THERAPEUTIC ALLIANCE FACTORS IN A SAMPLE OF DEPRESSED LATINOS RECEIVING BRIEF MOTIVATIONAL INTERVIEWING

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ABSTRACT

Latinos underutilize mental health services due to such disadvantages as language barriers, low income, and legal status. Successful ways to increase treatment engagement, retention, and effectiveness with this population are urgently needed. In line with this need, the present research project studied one factor with empirically based potential for enhancing treatment effectiveness with Latinos, namely, the therapeutic alliance as conceptualized by Bordin (1979) and by Horvath and Greenberg (1989). The presence of emotional bonds and clear and agreed upon goals and tasks between client and therapist was examined. This study focused on a convenience sample of low SES, Spanish-speaking Latinos (eight women and two men) with major depressive diagnoses. As part of a larger study, participants received two Motivational Interviewing (MI) sessions designed to increase adherence with anti-depressant medication and lower depression, as measured by the Beck Depression Inventory-II, Spanish Record Form (BDI-II). The first aim of the present study was to evaluate the MI sessions to determine if the Working Alliance Inventory Observer (WAI-O) form adapted by Tichenor and Hill (1989) from Horvath and Greenberg's (1989) measure of strength of alliance (WAI) predicted subsequent degree of improvement in medication adherence and the BDI-II. The second aim was to qualitatively analyze MI session transcripts using a grounded theory approach to identify specific qualitative categories of client-therapist interaction that describe the particular meanings of the WAI-O ratings. The quantitative results revealed moderate positive correlations of .455 and .467, respectively, between WAI-O and the two main outcome measures, both significant at the one-sided, .10 level. The qualitative results yielded three major areas of bonding—such as "acceptance" and "enhancing
confidence”—which in turn were divided into eight discreet therapist behaviors, including displays of affirmation, interest, and respect to help the client feel cared for, understood, and validated, as well as one client behavior of expressing belief that the therapist could help. Findings in the goals and tasks domains are also presented. Finally, the overall results are discussed in terms of promoting the tailoring of the therapeutic alliance to the mental health needs and life contexts of disadvantaged, depressed, Spanish-speaking Latinos.
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CHAPTER I

INTRODUCTION

Statement of the Problem

In the year 2000, the U.S. Census Bureau reported that 13% of the total US population (more than 35.3 million) was made up of Latinos.¹ Today, Latinos make up the largest ethnic minority population in the United States, with an estimated size of 44.3 million people in 2006 (U.S. Census Bureau website). However, these are not exact numbers since many Latinos are not counted in the Census due to undocumented status (Antshel, 2002; Sullivan & Rehm, 2005). According to the Department of Homeland Security (2009), there were approximately 11 million undocumented immigrants in this country in 2005. Most of these immigrants were of Latino backgrounds, with an estimated 57% originating in Mexico.

As a group, Latinos are vulnerable to poor physical and psychological health due to various factors, including immigrant status (i.e., documented or undocumented), language barriers, lack of insurance, and poverty (Brown et al., 2000; Marshall et al.,

¹ The term "Latinos" is being used to describe people from Spanish speaking countries in the Caribbean and in North, Central, and South America. It is a more culturally neutral term since it involves a wider array of people and is more recognized by native Spanish speakers. The term "Hispanic" is not being used because it was coined by the US Census Bureau in 1970 to classify Spanish speaking people and is more Eurocentric in nature (Falicov, 1998).
2005; Sullivan & Rehm, 2005). The World Health Organization (WHO) reported that in the year 2000, depression was the leading cause of disability worldwide, affecting people from all backgrounds, ages, and genders. Cabassa and Zayas (2007) reported that 41% of the 95 Latino immigrants they sampled identified with a vignette depicting an individual with major depression, which suggests that this is a common experience for this group. According to Hough, Landsverk, and Kano (1987), Latinos are at risk for experiencing depressive episodes in their lifetimes but are half as likely to receive treatment as their non-Latino White counterparts. They compared responses by Mexican-Americans residing in Los Angeles to the Epidemiologic Catchment Area (ECA) survey with non-Latino White responses to ECA surveys in New Haven, Connecticut, Baltimore, and St. Louis and found that Mexican-Americans diagnosed with a mental health disorder in the last six months used mental health services 11% of the time, whereas non-Latino Whites used these services 22% of the time.

Brown and colleagues (2000) reported that Latinos have the highest uninsured rates in the nation, with nearly 37% living without health insurance, compared with about 16% of the overall population (Center on Budget and Policy Priorities, 2010). They also reported that Latino non-citizens have even lower rates of insurance coverage, with 58% being uninsured. In their study of 197 documented and undocumented Latino women, Marshall et al. (2005) found that health insurance coverage was extremely low in this sample, who were mostly Spanish speaking (80.3% of the total sample did not speak English). Very low levels of public assistance use was reported by participants, with only two women reporting Medicaid as insurance and none reporting the use of emergency services. These findings appear to be consistent with the U.S. Census Bureau Current
Population Survey (2005), which reported that 31.8% of Latinos in this country did not have health insurance.

Latinos experience mental health service disparities due to insufficient bilingual providers, lack of health insurance, and unavailability of services (Aguilar-Gaxiola, Zelezny, Garcia, Edmonson, & Alejo-Garcia, 2002; Brown et al., 2000; Lagomasino et al., 2005). Research has highlighted a number of factors that seem to contribute to these disparities. The 2003 U.S. Census brief on language use and language speaking ability reported that Spanish was the non-English language most spoken at home in the year 2000. It also reported that 14.3 million Latinos, or 50%, spoke English “very well” (p. 2) and approximately 8 million, or roughly 30%, spoke English “not well” or “not well at all” that year (p.2). Lack of English language proficiency results in limited communication with providers and poor understanding of information related to diagnosis, treatment, and medication since this information is typically given in English (Antshel, 2002).

Presently, Latinos have low retention rates and are thus considered to be challenging to treat (Antshel, 2002; Interian & Diaz-Martinez, 2007; La Roche, 2002). It is possible that poor quality of care and barriers to entering and staying in treatment are some of the reasons why Latinos do not remain involved in mental health services. What is clear is that Latino mental health needs improvement, which includes finding effective ways to increase their treatment retention.

Goals of This Study

In sum, Latinos underutilize mental health services due to such disadvantages as language barriers, low income, and legal status. Successful ways to increase treatment
engagement, retention, and effectiveness with this population are urgently needed. In line
with this need, the present research project studied one factor with empirically based
potential for enhancing treatment effectiveness with Latinos, namely, the therapeutic or
"working" alliance as conceptualized by Bordin (1979) and by Horvath and Greenberg
(1989). The instrument employed to measure the working alliance was the Working
Alliance Inventory (WAI) developed by Horvath and Greenberg (1989), as adapted to an
observer rating form by Tichenor and Hill (1989)—called the "Working Alliance
Inventory, Observer" (WAI-O) instrument. The WAI-O yields a total score and three
subscale scores: the presence of emotional bonds and clear and agreed upon goals and
tasks between client and therapist. The three subscales are based on a pantheoretical
model of the working alliance theory originally developed by Bordin (1979).

This study focused on a convenience sample of low SES, Spanish-speaking
Latinos (eight women and two men) with major depressive diagnoses. As part of a larger
study, participants were receiving two Motivational Interviewing (MI) sessions that were
designed to increase adherence with anti-depressant medication and lower depression, as
measured by the Beck Depression Inventory-II, Spanish Record Form (BDI-II; Beck,

In line with the above, there were two specific aims in my study. The first was to
evaluate the MI sessions to determine if the WAI-O predicted subsequent degree of
improvement in medication adherence and in depression, as measured by the BDI-II. The
second aim, within the framework of the "bonds-goals-tasks" view of alliance, was to
qualitatively analyze the MI session transcripts using the ATLAS.ti software program and
a grounded theory approach (Corbin & Strauss, 2008) to identify specific qualitative
categories of client-therapist interaction that zoom in on and spell out the particular meanings of the WAI-O ratings for a disadvantaged and depressed Latino population.

The next chapter reviews more details from the research and scholarly literature that underlies this dissertation. Included are reviews of the literature on Latinos and mental health, the working alliance and its theoretical context, and motivational interviewing.
CHAPTER II

LITERATURE REVIEW

Latinos and Mental Health

Less than one out of 11 Latinos with mental health conditions seek mental health services, and less than one out of five seek services from general health care providers (DHHS, 2001). These numbers are greater among Latino immigrants, with less than 1 out of 20 seeking services from mental health providers, and less than 1 out of 10 seeking services from a general doctor (DHHS, 2001, p. 142). It has been hypothesized that this low representation in use of services may result from Latinos seeking care in moments of crisis and terminating services when the stressor subsides (Antshel, 2002). This manner of using services is usually viewed as resistant and uncommitted by providers, but it may simply be the result of inability to pay additional services and legal status questions leading to a lack of trust (Antshel, 2002; Sullivan & Rehm, 2005).

Access and quality of care are factors believed to affect the treatment and retention of Latinos (Lagomasino et al., 2005; Vega et al., 2007). Bernal and Scharron-del-Rio (2001) assert that ethnic minorities have been found to receive poorer quality health care when they seek it. They explain that “minorities cannot afford to ‘choose’ their treatment” (p. 332) due to their economic and minority status. They argue that
attempts to generalize treatments normed on the majority population, usually “White, female, educated, and from the middle and upper middle class”, to ethnic minorities reduces the quality of care (p. 332). Similarly, La Roche (2002) reports that most psychotherapies have been developed for White patients and do not take cultural differences into consideration.

In their study of the quality of care for depression and anxiety disorders in the U.S., Young and colleagues (2001) reported that provision of “appropriate care was strongly influenced by demographic factors” (p. 58) and that approximately 24% of Latinos receive appropriate care as compared to 34% of Whites. Most psychotherapeutic treatments overlook cultural differences and have been designed for a non-Latino White population (La Roche, 2002). Hwang (2006) argues for the need to adapt empirically supported treatments (EST’s) to ethnic minority populations because of the lack of information about the efficacy of these treatments with people from diverse backgrounds and because “there is no uniform methodology or framework for adapting or modifying treatment interventions” (p.704) for these groups.

Recently, Lagomasino et al. (2005) asserted that “Latinos are less likely than whites to be given a diagnosis of depression and to receive depression care” (p.1517). In a sample of 398 Latino patients and 777 White patients receiving treatment in 46 managed care settings, they found Latinos to be less than half as likely to receive depression treatment even when socio-demographic and clinical differences were controlled for.
Keeping Latinos Involved in Treatment

Sensitivity to culture and cultural differences in therapy is considered a way to promote ethnic minority involvement in treatment (APA, 1993; Bernal & Scharroon-del-Rio, 2001; La Roche, 2002; Sue, 1998). APA (1993) guidelines for working with people from diverse backgrounds include: recognizing diversity, understanding and respecting the role of culture (including family, religion, spirituality, and language factors), and understanding the impact of socioeconomic and political factors (including poverty, prejudice, racism, oppression, and sexism). This means that individuals from diverse backgrounds should receive treatment from someone who is knowledgeable about their cultural norms, including language, and who is sensitive to their experiences in this country. Sue (1998) has written about three characteristics of culturally competent providers, which include scientific mindedness (avoiding making premature conclusions about clients of a different culture by developing and testing hypotheses based on information); dynamic-sizing skills (knowing when to generalize and when to individualize); and culture-specific expertise (understanding one’s own culture as well as the client’s).

Interian and Diaz-Martinez (2007) sought to adapt cognitive behavior therapy (CBT) interventions to make them more culturally competent for treating Latinos with depression. They provided treatment to a group of depressed Latinos using the criteria outlined by Rogler and colleagues (1987), which includes providing ease of access, selecting interventions that fit the culture, and adapting treatment to the culture. Ethnocultural assessments, assertive statements, and a focus on cultural expressions of language (e.g., “dichos” or sayings) were used to administer CBT in a way that made
sense to the client. They recommend using Persons (1989) CBT case formulation model with this population to address underlying core beliefs that contribute to their presenting problems. Similarly, Hwang (2006) developed the psychotherapy adaptation and modification framework (PAMF) to make EST’s more culturally congruent to ethnic minorities. PAMF involves six therapeutic domains and 25 principles to adapt treatments. The domains enhance cultural sensitivity and include dynamic issues, orienting clients to therapy and promoting awareness of mental health issues, understanding cultural beliefs about mental health, improving the client-therapist relationship, understanding cultural differences in the expression of distress, and addressing cultural-specific issues to the population (Hwang, 2006, p. 706).

*Latinos and the Therapeutic Alliance*

The therapeutic alliance, or the working relationship between client and therapist, is considered to be critical to psychotherapeutic treatment and outcome (Bordin, 1994, 1979; Hatcher & Gillaspy, 2006; Horvath, 2005; Horvath & Greenberg, 1989; Horvath & Luborsky, 1993; Roth & Fonagy, 1996). According to Roth and Fonagy (1996), the therapeutic alliance has been widely studied in the last twenty years, with more than 100 published research reports on this topic. The authors describe the importance of establishing a good working relationship since it has been found to make a positive treatment contribution. They describe research that demonstrate the robust relationship between alliance, including Horvath and Symonds (1991) meta-analysis, which showed an average effect size of .26 linking alliance to outcome. Roth and Fonagy (1996) conclude that “available evidence indicates that the alliance-outcome relationship is more than a self-fulfilling prophecy” (p. 352).
Bergin and Garfield (1994) reach similar conclusions about alliance and treatment outcomes, stating that “evidence on the alliance strengthens the view that outcome can be predicted from early ratings of the therapeutic relationship” (p. 165). They describe the quality of the working alliance as stable overtime and predictive of outcomes throughout various forms of treatment. They report that a “direct association” (p. 484) has been found between the strength of the alliance and outcomes in short and long term individual treatment.

Based on this literature, enhancing the relationship between client and therapist would seem an effective way to promote Latinos’ involvement in mental health care. In an effectiveness study of psychotherapy with 79 Puerto Ricans experiencing problems with depression, anxiety, and anger, Bernal et al. (1998) found that 45% of the variance in effectiveness was related to the therapeutic alliance, indicating that alliance was a key component for predicting successful outcomes in this sample. Most of the participants (90.6%) reported experiencing a great deal of discomfort at the onset of therapy and, at the end of treatment, more than half (66.7%) reported experiencing improvement in the presenting problem. The authors found that symptom severity, participant age, number of sessions, and therapeutic alliance were related to treatment effectiveness, with alliance having highest correlation coefficients (r = .73). In a separate study, Paris et al. (2005) examined the working alliance and treatment satisfaction in 103 Latina women receiving treatment from culturally and linguistically competent providers. Participants reported strong therapeutic alliances and high levels of satisfaction with the treatment. In addition, less acculturated Latinas preferred to interact with someone similar to themselves in language, values, and characteristics (Paris et al., 2005). These findings suggest that
Latinos who feel stronger connections to their providers are more involved in their treatment and derive greater benefits from it.

There is a dearth of empirical research seeking to understand the experiences of people of Latino background in psychotherapy (Bernal et al., 1998; Bernal & Scharron-del-Rio, 2001; Guarnaccia et al., 1990; Vega et al., 2007). Although a great deal of attention has been given to the working alliance, the information on this relationship and ethnic minority populations is very limited (Bernal et al., 1998; Paris et al., 2005). The work by Bernal et al. (1998) and Paris et al. (2005) establishes that the therapeutic alliance is an important factor in the treatment outcome of Latinos and is therefore worthy of additional study. The results suggest that enhancing the client-therapist relationship among Latinos may improve treatment engagement and retention.

The Concept of the Therapeutic Alliance

The concept of the therapeutic alliance originated with the work of Freud (Gelso & Hayes, 1998). The interpretation of transference, or the patient’s projections of fantasies, wishes, and features of prior relationships onto the analyst, was the focus of his work. Freud wrote about positive transference as being part of the patient’s attachment to the analyst through which the patient associates past interpersonal experiences of affection with the analyst (Gelso & Hayes, 1998). He believed these “friendly and affectionate aspects of the analysand’s transference” (Gelso & Hayes, 1998, p. 25) to be essential for successful treatment and viewed them as distortions of reality, which allowed the affection that was displaced onto the analyst making it possible to accept the interpretations. Freud later concluded that this positive transference was a useful patient-therapist attachment that is grounded in reality because the patient’s positive ego was
capable of forming a true bond with the analyst’s rational ego (Gelso & Hayes, 1998). Since he viewed this manner of therapeutic interaction as free of neurotic projections from the patient, interpreting them was no longer necessary.

In the 1950s, Zetzel (2003) introduced the term therapeutic alliance to describe the real object relationship that allows the patient to tolerate the process of analysis. This alliance is the result of the patient’s identifications with the analyst and leads to a corrective emotional experience in which the patient can have an affective and interpersonal experience that is different than what he or she is familiar with (Zetzel, 2003). Zetzel believed that an “effective analysis depends on a sound therapeutic alliance” (p. 112) and that the ability to promote and maintain this alliance, even with very disturbed people, results in successful treatment.

Rogers (1949) believed that an effective therapeutic relationship depended on what the therapist brought to the treatment. His client centered theory holds that the therapist’s ability to provide empathy, to be congruent, and to accept the client unconditionally is essential to promote therapeutic change. Therapist and client can have an authentic relationship if the therapist can bring these elements into the work. Rogers (1949) asserted that the goal of client-centered therapists is to get inside “the attitudes of the client [and enter] the client’s internal frame of reference” (p. 89). He explained that understanding and accepting clients without emotion and evaluation allows them to accept themselves and frees them to set new goals and find new meanings.

Greenson (1965) added to the concept of the reality based relationship and called it the working alliance. He distinguished between transference neurosis and the working alliance and stressed the importance of each. He described the alliance as “the reasonable
and purposeful part of the feelings the patient has for the analyst”; in other words, it is the client’s ability to be an active participant in treatment by working with determination and purpose to change, to cooperate, and to follow the analyst’s instructions and insights. 

Greenson (1965) described the manner in which he worked with patients to establish an alliance, including indicating “genuine human concern for his welfare and respect for his position” (p. 167). He believed that successful treatment depended on a positive working relationship between patient and analysts because it affects the transference neurosis in the patient, which is central to a good analysis.

_Bordin’s Pantheoretical Model_

Bordin (1979) proposed a broader definition of the working alliance that could be “stated in forms generalizable to all psychotherapies” (p. 253). His pantheoretical definition expands on the work of Greenson by clarifying the patient’s transference and the concept of the therapeutic alliance (Horvath & Luborsky, 1993). Bordin (1994) argued that psychoanalytic therapy does not view the client in active terms because the therapist typically takes charge of the treatment. Bordin’s model also reflects the work of Rogers in the attention to the client. However, client-centered therapy mainly focuses on what the caregiver brings to the relationship and is not focused on setting goals or tasks (Bordin, 1994). His theory differs from psychoanalytic and client-centered approaches because the negotiation of goals and tasks is essential to promote alliance and overcome future ruptures (Bordin, 1994).

Bordin (1979, 1994) discussed three important features of alliance: agreement on goals, engaging in tasks, and creating bonds. He maintained that mutually agreed upon and supportive goals at the onset of therapy are crucial to the patient’s involvement in the
work. Bordin (1979) described the initial goal setting as “bargains” (p 253) that should take precedence at the outset of the work. Similar goals should be valued and endorsed by both the client and the therapist in order to have a strong therapeutic alliance because “circumstances of life create barriers toward acceptance of [goals]” (p. 253) to change oneself when there is a focus on getting basic needs met. Therefore, negotiation of goals is integral to establishing a sound alliance because change goals that capture the client’s current struggle become the focus of the work (Bordin, 1994). Tasks refer to the collaboration between patient and therapist in carrying out the specific work and procedures of therapy, both at the behavioral, cognitive, and affective levels. If there is a good alliance, both client and therapist recognize certain specific activities as relevant to the work and accept the responsibility to perform them. Bonds involve personal attachments between client and therapist that include trust, acceptance, and confidence (Bordin, 1979). The nature of the bonding varies depending on the shared activities and on the transference and real experiences that occur (Bordin, 1994).

Measuring the Therapeutic Alliance

Studies have found client, therapist, and observer ratings of the alliance to be predictive of therapeutic outcomes regardless of the type of intervention used, with client and observer ratings having the highest predictions (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). According to Horvath (2005), “the alliance-outcome correlation is moderate but significant” (p. 4) ranging from .22 to .29. Horvath and Symonds (1991), found the working alliance to have an average effect size of .26 and to be a factor connecting the therapeutic process to outcomes. Alliance at the beginning of therapy has been reported to be a good indicator of early termination from treatment and to best
predict outcomes specific to the individual client (Horvath, 2005; Horvath & Luborsky, 1993). Horvath and Symonds (1991) reported that early alliance (i.e., first to fifth session) is a better predictor of outcome, yielding an effect size of .31, than averaged or mid-treatment alliance ratings, which yield an effect size of .21. In addition, Horvath and Luborsky (1993) suggested that two alliance phases exist: 1) the initial development, which takes place within the first five sessions and 2) the period when the therapist starts to “challenge old neurotic patterns” (p. 567). The first phase focuses on joining and establishing trust and collaboration, while the second phase focuses on active interventions by the therapist to challenge the client’s dysfunctional beliefs and may be experienced as a loss of sympathy and support. It seems that there may be breaks in the alliance at various times during treatment and that repairing these breaks may lead to a stronger working relationship (Horvath & Luborsky, 1993).

Tichenor and Hill (1989) reported that clients, observers, and clinicians were found to have divergent assessments of the alliance, with clients giving greater alliance ratings. Across all instruments, client ratings of the working alliance have been reported to be more predictive of treatment outcomes than therapist and observer ratings (Horvath, 2005; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Outcomes were found to be better rated by clients and observers than therapists, with clients showing highest overall alliance ratings and observers showing higher alliance ratings than therapists (Horvath & Symonds, 1991). The authors reported that client and observer alliance scores had comparable effect sizes (ES) and appeared to be more correlated than therapist scores.
Overall, measures of alliance have been reported to have acceptable psychometric properties and significant alliance-outcome correlations (Cecero et al., 2001; Horvath, 2005; Horvath & Luborsky, 1993). The definition of alliance that is used by different authors seems to have in common “concepts of collaboration, mutuality, and engagement” (Horvath & Symonds, 1991, p.147). However, instrument subscales have been found to have low correlations (Horvath & Luborsky, 1993) and little agreement exists with respect to how the alliance functions and what the dyad must bring into the relationship to foster a strong alliance (Horvath & Symonds, 1991).

In a meta-analysis of 24 studies on the working alliance and outcomes in psychotherapy, Horvath and Symonds (1991) identified five alliance measures commonly used to assess the therapeutic alliance. As cited by the authors, these are: the California Psychotherapy Alliance Scale, CALPAS/ CALTRAS, (Gaston & Ring, 1992; Marmar, Weiss, & Gaston, 1989); the Working Alliance Inventory, WAI, (Horvath 1981; Horvath & Greenberg, 1989); the Penn Helping Alliance Scales, Penn/HAQ/HA, (Alexander & Luborsky, 1987); the Therapeutic Alliance Scale, TAS, (Marziali, 1984a); and the Vanderbilt Therapeutic Alliance Scale, VTAS, (Hartley & Strupp, 1983). Although most of these instruments were developed and progressed through various stages of modification independently from one another, there seems to be overlap between measures at the global levels (Horvath & Luborsky, 1993).

Tichenor and Hill (1989) compared six instruments on the working alliance (CALPAS, Penn, VTAS, and WAI-Observer or WAI-O, WAI-Client or WAI-C, and WAI-Therapist or WAI-T forms) and found that all “measures had high internal consistency, high interrater reliability, and high correlations with other measures of
working alliance” (p. 198). However, it seems that general overlap does not indicate that subscales have parallel underlying structures. According to Horvath and Luborsky (1993), most instruments aim to evaluate different components of the alliance based on different theoretical frameworks, which leads to low subscale correlations among scales. In their meta-analysis, Horvath and Symonds (1991) reported that the measures they analyzed were generally heterogeneous, with instrument families (i.e., the Pennsylvania family of HA, HAQ, PEN; the Vanderbilt family of VTAS and VPPS; the British Columbia family of WAI-O, WAI-C, WAI-T; and the California family of CALPAS, CALTRAS, and TAS) being relatively similar; they hypothesized that this may be due to equal overlap among scales but with different portions of the treatment outcome. The authors reported all measures had acceptable reliability, with mean reliability coefficient for client ratings of .85 and mean reliability coefficient for therapist ratings of .93.

Motivational Interviewing (MI)

Motivational interviewing is defined as a person-centered approach that explores and resolves ambivalence to enhance motivation to change (Miller & Rollnick, 2002). This approach emphasizes a collaborative relationship and validating the client’s autonomy to change as a way to promote motivation. The spirit of MI, which involves collaboration, autonomy, and evocation, is the key to eliciting the client’s motivation to change instead of imposing it on him or her (Miller & Rollnick, 2002). Through collaboration, a supportive interpersonal partnership is created that avoids an expert authoritarian style from the therapist and respects the client’s perspective and expertise. Evocation is used to explore the client’s values, goals, and worldviews to increase intrinsic motivation rather than providing the client with expert feedback. The client’s
autonomy to make choices is affirmed and respected since MI holds that people have the
right to be self directive. The authors argue that the spirit of MI strengthens the working
alliance as well as the client’s participation in the treatment because it focuses on
establishing a positive therapeutic relationship in which the client is accepted and
respected as the expert of his or her experience and is free to make choices.

The study by Boardman et al. (2006) on the therapeutic alliance with smokers
receiving motivational interviewing supports Miller and Rollnick’s (2002) argument.
Boardman et al. (2006) found that MI consistent style of intervention was associated with
stronger therapeutic alliance and client participation. Their assessment of the spirit of MI
index, which was an average of the Motivational Interviewing Skill Code (MISC)
counselor ratings on collaboration, egalitarianism, and empathy, showed a significant and
positive relationship with the alliance and client engagement.
CHAPTER III

METHODOLOGY

Participants

The participants were a sub-sample of the total participants recruited in the original study. This study used data from the first ten participants who completed all sections of that study, including the MI interviewing sessions. As shown in Table 1, the large majority of this sub-sample (80%) was comprised of female participants. The mean age was 36.4 years, the average length of time with a diagnosis of depression was 9.4 years, and the average length of time on antidepressant medication was 7.5 years.

Forty percent originated from the Caribbean, 30% were from Mexico, 20% were from South America, and 10% were from Honduras. Half of the participants had received less than a high school education, 30% had completed high school, 10% had some college, and 10% had graduated college.

Fifty percent of this sample was employed. In terms of language fluency, 60% reported that they did not speak English well or at all, 20% reported speaking English fairly well, and 20% reported being completely fluent. Regarding language preference, the majority of participants reported mostly speaking Spanish with family and friends (90% and 60% respectively), 10% reported speaking both English and Spanish with
family members, and 40% reported speaking both languages with friends. Ninety percent of participants in this sample spoke Spanish during MI and assessment sessions.

**Measures**

*Working Alliance*

Among the various instruments designed to measure the therapeutic alliance, the Working Alliance Inventory (WAI), created by Horvath and Greenberg (1989), is one of the most widely used in research to assess the strength of the alliance. Tryon et al. (2007) reported that out of 52 data sets examined, 27 (52%) used the WAI exclusively. In addition, the WAI had similar rates of use with other scales in the 24 studies included in the meta-analysis by Horvath and Symonds (1991).

The WAI was designed to measure Bordin’s concepts of the therapeutic alliance (Horvath & Greenberg, 1989). It has a total of 36 items with three 12 item subscales for each of Bordin’s alliance constructs (i.e., bonds, tasks, and goals). Each subscale is rated on an anchored, seven-point Likert scale (where 1 = never and 7 = always); scores can be obtained from each subscale with a range of 12 to 84, or all subscale ratings can be added for a total score with a range of 36 to 252. Higher scores are indicative of a stronger alliance.

There are three versions of the WAI; these include questionnaires for clients (WAI-C), therapists (WAI-T), and observers (WAI-O). Horvath and Greenberg (1989) found the three subscales to be highly correlated, with the goals and tasks scales having the greatest correlation (.88). Tichenor and Hill (1989) reported that the WAI had high internal consistency, with alpha coefficients for the WAI-C = .96, WAI-T = .95, and
WAI-O = .98. Tracey and Kokotovic (1989) found the WAI to be a valid instrument because it assesses general alliance, as well as specific alliance factors (i.e., bonds, tasks, and goals).

The WAI was adapted by Tichenor and Hill (1989) to be rated by observers (WAI-O). This version of the instrument was used to measure the strength of the therapeutic alliance during the MI sessions. The WAI-O is a 36 item measure with three 12 item subscales for bonds, tasks, and goals. Each subscale is scored using a 7 point likert-type scale; with higher scores indicating a stronger alliance. The WAI-O form has been found to have good internal consistency, with alphas ranging from .98 to .84 (Cecero et al., 2001; Hanson et al., 2002; Tichenor & Hill, 1989). Reliability estimates for the subscales have been reported to be lower, ranging from .68 to .92 (Horvath & Greenberg, 1994).

The WAI-O (Tichenor & Hill, 1989) version was selected to assess the strength of the therapeutic alliance in this study for several reasons. The data that was analyzed consisted of audio recordings of a psychotherapeutic intervention aimed at enhancing motivation, and the WAI-O is a highly reliable measure with good predictive validity for outcomes. It has been reported to have high interrater reliability of .92 and to be the most economical scale because it is straightforward and raters do not need to be trained (Tichenor & Hill, 1989). The WAI-O was used to generate a quantitative score of alliance, and to highlight portions of sessions that were relevant to alliance, which were qualitatively analyzed.
Outcome Measures

Two outcomes measures were employed. First, data on adherence to antidepressant medication was collected via use of an electronic medication container cap (Medication Event Monitoring System - MEMS®). At Time 1, upon completing the baseline evaluation, participants had their antidepressant medication transferred to a MEMS container with an appropriate label and were provided with instructions for using the MEMS container, such as taking medications only from the provided container. At Time 2, two months after Time 1, each participant's MEMS bottle was checked for the percentage of adherence the client had during the past two months. At Time 3, three months after Time 2, this same procedure was repeated, to assess percentage of adherence during the T2 to T3 time period, and for the entire T1 to T3 time period.

The Beck Depression Inventory-II, Spanish Record Form (BDI-II; Beck, Steer, & Brown, 1996), a psychometrically well established measure of self-reported depressive symptoms, was administered at all three time periods, allowing for the calculation of change scores.

Overall Procedures

Expedited Institutional Review Board (IRB) approval was received for this study from Rutgers University on May 19, 2008 because it was a secondary analysis of the data collected for an NIMH funded study on the effects of motivational interviewing and antidepressant adherence that received full IRB approval from UMDNJ in 2005.

The sample used in the current study was a convenience sample consisting of the first 10 Latino participants—out of a total of 26—who were assigned to the experimental condition of the larger RCT study. Participants were outpatients at a community mental
health clinic in an urban setting receiving treatment for depression; most were referred by their psychiatrists or psychotherapists, while a small number were self-referred via recruitment fliers. Participants were primarily low-income, Spanish-language-dominant female immigrants. Inclusion criteria required ethnic identification as Hispanic or Latino, treatment with antidepressant medication, diagnosis of depression, absence of psychotic diagnoses, age range between 18 and 65, and not being currently pregnant for women of child bearing age. University-IRB-approved informed consent procedures were completed with all participants, which consisted of Spanish and English language consent forms to participate and to be audio-recorded.

Structured face-to-face interviews were used in the original study to collect information at three different times: T1, at the beginning of the study; T2, two months later; and T3, three months after T2. These interviews were conducted in private rooms at the mental health clinic the participants attended. Participants were assigned a case number, the only identifier used on all response materials, as well as audio recordings and transcripts. Participants were randomly selected to receive the experimental condition, which consisted of two, once-per-week, one hour MI sessions and one booster MI session provided by a Spanish-English bilingual clinician, who had not conducted the structured assessment interviews and who was trained in the MI approach. Each MI session was audio recorded and scored with the Motivational Interviewing Treatment Integrity (MITI) code (Pierson et al., 2007) to ensure fidelity to the approach.

Procedures for Scoring the MI Transcripts

For the purposes of this dissertation, the first two MI intervention sessions received by first 10 participants in the experimental condition were selected to be
evaluated for strength of alliance using the WAI-O because the literature suggests that measures of early alliance (i.e., first to fifth session) and late alliance (i.e., towards the end of treatment) have greater effect sizes (.31 and .30 respectively) for outcomes criteria (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Therefore, the first 20 minutes of session one and the last twenty minutes of session two were examined.

The quantitative scoring and qualitative analysis of the 20 minute segments took place in two steps. The first step involved simultaneously listening to an audio recording of the segment while reading the transcript and scoring the segment on the 36 WAI-O items.

The second step involved qualitatively evaluating the segments rated with high alliance scores on the WAI-O items to identify in more precise detail the client-therapist interactions in the MI sessions that were associated with and seemed to underlay the positive WAI-O rated items. In other words, portions of sessions indicating a therapeutic interaction relevant to Bordin’s concept of alliance were coded, categorized, and annotated to determine their relevance in enhancing the relationship.

Data Analysis

Mixed-Methods Approach

The current study used a mixed-methods approach involving quantitative and qualitative methods to conduct a secondary analysis of a larger study investigating motivational interviewing and antidepressant adherence outcomes in a depressed Latino sample. Bernal and Scharron-del-Rio (2001) recommend using a mixed-methods approach to better apply treatment interventions with ethnic minorities. They assert that
few studies of empirically supported treatments have given formal consideration to cultural issues and that mainstream treatments “promote individualistic values rather than collectivistic or interdependent values on which minorities are often socialized” (p. 331), resulting in simple representations of mental health dynamics. The authors propose using a mixed-method approach that integrates “hypothesis-testing (contemporary) and discovery-oriented (alternate) research” (p. 335) to understand psychotherapy with ethnic minorities and to guide future research on this topic, as well as to increase the generalizability of findings.

Bernal and Scharron-del-Rio's recommendation fits well with the present study since it involves a small sample of Latinos who are mostly recent immigrants and Spanish monolinguals receiving a Motivational Interviewing intervention. The goal of this study is twofold: (a) to quantitatively analyze the data to determine if there is a linear relationship between working alliance and both medication adherence and reduction in depressive symptoms; and (b) to qualitatively analyze the data to identify and explore the specific processes that enhance alliance for this Latino sample within the MI intervention.

Quantitative Analysis

The Spearman rank correlation coefficient (Spearman rho; Siegel, 1956; Statsoft Electronics Statistics Textbook, 2010; Wikipedia, 2010) is a non-parametric measure of the strength of association between ordinal or interval variables. Because it is less sensitive to outliers, non-normality, and nonlinearity, the WAI-O total and subscale scores were analyzed using the Spearman rho to determine if there was a relationship between the therapeutic alliance and the two major outcome measures in the larger, RCT study over the course of the 5 months of the research project: (a) the clients' overall
antidepressant medication adherence rates, and (b) their improvement in level of depression.

Qualitative Analysis

In addition, transcribed MI audio recordings were analyzed and coded using ATLAS.ti, a qualitative analysis program that is consistent with the "Grounded Theory" approach (Corbin & Strauss, 2008; Strauss & Corbin, 1998), to find and code major themes that may be relevant to promoting alliance. (The grounded theory approach and procedures are described below in the next section.) ATLAS.ti provides tools to identify, code, and annotate findings to evaluate their relevance and consider complex relations between them. The program consolidates large volumes of documents into hermeneutic units (HU) that contain all notes, codes, quotes, memos, families, and networks from the primary documents which are all electronically linked, allowing for smooth movement between different parts of the data. The program also has specialized tools that display how codes are interrelated through its co-occurrence explorer. In this study, the primary documents were the transcripts of the Motivational Interviewing sessions, with a total of 20 primary documents since each participant received two MI sessions. Codes were concepts that came out of quotations from the first and last 20 minutes of these transcribed sessions. Memos were notes written about thoughts, ideas, questions, or hypotheses that came to mind as the data was coded. The ATLAS.ti program was used to implement the stages of grounded theory coding: open, axial, and selective (Corbin & Strauss, 2008; Strauss & Corbin, 1998).
Grounded theory is a systematic qualitative research methodology in which theory is developed from a body of data. According to Strauss and Corbin (1998), “theory derived from data is more likely to resemble the ‘reality’ [and] to offer insight, enhance understanding, and provide a meaningful guide to action” (p. 12). In order to accomplish this, the first step involves describing the data or identifying concepts by coding the text. Then, the codes are organized into discrete categories and compared according to a number of general properties and dimensions using conceptual ordering. The final step involves theorizing, creating, and formulating hypotheses into a “logical, systematic, and explanatory scheme” (Strauss & Corbin, 1998, p. 22). According to the authors, a theory should include clear categories, concepts, or themes that are interrelated through statements of relationship (i.e., who, when, where, why, how, and with what consequences) to explain a specific phenomenon. The benefit of using this approach is that it allows for the discovery of new variables and relationships and for understanding complex processes (Shah & Corley, 2006).

Open coding is the first stage of this analytic method and it involves identifying, labeling, categorizing, and describing phenomena in the data. Through this process, each line of each segment of the transcripts was read and coded individually to identify any categories by grouping together events, actions or interactions that were found to be conceptually similar (Strauss & Corbin, 1998). Quotes that represented various concepts received multiple codes, and memos were used to describe the codes and to record the thinking that took place as the data was analyzed. Since I was the only person conducting the analysis, two steps were taken to ensure that codes and definitions were being used
consistently throughout the coding process. First, definitions of codes were described in detail and reviewed before coding took place. Second, each MI segment was reviewed three times to make sure that quotes were properly coded within their specific definitions.

Axial coding is the second stage of analysis. It is the process of developing more precise and complete explanations about phenomena by relating code concepts and properties to one another (Strauss & Corbin, 1998). It entails identifying conditions, actions, interactions, and consequences associated to the themes found through open coding. In this study, the co-occurrence explorer in ATLAS ti. was used to determine if any codes were interconnected.

Selective coding is the last stage of analysis. It is the process of choosing a core category or the central idea around which everything else is based in the data. The coding process involves relating the core category to all other categories to arrive at a theory. Selective coding was not part of the data analysis for this dissertation since the qualitative focus of this work was to learn about the characteristics that promote the alliance in a small sample of depressed Latinos. My interest was in understanding what was happening within the therapeutic dyad that resulted in a stronger alliance. Is it influenced by therapist behavior, client behavior, or both? Do cultural elements play a role in alliance with this sample?
CHAPTER IV

RESULTS

Overview

The participants in this sample represent the therapeutic experiences of a small sub-sample of depressed Latinos living in an urban area. A mixed-methods analysis was conducted involving a Spearman rho correlation computation and Corbin and Strauss' (1998, 2008) grounded theory methodology to qualitatively evaluate the data. The results of this study were organized into two major areas describing the quantitative and the qualitative analyses, with the qualitative section being divided into relevant themes, an explanation of the overlapping qualities of bonding codes, and an explanation for the low frequency of codes under tasks and goals.

Quantitative Analysis

As mentioned in the Methods section, there were results on two sets of quantitative outcome measures in the original study: overall level of medication adherence during the study and improvement over the course of the study on level of depression, as measured by the Beck Depression Inventory-II, Spanish Record Form (BDI-II). The results for the 10 clients as a whole were consistent with the results for all the clients in the experimental condition of the RCT study, namely, as a group the 10
clients showed considerable overall success on the outcome measures along with sizable individual variability. These results for the whole group indicate the viability of using the depression and adherence outcome scores for correlational analyses with the WAI-O scores, which reflected quality of therapeutic alliance during the two MI sessions. The results of these correlational analyses are presented in Tables 2 and 3, respectively.

Table 2 shows the correlations between the WAI-O Total score and its three subscores with medication adherence. As shown, the correlations of the subscores with adherence are all positive but low and nonsignificant, ranging from .079 to .293. On the other hand, the WAI-O Total correlates moderately—.455—with adherence. While, due most probably to the low number of clients (N=10), this correlation does not reach traditional statistical significance at the one-sided .05 level, it is significant at the one-sided .10 level.

Table 3 shows the correlations between the WAI-O Total score and its three subscores with BDI-II change scores over three time assessment periods. These time periods include:

- T1, which represents assessment at the beginning of the study, with the two MI sessions coming at 1 week and 2 weeks into the study, respectively;
- T2, which represents an assessment 4 weeks into the study (and thus 2 weeks after the second MI session); and
- T3, which represents an assessment 5 months later (and thus 2 months after the T2 assessment and 2 1/2 months after the second MI session).

As seen in Table 3, for the T1 period to the T2 period, the pattern is similar to the medication adherence results in Table 2, namely, all the correlations for the subscales are
positive but low and nonsignificant, ranging from .030 to .390; and the WAI-O Total score correlates moderately—.467—with improvement on depression, significant at the one-sided .10 level.

Also as seen in Table 3, the results for the T2 period to the T3 period are similar in direction and pattern to the T1 to T2 results, but at a lower level. It would therefore seem that the effects of the therapeutic alliance on depression level were stronger in the shortterm (T1 to T2) and then wore off somewhat in the longterm (T2 to T3).

Note that the level of correlation between the WAI-O and the outcome variables—.455 and .467 in Tables 2 and 3, respectively—is similar to those frequently reported in the literature on the relationship between the WAI and outcome generally. For example, in the original article on the development of the WAI (Horvath & Greenberg, 1989), a correlation of .42 was found between client-reported WAI and client-reported outcome.

Qualitative Analysis

A Grounded Theory approach (Corbin & Strauss, 2008; Strauss & Corbin, 1998) was used to analyze portions of MI sessions that appeared to be associated with the elements of the therapeutic relationship (i.e., bonds, tasks, and goals) described by Bordin (1979, 1994) and that were scored with the WAI-O for strength of alliance. The major themes that emerged in this analysis suggest that for alliance to be strong with Latinos, the bonding concepts described by Bordin need to take place in therapy.

The codes that emerged from the grounded theory analysis are presented in Table 4 and form the basis for organizing the qualitative results below.
Bonding: Establishing a Personal Attachment

Several codes describing significant aspects of bonding between therapist and client emerged. These were arranged under the overarching theme of establishing a personal attachment, as it holds all the major codes in this section. The results suggest that the therapeutic relationship is strengthened through interactions that promote connecting and attaching, which were captured in the clusters of codes described below.

Part of the work in establishing a sound therapeutic alliance involves creating an environment that is safe and accepting in order to build a personal bond between client and therapist. The quality of this relationship is enhanced when the therapist displays warmth, empathy, understanding, tolerance, encouragement, and respect for the client (Beck, 1995; McWilliams, 2004; Wachtel, 1993). In the current study, the connection that occurred in the therapeutic dyad involved establishing a personal attachment (i.e., an interaction between therapist behaviors and client responses). This is an overarching theme of the bonding elements, as it holds three major sub-themes of acceptance, *valorar al cliente* (to value the client), and enhancing confidence, which appear to have a positive impact on the alliance. Acceptance involved therapist behaviors that resulted in the client feeling understood. In addition, *valorar al cliente* was a way to show respect and to empower the client by reducing the therapist’s role of expert. Finally, enhancing the client’s confidence in the work by showing interest, validating, and providing support allowed the client to believe he or she could be helped. Each sub-theme contains clusters of frequently occurring codes describing therapist-client interactions that advance the relationship which are described below (see Figure 1).
Acceptance

As discussed earlier, acceptance is an important factor that promotes the therapeutic alliance. It involves therapist behaviors that lead the client to feel welcomed and understood. It is necessary throughout the treatment but crucial at the onset of the work to ensure the client will become engaged in the therapy (Bordin, 1994, 1979; Hatcher & Gillaspy, 2006; Horvath & Greenberg, 1989; Roth & Fonagy, 1996). Because Latinos tend to distrust the mental health system and their retention rates are low (Antshel, 2002; Interian & Diaz-Martinez, 2007), it is especially important to help them feel accepted and appreciated when they enter treatment. Several codes were found to describe the manner in which acceptance seems to positively impact alliance. The cluster of codes that were most relevant to the concept of acceptance include, withholding judgment, trust/comfort, and you get me. These codes are described in detail because of their frequency in the data and their apparent importance to the participants.

Withholding judgment.

“Withholding judgment” appears to be an important contributor to the therapeutic alliance in the current sample. It occurred 15 times in the portions of audio-taped sessions that were reviewed. Withholding judgment is a therapist behavior involving acceptance of the client’s statements without censorship. When a therapist withholds judgment, he or she does not react to the content of what is being disclosed. Rather, the therapist remains neutral to the information, and if a reaction is given, it is to the valence of the emotion conveyed by the client. Withholding judgment seems to promote a sense of comfort and trust in the client, which may lead to a greater degree of openness to discuss issues and accept feedback, as well as a sense of being understood.
The following quote from participant 003, a female from the Dominican Republic with a long history of health problems, depression, and inconsistency with treatment, is a good example of how the therapist withholds judgment as she speaks about her psychiatrist doubting her symptoms and their impact on her ability to work:

P: Y al ponerme tan y tan mal, pues tuve que dejarlo, no pude más. El doctor ahí no me creía, no, a lo mejor pensaba que yo me estaba haciendo para no trabajar…Si yo estoy así es porque no puedo.
D: Así que en un aspecto, cuando estuviste pasando por este trabajo, el doctor…Entonces quizás no se sintió muy apoyada.

P: And when I got so sick, well I had to quit it, I couldn’t go on. The doctor there didn’t believe me, no, he probably thought I was faking to avoid work…If I’m like this is because I can’t do it.
D: So in one way, when you went through that hard time, the doctor…then you probably didn’t feel much support.

The therapist is observed to withhold judgment because he accepts the client’s difficulties with her doctor regarding her health concerns. It seems that she experienced the doctor’s line of questioning about her physical symptoms as a form of rejection or judgment. She indicated that his response made her feel as if she was “faking” to avoid work. Therefore, the therapist’s ability to sit with her statements without attempting to explore the reasons behind the doctor’s response likely provide her with reassurance that she is being heard and that her report is being taken at face-value. This point is made more clearly when the therapist reflects that it sounds as if she did not feel supported. This captures for her the fact that he has been listening with an impartial ear and is not making assumptions about her.

When judgment is withheld in the context of a therapeutic exchange, it seems to have a positive impact on the client’s willingness to share personal experiences. The client seems less reluctant to risk disclosing more parts of him or herself when a
judgmental response is not received. The audiotapes are rich with what sounds like pauses and doubts from the client as he or she reveals difficult material. Often, one hears the person speak in a tentative or halting manner, as if waiting to hear criticism from the therapist, and when it is not given, one hears the client’s speech flow in a more assured manner. Although the quality of these interactions is mostly lost in the text, the following quote from participant 012, a Mexican immigrant with a history of sexual abuse, conveys some of the elements I have attempted to describe:

P: …yo era de, hacerlos a un lado, al varoncito, a la niña, siempre con ese miedo que andaba, que, que él le fuera hacer algo a la niña, o, siempre pensando, cosas, lo que a mí me pasó, pensando en ellos que, por eso, yo a veces, con, esa rabia, yo, si he, eee como le digo, si he, lastimé a mi niño, le pegaba, yo no hablaba con él, yo sólo, y, sólo era de, tratar de que no se acercara a la niña…
D: Tenía miedo

P: …I used to push them aside, the boy, and the girl, always with that fear that he was going to do something to the girl, or always thinking, things, the stuff that happened to me, thinking about them, and sometimes I would be enraged, yes and eh like I tell you, yes I hurt my boy, I hit him, I wouldn’t speak with him, I only, I try so he wouldn’t go near the girl…
D: you were afraid

The therapist takes the position of witness rather than judge in this exchange, which seems to help the participant feel accepted and allows her to open up about a very sensitive issue. This type of response lacks judgment and conveys empathy for her experience. She does not question or censor the client’s behavior toward her children; instead, she connects with the fear that influenced the client’s actions. The therapist’s reaction to the emotional valence of the participant’s disclosure seems to accomplish two things: 1) to let her know that she is heard and that it is okay to speak about these issues and 2) to normalize the client’s experience and thereby reduce the shame she feels. When the therapist demonstrates acceptance for the client’s perceived “badness,” she is sending
the message that she will remain with the client regardless of what he or she says or does.

Participant 007, a Puerto Rican woman in her late thirties who was trying to regain custody of her children speaks about pain and shame of losing them, “…And people keep asking me questions why. On and on and I just don’t feel like it…not everyone knows the situation with my kids.” She seems to feel like others don’t understand her experience or judge her for it, which leads her to be guarded about disclosing. Therefore, the therapeutic intervention of conveying acceptance without censoring is important because it seems to enhance the bonding process and allows her to talk more freely, which is evident later, as she tells the therapist why her children were taken away: “Munchausen’s Syndrome by Proxy they charged me with but it was never…the social worker said I had it but no doctor never diagnosed me with it.” The therapist doesn’t react to the participant’s disclosure of being involved with the child welfare system because of Munchausen’s syndrome. She simply listens and reflects what the client is saying, and in doing so gives her the message that she accepts the parts the client is ashamed of, that she can tolerate all the forms of the client’s experience. By not asking for specific details regarding the diagnosis, the therapist shows that she has been attentive to the participant’s needs for acceptance, since she began the session by talking about hiding information about her children due to fears of being misunderstood.

In conclusion, this data suggests that the therapist provides emotional security for the client when he or she withholds judgment towards material that typically elicits some kind of negatively-laden response in the client’s experience. The participants in this sample responded positively to low criticism from their therapists, which may have resulted in feelings of acceptance and safety from shame, censoring, and labeling. In
other words, withholding judgment seems to have a major impact in the client’s ability to connect with the therapist and disclose personal and sensitive information. It appears to promote a sense of trust and comfort in the therapist and a feeling of being understood.

*Trust/Comfort.*

The therapeutic alliance also appears to be affected by client behavior. The client’s willingness to disclose about him or herself indicates feelings of comfort and trust within the session. This seems to occur when the client experiences a sense of security in the presence of the therapist, suggesting that the therapist has created a safe space, involving acceptance and understanding, for the client. In the data used for this study, “trust/comfort” was coded 30 times in the portions of the sessions that were reviewed. This particular code describes participant behavior, which involves relying on the therapist to listen, accept, or help when opening up about personal matters. It occurs when the participant talks in a way that indicates confidence in not being judged by providing more details, openly acknowledging his or her comfort level, or relying on the therapist’s expertise.

The following quote from participant 002, a Puerto Rican male with a long history of depression and noncompliance with treatment, shows that he is comfortable with the therapist and trusts him with sensitive information when he asks about medication side-effects:

P: Bueno, yo le iba a preguntar al doctor pero también se lo puedo preguntar a usted, yo quisiera saber que, yo le iba a decir que estos medicamentos muchos, a veces ponen impotentes a la persona y yo quisiera saber si eso es verdad o... porque yo le dije que a veces teniendo relaciones con una mujer a veces, como que me sentía sin ganas o... y entonces él me recomendó que tomara Viagra.
P: Well, I was going to ask the doctor but I can also ask you, I would like to know, I was going to say that these medications, sometimes make people impotent and I would like to know if it’s true or…because I told him that sometimes when I’m having relations with a woman, it’s like I feel like I have no desire or…and then he recommended I take Viagra.

The participant seems to feel safe to disclose some of his private experiences with the therapist. His comfort level is evident in that he provides details of his sexual difficulties. In addition, trust is indicated when the client asks for information regarding medication side effects because it shows that he believes the therapist can help him find answers.

Trust/comfort is also evident when participants allow themselves to be vulnerable in the presence of the therapist by being less guarded and displaying emotions. The following segment is from the first session conducted with participant 007. It shows that she is comfortable with the therapist and trusts her enough to disclose the pain she feels about the current state of her life:

P: you don’t know, I feel disgusted.
D: disgusted how?
P: with my body, with my appearance, the clothes that I’m wearing, the way my hair is, walking outside with no makeup.

The participant’s disclosure indicates that she feels very comfortable with the therapist to be open and honest about the way she views herself. She was in a lot of emotional pain, which was evident in the audiotape by the tightness in her voice and attempts to hold back tears, as she described the way she feels. It is likely that the safety she experiences in the session permits her to disclose her self-loathing and raw pain to another human being.
The data also shows instances in which participants literally describe feeling comfortable and trusting of their therapist or the clinic in general. Participant 008, a young Mexican immigrant struggling with family issues, talks about why she likes attending therapy during her second session: “…dan un trato especial, no como en otros lados que, que a uno nos trata mal…Que hasta sin ganas de ir, y no…Aquí yo siento que, que sí como que le dan esa importancia a la, a la persona.” (…you give special treatment, not like the other places, that treat people bad…leaves you without a desire to return, and no…here I feel that, that you are made to feel important). She seems very comfortable with her therapist as she describes the way the treatment team has made her feel welcome and important, which has helped her to remain motivated to continue attending sessions. She describes the treatment as “special” and compares it to “bad” treatment she has received in other places. She indicates that feeling taken care of leads her to feel confident that she can be helped.

The degree of disclosure a participant makes also indicates the level of comfort and trust he or she feels with the therapist. For example, an individual who gives brief answers or who provides few details is probably not comfortable or trusting of his or her therapist. On the other hand, someone who takes the risk to open up and give personal details that typically elicit a reaction or criticism from others, is probably experiencing comfort and trust in the therapeutic interaction. The following disclosure by participant 012 about the relationship she had with her children exemplifies this:

P: … yo casi no, no no hablo, de eso, pero yo ahorita pues, pues ya siento yo que lo voy un poquito superando eso, sí.
D: Con mucha fuerza personal…y muchas ganas de seguir…adelante, de, ser buena una mamá.
P: …no era para, darles ese cariño a mis hijos y ahora…me siento contenta porque el niño cada rato me da mami que te quiero o esto, que, me pasó
esto en la escuela, cosas que él, él miedo me tenía a decirme las cosas… porque sólo era yo gritos…yo siempre no soportaba, las cosas…que me hablaran…siempre andaba de mal humor…

P: …I usually don’t, don’t speak about that, but now well, I feel that I am getting over it a little, yes.
D: With a lot of personal strength…and a lot of desire to continue… forward, to be a good mother
P: …I wasn’t one to give my children affection and now…I feel happy because the boy is always telling me mommy I love you or, this happened at school, things that he used to be afraid to tell me…because I screamed, I couldn’t stand…to be spoken to…I was always in a bad mood…

The client seems to feel a great deal of trust for the therapist in this section, particularly when she speaks about the fear her behavior (i.e., yelling and impatience) instilled in her child. The tone of her voice suggests that this information is difficult for her to recall and talk about. Therefore, she must feel comfortable in the session in order to open up about this. In addition, the participant seems to trust the therapist because she prefaces her disclosure with the words, “I usually don’t…speak about that.” Although feelings of shame appear to be connected with this information, it seems that she is able to share her past experiences because she feels accepted, rather than judged, by the therapist.

Finally, feeling comfort and trust in the presence of the therapist appears to be essential in client disclosure and engagement. It is a participant behavior that occurs in response to therapeutic interventions demonstrating acceptance, understanding, and safety. The participant in turn reacts positively by providing more information, sharing emotions, asking for help, or describing how he or she feels supported.
You get me.

When the therapist uses key words to capture the client’s experience, it seems to result in the client feeling understood, as if the therapist “gets” the experience. When this occurs, a high level of connectedness is evident because the conversation flows more smoothly, client and therapist seem to finish each other’s sentences, or the participant often agrees with the therapist’s reflections or discloses more personal details. The therapist appears to tap into the participant’s experience by “reading between the lines,” almost decoding what the client is saying and presenting it to him or her in a way that implies: “This is how I see you.” This involves therapist behaviors, including providing safety and comfort by withholding judgment and listening, as well as reflecting key elements of the client’s statements to show empathy. The code labeled “you get me” was used to describe instances of this therapeutic interaction in the data collected. It occurred 38 times in the portions of the audiotapes that were analyzed.

The following quote is a good example of the occurrence of this code in the therapeutic interaction with participant 006, a young Argentinean immigrant who was struggling with marital conflict, child-rearing, and work responsibilities:

D: Todo esto ha sido como una lucha.
P: Ya.
D: Y como que lo que se de su parte es que encuentras que luchas más ahora, tienes más capacidad de batallar cosas que son difíciles en comparación a antes.
P: Tengo momentos en los que me quedo triste y empiezo a pensar muchas cosas y luego me digo “No, no tienes que pensar”…recaigo y luego solita me levanto.
D: …todavía sigues con dolor, cosas por dentro que son difícil pero que también se está encontrando con fuerzas y formas en que has crecido…

D: all this has been like a fight.
P: Yeh
D: And like what I know from you is that you find that you fight more now, you have a greater capacity to battle things that are difficult unlike before.
P: I have moments when I feel sad and I start to think about a lot of things and then I say to myself “No, you don’t have to think”…I relapse and then I get up myself.
D: …you still have a lot of pain, inside things are difficult but you are also finding strength and ways to grow…

The therapist seems to be paying close attention as he shows the participant that he understands her experience. He describes it as an ongoing battle, which captures her inner conflict of having to balance the pain of depression with the effort to make herself feel better to continue fighting. Through this intervention, the therapist lets her know that he has been listening and that he understands what she has talked about. Another example of this code in action is when participants add more personal details to the discussion and agree with the therapist’s observations, as was the case with participant 014, a twenty-something Mexican immigrant struggling with depression and health related problems:

D: Pero ese momento que…le parecía que se iba a morir, eso es bastante fuerte…
P: [Sí]
D: …y a, asusta… y me dijo que se sintió que, que se estaba volviendo loco
P: Ajá, incluso estuve a punto de decirle a mi amiga que, que me amarrara las manos, porque cuando, yo me sentía así digo, y sí hago algo…pero después yo le dije…mejor llévame rápidamente a, a emergencias...

D: But that moment that…you thought that you were dying, that’s very hard…
P: yes
D: …and scary…and you said that you felt that you were going crazy
P: Uhu, I almost told my friend to to tie my hands, because when, I felt that way I said, and if I do something…but then I said…it’s better to take me quickly to the emergency room
Here the therapist shows that she understands the fear the client experienced when he had a psychotic episode. She captures the emotional valence of his experience by describing his thoughts of dying and losing his mind, as well as his sense of entrapment and fear. The client responds by agreeing with her and by adding that, in his desperation, he wanted to be tied down.

Another way in which one can see how the therapist conveys understanding to the client occurs when client and therapist seem to finish each other’s sentences. The audio recordings of these instances sound like the dialogue of two people who know each other well and who have a sense of the way the other thinks. The following is a portion of participant 020’s second session:

D: La vida, conectada…a otra persona, tiene mucho más sabor.
P: Por eso dicen que la unión hace la fuerza, y yo creo que, que sí, en Miami me va a ir mejor.
D: … porque yendo pa Miami, ee esa conexión es algo que le va […]
P: [Mucho, me va a ayudar mucho]

D: Life, connected…to another person, it has so much more flavor
P: That’s why they say that unity makes strength, and I believe that, in Miami I will do better.
D: …because going to Miami, it’s that connection that will…
P: help me a lot

The therapist seems to understand the main reasons why the participant wants to move to Miami. He reflects that, for her, family and connectedness is very important and she hopes to feel better by regaining a sense of family. The dialogue between them sounds fluid and relaxed. Additionally, the therapist makes a powerful statement when he says, “life, connected…has so much more flavor,” because it captures the way she feels about close family ties and taps into the loss of leaving behind her lively Cuban roots.
This demonstrates to the client that the therapist has been attentive to her and has understood her experience.

Another way to show the participant that he or she is understood involves focusing on the emotions behind the words. Participant 025 seemed to respond well to this form of intervention since she often felt misunderstood by others because of her legal status, level of education, and physical symptoms:

D: Okay, usted está sola, aunque no esté…está sola.
P: Sí porque yo tengo un hermano aquí pero él se americanizó, y él se volvió muy frío y…yo no cuento con él…yo no tengo a nadie aquí.
D: O sea fue como otro fantasma.
P: Sí.
D: Bastante decepciones.

D: Okay, you are alone, even though you are not…you are not alone
P: Yes because I have a brother here but he is Americanized, and he turned very cold and…I don’t count on him…I have no one.
It’s like another ghost.
P: Yes.
D: A lot of disappointments.

Both therapist and participant flow nicely here and seem to be in-sync with each other. The participant is describing her lack of support and the ways in which significant figures in her life have let her down. The therapist responds by connecting to her emotional experience; she shows that she understands the client’s loneliness by describing her brother as a ghost and calling the experience a deception. The therapist also indicates that she has been listening closely by connecting their current dialogue to past discussions they have had in session.

In essence, the code you get me describes instances in which the participant feels heard and understood by the therapist. It involves behaviors by the therapist that indicate empathy, caring, and active listening through reflections about the client’s emotional and
situational reality. The participant tends to respond by disclosing more and agreeing with the therapist’s reflections. The audio recordings of these instances suggest a high level of comfort and trust between them, acceptance for the client’s experience, and a natural flow to the dialogue.

Valorar al Cliente

*Valorar al cliente* (to value the client) appears to be important in establishing the relationship that needs to develop between client and therapist. It shows sensitivity to cultural values, particularly *respeto* or respect, which is integral to the Latino culture and deals with mutual deference and “an admiration for an older adult’s life experience” (Añez, Silva, Paris & Bedregal, 2008, p. 156). It involves *amabilidad* (language that is polite or nice) as ways to communicate emotions or manage conflict (Falicov, 1998). *Respeto* serves to establish interpersonal connections and can lead to building a sound working alliance (Añez et al., 2005). In the data reviewed, the therapist’s ability to *valorar al cliente* appeared to be an important aspect of the engagement process. The most salient codes that emerged in this cluster were respect and checking in, which are described in detail below.

*Respect.*

*Respect.*

Items coded as “respect” describe behavior towards the client that conveys thoughtfulness and politeness and mitigates the one-down position in therapy. The therapist’s language when asking questions and providing feedback has fewer directives, and the choice of words and tone indicates that he or she is asking for permission or deferring to the client. When the participant is treated with respect, the message conveyed is that he or she is important and is being heard. In the sections that were reviewed,
respect, as defined here, was observed to occur on 22 occasions. The following quote is a
good example of this code in action. It was taken from the first session with participant
002 as the therapist was trying to understand what prevented him from giving up:

D: ¿Me puedes ayudar a entender algo? Porque te oigo claramente, la
batalla ha sido difícil, bastante difícil. Sin embargo, sigues entrando en la
batalla y sigues tratando de lograr eso.
P: [Tratando]
D: ¿…de dónde viene ese impulso para seguir echando pa’ lante?

D: Can you help me understand something? Because I hear you clearly,
the battle has been difficult, very difficult. Yet, you continue engaging in
battle and trying to achieve that
P: Trying
D: …where does that impulse to continue forward come from?

The therapist shows respect for the client's willingness to persevere by expressing
curiosity about the source of his strength in a manner that conveys admiration. He
recognizes the client’s struggle, and in doing so, validates his difficulties and his drive to
feel better. In the audio recording, the therapist sounds impressed that the client hasn’t
given up despite the challenges he has encountered. The respect for the client is heard in
the question asked: “can you help me understand?” which indicates that the therapist
needs the client’s input to understand his situation. In other words, the therapist is not the
expert and the work involves a joint effort.

Similarly, the therapist conveys interest in getting to know participant 020 by
speaking in a tentative manner and asking her to share about her experience: “Okay. Me
puede contar un poquito sobre (. ) yo veo a usted ahora y veo que se está recogiendo, y
empezando para echar pa’ lante otra vez, eee, ¿cómo llegó a caer?” (Okay, can you tell me
a little about (. ) I see that you are picking yourself up now, trying to move forward again,
eh how did you fall?). In the audio recording, one hears a questioning, tentative tone,
suggesting he is being thoughtful. His manner is humble and subdued, which places the client in control since she holds the information he needs to understand her condition.

Another way respect is shown involves thanking the client for their share of the therapeutic work. During session two with participant 002, one hears the therapist express gratitude for the client’s disclosures, indicating that his input is both welcome and needed, “Y yo le doy muchas gracias por su tiempo y…por contarme las cosas, no solamente honestamente sino por platicarme las cosas muy personales.” (And I thank you very much for your time and…for telling me your issues, not only honestly but for talking with me about personal things). By thanking the client in this manner, the therapist demonstrates that he values the client’s time and willingness to share delicate information about himself. The client is not taken for granted; his role in the therapy is important and he is reminded that he has a choice in how much he contributes towards improving his current experience. This can be perceived as an empowering intervention because the message is that the client is a valuable member of the dyad.

Another way to be respectful is to ask for permission to gather more information or to provide feedback. In session two with participant 008, one hears the therapist asking for permission to provide her with a summary of how he understands her issues: “¿Yo pudiera tratar de recaptarle a todo lo que, poder darle un resumen de todo lo que hemos hablado?” (Can I try to review everything that, can I give you a summary of what we have talked about?). He shows that he views her as an active participant in her treatment because he asks for her opinion instead of assuming she wants to hear what he has to say.

The therapeutic interaction with participant 025 is another good example of how the therapist can demonstrate respect for the client: “…como como le dije, esa es la forma
en...que yo la entiendo a usted, si me he equivocado, me perdona, y si me he equivocado quiero que, me diga, donde he ido mal." (As I said to you, that is the way...in which I understand you, if I have made a mistake, forgive me, and if I have made a mistake I would like you to, tell me, where I went wrong). One hears several forms of respect in this intervention: 1) The therapist is telling the participant that she is the expert of her experience, 2) the therapist is apologizing for the possibility of having misunderstood the client, and 3) the therapist is asking for feedback and corrections on ways to better understands the client. This is a good way to keep the participant involved in treatment since she is reminded that her feedback matters. The overall message that is conveyed here is one of interest for the participant’s experience and recognition for the client’s expertise in her own life.

In conclusion, this code describes the way the therapist’s behavior helps the participant to feel respected by using language and tone that indicates his or her participation is wanted, welcomed, and valued. The therapist’s ability to minimize the one-down position by asking for permission, apologizing, and allowing the client to feel empowered likely promotes engagement in therapy because the participant is not dismissed and is given the message that his or her participation is important to the therapist.

*Checking in.*

The audio recordings also revealed instances in which the therapist asked the participant for feedback regarding the accuracy of his or her conclusions. These moments were coded as “checking in” because they are invitations to correct the therapist when he or she misunderstands information. Checking in is a way to ensure that the therapist is on
the same page with the client by asking, directly or indirectly, if the assumptions or conclusions being made are correct. It involves a respectful way of saying to participants that they are expert in their experience and have the power to ensure the therapist has accurate information to better help them. To check in with the client invites him or her to join in the process by correcting, participating, and clarifying. This promotes participation in treatment because it suggests that client input is important and reduces the therapist’s role of expert since the participant is being asked to comment on how well the therapist understands the topic of discussion. This code occurred 12 times in the data, and the following segment taken from session one with participant 006 illustrates what takes place when the therapist checks in with the client:

D: Dígame entonces si le entiendo correctamente donde estás. Como que con el otro señor lo que usted llegó a ver fue algo muy diferente a lo que estaba acostumbrada y como que su meta es llegar a tener ese punto de vista otra vez, pero que todavía estás luchando para…tener su confianza y poder seguir adelante, para poder llegar a esa altura.
P: [Tener confianza en mi misma]…es algo que es para mí misma…

D: Tell me if I understand correctly where you are. It’s like with the other gentleman you saw something very different from what you were used to and your goal is to have that point of view again, but you are still fighting to be able to, to have your confidence and continue forward, to be able to arrive at that height.
P: [To be confident in myself]…it’s something for myself…

One hears the therapist express a desire to understand the client “correctly.” His succinct summary shows he has been listening and informs her about his conclusions. He provides her with the opportunity to clarify the areas he may have misunderstood. This leads the client to reiterate her need for self confidence, indicating agreement with the therapist’s assumptions. Later on, he attempts to check in with the client about how well
he has captured her experience by respectfully asking if he has heard her correctly,

“…para estar seguro de que le entiendo bien, como que ¿empezó a ver que los hombres
todos eran eh, iban a lastimar las mujeres?” (...to be sure that I understand you well, it’s
as if you started to see that all men were, going to hurt women?). His tone conveys the
message that he wants to be sure he has understood her. He refrains from making a
blanket statement about her views on men, which could be interpreted as a judgmental.
Instead, he implicitly asks her to endorse or refute his line of thinking.

Another example of the therapist voicing concern for having a clear
understanding of the client’s experience occurred during the first session with
participant 025: “…bueno para concluir…esa es la forma en…que yo la entiendo a usted,
si me he equivocado, me perdona, y si me he equivocado quiero que, me diga, donde he
ido mal…” (...well to conclude…that is the way…in which I understand you, if I have
made a mistake, forgive me, and if I have made a mistake I would like you to, tell me,
where I went wrong). The therapist uses a tentative tone with the client as she asks for her
input. Asking the participant for feedback and corrections lets her know she is viewed as
the expert and invites her to become an active participant in the therapy. The therapist’s
apology for the possibility of having misunderstood, as well as her expressed desire for
clarification, seems to shift the power dynamic since the therapist is saying, “You have
the answers, you know best.” During the last session with this participant, she responds to
the therapist’s attempt to check in with her by talking about her fears:

D: ...pero así fue que lo entendí y me dice si si me equivoqué, amm, es como que está lista a cerrar ese capítulo de su vida.
P: … yo me siento muy estancada muy, desperdiciada muy (.) sí como cuando uno deja pasar el agua entre los dedos.

D: …but that is how I understood you and tell me if if I was wrong,
umm, it’s like you are ready to close this chapter in your life.
P: …I feel stuck very, very wasted (.) yes like when you let water run through your fingers.

Here, the therapist is describing how she understands the participant’s experience. She concludes by reminding her to correct her if she is wrong in her assumptions. This intervention shows the client that she has been heard and that her feedback is valued, which leads her to be more involved since the participant responds by elaborating further about how she feels.

In conclusion, checking in with the client tells him or her that the therapist has been paying attention but doesn’t presume to know everything about the participant. By asking for feedback and corrections, the therapist shows respect for the client, conveys the message that the participant is the expert and his or her input is invaluable, and calls attention to the fact that the therapeutic work requires the client’s involvement.

Enhancing Confidence

Confidence in the therapist’s ability to help also appears to be a major factor in promoting participant engagement in treatment. It is related to the Latino value of trust (confianza), which is critical to establishing and maintaining interpersonal relationships (Añez, et al., 2005). Trust grows with positive interactions and can be seen at play in the therapeutic setting when clients report their level of comfort with the therapist (Añez et al., 2005; Añez et al., 2008). Therefore, enhancing the client’s degree of confidence for the therapist and the treatment is necessary for the client to remain invested it the work. In the data reviewed, this was achieved primarily through therapist behaviors involving validation, support, and interest, which resulted in the client feeling as though he or she could be helped. The most relevant codes in this cluster are described in detail and
include interest/caring, affirming, animo/apoyo (encouragement/support), and *me puede ayudar* (you can help me).

*Interest/Caring.*

The data showed instances in which therapist behaviors indicated that he or she was invested in the client. When these moments were present, they were coded as “interest/caring.” They occurred 14 times in the data and displayed therapist willingness to support the participant through offers to follow-up and be available outside of session, as well as a desire to know how the client will manage once sessions are over. The following segment is a good example of how the therapist shows participant 003 that he is interested in her experience and her efforts to find ways to resolve her problems:

D: este sería el último “appointment” por un rato y después si a usted le interesaría lo que le podría ofrecer sería verla en…dos meses, para ver cómo sigue y tener una conversación parecida como lo que hemos tenido.  
P: Ajá.  
D: Y ojalá oír noticias buenas de que se ha sentido mejor…Eso sería muy bueno poder oír. A la misma vez, si la batalla sigue pues aquí estamos para usted.  

D: this would be our last appointment for a while and then if you are interested what I can offer is to see you in…two months, to see how you are doing and have a conversation similar to the one we’ve had.  
P: Uhu.  
D: And hopefully to hear good news that you that you have felt better…That would be nice to hear. At the same time, if the battle continues we are here for you.

The therapist is saying that he would like to know how the client is doing and that he wants to help her to feel better. He seems to be saying, "I am here" and "I like talking with you." By showing a desire to follow-up with her, he is letting her know that he cares and that she can count on him, which may be a different message from those she typically receives. The interaction with participant 006 also demonstrates the therapist’s efforts to
show that he wants to follow-up on her progress: “…tenemos un folleto que hicimos acerca del medicamento y el tratamiento…¿Quisiera que le mande eso por el correo? OK. Yo le mando eso por el correo y una notita deseándole fuerza con todo esto que está luchando.” (…we have a pamphlet that we made about medication and treatment…would you like me to mail you one? OK. I will send it to you by mail along with a note wishing you strength with all that you are fighting). Here, the therapist shows the client that he wants to make contact with her outside of session by providing her with information about medication side effects. This suggests that he is invested in her recovery since he wants her to learn more about ways to combat her illness. Furthermore, the therapist’s statement about enclosing a note to wish her strength in her struggle indicates that he wants her to feel better and that he is a resource for her.

Interest and caring is also displayed when the therapist offers to obtain more information for the client to help her learn about her options, as was the case with participant 020: “Ee, si usted quiere yo puedo averiguar, si el medicamento suyo, como corresponde con lo que tienen ellos, y enviarle…como una notica simplemente para que la tenga en mente…” (Eh, if you want to I can find out, if your medication, how it matches what they have, and send you…like a note so that you have it in mind). The therapist displays interest in the client’s progress by offering to provide her with more information regarding low cost medication. He responds to her question with a willingness to do more than just “talk,” that is, he was open to meeting her basic needs for cost-effective medication, which likely makes her feel cared for. His behavior indicates that he is invested in helping her find symptom relief because he makes himself available to her outside the session to research her medicine and send her the information.
Furthermore, it seems that displays of pleasure to work with the client, as well as concern for his or her welfare, lead the client to feel as if the therapist is genuinely involved in helping to resolve the problem. The following segment that was taken from the last session with participant 025 exemplifies this: “…ha sido un placer hablar con usted, y, si me permitiría, me gustaría hablar con usted de aquí a unos dos meses para saber como le está yendo con esta decisión…y sí tiene alguna pregunta pues… yo estoy para servirle…” (…it has been a please to work with you, and, if you will allow me, I would like to speak with you in about one to two months to find out how you are doing with this decision…and if you have any questions…I am here to serve you…). Here, the therapist is indicating to the participant that she has enjoyed their meetings and that she would like to follow-up about her progress. She is also saying that she will be available over the phone if the client has questions. This suggests that the therapist likes the client and cares about what happens to her, which is likely encouraging since the client knows she can count on the therapist’s support.

In essence, working towards helping the client feel as if they are cared for and liked seems to be important because it may lead to greater therapeutic engagement. In other words, it seems that when the therapist demonstrates interest or caring for the participant, it leads him or her to feel supported. This probably has a positive impact in the therapeutic relationship because the therapist is viewed as reliable and engaged, and as a result, the client feels as though he or she is an important part of the treatment.

Affirming.

When the therapist was observed to acknowledge, recognize, or validate the participant’s emotional experience and/or his or her reported efforts to self care, the data
was coded as “affirming.” This code appeared on 16 separate occasions in the segments of the audio recordings that were reviewed for the purposes of this study.

When a client receives affirmation, a level of praise and admiration for him or her seems to take place since the therapist is, in essence, saying: “good work.” The therapist has to listen and recall information in order to affirm the participant. This involves being present for the client’s emotional experience in order to normalize feelings or reactions or be able to describe the ways in which the participant is able to take care of him or herself. When the therapist engages in affirmation, the client is reassured that he or she is being heard and is provided with support for his or her experience and efforts to self care. This may lead the participant to feel understood and appreciated by the therapist. In addition, when affirmation involves recognition of behavior or knowledge that can improve their condition, the client is told that he or she is doing a good job and has the ability to self care, which also serves as a behavioral reinforcer. The following quote from participant 002 exemplifies some of the elements involved in this code:

D: Mire, yo pienso que lo que usted está haciendo, hacer las preguntas para hacer la decisión, para aquí estamos para eso. Eso es, todas estas cosas, el experto de la vida suya es usted.
P: Mjm.
D: Y ya ha tenido sus experiencias, entonces usted solo está tratando de colectar la información necesaria para decidir lo que usted va a a hacer.

D: Look, I think that what you are doing, asking questions to make the decision that is what we are here for. In that, all those things, you are the expert of your life.
P: Uhu
D: And you’ve had your experiences, then you are only trying to collect the necessary information to decide what you are going to do.

The therapist is validating the participant’s line of thinking in order to reach a decision about his treatment. He calls the client the expert in his life and is almost telling
him that he is doing all the right things to take care of himself. The message conveyed is that the client knows best about his experience, which is a way of empowering him, since the participant is being told that he has the tools to solve his problems. Similarly, participant 003 received affirmation for her knowledge and emotional experience by her therapist when they were discussing her anti-depressant medication: “…que reconoces eso y que mira sería fácil si uno no tendría problemas con tomar el medicamento, pero sin embargo la realidad es que a veces es dificil…pero con el conocimiento que usted tiene, eso le ayuda en estos momentos a superar…” (...you recognize that and look it would be easier if we didn’t have problems taking the medication, but the reality is that sometimes it’s difficult…but the knowledge that you have, that will help you overcome in these moments). This is a double affirmation because the client’s feelings and concerns about medications, as well as her knowledge about herself, are recognized by the therapist. He validates the difficulties she has in taking medications to manage her symptoms and connects them to her self-knowledge, which seems to be important in helping her to feel heard and understood and likely result in recognizing that she needs the medication to feel better since she responds with, “Tengo que tomarmela.” (I have to take it).

In session two with participant 008, the therapist recognizes the emotional work and progress she has been making, “La forma que usted ha salido de esto… le ha traído una confianza muy grande de decir ‘bueno yo sé exactamente si se me presenta la depresión lo que tengo que hacer.’” (The way in which you have come out of this…it has brought you great confidence to say ‘well I know exactly what I have to do if depression comes again’). The therapist highlights the client's new level of confidence as a way to validate her progress and her ability to take care of herself in spite of the challenges she
has been facing. She comments that the client possesses the knowledge to fight
depression and gives her the message that she has the power and know-how to make
herself feel better if she relapses.

Another form of affirmation involves recognition of client behavior. The
therapeutic interaction with participant 012 is an example of how the therapist shows the
client that she understands and approves of the ways she is trying to help herself:

D: Usted puso un plan, una estrategia muy buena, para aguantar esos
momentos duros, usted se distrajo, con la gente que vive en su casa, usted,
este, usó su fe, y su religión…leyeron la Biblia…

D: You used a plan, a very good strategy, to withstand those difficult
moments, you distracted yourself, with the people who live in your home,
you used your faith…your religion…read the Bible…

The therapist reflects and validates the participant’s experience and her efforts to
lift herself out of depression. By affirming the client’s behavior, the therapist shows that
she is paying attention and is impressed with the client’s work. She gives the participant
the message that she can do it and that she has the ability and knowledge to manage her
depression and help herself to feel better. This intervention is probably very reinforcing
for the participant because she is being told that she has a “good strategy” that she can
use whenever she feels down.

In conclusion, affirmation involves listening and attending to the participant’s
emotional and behavioral experience in order to reflect their efforts back to them in a
manner that normalizes the experience and/or encourages self care. Validation of
behavioral efforts may have a greater impact because the client is getting the message
that they are doing a good job, which probably reinforces the behavior. Additionally,
affirmation of emotional experience may serve to draw the client in since the therapist shows he or she is listening and trying to understand.

*Animo/apoyo.*

Data was coded as “animo/apoyo” to indicate that the client was receiving either or both encouragement (i.e., *animo*) or support (i.e., *apoyo*) when the therapist acknowledged participant’s efforts to struggle through difficult moments or to deal with pain. Although it is similar to the affirmation code in that the client is being recognized for attempts to self care, it is less concrete since specific behaviors are not involved. *Animo/apoyo* is a way to connect with the participant by acknowledging the struggle and helping them to elaborate on their efforts. It is a way to tell the client that their hard work is noticed and that there is hope for improvement if he or she continues in this way. The underlying message that is conveyed in this code seems to be, “you can do this,” which can be motivating and supporting for the client. This code was found 15 times in the data reviewed. The following interaction that occurred with participant 007 is an example of what is involved in this code:

P: I don’t think no medication can stop this crying  
D: Because it’s just a pill and not a magic pill  
P: right  
D: but you are working the magic all by yourself…you are continuing to take the medication. What motivates you to take the medication?

The therapist supports the participant’s feelings by acknowledging and accepting that medication is not going to solve all her problems since it is “not a magic pill.” She also provides support and encouragement by noting that the client is working the “magic” to help herself feel better. This is an empowering statement that she links to the client’s
ability to remain committed to taking her medication. This intervention has a two-fold effect on the participant: it validates her doubts about medications and her current difficulties, and it promotes her ability to take care of herself and remain motivated to get better.

Another example of *animo/apoyo* in action occurred in the therapeutic interaction with participant 006, in which the therapist is supportive of the client by reflecting on the range of feelings he has noticed she is able to experience: “Y hay veces que tienes esa foto en mente…y eso duele…y también hay otros días que la imagen que usted ve es diferente y yo creo que eso fue la persona que yo vi la última semana…en la lucha constantemente.” (And sometimes you have that picture in your mind…and that hurts…and there are other days that the image you see is different and I think that is the person I saw last week…constantly in the fight). The therapist provides support for the participant by acknowledging the painful memories she carries with her. At the same time, he notes that the degree of pain varies depending on the occasion, meaning that she experiences increased motivation on the days she can access less upsetting images. He connects this to the idea that the client wavers in her battle to feel better and provides her with encouragement by showing he understands her daily struggle. In essence, he implies that he believes she will get past the low mood she is presenting since he saw a more positive demeanor in her in the previous session.

It seems that providing clients with animo and apoyo can help them get in touch with their inner strengths. In session two with participant 014, one can hear the client talk about his strengths in response to the therapist’s intervention:

D: Y para usted ha sido una, (.) un, un camino, llegar a este punto donde está ahora que que puede…no, no dejar que, que la enfermedad le le
derrumbe…
P: Voy a luchar…he, creado como, como una fuerza interna que me ayuda a salir

D: And for you it has been a, ( ) a, a road, arriving at this point where you now can…not allow that, that the illness breaks you down…
P: I am going to fight…I have created a sort of, of internal strength that helps me get out

This item was coded as *animo/apoyo* because the therapist is acknowledging both the participant’s resolve to fight against his disease and the inner strength he has found through this struggle. In validating his efforts to stay healthy, the therapist shows a good understanding of the client’s experience, including his ability to have a different and more positive outlook, as well as to remain motivated to take care of himself despite his condition. Hearing the therapist’s message that he is doing well seems to help the client access his inner resources and speak about his desire to “luchar” (i.e., fight) with conviction.

In conclusion, the code *animo/apoyo* is a message of encouragement to the client to continue with self care by acknowledging his or her experience and covertly saying “you can do this” or “you can get better.” The participant is provided with words of support and encouragement that indicate understanding and belief on the part of the therapist. In addition, these words help the client to feel less alone in their attempts to overcome their problems since they have someone who is an attentive cheerleader.

*Me puede ayudar.*

The code “*me puede ayudar*” (you can help me) emerged in the data when participants spoke about how treatment was helpful or why they continued to attend sessions at the clinic. During these moments, participants described feeling confident in
the therapist’s feedback, level of expertise, or profession and often demonstrated an investment to remain in treatment because they valued the therapeutic work. They indicated belief in the therapist’s ability or in the soundness of the therapeutic work and often gave examples of improvement in their condition. *Me puede ayudar* occurred 14 times in the audio recordings that were reviewed. It involves client behavior of trusting in the therapist and hoping for an increased sense of well-being. The following quote from participant 012 illustrates the meaning of this code:

P: Y yo dije pues, le dije a él me hace falta, ir a la terapia, (.) y, esperé, me tomé las pastillas para dormir, me dormí, desperté y pues, ya estoy acá, (risa) que, me siento más tranquila, (.) aaaa conversar esto, (.) porque tampoco se lo puedo estar conversando a cualquier persona…los que viven en la casa, por ejemplo a mi hermana, no, no, ellos lo que hacen, a veces se rien…

P: And I said well, I said to him I need it, to go to therapy, (.) and, I waited, I took my sleeping pills, slept, woke up, and I’m here (laughs), I feel calmer, (.) to speak of this (.) because I can’t discuss this with anyone…those who live in my house, for example my sister, no, no, what they do, sometimes they laugh…

Here, the client is explaining how she was able to cope with a relapse in depression by reminding herself and her husband that she needed to attend therapy. She is talking about the importance of remaining engaged in treatment because she has someone (i.e., her therapist) to talk to about her troubles. For her, it seems that therapy is a unique opportunity in which she has someone to confide in without feeling censored or judged. Her therapy appointments are important because they provide her with an outlet, someone to talk to without criticism since her sisters laugh at her when she tries to share her issues with them.

Participant 014 is heard expressing gratitude for the help he has received: “No gracias a ustedes, porque pues, me, me dan ayuda y me siento como, mejor…de hablar
con alguien, de tener, por lo menos a alguien que, que escuche, me sient, me hace sentir mejor…y útil.” (No, thanks to you, because well, you help me and I feel, better…to talk with someone, to have, at least someone who, who listens, I feel, makes me feel better…and useful). He seems to value the therapeutic work and to feel a deep sense of gratitude for the help he has received. Having someone to talk with and to listen to him has been an important factor in his recovery since he seems to have few outlets to speak about his issues, particularly the medical aspects of his condition. Therefore, feeling heard by an impartial person seems to have had a profound effect on him, especially in his ability to trust the therapist and to believe that she can help him. Additionally, the participant states that the therapy has helped him to feel useful, which seems to have renewed his sense of purpose and motivation for self-improvement. Although not captured by the text, the audio recording suggests that the client has a high regard for the therapist; he seems to hang onto her words, which likely results in his following through with interventions.

Another way participants show they believe the therapist can help occurs when they describe how it is helpful and why they remain engaged in treatment. An example of this is the following quote from participant 020:

P: Bueno yo me siento sinceramente, perdona que te interrumpa, como que ustedes están preocupados por mi salud y yo me preocupo porque ustedes me vean y me manden el medicamento y, y me hagan preguntas porque así yo me desahogo más, converso…puedo establecer una conversación con alguien, que yo no conozco y así, yo pienso que eso ayuda mucho…

P: Well I sincerely feel, forgive me for interrupting, like you all are worried about my health and I worry about you seeing me and giving me the medication and, and ask me questions because this way I can unload, I speak…I can establish a conversation with someone, that I don’t know, and I think that helps me a lot…
This participant seems to be describing the ways in which the interactions she had with the treatment team had a positive impact in her recovery. She reports that she found the interest displayed by her caretakers as helpful because it led her to be interested in herself. It seems that, for her, it was important to feel as though she was cared for by her therapist in order to trust his ability to help her, which kept her engage in the therapeutic work. Additionally, she reports that having a neutral person to talk to was helpful because she could “unload” and not feel criticized.

Confidence in the therapist’s opinion or expertise was also evidenced in this code. Participant 006 displays trust in the therapist’s profession and ability to guide her towards increased insight and improved mood:

P: Antes yo decía que quería ser psicóloga pero no para las personas sino para trabajar mi cabeza…quería que cuando yo tuviera un problema, yo supiera cómo resolverlo cómo llegar a mis conclusiones yo sola. Yo quería estudiar para mi.
D: Usted quería fortalizarse, ¿se dice así?
P: Mentalmente…Quería tener la capacidad para analizar las cosas que me pasan como lo hacen ustedes, porque a todo le encuentras el otro lado…

P: Before I used to say that I wanted to be a psychologist but not for other people but to work my head…I wanted to know how to solve my problems, to arrive at my own conclusions. I wanted to study for me.
D: You wanted to strengthen yourself. Is that how it’s said?
P: Mentally…I wanted to have the capacity to analyze the things that happen to me the way you do it, because you find the other side to everything…

The participant shows that she has a high regard for her therapist’s profession and for his ability to solve problems. It seems that she trusts his feedback because he can "see the other side to things," that is, he can analyze situations in order to find solutions. The client doesn’t seem to feel like she can do this because she needs help in solving her
problems. It seems that the participant finds the interactions helpful because she views him as expert in his role as psychologist and believes he knows how to understand her mental processes.

In conclusion, the code *me puede ayudar* appears to exemplify moments in the data when participants expressed feeling helped by the therapist or the treatment, as well as instances of expressed confidence in the therapist’s feedback or expertise. Believing that the therapist can help alleviate problems is important in client engagement because it seems to enhance their investment in the work, including continued participation in treatment and openness to accept feedback, which can lead to improvement in symptoms.

*Overlapping Qualities of Bonds Codes*

The sub-themes of acceptance, *valorar al cliente*, and enhancing confidence describe the important elements that were found in this sample that appear to impact the creation of the personal connection between client and therapist. They involve the “mutuality” described by Bordin (1979) or the interaction of the dyad rather than the individual components. Taken individually, the therapeutic moments described by these codes attempt to illustrate the reactions, emotions, and responses that take place as a result of the therapist’s or the participant’s behavior. For example, when the therapist checks in by asking for feedback and corrections, he or she minimizes the expert role and leads the participant to feel valued. However, the moments captured in these codes are better understood as a whole since they include interactions that involve aspects of various codes to create a therapeutic dialogue that is conducive to a working relationship (see Figure 1).
The therapeutic experience is complex and occurs within the context of a dyad, involving subtle and overt ways of relating. This experience is not one-dimensional and necessitates give-and-take between therapist and client in order for a working relationship to develop. The complexity of this interaction is evident in the codes described above, since they share unique and overlapping characteristics (see Table 5). In order for there to be a positive impact on the alliance, the individual qualities of each code have to be combined. For example, the distinct aspects of withholding judgment (i.e., therapist’s stance that is free of criticism and full of acceptance) come together with the distinct characteristics of trust/comfort (i.e., the participant experiences the therapist as non-critical and non-judgmental), which come together with the distinct qualities of you get me (i.e., client feels understood) and result in the complete experience of each code. In other words, for the participant to feel understood, he or she has to experience the therapist as accepting and non-critical, which occurs after the therapist has shown acceptance and lack of judgment for the participant.

Tasks

According to Bordin (1979, 1994), an important element of alliance involves tasks, or the in-session behaviors between client and therapist. He described these as the agreed upon exchanges (1979, p. 254) that occur in therapy that help clients get closer to their goals. In this study, evidence of tasks had low frequency, with only one relevant code emerging under this concept. Data from the MI sessions suggests that talking about possible problems and working towards finding solutions is an important element of alliance with this group since it helps participants find solutions to certain problems that can impact their treatment.
Problem Solving

Instances when the therapist and the participant engage in conversation about potential obstacles to achieving goals were coded as “problem solving” and occurred 16 times in the data that was reviewed. During these segments, one hears the therapist express curiosity about the barriers the participant thinks he or she will face and/or how to work through them. Furthermore, problem solving can also involve therapist feedback that includes possible options the participant may not have considered. The following quote, taken from session two with participant 007, is a good example of what takes place when this code is activated:

D: but what might get in your way?
P: the little bumps that come in my way
D: so like last week? …where you are like… I don’t care about anything.
P: yeah
D: so at this time, what are you prepared to do to help yourself feel better?
P: I have to stay motivated and it’s hard
D: what can you do to help you get motivated?

The therapist shows interest in the potential obstacles the participant may face as she attempts to achieve her goals. When the client responded in a somewhat evasive manner, the therapist acknowledges the difficulty of her situation and then asks her a direct question about how she can help herself. Problem solving takes place because the therapist gently insists that the client think of this topic. She helps her talk about the possible difficulties she may encounter by first supporting her struggle and then redirecting her to the task.

Another instance of problem solving can be observed in the interaction with participant 008, when the therapist helps her to talk about ways she can remain in treatment despite the challenges that may come her way: “…cuales barreras usted piensa
que se le presentarían en el futuro y cómo usted la pudiera romper?” (…what barriers do you think you will face in the future and how can you break it?). The client replies that time and shame may get in the way of accessing services in the future: “como falta de tiempo, esa es una…y otra pues sería como, como un poco de pena de volver a decir ‘ay volví a caer en lo mismo’…” (like not enough time, that’s one…and another would be like, like a little embarrassment about returning and saying ‘I relapsed on the same thing’ …). Here, the therapist helps the participant begin to talk about how she can overcome the barriers of time management to attend sessions or the shame she may experience if she relapses into depression. This is coded as problem solving even though the client does not provide elaborate responses as to how she will get through these difficulties because the verbal exchange shows that the participant is beginning to explore this issue, suggesting that she may engage in thinking that will help her find solutions in the future.

The following quote is part of the therapeutic interaction with participant 020, who is concerned about the medication side-effect of weight gain. This segment demonstrates how the therapist and the participant problem solve, including suggestions made by the therapist to help the client arrive at a solution:

D: Ee, qué piensa que serían sus opciones, si esto es una preocupación…
P: No, yo he tratado de hacer ejercicio cualquier cosa que me ayude a bajar para no dejar el medicamento…Incluso ya lo teníamos planeado, salir, a caminar mi esposo y yo todos los días como tengo la escuela y el parque cerca…
D: … okay, y, ee, ¿quisiera oír otra opción?
P: Pues sí.
D: Pudieras hablar con el doctor a ver…si puede, o ajustar el medicamento o cambiarlo…

D: Uh, what do you think would be your options, if this is a concern…
P: No, I have tried to exercise anything that will help me lose weight so I
won’t quit the medication…We even had it all planned, go out, to walk my husband and I every day since the school and the park are nearby…
D: …okay, and, uh, would you like to hear another option?
P: well yes.
D: you can speak with the doctor to see…if he can adjust or change the medication…

The therapist asks about the participant’s options regarding how she can manage the side effect of weight gain caused by her antidepressant medication without discontinuing it. It seems that the participant has only considered one option since she focuses on exercise and proceeds to describe what she plans to do. The therapist responds by taking on a more active role by suggesting that she consult with her psychiatrist regarding her options about medications to find some relief with the side-effect without having to discontinue the treatment altogether.

In conclusion, problem solving involves discussing the barriers or challenges the participant may face as he or she attempts to reach certain goals. Therapist curiosity is necessary to engage the client in this process. In addition, the therapist may take a more active stance by making suggestions to aid in this process.

Low Frequency of Tasks

The data examined yielded one code that was relevant to therapist and client tasks, or collaborative behaviors, described by Bordin (1979, 1994) as essential to the therapeutic alliance. The code labeled problem solving was pertinent because it involves cooperation in executing specific therapeutic work at behavioral, cognitive, and affective levels. The low representation of these aspects of alliance may have been influenced by several factors, including the specific segments of the data reviewed, the phase of the alliance, and the intervention used.
The intervention received by the participants in this data was limited to two motivational interviewing sessions (MI1 and MI2). The analysis in this study involved coding and analyzing the first 20 minutes of the first MI session and the last 20 minutes of the second MI session; therefore, it is possible that relevant data to the tasks described by Bordin were missed. It is also likely that the primary focus of these sessions was bonding with the participant since the treatment involved only two meetings, suggesting that the data examined captured the attempts at interpersonal connections that occurred in the therapeutic dyad.

Another important factor to consider is the phase of the alliance described by Horvath and Luborsky (1993). The authors suggested that phase I occurs within the first five sessions and involves the initial development of the alliance, with a primary focus of joining and establishing trust and collaboration with the client. Phase II takes place closer to the end of the work and focuses on active interventions to challenge the client’s dysfunctional beliefs and may be experienced as a loss of sympathy and support from the therapist. The alliance reported in this study was still in phase I since the data reviewed involved a two-session intervention, which probably had a greater focus on relationship building. This suggests that the low number of tasks that emerged may have been a function of the stage the work was in.

Furthermore, the way alliance is manifested depends on the therapist’s style and theoretical orientation (Bordin, 1994). That is, some elements of alliance may have more emphasis than others based on the interventions employed by the therapist. According to Bordin (1979), some therapies, including client-centered approaches, do not make tasks explicit in the work, as they evolve slowly and vaguely. The intervention the participants
of this study received was Motivational Interviewing, which relies heavily on establishing the bond between therapist and client. Miller and Rollnick (2002) described MI as a person-centered approach that involves creating an “interpersonal process” to promote motivation (p 22). The spirit of MI involves collaboration to create a supportive relationship that respects the client’s viewpoint and expertise and avoids the one-up position from the therapist, evocation to explore the client’s values and goals and to avoid providing expert feedback, and encouraging the client’s autonomy by affirming and respecting their beliefs and choices (Miller & Rollnick, 2002). These were elements found in the bonding codes described earlier, suggesting that the chosen intervention may have influenced the results because of its strong emphasis on relationship building.

Finally, it may be important to take another look at the elements involved in tasks to gain clarity for the emergence of only one significant code. Bordin (1979) described tasks as the behaviors that are the focus of attention in the therapeutic process for both the therapist and the client. As stated above, MI emphasizes collaboration, acceptance, respect, affirmation, and evocation of the client’s experience. Although the therapist provides these interventions to facilitate the relationship and enhance motivation, the client’s responses allow the give-and-take needed to establish the connection and begin the work. This is evident in the codes described under “bonds” because they involved the behaviors necessary for tasks to take place. For example, withholding judgment is a therapist behavior that includes acceptance and avoids criticism and often helps to create a sense of safety in the room. Participants were found to respond to low criticism and high acceptance with increased trust and comfort in the presence of the therapist. Because tasks involve the in-session “behaviors and cognitions that are the substance” (Horvath &
of the work, the interactions just described are also good examples of tasks. Therefore, it seems that tasks are embedded in the data that was coded under the umbrella of bonding since the clusters that emerged show how the codes are interrelated through behavioral interactions that take place in the dyad.

Goals

Client and therapist must agree on goals for treatment at the outset of the work. Bordin (1979, 1994) maintained that this was an important element of the working relationship because it involves mutual acceptance of what will be the focus of treatment. Two significant types of goals emerged in the present data: those that were directly related to the reason for referral and involved a desire to remain in treatment to reduce symptoms of depression, and those that were more ambitious and remote, involving desires that were beyond the initial goal of symptom relief.

Continue with Treatment

The code labeled “continue with treatment” emerged 16 times in the present data. It involves a statement from the participant about needing or wanting to stay in treatment, including taking medication or attending therapy. It describes the client’s recognition of the benefits of continued care to accomplish goals, such as feeling better, ayudarse (i.e., helping oneself), or working. When this code is in action, the participant is heard making statements about the importance of treatment to feel better or avoid relapse. The following quote exemplifies what occurs in this code. It was taken from the session with participant 006 as she talked about her feelings regarding antidepressant medication:

P: Y las medicinas las trato de tomar todos los días.
D: OK.
P: Para mi misma, no me gusta que la gente sepa que las tomo porque van a pensar que estoy media loca, pero sí las tomo porque sé que las necesito
P: and the medications, I try to take them every day.
D: OK
P: For myself, I don’t like it for people to find out that I take them because they will think that I’m half crazy, but I take them because I need them.

She reports that she takes her medications every day because she needs them. However, she does not share this information with people in her life since she doesn’t want to be labeled as “crazy.” This suggests that she places a high value on her treatment and finds a way to fit it into her life despite the stigma she faces. In other words, the risk of not taking her medication and relapsing into depression is greater than the risk of being found out by the people in her life.

Similarly, participant 008 reports accepting the benefits of medication treatment as a way to prevent depression: “…al principio cuando me dijeron…que iba a tomar por un cierto tiempo, no me pareció como buena idea, dije ‘ay, es mucho tiempo,’ pero analizando bien las cosas dije ‘no, está bien’…para que yo no vuelva a recaer en la depresión.” (…at the beginning, when they told me…that I had to take it for a certain time, I didn’t think it was a good idea, I said ‘it’s too much time,’ but after analyzing the situation I said ‘no, it’s okay’…so that I won’t relapse into depression). The participant recognizes that antidepressant medication plays a role in decreasing her symptoms. She indicates that she was initially resistant to the idea of taking medication but was able to reconsider after thinking that she does not want to relapse into depression. In other words, she is now open to the idea that she needs to take medication for a longer period of time, probably until she becomes stable, because she sees the benefits it can produce in her life.

Finally, participant 020 states that she believes that attending therapy and taking medication will help her to do well. She appears to be invested in following the “doctor’s
plan” because she finds him helpful and trustworthy: “Yo pienso que con las terapias, y con la ayuda de la, del plan del médico… de la medicina…yo creo que sí pueda salir adelante.” (I think that the therapies, and the doctor’s help, his plan…of the medication…I believe that I can get ahead).

In conclusion, data coded as continue with treatment describes instances when participants verbalize the need or desire for ongoing therapy or medication treatment. It indicates that the client values the idea of continued care because it will provide some symptom relief or lead to the attainment of other goals.

*Lograr Con La Vida*

Instances when the participant speaks about overarching goals that embody what he or she would like to attain were coded as “lograr con la vida” (achieve with life) and occurred 11 times in the data. These moments indicate a desire for some form of accomplishment that the client hopes to realize when he or she is doing well. Although these goals appear to be unrelated to the reason for referral, they speak to aspirations of overcoming obstacles and should be explored to maintain engagement in treatment and promote the gains already made. The following quote from session one with participant 012 is an example of this code:

P: …yo ahorita lo que quiero es salir adelante, quiero trabajar, sí.
D: Tiene metas todavía…que quiere alcanzar.
P: Sí, quiero trabajar, eee, más que nada, estar con mis hijos también.

P: …now what I want is to get ahead, I want to work, yes.
D: You still have goals…that you want to reach.
P: Yes, I want to work more than anything, to be with my children as well.

The participant is reporting a desire to “get ahead” through work and to spend time with her children. Because her presenting problem was an inability to get out of bed
and frequent irritability with bouts of crying, it is likely that she had difficulty working and relating to her children. Similarly, participant 008, who has a chronic health condition that precipitated his depressive episode, expresses a wish to be healthy in order to available to help others: “…para mi es, bastante importante así porque…hay personas que necesitan de mí…y yo no los voy a poder ayudar entonces voy a estar bien, y los ayudo.” …for me, it’s very important…there are people that need me…and and I won’t be able to help them so I will be well so that I can). His desire to “be well” to help his friends suggests that he is getting in touch with goals that go beyond remaining physically and mentally stable.

A major goal for participant 020 is be to become more like the person she was when she arrived in this country: “…yo quiero trabajar en la calle, y ya te digo, manejar, ser otra persona, la que yo quise ser cuando llegué a este país.” …I want to work on the street, and I tell you, drive, be someone else, like the one I wanted to be when I arrived in this country). She expresses a desire to work, learn to drive, and be like the woman of her youth. She wants to realize concrete and abstract goals that are probably not entirely part of her treatment plan but that would benefit from discussion since verbalizing them indicates that achieving certain aspirations are important to her. Likewise, participant 025 also describes a goal that is both abstract and concrete:

D: O sea, entonces su meta grande sería establecerse independientemente. P: Sí…la libertad de, no, no ser un, NN [no nombre] en este país…sino pues ser un ciudadano y poder, movilizarme hacia mi país, visitar a mi mamá…

D: so, then your big goal would be to establish yourself independently. P: Yes…the freedom of, not not being, an NN [no name] in this country…but a citizen and to be able to move about towards my country, visit my mother…

"..."
She is expressing a desire to have an identity in this country, not to be a “no name” anymore since she is an undocumented resident. Having legal status would allow her to be independent and visible in this country, which would likely impact her depressive symptoms since she hasn’t known this type of freedom for a long time.

In conclusion, the code *lograr con la vida* describes moments when participants give voice to wishes or desires that go beyond treatment goals of symptom relief. These are overarching goals for achievements that the participant hopes to reach when he or she is more stable. It is important to note that the act of speaking about these goals suggests hope to move towards these aims. Therefore, exploring these wishes, including ways to achieve them, would likely promote treatment engagement and maintain gains already made.
CHAPTER V
DISCUSSION

Summary

The Spearman rho computation yielded moderately positive correlations—.455 and .467, respectively—both significant at the 2-tailed, .10 level. These associations are consistent with the level of correlation frequently found in the literature between the WAI and therapy outcomes. The failure of these correlations to reach to traditional .05 level of significance is most probably due both to the low number of clients (N=10) and the actual moderate nature of the true relationship.

The positive findings in the quantitative analysis of the MI transcripts lend support for the strategy of using the WAI-O codes as guides to find qualitative processes associated with alliance building. This qualitative analysis indicated that bonding is a crucial element in creating a strong alliance. The overlap of the codes implies that connecting occurs through the interplay of therapeutic interactions between client and therapist. The data also suggests that working towards specific and mutually agreed upon goals is an important part of establishing a secure relationship. In particular, discussing far-reaching goals that encompass hope and desire to overcome difficulties may be a good way to promote engagement in the work while maintaining gains. However,
therapeutic tasks had low representation in the data, which may have been a function of the type of intervention used and the phase of alliance. In addition, tasks may have been embedded in the codes that emerged in the bonding section, as these involved client-therapist interactions. Overall, it appears that, for this small sample of Latinos, alliance is primarily enhanced by focusing on attachment, which occurs through in-session events involving acceptance, interest, respect, and support that help the client to feel understood, comfortable, validated, and cared for.

The meaning of the findings I have just summarized are explored below, along with recommendations regarding their implications for further research and clinical practice.

Enhancing Alliance with Latinos

Grounded theory was used to arrive at themes that describe what was happening in the working relationship. In this sub-sample of Latinos, connecting with participants was instrumental to creating a secure relationship. The bonding elements of alliance produced the most salient and frequently occurring codes explaining therapist-client interactions that appear to enhance the relationship. These codes were separated into three major themes of acceptance, *valorar al cliente* (to value the client), and enhancing confidence (see Figure 1).

Acceptance involves therapist behaviors that help the participant to feel understood and welcomed. Acceptance has been deemed important throughout treatment but critical at the onset of therapy to promote engagement (Bordin, 1994, 1979; Hatcher & Gillaspy, 2006; Roth & Fonagy, 1996). This is particularly relevant to Latinos seeking treatment since they distrust mental health services and have low retention rates (Antshel,
Furthermore, the theme of *valorar al cliente* shows the importance of decreasing the one-down position in therapy for the client by empowering and respecting the participant. This manner of relating is important to this population, as it has been found to be relevant in establishing personal relations (Añez et. al, 2005). Latinos value mutual respect, including admiration for another’s experience, as well as language that is polite when sharing emotions or handling conflict (Añez et. al, 2008; Falicov, 1998). Finally, enhancing confidence in treatment occurs when the therapist shows interest and gives support, which leads the client to believe he or she can be helped. This is also applicable to work with Latinos, as it is linked to the value of trust or confianza, which Añez and colleagues (2005) described as an important element in creating and maintaining interpersonal relationships.

The elements of tasks and goals were not well represented in the data. The findings suggest that setting immediate and far-reaching goals may enhance the alliance. However, few significant client-therapist in-session behaviors (i.e., tasks) were found to be significant. Problem solving was the only task that emerged as important to the therapeutic relationship. This is not entirely consistent with previous research, which has found urban, low-income Latinos often seek symptom relief, guidance, and a problem-centered approach when looking for mental health services (Organista & Muñoz, 1996). Several factors may have influenced these findings, including the brevity of the intervention and the segments reviewed. It also seems that the strong focus on creating an attachment of the MI intervention and the phase of alliance (i.e., Phase I, which occurs at the onset of treatment) may have lead to the low frequency of these elements. Moreover, the nature of MI, which involves a person-centered approach, may have resulted in tasks
that were not overtly stated (Bordin, 1979). Additionally, Falicov (1998) has noted that an understated, task-oriented approach that elicits emotions and goals for treatment in a subtle manner is more collaborative and better fitting with the Latino culture. Therefore, it may be that therapeutic behaviors that qualify as tasks were understated or embedded in the bonding codes, since they emphasized client-therapist interactions, which is the hallmark of tasks.

Limitations

This exploratory, mixed-methods study had several limitations. The small convenience sample used resulted in low power to detect significant differences in the quantitative, WAI-O analysis.

Also in both the quantitative and qualitative analyses, I was the only person doing the coding. Despite my efforts to maintain objectivity, the lack of a reliability check on my coding is also a major limitation, indicating the particular need to replicate these analyses to see if the results continue to hold.

In addition, the gender imbalance of participants is another limitation of this study. There were more female (80%) than male participants, which could have resulted in gender differences that were not explored. However, it should be noted that female overrepresentation appears to reflect the ratio of Latinos seeking community mental health services (Cabassa & Zayas, 2007).

Implications

This study explored the therapeutic experiences of depressed Latinos and had several implications. First, it adds to the growing body of literature and psychotherapeutic work about engaging Latinos in treatment. It is widely recognized that Latinos are
underrepresented in mental health services (Antshel, 2002) and in research exploring the impact of the therapeutic alliance on outcomes (Bernal et al., 1998 & Vega et al., 2007). This study offers an exploratory look at the in-therapy experiences of urban, primarily monolingual Latinos. It provides important information about what seems to help Latinos remain engaged in treatment, which is relevant to future research and clinical work.

Future research should continue to explore the factors that promote the therapeutic relationship and foster treatment adherence with this group. Quantitative research should be conducted using a large pool of participants to make the results more generalizable and to increase power to detect differences. Work, such as the one conducted by Bernal and colleagues (1998), is especially relevant in this area. They studied the effectiveness of psychotherapy in a Puerto Rican sample with problems related to depression, anxiety, and anger and found that 45% of the variance was related to alliance. However, Latinos are underrepresented in effectiveness studies because of their low participation in treatment; therefore, mixed-methodologies may be more successful in generating information about how to keep Latinos in treatment (Bernal & Scharron-del-Rio, 2001). Qualitative analysis should focus on the cultural and individual experiences that impact therapeutic interactions to better understand how alliance develops and is maintained with this group. In particular, overt and subtle client-therapist behaviors should be explored to determine what type of approach (e.g., direct vs. indirect) is more conducive to therapeutic engagement and achievement of goals.

Moreover, this study had several implications for clinical work with depressed Latinos. In general, this study underscores the importance of making active efforts to connect with clients throughout the work. Clinicians must remember that acceptance is
imperative in establishing a sound relationship, as it helps to ease the client’s concern of being judged and creates a comfortable and safe atmosphere. The Latino cultural concepts of respect and politeness can be used to enhance alliance by limiting the expert role. This can be accomplished through validation of the client’s self-knowledge and efforts to improve his or her condition, asking for permission, and checking the accuracy of conclusions.

Therapists should also be mindful of the host of problems Latinos present with, such as lack of English language skills, lack of information, unemployment, and lack of official documentation since these impact the therapeutic process. Providers can enhance confidence in treatment and increase therapeutic engagement by offering to be available outside of the therapy through brief contacts to help with concrete life problems that are not part of the formal therapy per se. Although the relationship is dependent on dyadic interactions, clinicians should not forget that they set the tone for what takes place at the onset of the work.

Conclusion

The data in this project suggest that the development of a sense of safety and trust within the dyad requires in-session behaviors that help the client feel understood, validated, and cared for, and thus requires that the therapist show displays of acceptance, interest, respect, and support. These bonding displays in turn foster discussions about problems and goals, the other crucial elements of the alliance. Overall, while the pilot nature and limitations of this study suggest caution in generalizing from it, the data do strongly suggest that for Latinos (a) the therapeutic relationship is importantly
strengthened by building connections, and (b) the therapeutic relationship is a crucial element in successful therapeutic engagement and outcome.
REFERENCES


Center on Budget and Policy Priorities (September 16, 2010). The number of uninsured Americans is at an all-time high. Available at: http://www.cbpp.org/cms/?fa=view&id=628. (Accessed on 12-26-10).


Table 1
Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>N=10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>2</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>Age (avg)</td>
<td>36.4</td>
<td>36</td>
<td>36.5</td>
<td></td>
</tr>
<tr>
<td>Years with depression (avg)</td>
<td>9.4</td>
<td>18.5</td>
<td>7.1</td>
<td></td>
</tr>
<tr>
<td>Years on antidepressant (avg)</td>
<td>7.5</td>
<td>18.5</td>
<td>4.8</td>
<td></td>
</tr>
<tr>
<td>Country of Origin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>Caribbean (Cuba, Dominican Republic, Puerto Rico)</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>South America (Argentina, Colombia)</td>
<td>2</td>
<td>2</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Honduras</td>
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<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Education</td>
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<td></td>
</tr>
<tr>
<td>&lt; High School</td>
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<td>1</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>Completed High School</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>Some College</td>
<td>1</td>
<td></td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Completed College</td>
<td>1</td>
<td></td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>English language fluency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not well/can’t speak</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>Fairly well</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Very well</td>
<td>2</td>
<td></td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Language spoken with family</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>90</td>
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<tr>
<td>English</td>
<td>1</td>
<td></td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language spoken with friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>English</td>
<td>1</td>
<td></td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Both</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>Language spoken in MI sessions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>90</td>
</tr>
<tr>
<td>English</td>
<td>1</td>
<td></td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Employed</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>50</td>
</tr>
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</table>
Table 2
Correlations Between WAI-O Scores and Adherence (N=10)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total WAI-O</th>
<th>Tasks</th>
<th>Bonds</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence</td>
<td>.455*</td>
<td>.293</td>
<td>.127</td>
<td>.079</td>
</tr>
</tbody>
</table>

*p < .10 (one-tailed test)

Table 3
Correlations Between WAI-O Scores and BDI-II Change Scores (N=10)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total WAI-O</th>
<th>Tasks</th>
<th>Bonds</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI-II T1-T2 change</td>
<td>.467*</td>
<td>.390</td>
<td>.188</td>
<td>.030</td>
</tr>
<tr>
<td>BDI-II T2-T3 change</td>
<td>.212</td>
<td>.134</td>
<td>.152</td>
<td>-.183</td>
</tr>
</tbody>
</table>

*p < .10 (one-tailed test).
Table 4
Codes that Emerged from the Grounded Theory Analysis of the MI Transcripts

<table>
<thead>
<tr>
<th>CODE NAME</th>
<th>DEFINITION</th>
</tr>
</thead>
</table>
| Withholding        | 1. When tx accepts what pt is saying without judgment/censorship  
                      2. Tx doesn’t react to the information content (e.g., discussion about losing children to system, HIV, death, SI, psychotic SX, etc).  
                      3. Tx stays neutral to the info disclosed and tends to "react" to the emotional valence within the dialogue. |
| judgment           |                                                                                                                                                                                                          |
| Trust/Comfort      | 1. Pt relies on tx to listen, help.  
                      2. Pt sounds relaxed and discloses difficult (e.g., anx producing) info                                                                                                                                 |
| You get me         | 1. When pt feels very understood by tx. Usually followed by pt responding, uhu, yes, or some other word(s) or by further elaboration of issue  
                      2. Tx empathy leads pt to further elaborate or get deeper/clearer understanding of issues  
                      3. Tx’s empathy facilities pt expression of problems, emotions, fears, etc in a way that is more detailed and self revealing |
| Affirming          | 1. Occurs when tx acknowledges, validates pt’s emotional exp and/or pt’s efforts or knowledge to self care.  
                      2. Only coded if validation, acknowledgement, recognition present for both emo content and knowledge or bx effort to self care OR if bx/knowledge validation is present alone. |
| Animo/             | 1. When tx acknowledges, encourages or supports pt’s exp or non-specific efforts to withstand pain or struggle to get better.                                                                           |
| Apoyo              |                                                                                                                                                                                                          |
| Respect            | 1. Tx’s thoughtfulness, politeness towards pt that takes out the one-down position and lets pt know he is seen and heard.  
                      2. Tx use of lang in questions and feedback is less directive and has an element of asking permission or deferring to pt |
| Checking in        | 1. Tx's way to ensure that he is on the same page with pt by asking, directly or indirectly, if his assumptions/conclusions are correct and requesting clarification if they are not.  
                      2. To check in with pt invites the pt to join in the process by correcting, participating, clarifying.                                         |
| Me puede ayudar    | 1. Pt’s trust and respect for tx’s opinion/feedback/profession/expertise  
                      2. Indication that pt believes/thinks tx can help or that therapeutic work is good/helpful                                                                                                      |
| Interest/          | 1. When tx makes a statement that lets pt know that he will be thinking about her, that he will be available, that he wants to follow up  
                      2. Tx offers to follow up with pt, to be available if needed, to provide more info or expresses a desire to know how pt is doing                                                         |
| Caring             |                                                                                                                                                                                                          |
| Continue with      | 1. Involves a statement from pt that says she needs tx or wants to stay in tx/take meds.  
                      2. Recognition of the benefits of med tx to feel better, ayudarse (help self), work, achieve  
                      3. Shows that pt le da importancia al medicamento (gives importance to meds) to feel better or avoid relapse.                                                                            |
| treatment          |                                                                                                                                                                                                          |
| Lograr con la vida | 1. Pt is mostly focused on attaining goals beyond feeling better or reducing SX of depression.  
                      2. Pt talks about or agrees with tx about things he wants to do with life if dep wasn’t an obstacle (e.g., work, study, be less dependent, stay connected with others, take care of fam, etc) |
| Problem            | 1. When tx and pt engage in talk about potential obstacles to achieving goals (e.g., staying in tx, working, relapse, losing motivation, etc).  
                      2. Often prompted by tx’s questioning, showing interest in how pt thinks obstacles will present themselves and/or how they hope to work through them  
                      3. Tx providing pt with options to solve probs and/or asking pt to think of solutions.                                                                                                  |
Table 5
Unique and Overlapping Qualities of Bonding Codes

Note: This table illustrates the overlap among individual code properties that captures interactions between client and therapist which seem to promote attachment.

<table>
<thead>
<tr>
<th>Code</th>
<th>Unique properties</th>
<th>Overlapping properties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withholding judgment</td>
<td>Therapist’s accepts without censoring.</td>
<td>Participant feels comfort and safety. Feels understood.</td>
</tr>
<tr>
<td>Trust/Comfort</td>
<td>Participant’s confidence in not being judged or criticized when disclosing information.</td>
<td>Therapist withholds judgment and criticism. Participant experiences sense of security.</td>
</tr>
<tr>
<td>You get me</td>
<td>Therapist shows he/she “gets” the participant. Participant feels understood.</td>
<td>Therapist withholds judgment and criticism, participant experiences sense of security.</td>
</tr>
<tr>
<td>Respect</td>
<td>Therapist asks permission and empowers participant</td>
<td>Therapist steps out of expert role, reduces one-down position. Participant feels valued</td>
</tr>
<tr>
<td>Checking in</td>
<td>Therapist asks for feedback and correction about conclusions.</td>
<td>Therapist steps out of expert role, reduces one-down position. Participant feels valued.</td>
</tr>
<tr>
<td>Interest/caring</td>
<td>Therapist shows investment and willingness to help or be supportive.</td>
<td>Participant feels valued and supported.</td>
</tr>
<tr>
<td>Affirming</td>
<td>Therapist recognizes participant’s emotional experience or efforts to self care; implicitly says: “good job.”</td>
<td>Participant feels understood. Therapist encourages self care.</td>
</tr>
<tr>
<td>Animo/apoyo (encouragement/support)</td>
<td>Therapist acknowledges participant’s struggle; implicitly says: “you can do this.”</td>
<td>Participant feels understood. Therapist encourages self care.</td>
</tr>
<tr>
<td>Me puedo ayudar (you can help me)</td>
<td>Participant expresses confidence in therapist’s ability to help.</td>
<td>Participant feels understood and supported.</td>
</tr>
</tbody>
</table>
Figure 1. Aspects of bonding. Illustrates how bonding emerges from one overarching theme.