Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Understanding therapeutic collaboration: triangulation of client, therapist, and observer perspectives

Sandra Iglesias
University of Minho
Susana Reis
University of Minho
Vânia Silva
University of Minho
Eugénia Ribeiro
eugenia@psi.uminho.pt

University of Minho

Research Article

Keywords: Therapeutic collaboration, Therapeutic Collaboration Coding System (TCCS), multiple case study, therapist training and clinical experience, client–therapist–observer triangulation

Posted Date: November 17th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11637734/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License

Additional Declarations: No competing interests reported.

Abstract

Therapeutic collaboration is a central relational process linked to positive outcomes in psychotherapy. Although research has examined this process either through external observation or through participants' perspectives, it has rarely examined both. This study addressed that gap by triangulating three perspectives - client, therapist, and an independent observer using the Therapeutic Collaboration Coding System (TCCS) – to explore collaborative and non-collaborative moments in early therapy sessions. A comparative multiple-case study design was employed with three therapeutic dyads that differed in therapists' clinical experience and prior training in the TCCS. Data comprised session recordings, a purpose-built questionnaire, and video-assisted recall interviews with therapists and clients. Findings showed strong alignment between client experience and observer coding across all dyads, supporting the coding system's sensitivity to clients' moment-to-moment experiences of safety or tensions within the therapeutic relationship. Alignment between therapist and observer perspectives varied with clinical experience and training, with greater convergence found among more experienced or trained therapists. Divergences proved theoretically informative, pointing to communicative differences with a neurodivergent client and to moments where therapists held simultaneously supportive and challenging intentions that the coding system could not fully capture. These results support using the coding system not only as a research tool but as a resource for training and supervision, helping therapists develop explicit awareness of the relational function of their interventions and refine responsiveness to clients whose engagement may not follow conventional markers.

Introduction

Therapeutic collaboration (TC) has been increasingly recognized as a central relational process in psychotherapy, with growing evidence of its relevance for therapeutic effectiveness (Tryon et al., 2018). It has been described as an achievement of the therapeutic dyad, involving the cooperative process and the mutual involvement of the psychotherapist and client in the therapeutic work and helping relationship (e.g., Hatcher, 1999; Tryon and Winograd, 2011). In this study, we aimed to study therapeutic collaboration at a moment-to-moment level of analysis, as a relational microprocess, viewed from the subjective perspective of the therapy participants and the researcher's observer perspective.

The present study was framed by the Therapeutic Collaboration Model (TCM, Ribeiro, et al., 2013), which articulates the therapist-client collaboration with the client's micro changes within the session. Consistent with narrative models of therapeutic change (Gonçalves et al., 2009; Stiles et al., 2011; White, 2006), the TCM proposed that change is a developmental process in which the clients move from a maladaptive self-narrative to a more functional narrative. To operationalize this developmental change, the model uses the concept of the Therapeutic Zone of Proximal Development (TZPD), based on Vygotsky's (1978) Zone of Proximal Development (ZPD), as adapted to psychotherapy by Leiman and Stiles (2001). The TZPD represents the evolving distance between a client's actual level of functioning and their potential developmental level, which can be progressively achieved through the therapist's help. The model proposes that the client's progression through their problems' TZPD involves a reciprocal process of alignment and mutual engagement, through which therapist and client continually negotiate their interaction within the client's problem TZPD. Therefore, Ribeiro et al. (2013) defined TC as the joint effort of both the therapist and client to work within the client's Therapeutic Zone of Proximal Development (TZPD).

To empirically operationalize the principles of the Therapeutic Collaboration Model, the authors developed the Therapeutic Collaboration Coding System (TCCS; Ribeiro et al., 2013), a microprocess-oriented, transtheoretical tool for examining therapist-client coordination and enabling fine-grained mapping of collaborative and non-collaborative therapeutic exchanges. The TCCS adopts a clinical-interpretative perspective, requiring coders to adopt both dyad members' positions to infer the intentions and experiences underlying the explicit verbal content. Some of the relational microprocesses captured by the TCCS may be imperceptible to participants themselves in real time. For example, the TCCS provides empirical access to subtle interruptions in the therapeutic collaboration and their subsequent reestablishment. In this regard, in a narrative therapy case study using the TCCS, Cardoso et al. (2019) found that a therapist's interventions, such as a formulation of new meaning or the recognition of client agency after a breakdown in collaboration, were decisive in re-establishing collaboration. A recent study by Cardoso et al. (2023) further demonstrated that when therapists inadvertently exceed the client's problem-therapeutic zone of proximal development, specific interventions (e.g., re-attuning to the client's perspective) play a key role in reestablishing collaboration. Moreover, studies of dropout cases using the TCCS (Pinto et al., 2018) showed increasing patterns of non-collaborative or ambivalent therapeutic exchanges, highlighting the instability of the TC in these therapy processes, which is not immediately recognized by therapists. From the TCCS observational perspective, the fine-grained analysis of the therapeutic exchanges offers valuable insights into the therapist's appropriate, responsive interventions and the dyad's negotiation of coordinated actions.

Like other well-documented relational microprocess approaches, such as alliance ruptures and repair analysis (e.g., Safran & Muran, 2000; Eubanks et al., 2019), the TCCS analytic proposal is based on an observational perspective and potentially useful for informing relational-based interventions and therapists' training. The advantages of therapy microprocess observational methods have been noted, as they allow for the analysis of subtle, co-constructed relational dynamics that may go unnoticed by therapist and clients themselves (Elliott, 2010; Timulak & Keogh, 2017). For example, observational coding studies, such as those conducted by Eubanks et al. (2018) and Levy Chajmovic & Tishby (2025), have revealed ruptures and repairs in the alliance that therapists themselves did not identify. In Levy Chajmovic and Tishby (2025) study, this observational perspective was further linked to the perception of therapist responsiveness, underscoring the importance of external codification for capturing microprocesses that are often invisible to the dyad due to immersion in the therapeutic interaction. This line of research aligns with emerging approaches to clinical training that emphasize validated, process-focused markers rather than strictly theoretical models or intervention-specific skills (Westra & Di Bartolomeo, 2024; Westra, et al., in press). Some examples include training programs aimed at enhancing therapeutic alliance skills (Eubanks et al., 2015; Muran et al., 2026), resistance (Westra et al., in press), or relational and contextual responsiveness (Boswell et al., 2024; Wu & Levitt, 2020). Process-informed clinical training incorporates real-time observation and feedback, allowing trainees to monitor and respond to communicational cues during sessions, attune their interventions to momentary variations in the therapeutic context, and to engage in the here-and-now of the dyadic interaction (Boswell et al., 2024; Constantino et al., 2023; Westra & Di Bartolomeo, 2024). Empirical evidence suggests that research-informed training protocols, such as the Alliance-Focused Training and Facilitative Interpersonal Skills, can produce measurable improvements in therapists' interpersonal skills, particularly when they focus on specific relational micro-skills rather than broad therapist competence (Perlman et al., 2020). Apart from some studies on therapeutic alliance, few complement the analysis of the observer's perspective with those

of both elements of the dyad regarding the relational processes. Both approaches have advantages and limitations arising from the subjective, usually retrospective position of the therapy participants and the objective, external position of the observer. Integrating subjective and observational perspectives may yield valuable insights into interpersonal microprocesses in therapy.

The study of clients' subjective experiences and perspectives on therapy has a long history in psychotherapy research (see Timulak & Keogh, 2017, for a review). Early qualitative studies used post-therapy interviews and self-reports to foreground the client as a privileged informant in their own change process (Elliott, 2010). These studies have reported valuable findings regarding the therapy process and what the therapist and client share or do not share with each other. For example, the pioneering work of Rennie (1994) showed that clients tend to avoid criticizing the therapist and show deference when disagreeing with objectives, which, if not perceived by the therapist, can have negative implications for the relational processes and the working alliance between them. A qualitative meta-analysis of the client's experience in therapy (Levitt et al., 2016) showed that relational themes such as care, collaboration, and recognition of differences with the therapist were among the organizing themes of the client's subjective experience. Therefore, studies focused on the client's experience in psychotherapy have shown that some subjective experiences are not shared and may therefore go unnoticed by the therapist, with implications for the therapy process and outcomes. In addition, these studies have supported the relevance of relational and interpersonal processes to the effectiveness of the therapeutic process from the client's perspective (Levitt et al., 2016; Noyce & Simpson, 2018; Timulak & Keogh, 2017). However, understanding the lived experience of psychotherapy is not limited to the client's perspective. Therapists, as both agents of change and relational participants, are also influenced by the therapeutic interaction (Levitt & Piazza-Bonin, 2011). Qualitative studies have shown that the client and therapist do not always agree on which moments are significant in the therapeutic process. When they identify the same significant moment, it is not always for the same reasons, and their subjective experiences of it can differ (Levitt & Piazza-Bonin, 2011). These findings show the complexity of the relational process in psychotherapy and clarify the need to analyze the different perspectives involved. As Levitt & Rennie (2004) suggested two decades ago, it may be difficult to understand clients' and therapists' experiences solely from the discourse shared in session. Studying both perspectives on the therapy process is crucial, as each participant contributes unique insights into in-session interpersonal processes, and examining them provides critical insights into the relational processes that contribute to therapeutic outcomes (Horvath et al., 2011). In our view, adding therapists' and clients' perspectives to the observational perspective used in relational coding systems (e.g., TCCS) can help capture subtle experiences, meanings, and communication signs that are useful for understanding the complexity of the relational process in psychotherapy.

The process-focused clinical training using observational coding systems as real-time instruments to understand the clients' and therapists' interpersonal process may contribute to overcoming limitations related to traditional clinical training (Knox & Hill, 2021) and with the difficulties of directly translating the results of qualitative studies to inform clinical decisions in real time (Levitt & Piazza-Bonin, 2011; Timulak et al., 2017). Therefore, we argue that combining therapists, clients, and observational perspectives to analyze specific collaborative and non-collaborative in-session moments may help strengthen the TCCS's usefulness in clinical training. To the best of our knowledge, no studies to date have examined the formative impact of research training on therapeutic collaboration, nor the use of the Therapeutic Collaboration Coding System (TCCS) as a tool to support clinical skill development (Ribeiro & Pinto, in press). This represents a significant

gap, given the TCCS's potential to make relational microprocesses visible and thus accessible to trainees. In addition, the TCCS observational perspective has never been used alongside the therapist's and client's perspectives. This triangulation of perspectives is crucial for a better understanding of in-session (non)collaborative processes that influence ongoing therapy and outcomes and may also help elaborate the theory and coding procedures behind the TCCS. Therefore, by examining the convergence of both perspectives on therapeutic collaboration, one may highlight the usefulness of the TCCS as a clinical training tool, beyond its use in research.

The present study builds on the TCM (Ribeiro et al., 2013) and the TCCS to explore moments of collaboration and non-collaboration from the perspectives of the client, therapist, and observer, and compares three clinical cases conducted by therapists with varying levels of TCCS coding training and clinical experience. We aimed to analyze the convergence of the three perspectives on identifying collaborative and non-collaborative moments. In addition, we aimed to understand the roles of therapists' TCCS training and clinical experience in influencing awareness and management of collaborative and non-collaborative therapeutic exchanges. Although existing evidence does not conclusively demonstrate that therapists reliably improve their competence through practice and training (Hill et al., 2017), studies on therapist responsiveness suggest that junior therapists demonstrate reduced ability to identify and respond appropriately to client cues compared with more experienced therapists (Wu & Levitt, 2020). More recent reviews focusing on junior therapists indicate that training can increase therapist self-efficacy, yet effects are often modest, inconsistent, and difficult to disentangle from other interrelated factors such as prior experience, personal therapy, or maturation (Knox & Hill, 2021).

Accordingly, this study addressed the following research questions:

1. How do clients and therapists perceive moments of therapeutic collaboration in the first four sessions of therapy?
2. How are the client's experience and the therapist's intention perceived across different perspectives?
3. How are therapists' training in the TCCS and their clinical experience related to the convergence of perspectives on therapeutic collaboration?

Method

Design

This study employed a comparative case study design (Baxter & Jack, 2008), using three clinical cases that differed in the therapist's clinical experience and prior training with the TCCS. Consistent with a *theory-building* approach (Stiles, 2009), the study aimed to deepen theoretical understanding of therapeutic collaboration by examining both collaborative and non-collaborative moments across cases. Data collection focused on the first four sessions of each therapy process, a period recognized as critical for establishing the therapeutic collaboration, alliance, and other relational processes (Kokotovic & Tracey, 1990; Lavik et al., 2018).

Participants

The three therapeutic dyads differed in terms of therapists' clinical experience (junior vs. senior), TCCS training (trained vs. untrained), and clients' diagnoses.

Dyad JT_trained

The client, a young adult, asked for psychological help due to relational difficulties, which negatively impacted his mood and daily functioning. Presenting problems included intense rumination, an intellectualized style of discourse, ambivalence in intimate relationships, and submissive and dependent interpersonal patterns. Rigid beliefs about relationships, dichotomous thinking, positive metacognitions about worry, and a heightened need for control were also identified. Specific therapeutic goals in the first four sessions included reducing cognitive avoidance, acknowledging neglected emotional needs, and enhancing tolerance for uncertainty. The client exhibited subclinical depression and anxiety symptoms.

The therapist, a doctoral student in Psychology, had less than 5 years of clinical experience and had reliable training in TCCS. The intervention followed a cognitive-behavioral approach, with weekly sessions and clinical supervision.

Dyad JT_untrained

The client is a young adult with a prior diagnosis of Autism Spectrum Disorder (Level 1), established during a previous therapeutic process. At the current process, no clinically significant distress associated with the autism diagnosis was reported. He presented subclinical anxiety symptoms and asked for psychological help with current problems related to specific difficulties in academic organization and procrastination. He also expressed concern about excessive video game use, which negatively affected his academic and family life. In the first four sessions, he showed motivation for change and openness to negotiating therapeutic goals focused on emotional regulation, as well as task and time management.

The therapist, who held a master's degree in psychology, had less than 5 years of clinical experience and had not received training in TCCS. The intervention followed a cognitive-behavioral approach, with weekly sessions and clinical supervision.

Dyad ST_untrained

The client, a young adult, asked for psychological support for persistent difficulties in emotional regulation. Although there were no criteria for clinical diagnosis, the client showed relational patterns of dependency on external validation, manifesting a struggle to affirm individuality, sustained by self-criticism, and fear of failure. Although the client demonstrated good insight into their functioning, a gap between cognitive understanding and emotional experience led to avoidance strategies and compulsive behaviors.

The senior therapist, with more than 15 years of experience, adopted an integrative approach combining cognitive-behavioral and emotion-focused therapies and conducted weekly individual sessions. The intervention in the first four sessions focused on promoting emotional awareness, strengthening autonomy and self-compassion, and developing adaptive strategies for emotional regulation.

Coders and Auditor

A doctoral student and a master's student, both members of a Research Team (omitted for blind review), coded the therapeutic collaboration, using the TCCS. The first two authors, who are members of the research team and hold master's degrees in clinical psychology, conducted and analyzed the interviews with therapists and clients. A senior psychotherapy researcher with training in the TCCS and qualitative methodology audited the TCCS coding and the interview content analyses.

Instruments

Therapeutic Collaboration Coding System (TCCS)

The TCCS (Ribeiro et al., 2013) micro-analyzes the therapeutic collaboration at the in-session level, evaluating each pair of therapist and client speaking turns, considering both the immediate and the overall session contexts. The therapist's interventions are coded into macro categories of supporting or challenging the client's perspectives. The former corresponds to interventions aimed at understanding the client's current perspective, either their problematic experience (supporting problem) or change (supporting innovation). The challenging intervention aims to promote the client's movement towards their potential zone of change by introducing new perspectives regarding their problem. These may focus on the client's potential for change (e.g., encouraging the adoption of new behaviors or meanings) or on the therapeutic process itself (e.g., promoting insight). The client's responses are interpreted as indicators of their level of safety or risk regarding the therapist's interventions. The validation response indicates that the intervention occurs within the TZPD, suggesting that the client's experience is attuned to the therapist's proposal, either by confirming, elaborating, or reformulating the usual perspective. Conversely, the invalidation response occurs when the intervention does not fit the client's TZPD, either because it is perceived as excessively demanding (intolerable risk) or irrelevant (lack of interest). Finally, ambivalent responses arise when the client alternates between validating and invalidating in the same response to the therapist's intervention. The TCCS includes several specific markers for therapist interventions and client categories (see Ribeiro et al., 2013, for more details). In this study, we only used the macro categories for therapist interventions and client responses. Empirical studies framed on the TCM and using the TCCS, across theoretical orientations, have demonstrated high interrater reliability ($\kappa = .92$ for therapist interventions; $\kappa = .93$ for client responses; >80% agreement for both).

Therapeutic Collaboration Questionnaire (TCQ)

The Therapeutic Collaboration Questionnaire was developed for the present study to capture participants' experiences of collaborative and non-collaborative moments during psychotherapy sessions. It is a qualitative instrument that invites participants to identify in-session significant moments in terms of their collaborative and non-collaborative properties.

We developed two parallel versions, one for clients and one for therapists. In the client version, participants first described moments in which they felt understood or misunderstood by the therapist. They were then asked to evaluate whether they experienced the moment as collaborative or non-collaborative, and, using structured prompts based on the TCCS, to rate their own experience, specifying whether they felt *'safe'*,

'challenged but prepared to move further', '*challenged and unprepared to accept the therapist intervention'*, or *'not challenged and not interested'*. To further enrich the description, participants were also asked about specific therapeutic interventions used at that moment, filling in a list of possibilities based on the TCCS specifications (e.g., whether the therapist reflected their feelings, offered alternative perspectives, or emphasized changes already achieved).

In the therapist version, participants were asked to report their own subjective experience while also inferring the client's experience at that specific moment. Guided by open-ended questions and structured prompts based on TCCS, they described the therapeutic exchanges, indicating the type of intervention they intended to implement (e.g., '*supporting the client's problem or emerging changes'*, or '*challenging the client's perspective'*), their perception of the client's needs that motivated their intervention (e.g. understand their difficulties), and the perceived client response (e.g., *'safe'*, *'challenged but prepared'*, '*challenged and unprepared'*, or *'not challenged and not interested')*. This structure allows therapists to provide qualitative descriptions of their clinical reasoning and perceptions of the intervention's immediate effects.

In both versions, participants were also asked to indicate the timing of each moment during the session, enabling the interviewer to locate and explore these moments in greater detail during subsequent interviews.

Semi-structured Interview on Moments of Therapeutic Collaboration

We conducted a semi-structured interview, based on the Brief Structured Recall procedure (Elliott & Shapiro, 1988), to explore in depth the moments of therapeutic collaboration identified through the TCQ from both therapist and client perspectives. Supported by video recordings, the interviews were conducted separately for therapists and clients following the first four sessions.

During the therapist's interview, they were invited to clarify their understanding of specific concepts, such as *supporting the problem*, *challenging*, and *supporting emerging changes*, as well as the client responses (e.g., *safe*, *challenged but prepared*, *challenged and unprepared*, or *not challenged and uninterested).* Therapists were also asked to identify the timing of each selected moment in the session. The interview then included questions designed to prompt reflection on their intervention. First, therapists were invited to report the intention of their intervention, using the open-ended question: *"What did you intend to accomplish with this intervention, and how would you classify it— as a challenge, support of the problem, or understanding of emerging changes?"* Second, they described the perceived client's needs that motivated the intervention, allowing assessment of whether the therapist accurately perceived the client's readiness, which could later be compared with the client's report. Third, therapists reported the perceived client's response to the intervention using the questions: *"What reactions did you observe in the client following your intervention? Was the response in line with your expectations for this intervention (e.g., validation, invalidation)?"*

During the client's interview, participants were asked to reflect on the meaning of their responses, such as feeling *safe*, *feeling challenged but prepared*, *feeling challenged but unprepared*, or *feeling neither challenged nor interested*. If no moments of understanding or misunderstanding were identified in some session, participants were asked whether this absence raised any doubts for them. This procedure ensured that the absence of

reported moments was itself considered rather than taken for granted, enabling a deeper understanding of the client's experience.

For reported moments, clients described the specific timing in the session and content that contributed to their sense of being or not being understood through open-ended questions: *"What was the main reason you felt understood during this moment?"; "What the therapist said or did to make you feel understood/misunderstood?".* Clients also evaluated their emotional response to the therapist's intervention using an open-ended question: *"How did you feel in relation to the therapist's intervention?"*, or a structured prompt: "*You said in the questionnaire you felt…* (e.g., *safe), can you elaborate on that?"*

This structured approach provided rich qualitative data on the therapist's intentions,, perception of client needs, and assessment of client responses, while ensuring comparability with observational coding of therapeutic collaboration using the TCCS. Throughout the interview, all participants were encouraged to immerse themselves in their original experience, focusing on thoughts, feelings, and sensations during each selected moment.

In this interview design, data collection was structured to allow cross-referencing within each dyad, enabling participants to reflect on moments identified by them and by the other member of the dyad. To support this, participants were asked to specify the exact start and end times of each moment, facilitating precise analysis and alignment across accounts. This design enabled a comparison between the client's experience and the therapist's perception, providing a foundation for a detailed analysis of the convergences and divergences in their understanding of collaborative and non-collaborative moments.

Procedure

The present study was approved by the Institutional Ethics Committee (omitted for blind review). Prior to the start of the therapeutic process, informed consent to participate in the study was obtained from participants, authorizing data collection and analysis, including audiovisual recording of sessions, completion of questionnaires, and the interviews.

Case selection and data material

The clinical cases were selected from therapy processes initiated at the University clinic in October 2024, according to the following inclusion criteria: a) the main problem should be related to emotional disorders (clinical or subclinical symptoms); b) therapists differing in levels of clinical experience and in TCCS training. Any case with a personality disorder diagnosis was excluded. This study was conducted in the context of two master's thesis. Therefore, the number of clinical cases at the onset of therapy and available to participate in the study, the complexity of data collection, and the real-time data analysis, along with the deadline constraints of master's thesis submission, conditioned the number and type of cases eligible for participation. Additionally, data collection and analysis were based on the first four sessions of each clinical case.

Identification and exploration of moments of therapeutic collaboration

Data were collected concurrently with ongoing therapy. After each session, both members of the dyad completed the TCQ to identify collaborative and non-collaborative moments. Initially, the researchers analyzed the responses to estimate the duration of these moments and their location in the session record. Subsequently, during interviews, each identified moment was accurately delimited with each participant specifying the exact start and end of each moment, using session recordings as a reference. The identified moments were explored in depth through individual interviews. First, the client reflected on their own identified moments. Next, the therapist discussed both their own and the client's identified moments. Finally, in a new interview with the client, they reviewed the moments selected by the therapist. This independent and sequential procedure allows for a detailed, cross-checked perspective. Each participant's interview lasted on average 90 minutes. We analysed a total of 43 moments: 14 from Dyad JT_trained (junior therapist with TCCS training; 5 selected by the client and 9 selected by the therapist), 15 from Dyad JT_untrained (junior therapist without TCCS training; 4 selected by the client and 11 selected by the therapist), and 14 from Dyad ST_untrained (senior therapist without TCCS training; 6 selected by the client and 8 selected by the therapist).

Coding with the TCCS

The total of twelve sessions from the three dyads were fully transcribed and coded using the TCCS. For each session, the pair of TCCS reliable coders jointly defined the client's problem TZPD. The first two sessions of each dyad were coded independently, achieving inter-coder agreement greater than 80% for therapist interventions and client responses. Once this criterion was met, discrepancies were discussed to reach a consensus, and the final coding was reviewed and audited by the senior researcher. The remaining sessions were coded by one of the coders and audited in a similar manner. For each of the 43 identified moments of therapeutic collaboration, while constructing the dataset, we decided to consider the most frequent type of therapeutic exchange, the typical code as a reference of the therapeutic collaboration at the moment, as it represented the most salient therapist's intervention and the client's response in that moment. This systematic approach was adopted due to variability in the number of therapeutic exchanges and codes per moment, to ensure rigor, consistency, and comparability with the broader codes used in the interviews. For example, if the predominant therapist's intervention was *'challenging'* and the subsequent client's response was *'invalidation'*, even when some validations occurred, the code for the moment would be classified as *'challenging-invalidation'*, as it was more frequent.

Interview content analysis

The interviews with each participant were transcribed verbatim. Framed by a postpositivist epistemological approach, the analysis employed systematic content analysis grounded in the main conceptual categories of the TCCS: therapist interventions classified as *supporting the problem*, *supporting emerging changes*, or *challenging*, and client responses classified as *validation* or *invalidation*. Coding was carried out independently by two researchers, achieving an agreement rate above 80%. Any discrepancies were discussed until consensus was reached, and the final coding was audited by a senior researcher.

Analysis of convergence between perspectives

After the interview analysis and session coding using TCCS, we compared the categories attributed to the interview content with the codes assigned by the TCCS coders to the respective moments. A comparative matrix was developed in which each moment was coded according to each perspective (therapist and client

during the interview, and observer using the TCCS). An agreement was considered when both perspectives assigned the same category to the same moment; otherwise, disagreement was registered. This analysis enabled exploration of the levels of convergence and divergence among the client, therapist, and observer.

Three moments were not included in this analysis since it was not possible to reach a definitive categorical decision regarding the therapist's intention during the audit process. Given the theory-building orientation of the present study, these moments were subsequently analyzed in depth, with particular attention to their relevance to the potential methodological refinement of the TCCS.

Comparison across dyads based on therapists' clinical experience and TCCS training

To examine the role of therapist clinical experience and TCCS training on identifying and reflecting on collaborative moments, the three dyads were compared across two intersecting factors: clinical experience (junior vs. senior) and TCCS training (trained vs. untrained). This allowed the study to investigate not only whether agreement among client, therapist, and observer varied with experience, but also whether specific training in process coding influenced the identification of collaborative and non-collaborative moments.

Results

Across the three dyads, a total of 43 moments of therapeutic collaboration were identified (Dyad JT_trained = 14; Dyad JT_untrained = 15; Dyad ST_untrained = 14). Table 1 presents the therapist's intention and client response codes identified across the three dyads at each moment from the therapist's, client's, and independent observer's perspectives.

Table 1

Therapist intentions and client responses across moments of therapeutic (non)collaboration (considering participants and observer perspectives) in the three dyads

Moments	Dyad JT_trained		Dyad JT_untrained		Dyad ST_untrained	
	Th_intention	**Cl_response**	**Th_intention**	**Cl_response**	**Th_intention**	**Cl_response**
	Th / Ob	**Cl /Ob**	**Th / Ob**	**Cl / Ob**	**Th/Ob**	**Cl / Ob**
1	SP / SP	V / V	SP / C	V / V	C / C	V / V
2	SP / SP	V / V	SP / C	V / V	C / SI	V / V
3	SI / SI	V / V	NC / C	V / I	C / C	V / V
4	C / C	A / I	SI / SI	V / V	SP / SP	V / V
5	SI / SI	V / V	SP / SP	V / V	SP / SP	V / V
6	SP / SP	V / V	NC / SP	V / V	C / C	V / V
7	NC / SP	V / V	C / C	V / V	SP / SP	V / V
8	C / SP	V / V	SI / C	V / V	C / C	A / A
9	SI / SI	V / V	SP / C	V / V	SP / SP	V / V
10	SP / SP	V / V	SP / SP	V / V	C / SP	V / V
11	C / C	I / I	C / C	V / V	C / SI	V / V
12	SP / SP	V / V	SI / SP	V / V	C / C	I / I
13	C / SP	A / V	SP / SP	V / V	SI / SI	V / V
14	SI / SI	V / V	C / C	V / V	SI / SI	V / V
15			C / SI	V / A		

Note. Th = therapist perspective; Cl = client perspective; Ob = observer perspective (TCCS coding). SP = Supporting Problem; SI = Supporting Innovation; C = Challenge; NC = Not coded- moments. V = Validation; I = Invalidation; A = Ambivalence.

Therapeutic (non)collaborative moments identified by clients and therapists in the early phase of therapy

Considering the respective participants' perspectives, the therapist's interventions across all identified moments were most frequently categorized as Supporting Problem (SP) or Challenge (C), with Supporting Innovation (SI) occurring less frequently. While both junior therapists, trained and untrained, used more supporting interventions (9 of 14 and 9 of 15 moments, respectively), the senior therapist showed a higher proportion of challenging interventions (8 of 14 moments). From the clients' perspective, most responses were experienced as Validation (V). In Dyad JT_untrained, all client responses were reported as V. In contrast, Dyad JT_trained and Dyad ST_untrained showed a more heterogeneous pattern of client experiences. Dyad

JT_trained included 2 responses of ambivalence and 1 of invalidation, while Dyad ST_untrained included 1 response of ambivalence and 1 response of invalidation.

Alignment between the observer perspective (using the TCCS) and the dyad's perspectives

Client experience: Observer–Client Alignment

Across all three dyads, convergence between client perspectives and observer coding was high (ranging from 85% to 100%; Table 1). Notably, in Dyad ST_untrained, the client showed complete agreement (14/14), indicating that the observer's coding closely reflected the client's subjective experience. An illustrative example of this alignment is presented in Table 2. In this moment, the therapist and client were discussing the client's self-demand in relation to parental expectations. The client reflected on the pressure to always perform at their best and the difficulty of feeling comfortable while meeting these expectations. The therapist highlighted this tension and reinforced the client's emerging self-compassion. The illustration reproduces the exact segment selected by participants.

Table 2

Illustration of client responses and convergence with observer coding during therapist–client interaction [Moment 12 of Dyad ST_untrained]

Dyadic interaction and observer perspective	**Client perspective**
C: "Yes, because now it's no longer the same, I still try to do my best, but now I try to do my best for myself. And I don't…" [V] T: "You're not as demanding as your parents ((laughs))." [SI] C: "I will not torture myself for not being able to do something as well as possible (...) I actually end up doing much better now because I know that failure will not bring that pain of having failed." [V] T: "Why? What makes you think that?" [SI] C: "Because I'm alone now, and I forgive myself (...) I allow myself to fail." [V] T: "That's it! Magic words: 'I forgive myself.'" [SI]	"(...) it was that path in which I was being guided (...) not only did I feel that I was ready, but I also showed it (...) because I managed to get there." **[V]**

Note: V- validation; SI- Supporting innovation

Dyad JT_trained and Dyad JT_untrained showed strong convergence (13 out of 15 and 12 out of 14 moments, respectively). In the first, divergences involved moments where the client experienced *ambivalence*, while the observer coded *invalidation* or *validation*. In the second, divergence emerged in instances where the client reported experiencing *validation*, whereas the observer coded the same exchanges as *ambivalent* or *invalidating*. Table 3 provides a clear example of the discrepancy in dyad JT_untrained, focusing on the client's preparation and experience presenting a dissertation-related task. In this moment, the therapist and client

discussed how the client practiced the presentation, the challenges faced during delivery, and strategies for improvement in future presentations. The illustration reproduces the exact segment selected by participants.

Table 3

Illustration of client responses and divergence from observer coding during therapist–client interaction [Moment 16 of Dyad JT_untrained]

Dyadic interaction and observer perspective	**Client perspective**
T: "Did J. practice the presentation beforehand?" [C] C: "I practiced, 2–3 times, more or less. Of course, I didn't speak very loudly, just a softer voice for myself. But my real problem is speaking in front of other people, in bigger groups." [A]	"I felt understood because he was trying to see if I had practiced, (...) if it was done in the best way or if it could be improved. I felt understood because the therapist showed concern in helping me (...)" **[V]**
Note: according to the TCCS, the "but" in the client's response indicates that he first validates the therapist's proposal, then devalues it, suggesting that the therapist was not understanding his real problem. This response is coded as ambivalence.	

Therapist intention: Observer–Therapist Alignment

Dyad JT_trained and **dyad ST_untrained** showed the highest levels of convergence, with 11 of 13 and 11 of 14 moments aligned, respectively. Table 4 presents an illustrative example of this convergence in Dyad JT_trained. At this moment, the therapist and client were discussing the client's tendency to carefully prepare what to say in social interactions. The therapist explored the function of this preparation and challenged the client to reflect on what it would mean not to be prepared, inviting reflection on the underlying sense of control associated with this behavior. The illustration reproduces the exact segment selected by participants.

Table 4

Illustration of therapist intentions and convergence with observer coding during therapist–client interaction [Moment 4 of Dyad JT_trained]

Dyadic interaction and observer perspective	**Therapist perspective**
T: "What if you're not prepared? I'm already challenging a little, okay?" [C] C: "Exactly, I don't like not being prepared (…)" [I] T: "What does it mean to be unprepared?" [C]	"At this moment, it was… basically I had a formulation hypothesis (…) related to the sense of control. So the idea here was to understand the insight he had regarding that, and to see if it was indeed that (…)" "(…) it is about trying to place the client in a scenario where it is not their first reaction, and to perceive the implications of that, and the function it serves." [**C**]
Note: C: challenging; I: Invalidation	

Regarding misalignment, in **Dyad JT_trained**, discrepancies arose when the therapist perceived an intervention as *supportive* while the observer coded it as *challenging*. In Dyad **ST_untrained**, disagreements reflected subtle differences in how intervention intentions were interpreted, such as the therapist reported a moment as a *challenge* while the observer coded it as *supporting innovation*.

By contrast, **Dyad JT_untrained** showed substantially lower convergence, with agreement on 7 of 13 moments. Divergences similarly clustered around whether an intervention was intended as *support* or a *challenge*. Table 5 illustrates Moment 9, in which the therapist viewed their intervention as supportive while the observer coded it as challenging. This moment occurred during a discussion about the client's management of upcoming academic tasks and involved a sequence of challenging interventions aimed at fostering insight into his preparedness through hypothetical scenarios. The illustration reproduces the exact segment selected by participants.

Table 5

Illustration of divergence between therapist perspective and observer coding during therapist–client interaction [Moment 9 of Dyad JT_untrained]

Dyadic interaction and observer perspective	**Therapist perspective**
T: "How difficult do you think it will be for you to prepare the presentation?" [C] C: "To prepare? To get myself ready for the presentation? ((therapist confirms)) It won't be very difficult. On the day of the presentation, when I'm presenting, then yes, I might have some difficulties because on the day I presented my project I was really nervous, my heart was beating very fast at the time." [V]	"Understanding the problematic perspective, introducing here an expectation that the presentation might go poorly, in a way, and trying to understand what specific difficulties he anticipates encountering." **[SP]**
Note: C: Challenging; V: validation; SP: supporting problem	

Non-categorizable moments

Three moments could not be unequivocally categorized due to overlapping or ambiguous indicators in the therapist's descriptions during the post-session interviews. These moments occurred in the Dyad JT_untrained (Moments 3 and 6) and the Dyad JT_trained (Moment 7), where therapists reported intentions that simultaneously reflected elements of supporting the problem (SP) and challenge (C). Table 6 presents the moment 3 of Dyad JT_untrained. Here, the therapist and client discussed barriers to family interaction. The client described his father working away, his mother's health, his sister's and grandmother's schedules, highlighting limited opportunities for shared activities such as playing cards. The therapist explored what had prevented him from spending more time with his family, inviting him to distance himself from their avoidant strategies and emphasizing the links to desired change. The illustration reproduces the exact segment selected by participants.

Table 6

Illustration of non-categorizable therapist intentions [Moment 3 of Dyad JT_untrained]

Dyadic interaction and observer perspective	Therapist perspective
T: "(...) this relates to the change that you want. Let me ask it this way: what has prevented you so far from spending more time with your family?" [C] C: "(...) Many things happened… playing cards, my dad (…) he works away, comes on holidays. With my mom, not much interest (…) My sister comes every other week (…) sometimes I can play with my grandmother, but we don't live in the same house (…) and my aunt works and has to take care of her." [I]	"It is about questioning the motivation—not only understanding it (**SP**), but also doubting the motivation he is reporting (**C**), understanding in the sense that he might be omitting something (**SP**). Doubting what he is telling me (**C**) while at the same time trying to understand (**SP**) (…) It was not highly challenging; it was still aimed at understanding the client's motivation (**SP**). (…) At the same time, I was challenging this motivation with a degree of suspicion (**C**)."

Note. Indicators of the intervention intentions (SP = Supporting Problem; C = Challenge) are highlighted throughout the therapist's description.

Comparison of observer–dyad alignment by therapist experience and TCCS training

Comparative analyses across the three dyads revealed systematic differences in the degree of convergence between perspectives, suggesting that both clinical experience and TCCS training may influence how collaboration is identified and understood.

When comparing therapists' clinical experience while holding TCCS training constant (i.e., considering only the untrained dyads), the dyad ST_untrained displayed higher levels of agreement with both observer and client perspectives than the Dyad JT_untrained. Therapist–observer perspectives agreement reached 78.6% in the senior dyad versus 53.9% in the junior dyad. Likewise, therapist–client agreement on the client's responses was substantially higher in the senior dyad (92.9%) compared to the junior dyad (66.7%).

When comparing dyads with and without TCCS training, agreement was higher in the trained dyad. Therapist–observer convergence was 83.3% in the dyad where the therapist had TCCS training, versus 53.9% in the other dyad. A similar pattern was found in therapist–client agreement, which was higher in the dyad with TCCS training (85.7%) than in the dyad without TCCS training (66.7%).

Discussion

This study integrates three distinct perspectives (the client, the therapist, and the observer) to analyze therapeutic collaboration in the early phase of psychotherapy. Framed within the Therapeutic Collaboration Model (TCM; Ribeiro et al., 2013) and employing the Therapeutic Collaboration Coding System (TCCS), this study examined how collaborative and non-collaborative exchanges are perceived, experienced, and coded across three clinical dyads that differed in therapist experience and TCCS training. The main findings showed convergence between clients' and observers' perspectives across all dyads, and greater convergence between more experienced or trained therapists' and observers' perspectives.

Observer-Client (dis)agreement: The TCCS as a window into subjective experience

One of the most significant findings was the high convergence between the observer's TCCS coding and the client's subjective experience across all three dyads. In most moments, the way an external coder categorized the client's response (as validation, ambivalence, or invalidation) matched how the client experienced that same moment from within. This finding is theoretically relevant because the TCCS interprets client responses as indicators of whether a therapist intervention occurs within, at the limits of, or outside the client's Therapeutic Zone of Proximal Development (TZPD; Ribeiro et al., 2013). The identified convergence suggests that the conversational markers employed by the TCCS may meaningfully correspond to clients' recalled experiences of safety, tolerable risk, ambivalence, or difficulty engaging with the therapist's proposal. The detailed accounts generated through video-assisted recall further indicate that clients can provide nuanced descriptions of their immediate reactions when invited to return to specific in-session exchanges. This is further supported by the quality of the clients' own accounts. Specifically, in the ST_untrained dyad, the client articulated their experience with self-reflection, describing their own movement from a current to a potential level within the TZPD. This degree of critical awareness, less expected in initial sessions, reinforces the ecological validity of the markers proposed by the TCCS (Krause, 2024). Taken together, these findings reinforce the empirical validation of the TCCS as a measure of the client's moment-to-moment experience regarding the TZPD, a key claim of the model that had not previously been tested through systematic triangulation with client self-report. These findings also resonate with the broader literature on alliance ruptures and repair, which shows that observer-based coding systems can detect relational microprocesses (such as confrontation and withdrawal markers) not always captured by participants' own global ratings (Eubanks et al., 2018).

The patterns of disagreement are, however, equally informative. In the JT_untrained dyad, which involved an autistic client (Autism Spectrum Disorder, Level 1), we found an underestimation of the therapeutic collaboration. The client's reported experience of validation diverged from both the therapist's and observer's perspectives, which had determined the same exchanges as ambivalence or invalidation (e.g., moment 16, Table 3). Several interpretations are possible. One concerns the client's specific communicative profile. Autistic adults may present communication differences involving literal and non-literal language, processing and response time, and nonverbal emotional expression, while the expression and interpretation of these features are highly individualized (Cummins et al., 2020; de Marchena et al., 2025). Such differences may have influenced how the therapist's interventions were perceived. Interventions perceived as less emotionally demanding tend to situate themselves within the client's TZPD, which may help explain the prevalence of validation responses in this dyad. The second concerns therapist factors. Clients have direct access to their own subjective experience, whereas therapists must infer aspects of that experience from what clients communicate within the interaction (Weiste et al., 2016). Therapist and client perceptions of the therapeutic relationship may consequently diverge (Bachelor, 2013). In this case, the general challenge may have been compounded by the therapist's limited experience with neurodivergent communication profiles. Communication styles commonly associated with autism, such as slower response times, atypical nonverbal expression, or differences in the use and interpretation of implicit social cues, may be misinterpreted by clinicians who rely on neurotypical expectations of engagement and emotional expression (de Marchena et

al., 2025). The therapist's relative inexperience may also have contributed to a more cautious interpretation of the interaction, potentially limiting responsiveness to the client's neurodivergent communication style and recognition of collaborative moments (Stiles & Horvath, 2017). The third interpretation concerns the coding system itself. Like many observational systems, the TCCS infers validation or invalidation from conventional conversational markers, such as elaborative responses, explicit affirmations, or the use of contrastive particles (e.g., “but”). Such markers may function differently or be absent in the communicative repertoire of neurodivergent individuals, whose interpersonal style may not map precisely onto the conversational expectations surrounding the system (Cummins et al., 2020). This limitation is theoretically framed by the Double Empathy Problem (Milton, 2012), which proposes that misunderstandings between autistic and non-autistic individuals arise from reciprocal communicative difference rather than from deficits located exclusively within the autistic person. From this perspective, the divergence between this client's subjective experience and the observer's coding may reflect a mismatch between the client's communicative style and the interpretive conventions on which the TCCS was built.

Taken together, these three interpretations underscore the importance of a clinically sensitive, individualized reading of collaborative markers and highlight the limits of any coding system grounded in normative communicative conventions when applied to neurodivergent populations. This finding invites future consideration of adapting the TCCS for neurodivergent populations, potentially through supplementary coding guidelines that account for communicative diversity. Such adaptations would require validation with larger samples of neurodivergent clients.

Observer-Therapist (dis)agreement: training, experience, and relational competence

We found three patterns of (dis)agreement between therapist self-report and external coding of collaboration. The most straightforward pattern was direct (dis)agreement, observed across all three dyads. When the therapist was able to identify the type of intervention delivered and to explain clearly how it had been achieved, agreement or disagreement with the observer became apparent. A more nuanced pattern emerged from a mismatch in congruence between the type of intervention the therapist declared having delivered and their explanation of how it was achieved. This pattern offered some of the richest observations of the study, opening a window onto the therapist’s mastery of relational skills beyond the level of surface (dis)agreement and revealing differing levels of conscious awareness of the therapeutic intervention.. This pattern, although found in all dyads, was most systematic in the ST_untrained. The ST_untrained demonstrated a good understanding of the intended purpose of each intervention, together with a greater capacity to explain it, reflecting an intuitive capacity to calibrate interventions within the TZPD. Even with these processual mismatches, most moments resulted in agreement between perspectives, reflecting the ability to translate intention into practice. Finally, both direct disagreement and mismatch-type disagreement were frequent in the JT_untrained, pointing to difficulty in both forming a clear therapeutic intention and in translating that intention into practice. Notably, the JT_trained dyad reached convergence levels comparable to the ST_untrained dyad despite far more limited clinical experience. This pattern is consistent with the hypothesis that TCCS training could partially promote the relational attunement that clinical experience typically develops only over years of practice, although this hypothesis requires replication with larger samples.

Taken together, the findings support the view that being able to reflect explicitly on one's therapeutic intentions constitutes the ongoing process of self-monitoring, enabling therapists to continuously evaluate whether their interventions remain aligned with the client's evolving therapeutic needs and to adjust their therapeutic interventions accordingly (Bennett-Levy, 2006; Stiles & Horvath, 2017). From this perspective, therapist intentionality should not be understood as a purely theoretical construct but as a potential mechanism that supports therapist responsiveness (Esposito et al., 2024; Hatcher, 2015; Stiles et al., 1998). This proposal resonates with evidence that process-focused, interpersonally oriented training enhances therapists' sensitivity to clients' subjective experience of the therapeutic relationship (Tasca et al., 2023; Wu & Levitt, 2020). In this line, the present study's findings could offer preliminary empirical support for using TCCS as a clinical training tool, promoting therapist responsiveness through an improved awareness of the relational meaning and appropriateness of their interventions (Ribeiro & Pinto, in press).

Non-categorizable moments as theory-building opportunities

An unexpected contribution of this study is the systematic analysis of non-categorizable moments, that is, instances where it was not possible to reliably categorize the therapist's intention, as reported in the interview. Notably, all three identified non-categorizable instances were observed exclusively among junior therapists. Different possibilities may explain this finding. First, it may reflect a difficulty in therapists' self-observation of their own therapeutic intentions. Alternatively, it may result from the absence of a clear purpose or from insufficiently defined implementation of it, a phenomenon documented in inexperienced therapists, for whom the multiple simultaneous demands of the therapeutic situation (listening, reflecting, confronting) can produce cognitive overload, compromising the clarity of purpose and, consequently, the effectiveness of interventions (Rønnestad & Skovholt, 2013).

Within a theory-building framework (Stiles, 2009), these moments reveal something theoretically significant about therapeutic collaboration. First, they may reflect a genuine hybridity of therapeutic action, where interventions could simultaneously validate the client's current perspective while gently probing its limits, thereby inhabiting both poles of the support–challenge continuum and representing an optimal therapeutic stance. Second, they may indicate a transitional phase in the therapist's intentional stance, in which competing therapeutic aims are being actively negotiated without yet settling on a clear direction.

These results point to a possible limitation of the TCCS, which assumes that the therapist holds a clear and unique intention for each intervention. A potential elaboration of the model, based on these findings, could involve introducing a supplementary category for ambivalent interventions, acknowledging the legitimacy of dual-intention moments. Future research could examine the presence and evolution of this intentional complexity through the therapist's training. Such developments could improve the TCCS's sensitivity to relational complexity and strengthen its ecological validity, thereby favoring its use in both research and clinical supervision.

Implications for clinical training and supervision

These study findings have potential implications for psychotherapy training and supervision. The process-oriented training and supervision using the TCCS may offer a complementary framework for attending to how

therapists' interventions act within moment-to-moment therapeutic exchanges and to the client's readiness to engage. The convergence of perspectives is consistent with the possibility that structured process coding may help beginning therapists develop process awareness and aligns with the growing emphasis on process coding as a means of developing psychotherapy expertise through feedback on therapists' actions and their immediate effects (Westra & Di Bartolomeo, 2024). Consistent attention to such moment-to-moment processes may help trainees develop a more differentiated understanding of their interventions and collaboration actions (Ribeiro & Pinto, in press; Westra & Di Bartolomeo, 2024). These considerations may be particularly relevant when working with clients whose communicative styles differ from therapists' expectations, for whom collaboration and engagement may not always be expressed through conventional linguistic or affective markers.

Limitations and future directions

While this study provides valuable insights, several limitations must be acknowledged. First, the study included only three dyads, with one therapist representing each combination of experience and TCCS training examined. Therapist experience and training were therefore confounded with individual therapist, client, therapeutic orientation, and case characteristics, and the absence of a senior therapist trained in the TCCS further limits the comparative design. Larger samples are needed to determine whether the observed patterns generalize across therapists and conditions. Second, all clients were young adult men, and the cases, while sharing a broad focus on emotion regulation, differed in their diagnoses. This limits generalisability across client populations and clinical contexts. Future studies should include more diverse clients, therapeutic orientations, and treatment settings. In addition, clients and therapists retrospectively reviewed selected moments using session recordings. Although video-assisted recall may support detailed recollection, retrospective accounts remain susceptible to reconstruction and interviewer influence, while participant selection may have favored particularly salient episodes. Future studies could combine participant-selected moments with independently or randomly sampled exchanges and include open-ended qualitative approaches alongside TCCS-informed interviews.

Finally, the analysis was restricted to the first four sessions and considered each selected moment by its predominant TCCS code. This may have obscured changes in collaboration within individual episodes and may not capture how convergence develops over the course of treatment. Longitudinal and sequential analyses could examine how collaboration is maintained, disrupted, and restored over time. Importantly, greater convergence should not be equated with therapeutic effectiveness as agreement may reflect shared understanding without necessarily indicating better treatment. Future research should therefore examine convergence alongside alliance, client experience, and clinical outcomes, while also distinguishing whether TCCS training improves knowledge of coding categories, recognition of relational processes, or the enactment of responsive interventions.

Declarations

Author Contribution

S.I. and S.R.: Conception of the study. Methodology, Data analysis, Writing the original draft of the manuscript text, Writing and revision & editingE.R.: Conception of the study. Methodology, Data analysis, Supervision of

the study, Writing and revision & editing.V.S.: Methodology, Data analysis.All authors reviewed the manuscript

Acknowledgement

This work was conducted at CIPsi, School of Psychology, University of Minho, supported by the Portuguese Foundation for Science and Technology (FCT; UID/01662: Centro de Investigação em Psicologia) through national funds.

References

1. Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences and relationship to therapy outcome. *Clinical psychology & psychotherapy*, *20*(2), 118–135. https://doi.org/10.1002/cpp.792
2. Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, *13*(4), 544–559. https://doi.org/10.46743/2160-3715/2008.1573
3. Bennett-Levy, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, *34*(1), 57–78. https://doi.org/10.1017/S1352465805002420
4. Boswell, J. F., Constantino, M. J., Gaines, A. N., & Smith, A. E. (2024). Responding to Key Process Markers as a Focus of Psychotherapy Training and Practice. *Clinical psychology in Europe*, *6*(Spec Issue), e11967. https://doi.org/10.32872/cpe.11967
5. Cardoso, C., Ferreira, Â., Pinto, D., & Ribeiro, E. (2023). Therapist's interventions immediately after exceeding the client's therapeutic zone of proximal development: A comparative case study. *Psychotherapy Research*, *33*(1), 70–83. https://doi.org/10.1080/10503307.2022.2153093
6. Cardoso, P., Savickas, M. L., & Gonçalves, M. M. (2019). Innovative moments in career construction counseling: Proposal for an integrative model. *Career Development Quarterly*, *67*(3), 188–204. https://doi.org/10.1002/cdq.12190
7. Constantino, M. J., Coyne, A. E., Boswell, J. F., Goldfried, M. R., & Castonguay, L. G. (2023). Training on context-responsive psychotherapy integration: An evidence-informed framework. In L. G. Castonguay, & C. E. Hill (Eds.), *Becoming better psychotherapists: Advancing training and supervision* (pp. 85–105). American Psychological Association. https://doi.org/10.1037/0000364-005
8. Cummins, C., Pellicano, E., & Crane, L. (2020). Autistic adults' views of their communication skills and needs. *International Journal of Language and Communication Disorders*, *55*(5), 678–689. https://doi.org/10.1111/1460-6984.12552
9. de Marchena, A., Cuneo, N., Gurbuz, E., Brown, M., Trujillo, J., & Bergstrom, J. (2025). Communication in autistic adults: An action-focused review. *Current psychiatry reports*, *27*(8), 471–481. https://doi.org/10.1007/s11920-025-01616-6
10. Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research*, *20*(2), 123–135. https://doi.org/10.1080/10503300903470743

11. Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant therapy. *British Journal of Medical Psychology*, *61*(2), 141–153. https://doi.org/10.1111/j.2044-8341.1988.tb02773.x
12. Esposito, G., Cuomo, F., Di Maro, A., & Passeggia, R. (2024). The assessment of therapist responsiveness in psychotherapy research: A systematic review. *Research in Psychotherapy: Psychopathology Process and Outcome*, *27*(1), 751. https://doi.org/10.4081/ripppo.2024.751
13. Eubanks, C., Muran, J. C., & Safran, J. D. (2015). Alliance-focused training. *Psychotherapy*, *52*(2), 169–173. https://doi.org/10.1037/a0037596
14. Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy*, *55*(4), 508–519. https://doi.org/10.1037/pst0000185
15. Eubanks, C. F., Muran, J. C., & Safran, J. D. (2019). The rupture and resolution rating system (3RS): Coding manual. *Psychotherapy Research*, *29*(1), 1–13. https://doi.org/10.1080/10503307.2017.1309555
16. Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative Therapy and the Nature Of Innovative Moments in the Construction of Change. *Journal of Constructivist Psychology*, *22*(1), 1–23. https://doi.org/10.1080/10720530802500748
17. Hatcher, R. (1999). Therapists' Views of Treatment Alliance and Collaboration in Therapy. *Psychotherapy Research*, *9*(4), 405–423. https://doi.org/10.1080/10503309912331332831
18. Hatcher, R. L. (2015). Interpersonal competencies: Responsiveness, technique, and training in psychotherapy. *American Psychologist*, *70*(8), 747–757. https://doi.org/10.1037/a0039803
19. Hill, C. E., Spiegel, S. B., Hoffman, M. A., Kivlighan, D. M., & Gelso, C. J. (2017). Therapist expertise in psychotherapy revisited. *The Counseling Psychologist*, *45*(1), 7–53. https://doi.org/10.1177/0011000016641192
20. Horvath, A. O., Re, D., Flückiger, A. C., C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, *48*(1), 9–16. https://doi.org/10.1037/a0022186
21. Knox, S., & Hill, C. E. (2021). Training and supervision in psychotherapy: What we know and what we need to know. In M. Barkham, W. Lutz, & L. G. Castonguay (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change*(50th anniversary ed, pp. 327–349). Wiley.
22. Kokotovic, A. M., & Tracey, T. J. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology*, *37*(1), 16–21. https://doi.org/10.1037/0022-0167.37.1.16
23. Krause, M. (2024). Lessons from ten years of psychotherapy process research. *Psychotherapy research*, *34*(3), 261–275. https://doi.org/10.1080/10503307.2023.2200151
24. Lavik, K. O., Frøysa, H., Brattebø, K. F., McLeod, J., & Moltu, C. (2018). The first sessions of psychotherapy: A qualitative meta-analysis of alliance formation processes. *Journal of Psychotherapy Integration*, *28*(3), 348–366. https://doi.org/10.1037/int0000101
25. Leiman, M., & Stiles, W. B. (2001). Dialogical Sequence Analysis and the Zone of Proximal Development as Conceptual Enhancements to the Assimilation Model: The Case of Jan Revisited. *Psychotherapy Research*, *11*(3), 311–330. https://doi.org/10.1080/713663986
26. Levitt, H. M., & Piazza-Bonin, E. (2011). Therapists' and clients' significant experiences underlying psychotherapy discourse. *Psychotherapy Research*, *21*(1), 70–85.

https://doi.org/10.1080/10503307.2010.518634

27. Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin*, *142*(8), 801–830. https://doi.org/10.1037/bul0000057
28. Levitt, H. M., & Rennie, D. L. (2004). Narrative Activity: Clients' and Therapists' Intentions in the Process of Narration. In L. E. Angus, & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 299–313). Sage Publications, Inc. https://doi.org/10.4135/9781412973496.d23
29. Levy Chajmovic, M., & Tishby, O. (2025). Therapists' responsiveness in the process of ruptures and resolution: Are patients and therapists on the same page? *Psychotherapy Research*, *35*(1), 4253. https://doi.org/10.1080/10503307.2024.2303318
30. Milton, D. E. M. (2012). On the ontological status of autism: The 'double empathy problem'. *Disability & Society*, *27*(6), 883–887. https://doi.org/10.1080/09687599.2012.710008
31. Muran, J. C., Eubanks, C. F., Samstag, L. W., & Macdonald, J. (2026). *Alliance-focused training: An evidence-based guide to negotiating ruptures in therapy*. American Psychological Association. https://doi.org/10.1037/0000473-000
32. Noyce, R., & Simpson, J. (2018). The experience of forming a therapeutic relationship from the client's perspective: A metasynthesis. *Psychotherapy Research*, *28*(2), 281–296. https://doi.org/10.1080/10503307.2016.1208373
33. Pinto, D., Sousa, I., Pinheiro, A., Freitas, A. C., & Ribeiro, E. (2018). The therapeutic collaboration in dropout cases of narrative therapy: An exploratory study. *Revista de Psicoterapia*, *29*(110), 167–184. https://doi.org/10.33898/rdp.v29i110.209
34. Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology*, *41*(4), 427–437. https://doi.org/10.1037/0022-0167.41.4.427
35. Ribeiro, E., & Pinto, D. (2026). Therapeutic Collaboration Coding System (TCCS). In H. Westra, E. Catherine, & T. Boritz (Eds.), *Developing Process Sensitivity: A Transtheoretical Path to Improving Psychotherapy Training and Clinical Outcomes*. APA.
36. Ribeiro, E., Ribeiro, A. P., Gonçalves, M. M., Horvath, A. O., & Stiles, W. B. (2013). How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system. *Psychology and Psychotherapy: Theory Research and Practice*, *86*(3), 294–314. https://doi.org/10.1111/j.2044-8341.2012.02066.x
37. Rønnestad, M. H., & Skovholt, T. M. (2013). *The developing practitioner: Growth and stagnation of therapists and counselors*. Routledge.
38. Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. Guilford Press.
39. Stiles, W. B. (2009). Logical operations in theory-building case studies. *Pragmatic case studies in psychotherapy*, *5*(3), 9–22. https://doi.org/10.14713/pcsp.v5i3.973
40. Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research*, *21*(4), 367–384. https://doi.org/10.1080/10503307.2011.582186

41. Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*, *5*(4), 439–458. https://doi.org/10.1111/j.1468-2850.1998.tb00166.x
42. Stiles, W. B., & Horvath, A. O. (2017). Appropriate responsiveness as a contribution to therapist effects. In C. E. Hill & L. G. Castonguay (Eds.), *How and why are some therapists better than others? Understanding therapist effects*(pp. 71–84). American Psychological Association. https://doi.org/10.1037/0000034-005
43. Tasca, G. A., Ravitz, P., Hunter, J., Chyurlia, L., Baker, S., Balfour, L., McQuaid, N., Pain, C., Compare, A., Brugnera, A., & Leszcz, M. (2023). Training community-based psychotherapists to maintain a therapeutic alliance: A psychotherapy practice research network study. *Psychotherapy*, *60*(1), 98–109. https://doi.org/10.1037/pst0000466
44. Timulak, L., & Keogh, D. (2017). The client's perspective on (experiences of) psychotherapy: A practice friendly review. *Journal of Clinical Psychology*, *73*(11), 1556–1567. https://doi.org/10.1002/jclp.22532
45. Vygotsky, L. (1978). *Mind in Society: the development of higher psychological processes*. Harvard University Press.
46. Weiste, E., Voutilainen, L., & Peräkylä, A. (2016). Epistemic asymmetries in psychotherapy interaction: Therapists' practices for displaying access to clients' inner experiences. *Sociology of Health & Illness*, *38*(4), 645–661. https://doi.org/10.1111/1467-9566.12384
47. Westra, H. A., & Di Bartolomeo, A. A. (2024). Developing expertise in psychotherapy: The case for process coding as clinical training. *American Psychologist*, *79*(2), 163–174. https://doi.org/10.1037/amp0001139
48. Westra, H. A., Eubanks, C. F., & Boritz, T. Z. (Eds.). (in press). *Developing Process Sensitivity: A Transtheoretical Path to Improving Psychotherapy Training and Clinical Outcomes*, United States: APA.
49. White, M. (2006). Externalizing conversations revisited. In A. Morgan & M. White, Narrative therapy with children and their families (pp. 2–56). Dulwich Centre Publications. https://dulwichcentre.com.au/wp-content/uploads/2022/04/Narrative-practice-with-families-with-children-Externalising-conversations-revisted-by-Michael-White.pdf
50. Wu, M. B., & Levitt, H. M. (2020). A qualitative meta-analytic review of the therapist responsiveness literature: Guidelines for practice and training. *Journal of Contemporary Psychotherapy*, *50*(3), 161–175. https://doi.org/10.1007/s10879-020-09450-y