Advanced Relational Interventions, Emotional Arousal, The Real Relationship, and Single Session Outcome

By

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Abstract

This study examined relationships among client-perceived session factors (self-reported emotional experience and judgments about the extent to which the therapist utilized process interventions), therapist-perceived session factors (judgments about extent to which clients experienced emotions, and self-reported use of process), the real relationship from client perspective, and client-reported session outcome. Specifically, the study attempted to determine the relative importance of client and therapist factors in predicting the real relationship, and explored the possibility of therapist-reported use of process contributing additional variance above and beyond variance contributed by client factors in predictions of the real relationship. The study also explored whether the real relationship mediated the relationship between client-perceived factors and outcome.

Forty client-therapist dyads at 10 university/college counseling centers completed measures assessing factors within one therapy session. Measures for therapists included reported use of process and perceived client emotional arousal. Measures for clients included reported emotional arousal, perceived therapist use of process, strength of the real relationship, and session outcome. Despite positive correlations between client-reported session factors (emotional arousal and therapist use of process) and the real relationship, client reports were not found to be more important than therapist variables in predicting client-reported real relationship. Therapist-reported use of process did not add significant variance above and beyond client variables in predicting client-reported real relationship. Mixed results were found regarding clients'

perception of the real relationship as a mediator on the relationship between client-reported emotional expression and client-reported outcome, as well as the relationship between client-perceived therapist use of process and client-reported outcome. Implications for future research and study limitations are discussed.

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I. Introduction

"But—and this seems important to me—so far as the patient has a healthy part of his personality, his relationship to the analyst is never wholly submerged. With due respect for the necessary strictest handling and interpretation of the transference, I feel still that we should leave room somewhere for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other. I wonder whether our—at times complete—neglect of this side of the matter is not responsible for some of the hostile relationship which we get from patients and which we are apt to ascribe to 'true transference' only. But these are technically subversive thoughts and ought to be handled with care."

--Anna Freud, 1954

Introduction

The real relationship is "the authentic connection between the 'human' sides of the client and therapist, defined as 'the feelings and attitudes the therapy participants have toward one another and the manner in which these are expressed'" (Gelso & Samstag, 2008, p. 268). How clients perceive this relationship, i.e., how authentic they perceive their therapist to be, and to what extent they feel like they can show their true selves to the therapist, is directly related to therapy outcomes (Baldwin, Wampold, & Imel, 2007; Gelso, 2010; Gelso et al., 2012; Markin, Kivlighan, Gelso, Hummel, & Spiegel, 2014). Therefore, it is no longer subversive to consider the real relationship between client and therapist significant.

Historically, the idea of a real relationship between client and therapist was considered problematic in that the real person of the analyst would influence patient insight and hinder progress (Freud, 1954). And yet, some analysts suggested that successful therapy included a "something more" that was often overlooked in client/therapist interactions (Gelso, 2002; Greenson, 1967). With the rise of attachment theory, therapists began to conceptualize client problems as relational, concluding that the antidote for problems of attachment is a corrective relationship with the therapist himself or herself (Bowlby, 1973). Additionally, Rogerian practice placed emphasis on fostering authentic positive feelings toward the client (Rogers, 1957), contributing to further weight being placed on the connection between client and therapist.

Gelso and Samstag (2008) conceptualized the real relationship as one of three components of a tripartite model of the therapy relationship. Considerable research indicates the viability of the real relationship as a construct; the real relationship is not only related to outcomes, but also to attachment style, therapist empathy, and the other components included in Gelso and Samstag's (2008) model: the working alliance and transference/countertransference (Marmarosh, Gelso, Markin, Majors, Mallery, & Choi, 2009). Further study of other aspects of therapy sessions (including interventions and therapist/client interactions) may add to this body of research. Besides empathy, little research has addressed factors that fluctuate within a session. Therefore, examination of the impact of additional session factors on the real relationship seems warranted.

One type of intervention that may relate to the real relationship in therapy is process interventions. This construct includes a wide range of therapist interventions that address the present moment in a therapy session, the relationship between client and therapist, and/or a combination of each of these. For the purpose of this paper, I define advanced relational interventions as a type of process intervention that includes both addressing the "here and now" and the therapy relationship. Because this type of intervention brings the relationship between client and therapist to the forefront of the therapy session, it is likely that this intervention is related to the client's perception of his or her real relationship with the therapist. As mentioned above, this perception of the real relationship is also related to the other components of the tripartite model, including working alliance and transference. Further exploration into the distinct differences between components of this model will be conducted later in the manuscript.

Additionally, client emotional arousal is another factor in therapy sessions that has yet to be examined in connection to the real relationship. Past research indicates that emotional arousal

is related to therapy outcome, the working alliance, and client ability to process emotion (Iwakabe, Rogan, & Stalikas, 2000; Missirlian, Toukmanian, Warwar, & Greenberg, 2005). Given emotional arousal's relationship to the working alliance (which, in turn, is a component of the overall therapy relationship), a significant connection between emotional arousal and the real relationship is likely.

Current Study

Current practice in many theoretical orientations in psychotherapy is to engage clients in dialogue to make overt those relational dynamics that relate to presenting concerns, strengthening the therapy bond. This practice also often elicits emotion and may positively or negatively impact a client's perception of the real relationship. The impact of advanced relational interventions on the real relationship is important because the client's perception of the real relationship is directly related to therapy outcome (Eugster & Wampold, 1996; Gelso et al., 2012; Markin et al., 2014). To date, no study has examined the relationship between emotional arousal, use of advanced relational interventions, and the client-perceived real relationship.

Additionally, research has yet to examine the relationship between emotional arousal, advanced relational interventions, the client-perceived real relationship, and single session outcome. Past research indicates that real relationship ratings are related to overall therapy outcome, as well as single session outcome (Gelso et al., 2012; Markin et al., 2014). However, the mechanism through which additional factors (such as emotional arousal and process interventions) affect the outcome of session has yet to be explored. I conjectured that the real relationship is a mediating factor through which additional factors affect the outcome of a session. The current study examined the relationship between emotional arousal, advanced relational interventions, the client-perceived real relationship, and single session outcome.

Utility of Current Study

Given the large body of research indicating the importance of the client-perceived real relationship, psychotherapists across multiple treatment theories place some degree of focus on the real relationship in psychotherapy. According to researchers who view relational work as transtheoretical, a relational focus serves as common ground within the psychotherapist identity during a period of history in which theoretical differences, rather than similarities, are highlighted (Markin, 2014; Wachtel, 2014). This focus on the real relationship could contribute to further momentum toward integrated theoretical orientations.

Research examining how process interventions and perception of emotional arousal serve to build the real relationship could contribute to a growing body of research that examines client and therapist characteristics. Such research could improve quality of services for clients. Despite a strong research base indicating that the client-perceived real relationship is vital to the process and outcome of therapy (Eugster & Wampold, 1996; Gelso et al., 2012; Markin et al., 2014), little research exists on interventions that seek to develop, correct, and/or examine the connection between client and therapist (with the exception of therapist expressions of empathy). Researchers and practitioners theorize a variety of reasons why the real relationship correlates with outcomes, as well as the exact vehicle by which it likely creates positive change for clients, including sustaining the client through difficult treatment and supporting other elements of the tripartite model (Gelso & Samstag, 2008; Markin, 2014). Hence, additional research in this area is indicated.

II. Review of Literature

Tripartite Model: The Therapy Relationship

Extensive recent literature within counseling psychology discusses the connection between therapist and client, alternately calling this connection the therapeutic relationship, the therapy alliance, personal relationship, genuine I-thou relationship, the working alliance, and/or the therapeutic bond (Gelso & Samstag, 2008). Such varied nomenclature is confusing and ambiguous, reducing the theoretical value of these concepts. I will trace the history of the real relationship in order to clarify the definition and disentangle the concept from other related concepts. I will adopt the construct of the real relationship as defined by Gelso and Samstag (2008) and examine this construct in relation to similar variables.

Gelso and Samstag (2008) conceptualize a model of the therapeutic relationship that is tripartite—made up of three parts: real relationship, working alliance, transference/countertransference. These three parts interact with one another, each coming to the forefront of the therapy relationship at different points in the therapy hour. The real relationship is considered the authentic connection between the "human" sides of the client and therapist, defined as "the feelings and attitudes the therapy participants have toward one another and the manner in which these are expressed" (p. 268). To connect to the "human" side of the client and/or therapist is to go beyond the roles of client and therapist. Being human involves the aspect of all relationships that essentially acknowledges kinship: the client and therapist are human beings with the same basic needs.

In contrast, the working alliance is defined as the alignment between the task- and goal-oriented sides of the client and therapist. The working alliance is said to "create the sense that the participants...are joined together in a shared enterprise, each making his or her own contribution

to the work" (Gelso & Samstag, 2008; p. 268). Central to this definition is that the client and therapist are engaged in a collaborative effort toward a common goal, while goals are not necessary to having a real relationship.

Gelso and Samstag (2008) define transference as "a phenomenon whereby internalized objects that exist within the patient—a kind of distillation of past important relationships—are displaced onto the therapist, influencing the nature of the therapeutic relationship in ways that are consistent with the client's relationship history" (p.270). These authors differentiate transference from the real relationship and working alliance by first acknowledging that every connection between two people is distorted by perception influenced by each person's past relationships. However, the transferential aspect of the therapy relationship is one in which the client theoretically "clings to the perception or experience of the therapist, failing to let go of it in the face of contrary evidence" (p. 271). Therefore, although assessing the true quality of the real relationship is limited to client, therapist, or observer perceptions, aspects of the therapy relationship become transferential only when the perceiver fails to alter perception based on new information. This differentiation appears to be based primarily on psychodynamic or psychoanalytic theories. However, it is likely that a majority of therapists, regardless of orientation, recognize a phenomenon (labeled "transference" by psychoanalytic theories) in which the client's previous relationships with significant others help shape and mold the client's expectations of, and relationship with, his or her therapist. Transtheoretical orientations might differentiate the real relationship from transference by the possible expectation that the client's relationship with the therapist becomes less transferential as a result of treatment—and increasingly "real" as clients' outside influences (brought into therapy) are altered by experience with the therapist.

Conceptualization of the Real Relationship

Although the tripartite model of the therapeutic relationship is rooted in the psychoanalytic tradition (Couch, 1999; Freud, 1954; Greenson, 1967; Menaker, 1942), Gelso and colleagues seek to refine the construct in light of considerable clinical experience suggesting the real relationship influences treatment across theoretical orientations. According to Gelso, the real relationship consists of two constructs, including genuineness (the extent to which both the client and therapist are able to be themselves in the therapy room, authentic in the here and now) and realism (perceiving the other in ways that befit him or her, rather than desirable or undesirable projections—such projections would be considered transference; Gelso, 2002; Gelso, 2009a; Gelso, 2009b; Gelso & Carter, 1985). A majority of quantitative studies of the real relationship ask the client and therapist (separately) to make judgments about the "genuineness" and "realism" present in the relationship. (Gelso, Kelley, Fuertes, Marmarosh, Holmes, Costa, & Hancock, 2005; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010). Although both the client and therapist participate in the same real relationship, each may have different perceptions of the same real relationship.

In addition to Gelso, other authors observe that the focus in the real relationship is being "genuine with the other" (Markin, 2014). This is not only a characteristic of the client or therapist as individuals, but also a quality of the connection between the two therapy participants. Also notable in the definition of the real relationship is the absence of the requirement that the interaction between two people be defined as "therapy." This suggests that the real relationship is a quality of all relationships, beyond the professional roles of client and therapist, even as therapy is being conducted. In other words, the real relationship is the extent to which two people connect on a very basic, human level. The real relationship is therefore present at all times, and

in all interactions between people, simultaneously occurring even as people interact with each other within professional and personal roles.

The Real Relationship and Carl Rogers

In addition to the earlier mentioned definition of what the real relationship *is*, the concept of the real relationship is further clarified by describing what it is *not*. The real relationship is not therapist *conditions*, as defined by Rogers' (1957) conditions of genuineness, empathy, and unconditional positive regard (Gelso, 2002; Gelso, 2009a; Gelso, 2009b; Gelso & Carter, 1985; Gelso & Samstag, 2008). However, Rogers' (1957) necessary and sufficient conditions of therapeutic personality change seem to relate, if not contribute, to the real relationship. Rogers describes the necessary therapy bond, which includes genuineness, or transparency, as a characteristic of a congruent, integrated therapist (not exactly the real relationship but something very close to it, in that the therapist's being genuine seems inextricably linked to the client's belief that the therapist is genuine). Unconditional positive regard is defined as a warm acceptance of each aspect of the client's experience as being a part of the client, rather than evaluating various aspects of the client as "good" or "bad." Lastly, empathy is considered understanding the client's awareness/experience as if it were the therapist's own.

According to Gelso & Samstag (2008), these conditions as defined by Rogers are inadequate because they only outline the therapist side of the real relationship, which is a co-constructed phenomenon between a client and therapist that may be perceived differently by each party. However, Rogers' conditions appear to theoretically underpin the modern definition of the real relationship in that Roger's conditions may affect client and therapist perception of the real relationship. If a therapist works to become genuine with his or her client, it is likely the client will perceive this, leading to increased client-perception of positive genuineness within the

real relationship. The real relationship is a construct in and of itself, which is perceived by therapists and clients, and may be *influenced* by therapist and client individual characteristics.

Real relationship theorists assert that the real relationship is also not interventions, which are tied to specific theories (Gelso, 2002; Gelso, 2009a; Gelso, 2009b.; Gelso & Carter, 1985; Gelso & Samstag, 2008). However, theorists propose that the quality of the delivery and reception of interventions may be influenced by the quality of the real relationship. The real relationship, which is defined as a-theoretical, cross-theoretical, and pan-theoretical is not a set of techniques bound to any theoretical orientation.

History of the Real Relationship

Literature acknowledges Greenson (1967) as responsible for popularizing the real relationship concept, which originated in psychoanalysis as the "something missing" catch-all for interactions that are not a part of interpretation/transference work (including transference which the client experiences) or the working alliance (Gelso, 2002; Couch, 1999). These ideas influenced modern authors' conceptualizations of the real relationship. In citing his predecessors (i.e., Freud & Stone, 1954), Greenson stated that the real relationship between patient and analyst has been noted, but inadequately defined. To this end, Greenson defined the real relationship as realistic and reality-oriented—in direct opposition to transference, which consists of patient defenses (which are distortions of reality). Greenson reasoned that some accurate perceptions of the analyst must exist alongside distortions/transference of the analyst, since all humans perceptions are both accurate and inaccurate (an idea borrowed from Freud): "There is no transference reaction no matter how fantastic without a germ of truth, and there is no realistic relationship without some trace of a transference fantasy" (p. 219).

Greenson (1967) was also the first psychoanalyst to acknowledge genuineness as a construct (in addition to the construct of realism) in the real relationship, defining this genuineness as authenticity in both the analyst and the patient, in contrast to the artificial or synthetic. Therefore, to Greenson, the real relationship was both the "realistic and genuine" relationship between patient and analyst. This real relationship sustains the working alliance when the task of managing transference becomes difficult for the patient, preventing the patient from terminating therapy early.

Addressing realism within the real relationship, Greenson's (1967) reasoning that a real perception of the analyst must exist if transference distortions exist is based on the ideas of both Menaker (1942) and Freud (1954). These mid-century psychoanalysts tentatively suggested that patients' accurate perceptions of reality are always submerged to some extent, but that patients' perceptions of the analyst always have some link to reality (amid transference). According to these theorists of that time, it is this link to reality in the person of the analyst that allows the patient to accept transference analysis. As a result of transference analysis, patients attain greater insight, essentially expanding that initial realism (present in perceptions of the analyst).

These ideas form the basis of the notion that realism within the real relationship sets the stage for the important work in therapy, as well as the modern idea that the real relationship navigates clients through difficult material. If both therapist and client feel like they have a realistic, mutual understanding of each other, difficult tasks are completed smoothly and more efficiently. Further, if one has positive realistic perceptions of one's therapist, it is easier to have similar positive realistic perceptions of others in one's life.

In further discussion of the term of "realism" (one of two constructs that contribute to the real relationship), Menaker (1942) also voiced opinion that the realistic aspect of interaction

between patient and analyst provides the basis for exploring "unreal" transference, stating that "it seems to us…important to distinguish between that part of the analytic experience which is relived *as* 'real' (transference, but is actually truly felt by client), and that part which *is* real, that is, which constitutes a direct human relationship between patient and analyst, which has an existence independent of the transference, and which is the medium in which the transference reactions take place" (p. 173). Menaker believed that although the real relationship might mimic transference in that both repeat an emotional pattern learned through early interaction with caregivers, it differs from transference in that the real relationship is a product of true, actual perception of the analyst (as opposed to the projections related to a previous caregiver that client attributes to the analyst).

It is important to note that from within this historical, psychoanalytic perspective, researchers take for granted the existence of an absolute "truth," believing it possible for a true "realism" to be sought after and understood in psychotherapy. In post-modern thought, the idea of an absolute truth is not taken for granted. Currently, researchers utilize client, therapist, and observer perceptions to measure the real relationship. This use of quantitatively measured perceptions is considered the best way to gather information closest to the "Truth," despite the fact that perceptions cannot ever be verified as completely "true."

The roots of the concept of the real relationship lie in psychoanalysis and are related to concepts of transference, debates on reality and perceptions of reality, professional boundaries, and therapy outcomes. Vestiges of psychoanalytic concern for impeding therapy through possible boundary crossing may continue to discourage a real relationship and instead encourage focus on technique. However, a growing body of research indicates that real relationships contribute to therapy outcomes regardless of specific techniques.

Relationship Related to Outcome

In an early study, Eugster and Wampold (1996) examined predictors of positive session evaluation for both clients and therapists. These proposed predictor variables included patient involvement, patient comfort, patient progress (defined as the patient making recognized gains or "break-throughs" within session), patient perception of the real relationship, therapist involvement, therapist comfort, therapist expertness, therapist interpersonal style, and therapist perception of the real relationship. These authors adopted Gelso and Carter's (1985) definition of the real relationship as "that relationship between patient and therapist that is based on accurate perceptions of each other, neither prescribed by technique or role fulfillment, nor dictated by the operations of transference or countertransference" (p. 1020). The authors created a comprehensive measure intended to assess the extent to which predictor variables (including the real relationship as perceived by client and therapist, respectively) were present within a single therapy session.

Results indicated that patient involvement, patient progress, therapist expertness, and therapist-perceived real relationship ratings predicted therapists' session evaluations. Of these predictor variables, therapist expertness emerged as the best predictor. However, significant predictors of patients' session evaluations included therapist real relationship, patient involvement, patient progress, and therapist interpersonal style, with therapist-perceived real relationship as best predictor. To measure the real relationship, the authors created items that tapped feelings of liking or dislike toward the other, relating to the other in an authentic way, and feeling personally connected. Examples of these items are: "In this session, I related to my therapist with genuine feeling" and "My therapist was honest and open with me in this session" (Wampold, personal communication, 2016).

This second finding is likely important in that for therapists' evaluations, the therapist-

perceived real relationship variable was a *negative* predictor of session evaluations. The authors explained this result by suggesting that the "actual human relationship with clients is treated with suspicion and admonitions against over-involvement, breach of boundaries, inappropriate gratification, and other departures from good technique" (p. 1025). However, results in this study also indicate that, for clients, their feelings about successfully connecting with their therapist on a real, human level is the strongest predictor of a positive session. Such findings contradict therapists' perception, as conjectured by Eugster and Wampold (1996), that the real relationship is associated with boundary violation, inappropriate gratification, and other egregious technical straying. These perceptions harken back to Freud's (1954) concern that recognizing a real relationship between client and therapist is "subversive."

Later studies in the area of real relationship research operationalize the client's and therapist's perception of the real relationship through use of a measure based on Gelso and Carter's (1985) definition of the real relationship. Both the therapist and client forms of the Real Relationship Inventory (RRI; Gelso, Kelley, Fuertes, Marmarosh, Holmes, Costa, & Hancock, 2005; Kelley, Gelso, Fuertes, Marmarosh & Lanier, 2010) assess participants' report of the valence (degree of positive or negative feeling) and amount of genuine and realistic perceptions of the interaction between client and therapist.

These studies further supported findings that the real relationship (as measured by the Real Relationship Inventory [RRI; Gelso et al., 2005; Kelley et al., 2010]), is significantly related to therapy outcome (Gelso, Kivlighan, Busa-Knepp, Spiegel, Ain…& Markin, 2012; Lo Coco, Prestano, Gullo, & Gelso, 2011; Marmarosh, Gelso, Markin, Majors, Mallery, & Choi, 2009). Specifically, client and therapist perceptions of the real relationship account for a significant amount of variance above and beyond that accounted for by other parts of the

tripartite model (therapist- and client-perceived working alliance and transference, as measured by the Working Alliance Inventory [WAI; Horvath & Greenberg, 1989] and Transference and Insight Questions [Graff & Luborsky, 1977], respectively), and other therapy factors (including attachment style and therapist provided conditions, such as empathy) in therapy outcome (Fuertes, Mislowack, Brown, Gur-Arie, Wilkinson, & Gelso, 2007; Lo Coco et al., 2011; Marmarosh et al., 2009). Strength and consistency of these findings across studies provides evidence for the validity of the perceived real relationship as a powerful aspect of psychotherapy that warrants further attention.

Additionally, the strength of the client-perceived real relationship following the first session predicts outcome ratings of therapy at termination as well as correlates with session-to-session client improvement. (LoCoco et al., 2011; Gelso et al., 2012). This finding is truly "subversive" in that it very nearly states that the initial client-perceived real relationship accounts for much of what counts in therapy outcome. This pattern is not seen when it comes to the therapist's perception of the real relationship. Throughout therapy, therapist perceptions of the real relationship are consistently unrelated to outcome (Fuertes, Mislowack, Brown, Gur-Arie, …& Gelso, 2007; Gelso 2012; LoCoco et al., 2011); additionally, therapist and client perceptions of the real relationship that did converge over time were not related to client-rated outcome, but to therapist-rated outcome. In other words, clients' perceptions of the real relationship are significant to client-rated outcome only when these perceptions do not match with their therapists' real relationship perceptions.

In addition to boasting high-quality client-perceived real relationships, the client-therapist dyads that exhibited the best outcomes also followed a similar pattern in regards to the real relationship: the client-perceived real relationship is strong at the beginning of treatment and

shows a slight linear increase through treatment. This trajectory differs from that of the working alliance, in which therapists and clients perceive resolved ruptures as related to strong positive outcomes (more so than working alliances that fail to experience ruptures), suggesting that ruptures to the real relationship may be more difficult to mend (Gelso et al., 2012).

Working Alliance and Transference

Since Gelso's original model posited that the proposed three parts of the tripartite relationship contribute to each other and are present, yet separately prominent at various stages in the therapeutic process, these three parts should relate to each other. Marmarosh et al. (2009) examined how the real relationship (as measured by the Real Relationship Inventory [RRI; Gelso et al., 2005; Kelley et al., 2010]) relates to variables from both client and therapist perspectives, including perceptions of the working alliance and transference. Results from these studies indicated that perceptions of transference appeared to be significant when negative, and even then, only for the therapist: therapist-perceived negative transference was negatively correlated with the therapist-perceived real relationship (the greater the negative transference, the less positive their perceptions of the real relationship). The working alliance, on the other hand, seems to have a positive relationship with the real relationship: Marmarosh et al. (2009) found that third-session client-perceived real relationship ratings positively correlated with both the client-perceived working alliance and therapist-perceived working alliance.

Research also finds a positive relationship among the client- and therapist- perceived real relationship and perceptions of the working alliance for both groups, respectively (Fuertes et al., 2007). Finally, client perceptions of the real relationship appear to predict ratings of therapy progress to a greater extent than working alliance perceptions (Fuertes et al., 2007). In addition to reporting the above findings that illustrate the correlation between the real relationship and

working alliance, these authors theorize that the real relationship is the initial connection between client and therapist. They suggest that the working alliance may grow from the real relationship. According to these authors, attention to fostering the real relationship should be given first priority if therapists wish to engage clients in effective working alliances.

Real Relationship and Client/Therapist Variables

Multiple variables contribute to the therapy process, and these variables are brought to the relationship by both the client and therapist to create a unique interaction. In examining the real relationship, researchers theorize that, among other potential variables, client and therapist attachment styles may consistently alter the real relationship, as well as therapist-provided conditions, such as empathy. In examining correlates of the real relationship (as measured by The Real Relationship Inventory [RRI; Gelso et al., 2005; Kelley et al., 2010]), Fuertes et al. (2007) found that therapist avoidant attachment and therapist perception of real relationship (including both subscales of genuineness and realism) were negatively related, but there was no correlation between therapist anxious attachment and therapist perception of real relationship. However, therapist anxious attachment was negatively associated with client-rated progress ratings.

In examining client attachment, researchers found a positive relationship between real relationship perceptions and secure attachment to therapist. Similar to the avoidantly-attached therapists, clients with increasingly avoidant attachment patterns perceived the real relationship more negatively, with this pattern beginning even before the onset of treatment (Marmarosh et al., 2009). Little to no evidence has been found linking client anxious attachment to the real relationship (Fuertes et al., 2007; Marmarosh et al., 2009).

The therapist-provided condition of empathy has also been examined by researchers, with

researchers finding a positive correlation between client ratings of therapist empathy and perceptions of the real relationship. It also appears that although related, the real relationship is not simply empathy interventions but a construct in and of itself, as theorized by Gelso (2002). Fuertes and colleagues (2007) found that client ratings of the real relationship predicted a significant amount of additional variance (14%) in ratings of psychotherapy progress above and beyond client ratings of attachment, working alliance, and therapist empathy. Because the real relationship is related to the other two constructs within Gelso's (2002) tripartite model (transference and working alliance), it seems expected that attachment style and empathy also alter perceptions of transference and the working alliance.

Real Relationship Throughout Course of Therapy

Given the idea that the working alliance might emerge from the real relationship (Gelso & Samstag, 2008), further study on the role that the real relationship plays in the therapy process has been conducted. Unlike the working alliance, in which consistent patterns of rupture and successful repair are evident, Markin et al. (2014) found that current session real relationship (as measured by the Real Relationship Inventory [RRI; Gelso et al., 2005; Kelley et al., 2010]) perceptions were consistently similar to the previous session's client and therapist perception. Specifically, therapist perceptions were significantly related to their own perceptions of the real relationship in the previous session, and client perceptions were significantly related to their own perception in the previous session. Given that client perception of real relationship predicts overall outcome regardless of therapist ratings, it seems consistent that the same authors found that client perceptions were significantly related to only their own real relationship perception in the previous session.

Additionally, researchers found that therapists tend to pay more attention to the real

relationship in the beginning of therapy, but decrease fostering of the real relationship as therapy progresses (Markin et al., 2014). Authors suggest that such fostering of the real relationship may include exploring the client's perception of the real relationship within session. However, this writer was unable to find research that examined interventions or therapist variables that intentionally "foster" the real relationship (with the exception of therapist expressions of empathy). However, Markin et al. (2014) emphasize that "clients rarely come to psychotherapy seeking a particular set of techniques, but to connect with a *real* person" (p. 422). This implies that any interaction in the service of providing connection with the genuine person of the therapist fosters the real relationship. Findings from this study suggest that therapists should try to develop and maintain the real relationship over time and through future sessions, even if they do not focus on the relationship as much as in early sessions. For example, a therapist may continue to periodically check in on how a client feels about the real relationship, and put effort into genuinely caring about the client. It seems that clients consider the real relationship important to change throughout the process, not simply in the beginning of treatment.

Why The Real Relationship is Related to Outcome—Conjectures

Researchers know that a client-perceived positive real relationship is correlated with positive outcomes, but the mechanisms by which it works remain unknown. Theorists have developed multiple conjectures. As discussed earlier, some theorize the real relationship keeps clients in therapy when the work becomes difficult and burdensome (Markin et al., 2014). This suggests that the real relationship is not healing in and of itself, but acts like the oil that eases the internal cogs and wheels of a clock, making it easier for therapy work to occur. Markin et al.'s study (2014) utilizing therapist participants practicing from varying theoretical orientations indicates that the real relationship relates to outcome regardless of therapist theoretical

orientation. It seems that regardless of whether the work of therapy involves addressing cognitive distortions, past relationships, self-exploration, or handling transference, the real relationship is significant. On the other hand, the real relationship itself might be responsible for healing—with some authors going so far as to suggest, using measures of the real relationship as an outcome measure for therapy, that a positive client-perceived real relationship may be indicative of health and healing regardless of outcome on other variables (Kivlighan, et al., 2014).

Further conceptualization of the exact mechanism of the real relationship in therapy depends on theoretical orientation or the healing ritual in which the therapist believes. Because most theoretical orientations do not differentiate between parts of the therapy relationship as do Gelso and Samstag (2008), these conceptualizations are often described in terms of the "therapy relationship," shifting away from the real relationship to address the therapy relationship generically. Theoretical mechanisms for the role of the real relationship seem to extend to the broad conceptualization of the therapy relationship. For example, in Rogerian therapy, the therapy relationship is a safe space in which a client can slowly lower his or her "mask" in the process of becoming a "real" person (Rogers, 1951). Emotion-focused therapists believe the therapy relationship is both innately therapeutic and also provides a safe space for change where affect is more likely to be processed (Greenberg, 2014). Additionally, the therapy relationship may be healing all on its own, not only because it soothes painful affect, but also eventually teaches the client how to self-soothe. Interpersonal process therapists view the therapy relationship as a teaching tool in which the client learns something new and applies it to improve his or her life or solve his or her problem (Teyber, 2006). Many therapists identifying as relational believe the relationship is a "social microcosm" where the client learns that he or she

will not be rejected by others as he or she fears. This lesson allows him or her the freedom to interact with others in new, more positive ways (Wachtel, 2014; Teyber, 2006).

Conceptualizations of the therapy relationship that differ from Gelso and Samstag's (2008) tripartite model appear broader, and include both therapist characteristics as well as therapist interventions (but, unlike Gelso's [2002] definition, lack inclusion of the influence of client-provided qualities). Norcross and Lambert (2011) state that there are eleven evidence-based elements of the therapy relationship, which include the alliance across treatment modalities, group cohesion, empathy, collecting positive feedback, goal consensus, collaboration, positive regard/affirmation, genuineness, repairing alliance ruptures, and managing countertransference. Research has demonstrated correlations between therapist characteristics, session ratings, and outcome (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). Generally, a positive therapy relationship contributes to positive outcomes, with up to 54% of variance in the treatment effects (which accounts for 14% of outcome) accounted for by the alliance (Duncan, 2010). Additionally, relationship quality contributes just as much, if not more, than the treatment method utilized (Norcross & Lambert, 2011), supporting Gelso and colleagues' assertion that the real relationship is transtheoretical. Broader conceptualizations of the general therapy relationship appear to include elements of Gelso's (2002) definition of the real relationship (including therapist genuineness and managing countertransference), and also include interventions that Gelso and Samstag (2008) posit influence the real relationship (including empathy). Therefore, it follows that both the real relationship (as defined by Gelso & Samstag, 2008) and the therapy relationship (broadly defined by Norcross & Lambert, 2011) are expected to relate to therapy outcomes.

Further, most relational clinicians seem to believe that the therapy relationship is important because it is a means to an end—it changes other relationships. Attachment psychotherapists work from the perspective that therapy provides a relationship to a "good object" that seeks to repair pain from maladaptive patterns learned in early caretaker relationships (Winnicott, 1965). The client then uses the relationship with the therapist as a "safe base" from which to attempt changes to other relationships (Winnicott, 1965).

Gelso and colleagues suggest that future research might also examine the role of the real relationship in conjunction with specific therapist interventions and client variables to determine whether any particular interventions or skills foster realistic and genuine perceptions of the relationship for clients and therapists. I conjecture that advanced relational process interventions and client emotional arousal relate to client perceptions of the real relationship.

Definition of Advanced Relational Process Interventions

Relational therapists provide interventions aimed at specifically deepening and exploring the connection between therapists and their clients. Basic skills taught to trainees focus on active listening, making the client feel understood, and communicating empathy with the intent of increasing trust and attachment (Teyber, 2006). In addition, Teyber and Teyber (2014) identify further skills (defined below) that directly address the therapy relationship. They consider these skills to be advanced relational interventions.

Advanced relational interventions are specific process interventions that in addition to addressing the "here and now," also focus on the "you and me" (Teyber & Teyber, 2014). For example, if a therapist senses some unidentifiable negativity from the client at the moment of encouraging the client to commit to some challenging homework, the therapist may first acknowledge that he or she has made a recommendation to the client. Then, the therapist may

then ask the client how the client felt about the therapist's action of encouraging homework. The therapist may say, "I just suggested the possibility of you trying out something new and maybe scary, and I'm wondering how you feel about me doing that? Help me understand what's going on between us right now." In this scenario, both the present moment in therapy (therapist assigning the homework) and the interaction between client and therapist (asking how the client felt about the therapist's act of suggesting) is explored. These types of interventions may bring about the following results, across the therapy process, as identified by Teyber and Teyber (2014): "establish and sustain a stronger working alliance; address resistance and schema distortions; clarify the client's problems with more specificity and better discern a treatment focus; and restore ruptures" (p. 335). These interventions may be helpful from the first therapy session, but not necessarily. As discussed later in this manuscript, the usefulness of advanced relational interventions may depend on the extent of process used and the timing of interventions.

By addressing both the present moment in therapy and the relationship between client and therapist, advanced relational interventions as a construct are more clearly defined and specific than other related process dimension constructs. These other related constructs include a wider range of process-type interventions, which may address the "here and now," but not the relationship between client and therapist. They may also address the relationship between client and therapist without focusing on the present interaction. Or, these constructs may include both. It seems that constructs of immediacy, self-disclosure, and self-involvement, and behavioral observations within the "here and now" are all types of process comments that may include any number of these combinations of addressing the present moment and the therapy relationship.

For the purpose of this study, I define advanced relational interventions as interventions that always address both, rather than the present or the relationship alone.

According to Kasper, Hill, and Kivlighan (2008), immediacy is defined as "disclosures within the therapy session of how the therapist is feeling about the client, him- or herself in relation to the client, or about the therapy relationship" (p. 281). Inherent to this definition is the therapist's act of sharing his or her own experience. In contrast, advanced relational interventions are not primarily focused on the therapist's *disclosure of feelings* about the client, him- or herself in relation to the client, or about the therapy relationship. Advanced relational interventions may involve a therapist disclosing her feelings in this way, but the focus of such interventions is to explore what may be happening between the client and the therapist. An example of immediacy might be a therapist saying to the client, "I feel closer to you when you are vulnerable," and the same statement could become an advanced relational intervention (as it is defined for this study) if an element of exploration of what is happening between client and therapist is added: "Right now, it seems as if you're being vulnerable with me, and I feel closer to you. What do you think is going on between us?"

Other authors name the act of sharing anything personal about the therapist, including feelings about the client as self-disclosure (Barnett, 2011). However, some make distinctions between sharing personal information and sharing feelings related to therapy. According to Kasper et al. (2008), self-disclosure relates to the therapist sharing information about himself (for example, sharing with the client that he is married and has a son), whereas self-involving statements relate to the therapist sharing reactions or emotions toward the client (for example, sharing with the client that the therapist feels closer to him or her when the client reported "letting my guard down"). These definitions are similar—so much so that Gelso and Palma

(2011) have described self-disclosure and self-involvement as the same construct, but at different ends of a continuum of information about themselves that therapists disclose to their clients. Self-disclosure and self-involvement also appear to have different effects on clients' perceptions of therapy. Henretty (2010) found that out of eight studies, six found evidence that clients endorsed self-involving statements as having a more positive impact on therapy than self-disclosure.

Therapists also sometimes use interventions that address the "here and now" in a therapy session without relating the present moment to the therapy relationship. These interventions are often intended to increase the client's awareness of his or her behavior during that particular moment in the therapy session. This behavior may signify areas of importance in the client's narrative, which both client and therapist may previously have been unaware of. For example, the therapist may point out to the client that he makes less eye contact when he mentions his family. Making explicit this behavioral observation may lead to greater discussion and insight into how this client's family contributes to his presenting concerns. Unlike advanced relational interventions, "here and now" behavioral observations do not necessarily relate to the relationship between client and therapist.

Because all of the above constructs are related, it appears that the process dimension in psychotherapy is a quality or characteristic of a therapy session—or a moment in session—that may be ushered in by a variety of interventions, including advanced relational interventions, immediacy, self-involvement, and/or "here and now" behavioral observations. Teyber and Teyber (2014) consider "process comments as a basic stance toward the client that reflects a broadly relational method of treatment" (p. 338). Such a quality could be associated with discussions prompted by considerations of either or both the "here-and-now" or "what is going

on between the two of us" (Teyber, 2006). This study is interested in capturing the effects of advanced relational interventions, which, as defined within this study, address both the present moment in the therapy session and also focus on the relational dynamics between client and therapist.

Concerns with Using Process Interventions

Although literature provides theoretical rationale for using advanced relational interventions in session, many therapists are concerned about using such interventions (Teyber & Teyber, 2014). These concerns may be related to the lack of guidelines prescribing the amount of process intervention that should be used, as well as the recommended timing of such interventions. First, cautions for the potential unethical use of self-disclosure may result in many "playing it safe" rather than potentially harming clients by turning the focus of therapy toward themselves (Barnett, 2011). Additionally, some research indicates that clients perceive therapists who self-disclose as less competent than therapists who do not self-disclose (Henretty, 2010). Certainly, the line between helpful self-involving statements and those that focus on the relationship to ease the therapist's own loneliness or desire for emotional connection may be thin.

Concern for client anxiety, as well as client irritation or feeling that the topic at hand is unrelated to him or her, may heighten the therapist's worry over how much process work is "too much." Gelso and Palma (2011) supply the term "inverted U," defined as predicted increases in immediacy that correlate with positive session ratings until immediacy level crosses a certain threshold, and then correlates with declining session ratings. Because advanced relational interventions are similar to immediacy in that they both fall under the umbrella of process comments, it is likely that these interventions correlate similarly with session outcomes.

Uncertainty in where that threshold lies for individual clients may increase therapist anxiety, resulting in too little (if any at all) use of process comments. To add to this uncertainty, some theorists suggest that self-disclosure-type interventions are beneficial simply for the fact that they are rarely used (Knox & Hill, 2003). These authors suggest that additional research should seek to examine the client-perceived amount of process-dimension work in relationship to other client outcome variables.

Process Interventions and Session Outcomes

Qualitative research suggests that utilizing techniques related to advanced relational interventions in sessions with clients results in both positive and negative session outcomes, supporting concerns about the amount of process-type work within therapy sessions. Kasper et al. (2008) described a case study involving immediacy in session. In observing therapy sessions over the entire therapy experience, the authors noted that client involvement was lower during immediacy interventions. However, following immediacy, the client was more likely to be immediate. Observers also gathered data on the client's reactions to immediacy, noting that reactions were mixed. Following sessions high in immediacy, the client reported higher expression of feelings, closeness, and overall satisfaction with the session. However, the client also reported feeling awkward, hurt, vulnerable, challenged, and pressured to respond.

In response to the negative reactions shared by clients, the authors suggested that processing client responses, educating clients on the purpose of immediacy interventions, and encouraging clients to share negative reactions to immediacy interventions may ultimately result in a stronger bond between client and therapist (Kasper et al., 2008). Taking these steps may increase the positive effects of interventions aimed at strengthening the real relationship between

client and therapist (and, consequently, therapy outcomes) while reducing negative "side effects."

Process Interventions and Emotional Arousal

Literature also indicates that working through such side effects is valuable due to the emotion generated by process comments. Consistently, relationally oriented therapists indicate that use of process comments results in higher emotional experience or charge in therapy (Kasper et al., 2008; Teyber & Teyber, 2014; Teyber, 2006). Although little, if any, quantitative research examines the outcome of specific interventions, higher emotional experience within the therapy session is significantly correlated with increased disclosure of difficult material, greater client insight, and increased client toleration of vulnerability (Wiser & Goldfried, 1998). It seems that the emotion generated by advanced relational interventions might yield the benefits of high emotional experience.

Therefore, another defining feature of process interventions is that such interventions usher an emotional charge into the therapy room. In non-therapy relationships, participants do not typically engage frequently in intentional advanced relational dialogue. That is, people do not intentionally point out a specific relationship dynamic in the "here and now" and then ask the other what they perceive as "happening between us" (Tebyer & Teyber, 2014). This suggests the primacy of such statements is unique to therapy, and introduces something new into the client's life. This study conjectures that another quality of process interventions includes the element of the healing therapy relationship described by Rogers (1951) as "emotionally charged." This emotional charge is induced by inviting a client to break social norms through process work, introducing the element of charting new social territory for both client and therapist.

Emotional Arousal in Emotion-focused Therapy

A relevant theoretical orientation to client emotional arousal is Emotion-focused Therapy (EFT; Greenberg, 2008). Within the framework of EFT, emotions represent meaning and provide important information that has ensured human survival. EFT posits that emotions traditionally viewed as "negative," including sadness and anger, are not troublesome burdens to be avoided or overcome as quickly as possible, but are instead informative and map the way to identifying areas in life that are problematic (Greenberg, 1986; Greenberg & Van Balen, 1998). To be informative and helpful, emotions must not simply be experienced. They must also be cognitively processed and conceptualized as symbols of what is occurring in real-life situations. In the EFT theoretical frame, emotion and cognitive processes both contribute to positive change (Greenberg, 2002; Whelton, 2004).

Greenberg (2002; 2008) defines and categorizes emotions based on purpose of the emotion and/or when the emotion is experienced. These categories are primary, secondary, instrumental, and adaptive and maladaptive emotions. Primary emotions are defined as the first automatic response to a situation, while secondary emotions are responses to primary emotions. For example, a primary response to a situation may be anger, and then a secondary emotion may be guilt for experiencing anger. Instrumental emotions are learned-behavior emotions that are activated to influence others—for example, crying to induce sympathy from others. Greenberg (2002, 2008) also categorizes primary emotions by their contribution to the client's problem at hand. Adaptive emotions are primary, reasonable responses to a situation and results in reasonable action, while maladaptive emotions are primary responses that have been learned and are not helpful—these are emotions that keep a client in a pattern of behavior that supports symptoms of depression, anxiety, or other pathology.

Within the therapy hour, EFT therapists activate primary adaptive or maladaptive emotions, and then facilitate the client's process in transforming maladaptive emotions to adaptive emotions (Greenberg, 2002; 2008). This transformation occurs through six processes posited by Greenberg (2012). These six processes are awareness of having an emotion, expression of the emotion, regulating emotions through tolerating or self-soothing, reflection that integrates emotion into a client's life narrative, transforming one emotion through experiencing another, and engaging in a corrective, emotional, new experience.

Therefore, a therapist's emphasis on identifying client emotional processing difficulties is a defining feature of EFT, and EFT-identifying therapists assist clients in resolving these difficulties (Pos & Greenberg, 2007). For such a process to occur, therapists must accurately perceive their clients' emotions and be willing to engage clients in emotionally charged work within session.

Emotional Arousal and Outcome

Studies examining the relationship between emotional arousal and therapy outcomes report mixed results. As mentioned earlier, emotional experience within the therapy session is significantly correlated with increased disclosure of difficult material, greater client insight, and increased client toleration of vulnerability (Wiser & Goldfried, 1998). Generally, expressing emotion in psychotherapy contributes to positive outcomes (Greenberg & Malcom, 2002). However, high arousal has been found to predict outcome only when the working alliance was rated positively (Iwakabe, Rogan, & Stalikas, 2000). Researchers hypothesize that emotional arousal may be inherent in change due to the impact of an emotionally charged memory. Lane, Ryan, Nadel, and Greenberg (2015) conjecture that from a cognitive perspective, positive therapy outcomes are a result of two processes. First, clients must recall emotionally intense

memories. Next, clients must alter recalled emotional content through new ways of interacting with the memory. This can include conceptualizing the meaning of the memory from an alternate point of view.

Timing of emotional arousal may also be significant: high levels of emotional arousal in early to middle treatment sessions predict outcome, possibly due to time provided in later sessions to process and make sense of high emotional arousal. Heightened emotion in earlier sessions and reduced emotional arousal in later sessions allowed clients clarity so they could become reflective about the emotion itself (Missirlian, Toukmanian, Warwar, & Greenberg, 2005). In addition to when emotion is experienced, how much time spent in high emotional arousal is also important. In an effort to determine the relationship between length of time expressing high-arousal emotion and therapy outcome, Carryer and Greenberg (2010) found that a frequency of 25% of total therapy time within high emotional arousal was found to be associated with better outcomes for clients within short-term therapy for depressive symptoms. Clients with higher or lower frequencies of high emotional arousal experienced poorer outcomes. Similar to Gelso and Palma (2011)'s conjecture that work within a process dimension follows the pattern of an inverted "U," it appears that both too little and too much work within an emotionally intense vein can lead to poorer outcomes.

Emotional Productivity and Emotional Arousal

In an effort to further determine how therapists may assist clients in emotional arousal that is beneficial to the therapy process, Greenberg, Auszra, and Herrmann (2007) examined emotional productivity, emotional arousal, and outcome in experiential treatment of depression. Based on previous work in the field on emotional process in therapy, these authors define emotional productivity as an in-session process in which a client experiences a primary emotion

related to therapy topics, recognizes that they are feeling the emotion, and is not "stuck in it or being a passive victim of the emotion" (p. 484).

Initial findings in this study found that clients who experienced better outcomes showed a mean percentage of 38.23% for high-arousal segments in therapy, compared with 54.82% for poorer outcome clients. This finding provided evidence that, like similar research in this area, more is not necessarily better when it comes to emotional arousal. However, clients from the same study within positive outcomes groups expressed more productive emotions, both low-arousal and high-arousal, than poorer outcome clients. These results suggest that when clients are able to use emotions to facilitate solving problems and work through maladaptive emotions, they fare better. This, perhaps, is the role of therapist: to facilitate sessions that allow clients to identify emotions and use emotion effectively. In fact, research has indicated that therapists who are able to help their clients express emotion generally have better outcomes. In a meta-analysis examining ten independent samples of short-term psychodynamic therapy, Deiner, Hilsenroth, and Weinberger (2007), found that therapist facilitation of emotional expression is positively associated with symptoms improvement.

Conclusion

Research on the real relationship has yet to explore how specific interventions, such as advanced relational interventions, may impact client perceptions of the real relationship. There are also additional client factors, such as the magnitude of emotion clients experience in session, that have yet to be examined in the real relationship literature. Client perception is particularly important to the study of the real relationship because client perception of the real relationship is positively correlated with outcome (Fuertes et al., 2007; Gelso 2012; LoCoco et al., 2011). Advanced relational interventions are likely to be related to the client perceived real relationship

because advanced relational interventions bring the connection between client and therapist to the forefront of the therapy conversation. This relationship is likely to be nonlinear, or, "inverted-U-shaped," as supported by Gelso & Palma's (2011) conjecture that a moderate amount of self-involvement by the therapist results in better alliance ratings, while a small or large amount of self-involvement results in low alliance ratings. It is expected that therapist-perceived use of advanced relational interventions impact the real relationship, implying that therapists have ability to positively influence client perception of the real relationship through discretionary use of these interventions. In addition, emotional experience in session, whether incurred by process work or not, is likely related to client-perception of the real relationship, due to previous findings that illustrate the relationship between emotional arousal and outcomes (Diener et al., 2007). Therefore, one next step in this area of research is to examine the relationship between advanced relational interventions and the real relationship, in addition to client emotional experience and the real relationship.

III. Hypotheses

Hypotheses:

1) Client predictor variables (client-reported emotional arousal and client-perceived therapist use of advanced relational interventions) will be more important than therapist predictor variables (therapist-perceived client emotional arousal and therapist-perceived use of advanced relational interventions) in predicting client perceptions of the real relationship (genuineness and realism).
Rationale: Past research indicates significant differences between client and therapist perceptions of the real relationship (Gelso et al., 2012; Kivlighan et al, 2014). I conjecture that the variables of emotional arousal and therapist-reported use of advanced relational interventions are related to the client-perceived real relationship. Because past research indicates lack of convergence between client and therapist perceptions of the real relationship, I expect that client-perceived independent variables matter more to the client-perceived real relationship than do therapist-perceived independent variables.

2) Therapist-perceived use of advanced relational interventions will contribute additional variance above and beyond the contributions of client independent variables (client-reported emotional arousal and client-perceived use of advanced relational interventions) in predicting scores on the subscales of the client-perceived real relationship (genuineness and realism).
Rationale: This prediction is based on the premise that therapists will be better judges of their own behavior and intentions than clients. Although past studies indicate client perception of the real relationship is more closely aligned with outcome than is therapist perception of the real relationship, research has yet to examine the impact of therapist-reported intervention on predicting the client-perceived real relationship. I expect that therapist intentionality accounts for

some additional variance in client perception of general outcome variables (including the real relationship).

3) Scores on subscales of the client-perceived real relationship (genuineness and realism) will mediate an indirect positive relationship between client independent variables (client-reported emotional arousal and client-perceived therapist use of advanced relational interventions) and client-perceived session outcome, such that increasingly positive genuineness and realism scores will explain the increasingly positive indirect relationship between independent variables and client-perceived session outcome.

Rationale: Past research has indicated a significant relationship between client perception of the real-relationship and both session and total therapy outcome (Fuertes et al., 2007; Gelso et al., 2012; Kvilighan et al., 2014; Markin et al., 2014). As mentioned earlier, I conjecture that the variables of emotional arousal and therapist use of advanced relational interventions are related to the client-perceived real relationship. Based on the latter and former statements, I conjecture that the client-perceived real relationship explains the potential connection between some in-session occurrences (in this study, client emotional arousal and therapist use of advanced relational interventions) and session outcome.

Linear Hypotheses Rationale

Due to the self-report nature of client and therapist perceptions of emotional arousal and use of advanced relationship interventions, I predicted that relationships between these independent variables and the dependent variables of the client perceived real relationship and client perceived session outcome would be linear. Past studies examining emotional arousal found evidence for a curvilinear relationship between emotional arousal and session outcome

(Carryer & Greenberg, 2010). However, these researchers utilized observers, who rated emotional arousal in clients, while this current study was interested in client and therapist perception. Other authors theorize that relationships between the amount of process (including the interventions I defined as advanced relational interventions) used by the therapist and session outcome are also curvilinear (Gelso & Palma, 2011); these authors based this theory on the objective reality of what occurs in the therapy room, a reality untainted by the bias introduced by any human perception. I was interested in measuring client and therapist perceptions, rather than the more objective perception of raters who observe the therapy session. Self-report studies tend to demonstrate convergence within ratings when participants rate their perception of multiple aspects of the same experience (Sandvik, Diener, & Seidlitz, 1993). Therefore, due to my interest in the self-reported perceptions of therapists and clients (rather than the perception of raters), I expected relationships to be linear because the participants are rating multiple aspects of an individual experience. As stated in the Results chapter, no evidence of a curvilinear pattern was found between variables.

IV. Method

Design

The study used a non-experimental, correlational design. The independent variables included: client-reported emotional arousal during session, therapist perception of client emotional arousal, client perception of therapist's use of advanced relational interventions, and therapist perceived use of advanced relational interventions. The dependent variables were client perception of the real relationship and single session outcome. Client perception of the real relationship was also expected to be a mediator variable between each of the client independent variables (client-reported emotional arousal and client perception of the therapist's use of advanced relational interventions, respectively) and client perception of single session outcome.

Participants

Emails were sent to directors at 62 college counseling centers asking permission to recruit therapists at their center. (See Appendices A and B for a copy of the first email and follow-up email to directors.) College counseling centers chosen for inclusion in this study were chosen based on the number of staff employed at the center and/or professional connections to the Auburn University Counseling Psychology Program (college counseling centers where alumni from the program are working, or who have staff who have worked with alumni from the program). I chose to recruit based on this criteria due to the likelihood that professionals connected to the program may participate more readily than professionals unconnected to the program. This decision decreased the ability to generalize results to the greater population of therapists; however, it increased the chances of recruiting participants.

Of the 62 colleges and universities invited, 14 directors granted permission for data collection. An email inviting therapist participation was then sent to therapists employed at those

centers. This invitation contained a brief description of the study (see Appendix C). Therapists from all training levels (including practicum students and interns) who were providing services at those counseling centers were invited to participate due to desirability for study results to generalize to a wide variety of therapists. If the counseling center staff had questions about participating in the study, I answered questions as needed by providing my email address in the information letter and inviting participants to contact me if they have any questions.

Client participants were invited to participate by therapists. Therapists were told not to invite clients who are experiencing symptoms of schizophrenia, exhibiting serious signs of suicidality, or exhibiting signs of serious dependence on substance use at the time of the session used for the study. Therapists were instructed to invite one client who had at least three previous sessions with his or her participating therapist and was at least 18 years old. Therapist and client responses were treated as independent for the purposes of this study. However, there is dependence between therapist and client data that is not accounted for in the statistical tests used. This limitation should be considered when interpreting results of this study. Therapists were limited to a single client because using multiple clients could have altered therapist activity during sessions and/or therapists' responses on dependent variables. Additionally, because each therapist and client participated only once, there is no concern of clients being nested within therapists. Therefore, all participants were informed that they could only participate once in the study.

Therapists were instructed to invite the next client they were scheduled to see following reading the information letter, provided the client met participation criteria. Only clients who had previously completed their third therapy session were eligible for invitation and participation. To help ensure generalizability, any session following the third one was acceptable for inclusion.

Clients were informed that their therapist would not have knowledge of whether or not they chose to participate, nor would they be penalized in any way for not choosing to participate.

A power analysis was performed through use of GPower 3.1 software (Faul, Erdfelder, Buchner, & Lang, 2009) to estimate sample size required for moderate power (power = .80; Cohen, 1988), given six possible predictor variables in a multiple hierarchical regression analysis, with two predictor variables being tested in each step. This analysis was based on a moderate effect size for studies utilizing regression equations (f^2 = .15; Aiken & West, 1991), and an alpha of .05, as advised by Cohen (1988). Results indicated a sample size of 68 would be adequate for moderate power. Therefore, this study attempted to obtain data from at least 68 therapist-client pairs.

However, due to exhausting the number of possible college counseling centers willing to participate, a total of 40 valid therapist-client pairs were obtained for this study. A total of 75 therapists and 40 clients participated. All client participants had a corresponding therapist participant, resulting in 35 therapist participants whose clients did not return surveys. This number of participants is similar to the sample size of studies using therapist-client dyads to examine the real relationship (Gelso & Kivlighan, 2012; Kivlighan et al., 2015; Marmarosh et al., 2009). Ten college counseling centers from the Southeastern (3 centers; 7 dyads), Northeastern (1 center; 3 dyads), Midwestern (4 centers; 10 dyads), Southwestern (1 center; 18 dyads), and Northwestern (1 center; 2 dyads) regions of the United States contributed to the final sample. Although 14 directors agreed to participate in this study, four of these centers only returned therapist packets—the clients of these therapists did not choose to participate, resulting in incomplete pairs that could not be used for analysis.

Table 1 includes the demographics of the client participants. Majority of the participants identified as Caucasian (70%), heterosexual (60%), and female (82.5%), with a mean age of 22.6 (*SD* = 5.2). The minimum age of client participants was 18, with the maximum age being 41. The most frequently identified college status was Senior (30%). Sixty percent of client participants reported completing the packet less than one day since their therapy session, with an additional 37.5% completing surveys within a week of their session. One participant completed his/her packet more than one week from his/her session. All client participants reported rating their most recent session.

Table 1. *Client Demographics (N = 40)*

		n	%
Gender Identification	Man	6	15.0
	Woman	33	82.5
	Genderqueer	1	2.5
	Other	0	0.0
Ethnicity	African-American	3	7.5
	Asian American	3	7.5
	Caucasian	28	70.0
	Latino(a)	2	5.0
	International	0	0.0
	Pacific Islander	0	0.0
	Multi-Ethnic	2	5.0
	American Indian	1	2.5
	Other	1	2.5
Sexual Orientation	Heterosexual	24	60.0
	Gay	0	0.0
	Lesbian	3	7.5
	Bisexual	12	30.0
	Other	1	2.5
College Status	First-year	8	20.0
	Sophomore	6	15.0
	Junior	8	20.0

	Senior	12	30.0
	Graduate Student	6	15.0
	Community (not enrolled)	0	0.0

Table 2 includes demographics of the therapist participants. Information regarding age, gender identity, ethnicity, or sexual orientation was not gathered for therapist participants in order to protect participants' anonymity. A little more than half of therapist participants were licensed (52.2%) providers, with a mean of 9.73 years of practice (*SD*=10.12). The minimum number of years practicing was .5, and the maximum number of years practicing was 42. The most frequently identified degree was doctoral (47.5%), with Interpersonal Process (37.5%) as the most-endorsed primary theoretical orientation from which participants practice. The most frequently identified client presenting concern was anxiety (42.5%), and the mean number of sessions held prior to completing the study with the client participant was 10.18 (*SD*=6.6) The minimum number of sessions was 3, and the maximum was 29.

Table 2. *Therapist Demographics (N = 40)*

		n	%
Educational Degree	Bachelor's + Some Master's	3	7.5
	Bachelor's + Some Doctoral	3	7.5
	Master's	7	17.5
	Master's + Some Doctoral	8	20.0
	Doctoral	19	47.5
	Other	0	0.0
Primary Theoretical Orientation	CBT	5	12.5
	Person Center/Humanist	6	15.0
	Interpersonal Process	15	37.5
	DBT	2	5.0
	Feminist/Multicultural	5	12.5
	Existential	0	0.0
	Family/Systems	0	0.0
	Solution-Focused	1	2.5
	REBT	0	0.0
	Psychodynamic	0	0.0
	Psychoanalytic	0	0.0
	Behavioral	1	2.5
	Attachment	0	0.0
	Other (responses include ACT, EFT, Integrative (2), and Eclectic)	5	12.5
License to Practice Status	Non-licensed	19	47.5
	Licensed	21	52.5
Primary Client Presenting Concern	Depression	5	12.5
	Anxiety	17	42.5
	Alcohol/Drug Use	0	0.0
	Academics	0	0.0
	Eating/Body Image	2	5.0
	Gender/Sexuality	2	5.0
	Religion/Spirituality	0	0.0
	Friendship/Relationships	5	12.5
	Family	2	5.0

Table 2, continued

		n	%
Primary Client Presenting Concern	Grief	2	5.0
	Sexual Abuse/Assault	2	5.0
	Physical Abuse/Assault	0	0.0
	Emotional Abuse	1	2.5
	Trauma	2	5.0
	Other	0	0.0

Comparisons between therapist groups (therapists whose clients completed surveys and therapists whose clients did not complete surveys) indicated no significant difference across therapist-reported use of process, educational degree, theoretical orientation, license to practice status, number of years practicing therapy, number of sessions held with the client, and client presenting concern. However, there was a significant difference in emotional arousal for therapists whose clients completed surveys and therapists whose clients did not complete surveys. Therapists whose clients completed surveys experienced significantly greater emotional arousal in session ($M = 4.31$, $SD = 1.48$) than therapists whose clients did not complete surveys ($M = 3.52$, $SD = 1.48$); $t(73) = 2.29$, $p = 0.025$). Tables 3 and 4 illustrate comparisons between therapist groups.

Table 3. *Independent Samples t-Test Comparing Therapists Whose Clients Completed Surveys And Therapists Whose Clients Did Not Complete Surveys (N = 75)*

Variable	Survey Status	*N*	*M*	*SD*	*t*	*p*
Therapist-Reported Use of Advanced Relational Interventions (TUARI)	Not Completed	35	10.83	7.64	.75	.453
	Completed	40	12.07	6.68		
Therapist-Perceived Client Emotional Arousal (TEA)	Not Completed	35	3.52	1.48	2.29	.025*
	Completed	40	4.31	1.48		
Years of Practice	Not Completed	35	8.71	6.63	.50	.616
	Completed	40	9.72	10.12		
Number of Sessions	Not Completed	35	11.94	9.33	.96	.342
	Completed	40	10.18	6.60		

*$p < .05$; **$p < .01$

Table 4. *Chi-square Tests Comparing Therapists Whose Clients Completed Surveys And Therapists Whose Clients Did Not Complete Surveys (N = 75)*

Variable	Survey Status	*N*	*%*	χ^2	*p*
Educational Degree	Not Completed	35	46.7	1.57	.82
	Completed	40	53.3		
Theoretical Orientation	Not Completed	35	45.9	12.48	.33
	Completed	40	54.1		
Licensure Status	Not Completed	35	46.7	0.82	.37
	Completed	40	53.3		
Presenting Concern	Not Completed	35	46.7	8.28	.69
	Completed	40	53.3		

*$p < .05$; **$p < .01$

Measures

Demographic Questionnaires

Client and therapist participants completed a demographic survey providing basic information about themselves (see Appendix G and Appendix H). The demographic form for therapist participants included questions about level of education, years of experience in the counseling field, educational degree level, theoretical orientation, licensure status, client presenting concern, and how many sessions they had held with the client in his/her dyad. As stated above, therapist participants were not asked for other additional demographic information due to the possibility that such information could reveal the identity of the therapist participant to the researcher. The demographics form for client participants included items assessing age, gender, ethnicity, sexual orientation, and educational status. These are basic demographic variables generally included to describe the sample. All measures were marked with a code to

match client participants and therapist participants to each other. For example, the measures for the first set of participants (one therapist and one client) were identified as 001 on both sets of measures.

Real Relationship Inventory-Client Form (RRI-C; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010)

This scale measured the strength of the real relationship from the client's perspective (see Appendix I). The measure served to operationalize the client-perceived real relationship. It contains 24 items, including two 12 item subscales that measure the two constructs consistent with the definition and the theoretical underpinning of the real relationship: realism and genuineness. Realism was defined by Gelso (2002) as perceiving the other in ways that befit him or her, rather than desirable or undesirable projections (i.e., transference). One example of an item that measured realism was "my therapist and I had a realistic perception of our relationship." Genuineness was defined as a quality of a relationship in which participants are being themselves, or are being authentic in the here and now. For example, an item from the RRI-C that measures genuineness was "My therapist seemed genuinely connected to me."

Items range on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores on the RRI-C reflect perceptions of the relationship as more real and genuine; overall, the higher the score on the RRI-C, the stronger the real relationship. Confirmatory factor analysis indicated that a two-factor model representing the two subscales of the RRI-C was a better fit than a one-factor model (Kelley et al., 2010). Therefore, the two subscales of genuineness and realism were analyzed separately in this study. Standard linear scoring was used, and average scores for each separate subscale was calculated for use in analysis.

The RRI-C has demonstrated satisfactory reliability, including internal consistency and test-retest reliability. Kelley et al. (2010) found an internal consistency of .95 for the entire instrument, .91 for the genuineness scale, and .90 for the realism Scale. The same authors also found that test-retest reliability was .87 for the total scale, .88 for genuineness, and .84 for realism. The RRI-C was found to be stable over 2-3 weeks (Kelley et al, 2010). Further, based on various studies, reliability estimates range from the mid .80s to the mid .90s (Fuertes et al., 2007; Kelley et al., 2010; Marmarosh et al., 2009).

The RRI-C has demonstrated adequate construct and discriminant validity (Kelley et al., 2010). It has been positively correlated with the bond subscale of the Working Alliance Inventory- Short Form (WAI-S; Tracey & Kokotovic, 1989), with a correlation of .81. The bond subscale of the WAI-S and the RRI-C should be highly correlated because they are conceptually related to each other (i.e., the working alliance emerges from the real relationship). The RRI-C was also positively correlated to the Barrett-Lennard Relationship Inventory (BLRI Form OS-64; Barrett-Lennard, 1964) with a correlation of .71. This inventory measures aspects of Rogers' (1957) therapist conditions. Demonstrating discriminant validity, the RRI-C was not significantly related to a measure of social desirability (r = .05). Lastly, the two subscales of genuineness and realism scales were significantly correlated (r = .80). This measure has been used extensively in research examining the real relationship, and has been found to demonstrate significant predictive validity in predicting overall therapy outcome (Gelso et al., 2012, Kivlighan et al., 2014; Lo Coco et al., 2011; Marmarosh et al., 2009). This measure has been published in both journals and books and so explicit permission to use the measure was unnecessary; however, I still sought permission from the authors of the measure, and permission was granted for use in this study.

Use of Advanced Relational Interventions, Therapist and Client Forms (UARI-T; UARI-C); Adapted from the Beth Israel Fidelity Scale (BIFS; Patton, Muran, Safran, Wachtel, & Winston, 1998)

The Use of Advanced Relational Interventions (UARI) operationalized the client-perceived therapist use of advanced relational interventions, and the therapist-reported use of advanced relational interventions (see Appendix J and Appendix K). The measure was derived from the Beth Israel Fidelity Scale (BIFS; Patton, Muran, Safran, Wachtel, & Winston, 1998). The original scale was created to assess therapist adherence to three psychotherapy modalities (from an observer/rater perspective), and was based on findings of empirical reviews of comparative psychotherapy modality literature (Patton et al., 1998). The original full scale contains three subscales: one that measures features characteristic of interpersonal/relational therapies (BRT), one that measures features characteristic of short-term psychodynamic therapies (BAP), one that measures features characteristic of cognitive-behavioral therapy (CBT), and another 8 additional items reflective of common factors. The original interpersonal/relational subscale, known as the Brief Relational Therapy (BRT) subscale, contains 12 items. The original psychodynamic scale, known as the Brief Adaptive/Short-Term Dynamic Psychotherapy (BAP) subscale, also contains 12 items. A 6-point scale assesses the extent to which a therapist frequently and clearly utilized a technique in session from 0 (*not at all*) to 6 (*extensively*). The CBT subscale was not used in this study.

The original BIFS (and both the BRE and BAP subscales, separately) exhibited moderate to strong reliability, with an interrater reliability coefficient of .63 for the BRE and BAP and an internal consistency coefficient of .94 for the BRE and BAP, separately (Santangelo, 1994). Evidence for discriminant validity was gathered through use of ANOVAs, which were run in

order to compare the BRE, BAP, and CBT subscales to each other. This was done with the intent to provide evidence for differences between the subscales. Significant results (in the form of significant differences between mean scores) indicated that items from the three separate subscales adequately distinguished between the three treatment modalities (interpersonal/relational, psychodynamic, and cognitive-behavioral). The full-scale BIFS has been utilized in studies evaluating efficacy of different treatment interventions, in which establishing accurate fidelity to specific types of therapy is required (Muran, Samstag, Safran, & Winston, 2005; Safran, Samstag, Muran, & Winston, 2005; Stevens, Muran, Safran, Gorman, & Winston, 2007).

For the purpose of this study, I used language from the original BRT and BAP subscales as a starting point, adapting items in order to place emphasis on advanced relational interventions defined as interventions that focus on both the "here and now" and "you and me." (Teyber & Teyber, 2014). Language was added to items to add this focus when it was not included in the original item. For example, an original item on the BAP reads: "Interprets/explores maladaptive patterns by linking components of a conflict." To add a "here and now" and "you and me" element, the item was adapted to read: "During today's session, my therapist linked our **current interaction** to my past concerns in order to explore negative patterns."

Additionally, aspects of this measure were altered to develop the therapist/client forms. Language was adapted from the observer/rater perspective to instead reflect the perspective of the therapist and client, respectively. For example, an original item on the BRT reads: "Directs or redirects the focus to the "here and now" whether with regard to the client's experience or with regard to the relationship between the client and therapist." To adopt the client's perspective on the client form, the item read: "My therapist directed focus to the present moment in order to

explore what was going on between us." Both client and therapist forms contained similar language, but with different pronouns.

Content validity of the UARI (created with language derived from the BRE and BAP subscales of the BIFS for the current study) was established through development of items with two professionals on my committee who are experts in use of advanced relational interventions in therapy. I define an "expert" as a professional holding a doctoral degree in applied psychology, and who has practiced relationally-oriented therapy for four or more years. Initial item construction was completed with assistance from these committee members. The instrument was then revised three times to increase the instrument's ability to measure the presence of interventions involving "here and now" and "you and me" in a therapy session from a therapist/client perspective (see Appendices J and K).

The final version included a 6-point scale (identical to the original BIFS) that assessed the extent to which a session was characterized by advanced relational interventions (from the client or therapist perspective) from 0 (*not at all*) to 6 (*extremely*). The final version contained five items. Standard linear scoring was used, and total scores for each separate measure (the UARI-T and UARI-C, respectively) were calculated for use in analysis.

It is important to note that the UARI was not a revision of, but a completely different instrument from, the Beth Israel Fidelity Scale (BIFS; Patton, Muran, Safran, Wachtel, & Winston, 1998). The UARI should in no way be confused with Patton et al.'s (1998) instrument. The UARI has not been endorsed by Patton et al., although these authors gave permission for some wording from the BIFS to be used in the UARI (see Appendix P).

Emotional Experience Self-Report and Emotional Experience Therapist-Report (EE-SR and EE-TR; Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli, & Peri, 2016)

The EE-SR and EE-TR measured the intensity of client-reported emotional experience and therapist-perceived client emotional experience within the therapy hour (see Appendix L and Appendix M). These measures operationalized client emotional arousal and therapist-perceived client emotional arousal. Both client and therapist forms contain one item, consisting of a single visual analog scale ranging from zero to seven centimeters. The scale is anchored at each end by a statement describing clients' potential in-session emotional experience (i.e., "In today's session, I was disconnected from my emotions" (0) and "In today's session, I fully and vividly experienced my emotions" (7)). The participant was asked to place a mark on the scale indicating the extent to which the client experienced his or her emotions in the session as prompted by the anchors.

Scoring was accomplished by measuring with a ruler the length from the beginning of the line on the left (the zero anchor) to the participant's mark. Standard linear scoring was used with zero indicating the least amount of emotional arousal, and seven indicating the greatest amount of emotional arousal. The scores for each separate measure (the EE-SR and EE-TR, respectively) were calculated for use in analysis.

Fisher et al. (2016) reported a test-retest reliability coefficient of .61 for emotional experience ratings using the methodology described above. In a study examining client emotional experience over multiple sessions, interclass correlation estimates indicated that 42.8% of the variance in the EE-SR was accounted for by differences between clients, while 57.2% of the variance was accounted for by between-session changes. Authors stated that these findings provide evidence for both the stability and sensitivity (identifying change within one

subject) of the EE-SR. Because this measure is unpublished, no published validity data exists. However, Fisher's (2016) study found that client and therapist forms were moderately correlated (r = .35), providing some minimal evidence for convergent validity. Permission has been granted by the authors for use of this measure in this study (Fisher, personal communication, 2016; see Appendix O). Visual analog scales have been widely used in psychological research and practice to measure dynamic states, such as mood and emotion (for a review, see Ahearn, 1997).

Client Task Specific Change Measure-Revised (CTSCM-R; Watson, Greenberg, Rice, & Gordon, 1999)

The CTSCM-R measures client self-reported change within a therapy session (see Appendix N). It served as an operationalized measure of client-perceived session outcome. The CTSCM-R consists of 16 items that identify changes that would be anticipated to occur in client-centered psychotherapy (three items), experiential psychotherapy (five items), and cognitive behavioral psychotherapy (four items); the remaining four items indicate general changes that might be generated by any of the three approaches. An example of an item that relates to all three approaches is: ''I was able to see the links between my thoughts, feelings and behavior." Each item is rated on a 7-point scale, from 1 (*not at all*) to 7 (*very much*). Higher scores indicate greater client-perceived change within one session.

According to Watson, Schein, and McMullen (2010), the CTSCM-R exhibits adequate internal consistency throughout treatment (with Cronbach's alpha coefficients ranging from .94 to .98). This same study also examined the validity of the CTSCM-R and found it predicted Beck Depression Inventory-II (BDI-II; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) scores at the end of treatment (R^2 = .30). It was also found to account for 13% additional variance above and beyond the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the Barrett-

Lennard Relationship Inventory (BLRI Form OS-64; Barrett-Lennard, 1964) in measuring overall treatment outcome as measured by the BDI-II. Although factor analysis indicated evidence of a two-factor model, no significant difference was found between factors and both reflect overall change (Watson et al., 2010). Therefore, the CTSCM-R total score was used in analyses. Standard linear scoring was used, and an average score was calculated for use in analysis.

Procedure

Permission (documented with an email from the director) was sought from the director of each of the counseling centers to recruit participants (including all levels of trainees) at that center. In this email, I also asked the director to estimate the number of packets to be sent to the center based on the number of therapists and trainees at that center. If the director did not respond, I waited two weeks and contacted the director a second time (see Appendices A and B for copies of the initial email and follow-up email to directors). If permission was granted, I confirmed the number of packets to be sent, and mailed the director a box with envelopes containing packets of measures and stamped envelopes addressed to the post-office box (which I set up in advance). The director was asked to place the packets in the counseling center mailroom. No further contact was made with directors who did not respond to one of these two invitations. A total of 152 packets were sent to the 14 centers that originally consented to participate.

Using counseling center websites and public directories published by universities, email addresses for 301 therapists were located. Three hundred and one therapist participants were invited to participate through email (see Appendix C). Therapists who elected to participate in the study picked up from the container in the mail room a packet that contained client and

therapist versions of an informed consent letter, demographic forms, and copies of the CTSCM-R, RRI-C, EE-SR, EE-TR, UARI-C, and UARI-T. All documents contained a unique numerical code in order to identify a dyad's data and to protect all participants' anonymity. One copy of client documents (informed consent letter, demographic form, CTSCM-R, RRI-C, EE-SR, and UARI-C) and one stamped and addressed envelope were enclosed in a separate envelope within the therapist-provided envelope to ensure ease of delivering documents to the client participant. As mentioned earlier, all measures were marked with a unique dyad code for analysis purposes.

Therapist participants reviewed the provided informed consent letter, which included a copy of the short description of the study also found in the invitation email. If they agreed to participate, the therapist participants were given instructions to invite the next client they saw who met inclusion criteria to participate in the study, read the study description to the client and provide the client with the client envelope containing client documents. This was done at the beginning of the session. This method of client recruitment is common in therapist-client studies (Gelso et al., 2012; Kivlighan et al., 2014; Markin et al., 2014). Following the session, participating therapists completed the demographic form, EE-TR, and UARI-T.

To prevent clients possibly feeling coerced to participate, the study description that therapists read to clients informed clients that therapists would remain unaware as to whether or not they participated and that their responses would be anonymous. Clients were informed (via what therapists read to them) that, should they choose to participate, they would complete the measures outside of the counseling center to protect their anonymity, would put their completed measures in the stamped envelope, and would then mail the envelopes. After answering any questions the client had, therapists proceeded with the therapy session.

At the end of the therapy session, clients were provided with the envelope containing client instruments and the stamped envelope. Clients were told that after they left the counseling center, they should review the informed consent letter and if they wished to participate, they should complete the client demographic form, RRI-C, EE-SR, UARI-C, and CTSCM-R. The information letter also requested that clients choosing to participate complete the measures as soon as possible after the session in which they were given the measures. They placed completed measures in the stamped envelope provided and mailed the envelope to a P. O. box. Based on trials with two people, I estimated it should take clients approximately fifteen minutes to complete the RRI-C, EE-SR, UARI-C, and CTSCM-R.

Following the therapy session, therapists completed the EE-TR and UARI-T. They placed completed measures in the stamped envelope provided and mailed the envelopes. The information letter also requested that therapists complete the measures as soon as possible after the session. Based on trials with two people, I estimated that it should take therapists approximately five minutes to complete the demographic questionnaire, EE-TR and UARI-T.

As an incentive for participation, the client envelope contained two dollars in order to encourage participation and thanked clients for their time. Clients were informed (through both the script read to them by therapists and through the client information letter) that they could keep the money even if they did not choose to complete the instruments. Clients were also informed that they could in the future ask their therapists about any questions they had about the study. Of the 301 therapists who received an email, 75 sought out a packet, invited one client participant, and completed therapist measures (a 24.9% response rate). Of the 75 clients who were invited by these 75 therapists, 40 returned a valid, completed client packet (a 53.3% response rate). This resulted in the final sample size of 40 client-therapist pairs.

V. Results

Descriptive Statistics

All participants in the sample of 40 pairs completed all instruments. Before analysis interpretation, data was examined to determine if it met assumptions of the analyses. The data met guidelines for normality, linearity, and homoscedasticity. Scatter plots of correlations between variables did not provide any evidence for curvilinear distributions. Table 3 presents sample size, means, standard deviations, and Cronbach's alphas of each measure within the current sample. All analyses were conducted using SPSS version 24.0

Table 5. *Descriptive Statistics and Cronbach's Alphas (N = 40)*

	M	*SD*	α
RRI-C Genuineness Subscale	51.95	4.99	0.83 (0.91)
RRI-C Realism Subscale	50.35	5.41	0.83 (0.90)
RRI-C Full Scale	102.30	10.00	0.91 (0.95)
UARI-T	12.08	6.78	0.82
UARI-C	20.33	7.33	0.88
EE-SR (single item analog scale)	5.23	1.36	0.00
EE-TR (single item analog scale)	4.31	1.48	0.00
CTSCM-R	80.70	15.67	0.88 (0.94)

Note: RRI-C = Real Relationship Inventory-Client Form. UARI-T = Use of Advanced Relational Interventions-Therapist Form. UARI-C = Use of Advanced Relational Interventions-Client Form. EE-SR = Emotional Expression-Self Report. EE-TR = Emotional Expression-Therapist Report. CTSCM-R = Client Task-Specific Change Measure-Revised.

( ) indicate α from past studies conducted by original authors examining these instruments.

Hypothesis 1: Comparing Importance of Client and Therapist Variables

Hypothesis 1 stated: "Client predictor variables (client-reported emotional arousal and client-perceived therapist use of advanced relational interventions) will be more important than therapist predictor variables (therapist-perceived client emotional arousal and therapist-perceived use of advanced relational interventions) in predicting client perceptions of the real relationship (genuineness and realism)." A series of z-tests of beta weights were used to examine the impact of client predictor variables and client perceptions of the real relationship, versus therapist predictor variables and client perceptions of the real relationship.

Bivariate relationships. To test the hypothesis that client independent variables will be more important than therapist independent variables in predicting the real relationship (Hypothesis 1), simple correlations among variables and *z*-tests of beta weights were used. Tables 4 and 5 present correlation matrices and *z*-test of beta weights for client-reported emotional arousal, therapist-perceived client emotional arousal, client-perceived use of advanced relational interventions, therapist-reported use of advanced relational interventions, client perceptions of therapist genuineness, and client perceptions of therapist realism (subsets of the client perceived real relationship). Calculations of the Pearson product-moment correlations for a sample size of 40 showed the following significant coefficients for client-reported emotional arousal and client-reported subscales of the real relationship (genuineness and realism): $r = .55$ for genuineness ($p < .001$) and $r = .43$ for realism ($p = .006$). Significant coefficients for client perceived use of advanced relational interventions and client-reported subscales of the real relationship (genuineness and realism) included $r = .33$ for genuineness ($p = .036$) and $r = .46$ for realism ($p = .003$).

Calculations of the Pearson product-moment correlations for therapist variables and client-reported subscales of the real relationship were conducted. Coefficients for therapist-perceived client emotional arousal and subscales for the real relationship (genuineness and realism) were both significant: $r = .48$ for genuineness ($p = .002$) and $r = .41$ for realism ($p = .009$). A significant correlation was also found between therapist reported use of advanced relational interventions and scores on the client-reported realism subscale of the real relationship ($r = .33$; $p = .040$). The correlation between therapist reported use of advanced relational interventions and genuineness ($r = .28$) was not significant ($p = .083$).

Analysis of beta weights. To further compare the importance of client and therapist variables on subscales of the real relationship, *z*-tests of the beta weights were performed. Results indicated no significant difference in importance between client variables and therapist variables in predicting the real relationship. Specifically, the correlation between client-reported emotional arousal and the client's perception of genuineness was not significantly different from the correlation between therapist-perceived client emotional arousal and client-perceived genuineness ($z = .44$; $p = .661$). Similar findings were obtained for client-perceived realism ($z = .13$; $p = .898$). Similarly, client-perceived therapist use of advanced relational interventions did not significantly differ from therapist-reported use of advanced relational interventions in predicting client-perceived genuineness ($z = .26$; $p = .797$) or client-perceived realism ($z = .66$; $p = .512$).

Analysis of beta weights indicated that the difference between correlations was not robust enough to indicate likelihood that differences are not due to chance. Therefore, Hypothesis 1 was not supported. Client-reported emotional arousal and client-perceived therapist use of advanced relationship interventions do not seem to be more closely related to client perceptions of the real

relationship than therapist-perceived client emotional arousal and therapist-reported use of advanced relational interventions.

Table 6. *Correlations: Client Emotional Arousal, Therapist-Perceived Client Emotional Arousal, Real Relationship (Genuineness & Realism) (N = 40)*

Variable	1	2	3	4
1. Client-Reported Emotional Arousal (CEA)				
2. Therapist-Perceived Client Emotional Arousal (TEA)	.36*			
3. Genuineness	.55**	.48**		
4. Realism	.43**	.41**	.85**	

*$p < .05$; **$p < .01$

Table 7. *Correlations: Client-Perceived Use of Advanced Relational Interventions, Therapist-Reported Use of Advanced Relational Interventions, Real Relationship (Genuineness & Realism) (N = 40*)

Variable	1	2	3	4
1. Client-Perceived Use of Advanced Relational Interventions (CUARI)				
2. Therapist-Reported Use of Advanced Relational Interventions (TUARI)	.05			
3. Genuineness	.33*	.28		
4. Realism	.46**	.33*	.85**	

*$p < .05$; **$p < .01$

Hypothesis 2: Client and Therapist Variables in Predicting The Real Relationship

Hypothesis 2 stated: "Therapist-reported use of advanced relational interventions will contribute additional variance above and beyond the contributions of client independent

variables (client-reported emotional arousal and client-perceived use of advanced relational interventions) in predicting scores on the subscales of the client-perceived real relationship (genuineness and realism)." Hierarchical multiple regression analysis was used to examine the amount of variance explained in relationship to client perceptions of the real relationship. Client variables were entered in step one, and therapist-perceived use of process was entered in step two.

Regarding genuineness, step one indicated that client-reported emotional arousal significantly accounted for unique variance in genuineness ($\beta = .49$, $p = .002$), but that client perceived use of advanced relational interventions did not ($\beta = .17$, $p = .258$). Overall, client-reported emotional arousal and client perceived therapist use of advanced relational interventions within step one account for a significant proportion of variance in client-perceived genuineness ($R^2 = .32$, $p < .001$). Adding therapist-reported use of advanced relational interventions in step two resulted in an R^2 change of .04 ($p = .133$; not significant), resulting in a total R^2 of .36. Additionally, therapist reported use of advanced relational interventions within step two did not contribute significant unique variance in genuineness ($\beta = .21$, $p = .133$). Results suggested that therapist reported use of advanced relational interventions does not explain significant unique variability in client perceived genuineness above and beyond client emotional arousal and client perception of therapist use of advanced relational interventions.

Table 8. *Summary of Hierarchical Multiple Regression Analysis for Variables Predicting Genuineness (N = 40)*

Variable	*B*	*SE B*	β	*sr*
Step 1				
CEA	1.80	.53	.50**	.46
CUARI	.11	.10	.17	.16
Step 2				
TUARI	.15	.10	.21	.21

Note: CEA= Client-reported Emotional Arousal; CUARI= Client-Perceived Use of Advanced Relational Interventions; TUARI= Therapist Reported Use of Advanced Relational Interventions.
*$p < .05$; **$p < .01$

Regarding realism, step one indicated that both client-reported emotional arousal and client perception of therapist use of advanced relational interventions contributes significant unique variance in realism ($\beta = .31$, $p = .043$ for emotional arousal, $\beta = .35$, $p = .022$ for perceived use of relational interventions), accounting for a unique significant proportion of variance in client-perceived realism ($R^2 = .29$, $p = .002$). Adding therapist-reported use of advanced relational interventions in step two resulted in an R^2change of (.07; $p = .051$) (not significant), with a final R^2 of .37. Therapist-reported use of advanced relational interventions within step two did not significantly relate to realism ($\beta = .27$, $p = .051$). Because therapist-reported use of process interventions did not add additional unique variance above and beyond client emotional arousal and client perceived use of process, Hypothesis 2 was not supported.

Table 9. *Summary of Hierarchical Multiple Regression Analysis for Variables Predicting Realism (N = 40)*

Variable	*B*	*SE B*	β	*sr*
Step 1				
CEA	1.23	.59	.31*	.29
CUARI	.26	.11	.35*	.33
Step 2				
TUARI	.22	.11	.27	.27

Note: CEA= Client-reported Emotional Arousal; CUARI= Client-Perceived Use of Advanced Relational Interventions; TUARI= Therapist Reported Use of Advanced Relational Interventions.
*$p < .05$; **$p < .01$

Hypothesis 3: Mediational Models

Hypothesis 3 stated: "scores on subscales of the client-perceived real relationship (genuineness and realism) will mediate an indirect positive relationship between client independent variables (client-reported emotional arousal and client-perceived therapist use of advanced relational interventions) and client-perceived session outcome, such that increasingly positive genuineness and realism scores will explain the increasingly positive indirect relationship between independent variables and client-perceived session outcome."

To test Hypothesis 3, bootstrapping procedures (as recommended by Hayes, 2009) were used to test four hypothesized mediation models. This process allowed the researcher to assess the meditational effects of the client-perceived real relationship (subscales genuineness and realism) on the relationship between the two client independent variables and session outcome. Analysis examined pathways *a, b, c,* and c' (with c' representing a direct path) in Preacher and Hayes' (2008) meditational model.

According to Preacher and Hayes (2008), the INDIRECT macro for SPSS is used to analyze hypothesized mediation models. Through use of normal theory significance tests and percentile-based bootstrap confidence intervals (CIs), the macro evaluates direct and indirect effects (it also tests *a, b, c,* and *c′* path coefficients). As recommended by Hayes (2009), the analyses for the proposed study used 1,000 bootstrapped samples with bias corrected and accelerated estimates and a 95% CI. Evidence for a significant effect was found if the CI does not contain 0. Full mediation is further supported by the direct path (*c*) being significant without the mediator but failing to be significant once the mediator is added (*c′*).

Model A (Figure 1) illustrates the testing of genuineness as a mediator on the association between client emotional arousal and session outcome. Model B (Figure 2) illustrates the testing of realism as a mediator between client emotional arousal and session outcome. Model C (Figure 3) illustrates the testing of genuineness as a mediator on the association between client perceived therapist use of advanced relational interventions and session outcome. Model D (Figure 4) illustrates the testing of realism as a mediator on the association between client perceived therapist use of advanced relational interventions and session outcome.

Path coefficients, significance tests, and bootstrapped 95% CI for the indirect effects were calculated for four separate models. Model A was significant F (2, 37) = 7.54, p = .002), and explained 28.9% of the variance in session outcome. The results for the relationship between client emotional arousal and genuineness (*a* path) were significant, indicating that higher levels of emotional arousal predicted increased perception of genuineness (B = 2.00, SE = .50, t = 4.01, p < .001). In addition, the relationship between genuineness and session outcome (*b* path) was significant (B = 1.19, SE = .52, t = 2.29, p = .028). The total effect of client emotional arousal on session outcome (*c* path) was also significant (B = 5.01, SE = 1.69, t

= 2.97, p = .005) according to bootstrapping procedures. Lastly, the direct effect (c' path) was not significant (B = 2.63, SE = 1.91, t = 1.38, p = .177). Results of the bootstrap test did not include zero in a bias corrected CI (.29, 5.34). The not significant result of the direct effect (c' path) and the result of the bootstrap test provide evidence that client perception of genuineness fully mediates the relationship between client emotional arousal and session outcome. However, the Sobel test result (z = 1.81; p = .069) was not significant, indicating that the indirect effect was not significant. Given the conservative nature of the Sobel test (MacKinnon, Warsi, & Dwyer, 1995), results concerning the mediating effect of client perception of genuineness on the relationship between client emotional arousal and session outcome is mixed.

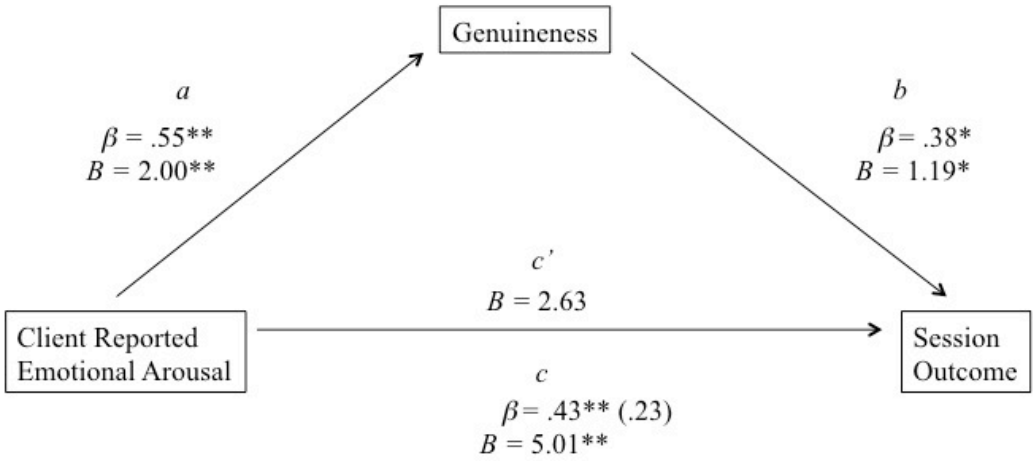

Figure 1: Model A. Testing of Mediation of Genuineness on Client Reported Emotional Arousal and Session Outcome

Note: β = (.23) is for Client Reported Emotional Arousal after adding Genuineness as a mediator.

* $p < .05$; ** $p < .01$

Model B was significant F (2, 37) = 9.25, $p < .001$), and explained 33.3% of the variance in session outcome. The results for the relationship between client emotional arousal and realism (a path) were significant, indicating that higher levels of emotional arousal

predicted increased perception of realism (B = 1.71, SE = .58, t = 2.93, p = .006). In addition, the relationship between realism and session outcome (b path) was significant (B = 1.22, SE = .43, t = 2.83, p = .007). The total effect of client emotional arousal on session outcome (c path) was also significant (B = 5.01, SE = 1.69, t = 2.97, p = .005). Lastly, the direct effect (c' path) was not significant (B = 2.93, SE = 1.71, t = 1.71, p = .096). Results of the bootstrap test did not include zero in a bias corrected CI (.39, 4.65). The non-significant result of the direct effect (c' path) and the result of the bootstrap test provide evidence that client perception of realism also fully mediates the relationship between client emotional arousal and session outcome. Sobel test results were significant with z = 2.04 and p = .042.

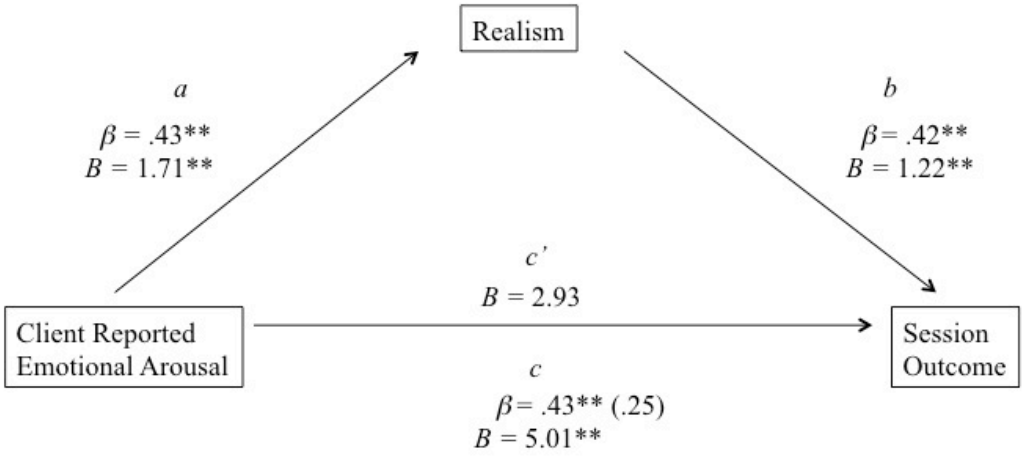

Figure 2: Model B. Testing of Mediation of Realism on Client Reported Emotional Arousal and Session Outcome

Note: β = (.25) is for Client Reported Emotional Arousal after adding Realism as a mediator.

* $p < .05$; ** $p < .01$

Model C was significant F (2, 37) = 9.69, $p < .001$), and explained 30.8% of the variance in session outcome. The results for the relationship between client perception of

therapist use of advanced relational interventions and genuineness (*a* path) were significant, indicating that higher levels of process use predicted increased perception of genuineness (*B* = .23, SE = .10, *t* = 2.17, *p* = .036). In addition, the relationship between genuineness and session outcome (*b* path) was significant (*B* = 1.25, SE = .44, *t* = 2.81, *p* = .008). The total effect of client perceived use of advanced relational interventions on session outcome (*c* path) was significant (*B* = .96, SE = .31, *t* = 3.12, *p* = .004). Lastly, the direct effect (*c*' path) was also significant (*B* = .68, SE = .30, *t* = 2.26, *p* = .030). Results of the bootstrap test did not include zero in a bias corrected CI (.01, .85). The significant result of the direct effect (*c*' path) and the result of the bootstrap test provide evidence that client perception of genuineness partially mediates the relationship between client perceived use of advanced relational interventions and session outcome. However, the Sobel test result (*z* = 1.72; *p* = .09) was not significant, indicating that the indirect effect was not significant. Given the conservative nature of the Sobel test (MacKinnon, Warsi, & Dwyer, 1995), results concerning the mediating effect of client perception of genuineness on the relationship between client-perceived use of advanced relational interventions and session outcome is mixed.

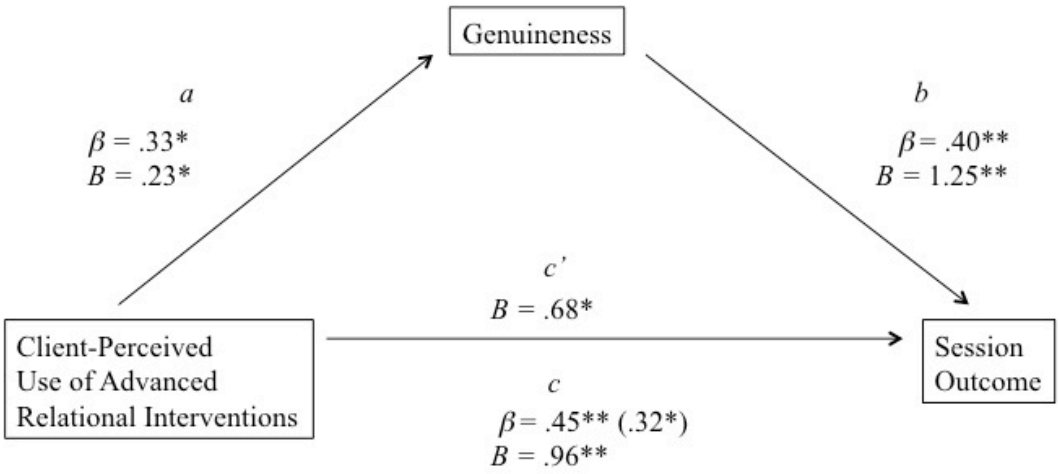

Figure 3: Model C. Testing of Mediation of Genuineness on Client-Perceived Use of Advanced Relational Interventions and Session Outcome

Note: $\beta = (.32^*)$ is for Client Reported Emotional Arousal after adding Genuineness as a mediator.

$^*p < .05$; $^{**}p < .01$

Model D was significant F (2, 37) = 9.36, $p < .001$), and explained 33.6% of the variance in session outcome. The results for the relationship between client perception of therapist use of advanced relational interventions and realism (*a* path) were significant, indicating that higher levels of process use predicted increased perception of realism (B = .34, SE = .11, t = 3.17, p = .003). In addition, the relationship between realism and session outcome (*b* path) was significant (B = 1.19, SE = .44, t = 2.72, p = .010). The total effect of client perceived use of advanced relational interventions on session outcome (*c* path) was significant (B = .96, SE = .31, t = 3.12, p = .004). Lastly, the direct effect (*c*' path) was not significant (B = .57, SE = .32, t = 1.76, p = .087). Results of the bootstrap test did not include zero in a bias corrected CI (.11, .96). The non-significant result of the direct effect (*c*' path) and the result of the bootstrap test provide evidence that client perception of realism fully mediates the

relationship between client perceived use of advanced relational interventions and session outcome. Sobel test results were significant with $z = 2.06$ and $p = .039$.

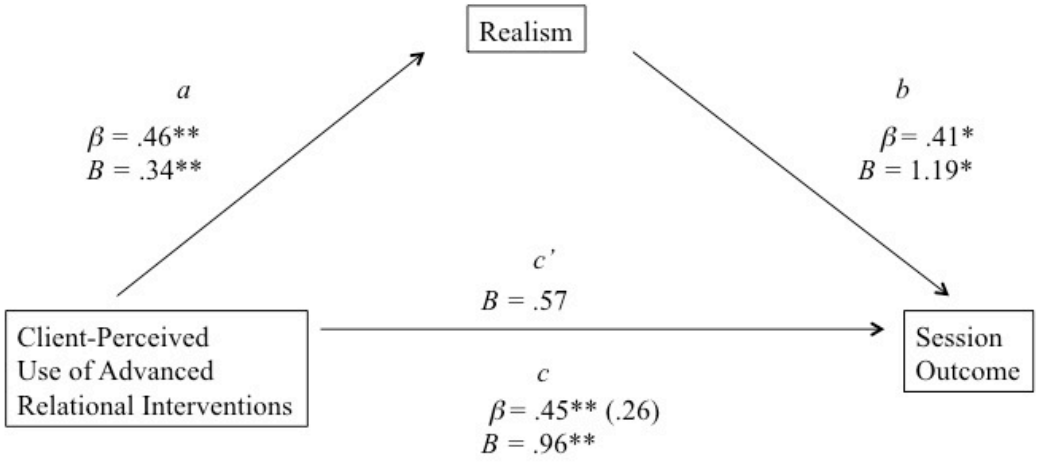

Figure 4: Model D. Testing of Mediation of Realism on Client-Perceived Use of Advanced Relational Interventions and Session Outcome

Note: $\beta = (.26)$ is for Client-Perceived Use of Advanced Relational Interventions after adding Realism as a mediator.

$^{*}p < .05$; $^{**}p < .01$

Summary of Results

In summary, results supporting hypotheses are mixed. Despite positive relationships between client variables and the real relationship, client-reported emotional arousal and client-perceived therapist use of advanced relationship are not more closely related to client perceptions of the real relationship than therapist-perceived client emotional arousal and therapist-reported use of advanced relational interventions. Results also suggest that therapist-reported use of advanced relational interventions does not add additional variance in predicting client perceived genuineness and realism above and beyond client variables. However, mediation models provide evidence that client perception of realism positively influences the

relationship between client emotional arousal and session outcome. Evidence indicates that realism also mediates the relationship between client perception of therapist use of process interventions and session outcome. Mediation models provide mixed results regarding client perception of genuineness as a positive influence on both the relationship between client emotional arousal and session outcome, and the relationship between client perception of therapist use of process and session outcome.

VI. Discussion

As stated above, the purpose of this study was to examine the associations between the real relationship, session factors (such as emotional arousal and use of relational interventions), and session outcome. Specifically, based on past research indicating client perception of the real relationship is more important than therapist perception of the real relationship in predicting therapy outcomes (Eugster & Wampold, 1996; Gelso et al., 2012; Markin et al., 2014), it was hypothesized that client perception of session factors would be more important than therapist factors in predicting the real relationship. However, it was also predicted that therapist use of specific interventions would explain some significant variance above and beyond client perception in predicting the real relationship. Lastly, it was anticipated that the real relationship (genuineness and realism) would influence the relationship between client factors and session outcome.

Implication of Findings

Client perceptions of therapy factors are not more important than therapist factors in regards to the real relationship. In examining beta weights, the results of this study did not support the hypothesis that client factors (client report of emotional expression and client perception of therapist use of advanced relational interventions) are more important than therapist factors (therapist perception of client emotional expression and therapist report of use of advanced relational interventions) in predicting the real relationship. Therapist perception of client emotional expression was positively related to genuineness and realism, suggesting that therapist attunement to client emotions may be an indicator of how authentic a client may perceive the therapy relationship to be. This suggests that both therapist and client factors are equal predictors of genuineness and realism.

Therapist perception of their own use of relational interventions was significantly related to clients' experience of realism within the real relationship, but not genuineness. This difference is unexpected, given the strong, association between items on the full-scale Real Relationship Inventory ($\alpha = .91$). It is possible that process interventions, which are focused on both the "here and now" and the "you and me," may be perceived by clients as frank, honest discussion rather than having the quality of genuineness, which seems to include a certain relational warmth that is not captured by items on the Realism subscale or the Use of Advanced Relational Interventions scales.

Therapists' perceptions of their use of process does not predict the real relationship above and beyond client factors. The results of the study did not support the hypothesis that therapist reported use of advanced relational interventions adds significant additional variance above and beyond client factors in predicting the real relationship. This prediction was based on the premise that therapists will be better judges of their own behavior and intentions than clients. Prior to this study, real relationship literature had yet to explore the impact of therapist-reported intervention on the client-perceived real relationship. I expected that therapist intentionality would account for some additional variance in client perception of general outcome variables (including the real relationship). Results did indicate that client factors contribute significantly (accounting for approximately 32% of variance) in predicting client perceptions of both genuineness and realism in the therapy relationship. This finding is consistent with past studies indicating client perceptions, rather than therapist perceptions, are what counts when considering the real relationship (Eugster & Wampold, 1996; Gelso et al., 2012; Markin et al., 2014). This study explored the possibility that therapist intention could impact client perception of the real relationship, and evidence from this study suggests that it does not. It is reasonable that client

perception of what happens in therapy (including their perception of their emotional experience and their perception of what their therapist says or does) predicts how they perceive the therapy relationship, which, as illustrated in previous literature, predicts outcome.

It was anticipated that therapists' perception of their own behavior (in this case, using process interventions) might contribute to client real relationship perception. Past research indicates that client perceptions of the real relationship are better than therapist perceptions of the real relationship in terms of predicting outcome (Fuertes et al., 2007; Gelso et al., 2012; Kivlighan et al., 2014), but past studies have not examined the influence of process comments on outcome. That therapist perception of their use of process does not seem to contribute to client real relationship perception (and was unrelated to client perception of use of process) adds to research that suggests continuing need to assess clients' reactions to their progress within treatment (Gelso & Palma, 2011).

Realism influences the association between client factors and outcome.

The results of this study partially supported the hypothesis that realism (a component of the real relationship) influences the association between client-reported emotional arousal and session outcome, as well as client-perceived therapist use of process and session outcome. Results also indicated that genuineness (a component of the real relationship) might influence the association between client-reported emotional arousal and session outcome, and client-perceived therapist use of process and session outcome (note results concerning genuineness are mixed due to the Sobel test indicating that the indirect path in mediation models for genuineness is not significant). Specifically, results indicated that client-reported emotional expression had a significantly positive relationship with both genuineness and realism within the real relationship, and that genuineness and realism had a significantly positive relationship with session outcome.

Both components of the real relationship were found possibly to mediate the connection between emotional expression and session outcome. It should be noted that results concerning genuineness are mixed, particularly because in one case the direct path remained significant after adding genuineness as a mediator. Therefore, these specific results should be interpreted with caution. Similarly, client perceived therapist use of advanced relational interventions had a significantly positive relationship with both genuineness and realism, and those components of the real relationship had a significantly positive relationship with session outcome. However, there were mixed results in that only realism was found to mediate the relationship between perceived use of process and outcome. Although models suggested that genuineness partially mediated this relationship, the Sobel tests suggested that this might not be the case.

This information adds to a body of research linking the real relationship to multiple client/therapist factors, such as attachment style (Marmarosh et al., 2009), outcome throughout the therapy process (Gelso et al., 2012), self-disclosurae (Ain & Gelso, 2011), the working alliance (Lo Coco et al., 2011), and empathy (Fuertes et al., 2007). These findings also add to the understanding of the role of the real relationship in the context of the therapy room. Although clients' appraisal of how fully they are experiencing emotion within therapy seems connected to outcomes, adding feeling genuinely cared for and understood on a human, person-to-person level seems to positively influence this connection further.

Limitations and Recommendations for Future Research

Findings of this study must be interpreted with caution due to several limitations. Multiple characteristics of the sample must be taken into consideration. First, the small sample size of 40 pairs decreased the power of the analyses. However, despite small sample size, initial significant results regarding realism as a mediator are encouraging and may provide directions

for future research in this area. Additionally, the client sample was largely homogeneous. Majority of participants identified as female (82.5%), Caucasian (70%), and heterosexual (60%). It is somewhat positive to note that in terms of clients, participation was variable across college levels (First Year, 20%; Sophomore, 15%; Junior, 20%; Senior, 30%; Graduate Student, 15%). The most often reported therapist theoretical orientation was Interpersonal Process (37.5%), with the most often reported client presenting concern as anxiety (42.5%). Therefore, results of this study are generalizable mainly to therapists and clients that match these sample characteristics from select institutions.

This sample was non-random; therefore, the sample may not be representative of the population and may have known or unknown characteristics which impacted the results. In turn, these potential selection bias factors make generalization challenging. For example, college counseling centers that had connections to Auburn University's Counseling Psychology program were invited to participate, limiting generalizability of the sample to centers with first- or second-hand connections to the researcher. Also, it is possible that therapists who identified as Interpersonal Process clinicians would be more interested than other therapists in responding to a research request involving relational interventions, resulting in results that can primarily be applicable to therapist-client pairs who engage in interpersonal process interventions. The homogeneity of the sample is unfortunate due to need to increase inclusive services that are helpful to a wide range of clients. Obviously psychotherapy research that utilizes a diverse sample of participants is to be preferred over studies with more homogeneous samples. Future study in this area could benefit from conducting research with a larger, more diverse sample, including increasing the number of client ethnic groups represented and increased gender and sexual orientation diversity. It may also be important to increase the number of therapist

theoretical orientations represented as well, in order to generalize results to all treatment modalities.

It is possible that therapists and clients who are more conscientious and altruistic would choose to participate. These characteristics likely positively influence their ability to form quality real relationships with each other, and could possibly impact study results. This study indicates that client perceptions of client emotional arousal and client perception of therapist use of process were not more important than therapist perception in predicting the real relationship. This finding may be in part due to therapist participants who choose to participate because they are more conscientious and altruistic than other therapists, who did not choose to participate. These altruistic therapists may be more likely to "match" client perception of what occurs in therapy, leading to results that are not significant. In future research, use of a larger sample size may include dyad pairs that vary across levels of altruism and conscientiousness.

An additional consideration is the self-report nature of the measures used in this study. Utilizing self-report measures limits understanding to aspects of therapy viewed through the lens of client and therapist, and data is thus subject to bias. As discussed earlier, the linear relationship (and lack of curvilinear relationships) between variables is likely related to therapist and client perception, rather than objective, third party observation. As stated earlier, self-report studies tend to demonstrate convergence within ratings when participants rate their perception of multiple aspects of the same experience (Sandvik, Diener, & Seidlitz, 1993). This study's findings (that genuineness and realism mediate the relationship between both client-reported emotional arousal and client-perceived therapist use of process and session outcome) may be due to clients' completing multiple surveys regarding their single therapy session. There may be

further understanding of the real relationship, session factors, and session outcome that may be accessible through third party observation or other data sources in future research.

This current study also explored only two aspects of session factors among many that may be related to session outcome and the real relationship. As stated above, past research has examined the relationship between attachment style (Marmarosh et al., 2009), self-disclosure (Ain & Gelso, 2011), the working alliance (Lo Coco et al., 2011), and empathy (Fuertes et al., 2007) and the real relationship. This study examined emotional arousal and use of advanced relational interventions in association with session outcome and the real relationship. Additional session factors for future research regarding the real relationship may include other interventions (other than process interventions or empathy statements), client personality characteristics, therapist personality characteristics, and additional aspects of other treatment modalities.

Conclusion

In conclusion, while additional evidence is needed to confirm the role of the real relationship as a mechanism by which session factors (in this case, client emotional expression and use of process interventions) contribute to outcome, the current study has explored how these variables may interact together within the therapy experience. The exploratory findings in this study add to a body of literature supporting the real relationship as positively related to session outcomes. Findings also increased understanding of psychotherapy process, providing initial support for realism as a mediator between the association between session factors and outcome. Combined, results suggest continued increased attention to monitoring client perception of therapy factors, as well as attending to client emotional arousal and using process interventions (and clients noting their level of emotional arousal and that the therapist is using process interventions) may contribute to a positive real relationship and session outcome.

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Appendix A

DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

DIRECTOR INITIAL RECRUITMENT EMAIL

Greetings,

My name is Shari Black and I am a doctoral candidate in the Counseling Psychology Program at Auburn University. I am working on my dissertation under the supervision of Dr. Randolph Pipes, and I am writing to ask your permission to recruit clients and therapists of all levels (including trainees) at your center. This study examines client and therapist factors within a single therapy session. In particular, I am interested in how the client and therapist experience of the session relate to each other.

Please note that therapist participants will invite one client to review client participation instructions. Therapists will not know whether or not clients actually participate. All data from all participants will be unidentifiable. The time commitment for therapists should be about 5 minutes. It should take clients about 15 minutes to complete surveys.

If you were to grant me permission to recruit at your center, I would mail you packets containing measures for both therapists and clients, with the request that you place the packets in the staff mailroom (or another accessible location). I would then proceed to email therapists at your center a copy of the recruitment email. (attached to this email for your review).

Would you please reply to confirm your permission to recruit at your center (your reply email will be used as documentation of your permission)? Also, please let me know approximately how many packets I should mail, based on the number of therapists at your center. If I do not hear back from you, I will follow up with you in two weeks.

This study has been approved by the Auburn University Institutional Review Board. Participation is voluntary, and participants are free to discontinue participation at any time without penalty. If you have any questions about the study, please contact me at smb0059@auburn.edu

Thank you for your consideration.

Shari Black

Appendix B

DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

DIRECTOR FOLLOW-UP RECRUITMENT EMAIL

Greetings,

My name is Shari Black and I am a doctoral candidate in the Counseling Psychology Program at Auburn University. I am conducting a study examining client and therapist factors within a single therapy session. I am emailing to follow-up on my initial email to you asking permission to recruit participants at your center.

Will you please review the email below, and reply to confirm your permission to recruit at your center (your reply email will be used as documentation of your permission to recruit at your center)? Also, please estimate how many packets I should mail to your center. Thank you for your time.

This study has been approved by the Auburn University Institutional Review Board. Participation is voluntary, and participants are free to discontinue participation at any time without penalty. If you have any questions about the study, please contact me at smb0059@auburn.edu

Thank you for your consideration.

Shari Black

Appendix C

DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

THERAPIST EMAIL INVITATION

Greetings,

My name is Shari Black and I am a doctoral candidate in the Counseling Psychology Program at Auburn University. Under the supervision of Dr. Randolph Pipes, I am conducting a study examining client and therapist factors within a single therapy session. In particular, I am interested in how the client and therapist experience of the session relate to each other. Your participation will increase our understanding of the process of therapy, especially how the psychotherapy relationship is related to client emotions and therapist-client interaction. I hope you will consider participating.

In order to participate in this study you must be a therapist employed by or receiving training at a college counseling center. If you are interested in participating, (director name) has agreed to make packets available to you. Further directions and an informed consent document are in the envelope.

You will be asked to invite the next client you see, who also fits the study requirements, after reading the informed consent document in the envelope to also participate. Do not invite a client whom you believe may be experiencing symptoms of schizophrenia, serious signs of suicidality, or serious dependence on substance use. You must have seen this client for at least three sessions, and the client must be at least 18 years old. It will take you about **5 minutes** to complete the surveys. It will take clients about 15 minutes to complete their surveys.

This study has been approved by the Auburn University Institutional Review Board. Your participation is voluntary, and you are free to discontinue your participation at any time without penalty. If you have any questions about the study, please contact me at smb0059@auburn.edu

Thank you for your consideration.

Shari Black

Appendix D

DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)

INFORMATION LETTER: THERAPIST FORM

Participant Selection and Purpose:

You are invited to participate in a research study because you are a therapist employed by or receiving training at a college counseling center. Please do not participate more than one time. The purpose of the study is to better understand the process of therapy, especially how the psychotherapy relationship is related to client emotions and comments made by the therapist. This study is being conducted by Shari Black, a doctoral candidate, in the Counseling Psychology Program in the Auburn University Department of Special Education, Rehabilitation, and Counseling under the supervision of Dr. Randolph Pipes.

Procedure and Duration:

Your participation is voluntary, and you are free to discontinue your participation at any time without penalty. If you decide to participate in this research study, you will be asked to invite the next client you see (following reading this letter) to also participate. Do not invite a client whom you believe may be experiencing symptoms of schizophrenia, serious signs of suicidality, or serious dependence on substance use. You must have seen this client for at least three previous sessions. The client must also be at least 18 years old.

You will read a short script to the client to invite participation. This script is intended to invite interested clients without forcing or coercing participation. If the client voluntarily expresses disinterest (do not directly ask the client if the client is interested) you will invite the next client. Immediately following your session with the participating client, you will provide the client with the envelope in this packet. You will then complete a short demographic form and two short surveys about elements of the session. Please complete the measures immediately after your session. Collectively, these surveys should take approximately 5 minutes to complete. It is possible that clients may ask you questions about the items in the future.

Risks and Benefits:

The risks to you for participating in this study are minimal; however, the risks associated with participating in this study are that you may feel slight discomfort as you invite your client to participate or consider elements of the session you just held with a client.

Potential benefits to you may include increased reflection on the therapy session you just held. If you decide to participate, you will not incur any costs.

Anonymity and Presentation of Data:

Any data obtained in connection with this study will remain anonymous. The surveys will not ask for your contact or identifying information. The results of the study may be published in scholarly journals and/or presented at a professional meeting.

If you have any questions about the study, please contact the principle investigator, Shari Black, at smb0059@auburn.edu.

If you have any questions about your rights as a research participant, please contact the Auburn University Office of Human Subjects Research or the Institutional Review Board at hsubjec@auburn.edu or IRBChair@auburn.edu, or by phone at (334)-844-5966.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. REMEMBER, YOU MAY DISCONTINUE THE STUDY AT ANY POINT WITHOUT PENALTY. THIS LETTER IS YOURS TO KEEP.

Thank you for taking the time to assist me in this research.

Sincerely,

Shari Black

Appendix E

DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)

INFORMATION LETTER: CLIENT FORM

Participant Selection and Purpose:

You are invited to participate in a research study because you are at least 18 years old and are seeing a therapist at a university counseling center. Please do not participate more than one time. The purpose of the study is to better understand the process of therapy. This study is being conducted by Shari Black, a graduate student, in the Auburn University Department of Special Education, Rehabilitation, and Counseling under the supervision of Dr. Randolph Pipes.

Procedure and Duration:

Your participation is voluntary, and you are free to discontinue your participation at any time without penalty. If you decide to participate in this research study, you will be asked to complete a short demographic form and four short surveys about elements of the therapy session you just had with your therapist. If you choose to participate, you will take the surveys with you, fill them out, place them in the stamped envelope, and put the envelope in the nearest mailbox. Please mail the surveys within a week from your last session.

If you choose not to participate, simply discard the envelope and surveys. Even if you told your therapist you would complete the surveys, your therapist will not know whether or not you actually completed the surveys or how you answered questions on the surveys. In total, these surveys should take approximately 15 to 20 minutes to complete. You may ask your therapist any questions about the surveys in the future. Know that if you choose to ask your therapist about any questions, your therapist may then know that you participated.

There are two dollars attached to this letter. This money is a thank you for considering participation and you may keep the money regardless of whether or not you choose to complete participation.

Risks and Benefits:

The risks to you for participating in this study are minimal; however, the risks associated with participating in this study are that you may feel slight discomfort as you consider elements of the session you just had with your therapist.

Potential benefits to you may include increased reflection on the therapy session you just held. If you decide to participate, you will not incur any costs.

Anonymity and Presentation of Data:

Any data obtained in connection with this study will remain anonymous. The surveys will not ask for your contact or identifying information. Your therapist will not know whether or not you participated and also will not have access to any of your data. The results of the study may be published in scholarly journals and/or presented at a professional meeting.

If you have any questions about the study, please contact the principle investigator, Shari Black, at smb0059@auburn.edu.

If you have any questions about your rights as a research participant, please contact the Auburn University Office of Human Subjects Research or the Institutional Review Board at hsubjec@auburn.edu or IRBChair@auburn.edu, or by phone at (334)-844-5966.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. REMEMBER, YOU MAY DISCONTINUE THE STUDY AT ANY POINT WITHOUT PENALTY. THIS LETTER IS YOURS TO KEEP.

Thank you for taking the time to assist me in this research

Sincerely,

Shari Black

Appendix F

INVITATION SCRIPT

.

Please read the following to your client:

"Our center is helping a graduate student with a research study. This study is about understanding the client and therapist's perspectives about elements of one therapy session.

At the end of today's session, I'll give this envelope to you. This envelope has a letter for you to read, and four surveys to fill out, and a second envelope with a stamp on it. You will take this envelope with you after our session today—please don't open it until you have left the counseling center. If you choose to participate, you may take them home, fill them out, put them in the stamped envelope, and then drop the envelope in the mail. It should take you about 15 minutes to finish the surveys. After you mail the envelope, you are completely done with the study.

If you choose not to participate, just discard the entire packet without filling out the surveys. The graduate student put two dollars in the envelope to thank clients for participating. It is for you to keep, regardless of whether or not you participate.

You are under no obligation to participate, and it is important to understand that your decision will not affect our sessions or our therapy relationship either way. Even if you choose to take the envelope with the surveys, I will not know whether or not you chose to fill out the surveys, and I also will not know how you answered any of the questions. All of your answers will be anonymous, and I will not see any of the completed surveys. They will be mailed directly to the graduate student and I will not have access to them at any time.

If you have any questions about the study, you can contact the graduate student. Her contact information is on the information letter in your envelope."

Appendix G

DEMOGRAPHIC SURVEY: THERAPIST FORM

Directions: Please answer the following questions. Write your answers or circle all that apply to you. DO NOT include your name or any other identifying information.

1. **Educational Degree:** Bachelors + Some Masters Bachelors + Some Doctoral

Masters Masters + Some Doctoral Doctoral Other

2. **Primary Theoretical Orientation (please choose only one)**:

CBT Person-Centered/Humanist Interpersonal Process

DBT Feminist/Multicultural Existential Family/Systems

Solution-Focused REBT Psychodynamic Psychoanalytic Behavioral

Attachment Other: _____

3. **License to Practice Status**: Non-licensed Licensed

4. **Number of Years Practicing Therapy**: _____

5. **Number of Sessions with the Client you invited to participate**: _____

6. **Primary Client Presenting Concern (please choose only one)**:

Depression Anxiety Alcohol/Drug Use Academics Eating/Body Image

Gender/Sexuality Religion/Spirituality Friendships/Relationships Family

Grief Sexual Abuse/Assault Physical Abuse/Assault Emotional Abuse

Trauma Other:_____

Appendix H

DEMOGRAPHIC SURVEY: CLIENT FORM

Directions: Please answer the following questions. Write your answers or circle all that apply to you. DO NOT include your name or any other identifying information.

1. **Age**: _____

2. **Gender Identification**: Man Woman Genderqueer Other

3. **Ethnicity**: African American Asian American Caucasian Latino(a)

International Pacific Islander Multi-Ethnic American Indian Other

4. **Sexual Orientation**: Heterosexual Gay Lesbian Bi-sexual Other

5. **College Status**:

First-year Sophomore Junior Senior Graduate Student

Community (Not enrolled)

6. **How long has it been since your therapist gave you this packet?**

Less than one day 1 Day Less than one week 1 Week More than one week

7. **Are you rating your most recent session?** Yes No

Appendix I

USE OF ADVANCED RELATIONAL INTERVENTIONS - THERAPIST FORM (UARI-T)

Please rate how characteristic each statement was of your therapy practice within *your session today.*	0 = Not at all		2 = Somewhat		4 = Moderately		6 = Extremely
1. During today's session, I **linked our current interaction** to my client's concerns and problems.	0	1	2	3	4	5	6
2. I deepened my client's awareness by bringing attention to what was **currently happening between us.**	0	1	2	3	4	5	6
3. I **directed focus to the present moment** in order to explore our relationship.	0	1	2	3	4	5	6
4. I encouraged emotional expression about **what was currently going on between us.**	0	1	2	3	4	5	6
5. I **identified in-the-moment shifts in our relationship** during the therapy session.	0	1	2	3	4	5	6

Note: No Subscales; No Reverse-Scored Items.

Appendix J

USE OF ADVANCED RELATIONAL INTERVENTIONS - CLIENT FORM (UARI-C)

Please rate how characteristic each statement was of *your session today.*	0 = Not at all		2 = Somewhat		4 = Moderately		6 = Extremely
1. During today's session, My therapist **linked our current interaction** to my concerns and problems.	0	1	2	3	4	5	6
2. My therapist deepened my awareness by bringing my attention to what was **currently happening between us.**	0	1	2	3	4	5	6
3. My therapist **directed focus to the present moment** in order to explore our relationship.	0	1	2	3	4	5	6
4. My therapist encouraged emotional expression about **what was currently going on between us.**	0	1	2	3	4	5	6
5. My therapist **identified in-the-moment shifts in our relationship** during the therapy session.	0	1	2	3	4	5	6

Note: No Subscales; No Reverse-Scored Items.

Appendix K

Email Permission to Use Emotional Experience Self-Report and Emotional Experience Therapist-Report (EE-SR and EE-TR; Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli, & Peri, 2016)

Re: Use of the EE-SR and EE-TR

Hadar Fisher

Sent: Sunday, March 13, 2016 at 2:13 PM

To: Shari Black

The EE-SR and EE-TR.docx (128.5 KB) Preview

You replied to this message on 3/16/16, 7:10 AM. Show Reply

Hi Shari,

I'm glad to hear you being interested in client's and therapist's report on client's emotional experience.
A good self report measure which can be use to measure this concept is indeed missing.
I believe you can ask fascinating questions comparing those point of view.

Attached is the questionnaires.
As you probably read in my paper it contains one question (one for client and one for therapist).
Thus, you may want to ask clients and therapists complete the measure after few sessions.

Let me know if you have any questions.
best,

Hadar Fisher
Bar-Ilan University

2016-03-10 17:48 GMT+02:00 Shari Black <smb0059@tigermail.auburn.edu>:

Hello Dr. Fisher,

My name is Shari Black and I'm a doctoral candidate in Counseling Psychology at Auburn University, Alabama, USA. I'm currently formulating my dissertation design, and I'm interested in examining relationships between the therapist-percieved client emotional experience and client-reported emotional experience.

I read your and your colleagues' study in this month's issue of Psychotherapy, and your Emotional Experience Self-Report measure is exactly the type of measure I've been hoping to find. I'm emailing to ask your permission to use both the EE-SR and the EE-TR.

I'm planning on having both clients and therapists complete the measure following one therapy session.

If you feel like this would be an appropriate and valid use of your measure, and you are willing to grant me permission to use it, would you please send me a copy? I would be very, very grateful.

Thank you for your time.

Appendix L

Email Permission to Use The Beth Israel Fidelity Scale (BIFS; Patton, Muran, Safran, Wachtel, & Winston, 1998)

Permission to Use Beth Israel Fidelity Scale for Dissertation

Shari Black
Sent: Wednesday, April 13, 2016 at 9:52 AM
To: JCMURAN@ADELPHI.EDU
Cc: Randolph Pipes

Dear Dr. Muran,

My name is Shari Black and I am a doctoral candidate in Counseling Psychology (APA-accredited) at Auburn University. I'm currently working on my dissertation under the direction of Dr. Randy Pipes (copied on this email), and I'm interested in examining client and therapist perception of process-type interventions used in a therapy session. I'm interested in interventions that capture the "here and now" as well as the "you and me"— both what is happening in the session at that moment, and the client/therapist relationship.

I have been unable to locate a measure that specifically looks at interventions with both of the above attributes, and which also has two versions—one from the perspective of the client and one from the perspective of the therapist (not an outside rater). Two measures that almost fit in my view are the Integrative/Brief Relational and Brief Adaptive Psychotherapy subscales of the Beth Israel Fidelity Scale. I am emailing to ask your permission to adapt and use some items from each of those subscales for my dissertation. This process would include creating items that can be answered from the client or therapist perspective, and adding language to reflect the "here and now" and the "you and me" when such language is not already present.

For example, item four on the Integrative/Brief Relational reads: "**4. Directs or redirects the focus to the "here and now" either with regard to the client's experience or with regard to the relationship between the client and therapist.** "What's happening for you right now?," "What would satisfy you with me right now?," "What's your fear of exploring those feelings with me right now?"

Thus, I might adapt this item to read something like this (for the client form): "My therapist directed focus to the present moment in order to explore what was going on between us."

If you would be willing to grant me permission to adapt and use your instrument, would you please let me know? I would cite your work in my dissertation, but I would give the adapted measure a different name and would explain in the dissertation that you have given permission for me to use some of your words. If needed, I'm happy to add further clarifying language noting your copyrighted material, etc., as you deem necessary.

If you have any questions, please contact me (or Dr. Pipes). Thank you for your time.

Re: Permission to Use Beth Israel Fidelity Scale for Dissertation

J. Christopher Muran
Sent: Wednesday, April 13, 2016 at 9:58 AM
To: Shari Black
Cc: Randolph Pipes

You replied to this message on 4/13/16, 10:03 AM.

Yes, Shari, you have my permission. Keep me posted & feel free to ask any further questions. Good luck, Chris

---
J. Christopher Muran, Ph.D.
Associate Dean & Professor, Derner Institute of Advanced Psychological Studies
Hy Weinberg Center, Adelphi University,158 Cambridge Avenue, Garden City, NY 11530
Director, Psychotherapy Research Program, Mount Sinai Beth Israel
President-Elect, Society for Psychotherapy Research

Appendix M

DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

NOTICE OF STUDY COMPLETION: EMAIL TO DIRECTORS

Greetings,

My name is Shari Black and I am a doctoral candidate in the Counseling Psychology Program at Auburn University. You and the therapists at your center kindly agreed to participate in a study examining client and therapist factors within a single therapy session. I am emailing to thank you for your participation and to inform you that the study has been completed.

Please discard any unused packets. Note that there are $2 in every unused client envelope. Before discarding the unused packets, feel free to remove the $2. I trust that your center will find a good home for any money in the unused envelopes. Thank you again for your participation.

This study has been approved by the Auburn University Institutional Review Board. Participation is voluntary, and participants are free to discontinue participation at any time without penalty. If you have any questions about the study, please contact me at smb0059@auburn.edu

Sincerely,

Shari Black