CONSTRUCTING THE THERAPEUTIC ALLIANCE IN ONLINE COUPLE THERAPY

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To the ones who inspire me to keep going, to myself.

DECLARATION OF ORIGINALITY

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

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ABSTRACT

The therapeutic alliance, traditionally understood as the collaborative relationship between therapist and client, has been widely studied in face-to-face therapy settings. However, there is limited research focusing on how this alliance is formed and maintained in online contexts, particularly in couple therapy. The shift to online therapy due to the COVID-19 pandemic has created new challenges in building and sustaining this alliance, including the absence of non-verbal cues and the complexities of managing multiple relationships within the couple. This study aims to investigate how the therapeutic alliance develops in online couple therapy by examining the behavioral dynamics between therapists and clients. Using the System for Observing Family Therapy Alliances (SOFTA) as a framework, the study analyzes session recordings to identify key behaviors that contribute to the alliance in online settings. The findings suggest that therapist contributions to emotional connection and engagement are strongly correlated with client engagement in the therapeutic process. Additionally, therapist contributions to emotional connection emerged as a significant predictor of both client engagement and emotional connection. The results offer valuable insights for therapists working in online settings, highlighting the importance of intentional engagement strategies and emotional attunement. The thesis concludes by discussing the implications of these findings for the practice of online couple therapy and suggesting areas for future research to further explore the nuances of alliance-building in digital environments.

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

ÖZET

Terapötik ittifak, terapinin başarısını etkileyen en önemli faktörlerden biri olarak kabul edilir ve mevcut literatürde genellikle yüz yüze terapilerde araştırılmıştır. Ancak çevrimiçi terapilerde bu ittifakın oluşumu ve sürdürülmesi üzerine yapılan çalışmalar sınırlıdır. Özellikle COVID-19 pandemisiyle birlikte çevrimiçi terapiye geçiş, sözsüz ipuçlarının eksikliği ve çiftler arasındaki dinamiklerin yönetilmesindeki zorluklar gibi yeni engeller ortaya çıkarmıştır. Bu çalışma, çevrimiçi çift terapisinde terapötik ittifakın gelişimini ve terapist ile danışan arasındaki davranışsal etkileşimleri incelemeyi hedeflemiştir. Araştırma, Sistematik Aile Terapisi İttifaklarını Gözlemleme Sistemi (SOFTA) çerçevesinde seans kayıtlarını gözlem kodlaması ile analiz ederek, çevrimiçi terapilerde ittifaka katkı sağlayan davranışları tespit etmeyi amaçlamaktadır. Bulgular, terapistin, danışanların duygusal bağlantı ve seans katılımına yönelik yaptığı katkıların, terapötik süreçteki danışan katılımı ile güçlü bir şekilde ilişkilendirildiğini göstermektedir. Ayrıca, terapistin duygusal bağlantıya katkılarının hem danışan katılımı hem de duygusal bağlantı üzerinde önemli bir öngörücü olarak ortaya çıkmıştır. Çalışma, çevrimiçi terapilerde çalışan terapistler için duygusal uyum ve etkileşimli stratejilerin önemini vurgulamakta ve bu alanda yapılacak gelecek araştırmalar için önerilerde bulunmaktadır.

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

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1. INTRODUCTION

The integral role of the therapeutic alliance has been consistently demonstrated in various therapeutic approaches, emphasizing its correlation with positive therapy outcomes both in individual psychotherapy (Baldwin et al., 2007; Finsrud et al., 2022; Horvath & Bedi, 2002) and couple psychotherapy (Garfield, 2004; Rait, 2000). The psychotherapy literature has widely studied the therapeutic alliance, especially in the Common Factors Model. According to research, the therapeutic alliance accounts for approximately 10-20% of the variability in psychotherapy outcomes (Lambert et al., 2001; Lutz et al., 2007). It consistently emerges as the most significant predictor of outcomes in psychotherapy, as indicated by studies (Barber et al., 2000; Jensen & Kelley, 2016; Lambert & Barley, 2001).

Considering that in couple therapy, the therapist should develop a separate alliance with each partner, with the relationship in between and also should follow the alliance in between the partners (Anker et al, 2010). Given the complexities, the construction of therapeutic alliance in an online couple therapy context is a broad concern for therapists (Machluf et al., 2021), requiring a focus in the field to be investigated. To address this, it is essential to explore the unique challenges and strategies for fostering a strong therapeutic alliance in an online setting, where non-verbal cues and in-person dynamics are limited.

Extending prior research, which indicates the therapeutic alliance's pivotal role, this study focuses explicitly on couple therapy, recognizing its increased complexity in relationships due to the involvement of multiple relationships. It addresses the unique challenges posed by the COVID-19 pandemic, highlighting the transition from face-to-face to online therapy. While studies have highlighted the significance of the therapeutic

alliance, there is limited research examining the process of "how" the therapeutic alliance is established, particularly in the context of online therapy.

Therefore, in line with this transition mentioned, this study aims to observe and analyze the formation of therapeutic alliances in online couple therapy sessions through the behavioral analysis of both clients and therapists.

In the following sections of this chapter, common factors in psychotherapy literature will be followed by the variance and importance of therapeutic alliance on therapy outcomes. Later, alliances within couple therapy will be investigated in more detail. After elaborating on the transition to online therapy the aims of the current study will be introduced in more detail.

1.1 Common Factors

The effectiveness of psychotherapy has been a central focus of research for decades, with numerous studies seeking to identify the key elements that contribute to successful therapeutic outcomes. While specific therapeutic models and techniques play a role, an extensive body of research suggests that common factors—elements shared across different therapeutic approaches—are fundamental in promoting change. Based on the "Dodo Bird Verdict," which states that no single psychotherapy technique is more beneficial than another, it is critical to examine the components that are universally effective independent of the exact therapy model used (Drisko, 2004).

In psychotherapy research, common factors theory offers a framework for comprehending the key factors that impact therapeutic outcomes, highlighting the importance of these factors for successful treatment in diverse therapeutic modalities. It provides a crucial basis for comprehending how various therapeutic approaches achieve comparable outcomes. The idea highlights common aspects that are universal to multiple

therapeutic modalities and significantly contribute to client outcomes (Huibers & Cuijpers, 2015). This implies that certain methods unique for particular treatments might not be as fundamental as previously believed (Cuijpers et al., 2019; Wampold, 2015). This claim is supported by an extensive body of research, which suggests that common factors, including empathy, client expectations, and the quality of the therapeutic alliance, are essential for efficient therapy (Wampold, 2015; Cuijpers et al., 2019).

A meta-analysis by Lambert (1992) found that common factors—such as the therapeutic relationship—can explain a large portion of the differences in therapy outcomes, contributing to 30% to 50% of the variance across various studies. The specific factors that contribute to outcomes can vary depending on the context of the therapy being used (Flückiger et al., 2018). Approximately 40% of the change in therapy can be attributed to client factors and external events, while 30% is linked to the therapeutic relationship itself. The role of hope and expectations in therapy accounts for 15% of the change, and another 15% is due to the specific therapy models and techniques used. Similarly, Wampold (2001) estimated that therapist effects account for 6% to 9% of the change, the therapeutic alliance accounts for 5% to 7%, and factors like expectations, hope, and allegiance contribute up to 4%, while specific models and techniques contribute only about 1%. These figures emphasize the significant role the therapeutic alliance plays in shaping therapy outcomes.

The therapeutic alliance, defined as the collaborative and trusting relationship between therapist and client, is consistently identified as a crucial common factor (Wampold, 2015; Krupnick et al., 2006). As stated, beyond the particular techniques used in various forms of psychotherapy, research has demonstrated that a strong therapeutic connection can improve treatment efficacy (Krupnick et al., 2006). Mutual respect,

alignment on goals, and emotional attunement are all components of the alliance (Krupnick et al., 2006). The efficacy of therapy may depend more on relational dynamics than on particular procedures, as evidenced by empirical studies showing a significant correlation between the quality of this alliance and client outcomes (Wampold & Ulvenes, 2019; Tschacher et al., 2015).

1.2 Therapeutic Alliance

The therapeutic alliance, characterized as the collaborative relationship between client and therapist, includes elements such as mutual trust, emotional connection, and a shared understanding of therapeutic goals and tasks, and has been consistently recognized as an essential element across diverse therapeutic modalities (Zilcha-Mano, 2017). Comprehending this fundamental provides insights into treatment dynamics and possible pathways for enhancing intervention effectiveness.

Extensive research has consistently demonstrated a positive correlation between a strong therapeutic alliance and positive therapy outcomes, encompassing diverse approaches and methodologies (Flückiger, 2018). A research that included nearly 4,000 clients revealed that the therapeutic alliance was the predominant component affecting therapy outcomes, regardless of the treatment approach utilized (Horvath et al., 2011).

Several case studies have shown how the therapeutic alliance evolves and develops with time, especially in the context of long-term therapy. In this regard, a case study of systemic relational psychotherapy found that both family dynamics and therapist involvement significantly contributed to the formation of a therapeutic alliance, which coincided with significant improvements in the client's symptoms and interpersonal relationships (D'Ascenzo et al., 2024). Such findings imply that the therapeutic alliance is more than just a byproduct of treatment; it is a facilitator of significant change,

strengthening the concept that a dynamic, evolving relationship is vital for effective therapy (D'Ascenzo et al., 2024; Martin et al., 2000).

An increasing body of evidence also highlights the bidirectional relationship between therapeutic alliance and clinical outcomes. It was investigated whether the alliance predicts symptom improvement or if it is a consequence of symptom change, revealing that both dynamics might be at play. Their randomized controlled trial indicated that a strong therapeutic alliance indeed correlates with reductions in depressive symptoms, suggesting a reciprocal relationship (Zilcha-Mano et al., 2014). Given the variance that therapeutic alliance has on therapeutic outcomes, the measurement of therapeutic alliance remains an important aspect of both research and practice.

Research on practice indicates that therapists who actively engage in alliance-building techniques can enhance the therapeutic relationship and promote better patient outcomes. A multilevel meta-analysis by Re et al. (2021) underlined that some therapists are more adept at forming strong therapeutic alliances, subsequently leading to improved patient outcomes (Re et al., 2021). This suggests that continual professional development aimed at alliance formation could yield substantial benefits in clinical practice. Furthermore, developing skills in alliance-building not only improves treatment effectiveness but also fosters a collaborative environment, encouraging patients to feel more engaged and supported throughout the therapeutic process (Del Re et al., 2021).

Various studies have also supported the claim that the therapeutic alliance peaks during the first couple of sessions of therapy. Notably, early measures of alliance have been shown to predict later treatment outcomes, highlighting the need to establish connections early in the therapeutic process (Knaevelsrud & Maercker, 2006; Wolf et al., 2022). These findings are consistent with recent research demonstrating that sessions two

or three are essential for alliance development, highlighting the crucial role of therapists being particularly aware of relational dynamics early in treatment (Corso et al., 2012; Johansson & Eklund, 2006).

Given the context of couple therapy, it becomes essential for the therapist to establish distinct alliances with each partner individually while also navigating the alliance dynamics between the partners. Therefore, investigating the therapeutic alliance as a primary component of therapy outcomes in couple therapy is crucial because it allows an in-depth understanding of the intricate relationships involved.

1.3 Therapeutic Alliance in Couple Therapy

Johnson and Talitman (1997) found that the quality of the therapeutic alliance is a more powerful and thorough predictor of success for couples than their initial stress levels, which have not been demonstrated to significantly predict long-term outcomes in Emotion-Focused Therapy. In contrast, other studies suggest that initial levels of distress are a significant predictor of long-term success in couple therapy. Therefore, this has been a noteworthy finding (Glebova et al., 2011; Knerr et al., 2011).

It is crucial to recognize that the therapeutic alliance takes on a higher level of complexity in couple and family therapy due to the involvement of multiple clients, each with their own perspectives and needs, requiring therapists to navigate multiple relationships simultaneously (Sprenkle et al., 2009). Multiple relationships existing in the session room necessitate the therapist's establishment of an alliance with each member present: among partners and between each partner, and between the therapist and the romantic relationship itself (Friedlander et al., 2018). Therefore, effectively balancing the individual needs of each client while fostering a cohesive and collaborative environment within the relationship poses additional challenges for therapists.

Specifically, in couple therapy, the alliance should involve shared understanding and emotional engagement between the therapist and the couple, with each partner feeling seen and validated in their experiences and perspectives during the therapeutic process (Porter & Ketring, 2011). This shared emotional engagement is vital, as discrepancies in the alliance between partners or in their perceptions of the therapist can significantly undermine therapy effectiveness (Davis et al., 2012).

This implies that comprehending the therapeutic alliance needs a multifaceted approach that takes into account the couple's individual and collaborative perspectives throughout therapy (Quirk et al., 2021). Furthermore, the study by Knobloch-Fedders and colleagues (2007) highlights the significance of early session alliances, pointing out that couples who remain in therapy through session eight form stronger relationships with their therapists than those who leave early. This highlights the importance of the therapeutic alliance's developmental trajectory for the progress of treatment (Knobloch-Fedders et al., 2007).

Building on these findings, Halford et al. emphasize how important it is to establish therapeutic alliances early on. Their research also supports the notion that predicting therapeutic outcomes are significantly influenced by the alliance's strength and consistency throughout therapy (Halford et al., 2014). The alliance essential for successfully addressing the couple's challenges during the course of therapy relies on the alliances formed in the initial sessions (Halford et al., 2014).

1.3.1 Between-System Alliances

Between-system alliances encompass how well the therapist connects individually with each partner and how these relationships affect the couple's overall therapeutic process (Fang et al., 2023). It also represents the relationships between the “couple

system" as a whole and the therapist. According to research, partners who develop a strong alliance with the therapist tend to communicate and cooperate more effectively throughout therapy, resulting in improved treatment outcomes. Furthermore, a shared understanding of the therapist's role and value helps the therapy process, facilitating the couple to handle conflict and work together on their relationship issues (Thomas et al., 2005).

Therapists might build a more solid alliance by actively involving both members of the relationship, minimizing any gaps that may occur. The issue is how to maintain a balance between these relationships and ensure that each partner feels represented and heard without allowing competitiveness to undermine therapy (Fang et al., 2023).

1.3.2 Split Alliances

Split alliances are cases unique to therapy while working with couples or families. This situation occurs in which one partner has a more positive view of their alliance with the therapist than the other. In terms of disagreement regarding the therapist's effectiveness, competence, or the extent to which the partners feel the therapist cares about the family (Friedlander et al., 2006a).

When working with couples or families in therapy, split alliances are an exceptional case. This happens when one of the couple views their alliance with the therapist more favorably than the other. Disagreements may arise regarding the therapist's efficacy, competence, or the degree to which the therapist demonstrates care and concern for the family (Friedlander et al., 2006a).

The dynamics of the therapy session as a whole may be impacted by this discrepancy, which may lead to conflicts and challenges throughout the process. Conflicts with communication, different commitment levels to the therapy, and opposing opinions

of the role of the therapist are some of the factors that can cause split alliances (Orlowski et al., 2022). Further, one of the partners may not have willingly chosen to attend therapy; partners may have distinct goals or hold differing views on the desired outcomes of change (Rait, 2000). Research suggests that when one partner feels in aligned with the therapist while the other does not, and if the therapist does not attend to this case, this might result in ineffectiveness in reaching the goals of therapy and impair the couple therapy's overall effectiveness (Escudero et al., 2021; Friedlander et al., 2021).

Split alliances have a particularly damaging impact when one partner tends to view the therapist as an ally against the other, which reinforces the couple's polarizing stances. As Escudero et al. point out, if this dynamic is not handled positively, it can result in early therapy session termination or dropout in addition to complicating the therapeutic process (Escudero et al., 2021). Consistent with the findings, split alliances have been found to show significant relationship with dropout rates (Bartle-Haring et al., 2012; Glebova et al., 2011; Muniz de la Peña et al., 2009). To maintain a sense of teamwork and safety within the therapeutic environment, therapists must be able to recognize and address split alliances effectively.

1.3.3 Within-System Alliances

In couples therapy, the therapist's attention is not solely directed at monitoring alliances between oneself and each member; there is also a need to observe the alliance within the couple itself, which is defined as within-system alliance (Pinsof, 1994). Alongside the partners' individual alliances with the therapist, within-system alliances illustrate the relationship dynamics occurring between the partners during therapy. This construct highlights the couple's internal dynamics by emphasizing how their interactions throughout therapy influence their progress and therapeutic alliance (Anderson &

Johnson, 2010). Partners are more likely to have interactions that promote understanding and commitment to the therapeutic process when they feel more connected and collaborated during therapy (Knobloch-Fedders et al., 2004).

Improvements in relationship satisfaction and individual well-being over time are indicators of a strong within-system alliance's positive correlation with therapy outcomes (Whittaker et al., 2022). According to these studies, the relationships between individuals and the therapist are just as important as the couple's ability to work together and support one another during therapy. A strong within-system alliance fosters a collaborative environment where both partners feel understood and supported, promoting deeper engagement in the therapeutic process. This dynamic not only enhances communication and emotional connection between partners but also enables the therapist to facilitate productive change, ultimately improving both relationship satisfaction and individual well-being (Friedlander et al., 2006).

The significance of the alliance between partners as a more potent predictor of outcomes in couple therapy compared to the alliance between partners and the therapist (Anderson & Johnson, 2010). Therefore, couple therapy places emphasis on the relationship between partners as a crucial catalyst for change, in addition to the importance of the between-systems alliance (Friedlander et al., 2018). Therapists in this situation need to create an atmosphere that supports the connection between the partners, encouraging constructive dialogue and collaboration during sessions.

1.4 Measuring Alliance in Couple & Family Therapy

The therapeutic alliance is typically characterized by three fundamental components: a mutual understanding of treatment goals, consensus on therapeutic tasks, and an emotional connection between the therapist and the client (Bordin, 1979). The

therapeutic alliance is assessed using different approaches including self-report questionnaires, observer ratings, and client-therapist interaction analyses, to capture its multifaceted nature.

1.4.1 Working Alliance Inventory-Couples (WAI-CO; Symonds, 1999).

One of the most widely used tools for measuring therapeutic alliance is the Working Alliance Inventory (WAI). The original WAI was developed by Horvath and Greenberg and later shortened into versions like the Working Alliance Inventory-Short Revised (WAI-SR) to improve practicality and ease of use. The WAI assesses three key dimensions of the therapeutic alliance: the goals of therapy, the tasks to achieve those goals, and the emotional bond between therapist and client (Münder et al., 2009). The WAI has demonstrated high internal consistency, with Cronbach's alpha values reported above 0.9, indicating robust reliability (Hatcher & Gillaspy, 2006).

1.4.2 Integrative Alliance Scales (IPAS; Pinsof & Catherall, 1986)

The Integrative Psychotherapy Alliance Scales (IPAS)**,** developed by Pinsof and Catherall in 1986, represent a significant contribution to the measurement of the therapeutic alliance in family and couple therapy contexts. The IPAS is designed to assess the alliance across various modalities - individual, couple, and family therapy - ensuring that the metrics capture the systemic nature of therapy, which is essential for effective treatment outcomes. Research exploring the validity and reliability of the IPAS has provided promising results. A study assessing the psychometric properties of these scales found that they demonstrated robust internal consistency, with Cronbach's alpha coefficients typically exceeding 0.80, indicating high reliability across different therapy modalities (Pinsof et al., 2008).

1.4.3 System for Observing Family Therapy Alliances (SOFTA; Friedlander, Escudero, & Heatherington, 2001).

In order to address this literature gap, SOFTA (Friedlander et al., 2001) was developed to investigate how client conflict and negativity affect CFT outcomes during sessions. This measure takes into account Bordin's (1979) notion of mutual collaboration and bonding, as well as the positives and negatives of client collaboration in CFT, such as a shared sense of purpose and safety within the therapeutic setting. Self-reports (SOFTA-s) and observational assessments (SOFTA-o) are the two instruments which compose up the SOFTA.

It is extended and identified with four key components of the alliance, which align with Bordin's foundational definition by Friedlander et al. (2006). These include engagement in the therapeutic process, emotional connection to the therapist, safety within the therapeutic system, and a shared sense of purpose within the family.

Engagement in the therapeutic process examines perceiving the treatment as essential and fostering a collaborative relationship with the therapist. Moreover, clients believe that therapeutic objectives and tasks can be discussed and negotiated with the therapist, emphasizing the importance of a serious dedication to the process. Clients thinks that the change can be accomplished (Friedlander et al., 2001; 2006a).

The feeling that the relationship is based on respect, trust, care, and sincere concern is explored via emotional connection with the therapist. According to Bordin's dimension of bonds theory, the therapeutic alliance is based on affiliation, trust, care, and concern (Bordin, 1979). The client feels that the therapist has accessibility, cares about them, and has similar ideals. Lastly, they appreciate the knowledge and experience of the therapist (Friedlander et al., 2001).

Whether or not the client sees therapy as an inviting and secure setting to take risk determines the safety of the therapeutic system. "The client viewing therapy as a place to take risks, be open, and be flexible; a feeling of security and assurance that learning and new experiences will occur, that treatment can be beneficial, that family conflicts can be resolved respectfully, and that one need not be defensive," is how Friedlander et al. (2001, p. 5) define safety.

Ultimately, "whether the family views themselves as working collaboratively to enhance interpersonal relationships and achieve goals" is a question asked by a shared sense of purpose within the family (Friedlander et al. 2001, p. 5). Since family members frequently have differing opinions on the goals and necessity of therapy, Pinsof's idea of within-system alliance (Pinsof, 1994) is evaluated in this dimension. Indeed, Friedlander, Lambert, and Muniz de la Pena (2008) found that the key to change in family therapy seems to be the family's sense of shared purpose for their therapy session. The latter two dimensions—a shared sense of purpose and safety inside the therapeutic system—illustrate the unique aspects of CFT.

Although there are various observation coding systems (İbrahim et al., 2018), the System for Observing Family Therapy Alliances (SOFTA; Friedlander et al., 2006) also measures within-system alliance specific to couple therapy with the dimensions mentioned and brings a systemic perspective to the observation of therapeutic alliance. The components mentioned are observable through specific interactions and behaviors, as well as verbal and non-verbal indicators.

In a more complex multi-client therapy scenario, watching alliance-related behavior is more beneficial than self-reported perceptions (Escudero et al., 2008). They contend that family members find it challenging to disclose the within-family alliance in

this setting. Therapeutic alliance is described by Escudero et al. (2008) as an intrapersonal process that necessitates the observation of interpersonal behavior, as well as an interpersonal phenomenon.

1.4.4 Timing of Measuring the Alliance

Alliance is typically assessed at three key points during therapy: early in treatment, which is during the first third of sessions, mid-phase, and late-phase. The average alliance score at the third session is frequently the focus of traditional alliance measurement techniques (Horvath & Symonds, 1991). Since alliance levels can be reliable indicators of treatment results, research suggests that tracking them between the third and fifth sessions is essential (Horvath & Symonds, 1991; Knobloch-Fedders et al., 2004). In couples therapy, alliance is generally evaluated after the first three sessions (Bourgeois et al., 1990; Heatherington & Friedlander, 1990; Knobloch-Fedders et al., 2004).

Katznelson et al. (2020) note that early measurements, particularly within the first sessions of therapy, provide valuable insights into the potential therapeutic alliance that forms. Evidence suggests that a strong therapeutic bond established early is predictive of better treatment outcomes later on (Olvera et al., 2022; Don et al., 2021). Furthermore, the immediate assessment of the alliance helps identify any discrepancies in perceptions between the client and therapist that can be addressed early (Karver et al., 2018). As therapy progresses, regular assessments at intervals such as session eight and beyond also play a critical role in ensuring that the therapeutic alliance remains strong and functional. Studies show that monitoring the alliance can prevent deteriorations that may lead to therapy dropouts, particularly when conflicts or stresses arise in the couple's dynamic (Bartle-Haring et al., 2012; Arnow et al., 2013).

1.5 Therapeutic Alliance in Online Therapy

1.5.1 The Shift to Online Therapy: Inclination and Adoption

The COVID-19 pandemic necessitated a rapid and obligatory transition from face-to-face to online psychotherapy, including couples therapy (Machluf et al., 2021). After the pandemic, online therapy has gained traction for several reasons, including flexibility, convenience, and accessibility. Research indicates that therapists with prior experience in online therapy reported greater confidence and comfort in utilizing this modality during the pandemic (Machluf et al., 2021).

As therapists navigated the challenges of the shift, many exhibited an increasing inclination toward online therapy. This finding aligns with Békés and Doorn's (2020) study, which revealed that many therapists not only adapted to online psychotherapy but also developed a somewhat positive outlook on its continued use beyond the pandemic. However, perspectives on the long-term adoption of online therapy have been mixed. While some therapists expressed a preference for returning to in-person sessions, others saw the benefits of continuing online therapy.

Hardy et al. (2021) found that 74% of the couple therapists surveyed intended to persist with online therapy even after the pandemic subsided and social distancing regulations were lifted. In contrast, Machluf et al. (2021) reported that certain therapists expressed less willingness to continue offering online therapy once the crisis was over. Despite its initially compulsory nature, online couples therapy remains widely utilized even five years after the pandemic, highlighting the need for further research into its long-term impact and the evolving attitudes of therapists and clients alike (Aviram, 2024; Bradford et al., 2024).

1.5.2 The Role of Therapeutic Alliance in Online Therapy

Despite the shift to digital platforms, the therapeutic alliance remains a crucial predictor of treatment outcomes, whether in online or face-to-face settings (Flückiger, 2018). While concerns initially emerged regarding establishing and maintaining a strong alliance in online therapy, research suggests that key therapeutic factors such as empathy, structured interventions, and engagement continue to play an essential role in virtual settings (Simpson et al., 2020).

However, both therapists and clients have raised concerns regarding the challenges of forming and sustaining an effective therapeutic bond in an online environment. Kessel et al. (2022) found that clients who had already established a strong therapeutic bond before transitioning to online sessions reported greater satisfaction with online therapy. However, their study also revealed that even newer clients—who had weaker initial relationships with their therapists—still reported positive experiences with online therapy. Despite the concerns, research consistently shows that therapists have demonstrated resilience and adaptability in making online sessions effective.

Doorn et al. (2022) reported that many therapists adjusted their techniques to suit virtual formats, ultimately leading to positive client outcomes. Similarly, Messina and Löffler-Stastka's (2021) systematic review revealed that, despite facing logistical and emotional difficulties during the transition, therapists were able to cultivate effective therapeutic environments in digital settings. This aligns with findings from Preschl et al. (2011), who conducted a randomized controlled trial that evaluated therapeutic alliances between patients and therapists in online versus face-to-face formats for cognitive-behavioral therapy (CBT). Their results indicated comparable levels of alliance in both

conditions, emphasizing that online modalities can replicate essential aspects of traditional therapeutic relationships (Preschl et al., 2011).

As the field moves forward, incorporating technology thoughtfully into the therapeutic relationship remains essential. Research by Luo et al. noted in their study conducted during early pandemic; that therapist self-disclosure during online therapy can enhance the relational aspect of therapy, affecting the quality of the therapeutic relationship positively (Luo et al., 2023). Careful balance in the delivery of self-disclosure and its appropriateness in the therapy context may further enrich the therapeutic alliance.

Understanding the particular interactions that lead to a successful therapeutic alliance within these online environments will remain essential to the development and success of the profession as online therapy continues to evolve as a viable treatment option for a variety of populations.

1.5.3 Therapeutic Alliance in Online Couples Therapy

The COVID-19 pandemic had a profound impact on romantic relationships. Measures such as quarantine and stay-at-home orders led to a heightened need for constant physical and emotional contact among cohabiting couples, which in turn presented various relational challenges (Lebow, 2020). The financial strain, health concerns, and general uncertainty associated with the pandemic contributed to increased relational distress, with studies noting a decline in relationship satisfaction (Pietromonaco & Overall, 2021) and a rise in infidelity rates (Coop et al., 2020).

The transition to online therapy extended to couples therapy, prompting discussions about its effectiveness in fostering a strong therapeutic alliance. Research indicates that online couples therapy can effectively improve relationship functioning (Doss et al., 2020). Additionally, studies suggest that a strong therapeutic alliance can be

formed in online therapy, including in couples therapy contexts (Aviram, 2023; Berger, 2016).

Despite its potential benefits, online couples therapy presents unique challenges. One primary concern among therapists is managing conflict in virtual sessions, as de-escalating high-intensity emotions can be more complex without physical presence (Machluf et al., 2021). However, research findings suggest that, even in the absence of physical presence, therapists can foster a strong alliance through intentional engagement strategies, such as structured interventions, active listening, and the use of interactive digital tools (Simpson et al., 2020).

While online couples therapy was initially an obligatory response to the pandemic, it has persisted as a widely utilized modality. Some therapists have indicated a reluctance to continue offering online therapy beyond the pandemic (Machluf et al., 2021), while others have actively embraced it as a long-term practice (Hardy et al., 2021). Given the continued prevalence of online couples therapy five years after the pandemic, further research is needed to explore its long-term effectiveness and the specific factors that influence therapeutic alliance formation in virtual settings (Berger, 2016).

1.6 The Current Study

As previously highlighted, much of the research on the construction of therapeutic alliance in couple therapy is based on face-to-face context; and focuses on only between-system alliances from the perspective of either the clients or the therapist. There is a gap in the literature regarding the increase of online couple therapy and “how” the alliances are formed in this context. The existing literature does support the therapeutic alliance being able to be built online too, however what contributes to this construction and how it can be observed is not known.

Existing research suggests that therapist contributions to the therapeutic alliance does play a crucial role in shaping therapeutic alliance observed from the clients (Welmers-van de Poll et al., 2021). Given the significance of the therapeutic alliance in online couples therapy, the present study aims to explore how the therapeutic alliance develops in online couple therapy by analyzing the observable behaviors of both clients and therapists within sessions and identifying key factors that contribute to a strong alliance in this context.

To achieve this, the study employs an observational analysis of session recordings, utilizing the System for Observing Family Therapy Alliances (SOFTA) to systematically assess both client and therapist behaviors. Specifically, the study investigates the extent to which therapist contributions to the therapeutic alliance predict client-observed alliance dimensions, offering insight into the interactive processes that foster engagement, emotional connection, safety, and a shared sense of purpose in therapy by examining between-dimension relationships. Accordingly, the research questions and hypotheses are as follows:

RQ1: How are the different dimensions of the therapeutic alliance are related to one another in online couples therapy?

H1a: Client engagement will be positively correlated with client emotional connection and safety.

H1b: A stronger shared sense of purpose will be positively correlated with higher engagement and safety.

H1c: Therapist contributions to emotional connection will be positively correlated with therapist contributions to shared sense of purpose and client safety.

RQ2: To what extent do therapist contributions to therapeutic alliance predict client observed alliance in online couples therapy?

H2a: Therapist contribution to emotional connection will significantly predict client engagement and emotional connection.

H2b: Therapist contribution to safety and shared sense of purpose will significantly predict client safety and shared sense of purpose.

H2c: Therapist contribution to engagement will significantly predict client engagement.

2. METHOD

2.1 Participants

In the current study, 10 couples and 10 therapists from Bilgi University Psychological Counseling Center and Özyeğin University Couple and Family Center have participated. Ten therapists contributed cases for this study were nine females and one male. All the therapists were Master Couple and Family Therapy students, practicing under the supervision of approved supervisors. Accordingly, the therapeutic alliance observed in this study occurred within a Turkish socio-cultural context, specifically among clients receiving services from university-based training clinics. These clinics primarily serve low- to middle-income individuals and couples, whose access to therapy is shaped by financial constraints. These contextual factors are important to keep in mind when interpreting alliance behaviors and engagement patterns.

The study has included ten heterosexual couples (20 individuals) as clients. Demographic details for the participants, including age, relationship duration, and other relevant characteristics, can be found in the following Table 1.1.

All clients were receiving couples therapy, and the 10 therapists observed in this study were the therapists of those clients. Each couple had a different therapist in this study. During the data collection period, the therapists were receiving an ongoing training and supervision in systemic therapy and practiced from a systemic perspective. Each participant was given a unique identification (ID) number in order to protect their privacy.

Table 1.1 *Demographics of the Clients*

Research_ID	Couple ID	Age	Gender	Education	Relationship Status	Marital Status	Relationship Length (Years)	Parent	Presenting Problem
112	1	35	F	High School	Long-term & cohabiting	Married	12	Yes	Anger
112		46	M	High School	Long-term & cohabiting	Remarried	11	Yes	Arguing or fighting too much
203	2	25	F	Postgraduate	Long-term & not cohabiting	Single	1	No	Communication
203		26	M	Postgraduate	Long-term & not cohabiting	Single	1	No	Problem solving or decision making
209	3	25	F	Bachelor	Long-term & not cohabiting	Single	4	No	Arguing or fighting too much
209		27	M	High School	Long-term & not cohabiting	Single	4	No	Arguing or fighting too much
212	4	30	F	Postgraduate	Long-term & cohabiting	Single	2	No	Arguing or fighting too much
212		27	M	Associate	Long-term & cohabiting	Single	2	No	Arguing or fighting too much
214	5	28	F	Bachelor	Long-term & cohabiting	Married	3	No	Communication
214		33	M	Postgraduate	Long-term & cohabiting	Married	3	No	Communication
215	6	28	F	Bachelor	Long-term & cohabiting	Married	1	No	In-laws / Extended family
215		28	M	Bachelor	Long-term & cohabiting	Married	1	No	Arguing or fighting too much
218	7	22	F	Bachelor	Long-term & not cohabiting	Single	1	No	Trust
218		21	M	Bachelor	Long-term & not cohabiting	Single	1	No	Trust
220	8	25	F	Bachelor	Long-term & cohabiting	Single	3	No	Trust
220		25	M	Bachelor	Long-term & cohabiting	Single	3	No	Trust
214-2	9	29	F	Bachelor	Long-term & cohabiting	Married	2	No	Infidelity
214-2		33	M	Postgraduate	Long-term & cohabiting	Married	4	No	Communication
223	10	29	F	Postgraduate	Long-term & not cohabiting	Single	3	No	Communication
223		29	M	High School	Long-term & not cohabiting	Single	3	No	Problem solving or decision making

Participants who exhibited significant psychotic symptoms were excluded. and clients had to have attended at least four therapy sessions in order to be eligible for this data analysis. As, studies on the formation of therapeutic alliances indicate that the initial sessions play a crucial role. It was found that positive individual behaviors observed in 3 sessions were associated with successful outcomes in family therapy (Escudero, 2008). Therefore, the study was planned to include the first three sessions of couples who started online couples therapy. However, as the second and third sessions were generally planned as individual sessions with each partner, with the guidance of Valentin Escudero, it was decided to observe the first 4 sessions in order to remedy the deficiency in observing within system alliance through the dimension of Shared Sense of Purpose.

2.2 Procedure

Ethical approval has been obtained from the Özyeğin University Ethics Committee since it is secondary research that is concurrent with Dr. Selenga Gürmen's TÜBİTAK project on "Couple Therapy Effectiveness in Turkey." The project's primary aim is twofold. It attempts to comprehend the impact of couples therapy on the individual and relational well-being of partners. The second major goal of the research is to perform a thorough investigation of the couples therapy process in order to understand better the mechanisms that contribute to change in therapy.

The quantitative data for the research is collected through an international clinical data network called the Marriage and Family Therapy Practice Research Network (MFT-PRN, Johnson et al. 2017). The MFT-PRN system is a network and data repository that facilitates secure and confidential data collection from clients in different clinical centers. It allows for the anonymous use of these data in cross-cultural comparisons. The MFT-PRN system is online based and has cybersecurity measures in place. It is designed to

allow therapists to access only their clients' data, and clients can only access scales sent specifically to them.

All online sessions took place through the Zoom platform. Before the sessions, participants received an email with an informed consent form that details the study's objectives, methods, voluntary participation, and data confidentiality policies. Recording began as soon as they consented to participate in the study. To ensure participant anonymity in research, each participant has a participant identification (ID) number. The audio recordings of the sessions are preserved with a participant ID number to protect participants. The first four session recordings of the clients have been preserved in an external disc.

SOFTA educators state that raters do not need extensive clinical experience, as the SOFTA-o rating task does not demand a high level of clinical sophistication. Even individuals, including students, with limited clinical exposure can achieve reliable results. Essential attributes for raters include good social skills, as judgments will be based on the meaningful interpretation of SOFTA-o items within context (Friedlander et al., 2005). Therefore, the coder team of 7 has been selected with interviews from the undergrad and grad applicants. The team included individuals from diverse backgrounds, including students with various academic levels and experiences. The team consisted of two male and five female coders. Three of the coders were grad students, four were in their undergrad psychology education. The selected coders have signed a confidentiality agreement. During the process, client information is only shared with the ID numbers with the coders.

Training occurred over the course of 12 weeks, consisting of 1-hour meetings paired with 2-4 hours of practice at home each week, as all coders practiced on training

tapes with roleplays. Coders started coding the research tapes once they regularly achieved an interclass correlation coefficient (ICC) of.70 on training tapes. Any information regarding the couples' therapy process was kept confidential from the coders. To ensure high-reliability estimations for the coding, coders double-coded the same recording every four sessions. Also, weekly meetings have proceeded to discuss each dimension and item and have feedback about the coding process.

2.3 Materials

2.3.1 Demographic Questionnaire

Variables such as age, gender, romantic relationship status, socioeconomic status, and education level are recruited from Marriage and Family Therapy Practice Research Network (MFT-PRN) data collected to understand the sample characteristics.

2.3.2 SOFTA-o.

Bachelor's and master's students received training in coding session recordings using the System for Observing Family Therapy Alliances (SOFTA-o), a rating scale developed by Friedlander et al. (2005). The SOFTA-o utilizes a collection of validated behavioral cues that represent positive or negative manifestations corresponding to each of the four dimensions within the SOFTA model.

These behavioral indicators are employed to identify client and therapist behaviors separately that contribute to either strong or weak alliances. Subsequently, a set of guidelines considering the frequency, valence, intensity, and clinical significance of these indicators are applied to assign a rating ranging from -3 (indicating significant issues) to +3 (indicating exceptionally strong aspects) across the four dimensions of the SOFTA model: (1) Engagement in the Therapeutic Process (e.g. "Client indicate agreement with

the therapist's goals" as a positive item for the client section; "define therapeutic goals or imposes tasks or procedures without asking the client(s) for their collaboration" as a negative item for the therapist), (2) Emotional Connection with the Therapist (e.g. "Client shares a joke or light-hearted moment with the therapist" as a positive item for the client; "not respond to clients' expressions of personal interest or caring for him or her" as a negative item for the therapist), (3) Safety within the Therapeutic System (e.g. "client shows vulnerability" as a positive item; "not attend to overt expressions of client vulnerability" (e.g., crying, defensiveness)" as a negative item for therapist), and (4) Shared Sense of Purpose within the Family (e.g. "Clients validate each other's point of view" as a positive item for client; "fail to address one client's stated concerns by only discussing another client's concerns" as a negative item for the therapist). (See Appendix A).

SOFTA-o is originally designed for face-to-face sessions. The bodily indicators in the dimensions that cannot be observed under the online context are revised to be more suitable for online therapy setting. The revisions are made by taking hardly observable behavioral and bodily expressions into consideration within the context of online therapy (see Appendix B). The revisions made are reviewed and approved by Dr. Selenga Gürmen and Dr. Valentin Escudero, one of the authors and educators of SOFTA.

2.4 Data Analysis

2.4.1 Shared Sense of Purpose Dimension Coding Considerations

The SOFTA dimension Shared Sense of Purpose is particularly relevant for couples therapy, as it captures the within-system alliance by assessing how partners

collaborate in therapy. However, this dimension requires both partners to be present in the session to be reliably coded.

In the current study, most second and third sessions were conducted individually to explore each partner's unique perspective and attachment history, a common practice in Emotionally Focused Therapy (EFT). This structure limited the availability of sessions where both partners were present, resulting in a high proportion of missing data for the Shared Sense of Purpose dimension.

Given that literature on the development of the therapeutic alliance in couple therapy recommends coding the first three sessions (Escudero, 2008), and to ensure a sufficient number of coded observations, the decision was made to code the first four sessions, following the advice of SOFTA developer Valentin Escudero. Despite this adjustment, after running preliminary analyses in SPSS, the SSP dimension still had too much missing data for reliable statistical analysis. Consequently, Shared Sense of Purpose was not included in the final analyses.

Although the Shared Sense of Purpose dimension could not be analyzed statistically due to missing data, efforts were made to observe signs of collaboration in sessions where both partners were present. To compensate for this, intercoder reflections were also integrated on this dimension. Therefore, despite the statistical omission, coder feedback on SSP aims to provide a qualitative insight into the complexity of capturing within-system alliances in early, online couple therapy sessions.

3. RESULTS

3.1 SOFTA-o: Inter-rater Reliability & Validity

The psychometric validity of the SOFTA-o is affirmed through five studies evaluating reliability and validity. Additionally, an exploratory factor analysis conducted with data from 120 couples and families representing diverse English- and Spanish-speaking backgrounds further supports its psychometric properties (Friedlander et al., 2006). Furthermore, a recent meta-analysis discovered that among the different measures of alliance employed in research on couple and family therapy, the SOFTA system demonstrated the most robust correlation with clinical outcomes (Friedlander & Escudero, et al., 2018). Therefore, SOFTA-o has been chosen as a reliable instrument for observing and analyzing therapeutic alliances.

In addition, the results of the inter-rater reliability analysis are provided so we can demonstrate a significant degree of inter-rater reliability within the raters team before delving into the specific outcomes. Before starting the analyses, a 15-hour training session was undertaken with Valentin Escudero. To ensure strong interrater reliability, it is recommended to select 6-8 practice video tapes which are representative of the final data set at its finest. Ideally, these training tapes are indicated to have few clients and high-quality sound and video, as well as examples of both negative and positive Engagement, Emotional Connection, Safety, and Shared Purpose. Our training tapes include role plays that consist of all of the dimensions. When the coders regularly obtained a minimum intraclass correlation coefficient (ICC) of.70 on the training tapes, they began coding the research tapes. Afterward coders' team of seven have divided into three sub-groups in order to accelerate the coding process.

After the training, coders watched each session a minimum of two times in the upcoming coding process: initially to assess the couple's behaviors and subsequently to evaluate the therapist's behaviors by also taking notes. For each video, coders gave ratings for every dimension using a 7-point Likert scale, with anchors at -3 (indicating significant issues), 0 (considered unremarkable or neutral), and +3 (indicating exceptional strength), adhering to the rating guidelines outlined in the SOFTA-o. To ensure coding reliability and prevent coder drift, the same video was double-coded by all seven coders every four sessions, establishing reliability estimates for coding, with ICCs ranging from .70 to .97.

To determine whether the SOFTA-o dimensions varied in terms of having higher or lower reliability among the raters, intraclass correlations were performed for each dimension, including the client and therapist dimensions. The manual states that in order to get adequate reliability, a minimum of 10 therapist tapes or five client tapes are required. In order to track progress, the team coded six complete sessions before analyzing the ICC for the client dimensions. After ten session recordings were coded, the therapist dimensions were also examined.

For every dimension, a substantial level of inter-rater reliability was shown. A strong level of inter-rater reliability was demonstrated for each dimension. The highest reliability was found for the dimensions of Shared Sense of Purpose (.97) and Engagement (.87). Somewhat lower but still sufficient scores of reliability were obtained for Safety (.83) and Emotional Connection (.76), aligning with previous research by Friedlander et al. (2006).

As the inter-rater reliability was found to be adequate for the coding process, in line with the manual, the team was divided into 2-2-3 sub-groups, as stated, to continue with the consensus ratings. Bi-weekly booster sessions continued to be conducted to

ensure continued training. During these sessions, the sub-groups compared their results and negotiated to a consensus, ensuring high reliability in the ratings.

3.2 Dimension Totals and Group Differences

Preliminary analyses were conducted via SPSS. The Pearson bivariate correlations were conducted to test the associations between the dimensions. Further, an independent samples t-test was conducted to compare the SOFTA-o dimension scores between two groups: clients and therapists. The assumptions of normality and homogeneity of variance were tested before performing the t-tests. Levene's test for equality of variances was not significant for Client Engagement and Safety, indicating that the assumption of homogeneity was met. However, Levene's test for Emotional Connection approached significance, suggesting a potential violation of the equal variance assumption. In such cases, results were interpreted with the adjusted degrees of freedom.

For Client Engagement, clients (M =1.29, SD =0.42) and therapists (M =1.44, SD= 0.50) did not differ significantly, $t(18) = -0.731$, p =.47, with a mean difference of -0.15 (95% CI: -0.581 to 0.281). These results suggest that engagement levels were similar across both groups. For Emotional Connection, a significant difference was found between clients (M =0.88, SD =0.29) and therapists (M = 1.28, SD = 0.46), $t(18) = -2.345$, $p < .05$, with a mean difference of -0.40 (95% CI: -0.758 to -0.042). The difference remained significant even when equal variances were not assumed, $t(15.222) = -2.345$, $p < .05$, indicating that clients reported significantly lower emotional connection compared to therapists. For Safety, clients (M = 0.96, SD = 0.28) scored significantly higher than therapists (M = 0.66, SD = 0.34), $t(18) = 2.149$, $p < .05$, with a mean difference of 0.30 (95% CI: 0.007 to 0.593). This difference remained significant when equal variances were

not assumed, $t(17.212) = 2.149$, $p < .05$, suggesting that clients perceived greater safety in the therapeutic relationship than therapists (see Table 3.1).

Table 3.1 *Descriptive Statistics for the Dimensions*

	Clients			Therapists			Clients		Therapists	
	n	*M*	*SD*	*n*	*M*	*SD*	Range *Min*	*Max*	Range *Min*	*Max*
Engagement	10	1.28	.41	10	1.43	.49	0	3	0	3
Emotional Connection	10	.87	.28	10	1.27	.45	0	2.5	0	2.5
Safety	10	.96	.27	10	.96	.34	-1	2	0	2

To further interpret the magnitude of these differences, effect sizes were calculated using Cohen's *d*. For Client Engagement, Cohen's *d* was -0.327 (95% CI: -1.205 to 0.560), indicating a small effect size. These results confirm that the difference in Client Engagement between clients and therapists was minimal. For Emotional Connection, Cohen's *d* was -1.049 (95% CI: -1.976 to -0.096), reflecting a large effect size. These findings suggest that the observed difference in Emotional Connection between clients and therapists' contribution to emotional connection was not only statistically significant but also meaningful in terms of effect size. For Safety, Cohen's *d* was 0.961 (95% CI: 0.019 to 1.880), indicating a large effect size. The effect size interpretation aligns with the significant t-test results, reinforcing the conclusion that clients perceived significantly higher safety in therapy than therapists' contribution to the safety.

3.3 Intercorrelations among Dimensions

There was a significant positive correlation between client engagement and therapist contribution to engagement, $r(10) = .699$, $p < .05$, suggesting that while clients were observed being engaged in therapy, therapists were also more likely to contribute

actively to fostering engagement. Similarly, client emotional connection was significantly correlated with client engagement, $r(10) = .707$, $p < .05$, indicating that clients who felt emotionally connected in therapy also tended to report higher engagement.

Therapist contribution to emotional connection was significantly associated with both client engagement, $r(10) = .908$, $p < .001$, and client emotional connection, $r(10) = .739$, $p < .05$. Additionally, therapist contributions to engagement and emotional connection were significantly correlated, $r(10) = .659$, $p < .05$, indicating that therapists who focused on fostering engagement in therapy were also more likely to actively contribute to emotional connection.

Table 3.2 *Correlation Table of the Dimensions*

Variables	1	2	3	4	5	6
1. Cli_Eng						
2. Th_Eng	.69*					
3. Cli_EmoCon	.70*	.19				
4. Th_EmoCon	.90*	.65*	.73*			
5. Cli_Saf	.26	.33	.30	.49		
6. Th_Saf	.81**	-.63*	.63	.85**	.50	

*Note. * p≤.05 (2-tailed), ** p ≤ .01 ***.*

While client safety did not show significant correlations with other variables, therapist contribution to safety was strongly associated with multiple dimensions. A significant correlation was found between client engagement and therapist contribution to safety, $r(10) = .813$, $p < .01$, suggesting that when clients felt engaged in therapy, therapists were more likely to contribute to a sense of safety in the therapeutic relationship. Furthermore, therapist contributions to safety were significantly associated with their contributions to both engagement, $r(10) = .634$, $p < .05$, and emotional

connection, $r(10) = .858$, $p < .01$. These findings indicate that when therapists actively worked to foster emotional connection and engagement, they also contributed to a greater sense of safety in the therapeutic process. For detailed correlation coefficients, please see Table 3.2.

3.4 Regression Analyses

In order to examine the extent to which therapist contributions predict client experiences in therapy, three separate hierarchical multiple regression analyses were conducted, with each client-observed dimension (engagement, emotional connection, and safety) as a dependent variable. This approach allowed for a clearer understanding of how different therapist contributions (to engagement, emotional connection, and safety) influence each specific client experience rather than collapsing them into a single model. Given that previous research highlights the therapeutic alliance as a multifaceted construct, this analytical strategy provides a more nuanced perspective on the therapeutic process.

Each regression analysis followed a hierarchical approach: the therapist's contribution to the corresponding dimension was entered first, followed by additional therapist contributions to assess whether they provided incremental predictive value.

3.4.1 Predicting Client Engagement

In Model 1, the therapist's contribution to engagement was entered as the sole predictor. The model was significant, $F(1, 8) = 7.65$, $p < .05$, explaining 48.9% of the variance in client engagement. Therapist engagement was a significant predictor, ($B = 0.586$, $\beta = .699$, $t(8) = 2.77$, $p < .05$).

In Model 2, therapist contribution to emotional connection was added. The model fit significantly improved, $F(2, 7) = 18.82$, $p < .01$, with variance explained increasing to 84.3%. Therapist emotional connection was a strong predictor, B = 0.724, SE = 0.182, β = .791, $t(7) = 3.98$, $p < .01$, while therapist engagement became non-significant ($B = 0.149$, $\beta = .178$, $t(7) = 0.89$, $p = .401$).

In Model 3, therapist contribution to safety was included. The model remained significant, $F(3, 6) = 10.90$, $p < .01$, but therapist safety did not significantly improve model fit ($\Delta R^2 = .002$, $p = .803$), while therapist engagement ($p = .469$) and therapist safety ($p = .803$) remained non-significant.

3.4.2 Predicting Client Emotional Connection

In Model 1, therapist emotional connection was entered as the sole predictor. The model was significant, $F(1, 8) = 9.63$, $p = .015$, explaining 54.6% of the variance in client emotional connection. Therapist emotional connection was a significant predictor, $B = 0.468$, $\beta = .739$, $t(8) = 3.10$, $p < .05$.

In Model 2, therapist contribution to safety was added. The model did not significantly improve, $F(2, 7) = 4.22$, $p = .063$, with no meaningful increase in variance explained. Neither therapist safety ($p = .975$) nor therapist emotional connection ($p = .172$) significantly predicted client emotional connection.

In Model 3, therapist engagement was included. Adding therapist contribution to engagement did not significantly improve model fit, $\Delta R^2 = .156$, $p = .127$. None of the therapist contributions in this model were significant predictors.

3.4.3 Predicting Client Safety

In Model 1, therapist contribution to safety was entered as the sole predictor. The model was not significant, $F(1, 8) = 2.80$, $p = .133$.

In Model 2, therapist emotional connection was added. The model remained non-significant, $F(2, 7) = 1.30$, $p = .332$, and variance explained did not increase. Neither therapist safety ($p = .610$) nor therapist emotional connection ($p = .756$) significantly predicted client safety.

In Model 3, therapist engagement was added. The model remained non-significant, $F(3, 6) = 0.74$, $p = .565$, and variance explained did not change. None of the therapist contributions significantly predicted client safety.

Across all three regression analyses, therapist emotional connection emerged as the strongest predictor of both client engagement and emotional connection, while therapist contributions to engagement and safety did not significantly predict these client-reported dimensions. Furthermore, client-observed safety was not significantly predicted by any therapist contribution, suggesting that it may be influenced by factors beyond the therapist's actions.

3.5 Reflections from Coders' Perspectives

The process of coding using the SOFTA framework has presented both challenges and valuable insights from the intercoder team. As the intercoder team, we encountered various insights and challenges that highlighted the complexity of applying the SOFTA dimensions, especially in online therapy sessions. In this section, reflection on these challenges, the difficulties of coding certain dimensions, and the broader implications of cultural and methodological factors on the analysis are provided. Afterward, commonly

observed items identified during the coder team meetings and reflecting on their significance in relation to the findings will be discussed.

3.5.1 Challenges in Applying SOFTA Dimensions

One of the main challenges faced by coders was the interpretation of client engagement, especially in cases where the client's engagement was expressed in subtle or indirect ways or expressed to different extents by partners. For instance, when the client's emotional state was multifaceted or unclear, coders often struggled to rate engagement consistently, or when clients were stuck in one problem itself but very engaged under these boundaries. In particular, client engagement was more difficult to assess when it was not overtly expressed but rather implied through tone, pacing, or brief responses. In these cases, coders had to rely heavily on subjective judgment, which sometimes led to variance in the ratings. As a team, we addressed this challenge by discussing specific examples and refining our guidelines for such ambiguous situations, ensuring that we could apply consistent criteria in future coding.

Additionally, the safety dimension was one of the most difficult dimensions to code accurately, which is also observable from the lowest of ICC ratings. Initially, safety items were designed with physical or bodily cues in mind, which posed difficulties in an online therapy setting where such cues were either absent or less clear. This discrepancy between the original item design and the nature of online therapy led to challenges in how coders could assess a client's sense of safety without the traditional, physical signs such as protecting self with a closed body posture and expressing anxiety through shaking or tapping. Revising these items to better reflect the virtual nature of online therapy sessions became necessary, as the standard measures did not capture the full spectrum of psychological safety online clients might experience. This revision process also

illustrated the unique challenges of adapting existing frameworks to new and evolving therapeutic contexts.

3.5.2 Feedback Meetings with Our Coders

One of the recurring reflections during our meetings was the ease with which positive items were coded. Some coders noted that it was simpler to rate positive behaviors or interactions, possibly because they were easier to identify or because there was a tendency to want to see positive aspects in the interactions. This was particularly evident when coders found themselves perceiving positive behaviors that they were hoping to observe, highlighting the subjective nature of the coding process.

For some, the process had personal significance beyond the technical aspects of the work. One coder reflected that coding emotional connection, specifically within the therapist-client dynamic, had been beneficial for their own therapy process. This coder also noted an unconscious tendency to identify with female clients more easily, which affected their coding. This personal connection to the data underlined the human element of the coding process, reminding us of the emotional and subjective layer that coders bring to the table when analyzing therapy sessions.

The feedback from another coder revealed that they found it easier to code the therapist's behavior rather than the client's. This was tied to an underlying tendency to feel sympathy for the client, which may have influenced their rating of therapist behavior. This observation also pointed to an important dynamic in coding, where the coders' personal biases or emotions towards the client could influence how they perceived the therapist's emotional connection or behavior.

Another coder observed that one particular client was trying to present themselves as flawless, which made it difficult to capture authentic moments of emotional

connection. The perception that the client was concealing aspects of themselves brought up the idea of potentially revisiting future sessions for a deeper observation, suggesting that patterns may become clearer with time. This reflection added an important layer to the analysis, showing how clients' attempts to hide vulnerabilities could affect how we code emotional connection and engagement.

A further interesting reflection came from another coder who noted the tendency for certain therapists, due to their theoretical orientation, to maintain a more distant stance. This created a dynamic where the therapist's emotional connection appeared lower in SOFTA ratings, despite the therapist's efforts to remain engaged in the process.

Another point raised was the difference in communication styles between male and female clients. One coder noted that female clients, although using more sharp or critical language, might actually be feeling more positive, though their emotional connection appeared lower in the SOFTA framework. This observation suggested that communication style could influence the way we rate emotional connection and engagement, emphasizing the complexity of coding in therapeutic relationships.

Finally, some coders noted discrepancies between what they perceived as safety in the sessions and the items in the SOFTA framework that did not fully capture the nuances of the feeling of safety. One coder reflected on how some couples seemed surprising in their willingness to engage in therapy, particularly with male clients who appeared to hold traditional biases, reflecting generational differences in attitudes towards therapy. Additionally, the way clients tended to shape their narratives, particularly when trying to appear favorable to the therapist, further demonstrated the complexities of capturing genuine emotional connection and engagement.

In addition, a remarkable contrast was discovered through consideration of the Shared Sense of Purpose (SSP) dimension. Coders reported that it was often more straightforward to agree on SSP ratings in sessions with both couples present, even though SSP was not feasible to be included in the statistical analyses due to missing data. A common understanding of the behavioral indicators associated with this dimension was supported by the strong interrater reliability achieved during training and observed in relevant sessions. But coders also pointed out that it occasionally took more contextual judgment to determine if these behaviors represented a genuine shared intention rather than surface-level agreement. Sometimes, there was uncertainty about how to categorize a moment since SSP-related behaviors are interconnected with emotional connection or safety. These observations highlighted the significance of interpretative depth in addition to coder agreement, especially in early sessions when couple dynamics were still developing. Despite the fact that SSP was not statistically examined, the coder team's observations offered a useful perspective on the complexity of observing within-system alliances.

In conclusion, these reflections from the intercoder team highlight the subjective nature of the coding process and the complexities of capturing emotional connection, engagement, and safety within the therapeutic relationship. The personal biases, unconscious tendencies, and theoretical orientations of the coders are all factors that shape how these dimensions are rated. These reflections suggest that while the SOFTA framework provides a useful structure, it also requires continuous calibration and open discussion among coders to account for the nuanced and sometimes subtle dynamics that influence the therapeutic alliance in online couple therapy. These insights from the coders will not only enhance the coding process moving forward but will also contribute to a

deeper understanding of how emotional connection and engagement play out in therapy, aligning with the broader goals of the study to analyze and refine the therapeutic alliance in online therapy contexts.

3.5.3 Commonly Observed Items & Reflections

Throughout the coding process, certain patterns and behaviors were consistently observed across multiple sessions, revealing insights into the therapeutic dynamics and client-therapist interactions. With the coder team, it was considered that to provide a deeper understanding of the key factors influencing the therapeutic alliance in online therapy, it is essential to examine the most commonly observed items for each of the core dimensions identified in the analysis. This section outlines some of the commonly observed items identified during the coder team meetings and reflects on their significance in relation to the findings of the statistical analyses presented earlier.

While the regression and correlation results highlighted significant relationships between therapist contributions and client experiences, it is through the observed behaviors that we gain valuable insights into how these dimensions manifest in practice. By focusing on the most frequently observed items, we can better understand the specific therapist's actions that contribute to client engagement**,** emotional connection**,** and safety. Thus, a closer examination of these commonly observed behaviors was expected to enhance our understanding of the dynamics at play and further inform the development of the therapeutic alliance framework.

Given the strong correlation and its significant role in the regression models, the dimension of therapist contributions to emotional connection was prioritized when discussing the most commonly used items related to emotional connection. One of the most frequently observed therapist behaviors in this dimension was the use of lighthearted

moments or jokes. During the feedback meetings, the coder team reflected on how these moments often helped to ease tension between the therapist and the client. These brief moments of humor or warmth created a more comfortable atmosphere, allowing clients to feel more at ease and engaged in the therapy process. Coders noted that these lighthearted moments were particularly effective in online therapy, where the absence of physical proximity can sometimes create a sense of emotional distance. The coder team observed that these moments led to increased client participation, as clients seemed more willing to engage in discussions and therapeutic tasks when they felt the session was not only about addressing challenges but also about connecting on a human level.

The expression of interest by therapists in the client's life outside of the discussion regarding therapy also became an often-noticed behavior. Coders reflected on how therapists occasionally asked questions about the client's personal life or showed curiosity about their well-being outside of the therapy room. These moments of genuine interest made the client feel seen and valued as an individual, not just as a case to be worked on.

Additionally, coders frequently observed that therapists were able to verbally or nonverbally express empathy for the client's struggle. Expressions such as "I know this is hard" or "I feel your pain" were common in sessions, and coders noted that these empathic responses were crucial in helping clients feel understood and supported. The coder team reflected on the importance of empathic communication, particularly in online therapy where physical cues like a comforting touch or a reassuring smile are not possible. Coders agreed that when therapists expressed empathy, it provided clients with a sense of emotional validation. The regression results supported this reflection, showing that

therapist emotional connection significantly predicted both client engagement and client emotional connection.

Lastly, the coder team often observed therapists normalizing a client's emotional vulnerability during difficult moments, such as when clients expressed sadness, fear, or frustration. Coders noted that therapists who reassured clients that it was okay to feel vulnerable, whether through statements like "It's okay to cry" or "What you're feeling is understandable," helped clients feel more comfortable expressing their emotions. These moments of reassurance were interpreted to be particularly impactful in online therapy, where clients might feel less secure due to the physical distance between them and the therapist. By normalizing vulnerability, therapists helped clients feel more at ease reinforcing the idea that therapy is a safe space for emotional exploration.

Client engagement was discussed to be another key focus area because it is directly influenced by therapist actions both emotional connection and engagement. One key item that was commonly observed was when clients indicated agreement with the therapist's goals**.** Coders reflected that when clients actively expressed alignment with the therapist's objectives for the session or the broader therapy process, they seemed more invested in the session and more willing to engage in the tasks and discussions proposed by the therapist. When a therapist clearly communicates the goals of therapy and works collaboratively with the client, it often results in the client's active participation and agreement with the therapeutic process, reinforcing the idea that engagement is reciprocal; clients are more likely to engage when therapists set clear, collaborative goals.

Another commonly observed behavior that stood out was when clients introduced a problem for discussion. Coders noted that when clients brought up their own issues or concerns, it was often a sign of proactive engagement in the therapy process. This

behavior, in which clients take the initiative to bring up personal challenges or specific topics, indicates that the client sees the therapeutic space as one where they can address meaningful issues. This behavior aligns well with the findings from the correlation analysis, where client engagement was significantly correlated with client emotional connection, suggesting that clients who feel more emotionally connected to the therapist are also more likely to actively engage in the therapy process. When a client feels understood and supported, they may be more likely to initiate discussions, thereby increasing their involvement in the therapeutic work.

The expression of optimism was another frequently observed item that directly connected to client engagement. Clients mostly expressed their optimism through phrases such things like "We can make something happen," "Things are shaping." or "We're heading somewhere finally." Even more indirect expressions of hope, such as references to focusing on the positives or believing in small improvements, were observed. The client's trust in the therapeutic process was presumably strengthened by this optimism, which also encouraged them to engage fully in the sessions. Finally, the mention of the treatment, the therapeutic process, or a specific session was a relatively frequent observation that illustrated the client's active involvement in the therapy. Coders noticed that clients who brought up therapy-related topics—such as commenting on past sessions, expressing interest in the process, or questioning the duration of therapy—were demonstrating engagement with the therapeutic work. These comments often indicated that the client was reflecting on the therapy and thinking about its purpose, progress, and future direction. When clients showed interest in the therapeutic process, it reflected an active mental investment in the therapy, reinforcing the collaborative nature of therapy. This also may suggest that clients who feel comfortable discussing the therapy process

are more likely to remain engaged and committed to the sessions as they actively reflect on their progress and the relevance of the therapy to their personal goals.

In conclusion, this section aimed to provide a deeper understanding of the key factors influencing the therapeutic alliance in online therapy by reflecting on the most commonly observed items related to client engagement, emotional connection, and safety. Through the coder team's observations and feedback meetings, it became clear that therapist actions, such as expressing empathy, sharing lighthearted moments, and normalizing emotional vulnerability, were crucial in fostering a strong therapeutic bond and encouraging client participation. The observed items shed light on how therapists' contributions to emotional connection significantly contribute to creating a collaborative and safe space for clients, ultimately enhancing the therapeutic process. By examining these behaviors, we gain a clearer understanding of the dynamic interactions between therapist and client, reinforcing the need for a nuanced approach to building the therapeutic alliance in online therapy contexts.

4. DISCUSSION

The primary aim of this study was to examine the therapeutic alliance in online couple therapy and to explore the relationships between various dimensions of the alliance. In doing so, the study sought to provide insight into how therapist contributions shape client experiences in therapy, particularly in the context of engagement, emotional connection, safety, and shared sense of purpose. The study provided a detailed exploration of the therapeutic alliance in online couple therapy, focusing on both therapist and client perspectives using the SOFTA-o framework. The results revealed important insights into how different dimensions of the therapeutic alliance are shaped by the therapist's contributions and how these dimensions interact with each other during therapy.

The first research question aimed to examine the interrelationships between the different dimensions of the therapeutic alliance in online couples therapy. Specifically, we hypothesized that client engagement would be positively correlated with client emotional connection and safety (H1a). The results of the Pearson bivariate correlations confirmed this hypothesis, showing that when clients are more engaged in therapy, they also report higher levels of emotional connection and safety. These findings are in line with previous studies, which suggest that engagement is a key factor in establishing a secure therapeutic environment and solid therapeutic relationship (Quirk et al., 2018).

Next, we hypothesized that a stronger shared sense of purpose would be positively correlated with higher engagement and safety (H1b). Unfortunately, this hypothesis could not be tested as we were unable to analyze the Shared Sense of Purpose dimension in this study. Due to limitations in the data and the coding process, we were unable to fully explore the relationship between SSP and the other dimensions of the therapeutic alliance.

This is an important area for future research, as the shared sense of purpose has been identified in the literature as a key factor in fostering a strong therapeutic alliance (Friedlander et al., 2006).

Lastly, we hypothesized that therapists' contributions to emotional connection would be positively correlated with their contributions to a shared sense of purpose and client safety (H1c). While therapist emotional connection was significantly correlated with both client engagement and emotional connection, the correlation with client safety was weaker than expected. This finding echoes previous research suggesting that emotional connection plays a central role in alliance formation (Norcross & Lambert, 2018), but also highlights that perceptions of safety may be influenced by broader factors, including client attachment history, trauma experiences, and perceptions of vulnerability (Mallinckrodt, 2010), or a shared sense of purpose within the couple, which could not be analyzed as stated.

The second research question aimed to examine the extent to which therapist contributions to the therapeutic alliance predict client-observed alliance. We hypothesized that therapist contributions to emotional connection would significantly predict client engagement and emotional connection (H2a). The results of the hierarchical regression analyses supported this hypothesis, showing that the therapist's contributions to emotional connection were a significant predictor of both client engagement and emotional connection. This finding underscores the critical role of emotional attunement in creating a strong therapeutic alliance, which is consistent with Bordin's (1979) foundational definition of a therapeutic alliance. In particular, the results highlight the dominant influence of therapist emotional connection in fostering both client engagement and client emotional connection, with therapist contributions to engagement and safety

not having the same predictive value once the emotional connection was accounted for. Therapist engagement became non-significant after therapist emotional connection was added**,** suggesting that emotional connection played a more substantial role in influencing client engagement than traditional task-oriented engagement behaviors.

This finding implies that, in the context of online therapy, emotional connection may be more influential in fostering client engagement than safety concerns, at least within the model tested. Therapist contributions to safety did not significantly predict client safety in any of the models. We also hypothesized that therapist contributions to safety and a shared sense of purpose would significantly predict client safety and a shared sense of purpose (H2b). However, this hypothesis could not be fully tested as we were unable to analyze the Shared Sense of Purpose (SSP) dimension in this study. Due to data limitations and the coding process, the SSP dimension could not be included in the analysis. As a result, we were unable to examine the predictive relationship between therapist contributions to SSP and client perceptions of safety and shared sense of purpose. This limitation highlights the need for future studies to explore SSP in more depth and to assess its predictive value in shaping the therapeutic alliance. Despite this limitation, the findings suggest that therapist contributions to safety did not significantly predict client safety, indicating that other factors beyond therapist behavior may influence client perceptions of safety.

Finally, we hypothesized that therapist contributions to engagement would significantly predict client engagement (H2c). While therapist contributions to engagement were positively correlated with client engagement, the regression analysis did not find a significant predictive effect. This indicates that client engagement may be influenced by additional factors beyond the therapist's contributions, such as individual

motivations, personal factors, and, as we could not analyze, a shared sense of purpose of the couple.

Accordingly, one of the key findings of this study was that therapist contributions to engagement and emotional connection were significantly predictive of client outcomes in these dimensions. Specifically, the therapist's contributions to emotional connection were identified as a strong predictor of both client engagement and emotional connection, highlighting the central role that the therapist's emotional involvement plays in fostering a strong therapeutic alliance, which is in line with the existing literature (Norcross & Lambert, 2018).

In terms of client perceptions, the results indicated that clients reported higher levels of safety in the therapeutic relationship compared to therapists' safety assessments. This suggests that clients may experience a greater sense of security than therapists perceive, possibly due to differing perspectives on what constitutes a "safe" therapeutic environment. These results contribute to the growing body of research suggesting that safety is a complex and multidimensional construct in therapy, one that may involve not only the therapist's behavior but also the client's personal history and expectations (Friedlander et al., 2006).

Regression analyses revealed that therapist contributions to emotional connection were the most significant predictors of client engagement and emotional connection. These findings underscore the importance of therapist engagement and emotional responsiveness in fostering a productive therapeutic environment. However, therapist contributions to safety did not significantly predict client safety in the regression models, suggesting that client safety may be influenced by factors beyond the therapist's behavior. This finding may imply that client safety is likely influenced by a more complex interplay

of individual factors, such as previous therapeutic experiences, attachment styles, and personal histories, including past trauma or relational difficulties that may affect the client's perception of trust in therapy (Mallinckrodt, 2010). Additionally, broader relational dynamics, including the client's social support network, family environment, and current life stressors, may play a crucial role in shaping their sense of safety, making it less dependent on the therapist's actions alone. Future research could, therefore, expand the scope of inquiry by investigating how these external factors interact with therapist behaviors to influence client safety.

4.1 Strengths and Limitations

This study represents a pioneering contribution to the field, offering one of the first investigations of therapeutic alliance through direct observation of therapy sessions within this specific cultural context. By employing a comprehensive approach, it explores both therapist and client perspectives, providing a more holistic understanding of the therapeutic dynamics at play. Incorporating both therapist and client perspectives contributes to a more nuanced and relationally grounded understanding of alliance processes, consistent with calls in the field for systemic conceptualizations of the alliance (Friedlander et al., 2006).

Additionally, the study provides valuable insights into the dynamics of the therapeutic alliance in online therapy, particularly through the application of the SOFTA framework. One of the key strengths of this study is its novelty, as it focuses on online therapy, a context that has grown increasingly relevant with the rise of virtual mental health services. The use of a structured, observer-based coding system like SOFTA allowed for quantitative and qualitative analysis of the therapist-client relationship,

offering a detailed understanding of how specific therapist behaviors influence client experiences.

The study also provides valuable practical insights for therapists working in an online context, highlighting the therapist behaviors most strongly associated with fostering client engagement and emotional connection. By identifying commonly observed items, the study provides actionable insights for improving therapeutic practices in online settings.

While the study offers contributions to the field, it is not without limitations. One limitation is the composition of the research team, which consisted primarily of female raters. This may introduce a gender-related bias in interpreting interpersonal behaviors. As noted by SOFTA trainees, it is recommended that both male and female raters be included in the process, as gender can influence the interpretation of behavior in therapy sessions. This should be considered when interpreting the results, and future studies may benefit from a more balanced rater team.

Another limitation is the adaptation of the SOFTA-o tool for online therapy. While this adaptation provides an opportunity to explore online therapeutic alliances, there is a limited body of research on the validity of the SOFTA-o in online therapy settings. As one of the first studies in this domain, caution must be exercised in generalizing our findings to other online therapy contexts. Additionally, the sample characteristics—such as the specific cultural and demographic features of the participants—may limit the broader applicability of the results.

Additionally, the shared sense of purpose dimension could not be analyzed in this study due to the nature of the data collected. This dimension, which focuses on the collective goals and mutual understanding between partners and the therapist, could offer

valuable insights in future research. The study also faced a challenge in being unable to analyze dyadic processes in depth, particularly in situations where both partners were seen as a single unit. While important, the individual impacts of each partner were difficult to isolate in this context, which could be a potential limitation for understanding how the therapeutic alliance operates on an individual level. Therefore, the inability to analyze the Shared Sense of Purpose dimension further limits the depth of conclusions drawn about alliance complexity. Future studies incorporating this dimension could offer a fuller understanding of dyadic processes critical to couple therapy outcomes (Pinsof & Catherall, 1986).

Last but not least, one of the main limitations of this study is the sample size, which may have affected the statistical power of the analyses. The relatively small sample size of 10 couples limits statistical power, increasing the risk of Type II errors (Cohen, 1988). Although the correlations and regression analyses provided valuable insights into the therapeutic alliance in online therapy, caution must be exercised in generalizing these findings. Larger, more diverse samples would enhance future research's robustness and external validity in this emerging field.

4.2 Future Directions

Future research should consider comparing therapeutic alliances in online and face-to-face therapy settings, ideally using the same therapists in both conditions. Such a comparison would allow for a more direct evaluation of the effects of modality on the therapeutic alliance, providing further clarity on how the online format may influence the development of the therapeutic relationship. Additionally, a thematic analysis of the emotional connection in therapy could offer valuable insights into why certain items related to emotional connection are so crucial in fostering a strong alliance.

Understanding which aspects of the alliance are most visible and influential could help to refine therapeutic practices and further elucidate how these dynamics unfold in therapy.

A mixed-methods design could be another promising approach in future studies. Combining quantitative measures with qualitative insights would allow for a deeper exploration of how specific alliance-building behaviors are manifested and their impact on the therapeutic process. This could provide a more comprehensive understanding of the therapeutic alliance, particularly in the context of online therapy.

Furthermore, longitudinal studies examining the evolution of the therapeutic alliance over time in online therapy would be valuable in assessing how sustained engagement and emotional connection develop and whether online therapy presents unique challenges in maintaining a strong alliance throughout treatment.

Future research could also explore the cultural dimensions of the therapeutic alliance, particularly in online therapy settings. Given the global nature of online therapy, it is crucial to examine how cultural differences in communication styles, emotional expression, and relationship-building influence the dynamics of the therapeutic alliance. For example, therapists and clients from different cultural backgrounds may have varying expectations regarding emotional connection, trust, and the role of the therapist in the therapeutic process. Investigating how these cultural factors shape the alliance can lead to a more nuanced understanding of how therapists can adapt their strategies to create a culturally sensitive therapeutic environment, which could ultimately improve client engagement and outcomes.

For instance, in Turkey, although awareness of psychotherapy has grown in recent years, cultural norms continue to influence how clients approach therapy. Emotional expression is often shaped by family roles, gender expectations, and generational

attitudes, which can result in hesitancy, passivity, or reluctance to share vulnerability, particularly among clients from lower to middle socioeconomic backgrounds (Coşan, 2015). These tendencies may influence how core alliance elements such as engagement, emotional connection, and safety are expressed and interpreted during therapy. Understanding the therapeutic alliance within this cultural framework is essential, especially in online therapy, where the absence of physical presence may further complicate relational attunement.

4.3 Clinical Implications

For therapists seeking to enhance the effectiveness of their practice, the establishment of a robust therapeutic alliance should be a primary focus. A strong alliance is associated with positive treatment outcomes and successful therapy completion, whereas a weak alliance can contribute to negative outcomes, such as early termination or stagnation in therapy (Horvath et al., 2011). By paying attention to the behaviors indicative of the alliance's strength or weakness, therapists can create an environment conducive to positive therapeutic progress.

The findings from this study have valuable implications for therapist training programs, particularly those focused on online therapy. Training programs for therapists should emphasize the role of emotional attunement and responsiveness, as these behaviors are critical for creating a collaborative and supportive therapeutic environment. It is essential for training programs to incorporate the insights gained from this research into their curricula, especially in terms of identifying specific behaviors that support a strong therapeutic alliance in online sessions. This could significantly enhance therapists' competency in working within the evolving landscape of online therapy, ensuring that

they are equipped with the skills needed to foster meaningful connections with clients in continually evolving virtual spaces.

Therapists need to be trained not only in emotional attunement but also in using technology effectively to create an emotionally safe and engaging environment. For instance, therapists might need to modify their body language, adjust the tone of their voice, or incorporate other techniques, such as active listening or visual cues, to compensate for the lack of physical presence. Simulated online therapy scenarios could be incorporated into training curricula to help therapists develop fluency in these skills, ensuring they can maintain therapeutic presence despite physical distance. Building competency in using technological platforms and managing technological disruptions empathetically is also critical for preserving alliance quality.

4.4 Conclusion

This study explored the role of therapist contributions to the therapeutic alliance, focusing specifically on how these contributions influence client engagement, emotional connection, and client safety in the context of online therapy. The findings indicated that the therapist's contributions to emotional connection was the most significant predictor of both client engagement and client emotional connection, emphasizing the importance of emotional attunement in building a strong therapeutic alliance. However, despite the strong correlations between therapist emotional connection and client engagement and emotional connection, therapist contributions to safety did not significantly predict client safety, highlighting the complexity of factors that contribute to a client's sense of security in therapy. This finding suggests that client safety may be influenced by external factors—such as client history or interpersonal dynamics outside therapy—that go beyond the therapist's actions. Future research could explore these external influences

more deeply to better understand how they interact with therapist behaviors to shape the therapeutic environment.

From a clinical perspective, the study underscores the necessity for therapists to prioritize emotional connection and empathic attunement in their work, particularly in online therapy, where the absence of non-verbal cues can make it more challenging to establish rapport. The study also calls attention to the fact that while client safety is crucial, it might require a broader consideration of factors such as client background and life circumstances, which may not always be within the therapist's control.

In summary, this study makes an important contribution to the literature by emphasizing the pivotal role of therapist contributions to emotional connection in the development of a strong therapeutic alliance and provides insights for improving therapeutic practices, particularly in the context of online therapy, where emotional connection and engagement are key to promoting positive client outcomes. Moving forward, these findings can inform therapist training programs and help design interventions that address both the individual and relational aspects of the therapeutic process to foster a more effective and sustainable therapeutic alliance.

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APPENDICES

APPENDIX A. INFORMED CONSENT FOR PARTICIPANTS (TURKISH)

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

Tübitak 3501 Araştırma Projesi

Proje yürütücüsü: Dr. Öğretim Üyesi Selenga Gürmen

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

Süreç: Bu araştırma dahilinde belirtilen veri toplama süreçleri gerçekleşecektir:

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

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

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

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

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

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

_____	_____	_____
İsim Soyad	İmza	Tarih

APPENDIX B. SYSTEM FOR OBSERVING FAMILY THERAPY ALLIANCES

(SOFTA-O; FRIEDLANDER ET AL., 2005)

Client Variables

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

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

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

Client refuses or is reluctant to respond when directly addressed by another family member*
Client responds defensively to another family member*
Client makes an uneasy or anxious reference to the camera, observation, supervisor, or
research procedures*
Shared Sense of Purpose
Family members offer to compromise
Family members share a joke or a lighthearted moment with each other
Family members ask each other for their perspective
Family members validate each other's perspective
Family members mirror each other's body posture
Family members avoid eye contact with each other*
Family members blame each other*
Family members devalue each other's opinions or perspectives/Client makes hostile or
sarcastic comments to family members*
Family members try to align with the therapist against each other*
Family members disagree with each other about the value, purpose, goals, or tasks of therapy,
or about who should be included in the sessions*
***Negative indicator**

Therapist Variables

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

Emotional Connection
Therapist shares a lighthearted moment or joke with the client(s)
Therapist expresses confidence, trust, or belief in the client(s)
Therapist expresses interest in the client(s) apart from the therapeutic discussion at hand
Therapist expresses caring or touches client(s) affectionately yet appropriately (e.g., handshake, pat on head)
Therapist discloses some fact about his or her personal life
Therapist discloses his or her reactions or feelings toward the client(s) or the situation
Therapist remarks on or describes how his or her values or experiences are similar to the clients'
Therapist (verbally or nonverbally) expresses empathy for the clients' struggle (e.g., "I know this is hard," "I feel your pain," crying with client)
Therapist reassures or normalizes client's emotional vulnerability (e.g., crying, hurt feelings)
Therapist has hostile, sarcastic, or critical interactions with the client(s)*
Therapist does not respond to clients' expressions of personal interest or caring for him or her*
Safety
Therapist acknowledges that therapy involves taking risks or discussing private matters
Therapist invites discussion about intimidating elements in the therapeutic context (e.g., recording equipment, reports to third parties, treatment team observation, one-way mirror, research, etc.)
Therapist helps clients to talk truthfully and non-defensively with each other
Therapist attempts to contain, control, or manage overt hostility between clients
Therapist provides structure and guidelines for safety and confidentiality
Therapist actively protects one family member from another (e.g., from blame, hostility, or emotional intrusiveness)
Therapist changes the topic to something pleasurable or non-anxiety arousing (e.g., small talk about the weather, room décor, TV shows, etc.) when there seems to be tension or anxiety
Therapist asks one client (or a subgroup of clients) to leave the room in order to see one client alone for a portion of the session
Therapist allows family conflict to escalate to verbal abuse, threats, or intimidation*
Therapist does not attend to overt expressions of client vulnerability (e.g., crying, defensiveness)*
Shared Sense of Purpose
Therapist encourages clients to compromise with each other
Therapist encourages clients to ask each other for their perspectives
Therapist praises clients for respecting each other's point of view

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

Scoring

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

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

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

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

APPENDIX C. SYSTEM FOR OBSERVING FAMILY THERAPY ALLIANCES

(REVISION FOR ONLINE CONTEXT)

Client Variables

Engagement
Client indicates agreement with the therapist's goals
Client describes or discusses a plan for improving the situation
Client introduces a problem for discussion
Client agrees to do homework assignments
Client indicates having done homework or seeing it as useful
Client expresses optimism or indicates that a positive change has taken place
Client complies with therapist's requests for enactments
****Client leans forward** ***(In online sessions, the couple might sit on the sofa, connect from their phone which leads us to only see their faces. They may not be as physically responsive to each other's words as they would be in the session room.)***
Client mentions the treatment, the therapeutic process, or a specific session
Client expresses feeling "stuck," questions the value of therapy, or states that therapy is not or has not been helpful*
Client shows indifference about the tasks or process of therapy (e.g., paying lip service, "I don't know," tuning out)*
Emotional Connection
Client shares a lighthearted moment or joke with the therapist
Client verbalizes trust in the therapist
Client expresses interest in the therapist's personal life
Client indicates feeling understood or accepted by the therapist
****Client expresses physical affection or caring for the therapist** ***(This will be revised by excluding physical affection and only include caring in the item description.)***
****Client mirrors the therapist's body posture** ***(This item might include only leaning forward or hand/arm gestures.)***
****Client avoids eye contact with the therapist*** ***(There may be more distracting factors in the environment where the online session takes place (such as home environment, children). These conditions can also be added to the item description as exclusions for online sessions.)***
Client refuses or is reluctant to respond to the therapist*
Client has hostile or sarcastic interactions with the therapist*
Client comments on the therapist's incompetence or inadequacy*
Safety
Client implies or states that therapy is a safe place
Client varies his/her emotional tone during the session
Client shows vulnerability (e.g. discusses painful feelings, cries).

****Client has an open upper body posture** ***(In online sessions, it is possible to even change the sitting position for comfort. Additionally, clients connecting to the session via phone may also pose problems regarding movement-related items. Almost only their faces are visible during the sessions.)***
Client reveals a secret or something that other family members didn't know
Client encourages another family member to "open up" or to tell the truth
Client directly asks other family member(s) for feedback about his/her behavior or about herself/himself as a person
****Client expresses anxiety nonverbally (e.g., taps or shakes) *** ***(This item might need more detail in terms of nonverbally anxiety expressions that are visible on the face (such as biting lips/nails, observably/ constant deep breaths, or fidgeting if hands are visible). Shaking legs etc. would be excluded.)***
****Client protects self in a nonverbal manner (e.g., crosses arms over chest, doesn't take off jacket or put down purse, sits far away from group, etc.) *** ***(Crossing arms over chest is possible if body is seen. Leaning out of the camera might be interpreted as nonverbal protection.)***
Client refuses or is reluctant to respond when directly addressed by another family member*
Client responds defensively to another family member*
****Client makes an uneasy or anxious reference to the camera, observation, supervisor, or research procedures***
(This might be revised specific to recording.)
Shared Sense of Purpose
Family members offer to compromise
Family members share a joke or a lighthearted moment with each other
Family members ask each other for their perspective
Family members validate each other's perspective
Family members mirror each other's body posture
Family members avoid eye contact with each other*
Family members blame each other*
Family members devalue each other's opinions or perspectives/Client makes hostile or sarcastic comments to family members*
Family members try to align with the therapist against each other*
Family members disagree with each other about the value, purpose, goals, or tasks of therapy, or about who should be included in the sessions*

***Negative indicator**
****Items to be revised or excluded**

Therapist Variables

Engagement
Therapist asks what they want to talk about in the session
Therapist encourages client(s) to articulate their goals for therapy

Therapist asks client(s) whether they are willing to follow a specific suggestion or do a
specific homework assignment
Therapist asks about the impact or value of a prior homework assignment
Therapist expresses optimism or notes that a positive change has taken place or can take place
Therapist asks client(s) whether they are willing to do a specific in-session task (e.g., enactment)
Therapist pulls in quiet client(s) (e.g., by deliberately leaning forward, calling them by name, addressing them specifically)
Therapist explains how therapy works
Therapist asks if the client(s) have any questions
Therapist praises client motivation for engagement or change
Therapist defines therapeutic goals or imposes tasks or procedures without asking the client(s) for their collaboration*
Therapist argues about the nature, purpose, or value of therapy*
Therapist shames or criticizes how clients did (or did not do) a prior homework assignment*
Emotional Connection
Therapist shares a lighthearted moment or joke with the client(s)
Therapist expresses confidence, trust, or belief in the client(s)
Therapist expresses interest in the client(s) apart from the therapeutic discussion at hand
****Therapist expresses caring or touches client(s) affectionately yet appropriately (e.g.,**
handshake, pat on head)
(This item will be excluded.)
Therapist discloses some fact about his or her personal life
Therapist discloses his or her reactions or feelings toward the client(s) or the situation
Therapist remarks on or describes how his or her values or experiences are similar to the
clients'
Therapist (verbally or nonverbally) expresses empathy for the clients' struggle (e.g., "I know this is hard," "I feel your pain," crying with the client)
Therapist reassures or normalizes client's emotional vulnerability (e.g., crying, hurt feelings)
Therapist has hostile, sarcastic, or critical interactions with the client(s)*
Therapist does not respond to clients' expressions of personal interest or caring for him or her*
Safety
Therapist acknowledges that therapy involves taking risks or discussing private matters
****Therapist invites discussion about intimidating elements in the therapeutic context (e.g., recording equipment, reports to third parties, treatment team observation, one-way mirror, research, etc.)**
(Examples will be revised specifically on recording and research-based.)

Therapist helps clients to talk truthfully and non-defensively with each other
Therapist attempts to contain, control, or manage overt hostility between clients
Therapist provides structure and guidelines for safety and confidentiality
Therapist actively protects one family member from another (e.g., from blame, hostility, or emotional intrusiveness)
****Therapist changes the topic to something pleasurable or non-anxiety arousing (e.g., small talk about the weather, room décor, TV shows, etc.) when there seems to be tension or anxiety** ***(Examples will be revised.)***
Therapist asks one client (or a subgroup of clients) to leave the room in order to see one client alone for a portion of the session
Therapist allows family conflict to escalate to verbal abuse, threats, or intimidation*
Therapist does not attend to overt expressions of client vulnerability (e.g., crying, defensiveness)*
Shared Sense of Purpose
Therapist encourages clients to compromise with each other
Therapist encourages clients to ask each other for their perspectives
Therapist praises clients for respecting each other's point of view
Therapist emphasizes commonalities among clients' perspective on the problem or solution
Therapist draws attention to clients' shared values, experiences, needs, or feelings
Therapist encourages clients to show caring, concern, or support for each other
Therapist encourages client(s) to ask for feedback
Therapist fails to intervene when family members argue with each other about the goals, value, or need for therapy*
Therapist fails to address one client's stated concerns by only discussing another client's concerns*

***Negative indicator**

****Items to be revised or excluded**