Psychotherapy
2011, Vol. 48, No. 4, 391–400

0033-3204/11/$12.00 DOI: 10.1037/a0025248

Exploration of Session Process: Relationship to Depth and Alliance

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This study investigates the relationship between the Depth of elaboration, the therapeutic alliance, and dimensions of the psychotherapy process—the therapist interventions, the patient contributions, and patient/therapist patterns of interaction. Sixty psychotherapy sessions that were audio-taped and transcribed were rated by external judges by using a battery of instruments that included the Psychotherapy Process Q-Set (Jones, 1985, 2000), the Working Alliance Inventory–Observer (Horvath, 1981, 1982; Horvath & Greenberg, 1989), and the Depth Scale of Session Evaluation Questionnaire (Stiles & Snow, 1984a). The results show a significant positive correlation between Depth and therapeutic alliance, as well as between Depth, therapeutic alliance, and some variables of the therapeutic process. The findings indicate the importance of therapist interventions that focus on the patient's affects, relational patterns, and the "here and now" of the relationship in the increase of the Depth of elaboration and therapeutic alliance. The clinical implications of this study will be discussed.

Keywords: Depth, therapeutic alliance, therapist interventions, psychotherapy process, PQS

This study investigates the relationship between the Depth of elaboration, the therapeutic alliance, and dimensions of the psychotherapy process—the therapist interventions, patient contributions, and patient/therapist patterns of interaction.

The Depth of elaboration is a dimension of the quality of psychotherapy sessions. It indicates whether they are powerful/weak, valuable/worthless, deep/shallow, full/empty, and special/ordinary, and shows a positive correlation with the therapy outcome (Stiles, Gordon, & Lani, 2002). The evaluation of session Depth seems to also estimate the effectiveness of an ongoing treatment and can be considered as a measure of the session's impact and outcome. Measuring a session impact—its immediate effects—permits a closer look at what intervenes between process (i.e., the events within sessions) and long-term outcome (i.e., the effects of a series of sessions or of a whole treatment). Impact research offers a two-stage strategy for studying process-outcome relations; first linking process to session impact and then linking impact to outcome (Stiles, 1980). This article addresses questions at the first of these two stages.

When we have to face the problem of determining which elements of the psychotherapy process are related to outcome (or, as in our study, to session outcome), it is easy to be a victim of "the culture wars of psychotherapy that pit the therapy relationship against the treatment method" (Norcross & Wampold, 2011, p. 101).

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Regarding the Depth of elaboration, research has focused the investigation on both technical and relational factors, but it has often evaluated these two dimensions separately. In essence, research has investigated the relationship between the session Depth and (1) therapeutic alliance, (2) different patient/therapist styles of interaction, or (3) specific therapist interventions.

Several studies have found that a greater Depth of elaboration is associated with a good quality of therapeutic alliance (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Mallinckrodt, Porter, & Kivlighan, 2005; Raue, Goldfried, & Barkham, 1997; Romano, Fitzpatrick, & Janzen, 2008; Svensson & Hansson, 1999). In a study on psychological assessments, Ackerman et al. (2000) suggested that a deep and broad exploration of interpersonal issues, which is more salient for the patient, may increase the therapeutic alliance between the patient and clinician. More specifically, the relationship between the session Depth and the therapeutic alliance seems to be circular: A good alliance can achieve greater Depth and the exploration of complex issues can enhance the experience of a positive alliance (Svensson & Hansson, 1999). Other studies, which have focused their investigation on the patient/therapist interaction style, have found that sessions rated with greater Depth are those in which the dialogue between patient and clinician is clearer, defined, and well articulated (Friedlander, Thibodeau, & Ward, 1985; Fuller & Hill, 1985; Hill, Helms, Spiegel, & Tichenor, 1988; Kelly, Hall, & Miller, 1989; Stiles, Shankland, Wright, & Field, 1997). Conversely, several studies suggested that, in sessions with low Depth levels, patients and therapists tend to exchange information regarding concrete facts or specific events but they do not explore the feelings associated with these events (Fuller & Hill, 1985; Hill et al., 1988).

Various studies have focused on therapists' techniques by observing that sessions characterized by high Depth were more likely to occur when the therapist uses interventions that emphasize the pa-

tient's emotional experiences and help him/her to recognize and make contact with psychological content that is more difficult to process (Hill et al., 1988; Regan & Hill, 1992). Still, other studies have found a positive correlation between session Depth and the use of specific intervention techniques, such as psychodynamic-interpersonal techniques rather than those that are cognitive–behavioral in nature (Stiles, Shapiro, & Firth-Cozens, 1988). These findings get further support in the study by Pesale and Hilsenroth (2009), who examined the relationship between session Depth and the techniques used by the therapist—psychodynamic-interpersonal and cognitive–behavioral—with certain covariate variables (i.e., Axis II pathology, the patient level of psychological functioning, and the therapeutic alliance). These variables seem to have had a nonsignificant impact on the relationship between dynamic-interpersonal techniques and the session Depth (Pesale & Hilsenroth, 2009). Finally, other studies have evidenced that, during moments of resistance or impasse, the use of confrontation by the therapist rather than the validation of the patient's feelings, clarification, and reinforcement can hinder further elaboration (Stiles, Honos-Webb, & Surko, 1998; Stiles et al., 2002).

In summarizing these results, we could say that (a) therapeutic alliance is related to Depth of elaboration; (b) some specific therapist interventions, characterized by the focus on affects and feelings, are related to the Depth of elaboration; and that (c) these two elements, therapeutic alliance and therapist interventions, have been often studied separately.

Another central point of Depth research is the issue of evaluation perspective. The majority of studies have evaluated Depth and its relationship to other variables of the psychotherapy process by using self-report measures (i.e., both from patient and therapist perspective); however, there are very few studies that consider a clinical observer's perspective (Stiles et al., 1988; Kahn, Vogel, Schneider, Barr, & Herrel, 2008). Every evaluation perspective has its strengths and limitations.

The major advantage of evaluations based on patient or therapist perspectives is that we can directly listen to their voices; the administration of such instruments is also quite economic. Another strength of using therapist perspective is that clinicians are "experienced observers," and that they can provide highly reliable judgments (Westen & Weinberger, 2004). Finally, self-report measures are likely to serve as an organizing function of the therapeutic experience (Stiles & Snow, 1984a).

However, the use of self-report instruments for Depth evaluation presents some limitations. One example is the influence of implicit processes, or those that are inaccessible to conscious thought, in the areas of memory, cognition, affect, and motivation. These implicit processes may disrupt the formulation of valid and reliable opinions and cause the individual to distort self-evaluation in a defensive or socially desirable way (Westen & Shedler, 1999a). Depth assessment may be influenced by the emotional tone of the session. For example, the patient may dissociate and distance himself/herself from the emotionally charged content that emerges during deep-probing but turbulent sessions. Alternatively, conflict-related pain and psychological distress may affect patient response and lead to an underestimation of the value of the session. Finally, it must be considered that the therapist assessment may be influenced by the theoretical preconceptions related to her/his therapeutic approach. For example, a dynamic therapist may judge sessions as being deeper the more similar they are to her/his ideal model of intervention (Ablon & Jones, 1998). It is important to observe that the aforementioned limitations can also be considered for the evaluation of other variables, such as therapeutic alliance, which have very often been studied in relation to Depth (Colli & Lingiardi, 2009).

These limitations probably explain the low level of agreement between the therapist and the patient in the evaluation of Depth, particularly at session level (Dill-Standiford, Stiles, & Rorer, 1988; Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988; Mallinckrodt, 1993). For example, when comparing patient and therapist ratings of session Depth carried out on the same sessions, it appears that smooth and less turbulent sessions tend more to be judged as better by patients rather than by therapists, who assess these sessions as being neutral or insignificant (Stiles, Reynolds, Hardy, Rees, Barkham, & Shapiro, 1994). Other researchers have identified a significant negative correlation, albeit modest, between therapist evaluations of Depth and patient evaluations of smoothness (Stiles & Snow, 1984a).

Clearly, a clinical observer perspective also has its own limitations and strengths. The major limitations are (a) observer measures are more expensive and time-consuming (e.g., for reading and evaluating sessions, and for rater training); (b) they do not capture the subjective experience of patient and therapist; (c) in the case of evaluation based on session transcript, we lose information about nonverbal phenomena and, in general, we have less information about the session atmosphere. On the other hand, observer perspective seems to be unaffected by the emotional tone of the session because the observer is not directly involved in the interaction. And in general, memory biases are less relevant.

In any event, what we wish to bring to light here is not the superiority of one perspective over the other; rather, it is the need to study a phenomenon, such as Depth of elaboration, from the observer perspective. Our consideration is consistent with the recommendations provided by the interdivisional task force on evidence-based therapy relationships on the necessity of addressing the observational perspective (e.g., therapist, patient, or external rater) in future studies and reviews of "what works" in the therapy relationship. Agreement among observational perspectives provides a solid sense of established fact; divergence among perspectives holds important implications for practice (Norcross & Wampold, 2011).

Therapeutic alliance is probably the most-cited "common factor" in psychotherapy and one of the most investigated constructs in psychotherapy research. In a recent meta-analysis, Horvath, Del Re, Flückiger, and Symonds (2011) found, on electronic databases, over 7000 items that include the key words "alliance," "helping alliance," "working alliance," and/or "therapeutic alliance." As observed by Horvath (2006; 2011) in spite of this volume of research, the definition of the construct still remains problematic and the question "What is the alliance?" (Henry & Strupp, 1994) is clearly a pressing one for psychotherapy research. One way to address this question is by investigating what part or parts of the psychotherapy process are being assessed by alliance measures (Price & Jones, 1998). In relation to this point, it is also important to observe that there is still a lack of knowledge about how patients and therapists construct the alliance during psychotherapy process (Horvath, 2006) and, in particular, what are the specific in-session actions (i.e., of patients and therapists) that contribute to the construction and maintenance of the alliance.

Finally, as we have already observed, the therapeutic alliance resulted significantly in association with Depth of elaboration, but the way in which these two elements interact is still unclear. Research into exactly how therapeutic alliance and Depth of elaboration interact within the psychotherapy process and in which way they differ would likely promote a better understanding of their relationship.

Using these topics as a starting point, the aims of our study are to (a) examine the relationship between Depth and therapeutic alliance; (b) identify the elements of the therapeutic process, such as therapist interventions, patient contributions, and patient/therapist pattern interactions that are related to session Depth; (c) identify the elements of the therapeutic process, such as therapist interventions, patient contributions, and patient/therapist pattern interactions that are related to therapeutic alliance; (d) investigate whether or not the elements of the therapeutic process related to Depth of elaboration pertain only to the quality of therapeutic alliance and relationship in general, or whether they relate to specific therapist interventions; and (e) investigate the relationship between these variables from an observer perspective.

We hypothesized that (a) there is a positive correlation between therapeutic alliance and Depth of elaboration; (b) several elements of the psychotherapy process are related to Depth of elaboration and therapeutic alliance; (c) these elements concern the patient, the therapist, and their interaction; (d) these elements concern both relational and technical aspects; and (e) therapists' interventions related to Depth and therapeutic alliance are characterized by the focus on the elaboration of affects.

Method

Patients

The sample consisted of 60 Caucasian participants (i.e., 40 females and 20 males), with an average age of 34 years (min = 29.5 years, max = 38.5, *SD* = 4.5). In particular, 6 patients were of low educational level (10 years), 15 of middle educational level (<13 years), and 39 of high educational level (>18 years). The majority were middle class (n = 42), 8 were rated as working class, and 10 as upper class. Only 18 participants were married, 40 were single, and 2 were divorced. The patients, as well as the sessions, were chosen randomly from our database. This sample has not been used in previous research. All patients were recruited from independent practice. Each patient has been evaluated by his or her therapist according to DSM–IV–TR (APA, 2000) Axis I and Axis II categories. Many patients (n = 38) had an Axis I diagnosis: mood disorders (n = 15), anxiety disorders (n = 13), eating disorders (n = 7), and adjustment disorders (n = 3). Most patients (n = 27) had also an Axis II personality disorder: Cluster B (n = 10) and Cluster C (n = 17); some patients (n = 10) had at least one Axis II personality disorder without Axis I disorders: Cluster A (n = 1); Cluster B (n = 8); Cluster C (n = 1). The other subjects (n = 12) had prominent subclinical traits of personality pathology. All participants were in their first psychotherapy experience. They all gave their consent to the audio-recording of the sessions and authorized the use of the transcripts for research purposes, even if they did not know the rationale of the study.

Clinicians

The sample consisted of 60 clinical therapists (i.e., 28 females and 32 males), all Caucasian with an average age of 45 (min = 38, max = 52, *SD* = 7). Three different theoretical approaches were represented: psychodynamic (n = 35), cognitive–behavioral (n = 17), and integrative (n = 8). The clinicians of this study constituted a sample of experienced psychiatrists and psychologists. The average length of their clinical experience was 15 years (*SD* = 5) and all saw patients in independent practice. All clinicians included in this study signed informed-consent forms.

Treatment and Sessions

To obtain a cross-section of psychotherapy patients seen in clinical practice, we contacted clinicians from different Italian psychological associations and requested that they select a nonpsychotic patient of at least 18 years of age. To minimize selection biases, we directed clinicians to consult their calendar to select the last patient they saw during the prior week who met the study criteria. We asked them to complete a large battery of measures and, if they agreed, to also audio-record at least two consecutive sessions. Each clinician described only one patient in order to minimize rater-dependent biases. Clinicians did not receive an honorarium for this procedure. Only a small number of the clinicians (n = 87) agreed to record sessions and furnished 348 sessions; most of the clinicians furnished more than two sessions from different phases of the therapy. The other clinicians contacted agreed to complete self-report instruments but not to audio-record sessions.

From the sample of clinicians who recorded sessions, we randomly selected 60 patient and therapist dyads. For every dyad, we randomly selected one session. In this way, we evaluated only one session for each patient–therapist dyad. The length of treatments averaged 15 months, with a median of nine months. The distribution of the sessions selected was five sessions drawn from the early phase of therapy; seven sessions from the third month; 10 sessions from the sixth month; 15 sessions from the 12th month; 10 sessions from the 18th month; 11 sessions from the 24th month; and two were from the 36th month.

Raters

Three different coding groups were recruited and trained (i.e., one group for each instrument). Each team was composed of two junior raters and one senior rater. No author of this project was included. The raters represented a range of various theoretical perspectives. Two senior raters were cognitive therapists and one was a psychodynamic therapist; four junior raters were attending a training course in dynamic psychotherapy, one in cognitive interpersonal therapy and two had no psychotherapy training. The three senior raters (i.e., one female and two males) were psychologists who each had more than 10 years of clinical experience and were expert in the use of the instruments used in this study. The six junior raters (i.e., four females and two males) were advanced doctoral-level students of Psychology, Sapienza University of Rome. Four of them had one year of clinical experience, whereas two had no clinical experience. All of the junior raters had at least one previous experience in rating session transcripts.

The senior and junior evaluators had received specific, intensive training from the first two authors of this study to enable them to use each instrument and obtain adequate reliability. Training consisted of studying the coding manual of the measures, participating in group discussions, and consensus-rating of 10 session transcripts, as well as doing homework assignments. The classroom portion of the training lasted for a total of 32 hours, which was spread over two-hour sessions twice per month, in addition to the homework. The sessions used for training were not included in the study. To partially reduce some rater biases (e.g., preferences for a specific psychotherapeutic approach, expectations of a better or worse session in relation to the diagnosis or phase of the therapy), we gave no information about therapies. When the raters reached a satisfactory reliability (intraclass correlation $>$ .65), they were randomly assigned to the three coding groups.

Rating Procedure

Every rater was blind to the results of the other raters' assessments, from the period of treatment from which the sessions were extracted and to the therapist orientation. Sessions were rated in a random order.

Measures

Psychotherapy Process Q-set. The Psychotherapy Process Q-set (PQS; Jones, 1985, 2000) is an instrument that consists of 100 items that are based on the Q-sort method (Block, 1961/1978). PQS items cover a wide range of several dimensions of the psychotherapy process including both relational and technical aspects. Moreover, PQS contains items that separately describe patient contributions to the psychotherapy process (e.g., Q97 Patient is introspective, readily explores inner thoughts and feelings), therapist contributions (e.g., Q50 Therapist draws attention to feelings regarded by the patient as unacceptable, such as anger, envy, or excitement), and patient/therapist interactions (e.g., Q39 There is a competitive quality to the relationship). PQS furnishes a description of the psychotherapy process that is suitable for comparison and quantitative analysis (Jones, 2000).

After studying the transcripts of a therapy hour, clinical judges proceed to the ordering of the 100 items, each of which are printed separately on cards to permit easy arrangement and rearrangement. The items are sorted into nine piles that range on a continuum from least (Category 1) to most characteristic (Category 9). PQS ratings, as other Q sort measures such as, for example, Shedler–Westen Assessment Procedure (SWAP-200; Westen & Shedler, 1999a, 1999b), are based on a "forced choice." The number of cards sorted into each pile is fixed (e.g., ranging from five at the extremes to 18 in the middle category) and conforms to a normal distribution, requiring judges to make multiple evaluations among items and thereby avoid either negative or positive halo effects, and attenuating the influence of response sets (Block, 1961, 1978). The reliability of the instrument was shown to be more than adequate, with the coefficient alpha ranging from .83 to .92 with evaluators of different theoretical orientations (Jones, Hall, & Parke, 1991; Jones & Pulos, 1993). Finally, PQS results were reliable in the evaluation of the session's transcripts of different orientations and displayed an ability to differentiate from among the different types of therapies.

Working Alliance Inventory–Observer Version. Length form. The Working Alliance Inventory–Observer Version (WAI–O; Horvath, 1981, 1982; Horvath & Greenberg, 1989) was used to assess the therapeutic alliance from the observer's perspective. The Working Alliance Inventory (WAI) is a measure based on Bordin's pantheoretical model, which describes the alliance as an agreement on objectives (*goals*) and the change tasks (*tasks*) necessary to achieve them, along with the establishment of a bond (*bond*) that maintains the collaboration among participants in the therapeutic work (Bordin, 1979).

The WAI consists of the following three scales: the goal subscale refers to the agreement regarding the goals of therapy, the task subscale concerns the agreement regarding the tasks that are necessary to achieve the treatment goals, and the bond subscale refers to the mutual relationship between patient and therapist. The three dimensions of the WAI (e.g., the goal, task, and bond) are strongly correlated, with scores ranging from .60 to .80 (Horvath & Greenberg, 1989; Plotnicov, 1990; Safran & Wallner, 1991; Tichenor & Hill, 1989; Tracey & Kokotovic, 1989). Despite the very high correlations, some research has shown that these are distinct but overlapping dimensions (Tracey & Kokotovic, 1989).

Depth scale of the Session Evaluation Questionnaire. The Depth scale of the Session Evaluation Questionnaire (SEQ–D; Stiles & Snow, 1984a) was used to assess the session Depth from the perspective of external raters. It is a measure of five items based on a format of bipolar adjectives applied to the session (i.e., powerful/weak, valuable/worthless, deep/shallow, full/empty, and special/ordinary) and rated on a seven-point scale. The internal consistency of the instrument, which is measured by using the coefficient alpha, was high (from .90 to .91) in different conditions and settings (Bunce & West, 1996; Stiles et al., 1994; Stiles & Snow, 1984b). The level of agreement between the external raters was between .80 and .90 (Stiles, Shapiro, & Firth-Cozens, 1988, 1990).

Results

Reliability and Descriptive Statistics

We calculated the degree of agreement among the judges who had evaluated the transcribed sessions with the instruments in this study. To assess inter-rater reliability for PQS, SEQ–D and the WAI–O ratings, we used the intraclass correlation (Shrout & Fleiss, 1979). The inter-rater reliability can be considered good ($>$.60) for the WAI and PQS and excellent ($>$.74) for the Depth scale (Fleiss, 1981; Fleiss & Cohen, 1973; Shrout & Fleiss, 1979; Cicchetti, 1994; Cicchetti, 1981; Table 1).

Depth and Therapeutic Alliance

To investigate the relationship between Depth and the therapeutic alliance, we calculated the correlations (Pearson's r, two-tailed) between the Depth scale, the overall score for the therapeutic alliance (WAI–O), and the scores for the individual subscales—bond, task, and goal. The global index of Depth scale correlated significantly with the WAI–O overall score ($r = .364$, $p < .05$) and

Table 1
Reliability and Descriptive Statistics of PQS, WAI–O, and SEQ–D

	Inter-rater reliability[a]	Descriptives[b]			
		Mean	Min	Max	*SD*
PQS	.67	—	—	—	—
WAI–O overall score	.68	5.24	3.63	6.74	.63
Bond	.69	5.79	4.42	6.83	.70
Task	.68	5.15	3.90	6.41	.63
Goal	.67	5.15	3.64	6.32	.66
SEQ–D	.75	4.72	3.21	6.53	.95

Note. $N = 60$; PQS = Psychotherapy Process Q-set; WAI-O = Working Alliance Inventory Observer Form, overall score and Bond, Task, and Goal subscales; SEQ-D = Depth scale of Session Evaluation Questionnaire.
[a] Intra-class correlation coefficient, two-way random effects model, absolute agreement (Shrout & Fleiss, 1979). [b] Descriptive statistics of PQS have not been computed because the instrument is not divided into subscales.

the average scores of the subscales bond ($r = .352$, $p < .05$), task ($r = .516$, $p < .01$), and goal ($r = .434$, $p < .05$).

Depth and Therapeutic Process

To understand the characteristics of the therapeutic process that are associated with Depth, we conducted an exploratory correlational analysis. We calculated the correlations (Pearson's *r*) among the 100 items of the PQS and Depth scores for each session. In this way, we were able to identify those items of the PQS—related to the therapist, the patient, and the interaction between the patient and therapist—which were significantly correlated, either positively or negatively, with the session Depth (SEQ–D).

In Table 2, we reported only the items of the PQS that were significantly associated ($p < .05$) with Depth.

Therapeutic Alliance and Therapeutic Process

To understand the characteristics of the therapeutic process that are associated with therapeutic alliance, we conducted an exploratory correlational analysis. We calculated the correlations (Pearson's *r*) among the 100 items of the PQS and WAI scores for each session. In this way, we were able to identify those items of the PQS—related to the therapist, the patient, and the interaction between patient and therapist—which were significantly correlated, either positively or negatively, with the therapeutic alliance (WAI–O).

In Table 3, we reported only the items of the PQS that produced results that were significantly associated ($p < .05$) with therapeutic alliance.

Discussion

The first aim of our study was to investigate the relationship between Depth of elaboration and therapeutic alliance from an observer's perspective. It is the first time that the relationship between the two variables has been investigated from such an outlook.

The Depth index was significantly correlated with the overall score of therapeutic alliance and the three subscales (i.e., task, goal, and bond). This result is consistent with other studies that have investigated the relationship between Depth and the therapeutic alliance from patient and therapist perspectives (Raue et al., 1997; Ackerman et al., 2000; Mallinckrodt et al., 2005; Romano et al., 2008).

Table 2
Significant Correlations Between PQS Items[a] and SEQ–D Scores[b]

N° item	Description PQS item	SEQ–D*
	Positive Correlations	
Q62	Therapist identifies a recurrent theme in the patient's experience or conduct	.61
Q98	The therapy relationship is a focus of discussion	.48
Q32	Patient achieves a new understanding or insight	.43
Q36	Therapist points out patient's use of defensive maneuvers (e.g., undoing, denial)	.42
Q50	Therapist draws attention to feelings regarded by the patient as unacceptable (e.g., anger, envy, or excitement)	.41
Q28	Therapist accurately perceives the therapeutic process	.39
Q4	The patient's treatment goals are discussed	.38
Q63	Patient's interpersonal relationships are a major theme	.38
Q68	Real vs. fantasized meanings of experiences are actively differentiated	.38
Q92	Patient's feelings or perceptions are linked to situations or behavior of the past	.38
Q6	Therapist is sensitive to the patient's feelings, attuned to the patient, empathic	.37
Q82	The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously	.37
Q67	Therapist interprets warded-off or unconscious wishes, feelings, or ideas	.33
	Negative Correlations	
Q9	Therapist is distant, aloof (vs. responsive and effectively involved)	−.57
Q44	Patient feels wary or suspicious (vs. trusting and secure)	−.50
Q69	Patient's current or recent life situation is emphasized in discussion	−.48
Q77	Therapist is tactless	−.39
Q14	Patient does not feel understood by therapist	−.38

Note. $N = 60$; PQS = Psychotherapy Process Q-set; SEQ–D = Depth scale of Session Evaluation Questionnaire.
[a] We reported only the PQS items that resulted in a significant correlation with Depth. [b] Overall Index of SEQ-D scale.
* $p < .05$, two-tailed.

Table 3
Significant Correlations Between PQS Items[a] *and WAI-O Overall Score*

N° item	Description PQS item	WAI–O*
	Positive Correlations	
Q95	Patient feels helped	.68
Q45	Therapist adopts supportive stance	.45
Q97	Patient is introspective, readily explores inner thoughts and feelings	.45
Q92	Patient's feelings or perceptions are linked to situations or behavior of the past	.41
Q6	Therapist is sensitive to the patient's feelings, attuned to the patient, empathic	.40
Q32	Patient achieves a new understanding or insight	.40
Q65	Therapist clarifies, restates, or rephrases the patient's communication	.40
Q98	The therapy relationship is a focus of discussion	.40
Q100	Therapist draws connections between the therapeutic relationship and other relationships	.40
Q50	Therapist draws attention to feelings regarded by the patient as unacceptable (e.g., anger, envy, or excitement)	.39
Q63	Patient's interpersonal relationships are a major theme	.38
Q73	The patient is committed to the work of therapy	.38
Q81	Therapist emphasizes patient's feelings in order to help him or her experience them more deeply	.37
Q82	The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously	.37
Q91	Memories or reconstructions of infancy and childhood are topics of discussion	.37
Q62	Therapist identifies a recurrent theme in the patient's experience or conduct	.36
	Negative Correlations	
Q44	Patient feels wary or suspicious (vs. trusting and secure)	−.67
Q51	Therapist condescends to or patronizes the patient	−.53
Q58	Patient resists examining thoughts, reactions, or motivations related to problems	−.49
Q9	Therapist is distant, aloof (vs. responsive and affectively involved)	−.49
Q14	Patient does not feel understood by therapist	−.45
Q99	Therapist challenges the patient's view (vs. validates the patient's perceptions)	−.43
Q77	Therapist is tactless	−.43
Q49	The patient experiences ambivalent or conflicted feelings about the therapist	−.43
Q17	Therapist actively exerts control over the interaction (e.g., structuring, and/or introducing new topics)	−.43
Q39	There is a competitive quality to the relationship	−.42
Q15	Patient does not initiate topics; is passive	−.37

Note. $N = 60$; PQS = Psychotherapy Process Q-set; WAI–O = Working Alliance Inventory Observer Form, overall score.
[a] We reported only the PQS items that resulted significantly correlated with therapeutic alliance.
* $p < .05$, two-tailed.

The second aim of our study was to identify the elements of the therapeutic process—therapist interventions, patient contributions, and patient/therapist patterns of interaction—that are related to session Depth. Several elements of the psychotherapy process that are measured by PQS were correlated with the Depth of elaboration. Some of those are therapist activities that are associated to an exploratory style of intervention. This result is consistent with a previous study that investigated, from the observer perspective, the relationship between exploratory versus prescriptive forms of treatment and found a positive significant relationship between Depth and exploratory interventions (Stiles, Shapiro, & Firth-Cozens, 1988).

A related purpose was to investigate whether the elements of the therapeutic process related to Depth of elaboration are linked only to relational variables and nonspecific factors, such as therapeutic alliance, or also to specific factors, such as therapist interventions.

Some items (e.g., Q6 Therapist is sensitive to the patient's feelings, attuned to the patient, empathic; Q14 The patient feels understood by therapist, etc.) showed significant correlation with the Depth of elaboration and seem associated to the quality of the relationship and, in particular, to the bond dimension of therapeutic alliance as formulated by Bordin (1979). This result is consistent with research that found that when patients feel understood and supported by the therapist, they rate sessions as deeper (Elliott & Wexler, 1994; Stiles et al., 1994).

Several PQS items associated with Depth of elaboration refer to therapist interventions that are focused on the elaboration of affects. (e.g., Q81 Therapist emphasizes patient's feelings in order to help him or her experience them more deeply; Q67 Therapist interprets warded-off or unconscious wishes, feelings, or ideas; Q50 Therapist draws attention to feelings regarded by the patient as unacceptable, e.g., anger, envy, or excitement.)

These results are consistent with several studies that have found a relationship between affect-focused techniques and positive therapy outcomes (Diener, Hilsenroth, & Weinberger, 2007; Diener, & Hilsenroth, 2009; Lingiardi, Gazzillo, & Waldron, 2010). Moreover, some items related to the Depth of elaboration seem to be ascribed to the therapist's focus on the "here and now" of the relationship as well as building links between some aspects of the current relationship (including the relationship with the therapist) and past relational experiences. This result seems to confirm the importance given to the role of the therapist's focus on the therapeutic relationship, as suggested by several authors (Gabbard & Westen, 2003; Safran & Muran, 2000; Hill & Knox, 2009).

It seems interesting to compare our results with the review of research by Blagys and Hilsenroth (2000), who conducted a search of the PsycLit database to identify empirical studies that compared the process and technique of psychodynamic therapy with that of cognitive–behavioral therapy. According to Blagys and Hilsenroth, seven features reliably distinguished psychodynamic therapy

from other therapies, as determined by empirical examination of actual session recordings and transcripts (Table 4). The seven core features are given as follows: (1) Focus on affect and expression of emotions; (2) Exploration of attempts to avoid distressing thoughts and feelings; (3) Identification of recurring themes and patterns; (4) Discussion of past experience (developmental focus); (5) Focus on interpersonal relations; (6) Focus on the therapy relationship; (7) Exploration of fantasy life.

In Table 4, we have conceptually associated the seven core features of psychodynamic therapies according to Blagys and Hilsenroth (2000) with the PQS items describing therapist interventions that, in our study, resulted in a significantly positive correlation with Depth and therapeutic alliance observer ratings. Our results also support the findings of Pesale and Hilsenroth (2009), who found a positive relationship between psychodynamic interpersonal techniques and Depth of elaboration, and are also consistent with prior research by Elliott and Wexler (1994); Thompson and Hill (1993); and Stiles et al. (1994), who found that psychodynamic (i.e., exploratory) techniques are related to patients' higher Depth ratings.

The third aim of our study was to identify the elements of the therapeutic process—therapist interventions, patient contributions, and patient/therapist pattern of interaction—that are related to therapeutic alliance. Comparing our results with the findings of Price and Jones (1998), who, like us, used PQS to investigate the relationship between process and alliance from an observer perspective, we can observe several similarities and some important differences. As in Price and Jones' results, we found a significant correlation between therapeutic alliance and PQS items describing patient commitment (e.g., Q97 Patient is introspective, readily explores inner thoughts and feelings; Q73 The patient is committed to the work of therapy, etc.), PQS items describing the quality of the relationship according to the therapist (Q6 Therapist is sensitive to the patient's feelings, attuned to the patient, empathic; Q9 Therapist is responsive and affectively involved), and to the patient (Q95 Patient feels helped), and PQS items describing the quality of the interaction (Q39 There is (not) a competitive quality to the relationship). Unlike Price and Jones' results, we found significant correlations between specific therapist interventions (Q65 Therapist clarifies, restates, or rephrases the patient's communication; Q50 Therapist draws attention to feelings regarded by the patient as unacceptable, such as anger, envy, or excitement; Q62 Therapist identifies a recurrent theme in the patient's experience or conduct) and therapeutic alliance. From this point of

Table 4
Psychodynamic Intervention Style and PQS Therapist Interventions Related to Depth and Therapeutic Alliance

Psychodynamic intervention style (Blagys & Hilsenroth, 2000)	Therapist PQS item[a] related to	
	Depth[b]	Therapeutic alliance[c]
1. Focus on affects and expression of emotions	Q67 Therapist interprets warded-off or unconscious wishes, feelings, or ideas	Q81 Therapist emphasizes patient's feelings in order to help him or her experience them more deeply
2. Exploration of attempts to avoid distressing thoughts and feelings	Q36 Therapist points out patient's use of defensive maneuvers (e.g., undoing, denial) Q50 Therapist draws attention to feelings regarded by the patient as unacceptable (e.g., anger, envy, or excitement)	Q50 Therapist draws attention to feelings regarded by the patient as unacceptable (e.g., anger, envy, or excitement)
3. Identification of recurring themes and patterns	Q62 Therapist identifies a recurrent theme in the patient's experience or conduct	Q62 Therapist identifies a recurrent theme in the patient's experience or conduct.
4. Discussion of past experience (developmental focus)	Q92 Patient's feelings or perceptions are linked to situations or behavior of the past	Q91 Memories or reconstructions of infancy and childhood are topics of discussion Q92 Patient's feelings or perceptions are linked to situations or behavior of the past
5. Focus on interpersonal relations	Q63 Patient's interpersonal relationships are a major theme	Q63 Patient's interpersonal relationships are a major theme Q100 Therapist draws connections between the therapeutic relationship and other relationships
6. Focus on the therapy relationship	Q82 The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously Q98 The therapy relationship is a focus of discussion	Q82 The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously Q98 The therapy relationship is a focus of discussion
7. Exploration of fantasy life	Q68 Real vs. fantasized meanings of experiences are actively differentiated	

Note. PQS = Psychotherapy Process Q-set.
[a] We refer to PQS items describing therapist's interventions that have significant correlations with Depth and therapeutic alliance. [b] Evaluated with SEQ–D = Depth scale of Session Evaluation Questionnaire. [c] Evaluated with WAI–O = Working Alliance Inventory Observer Form, overall score.

view, our results suggest that the therapist's contribution to therapeutic alliance includes not only relational factors (i.e., empathy or tact), but also technical factors. Our findings also indicate a positive correlation between therapists who focus on the here and now and therapeutic alliance. This result seems to confirm the importance of maintaining an exploring focus on the relationship to maintain (or repair) the alliance quality (Safran & Muran, 2000).

Our findings are also consistent with the results of the review by Ackerman and Hilsenroth (2003) who found, among others, a positive relationship between supportive, facilitating affect expression, explorative interventions, and therapeutic alliance. Our results are also consistent with the negative relationship reported by Ackerman and Hilsenroth (2001) between therapist characteristics (i.e., distant and aloof among others) and therapeutic alliance.

In summarizing these results, it is noteworthy that several therapist interventions described by PQS correlated to therapeutic alliance, which, in our study, is conceptually linked and substantially overlap with the features of a psychodynamic intervention style (Blagys & Hilsenroth, 2000; Table 4).

Clearly this work presents some limitations. First of all, results must be considered as exploratory and partial. This is a correlational study, and we do not know if there is a causal relationship between these variables. At this level of analysis, we do not know if therapist interventions focused on affect enable the patient and therapist to achieve a greater alliance and, as a consequence, a deeper elaboration or, vice versa, if, by focusing on affect, the patient and therapist increase the Depth of elaboration and, as a consequence, there is an increase in therapeutic alliance. Second, we do not know if our data are strongly dependent on the specific characteristics of our sample; for example, the seeming relevance of psychodynamic techniques could be determined by a higher presence of psychodynamic therapists in our sample compared with therapists who follow other approaches. Third, in this study, we have a lack of outcome data. In the future, it will be necessary to verify these findings in relation to therapy outcome. Fourth, the session ratings of our study have been completed by judges who were still in training. Further research should involve more experienced clinicians. Fifth, we used only one perspective of evaluation—observer—and, although our findings are in line with similar studies conducted that use both patient and therapist perspectives, in the future, it will be necessary to test our results by using the three perspectives simultaneously.

Despite these limitations, our results seem to offer a course of action for clinicians in order to increase the Depth of elaboration and therapeutic alliance. In summary, our results seem to suggest that clinicians should:

(1) Focus on affect. Therapists should focus their interventions first on patient emotions: Encourage the exploration of the full range of patient emotions and, in particular, the feelings regarded by the patient as unacceptable (e.g., anger, envy, or excitement). Help patients to describe and verbalize their contradictory and threatening feelings and exploring their attempts to avoid distressing thoughts and feelings.

(2) Focus on the here and now. Clinicians should, when possible, focus their attention on the here and now of the relationship to help patients to express their feelings in relation to the therapist or the therapy (see point 1) and draw connections between the psychotherapy relationship and other relationships.

(3) Relational patterns. Consistent with the previous point is the importance for the therapist to explore, with the patient, their interpersonal issues, identifying recurring themes and relational patterns in patients' past relationships and to identify when these patterns are active in the psychotherapy relationship.

(4) Therapists' emotional experience. Last but not least, our findings suggest that the therapists' quality of emotional experience is associated with the patients' Depth of elaboration and therapeutic alliance. Each of the three aforementioned technical points may be useful only if promoted by a therapist who is emotional involved, tactful, and respectful of the patient's subjective experience.

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Received February 20, 2011
Revision received July 18, 2011
Accepted July 18, 2011 ■