connection, and Safety) support the emergence of a Shared Sense of Purpose, as they help create a foundation for it to grow (Friedlander et al., 2006). Previous literature supports this idea as well, such as in Bordin's model of therapeutic alliance (1979), where the goals and tasks of therapy become more important later in the process, compared to others. Additionally, Escudero and colleagues (2008) found that among the dimensions of SOFTA, early behaviors of the therapeutic alliance predict the Shared Sense of Purpose dimension, which in turn predicts the outcomes of systemic therapy.

### 1.5 The Current Study

This study aims to examine how the therapeutic alliance emerges and develops in a face-to-face setting within a Turkish context, considering the cultural and relational dynamics that shape therapeutic processes. In line with previous research, the Shared Sense of Purpose dimension of SOFTA was chosen for investigation to gain a deeper understanding of the therapeutic alliance in systemic therapy, as it helps capture an integrative representation of the therapeutic alliance in couple and family therapy (Escudero et al., 2008; Friedlander et al., 2006). Additionally, since previous literature suggests that clients' reports of the therapeutic alliance are stronger predictors of therapy outcomes than therapists' reports, clients' experiences are considered in understanding the trajectory of the therapeutic relationship in couples therapy (Norcross & Lambert, 2018). This study also tries to contribute to a broader understanding of how therapeutic alliance quality can be captured through a multiple-dimensional perspective of SOFTA.

Previous research on therapeutic relationships indicates that the first few sessions are crucial for establishing a solid foundation for the alliance. Escudero and colleagues (2008) found that when clients exhibit behaviors that help establish a therapeutic alliance during the first three sessions, more favorable outcomes in family therapy are more likely to occur. Thus, the inclusion of the first three therapy sessions was logical. Nevertheless, since most therapists in this study preferred individual sessions during the second and third sessions, the fourth session will also be included in the study. The goal was to reunite the couples at the fourth session and gather more data regarding their within-system alliance.

Accordingly, the research question is as follows: How does therapeutic alliance in couples therapy develop in the early sessions in the Turkish context, considering both the observed alliance dimensions of SOFTA and the perceptions of clients and therapists?

# 2. METHOD

## 2.1 Participants

In the current study, nine couples and six therapists provided data. They participated in the study from Özyeğin University Couple and Family Center and Bilgi University Psychological Counseling Center. The therapists who participated in this study were all master's students of Couple and Family Therapy programs. They were practicing under supervision, which was mandatory for their master's program. From these therapists, one of them was male and the other five were female. On the other hand, the couples included in the study were heterosexual couples. Each couple was given an identification number to ensure anonymity (See Table 2.1).

The setting of this study entailed some socio-economic and cultural considerations. Firstly, all therapy sessions took place in a Turkish cultural context in Istanbul, a metropolitan city characterized by significant regional diversity. Although all clients lived in Istanbul, variations in their districts of residence and cities of origin may contribute to their social values and dynamics. Moreover, cultural differences may occur based on the client's city of origin. Secondly, the university training centers provide affordable service; hence, the clients mainly come from low to middle-income couples. This financial context may shape their accessibility to therapy, as well as their daily life stressors. Consequently, these factors should be taken into account when interpreting the study's results.

**Table 2.1** *Demographic Information of the Participants*

| Couple ID | Age | Gender | Education | Marital Status | Parent | Presenting Problem |
|---|---|---|---|---|---|---|
| 1 | 30 | F | Associate | Married | Yes | Arguing or fighting too much |
| | 37 | M | High School | Married | Yes | Divorce/separation concerns |
| 2 | 35 | F | Bachelor | Married | Yes | Infidelity |
| | 44 | M | High School | Married | Yes | Problem solving or decision making |
| 3 | 50 | F | Bachelor | Married | Yes | Arguing or fighting too much |
| | 53 | M | Bachelor | Married | Yes | Arguing or fighting too much |
| 4 | 37 | F | Associate | Married | No | Arguing or fighting too much |
| | 44 | M | Postgraduate | Married | No | Arguing or fighting too much |
| 5 | 28 | F | Bachelor | Married | No | Arguing or fighting too much |
| | 28 | M | Bachelor | Married | No | Arguing or fighting too much |
| 6 | 26 | F | Postgraduate | Married | No | Communication |
| | 30 | M | Bachelor | Married | No | My partner is overly critical of me |
| 7 | 25 | F | Bachelor | Married | No | Communication |
| | 27 | M | High School | Married | No | Arguing or fighting too much |
| 8 | 25 | F | Associate | Married | Yes | Communication |
| | 32 | M | Bachelor | Married | Yes | Problem solving or decision making |
| 9 | 30 | F | Bachelor | Married | No | In-laws / Extended family |
| | 32 | M | Bachelor | Married | No | Communication |

All sessions included in the study were couples therapy sessions. Among the therapists who participated, one was the therapist for three couples, another was the therapist for two couples, and the remaining four therapists were seeing a couple each. During the data collection period, the therapy sessions were conducted under the ongoing training and supervision of systemic therapy; hence, all therapists practiced from the same perspective.

Participants were required to complete the first four sessions of their therapy process to be included in the data analysis. The selection of the first four sessions was based on the understanding that those initial sessions play a crucial role in shaping the therapeutic alliance. Research by Escudero (2008) indicated that the presence of positive individual behaviors across three therapy sessions was linked to more favorable outcomes

in family therapy. However, due to the inclusion of two individual sessions, generally in the second and third sessions, it was decided to include the first four sessions. This change was made to ensure that the Shared Sense of Purpose dimension could be analyzed properly, since it required both clients to be present. Participants with the identification number 103 were excluded because their video recordings from the first and fourth sessions were both auditorily and visually incomprehensible, making it difficult to observe and rate them in accordance with the coding criteria.

### 2.2 Procedure

During the first sessions, participants received an explanation along with an informed consent form that detailed the study's goals, methods, voluntary participation, and data confidentiality policies (Refer to Appendix B). The recording process began once they agreed to participate in the planned study. Every participant in a study was assigned a participant identification (ID) number to protect their privacy. To protect participants, the video recordings of the sessions were saved with a participant ID number. An external encrypted USB contained the client's first four session recordings.

Sessions took place at the Bilgi University Psychological Counseling Center and the Özyeğin University Couple and Family Center. All sessions happened in a face-to-face setting. Clients were sent questionnaires regarding their therapeutic alliance before each session, except the first one. Therefore, therapists were able to see how their clients perceived therapeutic alliance prior to the second, third, and fourth sessions. Before the first session, they were sent questionnaires to gather information about their demographics. Additionally, clients received an informed consent form that had detailed information regarding the study and its purpose, along with procedures to ensure confidentiality.

Since the SOFTA-o rating task does not require clinical expertise, raters do not require substantial clinical experience, according to SOFTA trainers. Reliable results can be obtained even by those with little clinical experience, such as undergraduate and graduate-level students. Since evaluations will depend on the meaningful interpretation of SOFTA-o items within context, raters must be trained to understand the system correctly. As a result, coders underwent a training phase before systematically coding the video recording. The chosen coders have signed a confidentiality agreement. Only the clients' ID numbers are given access to client information throughout the procedure to preserve their anonymity.

The observers have been trained with the SOFTA-o guidelines. During the coding process, coders watched each session at least twice after the training: once to evaluate the couple's behaviors and again to evaluate the therapist's behaviors while taking notes. Following the rating rules specified in the SOFTA-o, coders provided ratings for each dimension of each video recording of face-to-face sessions using a 7-point Likert scale, with the extremes at -3 (signaling severe problems), 0 (considered unremarkable or neutral), and +3 (signaling excellent strength). Every five sessions, coders double-coded the same video to establish reliability estimates for coding and prevent the coder from drifting from the group. The items in SOFTA-o included both verbal and non-verbal cues. Given that nonverbal cues can be subtle and easily overlooked during observation, this process needed an extra step to ensure adequate attention to detail was given. Therefore, the double-coding procedure was crucial to improve the reliability and accuracy of the coding process.

## 2.3 Materials

As part of Dr. Selenga Gürmen's TÜBİTAK project on "Couple Therapy Effectiveness in Turkey," ethical approval was obtained from the Özyeğin University Ethics Committee. The TÜBİTAK project examines the impact of couples therapy on partners' personal and interpersonal well-being. It also comprehensively analyzes the couples therapy process to better understand the mechanisms that lead to therapy change.

The project data is intended to be gathered from roughly 100 couples (200 partners) receiving couples therapy. At the start of therapy, after the fourth, eighth, twelfth, and sixteenth sessions, and every eight sessions thereafter, up to a maximum of 32 sessions, quantitative and qualitative data are collected. Additionally, therapists will gather information to emphasize the characteristics and themes that clients and therapists view similarly or differently during the change process.

### *2.3.1 Demographic Questionnaire*

In order to understand the sample characteristics, variables such as age, gender, romantic relationship status, and educational attainment are collected from the Marriage and Family Therapy Practice Research Network (MFT-PRN) data. The Practice Research Network (PRN), an international clinical data network, is used to gather quantitative data for the study (Johnson et al., 2017). The PRN system is a network and data repository that facilitates the collection of private and secure client data from various clinical facilities. It enables the use of this data anonymously for cross-cultural comparisons. Cybersecurity safeguards are in place for the online-based PRN system. It is designed so that clients can only access scales sent directly to them, and therapists can only access their clients' data.

### *2.3.2 SOFTA-o*

Students pursuing bachelor's and master's degrees were trained to code session recordings using Friedlander et al. (2005)'s System for Observing Family Therapy Alliances (SOFTA-o). The SOFTA-o utilizes a set of behavioral indicators that have been proven to be either positive or negative and correlate with each of the four SOFTA model dimensions.

These behavioral markers pinpoint individual client and therapist behaviors that strengthen or weaken partnerships. The four dimensions of the SOFTA model are then rated from -3 (indicating significant issues) to +3 (indicating powerful aspects) based on a set of criteria that take into account the frequency, valence, intensity, and clinical significance of these indicators: (1) Engagement in the Therapeutic Process (e.g., "Client indicate agreement with the therapist's goals"), (2) Emotional Connection with the Therapist (e.g., "Client shares a joke or lighthearted moment with the therapist"), (3) Safety within the Therapeutic System (e.g., "client shows vulnerability"), and (4) Shared Sense of Purpose within the Family (e.g., "Clients validate each other's point of view") (Refer to Appendix A).

SOFTA's dimensions align with systemic alliance categories differently. Firstly, the Engagement dimension is related to both within-system and between-system alliances, as it encompasses how each party in therapy is involved in the process, and this involvement can occur between the therapist and the clients or between the clients. (Friedlander et al. 2005). The Emotional Connection dimension, on the other hand, primarily focuses on the between-system alliance, as its primary focus is on the relationship between the couple and the therapist (Friedlander et al., 2005). The Safety dimension is similar to Engagement, as it encompasses the sense of vulnerability within

the couple and how the therapist contributes to building trust in the process (Friedlander et al., 2005). Finally, Shared Sense of Purpose is different, because its area of focus is on the within-system alliance as it observes the team spirit within the couple system (Friedlander et al., 2005).

## 2.4 Data Analysis

### *2.4.1 Shared Sense of Purpose Dimension Coding Considerations*

While investigating the System for Observing Family Therapy Alliances (SOFTA) and its dimensions, the Shared Sense of Purpose (SSP) dimension represents the degree of within-system alliance of the clients by examining how partners collaborate during sessions. Therefore, reliable coding of this dimension requires the presence of both partners.

In the present study, the majority of the second and third sessions were conducted individually, as per the therapists' practical preferences. Yet, this approach limited the number of sessions where the couple is present at the same time. Thus, the data for the SSP dimension lacks some crucial information. On one hand, previous research on the development of therapeutic alliances in couple and family therapy recommends including the first three sessions (Escudero, 2008). However, the coding process is extended to include the fourth session in the current study. This change occurred following the guidance of SOFTA developer Valentin Escudero.

# 3. RESULTS

## 3.1 SOFTA-o: Inter-Rater Reliability & Validity

SOFTA-o's psychometric validity has been supported by the previous research. Friedlander and colleagues conducted a study in 2006 with 120 couples and families from English and Spanish-speaking backgrounds. They managed to confirm SOFTA-o's psychometric abilities in the same study. Moreover, another study examined different therapeutic alliance measures used in couples and family therapy, and it was found that SOFTA was associated with higher levels of positive outcomes compared to the other measures in the meta-analysis (Friedlander et al., 2018). In accordance with the findings of these studies, SOFTA-o was selected as a reliable measure for observing and investigating therapeutic alliance in the present study.

Prior to coding, all coders completed a 15-hour-long training led by Valentin Escudero. To maintain strong interrater reliability prior to rating the session video recordings, the team has coded six to eight role-play video recordings. These recordings consisted of both positive and negative examples of Engagement, Emotional Connection, Safety, and Shared Sense of Purpose, along with clear audio and visual quality. The coding process for the actual sessions began after the coders achieved a minimum intraclass correlation coefficient (ICC) of 0.70 on the role-play recordings.

During the coding phase, each session was viewed at least twice: once to examine the couple's behaviors and once to examine the therapist's behaviors. During the viewing processes, the coder also took notes explaining their reasoning behind their ratings. Each dimension was rated on a 7-point Likert scale, which ranges from -3 to +3, indicating severe problems on the dimension and a strong alliance score for the dimension, respectively. If coders did not find anything remarkable, they assigned a score of 0 for

that dimension. This scoring process was conducted separately for the clients and the therapist. To maintain reliability and minimize the possible occurrence of different interpretations between the coders, four coders coded the same seven sessions altogether. Then, to complete the ratings of the session recordings, the team was divided into two subgroups, each containing two coders. According to the manual, at least ten therapist sessions or five client sessions are required to determine adequate reliability. In line with this rule, only client reliability was adequately calculated. To overcome this limitation, the coding team's previously established therapist dimensions' ICC scores from the online session ratings were incorporated in this study. Biweekly meetings were held throughout the process, where subgroups reviewed and discussed their ratings. At each meeting, they were expected to reach a consensus regarding their ratings to sustain their reliability levels.

Interrater reliability for SOFTA-o dimensions (Engagement, Emotional Connection, Safety, Shared Sense of Purpose) was examined using intraclass correlations (ICC) with a consistency definition for both roles separately (client and therapist). The SOFTA-o manual indicates that the coders need to code at least five sessions together to assess the clients' reliability, and ten sessions together for the therapist dimensions' reliability. The coder team was able to rate seven sessions together. The other sessions were coded with sub-groups. Therefore, the clients' reliability scores were calculated. However, the therapists' scores are compensated by using the team's previous reliability scores, which were assessed by analyzing online sessions.

For the client dimensions, the results indicated somewhat moderate to high reliability across all dimensions. The engagement dimension had the lowest reliability score, at 0.53. Then, emotional connection had a moderate ICC score of 0.76, safety had

a score of 0.77, and Shared Sense of Purpose had the strongest reliability score, at 0.95. In other words, the values indicate lower consistency for the Engagement observation scores, moderate consistency for the Emotional Connection and Safety dimensions, and high consistency in the Shared Sense of Purpose dimension.

On the other hand, as mentioned above, the therapist ICC scores could not be calculated due to the lack of sessions, which the coders rated altogether. However, the reliability scores for the therapist dimensions were derived from ratings of the online session video recordings. The coder team, which rated the face-to-face sessions, was a part of the bigger team that coded the online session video recordings. Therefore, an inter-coder reliability between the members of the face-to-face coder team has already been established, as they were a part of the online session coding team previously. Therefore, the scores of the previously established therapist dimension scores were interpreted to be representative. The reliability coefficients of ICC demonstrated high consistency across all therapist-related dimensions. Engagement had a score of 0.93, Emotional Connection had a score of 0.94, Safety had a score of 0.81, and the Shared Sense of Purpose dimension had a reliability score of 0.91.

### 3.2 Dimension Patterns

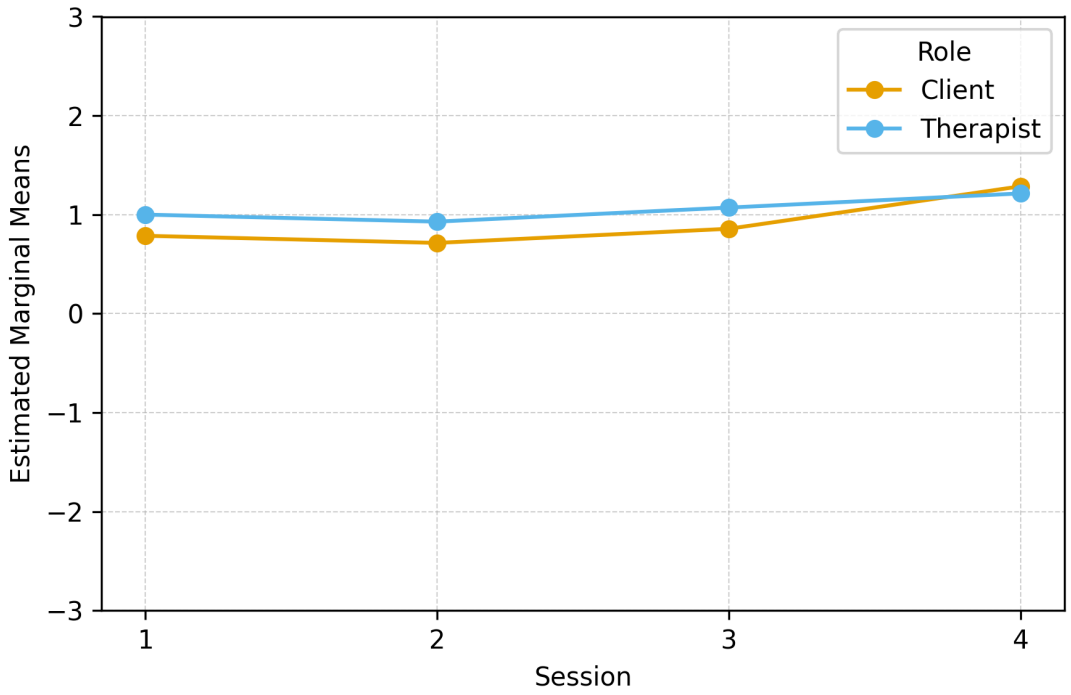
While examining the therapeutic alliance in couples therapy, four dimensions mentioned in SOFTA were included in the analysis. Namely, they were Engagement, Emotional Connection, Safety, and Shared Sense of Purpose. The analyses consisted of the first four sessions, and ratings were made from clients (n = 7) and therapists (n = 7). However, due to missing values, the Shared Sense of Purpose dimension had data from five clients and therapists. Repeated-measures general linear models were used to test changes across sessions (from one to four), differences between roles (therapist and

client), and the interaction between Role and Session for each dimension. Session was entered as a four-level within-subjects factor, and Role was entered as a between-subjects factor.

### *3.2.1 Engagement Dimension*

Engagement scores were high on average for both roles and remained stable over time. Clients' ($M = 1.32$, $SD = .09$) and therapists' ($M = 1.16$, $SD = .12$) between-subjects effect of role on engagement was not statistically significant, $F(1, 12) = 1.14$, $p = .31$, $\eta^2 = .09$. This result indicates that clients and therapists did not differ significantly in their general perception of engagement. Engagement did not significantly change across sessions, $F(3, 36) = 0.32$, $p = .81$, $\eta^2 = .03$, it remained relatively constant. The Session × Role interaction was also not statistically significant, $F(3, 36) = 0.69$, $p = .56$, $\eta^2 = .05$, indicating that the trend of engagement over the first four sessions was similar for clients and therapists (See Figure 3.1).

**Figure 3.1** *Estimated Marginal Means of Engagement Across Four Sessions for Clients and Therapists*



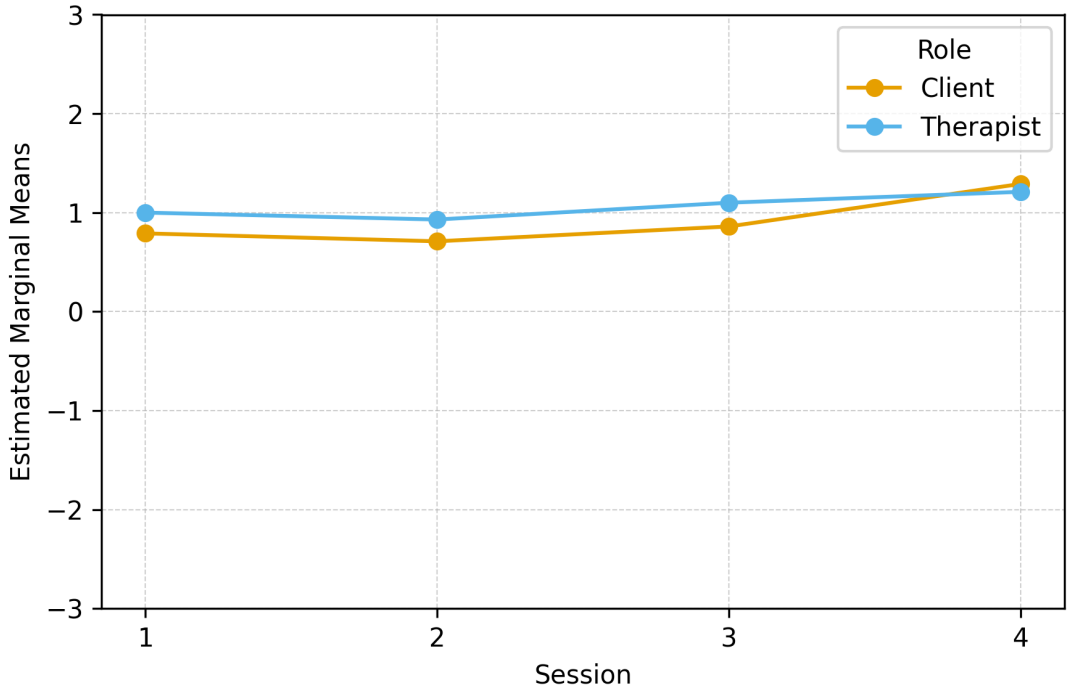

### *3.2.2 Emotional Connection Dimension*

According to the analysis, emotional connection scores increased over time. Clients' ($M$ = .91, $SD$ = .26) mean of emotional connection ratings increased from 0.79 in the first session to 1.29 in the fourth session. Therapists' ($M$ = 1.06, $SD$ = .12) means of emotional connection ratings also followed an increasing pattern, throughout sessions (Session 1 = 1.00; Session 4 = 1.21). The main effect of Session on Emotional Connection was statistically significant, $F(3, 36) = 4.53$, $p = .009$, $\eta^2 = .27$. Follow-up contrasts showed a significant linear trend, that increased with step-by-step manner, $F(1, 12) = 6.00$, $p = .031$, $\eta^2 = .33$, consistent with a gradual increase rather than a great increase at one specific session.

The main effect of Role on Emotional Connection was found to be not significant, $F(1, 12) = 0.57$, $p = .467$, $\eta^2 = .05$. On average, clients (M = 0.91, SE = 0.13)

and therapists (M = 1.05, SE = 0.13) were observed to show similar levels of emotional connection scores. Additionally, Session and Role interaction was not statistically significant, $F(3, 36) = 0.66$, $p = .585$, $\eta^2 = .05$. Therefore, emotional connection increased across the four sessions, and this increase was true for both roles (See Figure 3.2).

**Figure 3.2** *Estimated Marginal Means of Emotional Connection Across Four Sessions for Clients and Therapists*

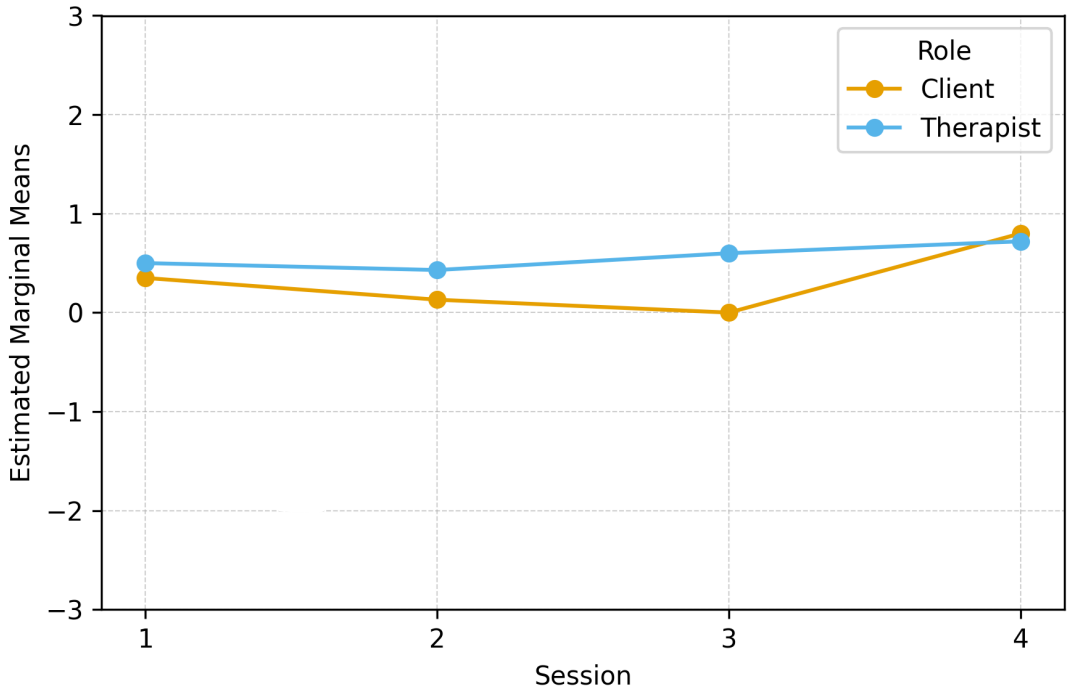



### *3.2.3 Safety Dimension*

Safety ratings were not as high in level compared to the engagement and emotional connection dimensions. Clients showed lower safety scores early in therapy (Session 1, $M = 0.36$; Session 2, $M = 0.14$; Session 3, $M = 0.00$), while therapists perceived the same sessions as notably safer (Session 1, $M = 0.86$; Session 2, $M = 0.43$; Session 3, $M = 0.79$). By Session 4, both groups converged (client $M = 0.71$; therapist $M = 0.71$).

The main effect of role was found to be significant across sessions, $F(1, 12) = 5.22$, $p = .041$, $\eta^2 = .30$. Namely, therapists rated the environment as safer ($M = 0.67$, $SE = 0.12$) than clients did ($M = 0.30$, $SE = 0.12$). On the contrary, safety scores did not differ significantly across sessions, $F(3, 36) = 1.16$, $p = .338$, $\eta^2 = .09$, and the Session × Role interaction was not significant as well, $F(3, 36) = 0.84$, $p = .482$, $\eta^2 = .07$. In other words, safety did not show a consistent increasing pattern across sessions, rather role showed a more robust effect with safety (See Figure 3.3).

**Figure 3.3** *Estimated Marginal Means of Safety Across Four Sessions for Clients and Therapists*



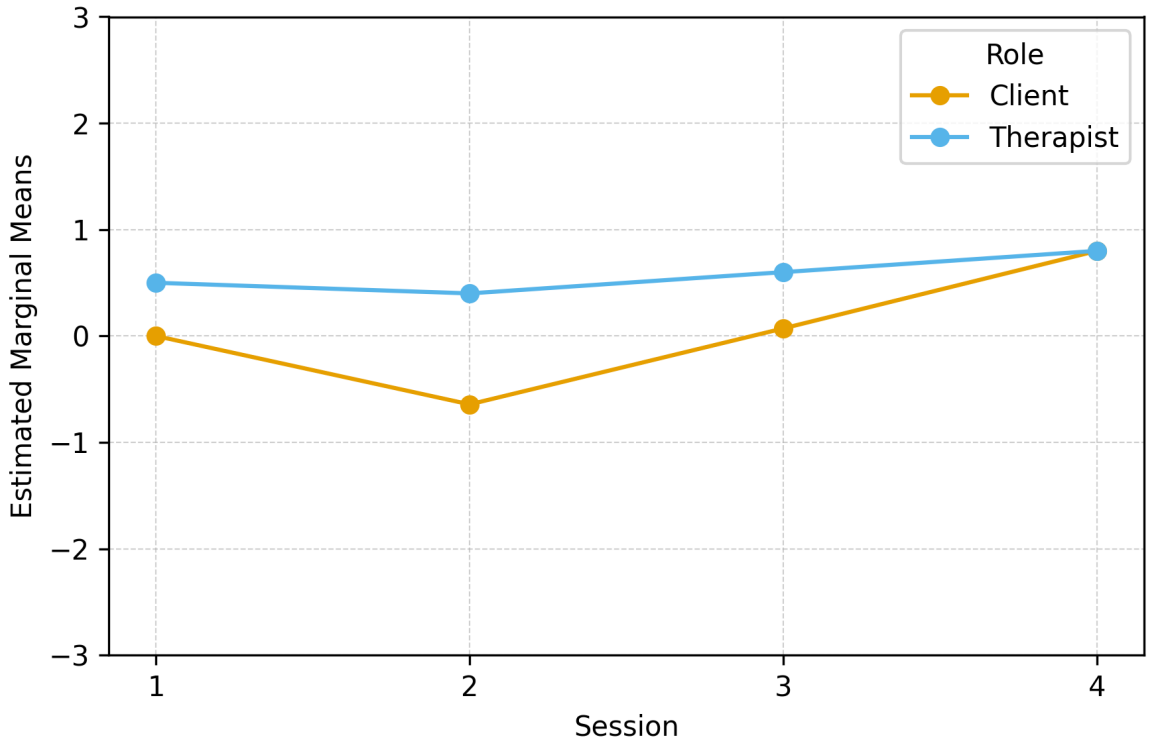

### *3.2.4 Shared Sense of Purpose Dimension*

Shared Sense of Purpose (SSP) was only available for a subset of the data (n = 5 for both therapists and clients). The clients' (M = .15, SD = .44) means across the first and fourth sessions were 0.00, –0.10, –0.10, and 0.80, indicating that perceived shared

purpose was weak or even negative in the early sessions, then rose by the fourth session. Therapists ($M$ = .58, $SD$ = .17) showed the same increase at the fourth session ($M$ = 0.80). However, therapists tended to rate SSP higher than clients in the first three sessions (M = 0.50, M = 0.40, M = 0.60, respectively).

In the repeated-measures model, neither session nor role showed statistically significant effects. The main effect of session on SSP was not statistically significant, $F(3, 24) = 2.09$, $p = .13$, $\eta^2 = .21$. The main effect of role was not statistically significant, $F(1, 8) = 0.81$, $p = .39$, $\eta^2 = .09$ (clients: $M = 0.15$, $SE = 0.33$; therapists: $M = 0.58$, $SE = 0.33$). The Session and Role interaction was also not significant, $F(3, 24) = 0.53$, $p = .66$, $\eta^2 = .06$ (See Figure 3.4).

**Figure 3.4** *Estimated Marginal Means of Shared Sense of Purpose Across Four Sessions for Clients and Therapists*



### 3.3 Correlations Among Dimensions

To examine the relationships between SOFTA-o dimensions interacting with the role variable, a Pearson's r Bivariate Correlation was conducted. As shown in Table 3.1, the Engagement dimension of the clients was significantly and positively correlated with the Engagement dimension of the therapists, $r(8) = .82$, $p = .012$, 95% CI [−.09, .97]. The Engagement dimension of the clients was found to be correlated with their Shared Sense of Purpose, as well, $r(8) = .72$, $p = .044$**,** 95% CI [−.58, .99]**.** Similarly, Engagement of the therapists was positively associated with the Shared Sense of Purpose dimension of the clients, $r(8) = .71$, $p = .047$, 95% CI [−.08, .95]**.** Client-rated Emotional Connection showed a strong, significant positive correlation with therapist-rated Emotional Connection ( $r(8) = .90$, $p = .002$, 95% CI [.67, .99]) and with therapist-rated Shared Sense of Purpose ( $r(8) = .82$, $p = .013$, 95% CI [.46, .97]). Moreover, confidence intervals show that precision is limited due to the small sample size.

Other correlations were not found to be statistically significant; however, several were positive and in the expected direction, as reported in the previous literature. While clients and therapists may perceive therapeutic alliance similarly, this alignment was not consistent across all four dimensions. In particular, correlations involving the safety dimension were relatively weaker, implying that perceptions of safety may be less shared during the first four sessions of couples therapy compared with the other therapeutic alliance components.

Overall, these results show that stronger Engagement and Emotional Connection, for both clients and therapists, tend to co-exist with a greater Shared Sense of Purpose in couples therapy. Findings partially support the idea that clients and therapists perceive therapeutic alliance similarly during the early phase of therapy.

**Table 3.1** *Correlation Table of the Dimensions*

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 1. Engagement – Client | — | .82* | .37 | .03 | .56 | .31 | .72* | .68 |
| 2. Engagement – Therapist | | — | .45 | .19 | .43 | .14 | .71* | .66 |
| 3. Emotional Connection – Client | | | — | .90** | .70 | −.26 | .63 | .82* |
| 4. Emotional Connection – Therapist | | | | — | .43 | −.37 | .31 | .69 |
| 5. Safety – Client | | | | | — | −.29 | .62 | .57 |
| 6. Safety – Therapist | | | | | | — | .27 | .17 |
| 7. Shared Sense of Purpose – Client | | | | | | | — | .65 |
| 8. Shared Sense of Purpose – Therapist | | | | | | | | — |

*Note. N = 8. p < 05*, p < .01** (two-tailed).*

### 3.4 Reflections on SOFTA's Challenges

The observational framework of SOFTA provided several benefits to the analysis process. The literature demonstrates its suitability for research in various contexts. However, there were also some challenges in applying the framework, which have been reflected in the results.

Firstly, during the coding phase, it was hard to follow facial expressions and minute gestures. In many video recordings, the cameras used to record the sessions were located on the ceiling, which created a perspective that made it difficult to see the clients' and the therapist's faces clearly. Due to the layout of the therapy rooms, only half or two-thirds of faces could be seen in most videos. Therefore, even though coders were able to observe facial expressions, they did so with some uncertainty.

Early sessions were marked by ambiguity due to the clients' unfamiliarity with couples therapy. This may have created some confusion in understanding whether the clients are disengaged or if they are not comfortable enough due to their emotions, such as shyness. This confusion may be related to the low ICC scores of the clients' Engagement dimension, since different coders perceived the emotions and behaviors differently.

Certain items were associated with specific cultural contexts. For instance, smiling and joking were quite common in many sessions, which decreased the importance given to those items by coders. It was thought that these behaviors could be related to the cultural context of the clients. Even though those items were marked, their contribution to the overall dimension score was not seen as high as some other items.

Coders may have focused on different cues from the same session recordings. Since many cues require attention to detail, it can be hard to notice every cue in the session. Therefore, the difference in attention and which cue captures the coder's attention first may lead to differences in ratings. Additionally, dimensions, except for Shared Sense of Purpose (Emotional Connection, Safety, and Engagement), have some overlapping concepts, which may lead to different interpretations of the same behavior. For example, one specific behavior can be appropriate for multiple dimensions based on the observer's perspective. These issues were tried to be compensated for by holding bi-weekly meetings. Yet, in dimensions that have more subtle items and allow for different interpretations, they were harder to resolve, hence more evident in the results. The Engagement dimension can be given as a primary example of the dimensions that may have been affected by this problem.

# 4. DISCUSSION

The goal of the current study was to investigate the formation of the therapeutic relationship in in-person couple therapy. According to the four aspects of the System for Observing Family Therapy Alliances (SOFTA), engagement, emotional connection, safety, and shared sense of purpose, it specifically looked at how alliances form and grow (Friedlander et al., 2006). Along with the trajectory of these dimensions, whether the clients and therapists share or differ in their perspectives was investigated in the study. Also, how these dimensions shape clients' perception of therapeutic alliance in couples therapy was investigated as well. By focusing on both the process and measurement of the therapeutic alliance in couples therapy, this study sought to contribute to a broader understanding of how relational dynamics shape therapeutic alliance development in couples therapy.

As the literature suggests, cultural influences may lead to differences in clients' perceptions and behaviors regarding therapy (Al-Krenawi, 2019). For instance, the concept of therapy in Türkiye has a reputation that may induce stigma due to societal norms and cultural factors (Topkaya et al., 2017). Therefore, the expected behavioral cues that signal a therapeutic relationship may have different meanings among clients and therapists from different cultural backgrounds. This cultural difference may be related to the results and should be considered when interpreting them.

## 4.1 Interpretations of the Results

### *4.1.1 Interpretations of the General Linear Model*

It was found that the engagement dimension had high ratings across all four sessions, indicating that it was relatively high compared to the other three dimensions and

stable. There was no significant main effect of session on engagement, further showing its stability across sessions rather than the existence of a specific point of change in the therapy process. Additionally, there was no significant main effect of role on engagement, meaning that both clients and therapists perceived engagement similarly. Moreover, there was no interaction between the number of sessions or the role of the participant, which shows that the trajectory of emergence and development of engagement with the therapy was parallel across groups over time. These findings suggest that the engagement dimension appears to develop early in the process, as early as the initial session. Then, it continued to be sustained over four sessions, suggesting that both parties in the therapy were committed to it from the start and maintained their engagement levels. In accordance with previous research, the Engagement dimension occurred early in the process and remained stable over time (Flückiger et al., 2018).

Unlike the engagement dimension, emotional connection showed an increase over the course of four sessions. This growth was significant and linear, suggesting a consistent growth across sessions. According to Stiles and colleagues (2004), emotional bond within therapeutic alliance develops with time. Therefore, this result was in line with the literature. Additionally, this pattern was similar for both clients and therapists, meaning that the role did not influence emotional connection, and both parties perceived similar levels of this dimension.

When examining the components of emotional connection, it can be inferred that emotional warmth and responsiveness develop progressively in couples therapy. This process takes time as emotional connections do not start off at high levels; instead, they increase as clients and therapists spend time together in sessions. A possible underlying mechanism for this process may be the deepening of trust and emotional attunement that

occurs between the two parties in couples therapy. As clients and therapists develop trust and emotional understanding with each other, their emotional connection may deepen (Horvath & Greenberg, 1989). In addition, growth in emotional connection may signify a developmental change in the therapeutic alliance, which is in line with the literature, as it is an expected occurrence in the early to mid-therapy process (Bachelor & Salamé, 2000; Stiles et al., 2004).

The Safety dimension was the only one that showed a significant difference between roles. According to the results, therapists perceived sessions as safer than clients did. There were no significant interaction effects, indicating that the gap between the therapist and clients remained unchanged over time. This result may suggest that clients feel less safe than therapists thought. According to Glebova and colleagues (2011), therapists show a trend to rate therapeutic alliance more positively than clients. Hence, the Safety dimension in this study aligns with the findings of the literature. Therapists' blind spots, such as overestimating client comfort during sessions or underestimating small signals of distress, may be connected to this. This discomfort may show itself as anxiety, distance, defensiveness, or resistance. Therefore, safety may be interpreted as a critical dimension where the alignment between the therapist and clients may be the weakest and needs the most work to be repaired.

The Shared Sense of Purpose showed a visible but not statistically significant increase over the course of the first few sessions. There was no main effect of role; however, therapists' mean scores were higher in the early sessions. Similar to the safety findings, according to Glebova and colleagues (2011), therapists show a trend to rate therapeutic alliance more positively than clients. Although the difference was not statistically significant, it can be explained by previous research. Again, there was no

significant interaction between role (therapist or client) and session (first to fourth). However, it is important to consider that due to the setting of couples therapy that was conducted with the Emotion Focused Therapy (EFT) modality, there were two sessions where clients attended individually rather than as a couple. Therefore, their shared sense of purpose could not be observed in those sessions. Additionally, there was more missing data compared to the other dimensions in the Shared Sense of Purpose. Therefore, it is important to consider these factors when interpreting the results.

While keeping the statistical shortcomings in mind, two important findings can be interpreted. Firstly, the visible but not statistically significant increase in the mean by the fourth session may indicate that the sense of a shared purpose strengthened over time. Secondly, this late development of SSP may be related to the development of the other dimensions, especially emotional connection and safety, since their levels were not high from the start. This interaction may suggest that shared goals and the sense of being a team emerge as trust and emotional connection develop. Therefore, creating a possible chronological order between these dimensions.

When looking at the cross-dimensional dynamics, engagement levels were consistently high, unlike the other dimensions, which grew or changed over time. This relation may suggest engagement as a predecessor of a deeper therapeutic alliance. With engagement's presence, the other dimensions find a ground where they can develop as well. The gradual increase in Emotional Connection parallels the eventual increase in SSP at the fourth session. This may indicate that with emotional connection, it becomes easier to create an environment where unity of purpose is possible. Another important finding is that safety and emotional connection tended to be present at high levels, especially for therapists, which may indicate the potential for a perceptual co-occurrence of positive

alliance qualities. Finally, when examining the order of emergence and the development of patterns, it can be argued that there may be a temporal relationship between the dimensions. The first one to occur and create a ground was engagement, which enables behavioral collaboration between and within systems. This collaboration may create a social environment that allows the other dimensions to develop. The second one to occur was emotional connectedness, since the social link between systems may lead to relational attunement over time. Then came safety, which enables emotions to be worked on in a secure environment. Finally, the levels of shared sense of purpose emerge last, since goal and task alignment may require collaboration, attunement, and security to be present.

### *4.1.2 Interpretations of the Correlation Analysis*

Investigating the results of the correlation matrix reveals some meaningful associations between SOFTA-o dimensions of therapeutic alliance. Firstly, clients' Engagement dimension showed strong and positive correlations with both therapists' Engagement dimension and clients' Shared Sense of Purpose dimension. This association suggests that when clients feel more engaged in the couples therapy process, they are also more likely to perceive themselves as a team with their partner. This supports the literature in that engagement is a reflection of commitment to the therapy and that it is related to early alliance development (Escudero et al., 2008).

The Emotional Connection dimension of the clients correlated with therapists' Emotional Connection and with both roles' Shared Sense of Purpose. This link of relations, and especially emotional involvement among therapists and clients, reflects that there could be an interdependence between the two roles in couples therapy regarding emotional responsiveness and therapeutic alliance formation. This interdependence could

highlight the importance of synchrony in both within-system and between-system alliances as an essential force driving couples therapy (Anderson & Johnson, 2010).

Unlike other dimensions, Safety correlations were weaker and inconsistent. While clients' Safety dimension correlated moderately with clients' Shared Sense of Purpose, therapists' Safety did not show any remarkable associations with most other dimensions. This may indicate that observable safety behaviors, which are mostly nonverbal, are less apparent in early sessions. Another interpretation could be that different roles may be experiencing the Safety dimension differently (Anderson & Johnson, 2010).

In other words, the correlational pattern of SOFTA-o dimensions suggests that there might be an important dynamic happening among dimensions. The Engagement and Emotional Connection dimensions were found to be the most dynamic and interrelated dimensions of the therapeutic alliance in couples therapy, whereas Safety and Shared Sense of Purpose do not follow a similar trajectory as the other dimensions.

### 4.2 Strengths and Limitations

This study has several notable strengths. First of all, unlike much of the existing research in the field, it focuses on incorporating observer assessments of therapeutic alliance. The use of SOFTA-o provided a detailed behavioral analysis of therapeutic alliance in couple and family therapy indicators (Engagement, Emotional Connection, Safety, and Shared Sense of Purpose). This methodology allows for a nuanced, detailed, and validated perspective of client and therapist dynamics in couples therapy that other types of self-report measures alone would not be able to capture. The application of this methodology is novel in Türkiye; therefore, the study aimed to explore an area where there is little to no information regarding the issue at hand.

Secondly, during the coding phase of the study, coders underwent rigorous training. The team had access to and completed a structured training given by Valentin Escudero. Biweekly meetings also provided insight to coders from their group members in order to prevent potential drifts and differences in perception. The resulting Intra-Class Correlation Coefficient scores indicate that the coding team achieved a consistent understanding of therapeutic alliance indicators across the initial sessions of the therapy process.

The focus on observing the first four sessions enabled the investigation of understanding early therapeutic alliance development. In other words, this study provides insight into how the alliance emerges, stabilizes, or changes during the initial period of couples therapy, and the literature suggests that this period may be associated with later outcomes.

This study extends SOFTA-o research and its application into a Turkish context, which differs from the majority of studies that have utilized SOFTA-o. This cultural difference can aid in understanding couple interactions and alliance behaviors in various settings, particularly in non-Western samples. Moreover, this study tries to bring novelty to the application, and it is one of the first attempts to explore the therapeutic relationship in a different cultural setting.

This study also has some limitations. Firstly, couples participating in this study are mainly recruited via the snowballing method. Additionally, most of them come from a similar socioeconomic and cultural background, and this study only included heterosexual couples. Therefore, the results of this study may not accurately represent diverse demographics, and they should be interpreted with caution.

An important limitation of the study is that the clients' Engagement dimension has a relatively low ICC score, yet it is also related to the main findings of the study. This limitation may stem from the coding team's different ratings of their observations of the clients' engagement behaviors. Since clients' engagement behaviors can be culture-dependent and not overt, the coders may have evaluated some session recordings differently, which could have decreased the ICC scores. Therefore, even though the clients' Engagement score was found to be predictive for interpreting therapeutic alliance, it should be interpreted cautiously.

Along with the low ICC score of the clients' Engagement dimension, the study has limited statistical power due to the small sample size. It is challenging to determine whether the non-significant results reflect an absence of effect or are related to the insufficient sensitivity of the statistical models. While the study's findings provide support for exploring the therapeutic relationship in couples therapy, they should be interpreted with caution.

All therapists who participated in this study were trained in the systemic approach and are in their graduate practicum years. Therefore, like the couples participating in the study, this study also lacks a diverse group of therapists. Hence, the study may have limited generalizability.

Another important restriction of the study was that, due to procedural limitations during the coding phase, only seven sessions were coded by the whole team. Therefore, the SOFTA-o manual's criteria for assessing therapist sessions' reliability were not met. Even though this limitation was tried to be remedied by importing reliability from the previous work of a team that included the current coder team, this situation restricts the reliability of the study.

Although the observational design enables objective rating, the lack of complementary self-report data limits the understanding of how the dynamics between therapeutic alliances are experienced by the clients. This limitation restricts the interpretive depth of the study, leaving out subjective experiences or perceptions of therapy effectiveness.

Finally, although SOFTA-o is widely used in international studies, it was originally developed in Western contexts. Therefore, certain culturally specific interaction styles or emotional behaviors in Turkish couples may not be accurately interpreted by the coding items.

### 4.3 Future Directions

By broadening the focus of inspections and the observational therapeutic alliance approach, future research can build upon the existing findings. One way of doing so is to incorporate more conjoint sessions and a larger sample size, which would improve statistical power and enable more predictive comparisons. Longitudinal designs could be especially insightful, as they would enable the tracking of therapeutic alliance trajectories over sessions and the investigation of key points in couples therapy where the alliance may experience ruptures or repairs.

To better understand how observed therapeutic alliance behaviors are mirrored in and experienced by the individuals involved in the treatment process, future research may consider improving methodology by combining observational data with other techniques, such as client and therapist self-reports. Another way of enhancing methodology can be achieved by ensuring an accurate and detailed cross-cultural adaptation, where even the nuanced behaviors can be captured by the observers easily.

Finally, qualitative or mixed-method approaches could shed light on deeper insight into the meaning and experience of therapeutic alliance behaviors within the couples therapy context. In addition to quantitative methods, qualitative studies can enrich the systemic understanding of how the therapeutic alliance emerges and develops over its trajectory.

### 4.4 Clinical Implications

The study has several clinical implications. First of all, while emerging therapists learn to establish therapeutic alliances, they may have some blind spots that they cannot identify correctly. With more than one client present in the room, therapists can easily miss some nonverbal cues. Another blind spot can be that, while working with clients, some therapists can interpret the alliance with their clients as high because they agree with the therapist during sessions. Yet, by neglecting the other aspects of therapeutic alliance, they can have a hard time navigating through the therapy process. Similarly, they may lack the full grasp of establishing and maintaining a successful alliance and the knowledge or expertise to comprehend what is missing, even if they communicate with their clients. With the help of observers and a standardized framework, their sessions can be investigated further. Hence, emerging therapists will be able to gain a deeper understanding of their cases and refine their techniques to enhance their performance. This enhancement can enable a space where therapists and clients can feel more engaged in their process. With a stronger engagement, the rates of dropouts could drop, leading to a more fruitful context (Flückiger et al., 2018; Norcross & Lambert, 2018).

The results of the study suggest that engagement can be crucial in predicting a Shared Sense of Purpose, highlighting the importance of creating sessions where clients can feel engaged in the process. Therapists may benefit from prioritizing the development

of engagement in their sessions. Additionally, the weaker associations between emotional connection and safety, as well as other alliance indicators, in the early phases may reflect the importance of gradually developing these factors rather than an instant increase in the early stages (Bachelor & Salamé, 2000; Escudero et al., 2008). That way, therapists can maintain expectations in accordance with the trajectory of the therapeutic alliance in couples therapy.

Finally, as the therapeutic alliance is linked with the outcome of therapy (Horvath & Symonds, 1991), enhancing it will also benefit the outcome. Considering the objective perspective that SOFTA provides through trained observers, therapists can address discrepancies in the perception of the alliance. Hence, they can create an action plan with more accurate data. This adjustment includes being engaged with the clients and creating a safe space for the couple to share their thoughts and emotions without inhibitions. This will help therapists to adjust their approach to benefit their clients. As the therapeutic alliance increases, adherence of the clients to their therapy processes can improve as well (Harmon et al., 2007).

### 4.5 Conclusion

In conclusion, this study aimed to deepen the understanding of how therapeutic alliance emerges and evolves during the initial sessions of couples therapy. With the use of SOFTA-o, the study highlighted Engagement as the most consistent and powerful alliance dimension in creating a Shared Sense of Purpose in both within-system and between-system contexts. This finding emphasizes the importance of collaboration and participation in the early stages of couples therapy, through which the clients and therapists begin to form a working team together.

Apart from the statistical results, the study tried to contribute to the expanding cross-cultural literature on the therapeutic alliance in couples and family therapy. The key alliance indicators, which are engagement, mutual collaboration, and emotional attunement, are universal in their importance regarding therapeutic relationships. However, their specific expressions may be shaped by the cultural contexts that the clients belong to. Since this study examines therapeutic alliance behaviors in a Turkish setting, it offers practical insights in this context.

Moreover, the study's findings align with the notion that the therapeutic alliance in couple and family therapy is a dynamic and systemic process that is shaped by every person in the therapy room. The investigation of therapeutic alliance in the initial stage of couples therapy can give valuable information about how the essential parts of the alliance emerge and develop. Understanding these dynamics can be fruitful for therapists to work on therapeutic alliance within the couples therapy framework.

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# APPENDICES

## APPENDIX A. SYSTEM FOR OBSERVING FAMILY THERAPY ALLIANCES

### (SOFTA-o; Friedlander et al., 2005)

### Client Variables

| **Engagement** |
|---|
| Client indicates agreement with the therapist's goals |
| Client describes or discusses a plan for improving the situation |
| Client introduces a problem for discussion |
| Client agrees to do homework assignments |
| Client indicates having done homework or seeing it as useful |
| Client expresses optimism or indicates that a positive change has taken place |
| Client complies with therapist's requests for enactments |
| Client leans forward |
| Client mentions the treatment, the therapeutic process, or a specific session |
| Client expresses feeling "stuck," questions the value of therapy, or states that therapy is not or has not been helpful* |
| Client shows indifference about the tasks or process of therapy (e.g., paying lip service, "I don't know," tuning out)* |

| **Emotional Connection** |
|---|
| Client shares a lighthearted moment or joke with the therapist |
| Client verbalizes trust in the therapist |
| Client expresses interest in the therapist's personal life |
| Client indicates feeling understood or accepted by the therapist |
| Client expresses physical affection or caring for the therapist |
| Client mirrors the therapist's body posture |
| Client avoids eye contact with the therapist* |
| Client refuses or is reluctant to respond to the therapist* |
| Client has hostile or sarcastic interactions with the therapist* |
| Client comments on the therapist's incompetence or inadequacy* |

| **Safety** |
|---|
| Client implies or states that therapy is a safe place |
| Client varies his/her emotional tone during the session |
| Client shows vulnerability (e.g. discusses painful feelings, cries). |
| Client has an open upper body posture |
| Client reveals a secret or something that other family members didn't know |
| Client encourages another family member to "open up" or to tell the truth |
| Client directly asks other family member(s) for feedback about his/her behavior or about herself/himself as a person |
| Client expresses anxiety nonverbally (e.g., taps or shakes) * |
| Client protects self in a nonverbal manner (e.g., crosses arms over chest, doesn't take off jacket or put down purse, sits far away from group, etc.) * |

Client refuses or is reluctant to respond when directly addressed by another family member*
Client responds defensively to another family member*
Client makes an uneasy or anxious reference to the camera, observation, supervisor, or research procedures*

***Shared Sense of Purpose***

Family members offer to compromise
Family members share a joke or a lighthearted moment with each other
Family members ask each other for their perspective
Family members validate each other's perspective
Family members mirror each other's body posture
Family members avoid eye contact with each other*
Family members blame each other*
Family members devalue each other's opinions or perspectives/Client makes hostile or sarcastic comments to family members*
Family members try to align with the therapist against each other*
Family members disagree with each other about the value, purpose, goals, or tasks of therapy, or about who should be included in the sessions*

***Negative indicator**

**Therapist Variables**

***Engagement***

Therapist asks what they want to talk about in the session
Therapist encourages client(s) to articulate their goals for therapy
Therapist asks client(s) whether they are willing to follow a specific suggestion or do a specific homework assignment
Therapist asks about the impact or value of a prior homework assignment
Therapist expresses optimism or notes that a positive change has taken place or can takeplace
Therapist asks client(s) whether they are willing to do a specific in-session task (e.g., enactment)
Therapist pulls in quiet client(s) (e.g., by deliberately leaning forward, calling them by name, addressing them specifically)
Therapist explains how therapy works
Therapist asks if the client(s) have any questions
Therapist praises client motivation for engagement or change
Therapist defines therapeutic goals or imposes tasks or procedures without asking the client(s) for their collaboration*
Therapist argues about the nature, purpose, or value of therapy*
Therapist shames or criticizes how clients did (or did not do) a prior homework assignment*

***Emotional Connection***

Therapist shares a lighthearted moment or joke with the client(s)
Therapist expresses confidence, trust, or belief in the client(s)
Therapist expresses interest in the client(s) apart from the therapeutic discussion at hand

Therapist expresses caring or touches client(s) affectionately yet appropriately (e.g., handshake, pat on head)
Therapist discloses some fact about his or her personal life
Therapist discloses his or her reactions or feelings toward the client(s) or the situation
Therapist remarks on or describes how his or her values or experiences are similar to the clients'
Therapist (verbally or nonverbally) expresses empathy for the clients' struggle (e.g., "I know this is hard," "I feel your pain," crying with client)
Therapist reassures or normalizes client's emotional vulnerability (e.g., crying, hurt feelings)
Therapist has hostile, sarcastic, or critical interactions with the client(s)*
Therapist does not respond to clients' expressions of personal interest or caring for him or her*

***Safety***

Therapist acknowledges that therapy involves taking risks or discussing private matters
Therapist invites discussion about intimidating elements in the therapeutic context (e.g., recording equipment, reports to third parties, treatment team observation, one-way mirror, research, etc.)
Therapist helps clients to talk truthfully and non-defensively with each other
Therapist attempts to contain, control, or manage overt hostility between clients
Therapist provides structure and guidelines for safety and confidentiality
Therapist actively protects one family member from another (e.g., from blame, hostility, or emotional intrusiveness)
Therapist changes the topic to something pleasurable or non-anxiety arousing (e.g., small talk about the weather, room décor, TV shows, etc.) when there seems to be tension or anxiety
Therapist asks one client (or a subgroup of clients) to leave the room in order to see one client alone for a portion of the session
Therapist allows family conflict to escalate to verbal abuse, threats, or intimidation*
Therapist does not attend to overt expressions of client vulnerability (e.g., crying, defensiveness)*

***Shared Sense of Purpose***

Therapist encourages clients to compromise with each other
Therapist encourages clients to ask each other for their perspectives
Therapist praises clients for respecting each other's point of view
Therapist emphasizes commonalities among clients' perspective on the problem or solution
Therapist draws attention to clients' shared values, experiences, needs, or feelings
Therapist encourages clients to show caring, concern, or support for each other
Therapist encourages client(s) to ask for feedback
Therapist fails to intervene when family members argue with each other about the goals, value, or need for therapy*
Therapist fails to address one client's stated concerns by only discussing another client's concerns*

***Negative Indicator**

**Scoring**

Below is an example of how we kept track of the total scores and scoring anchors. The subscales were scored slightly differently from the final totals.

*Scoring Anchors*
-3 = extremely problematic
-2 = moderately problematic
-1 = somewhat problematic
0 = unremarkable or neutral
+1 = somewhat strong
+2 = moderately strong
+3 = extremely strong

*Scoring Subscales*
1-2 = 1
3-4 = 2
5+ = 3
(same for negative)

*Scoring Final Totals*
1-3 = 1
4-5 = 2
6+ = 3
(same for negative)

## APPENDIX B. INFORMED CONSENT FOR PARTICIPANTS (TURKISH)

**Projenin Adı:** Türkiye'de Çift Terapisi Etkinlik ve Değişim Süreci Araştırması

**Tübitak 3501 Araştırma Projesi**

**Proje yürütücüsü:** Dr. Öğretim Üyesi Selenga Gürmen

**Projenin amacı:** Mevcut projede merkeze başvuran danışan çiftlerin geldikleri ve terapiye devam ettikleri süreçte genel psikolojik durum ve ilişki doyumlarını ölçerek gerçekleşen terapötik müdahalelerin etkileri araştırılacaktır. Danışanların terapi sürecindeki deneyimleri hem anket verisiyle hem mülakat hem de gözlem verileriyle ölçülecektir. Ayrıca, araştırmaya katılacak vakaların terapistleriyle değişim sürecine dair mülakatlar yapılacak ve seans içi davranışlar kodlanarak terapide süreç araştırması yapılacaktır.

**Süreç:** Bu araştırma dahilinde belirtilen veri toplama süreçleri gerçekleşecektir:

1- Danışanlarınız dolduracağı ölçeklere ve yapılacak mülakatlara ek olarak, vakaların terapistleriyle de 4., 8., 12., 16., 24 ve 32. seanslardan sonra önceden planlanmış, yüz yüze ya da Zoom üzerinden "Değişim Süreci Mülakatları" yapılacaktır. Ses kaydı alınacak, daha sonra transkripte edilerek anonimleştirilecektir.

2- Merkezdeki **seans kayıtlarınız** özel ve güvenli bir program aracılığıyla kaydedilip saklanacak ve araştırma ekibimiz tarafından gözlem verisi olarak kodlanacaktır. Kodlamalar tamamlandıktan sonra kaydınız silinecektir. Bu kodlamalar sadece araştırma amaçlı olup, sizin terapist eğitiminiz için bir değerlendirme aracı olmayacaktır.

**Gizlilik:** Sizden edinilen bilgiler **tamamen gizli** tutulacaktır ve veriler işlendikten sonra anonimleştirilip o şekilde analiz edilecektir. Soruların hiçbiri mahremiyetinize ve size zarar verici nitelikte değildir. Sizlerden elde edilen bilgiler bireysel değil, grup olarak değerlendirilecektir. Mevcut verilerinize araştırmacı ve araştırma asistanları ile merkez çalışanları haricinde kimseler erişemeyecektir.

**Gönüllü Katılım:** Eğer bu araştırmaya gönüllü olarak katılmak istiyorsanız, lütfen formun aşağısındaki ilgili kısmı imzalayınız. Projeden ayrılmakta ve daha önce alınmış ama işleme konmamış verileri geri almakta her zaman özgür olduğunuzu bilmenizi isteriz. Araştırmaya katılıp katılmamanızın terapi/eğitim/süpervizyon sürecinize olumlu ya da olumsuz bir etkisi olmayacaktır. Araştırma sırasında veya sonrasında herhangi bir sorunuz ya da sorularınız olursa lütfen aşağıda verdiğimiz iletişim bilgilerinden bize ulaşınız. Değerli katkılarınızdan dolayı şimdiden çok teşekkür ediyoruz**.**

Bu formda anlatılan araştırmanın etik yönleriyle ve/veya araştırma detaylarıyla ilgili sorularınız, sorunlarınız veya önerileriniz varsa lütfen Özyeğin Üniversitesi Etik Kurulu ile (…) nolu telefondan temasa geçiniz.

Yukarıda sözü geçen “Türkiye’de Çift Terapisi Etkinlik ve Değişim Süreci Araştırması” isimli araştırma projesinin detaylarını okudum ve bu proje ile ilgili sorularım cevaplandı. Bu çalışmaya gönüllü olarak katılıyorum.

| _____ | _____ | _____ |
|---|---|---|
| İsim Soyad | İmza | Tarih |