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**GAINING PERSPECTIVE:
INCIDENTS THAT DAMAGE THE
THERAPEUTIC ALLIANCE AS DESCRIBED
BY MALE MENTAL HEALTH CLIENTS**

By

Michelle Richards

Accepted in Partial Completion
of the Requirements for the Degree
Master of Science

Moheb A. Ghali, Dean of the Graduate School

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MASTER'S THESIS

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Michelle Richards
January 3, 2012

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THERAPEUTIC ALLIANCE AS DESCRIBED
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A Thesis
Presented to
The Faculty of
Western Washington University

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of the Requirements for the Degree
Master of Science

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Michelle Richards
December 2011

Abstract

This study investigated what incidents male clients found to be most detrimental to the formation or strengthening of the alliance with their mental health care providers, using an abbreviated version of the qualitative critical incident technique (a written form focusing on hindering incidents). Participants were 86 adult ($M = 36.87$ years old) male outpatients. Most (90.7%) were receiving individual counseling or psychotherapy at the time of the study. A total of 76 critical incident statements were extracted. After redundant statements were eliminated, 56 statements remained. The statements were sorted into categories by three participants and two researchers, according to what each sorter understood as the commonalities between the incidents in relation to what male clients saw as hindering or weakening the alliance. The consensus structure, based on the individual sort structures, contains 12 categories: Not the Right Fit, Unexpected Actions/Personality of Counselor/Psychotherapist, Communication Problems, Unprofessional, Client Needs to Build Trust, No Choice, Unsure of Therapist/Therapy, Client Not Putting in Work, Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues, Acting on Assumptions About Client, Pushy Counselor/Psychotherapist, and Time Problems. These categories can serve researchers in developing measures to better represent the male client's perspective on the alliance and can aid practitioners in providing gender-sensitive care by helping them become alert to the ways in which strains in the alliance may manifest with male clients.

Acknowledgements

The generous award of the Western Washington University Fund for the Enhancement of Graduate Student Research made this study possible. Many thanks for the hard work of Allyson Fleming and Faith Miller in assisting with the research, the unfailing support of my advisor Dr. Rob Bedi, the sage advice of my committee members Dr. Deborah Forgays and Dr. Jeff King, and the contributions of my proofreaders Lauren Beall, Courtney Young, Caleigh Horan-Spatz, and Jaleh Davari. I greatly appreciate the cooperation of the social service agencies and mental health practitioners of Whatcom County who made information about this study available to their clients, as well as KUGS-FM who announced the study on their radio broadcast. Thanks also to Janai Symons for her consultation on research ethics, to Dr. Jim Graham for his advisement on statistical analysis, and to Dr. James Mahalik for his provision of the Conformity to Masculine Norms Inventory and related data.

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Gaining Perspective: Incidents That Damage the Therapeutic Alliance as Described by Male Mental Health Clients

Over the last 50 years, counseling and psychotherapy researchers have been refining the concept of the therapeutic alliance. Early conceptualizations were grounded in psychoanalytic theory, with Freud's writings presenting conflicting views of the potential and role of the client-psychotherapist relationship (Horvath & Luborsky, 1993). Several object-relations theorists have subsequently argued for a distinction of reality-grounded aspects of the therapeutic relationship (alliance) from aspects of the relationship distorted by the client's past experiences (transference) (Horvath & Luborsky, 1993). Zetzel (1956), one of the first to use the term *therapeutic alliance*, brought significant attention to the alliance's potential impact on psychotherapy's effectiveness. Rogers (1957) carried this idea forward, positing that the quality of the therapeutic relationship is both a necessary and sufficient condition for clinical change. Greenson (1967), using the term *working alliance*, incorporated the concept of collaboration. He referred to the ability of psychotherapist and client to work together on the tasks of analysis. During the next decade, alliance theory took an important step forward thanks to the work of Bordin (1979) and Luborsky (1976), who extended the concept of the alliance beyond a single theoretical approach (i.e., primarily psychodynamic) and into the realm of the transtheoretical.

Bordin's (1979) theoretical conceptualization of the alliance included three critical components: development of a bond between psychotherapist and client, mutual agreement of psychotherapist and client on the goals of psychotherapy, and collaboration of client and psychotherapist on the tasks of psychotherapy. Tasks are defined as the specific activities that client and psychotherapist will engage in over the course of psychotherapy in order to

facilitate desired change. Goals are the desired outcomes, which are the target of treatment. Bond refers to the affective quality of the client-psychotherapist relationship, which includes feelings of mutual trust and respect, liking, and confidence. Bordin's theory allowed for variation of the types of goals, tasks, and bonds across treatment approaches (Bordin, 1979). He proposed that the strength of the alliance reflects how well the characteristics of a given psychotherapist and client suit the kind of alliance engendered by the treatment approach being used. Bordin (1980) also proposed that the strength of the working alliance would build and ebb in the normal course of psychotherapy, and that the construction and repair of the alliance would form one of the core tasks of psychotherapy.

Luborsky (1976) conceptualized the alliance as one component of the therapeutic relationship (the other being transference). He described two phases of development of the alliance, calling the first *helping alliance* (Type I) and the second *working alliance* (Type II). In the first phase, the client comes to perceive treatment as helpful and the psychotherapist as warm and caring; in the second phase, the client works together with the psychotherapist toward alleviating her or his own difficulties. Luborsky described a transition from Type I to Type II alliance, with the client moving from a sense of being helped by the psychotherapist to a sense of shared responsibility and working together, though he noted that a Type II alliance is not reached by every psychotherapy dyad. Luborsky believed that Bordin's theory and his own could be used in conjunction, Bordin's to conceptualize the alliance broadly and Luborsky's Type I and II concepts to more specifically define its phases. He suggested the strength of the alliance be measured by "its capacity to withstand stress under pressure" and by the client's "dedication to and persistence in the work of treatment to overcome obstacles in oneself" (pp. 94-95).

Much research on the therapeutic alliance that has come after Bordin's (1979) and Luborsky's (1976) seminal works has focused on refining and supporting these conceptualizations. Many measures have been developed to quantify the strength of the alliance; versions of the Helping Alliance questionnaire (Alexander & Luborsky, 1986) most closely parallel Luborsky's theory, while the Working Alliance Inventory (WAI; Horvath, 1981) and subsequent variations are based on Bordin's theory. Using these measures, researchers have explored how the alliance develops (e.g., de Roten et al., 2004; Dinger, Strack, Sachsse, & Schauenburg, 2009; Stevens, Muran, Safran, Gorman, & Winston, 2007) and identified factors that are linked to strong and weak alliances (e.g., D'Iuso, Blake, Fitzpatrick, Drapeau, 2009; Eames & Roth, 2000; Samstag et al., 2008). Such research has included input from psychotherapists, clients, and trained observers. Continued focus on the alliance has contributed to the further development of theories and measures (e.g. Gaston & Marmar, 1994; Hatcher & Barends, 2006; Safran & Muran, 1996) and has been supported by the establishment of a persistent empirical link between alliance strength and outcome (Horvath & Bedi, 2002).

While the alliance has been acknowledged as a common factor present in various treatment approaches (Hanson, Curry, & Bandalos, 2002), psychotherapists utilizing particular treatment approaches still differ in the role and emphasis they allow for the alliance within psychotherapy (Stevens, Muran, & Safran, 2003). Discrepancies in understanding of the alliance are also present in counseling and psychotherapy research literature. For example, a variety of terms continue to be applied to the alliance: therapeutic alliance, helping alliance, working alliance, counseling alliance, and ego alliance. Certain authors favor a specific one of the aforementioned terms (Kiesler & Watkins, 1989; Puschner, Bauer,

Horowitz, & Kordy, 2005) while other authors treat these terms as synonymous (e.g., Bedi, Davis, & Arvay, 2005; Horvath & Luborsky, 1993). The presence of divergent conceptualizations of the alliance in research and practice are supported in the review by Elvins and Green (2008), who concluded that continuing research has not resulted in consensus among the psychotherapy community as to what constitutes and contributes to the alliance. They also noted that, while there are many measures of the alliance, no measure incorporates items from all major theoretical and research contributions to the alliance construct. They stress the exigency for future research that clarifies the concepts underlying the alliance. According to these authors, “the alliance concept has remained essentially at the descriptive level, with little rigorous fundamental research as yet into the underlying process behind its formation” (p. 1184). There is an important need for research to clarify what contributes to and detracts from alliance formation. Due to variability in terms used to describe aspects of the alliance or the alliance as a whole in previous works and the exploratory nature of the current study, the term *alliance* will be used throughout this work to refer generally to all of these constructs, unless otherwise specified.

Importance of the Alliance

While there is work yet to be done towards a unified definition of alliance, there is little question about the importance of the alliance to counseling and psychotherapy. Early pantheoretical alliance theory and research suggested a link between alliance strength and therapeutic outcome. Bordin (1980) described the alliance as essential to clients in order to achieve change through psychotherapy. Initial research for development of the Penn Helping Alliance Questionnaires also pointed to a link between alliance formation and improved outcome (Luborsky, 1976). In subsequent years, a vast body of research supporting this link

has accumulated (Horvath & Bedi, 2002; Horvath, Fluckiger, Del Re, & Symonds, 2011). Alliance quality has been linked positively to outcome in a variety of settings and treatment modalities (Horvath & Symonds, 1991; Kiesler & Watkins, 1989; Martin, Garske, & Davis, 2000; Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Hoglend, Hersough, Amlo, Bogwald, & Marble, 2011) and in treatment addressing a variety of mental disorders (Owen & Hilsenroth, 2011). The relation between alliance and outcome is evident in data from observers, practitioners, and clients (Orlinsky, Grawe, & Parks, 1994; Horvath et al., 2011). This connection, while moderate, is robust and consistent; alliance quality is one of the best predictors of therapeutic outcome (de Roten et al., 2004; Horvath & Bedi, 2002; Messer & Wampold, 2002; Safran, Muran, Proskurov, 2008; Samstag et al., 2008). Importantly, alliance ratings have been linked not only to measures of overall change but also to symptom reduction and improved interpersonal functioning (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Kelly & Yuan, 2009; Stevens et al., 2007). Alliance has also been positively and significantly associated with both client adherence to treatment (Keller, Zoellner, & Feeny, 2010; Rungruangsiripan, Sitthimongkorn, Maneesriwongul, Talley, & Vorapongsathorn, 2011) and treatment completion (Keller et al., 2010).

Weak or Hindered Alliance

Disruptions to the alliance can critically impact counseling and psychotherapy outcome. Bordin (1980) suggested that addressing strains in the alliance is an important key to lasting therapeutic change, and that the skills clients develop while working through experiences of therapeutic alliance strain can carry over to coping with disruptive experiences outside of psychotherapy. In an exploratory study by Lansford (1986), the psychotherapist-client dyads who spent the most time actively dealing with points when the

alliance weakened reported the best psychotherapy outcomes. Also, these points when the alliance weakened were linked to the clients' most salient issues. So it may be, as Bordin (1980) theorized, that working through weaknesses in the alliance actually contributed to therapeutic change for these clients. There is also ample evidence supporting the notion that weak or hindered alliances are correlated with premature, unilateral termination (Muran, 2002; Samstag, Batchelder, Muran, Safran & Winston, 1998; Tryon & Kane, 1990, 1993, 1995). The association of alliance with outcome highlights not only the need for research to establish how healthy alliances are built but also the need for research to foster an understanding of what is detrimental to establishing or maintaining an alliance.

Several studies have focused on identifying client qualities that are associated with weaker alliances in ongoing counseling or psychotherapy. Some have explored how the interpersonal style of the client may impact the alliance. For example, one found that clients with avoidant coping styles generally assigned lower ratings to the alliance with their psychotherapists (Glass & Arnkoff, 1997). Another found evidence that "individuals who make assumptions with regards to what others might be thinking are more likely to have a more negative view of the relationship with their therapist" (D'Iuso et al, 2009, p.112). Also, clients who cope by becoming submissive typically ascribed lower ratings to the bond component of the alliance (D'Iuso et al, 2009). Fearfulness in relationships, involving attachment-related anxiety and avoidance of intimacy, may also hinder the development of a working alliance (Eames and Roth, 2000). A meta-analysis by Diener and Monroe (2011) found that weaker attachment security predicted weaker alliance scores, with a small to medium effect size. Kiesler and Watkins (1989) found that clients who displayed more

hostile behavior in session rated their therapeutic alliances as weaker. These types of clients, with a low prognosis for alliance, may experience particular difficulty during treatment.

Other studies have linked psychotherapist qualities to weaker alliance ratings. For example, Sauer, Lopez, and Gormley (2003) linked psychotherapist attachment anxiety to an alliance course with initially higher ratings that dropped over time. Dinger et al. (2009) expanded on this. Both high client interpersonal difficulty and high attachment preoccupation of psychotherapists were associated with lower alliance qualities. When both of these factors were present, the alliance quality declined over time. In another study, clients paired with psychotherapists who displayed greater hostility in sessions described less alliance with their psychotherapists in terms of agreement on therapeutic goals (Kiesler & Watkins, 1989).

Research has shown that the presence or absence of behaviors within psychotherapy, rather than preexisting qualities of the client or psychotherapist, may also hinder alliance development. For example, clients who reported that they kept a relevant secret from their psychotherapist, compared with clients who reported they had not, rated the working alliance with their psychotherapist as weaker; their psychotherapists also rated the alliance as weaker. The more frequent the secret-keeping behavior, the lower the client's rating of the alliance (Kelly & Yuan, 2009). Another factor linked to weakened alliance is racial prejudice. Constantine (2007) found a significant negative correlation between African-American clients' perception of racial microaggressions by their White psychotherapists and ratings of the therapeutic working alliance. Factors outside of the session can also impact alliance strength. Clients who reported less social support rated their working alliances as weaker;

social support was a significant predictor of client-rated working alliance (Mallinckrodt, 1991).

Alliance Ruptures

Another way of exploring what is detrimental to establishing or maintaining an alliance has been, and continues to be, through the study of alliance ruptures. The researchers who have most frequently studied alliance ruptures report that they are a challenge to define and operationalize (Samstag et al., 1998). Safran, Crocker, McMMain, and Murray (1990) offer this broad definition: “An *alliance rupture* consists of an impairment or fluctuation in the quality of the alliance between the therapist and client” (p.154). Some definitions of alliance rupture are grounded in psychoanalytic theory and emphasize unconscious interactions (Safran and Muran, 2006). Samstag, Muran, and Safran (2004) wrote about the rupture as a precursor to deterioration in the alliance, an “emotional disconnection between patient and therapist creating a negative shift in the quality of the alliance” (p. 193). Safran, Muran, Samstag, and Stevens (2002) described an alliance rupture as a breakdown in the collaborative relationship between psychotherapist and client—a disagreement about the tasks or goals of treatment or a strain in the therapeutic bond. Stevens et al. (2007) operationalized a rupture as a downward shift in WAI ratings from a stable point, at least a single rating point drop in one or more consecutive sessions. The Rupture Resolution Questionnaire is the most commonly used tool to measure alliance ruptures. It focuses on measuring experiences of conflict between client and psychotherapist, and on measuring the negotiation of such conflict (Safran et al., 2008). Although the broadest definitions of alliance rupture include failure to develop a collaborative process

between psychotherapist and client (Safran et al., 2008), most research related to alliance ruptures has focused on fluctuations in an existing alliance.

Given the wide variability in the definition of alliance ruptures, it is not surprising that descriptions of how they may be observed or experienced also cover a broad range. Ruptures have been observed to vary in intensity and duration. Ruptures may be signified by minor fluctuations in the alliance that are extremely difficult to detect, a client's overt expression of negative experience, or premature termination (Safran et al., 1990). Ruptures are described as an interactive process with two phases. There is a misunderstanding event (including the background—what the client and psychotherapist were engaged in—and precipitant—psychotherapist did something unneeded or failed to do something needed) followed by a rupture marker (reaction within the therapeutic relationship to the misunderstanding event). It may be experienced as an emotional disconnection, tension in the therapeutic relationship, or the client feeling misunderstood by the psychotherapist (Samstag et al., 1998; Samstag et al., 2004). Two broad categories of ruptures have been identified: withdrawal ruptures (passive in nature) and control ruptures (active in nature, though sometimes indirect) (Samstag et al., 2004). Some potential manifestations of withdrawal ruptures include abrupt withdrawal, silence, changing the topic, and missed sessions; some potential manifestations of control ruptures include attack of technique or setting, attack of psychology or psychotherapy, blaming, coming late, constant need to change appointment times, wearing provocative clothing, and acting in a manner not suitable to a professional relationship (i.e., overly ingratiating or overly casual; Samstag et al., 2004; Stevens et al., 2003).

While some have theorized that strains or ruptures in the alliance are an inevitable part of psychotherapy and alliance formation (Samstag et al., 2004), reports of alliance rupture frequency indicate great variability. Rupture occurrence may vary by strength of client-rated alliance, with more ruptures occurring in weaker alliances (Safran, Muran, Samstag, Stevens, 2001). Studies suggest that rupture frequency also varies by treatment modality (e.g., less frequent in cognitive behavioral than psychodynamic; Kiesler & Watkins, 1989; Safran et al., 2002; Stevens et al., 2007). Estimates of frequency across modality suggest ruptures occur in 10-50% of sessions (Safran et al., 2002) and 50% of alliances (Stevens et al., 2007). Clients and psychotherapists differ in how often they report ruptures, with psychotherapists reporting more frequent occurrence of ruptures (Muran et al., 2009; Safran et al., 2002). In one study, the average of client frequency reports indicate that ruptures occurred in 37% of sessions while the average of psychotherapist frequency reports indicate that ruptures occurred in 56% of those same sessions (Muran et al., 2009). These authors note that rupture occurrence was only examined in early sessions and thus their findings may incorrectly estimate the frequency of ruptures across the course of psychotherapy.

While ruptures may not occur in every session or even in every alliance, that fact does not discount the significance of their impact when they do occur. From one perspective, an alliance rupture may represent an opportunity for change, an inroad to therapeutic progress (Samstag et al., 2004). One study suggested that ruptures “can serve as early warning indicators of problems in the therapeutic relationship” (Muran et al., 2009, p. 246). Unfortunately, ruptures can be quite difficult even for skilled psychotherapists to detect and address (Muran et al., 2009; Safran et al., 2008; Samstag et al., 2004). According to Samstag

et al. (2004), ruptures are considered part of a moment-to-moment negotiation process that typically takes place outside of the psychotherapist's and client's awareness. When clients do become aware of strains in the alliance, they may refrain from expressing their negative experiences during psychotherapy out of deference to their psychotherapists (Rennie, 1994). Studies suggest that clients frequently feel unable to express negative thoughts or feelings in psychotherapy, and that their psychotherapists often remain unaware of those negative experiences throughout the course of psychotherapy (Hill, Thompson, Cogar, & Denman, 1993; Regan & Hill, 1992; Rhodes, Hill, Thompson, & Elliot, 1994).

When psychotherapists are not aware of their clients' negative experiences, they miss the opportunity to address them. Unresolved ruptures may contribute to the client prematurely terminating psychotherapy (Muran et al., 2009; Rhodes et al., 1994). Results are mixed as to whether the presence of ruptures relates to therapeutic outcome (Kivlighan & Shaugnessy, 2000; Stevens et al. 2007), but Safran et al. (2002) caution against concluding a lack of importance of ruptures, given the limited number of studies currently available. A recent study found that alliance ruptures were predictive of poorer treatment outcome, through impacting client expectations of treatment outcome (Westra, Constantino, & Aviram, 2011). Even when psychotherapists are aware of ruptures, they can be difficult to interpret and effectively address. Certain psychotherapist responses to ruptures will have little impact and some can exacerbate the situation, leading to repeated ruptures or poor therapeutic outcome (Castonguay et al., 1996; Foreman & Marmar, 1985; Safran & Muran, 1996; Samstag et al., 2004). Alliance ruptures can be challenging to navigate; they represent both a need to avoid causing further harm and an opportunity for a strengthened alliance (Stevens et

al., 2003). Resolution of ruptures can actually enhance the therapeutic alliance (Rhodes et al., 1994).

While the above research demonstrates the potential therapeutic power of recognizing and addressing ruptures in the alliance, it also shows that such ruptures have not been clearly and consistently defined. Also, given the research designs employed, it is unlikely that explorations of alliance ruptures have fully captured clients' experience of strains in the alliance. Bordin (1994) theorized that the strength of the alliance, the power of therapeutic tasks, and the dynamics of strain in the alliance all influence therapeutic change. He notes, "It is important to distinguish between strains as difficulties in the formation of the initial alliance and later appearing strains after the initial alliance has been established" (p. 19). Thus, strains can hinder the development of an alliance or damage an existing alliance. Ruptures appear to fall more into the second category, and a need remains for alliance strain research that includes exploration of what hinders initial alliance development. Bordin (1994) also points to the tendency of Safran's research group to focus on psychotherapist-attributable strains when there may, in fact, be many other elements that contribute to strains in the alliance. Therefore, a new research design that is open to all sources of alliance strain (such as behaviors of the client or events outside of counseling or psychotherapy) may further illuminate this element of therapeutic process.

The Client's Perspective on the Alliance

Importance

Another facet of alliance research to consider when striving for a comprehensive understanding of alliance strain is the difference in perspective of all parties involved. Luborsky (1976) and Bordin (1979) described alliance-building as involving both

psychotherapist and client. Research on the alliance allows for exploration of other perspectives as well: those of researchers and observers. Psychotherapists, clients, researchers, and observers have all evinced distinct perspectives of alliance formation within the same therapeutic relationship (Horvath and Symonds, 1991; Tichenor and Hill, 1989). Martin et al. (2000) found that clients tended to assign more consistent ratings to the alliance across sessions than did psychotherapists or observers. They interpreted this as suggesting that “patients tend to view the alliance as stable, whereas therapists and observers tend to indicate more change over time in their alliance ratings” (p.447). While the findings of Bachelor and Salamé (2000) run contrary to this, indicating that psychotherapists’ perceptions of the alliance stabilize around the 10th session and clients’ perceptions continuing to change through the course of psychotherapy, they nevertheless point to a divergence of client and psychotherapist perceptions of the alliance.

Researchers have repeatedly found only small to moderate correlations between client and counselor ratings of the therapeutic alliance (Fitzpatrick, Iwakabe, & Stalikas, 2005; Horvath & Marx, 1990; Mallinckrodt, 1991; Tichenor & Hill, 1989; Tryon & Kane, 1990, 1993, 1995). Also, client ratings of the alliance are often higher on average than psychotherapist ratings of the alliance (Fitzpatrick et al., 2005; Kokotovic & Tracey, 1990; Lysaker, Davis, Buck, Outcalt, & Ringer, 2011; Mallinckrodt, 1991; Tryon & Kane, 1993; Tryon & Kane, 1995). The pattern of low to moderate correlations between client and counselor perspectives carries over into reports of rupture intensity and resolution (Muran et al., 2009). Clients may also view the alliance as more similar to their other relationships outside of psychotherapy. Diener and Monroe (2011), in a meta-analysis of the relationship between adult attachment style and therapeutic alliance, found that patient-reported alliance

scores more strongly relate to patient-reported attachment than do psychotherapist-rated alliance scores, suggesting that clients experience the alliance in ways that more closely relate to their general attachment style. In sum, the above findings substantiate the notion that clients and psychotherapists have markedly different views of the alliance; clients may even use different criteria than their psychotherapists in forming their view of the alliance, its formation, and its impairment (Mallinckrodt, 1991; Samstag et al., 1998).

As noted above, it has been established that client and practitioner viewpoints of the alliance are distinct. In addition, there is reason to believe that clients' perspectives of the alliance may be of particular value to researchers and practitioners. Meta-analyses suggest that clients' ratings of alliance strength better predict counseling outcome than do psychotherapists' ratings of alliance strength (Horvath & Bedi, 2002; Horvath & Symonds, 1991). Although at least one study suggests that psychotherapists' assessment of alliance may become a better predictor of outcome later in psychotherapy (Kivlighan & Shaugnessey, 1995), early alliance ratings appear to be a better predictor of outcome overall than alliance ratings assessed later in psychotherapy (Horvath & Bedi, 2002). When psychotherapists' and clients' alliance ratings for the same client-psychotherapist dyads were compared, there was no indication that psychotherapists who generally reported stronger alliances had clients with better outcomes. However, psychotherapists whose clients generally reported stronger alliances had, on average, better client outcomes (Marcus, Kashy, & Baldwin, 2009). Research also suggests that clients' ratings of the alliance are more consistent and homogenous than those of psychotherapists (Horvath, 2001; Martin et al., 2000). One study suggests that clients may more clearly discriminate between alliance dimensions (such as bond, tasks, and goals) than do psychotherapists (Horvath & Marx, 1990). Additionally,

another study found a significant and moderate correlation between client ratings of alliance and client expectations of treatment outcome (Westra et al., 2011). So alliance may not only be related to treatment outcome but also to clients' faith in the psychotherapy process.

Given the ample evidence supporting the value of the distinct perspective clients have on the alliance, a surprisingly small number of studies have sought to capture this perspective. While some studies have used trained observers to research what is important to the client in alliance formation using measures such as the WAI – Observer Form (Horvath & Greenberg, 1986), the California Psychotherapy Alliance Scales – rater version (Marmar, Weiss, & Gaston, 1989), the Penn Helping Alliance Rating Scale (Alexander & Luborsky 1986), or the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983), these observer-based measures are “unable to capture directly the subjective, attitudinal or motivational aspects” of the client’s experience of the alliance (Elvins & Green, 2008, p. 1181). There are also several self-report measures designed to measure the client’s perspective on the alliance, such as the client version of the WAI (Horvath & Greenberg, 1986) and the patient-rated version of the Helping Alliance questionnaire-I (Luborsky, McLellan, Woody, O’Brien, & Auerbach, 1985). However, these, and many existing measures of alliance, are based in theory and clinical experience and do not directly incorporate clients’ subjective understanding of the alliance (Mohr & Woodhouse, 2001). The items on even self-reported measures of alliance are designed by researchers and psychotherapists and have been shaped by their understanding of the alliance. Bedi, Davis, and Arvay (2005) note that “to date, the literature examining the alliance from the client’s phenomenological perspective is scarce” (p. 72). Commonly used measures of alliance offer an indirect route to client experience; as they are shaped by researchers’ understandings of

alliance concepts, they likely cannot fully represent clients' subjective understanding (Bedi, 2006). Horvath (2001) addresses the impact that this limited understanding can have on clinical work, noting the trend in the research of psychotherapists to misjudge how clients feel about the alliance and calling for psychotherapist training to "take account of the dissimilarities between theoretically based judgments of the correct therapeutic relationship and the client's felt experiences" (p. 173).

Research

A handful of researchers have sought to be more inclusive of the client's subjective perspective. Rennie's (1994) qualitative study derived units of meaning from clients' retrospective recall of their moment-to-moment experiences of the therapeutic process. Fifty-one categories of meaning emerged. The four most commonly experienced by participants were: concern about the psychotherapist's approach, fear of criticizing the psychotherapist, understanding the psychotherapist's frame of reference, and meeting the psychotherapist's perceived expectations. The most common theme across the categories (noted in 8 of 51) was deference of the client to the psychotherapist; some examples include actions taken to protect the psychotherapist's feelings and viewing the client's role in treatment as an acquiescent one. An act of deference toward the psychotherapist may represent a client's attempt to protect the alliance. Unfortunately, deference may also contribute to clients' hesitance to reveal when they disagree with or are made uncomfortable by the direction of psychotherapy. If clients are feeling compelled to protect psychotherapists in order to maintain the alliance, then it is doubly important for psychotherapists "to pick up on cues that the alliance is in trouble" (Safran et al, 2001, p.

407). However, as previously noted, research has shown that even experienced psychotherapists may find it challenging to recognize such cues.

To examine clients' experience of the clinical reality of the alliance and how this compared to existing theory-derived notions of such, Bachelor (1995) used a qualitative phenomenological approach. At three different points of alliance development, clients were asked to write in detail about their understanding of a good working relationship between client and psychotherapist. Analysis of the data showed that the qualities described by clients formed three distinct categories of alliance type: insight-oriented, nurturant, and collaborative. Bachelor described these alliance types as incorporating elements of certain theoretical viewpoints but not fitting within any extant alliance theory. Bachelor's findings suggest that clients perceive the alliance as a function primarily of psychotherapist contributions.

A similar conclusion was reached by Mohr and Woodhouse (2001), who developed their own client self-report measure (Therapy Priorities Q Sort) to collect information on psychotherapy process. For the Therapy Priorities Q Sort, participants were provided with a number of cards on which an array of psychotherapy characteristics were printed and asked to sort them based on their degrees of importance as helpful or harmful to psychotherapy. Blending this quantitative data with qualitative data from an essay writing task and analyzing them with Q-technique factor analysis yielded two factors, which the researchers dubbed Personal Alliance and Professional Alliance. These two factors accounted for the majority of the variance in their data. Notably, some of their Q Sort findings contradicted popular alliance theory; certain characteristics of psychotherapy touted by popular theory as essential

to a strong alliance (e.g. an emotional bond between therapist and client) were rated as unimportant or harmful by some participants.

Whereas both Bachelor (1995) and Mohr and Woodhouse (2001) accentuated alliance types as conceptualized by clients, other researchers sought to explain the client's perspective on how alliances are effectively formed. Bedi, Davis, and Arvay (2005) used the critical incident technique (Flanagan, 1954; CIT) to obtain and analyze qualitative interview data from a small number of participants who were currently or recently in individual counseling or psychotherapy. From the interviews, they extracted incidents that could be translated into specific, observable, behavioral terms. Eight categories of critical incidents were identified: General Counseling Skills, Expression of Positive Affect and Sentiment, Tracking the Counseling Process, Counseling Environment, Punctuality and Use of Time, Going Beyond Normative Expectations, Personal Attributes of the Counselor, and Positive First Encounters. As with the findings of Bachelor (1995) and Mohr and Woodhouse (2001), not all of the client responses could be contained within existing alliance theory. Some clients also described qualities as critical to the alliance that researchers and theoreticians do not typically recognize, such as the type of physical environment where counseling takes place. Likewise, certain variables typically included in more psychotherapist-centered measures of alliance formation, such as client-psychotherapist collaboration, were scarcely referred to by clients.

Bedi, Davis, and Williams (2005), in an effort to replicate the results of Bedi, Davis, and Arvay (2005), used a larger sample to more comprehensively capture which incidents clients experience as critical to positive alliance development. The researchers identified 25 categories of critical incidents through analyzing close to 400 critical incidents (see original

article for full listing). Some of the categories of incidents most commonly experienced by participants as helpful for alliance formation were Technical Activity, Nonverbal Communication, Service Beyond Normative Expectation, Active Listening, and Client Agency. In this study, as in Bachelor (1995), participants mentioned few client-driven elements of alliance formation. The results of this study lend further support to the notion that clients' subjective understanding of the alliance differs substantially from the existing theories and measures. Again, elements outside of standard alliance theory emerged, such as environment where counseling takes place and visible characteristics of the psychotherapist. Also, clients pointed to particular therapeutic interventions as contributing directly to the alliance.

To further incorporate clients into the process of identifying variables important to alliance formation and conceptualizing how these variables relate to one another, Bedi (2006) employed multivariate concept-mapping techniques (see Bedi & Alexander, 2009). While semi-structured interviews were used to gather data, and similar techniques were used to extract concrete incidents that occurred early in the alliance, this study diverged greatly from previous research in the methods used to categorize the data. Rather than have researchers sort and categorize the data, a large proportion of the participant group that generated the alliance-formation incidents was called upon to sort the statements into thematic groups of their own choosing and to give names to these categories. A system of matrices, multidimensional scaling, and cluster analysis were used to identify how the incidents were most commonly sorted together and the number of categories best representing participants' sorting, to form titles for the categories (based on participants' own wording), and also to provide a visual representation of how the incidents and categories related to one another.

The eleven categories of client-identified alliance formation variables were Nonverbal Gestures, Emotional Support and Care, Presentation and Body Language, Setting, Session Administration, Client's Personal Responsibility, Referrals and Recommended Materials, Guidance and Challenging, Education, Honesty, and Validation. As in previous studies, participants did identify client contributions to the alliance, but the majority of incidents identified related to non-client contributions.

Continuing the quest to understand how clients experience early alliance development, Fitzpatrick, Janzen, Chamodraka, and Park (2006) applied the consensual qualitative research method to collect and examine data from a group of student clients seeing psychotherapists-in-training. Clients were undergraduates participating in an experiential element of their program, and psychotherapists were master's-level trainees in practicum. Fitzpatrick et al. explored the following question: "How do clients understand events that influence the development of their relationships with their therapists?" Semi-structured interviews were conducted, researchers identified domains that encompassed the structure of the data, core ideas were extracted from participant responses, and researchers categorized the ideas to show where they converged within domains. The five domains of incidents identified were Description of Critical Incident, Meaning of the Incident, Client Contribution to the Incident, Impact of Incident on the Relationship, and General Outcome of the Incident. Each domain contained between three and five categories; some were subcategorized. One of the 20 participants identified a negative incident impacting alliance development. Among the data from the other 19 participants, the researchers identified a "positive emotion-exploration spiral," in which clients ascribed positive meanings to psychotherapist interventions and responded with increased openness and exploration,

leading to a positive experience of the relationship and even more openness or further exploration.

In a subsequent and related study of clients' perceptions of early alliance formation, Fitzpatrick, Janzen, Chamodraka, Gamberg, and Blake (2009) again elected to use consensual qualitative research methodology. The group studied in this instance, clinically depressed clients working with experienced psychotherapists, differed considerably from the previous group studied. Semi-structured interview data were analyzed, the domains from the Fitzpatrick et al. (2006) study were used as a starting point for categorizing the data, and core ideas were extracted and categorized by researchers. Six final domains were agreed upon: Description of Critical Incident, Meaning of the Incident, Client Contribution to the Incident, Comparison to Previous Therapy, Emotional Impact of the Incident, and General Outcome of the Incident. Each domain contained between two and six categories. Adding to previous similar findings, while participants identified some client contributions to the alliance, many more incidents named related to psychotherapist contributions. Participants tended to describe their psychotherapist's contribution to the alliance in relation to an unexpressed wish of the client's. The researchers explained that several participants who noted positive contributions to the alliance described a psychotherapist's intervention as addressing an unexpressed wish of the client's, while the two participants who identified negative contributions to the alliance described the psychotherapist's lack of attending to an unexpressed wish. In a comparison of this study's results to those of Fitzpatrick et al. (2006), the authors noted that client interpretation of the incident centered more around intrapersonal meaning (e.g., "I'm important," "I'm okay," "Now I know what to do here") in the previous (2006) study, while in this study it centered around interpersonal meaning (e.g.,

“Therapist cares about me, understands me, really listens to me and is skilled in dealing with me”). Also, depressed clients focused more on alleviation of symptoms and increasing positive expectations whereas healthier clients focused more on increased openness and productivity.

Building on the work of Bachelor (1995) and Mohr and Woodhouse (2001), Bedi and Duff (2009) studied clients' preferences for several different types of alliance. They examined preferences for both the personal and professional alliance types identified by Mohr and Woodhouse (2001) and the nurturant, insight-oriented, and collaborative alliance types identified by Bachelor (1995). Participants were also asked to rate the importance of each of these alliance types as an element of the ideal alliance. Additionally, they were asked which categorization system was the best way of categorizing preference for alliance type. Across two samples, Bedi and Duff found that an insight-oriented alliance was preferred over other alliance types and that the nurturant alliance type was preferred by the smallest number of participants. With regards to the most important elements in an ideal alliance, in one sample, collaborative was rated as a statistically significantly more important element than nurturant, while in the second sample insight-oriented was rated as statistically significantly more important than nurturant or collaborative. This contrasts with the findings of Bachelor (1995), who found that participants most frequently described a nurturant alliance when describing elements of an ideal counseling alliance. Roughly equal numbers of participants preferred personal and professional alliance types. Clients most preferred either Bachelor's (1995) alliance types or those alliance types in combination with the alliance types of Mohr and Woodhouse (2001) as a way to conceptualize the alliance.

Seeking to lend more empirical weight to clients' understanding of alliance development, Duff and Bedi (2010) examined the statistical relationship between alliance strength and counselor behaviors previously identified by clients as important to the alliance. They administered to clients both the WAI (Short form, Revised), a well-established measure of alliance strength, and a measure of their own design, called the Therapeutic Alliance Critical Incidents Questionnaire (TACIQ), which consisted of 15 items identified by clients in a previous exploratory study as being helpful to forming and strengthening the alliance. Most of the items on the TACIQ had acceptable correlations with one another, and the correlation between the overall TACIQ scores and the total WAI scores was large ($r = 0.75$, $\alpha = 0.01$, 2-tailed). Based on a regression analysis of the results of 79 participants, Duff and Bedi identified four items as candidates for elimination from the scale. Among the other 11 items, three supercategories of counselor behaviors were identified as most predictive of alliance strength. These were *Validation*, *Non-verbal Behaviors Focusing on the Client*, and *Communicating Positive Regard to the Client*. Generally, the results lend empirical support to the notion that the conditions clients perceive as helpful for strengthening the alliance actually are likely to help strengthen the alliance.

Clients Who Leave Psychotherapy Prematurely

Despite the slowly growing body of client-focused research, there are indicators that client needs are still not being adequately met. One important example is the lack of improvement in client attrition rates. Wierzbicki and Pekarik (1993), in their meta-analysis of 125 studies, found a mean dropout rate of 46.86%. Clients continue to drop out of psychotherapy at a rate comparable to that found 50 years ago (Barrett, Chua, Crits-Christoph, Gibbons, and Thompson, 2008). The clients who leave tend to do so early in

treatment. In their review of the literature on attrition, Barrett et al. (2008) note that over half of clients attend fewer than six sessions and over 65% of clients leave psychotherapy before the 10th session. Current research indicates that this is not enough treatment for most clients to achieve significant therapeutic change. Lambert (2007) describes a series of five studies designed to assess how many sessions are needed for clients to reach reliable and clinically significant change. Across these studies, after 11 to 21 sessions, 50% of clients had reached this point, and after 25 to 45 sessions, 75% of clients reached this point. In a direct comparison of therapeutic outcome between clients who dropped out of psychotherapy and those who completed their contracted number of sessions, 71% of completers met criteria for reliable and clinically significant change while only 13% of non-completers did so (Cahill et al., 2003).

As already noted, client dropout has also shown links to weak alliances. Unfortunately, in many studies, information about clients who drop out is not included or available. Thus, relatively little is known empirically about alliance-building or alliance-hindering with clients who do not stay in psychotherapy for the full course. In one study that did examine dropout, matching 22 participants who dropped out of psychotherapy to 22 participants who completed psychotherapy, alliances including a client who dropped out were rated as weaker by the client early in psychotherapy and by the psychotherapist directly after the final session (Piper et al., 1999). Another study compared alliance ratings of clients who did not complete their scheduled number of sessions to alliance ratings of clients who completed psychotherapy and reported a good outcome, and to clients who completed psychotherapy and reported a poor outcome. Client ratings of the alliance were lowest in the group who did not complete psychotherapy (Samstag et al., 1998). Moreover, Tryon and

Kane found that both early-psychotherapy client ratings of the alliance (1990) and mid-psychotherapy psychotherapist ratings (1993) of the alliance were predictive of premature termination. In a later study (1995), they found that when client and psychotherapist both rate the alliance as weak, clients are significantly more likely to unilaterally terminate than when client and psychotherapist both rate the alliance as strong. A meta-analysis examining the relationship between alliance and dropout was only able to analyze 11 studies, as few studies have provided such information. Even with this small number of studies, they found a moderate relationship ($d = .55$) between the alliance and dropout, indicating that clients in weak alliances were more likely to drop out of psychotherapy (Sharf, Primavera, & Diener, 2010). Clients who drop out of counseling or psychotherapy, having been parties to particularly unsuccessful alliances, may have a unique perspective on what hinders the building of the therapeutic alliance; their perspective warrants further investigation. In fact, client-rated alliance scores have been shown to more effectively distinguish between dropout and poor outcome groups than do psychotherapist-rated alliance scores (Samstag et al., 2008), demonstrating that it is particularly important to capture the perspective of the client in counseling dyads that may be headed for unilateral termination.

Many clients do not continue with psychotherapy long enough to experience therapeutic change, but learning more about the client's perspective on weak early alliances may allow for more effective recognition and treatment of clients who would otherwise soon drop out. It is imperative to continue the study of the client's subjective perspective of weak early alliances and to make every effort to include the perspective of clients who prematurely terminate psychotherapy. Including data only for clients who complete treatment means drawing conclusions on a persistent, well-motivated subset of clients (Cahill et al, 2003).

Male Clients and the Alliance

Like clients who unilaterally terminate, male clients have also scarcely been represented in the alliance literature. In a meta-analysis conducted by Martin et al. (2000), men comprised only one third of the participants in 79 studies over an 18-year span. For examples of how men have been represented in studies on the client's subjective perspective of the alliance, examine the following participant ratios: Bachelor (1995), 7 men: 27 women; Bedi, Davis, and Williams (2005), 9 men: 31 women; Bedi (2006), 9 men: 31 women; Fitzpatrick et al. (2006) 4 men: 16 women; and Fitzpatrick et al. (2009) 3 men: 12 women. Men have been somewhat better represented in studies on hindered or weakened alliances (e.g. Muran et al., 2009; Samstag et al., 2008; Stevens et al., 2007), but the following recent participant ratios indicate room for improved representation: Constantine (2007), 7 men: 17 women; Dinger et al. (2009) 94 men: 187 women; and Kelly and Yuan (2009), 17 men: 66 women.

The lack of studies representing the male perspective on the alliance is particularly distressing given an apparent mismatch between traditional therapeutic approaches and traditional masculinity. To best explain this mismatch, it is necessary to first provide background on male gender role theory. Social learning paradigms, often used by psychologists studying gender, assume that social environments teach behaviors, beliefs, and attitudes about gender through reinforcement, punishment, modeling, and relaying of schemas. Roles are viewed as specific ways of being and doing based on social position (Addis & Cohane, 2005). Historically, gender research has focused on differences between male and female gender roles, but a newer area of research relates to variation within each of these genders. The term "masculinities" describes variation within the male gender (Addis &

Cohane, 2005, Blazina, 1997). While it is undeniable that the concept of male gender varies across region, socioeconomic status, age, religion, and many other factors (Blazina, 1997), what may be described as “traditional masculinity” still influences how many men enact their gender. This is the dominant form of masculinity in the United States and other Western countries, weighing heavily in what members of this culture consider to be normative (Englar-Carlson & Stevens, 2006).

Male Gender Role Norms

Instruction in the ways of traditional masculinity begins in infancy. Infants aged 18 months and 24 months have both shown significant stereotyping of masculine-typed objects, and these results are supported by other studies indicating more rigid male gender stereotyping than female gender stereotyping in young children (Eichstedt, Serbin, Poulin-Dubois, & Sen, 2002). The acquisition of gender roles and stereotypes is gradual (Eichstedt et al., 2002). A boy continues to learn through interpersonal relationships in childhood and adolescence what it means to be a boy, and this conceptualization will later inform his idea of what it means to be a man (Addis & Cohane, 2005; Rabinowitz & Cochran, 2002). Sometimes adhering to traditional masculinity tenets can be constraining and damaging.

The masculine gender socialization messages common to Western culture can be summarized in four tenets. David and Brannon (1976) described four problematic elements of masculinity in U.S. culture. These are social injunctions to work the “big wheel,” be a “sturdy oak,” “give ‘em hell,” and engage in “no sissy stuff.” Pollack (1998) revisited these in his description of the “boy code.” The “sturdy oak” is the expectation for boys and men to be stoic and independent even in the face of pain or adversity, to “give ‘em hell” is based on the misconception that boys’ biology dictates they will act in a daring and high-energy way,

the “big wheel” is the imperative driving men to put excessive amounts of energy into school or work to achieve status and power, and “no sissy stuff” sums up the taboo against boys expressing any urges, feelings, or behaviors typically labeled as “feminine.” Boys and men are pressured to act in these ways in order to feel safe and avoid ridicule (Good & Robertson, 2010; Kivel, 1999). In their model of gender role conflict, O’Neil, Good, and Holmes (1995) describe four prevalent elements of masculine gender role strain that appear closely related to the “boy code.” These are preoccupation with success, power and competition; restrictive emotionality; restrictive sexual and affectionate behavior between men; and conflicts between work and family relations. As Kaufman (1994) wrote:

“There are many things men do to have the type of power we associate with masculinity: We’ve got to perform and stay in control. We’ve got to conquer, be on top of things, and call the shots. We’ve got to tough it out, provide, and achieve. Meanwhile we learn to beat back our feelings, hide our emotions, and suppress our needs” (p. 148).

Although a range of both traditional masculinities and therapeutic approaches exist, traditional elements of counseling and psychotherapy and traditional elements of masculinity seem mismatched, leaving many men unlikely to seek mental health care or to receive gender-informed care (Addis & Mahalik, 2003; Betz & Fitzgerald, 1993; Mahalik et al., 2003). Masculinity can also influence how a man is likely to act or respond in counseling or psychotherapy. Since “masculinity is a focal organizing principle for all aspects of a man’s life,” it “can be an influential contributor to not only why (or why not) a man is in psychotherapy but also how psychotherapy is ultimately enacted” (Englar-Carlson & Stevens, 2006, p. 13).

Mismatch of Male Gender Role Norms with Psychotherapy

One way that traditional male gender role conflicts with psychotherapy relates to the masculine injunction “no sissy stuff.” This injunction teaches men to avoid all things feminine, yet many aspects of psychotherapy are associated with the traditionally feminine. Desirable qualities in a client include clear expression and verbalizing of emotions, the ability to discuss personal pain, the willingness to be vulnerable and to turn to others for help resolving problems; these are all skills associated more typically with the feminine gender role (Osherson & Krugman, 1990; Scher, 1990). Even physical aspects of the psychotherapy or counseling environment may also be more in line with feminine practice. For example, face-to-face positioning is more common among mothers interacting with children, whereas fathers tend to have side-by-side interactions with their children (Osherson & Krugman, 1990). Men who have these aspects of psychotherapy in mind may view it as a feminizing practice and believe that seeing a mental health professional would threaten their masculinity (Englar-Carlson & Shepard, 2005).

A second way masculine gender norms conflict with psychotherapy relates to the expectation for men to be “sturdy oaks.” Men are counted upon to be unmoved by pain, able to stand alone in the face of adversity. Masculine gender development emphasizes separation and independence at the cost of attachment and connection, yet psychotherapy calls for openness to connection and a bond between psychotherapist and client (Osherson & Krugman, 1990). Men may be unsettled by the language of psychotherapy, which is often focused on connection and intimacy, and the process of psychotherapy, which often expects open talk about pain and problems (Kaufman, 1994). Some men who associate manliness

with a high tolerance for pain delay treatment until symptoms are unbearable, risking their health to maintain their gender role (Boman & Walker, 2010).

A third conflict with masculine gender norms centers around a common practice in psychotherapy. An element of many psychotherapies that conflicts with masculine norms is the call for emotional intimacy (Betz & Fitzgerald, 1993). That conflict is related to both the norm to avoid things associated with the feminine and the norm to avoid showing pain or fear. Robertson, Lin, Woodford, Danos, and Hurst (2001) demonstrated that even men who rigidly adhere to masculine gender norms physiologically experience emotions, yet the call to describe their experience created physical signs of stress. Men who adhere rigidly to traditional masculine gender norms often find it anxiety-provoking to express “tender emotions” such as affection, love, or sadness (Saurer & Eisler, 1990). This may stem from a restricted ability to recognize and express emotions, from an unwillingness to express such emotions due to internalized gender role prohibitions, or from fear of exposing their unfamiliarity and discomfort with emotional language (Englar-Carlson & Shepard, 2005). Regardless of the cause, adherence to the norm of emotional control impacts men’s healthcare-seeking through their concerns about how such care will negatively impact their ability to manage emotions (Boman & Walker, 2010).

A fourth major conflict between masculine gender norms and psychotherapy is the vulnerability associated with the role of the client. This runs counter to the expectation for a man to achieve and maintain a position of power and status. “The traditional man is committed to representing himself as strong, independent, rational, competent, and fearless. This man does not want to put himself in a situation (like a psychotherapist’s office) that may challenge his perception of being in control and powerful” (Lanzillo, 1999, p.119). Talking

to someone else about a mental health concern represents admitting a lack of certainty in oneself or a need for someone else's help to work through problems. Yet, men also face pressure to be ultimately accountable for themselves, to hold the responsibility for the well-being of their health, employment, and relationships. Their fear of putting trust in a counselor or the counseling process is contextualized by the common belief that if something goes wrong in counseling, they will still be held accountable for its impact on their lives (Good & Robertson, 2010). Even structural issues of psychotherapy, such as assessment procedures, contracting for number of sessions, payment, medication regimens, suggestion for lifestyle changes, and cancellation policies may all be perceived as a threat to a male client's independence and control (Boman & Walker, 2010; Osherson & Krugman, 1990).

Another way that the mismatch of male gender norms and psychotherapy norms can play out is through discrepancy in which topics are addressed in treatment. At two inpatient alcohol treatment centers, Klingemann and Gomez (2010) found that issues identified by male clients as primary concerns (fatherhood, violence, sexual concerns) were rarely or never brought up during individual therapy. The lack of focus on sexual concerns is particularly disturbing given that 29% of the male clients in this study reported that they had been victims of some form of sexual abuse, coercion, or unwanted touching at some point in their lifetime. Instead, treatment focused mainly on issues (feelings, work-related problems) that male clients later indicated were of little importance to them.

Addressing the Mismatch

While the mismatch between traditional Western masculinities and the requirements for full participation in many forms of psychotherapy is clear, there is little consensus on the best approach to addressing the issue. While some take the approach that programs should

be developed to help men change and increase their help-seeking and participation in psychotherapy, others believe it is psychotherapy, not men, that should adapt (Betz & Fitzgerald, 1993). Current ethical codes of counselors' and psychologists' professional organizations appear to support the second approach, adjusting practice to meet the needs and values of the client. According to the American Counseling Association *Code of Ethics* (2005), "In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly" (p. 4). It also asserts "Counselors are aware of their own values, attitudes beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants" (p. 4-5). According to the American Psychological Association *Ethical Principles of Psychologists and Code of Conduct* (2002), "Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, *gender*, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices" (p. 1063, italics added).

Even those who agree that counseling and psychotherapy should adapt to fit gender-specific needs disagree about the manner in which it should be adapted. The two primary competing approaches are captured by the complementary and reinforcing hypotheses. According to the complementary hypothesis, men and women learn a limited set of skills and characteristics through gender socialization, so psychotherapists ought to balance their clients' skill sets by teaching alternative coping strategies. According to the reinforcing

hypothesis, it is most beneficial to support and enhance the existing skill set of clients based on their gender norms (Owen, Wong, & Rudolfa, 2010). Preliminary research supporting these hypotheses is conflicting. For example, Ogrodniczuk (2006) found that men had better therapeutic outcomes and made more reliable and consistent change in interpretive rather than supportive psychotherapy. This is consistent with the reinforcing hypothesis. However, Owen et al. (2010) found that, when asked what their psychotherapists did to help them change, the responses of clients who reported greater conformity to masculine norms (regardless of their biological sex) more frequently related to relationship and insight than to the provision of information. This is consistent with the complementary hypothesis.

In recent years, work has begun on a model of male-friendly psychotherapy, incorporating awareness of sex-based discrepancies (Brooks, 2010; Good & Brooks, 2005). As research aimed at understanding the male client's experience of psychotherapy is scarce, the model has primarily been based on clinical experience and theory. A more direct understanding of how therapeutic alliances with male clients are weakened or hindered could richly benefit the development of a male-friendly psychotherapy model.

Urgency of Improved Care for Men

The mismatch of psychotherapy with traditional masculine gender norms becomes a pressing issue in light of the mental health concerns currently facing men. The many mental health concerns associated with traditional masculinity highlight the urgency of developing the type of male-friendly psychotherapy argued for above. These include gender role stress, gender role conflict, and a host of associated psychosocial issues. Men also experience greater rates of substance abuse, problems with interpersonal violence, and greater biomedical concerns than women (Levant, 1995; Vessey & Howard, 1993). Men

experiencing stress associated with the masculine gender role are at particular risk of physically unhealthy behaviors (Mahalik & Burns, 2011), harming their intimate partners (Moore, McNulty, Stuart, Addis, Cordova, & Temple, 2010), and negativity or aggression towards sexual minorities (McCusker & Galupo, 2011; Parrott, Peterson, & Bakeman, 2011). Primarily addressed here will be gender role stress, gender role conflict, and the associated mental health concerns.¹

Gender Role Stress and Conflict. Men with a traditional masculine ideology may experience masculine gender role stress and gender role conflict. Gender role stress refers to the type of distress a man may experience in relation to the way he assigns meaning to situations in his life in relation to his identity or competence as a man (Wexler, 2009). Men who assess as stressful situations that include “masculine threats or challenges” are considered to have high masculine gender role stress (Saurer & Eisler, 1990). Kaufman (1994) suggests that acquiring hegemonic masculinities involves a process of suppressing emotions, needs, and possibilities that are experienced as inconsistent with such masculinity; rather than disappearing, the needs are simply kept in check in potentially unhealthy ways.

O’Neil (1981) defines gender role conflict as “a psychological state in which gender roles have negative consequences or impact on the person or others,” restricting that person or another person’s potential (p. 203). More broadly, gender role conflict occurs when “socialized gender roles have negative consequences for the person or others” (O’Neil et al.,

¹ Women also face gender role stress, gender role conflict and related mental health issues (for examples, see American Psychological Association, Joint Task Force of APA Divisions 17 and 35, 2007; Bekker & Boselie, 2002; Canadian Psychological Association, CPA Section on Women and Psychology, 2007; Livingston, Burley, & Springer, 1996; and Mussap, 2007). The author acknowledges the possibility that a case could be made for gender-specific research and counseling or psychotherapy to address these issues for women. However, that falls outside the purview of the current study, which calls attention to and seeks to address, in part, the underrepresentation of men in counseling and psychotherapy research and the lack of a system of counseling or psychotherapy adapted to the needs and experiences of men.

1995). Gender role strain, the associated condition of mental or physical tension caused by gender role conflict, may also be experienced (O'Neil, 1981). O'Neil's earlier work identified six patterns of masculine gender role conflict, but this was later pared down to four through factor analysis: restrictive affectionate behavior between men; restrictive emotionality; conflicts between work and family relations; and success, power, and competition issues. He posited that these emanated from gender role socialization, fear of femininity, and "the Masculine Mystique" (O'Neil, 2008).

Restricted Affect. The condition of restricted emotional expressivity, as it appears in men, has received attention in recent literature (e.g., Levant et al, 2006; Levant, Hall, Williams, & Hasan, 2009; Robertson et al., 2001). Baby boys display a greater range of emotional expression and reaction than girls, but by age 2 years boys are less verbally expressive of emotions than girls and by age 6 years are less facially expressive (Levant et al., 2006). While restricted emotionality may have its roots in the gender code that boys learn through social interaction (Pollack, 1998), as these boys grow into manhood, the situation appears to progress from adherence to a normalized code to a genuine lack of ability to express emotions. This condition has been referred to as normative male alexithymia and, while nonclinical, its prevalence is concerning (Pollack & Levant, 1998). Both clinical and nonclinical levels of alexithymia have been linked to traditional masculine gender roles (Fischer & Good, 1997; Levant et al, 2006; Pollack & Levant, 1998).

Levant et al. (2006) distinguish between the characteristics of normative male alexithymia and clinical alexithymia. Men with normative male alexithymia have not learned a set of emotional skills and display a lack of awareness of emotions, thus limiting understanding of themselves and of their interactions with others. Those with clinical

alexithymia display a greater severity of symptoms, lacking the ability even to recognize physiological components of emotion and themselves displaying stiff facial expressions devoid of emotion. A recent meta-analysis confirmed that alexithymia is more prevalent in men than women, with men having statistically significantly higher mean scores on measures of alexithymia (Levant et al., 2009). Effect sizes were small to moderate but support development of approaches to address emotional awareness and expression in men. The findings of Robertson et al. (2001) may offer some direction to such approaches. They suggest that men physiologically experience emotion and that the difficulty lies mainly in the relaying of emotions to others.

While restricted affect may in itself be a downside of traditional masculinity, it is also associated with other unwanted conditions. For one, these men are likely to experience problems with interpersonal intimacy. Men who have a restricted range of affect and are less expressive of their emotions are particularly likely to experience fear of intimacy (Fischer & Good, 1997). Restricted emotionality has also been significantly correlated to lower self-esteem and higher rates of symptoms of depression and anxiety (Sharpe & Heppner, 1991). While clinical alexithymia has been linked to higher rates of substance abuse and mental illness, only recently has a measure been developed specifically to measure normative male alexithymia (Levant et al., 2006). Thus, researchers have yet to specifically link such negative side effects to the condition known as normative male alexithymia.

Expression of Psychological Distress. Traditionally masculine men are also at risk for other symptoms of psychological distress. Male restrictive emotionality, most strongly and broadly associated with psychological distress, is specifically predictive of paranoia, interpersonal sensitivity, psychoticism, depression, anxiety, and lower self-esteem

(Cournoyer & Mahalik, 1995; Good; Robertson & Fitzgerald, Stevens, & Bartels, 1996; Sharpe & Heppner, 1991). The drive for success, power, and competition significantly predicts paranoia (Good et al., 1996). Conflict between work and family relations significantly predicts depression and obsessive-compulsive symptomatology (Good et al., 1996; Hayes & Mahalik, 2000). Male gender role conflict has also been linked to hostility and social discomfort (Hayes & Mahalik, 2000). The stress of the masculine gender role can have a damaging impact on both the symptoms of, and recovery from, mental illness. In a sample of 33 men in a residential substance treatment program for crack/cocaine, masculine gender role stress was significantly and positively associated with PTSD symptom severity (McDermott, Tull, Soenke, Jakupcak, & Gratz, 2010). At two inpatient alcohol treatment programs, higher scores of masculine gender role stress significantly correlated to a greater number of relapses during treatment and a more negative estimate by psychotherapists of patients' future chances of recovery (Klingemann & Gomez, 2010).

Depression may have a particularly strong relationship with gender role conflict. Good and Mintz (1990) found evidence of significant relationships between depression and all four factors of gender role conflict (success, power, and competition; restrictive emotionality; restrictive affectionate behavior between men; and conflicts between work and family relations). Men with traditional conceptualizations of masculinity have greater risk of depression but are less willing to seek treatment (Good & Wood, 1995). When asked about how masculinity impacted their depression, a group of men shared that depression was not socially acceptable for men, that they felt social pressure to hide their emotions, that support for men with depression seemed unavailable, that they felt it was inappropriate for men to

seek help for depression, and that men with depression are viewed as weak (Chuick et al., 2009).

Unfortunately, it can be difficult for those close to men to recognize they are experiencing depression. Men coping with depression are more likely than women with depression to use a distraction response style (Cochran & Rabinowitz, 2000). The behaviors used to distract themselves may be benign or reckless and risky (Cochran & Rabinowitz, 2000). As noted by Cochran and Rabinowitz (2000), while distraction appears helpful in the short term, it can result in more long-term damage than a ruminative coping style. They also found that men with depression are also more likely to report problems at work, social withdrawal, and somatic symptoms, as consistent with the gender stereotype of an instrumental, outwardly focused man who struggles to maintain control. Furthermore, they concluded that men often utilize externalization-based defenses. This has spawned the concept of “masked depression,” the notion that depression in men may be expressed in nontraditional symptoms such as alcohol abuse, delinquency, reckless behavior, anger, somatic complaints, aggressive behavior, and accidental or purposeful self-injury (Cochran & Rabinowitz, 2000). Men may perceive such nontraditional symptoms as a more socially acceptable way for them to express their depression (Cochran & Rabinowitz, 2000). Men in the Chuick et al. (2009) study typically displayed coping strategies designed to conceal emotions. They reported both typical symptoms of a major depressive episode and atypical symptoms that are harder to recognize as symptoms of depression. The atypical symptoms tended to escalate in nature and included difficulty managing anger, interpersonal conflict, and substance abuse. The consequences of untreated depression can be tragic. Men are at a greater risk of suicide than women, between two and five times as many men as women

commit suicide (Addis & Cohane, 2005; Cochran & Rabinowitz, 2000). The impact of masculine gender role conflict and associated symptoms can also reach those close to men in other ways. Difficulties regulating emotion, in combination with belief in dominance over women, in one study accounted for 25% of variance in intimate partner abuse (Tager, Good, & Brammer, 2010).

Military training and service can also have particularly detrimental interactions with gender role socialization. According to Lorber and Garcia (2010), one emphasis of military training is instilling emotional control, with the goal of increasing chances of mission completion and survival. Lorber and Garcia explain that this training can act as an extreme version of masculine gender role socialization, creating rigid emotional control and avoidance of many emotions. They also note that while both men and women receive this training, it appears that differing gender role socialization contributes to different behavioral outcomes. Nearly 1.8 million U.S. veterans have now served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF; Garcia, Finley, & Lorber, 2011), and male veterans of OEF in Afghanistan and OIF in Iraq are dropping out of psychotherapy at higher rates than female veterans from the same operations (Lorber & Garcia, 2010). Also, male veterans of OEF and OIF are responding differently than veterans of other eras and previous wars; they are dropping out of psychotherapy at higher rates and engaging in more substance abuse (Lorber & Garcia, 2010). Veterans' adherence to traditional masculine gender norms may interfere with their ability to recover after exposure to traumatic events. In a sample of 69 male OEF/OIF veterans seeking outpatient treatment, adherence to certain male gender-normed behaviors—Restrictive Emotionality, Inhibited Affection, and Exaggerated Self-Reliance and Control—was found to positively relate to severity of PTSD

avoidance symptoms at a level of statistical significance. Exaggerated Self-Reliance and Control was also significantly and positively correlated with overall PTSD severity and hyper-arousal (Garcia et al., 2011). These added issues facing military men today highlight the importance of psychotherapy adapted to meet their needs and research to inform psychotherapists how best to accomplish this.

Lest it be misconstrued that all counselors and psychotherapists regard traditional masculinity as negative, it should be noted that there are also potential mental health benefits of masculinity that have therapeutic implications (Englar-Carson & Shepard, 2005; Hammer & Good, 2010). The effects of conformity to masculine norms are complex. In a recent study, overall conformity to 11 traditional masculine norms was significantly positively correlated to endurance but significantly negatively correlated to grit, personal control, and autonomy. Specific masculine norms, such as emotional control and self-reliance, were each positively or negatively correlated with various psychological strengths, such as courage and resilience (Hammer & Good, 2010). One male gender-normed behavior, Success Dedication, demonstrated a significant negative correlation with PTSD avoidance symptoms, indicating that it may be a protective factor (Garcia et al., 2011). Nevertheless, the strengths associated with certain masculine gender role norms do not appear to overcome the mismatch between masculine norms and psychotherapy.

Men Less Likely to Seek Help. As described above, the many men who follow traditional masculine gender norms are faced with an array of mental health concerns. Unfortunately, these men are not likely to seek out mental health care. Based on data from three surveys of national probability samples, Vessey & Howard (1993) concluded that men and women were equally likely to suffer from a mental disorder. However, only one third of

people who made at least one mental health visit to an outpatient clinic were male. Men had a 2.6% chance of making an initial visit and a 37% chance of returning given an initial visit. Men's rate of psychotherapy use increased very little in over a decade. Olfson, Marcus, Druss, & Pincus (2002), in their examination of data from the 1987 National Medical Expenditure Survey and the 1997 Medical Expenditure Panel Survey, found that men's rate of psychotherapy use per 100 persons increased from 2.67 men in 1987 to 2.96 men in 1997 (not a statistically significant increase); women's rate of use increased slightly more from 3.77 to 4.16 (also not statistically significant). Good and Robertson (2010) summed up cultural influences on men's help-seeking, "It is axiomatic in our culture: men are reluctant to seek help" (p. 306). Men are less likely than women to seek help for a diverse array of problems, not only mental health issues but also including physical disabilities and substance abuse (Addis & Mahalik, 2003). Even when men experience higher rates of an issue than women, as is the case with problems related to substance abuse, they are less likely to seek help (Addis & Cohane, 2005; Addis & Mahalik, 2003). In fact, although substance use disorders are more common among men than women, men may be particularly unlikely to seek help for these disorders. Ray, Primack, Chelminski, Young, and Zimmerman (2011) found that, in a sample of 986 men who met lifetime criteria for a substance use disorder, men were more likely to seek treatment for comorbid anxiety and depressive disorders than for a substance use disorder. Yet, overall Addis and Cohane (2005) summarize, "men underutilize health services relative to women for virtually every mental and physical health problem for which help-seeking has been studied" (p. 634).

Not only, as previously mentioned, do masculine norms conflict with the processes of psychotherapy, they also conflict with the very idea of seeking out help. Mahalik, Good, &

Englar-Carlson (2003), in their review of the relationship between masculine ideology and mental health, note the lack of fit between conceptualizations of masculinity and the popular perception of counseling and mental health services as a likely reason for lack of mental health utilization by men. Boys and men receive messages from many sources that teach them to actively reject anything that may be construed as dependence on others and to fear the consequences of asking for help (Good & Robertson, 2010). The tasks required for seeking psychotherapeutic help—recognizing an emotional problem, admitting a need for help, relying on others—conflict with the messages about the importance of self-reliance and emotional control to masculinity (Addis & Mahalik, 2003). Psychotherapy is often viewed as a refuge for women or men too weak to handle their problems on their own (Rabinowitz & Cochran, 2002; Scher, 1990). When faced with the decision of whether to alleviate their symptoms and feel emasculated, or to maintain a sense of masculine independence in the face of worsening symptoms, many men put off seeking help until their symptoms are so severe that they are unable to hide their symptoms from others, allowing for outside intervention (Chuick et al., 2009). Help-seeking implies dependence, which is stigmatized by Western culture and may bring about feelings of neediness, powerlessness, vulnerability, shame, and failure (Scher, 1990; Wexler, 2009).

Research validates the above explanations through application of theory and from clinical experience. Boman and Walker (2010) found that men with greater endorsement of masculine gender norms perceived more barriers to help-seeking. In vignettes responded to by male and female college students, a heterosexual man who sought psychological help for depression was perceived as significantly more feminine than a heterosexual man who did not. In this same group of college students, negative attitudes toward seeking psychological

help were significantly correlated with high levels of traditional masculine ideology (McCusker & Galupo, 2011). Good, Dell, and Mintz (1989) found that men with high restrictive emotionality both reported fewer previous occurrences of help-seeking (inclusive of friends, partners, relatives, clergy, doctors, and professional mental health care providers) and less likelihood of future help-seeking than those with lower restrictive emotionality. More traditional views of the male role as well as concern about expressing emotions were associated with fewer reports of past help-seeking and negative attitudes toward seeking professional psychological help. Graef et al. (2010) found that these patterns carry over to perceptions of career counseling. Men who reported greater endorsement of traditional masculine norms placed less value on career counseling, perceived more stigma towards utilizing it, and said they would be less likely to seek out such services. The lack of men's help-seeking behavior in the face of mental health issues emphasizes the need for counseling and psychotherapy researchers and practitioners to learn as much as they can from the relatively few men who do seek help. Wester, Sedivy, Arndt, and Arndt (2010) examined the stigma associated with counseling in a group of 178 male law enforcement officers. They found that as gender role conflict increases, so does the anticipated risk of seeking psychological help, and as anticipated risk increases, so does stigma. Conversely, as gender role conflict increases, anticipated benefit of seeking psychological help decreases. Gender role conflict also has a statistically significant direct influence on public stigma but not on self-stigma—as gender role conflict increases, so does public stigma. Anticipated risk mediates the role between both types of stigma and gender role conflict; the potential loss of self-esteem that a man would feel for seeking psychological help is more directly related to stigma than to the notion of violating male gender norms.

Lack of Alliance Research Representing Men

More specifically, counselors and psychotherapists need to utilize the perspectives of men who continue receiving mental health services and those who do not in pursuit of understanding how to best build strong alliances with male clients. Some alliance researchers have noted the underrepresentation of male clients in their studies and called for future researchers to further examine their perspective (Bachelor, 1995; Bedi, 2006). One study (Bedi & Richards, 2011) answered this call, utilizing a sample of all male participants to sort the incidents from Bedi (2006) and rate the helpfulness of each. As in Bedi (2006), multivariate concept-mapping techniques were utilized, allowing researchers to capture the perspectives of male clients on how the incidents related to the alliance and to one another. The incidents were generally rated as moderately helpful. The nine categories that emerged from hierarchical cluster analysis were: Bringing out the Issues, Non-Verbal Psychotherapist Actions, Emotional Support, Formal Respect, Practical Help, Office Environment, Information, Client Responsibility, and Choice of Professional. A concept map displayed the relation of these categories on both a Client/Practitioner Agency axis and a Non-affective/Affective axis. This study focused only on incidents that were helpful to alliance formation and included only participants who were currently seeing a counselor or psychotherapist.

Continuing Needs and the Current Study

Another gap in the alliance research noted by Bachelor (1995) and Bedi (2006) is the need for qualitative work that addresses the client's experience of hindered or weakened alliances. As Bedi (2006) explained, "We cannot assume that 'good' and 'bad' alliance fall on a continuum. It is an assumption that the factors involved in fostering highly positive

alliances are just more of or less of what is present in weaker alliances—there may be some distinct factors present in each” (p. 33). For example, while client responsibility was noted as important to men’s subjective experience of building strong alliances in Bedi and Richards (2011), this does not necessarily mean that a lack of client responsibility holds equal importance in hindering the development of an alliance. The negative cases noted in previous studies (Bedi & Richards, 2011; Fitzpatrick et al., 2006; Fitzpatrick et al., 2009) hint at the value such data may provide, but no full studies with this aim have been conducted.

The current study builds on the existing body of literature reporting the client’s subjective experience of the alliance. An abbreviated version of the CIT was applied, utilizing structured written data collection and focusing only on ineffective incidents. The CIT was designed to gather important facts about behavior in a specific situation (Flanagan, 1954). In this study, the aim was to identify behaviors that were specific, observable events that hindered the formation of a working alliance or weakened an existing alliance with a mental health professional. This could be something that either the client or the professional did, something they did together, or something else that impacted the alliance. It could be something that happened within or outside of the sessions. These incidents were described by male participants either currently in, or having recently terminated, individual counseling or psychotherapy.

Some may question the accuracy of participant recall, as opposed to direct observation. However, in the current study, recall allowed for coverage of a broad range of experiences that may have occurred over a long period of time. Such an extensive range of experiences would be impractical to measure with observation and may have occurred in

places (such as outside of session) that it would not be possible or appropriate to observe. It has been argued that the accuracy of participants' recall may be gauged by the amount of full and precise details provided and their confidence in their own recollections (Brewer & Weber, 2008; Flanagan, 1954), although the reliability of these indicators remains in questions (Laney & Loftus, 2008). Other elements in this study that may have contributed to accuracy of the events recalled include open-ended questions and the element of negative experience. Memories recalled in response to open-ended questions, as opposed to memories that were cued with further details, have been associated with greater accuracy (Bahrick, Hall, & Da Costa, 2008). Also, when a person experiences a negative mood at the time of an event, it changes the way that person processes information, contributing to greater recall of details at a later time, especially details associated with the source of the negativity (Bluck & Li, 2001; Kensinger, 2007; Storbeck & Clore, 2005). To clarify, memories conveyed with more emotionality are not necessarily more accurate or truthful (Laney & Loftus, 2008); rather, experiencing an event with greater emotion, specifically negative emotion, contributes to more accurate recall of that event. Yet, the CIT does hinge on self-report. Thus, in the approach of this study, as with many qualitative approaches to research, there is an element of trust in the participant. While there is no way to fully verify the accuracy of information participants relay, and there remains the possibility that some or all of them could be mistaken in their recollections, using multiple sources of information (many participants' recollections of the same type of incident) reduces the impact of faulty self-reporting (Kain, 2004).

The current study employed questionnaires to collect data. Although it has been suggested by some researchers that in-person interviews are the most effective method of

gathering critical incident data in counseling research (Butterfield, Borgen, Maglio, & Amundson, 2009), it has also been noted that questionnaire data can provide qualitatively equivalent results if the participants are motivated to read the instructions carefully and answer conscientiously (Flanagan, 1954). In addition, the questionnaire format has been shown to produce similar rates of disclosure to face-to-face or telephone interviews (Reddy et al., 2006), although these results have been somewhat inconsistent (Carter, Aimé, & Mills, 2001). The questionnaire format also demonstrated a comparably low tendency to elicit socially desirable responses, more similar to computer assisted self-report than face-to-face interviews (Richman, Kiesler, Weisband, & Drasgow, 1999). Participants attended an appointment with a research assistant to complete their questionnaires. This allowed research assistants to clarify any questions participants had and to check that participants' answers were full and complete. Rather than being like a checklist, the critical incident questionnaire is very open-ended. An advantage of the CIT is that it gives power to participants to determine which of their experiences are most "critical" (Kane, 2004). Asking participants to tell their story, with a researcher present to clarify and probe, allows researchers access to the participants' knowledge in a format that can be very engaging.

Unlike any previous studies on clients' subjective experiences of the alliance (Bachelor, 1995; Bedi, 2006; Bedi, Davis, Arvay, 2005; Bedi, Davis, Williams, 2005; Bedi & Richards, in press; Fitzpatrick et al., 2006; Fitzpatrick et al., 2009; Mohr & Woodhouse, 2001), this study exclusively catalogued the incidents that clients perceived as hindering the development of an alliance with their counselor or psychotherapist or weakening the existing alliance with their counselor or psychotherapist. As only one other published study on the alliance (Bedi & Richards, 2011) and one unpublished study (Martin, 2007) have done,

exclusively male participants were recruited, to more fully address the need for representation of male clients in alliance research. While the ratio of male to female participants in previous alliance research (about 1:3, Martin et al., 2000) has been roughly equivalent to the ratio of male to female clients in outpatient mental health clinics (about 1:3, Vessey & Howard, 1993), alliance research focusing specifically on male clients may help researchers to discover, and practitioners to better address, gender-specific needs of male clients. An effort was made to incorporate the experiences of participants currently in counseling or psychotherapy as well as the experiences of those who have unilaterally terminated. The testimonial validity of some past qualitative studies of the client's subjective perspective of the alliance may have been compromised by researchers' categorization of the data (e.g., Bachelor, 1995; Bedi, Davis, Arvay, 2005; Bedi, Davis, Williams, 2005; Fitzpatrick et al, 2006; Fitzpatrick et al. 2009). To minimize the influence of researchers' existing understanding of the alliance, steps were taken to better incorporate clients' own perspective into the categorization and interpretation of critical incidents.

Specifically, this study sought to address the question, "What do male clients understand to be most detrimental to the formation of the alliance?" These data are preliminary, as there is little published literature pertaining to the male client's subjective experience of incidents as hindering or weakening to the alliance. The exploratory nature of information generated by the CIT has been deemed very applicable to areas that have not been well researched (Woolsey, 1986).

Method

Participants

Clients. Participants were recruited through flyers posted on the Western Washington University campus (6.98%), flyers at local social service agencies and private practices (34.88%), postings on online job forums (33.72%), through word of mouth (12.79%), through radio advertisement (2.33%), and through the university psychology department's online recruitment website (4.65%). At the time of the screening interview, the following were required for a person to qualify for participation: male gender, age of 18 or older, completion of 10th grade education or equivalent, individual outpatient counseling or psychotherapy (ongoing or within the last 30 days), and ability to travel to the university research lab. Data were first collected from 45 participants meeting the above criteria and in accordance with the procedures outlined below. Then, two years later, an additional 41 participants were recruited. Persons expressing interest in participating were contacted by phone for a brief screening interview. Those not meeting the participation criteria were thanked for their time; those meeting criteria were scheduled for a data collection appointment and mailed directions to the research lab.

In total, participants were 76 men ($N = 76$); of the 86 from whom data were collected, 76 provided viable critical incident data. The age of participants ranged from 19 to 63 years ($M = 35.61$, $Mdn = 34.29$, $SD = 12.76$). Self-reported ethnicity of participants was primarily White/Caucasian/European/European American/Anglo Saxon (85.53%), with several other ethnic groups making up the remaining 14.47% (African American/Black American 2.63%, American 1.32%, Asian 1.32%, White/Caucasian/European/European American/Anglo Saxon and Native American 2.63%, Hawaiian 1.32%, Mixed 1.32%, Native American 2.63%). The majority of participants (68.42%) were single/never married; others were married/partnered (14.47%), divorced/separated (14.47%), or widowed (2.63%). The

majority of participants had completed high school (56.58%), while others had education beyond high school (technical degree 3.95%, associate's degree 21.05 %, bachelor's degree 11.84%, and master's degree 6.58%). There was a wide range of type of employment among the participants. Part of the sample were students (25.0%), others were not currently working (unemployed 26.32%, disabled 7.89%), and the rest (40.79%) were employed in various occupations (e.g., agriculture, education, customer service). Mean reported time spent in the United States was 34.49 years ($Mdn = 33.38$, $SD = 13.86$).

Participants also reported on the mental health care they had received. Most men were still in treatment (89.47%) but some had recently ended treatment (10.53%). Mean rating of alliance quality in their current or most recent psychotherapy relationship, on a single-item scale from 1 (*extremely negative and/or extremely weak*) to 10 (*extremely positive and/or extremely strong*) was 7.47 ($Mdn = 8.00$, $SD = 1.99$). This indicates the participants had, on average, strong alliances with their mental health professionals. The men reported a wide range in the number of mental health professionals they had been treated by in their lifetimes (min = 1, max = 275), but the majority (57.89%) had been treated by four or less ($M = 9.43$, $Mdn = 4.00$, $SD = 31.72$). With their current or most recent mental health professional, there was also quite a range reported for number of weeks spent in counseling (min = 1, max = 1040, $M = 104.32$, $Mdn = 38.50$, $SD = 162.83$). Number of sessions ranged from 1 to 700 ($M = 38.45$, $Mdn = 10.00$, $SD = 92.97$); the majority of participants (54.67%) had twelve or less sessions at the time of data collection. Participants were currently or had most recently been treated in a variety of outpatient settings (private practitioner's office 51.32%, community agency 36.84%, university/college counseling center 7.89%, and other 3.95%). The participants were currently seeing or had most recently

seen both male (53.95%) and female (46.05 %) mental health professionals. The majority of participants reported the primary reason they sought counseling as either anxiety (25.00%) or depression (32.89%), though many other concerns were also reported (e.g., bipolar disorder 5.81%, alcohol/drug use 6.58%, trauma 3.95%, relationship issues 5.26%). While the majority of participants (68.42%) were uncertain about the type or style of treatment they were receiving, those who did know reported a broad array of treatment approaches (e.g., art therapy, cognitive behavior therapy, dialectical behavior therapy, motivational therapy, person-centered, psychodynamic, rational emotive behavior therapy).

Comparisons were made between the 76 participants who provided viable critical incident data and the 10 men whose data did not yield viable critical incident statements. On most demographic and mental health care variables, no significant differences were found. Significant differences were noted on age ($t = 4.492$, $df = 21.53$, $p < .01$), time spent in the United States ($t = 4.797$, $df = 24.11$, $p < .01$), and type of setting where treatment was received ($\chi^2 = 15.96$, $df = 4$, $p < .01$). For the 10 men whose data were excluded, their age tended to be higher ($M = 46.47$ years, $Mdn = 46.75$ years, $SD = 6.09$ years) and they tended to have spent more time in the United States ($M = 46.47$ years, $Mdn = 46.75$, $SD = 6.09$ years) than the 76 participants. Compared to the 76 participants, the 10 men whose data were excluded were less often treated by private practitioners, more often treated in community agencies, more often treated in hospitals, less often treated in university/college counseling clinics, and less often treated in other settings.

Participation was not limited to only participants who believed they had a weak or hindered alliance with their mental health professional at the time of recruitment. This decision was informed by theory and research suggesting that alliance strains may be

resolved, resulting in as strong or stronger alliances (Bordin, 1980; Lansford, 1986; Rhodes et al., 1994). The alliance begins to develop very early in counseling or psychotherapy, and researchers often measure alliance strength within the first five sessions, yet it continues to develop in later sessions (Bachelor & Salame, 2000; Dinger et al., 2009; Eames & Roth, 2000; Horvath & Bedi, 2002; Horvath & Marx, 1990). For this reason, there were no minimum or maximum cutoffs for the number of sessions a client must have had to participate in the current study; including clients with only one or two sessions and clients with over one hundred sessions could provide valuable information on hindrance or weakening in alliance development across the entire course of counseling or psychotherapy.

Coding team. The primary coding team consisted of a female master's student in the mental health counseling program and a female undergraduate psychology student. The auditor was a male professor with previous research experience in, and multiple publications using, the CIT. Additionally, three of the original client participants were called upon to inform the creation of the initial category schemes.

Measures

Demographics questionnaire. Participants were asked to complete a brief questionnaire about demographics (see Appendix K). This allowed for an estimation of how representative of a sample had been obtained. With critical incident methodology, sample sizes are often small, and characteristics of respondents have a great impact on the generalizability of the study (Woolsey, 1986).

Critical incident questionnaire. In place of the semi-structured interview often used in critical incident studies, a structured written form (see Appendix L) was used to collect critical incident data. This format allowed for standardization of data collection. It also

helped to ensure that all incidents contained the necessary criteria for inclusion in a critical incident study—information describing what led up to the event, a detailed description of a specific and observable incident, and information describing the outcome of the incident (Butterfield, Borgen, Amundson, & Maglio, 2005). At least one researcher was present while each participant completed the questionnaire to verify that questions were answered completely and that the researcher could clearly read all of the participant's handwriting; the researcher also clarified or verbally expanded upon instructions and prompts as needed. The questionnaire included a primary prompt and several follow-up questions to add detail and context to the incident. The following prompt was used to initially elicit critical incident information:

What was the most important thing that weakened and/or hurt the formation and strengthening of the counseling or therapy relationship? Please describe it completely and in as much detail as possible.

Note that the term *alliance* was not used in the prompt or follow-up questions. Instead the terms *working relationship*, *counseling relationship*, and *therapy relationship* were used. This is because the term alliance is not typically used or understood by clients and would likely not be interpreted by them in accordance with the meaning intended (Bachelor, 1995; Fitzpatrick et al., 2009). Incidents collected from this prompt were considered critically detrimental to the alliance as the participants were reminded both within this prompt and in one other place on the questionnaire to describe “the *single most important thing* that weakened or hurt the formation and/or strengthening of the working relationship.” This provided an alternative to other methods of determining how critical an incident was, such as rating systems of importance.

In order to allow participants to engage the memories elicited by the critical incident prompt with less emotional bias and to provide an opportunity for more comprehensive reporting, a prompt relating to experiences that strengthened the alliance was also included. To avoid negative emotional priming by allowing participants to first access helpful or strengthening incidents, it was presented to participants prior to the prompt relating to what weakened the alliance.

Conformity to Masculine Norms Inventory. The Conformity to Masculine Norms Inventory (Mahalik et al., 2003; CMNI) is a 94-item self-report measure of attitudes, behaviors, and cognitions reflecting both conformity to, and non-conformity to, eleven masculine normative messages. Participants rate how much they agree or disagree with each statement on a four-point scale (*Strongly Disagree, Disagree, Agree, Strongly Agree*). The measure generates an overall score as well as scores on the following eleven subscales: Winning, Emotional Control, Risk-Taking, Violence, Power Over Women, Dominance, Playboy, Self-Reliance, Primacy of Work, Disdain for Homosexuals, and Pursuit of Status. The factor structure, internal consistency, test-retest reliability, and concurrent validity of CMNI scores were initially established by Mahalik et al. (2003) in a series of five studies. For the total score, alpha was .94, and for the subscale scores, alphas ranged from .72 to .91 (Mahalik et al. 2003). Additional support for reliability has been provided by Liu and Iwamoto (2007); Mahalik, Lagan, and Morrison (2006); Burn and Ward (2005); and Tager and Good (2005). Administration of the CMNI (for sample CMNI items, see Appendix M) provided a helpful indicator of to what extent participants adhere to traditional masculine gender norms.

Procedures

The study was reviewed and approved by the ethical review board of the participating university. Convenience sampling techniques were used. The wording of recruitment and screening materials was designed to encourage the participation of clients who had recently terminated counseling or psychotherapy as well as those who were still being treated at the time of recruitment.

Training of coders and assistants. Researchers and assistants received training prior to data collection. Training varied according to research duties. In order to minimize differences in data collection, those collecting data received supervision from an experienced researcher during two mock data collection runs. The coding team was also instructed in the CIT and conducted one mock extraction (of 10 critical incident statements [CISs]) and consensus coding with the auditor prior to working with the actual data. In the manner of Woolsey (1986), the auditor, having previously conducted research with the CIT, assisted the coding team in achieving consistency of the type of incidents extracted from the questionnaire data and uniformity in the level of detail included.

Critical incident description. Participants completed the questionnaires at individual data collection appointments. One or two researchers were present during each appointment. It took each participant approximately one hour to complete the demographic questionnaire, critical incident questionnaire, and CMNI. The researchers examined each participant's completed questionnaires during the appointment to check for readability of handwriting and clarity and completeness of answers. To thank participants for their time, they received an honorarium of \$10.00 and to offset any transportation or parking costs incurred, they received \$5.00; each participant received a total of \$15.00 for completion of the study.

Student participants had the option to receive one hour of research credit rather than a cash honorarium.

Client category formulation. During each data collection appointment, the participant was asked whether he was willing to participate in category formation. Once all CISs were extracted and redundancies eliminated, three participants were randomly selected (from those who indicated they were willing to return) and invited to sort the CISs into categories. Participants were reminded of the aim of the study (“to learn from men what most damaged or hurt the working relationships they’ve had with their counselors or psychotherapists”) and asked to look for themes among the CISs as they related to this aim. They were asked to sort according to the themes they saw. Each CIS was only allowed to be sorted into one pile. The participants were asked to provide a name and brief description for each category. They were advised that they would likely find the need to adjust their categories as they continued sorting, adding new categories if the existing ones became too broad or merging categories where they found overlap. See Appendix N for the sorting task instructions participants were provided with and Appendix O for the abbreviated sorting guidelines they were given to refer to while sorting. Also included in the appendices are the other forms used during the sorting data collection appointments (Appendix P: Category Record Form, Appendix Q: Category Description Form, Appendix R: Payment Form, Appendix S: Resource List).

The inclusion of participant sorting data in this study helps to support the validity of the final category structure as representative of male clients’ understanding. While the understanding of every participant is valuable, inviting every participant back to sort would surpass the limits of time and cost allotted for this study. Also, the larger the number of

individual sorts, the more difficult it could become to later incorporate them into one consensus sort. Thus, three participants were sampled to loosely represent the higher-level perspective of clients in this study.

It was anticipated that it would require each participant who assisted in the category creation approximately two hours to complete this task. Thus, three participants each received \$20.00 for an anticipated two hours of sorting and \$5.00 for transportation costs (a total of \$25). The actual time required for the task varied between 45 minutes and three hours.

The primary coders supervised client category formulation appointments and entered data from these appointments. In order to minimize the influence of the participants' category structures on the coders' own category structures, the coders began their own independent sorting of the CISs before the participant sorting appointments. The coders completed their category structures and descriptions between the first and second client category formulation appointments.

Follow-up interviews. Participants were asked during their data collection appointment whether they were willing to participate in a follow-up interview by phone to help researchers verify that the resulting CISs and categories accurately represented their experiences in counseling/psychotherapy. No additional honorarium was provided to participants who participated in follow-up interviews. While this process may have introduced a self-selection bias to this aspect of validation (as not all participants elected to participate), this was one of many analyses designed to affirm the credibility of the data. Participants who agreed to the interview were contacted via phone for a brief follow-up interview. In accordance with the suggestion of Butterfield et al. (2009), participants were

asked to answer the following questions relating to the CIS generated from their questionnaire data:

1. Does this (CIS) accurately describe what happened that hindered or weakened the working relationship with your counselor or psychotherapist?
2. In the sentence describing your experience, is anything missing?
3. In the sentence describing your experience, is anything missing?
4. In the sentence describing your experience, is there anything that needs to be changed?
5. Do you have any other comments?

The CIS read to each participant was from the consensus list of CISs, once redundant CISs had been combined (see below for further information on consensus process and treatment of redundancies). Participants were also read a list of the categories and each was told into which category his CIS was sorted. They were asked the following questions relating to the categories:

1. Do the category names make sense to you?
2. Does the name of the category your experience was sorted into capture your experience and the meaning the incident had for you?
3. If your experience does not seem to fit in this category, where do you think it belongs?

Reactions and concerns of the participants were noted. Researchers determined how best to incorporate client suggestions. Inviting participants' commentary on the CISs and categories and incorporation of their feedback supports the testimonial validity of the

researchers' interpretation (see Bedi, Davis, & Williams, 2005) and protects the fidelity of the representation of participants' experiences.

Participants were also asked to assign a detrimentality rating to each category of CISs. They were asked to verbally rate on a scale from 0 (*helpful or positive*) to 5 (*extremely damaging*) to what extent each category hindered or weakened their working relationship with their counselor or psychotherapist. An average detrimentality score was calculated for each category. This was to help establish the validity of the categories as detrimental to alliance formation and maintenance (see Andersson & Nilsson, 1964). The complete follow-up interview form is included in Appendix T.

Data entry and storage. Data from the demographics questionnaire, the CMNI, and follow-up interviews were entered into SPSS. Data from the critical incident questionnaire were entered into SPSS and Microsoft Excel. Extracted incidents were printed individually on index cards to facilitate ease of client sorting. Sort data was first transferred to a handwritten form, and then entered into Microsoft Word and Microsoft Excel.

Data Analysis

Critical incident extraction. Extraction of CISs began with data from the 45 participants whose data was first collected and continued with the 41 incidents as they were later collected. To represent a valid incident, data must have provided detailed descriptions of occurrences that translated into specific and concrete terms. The CISs were extracted in small batches (of approximately 10); each coder extracted each batch of CISs using an individually randomized list to determine order. Both primary coders independently extracted what they believed the CIS was from each critical incident questionnaire.

On any questionnaires where it seemed plausible that multiple incidents had been described in response to the incident prompt, the coders first looked for any clear indications of which incident was experienced by the participant as most detrimental to the alliance. If no such indication was available, they deferred to coding the incident described in greatest detail.

The rate of agreement between coders on CISs, or the concordance rate, was calculated. CISs were judged as concordant if they described the same main concept with the same wording (“the client arrived late to several appointments” and “the client arrived late to several appointments”), described the same main concept with different wording (“the client arrived late to several appointments” and “the client was not on time to many appointments”), described the same main concept in different verb tenses or grammar (“the client was consistently late to appointments” and “the client is consistently late to appointments”), or described the same main concept with different levels of specificity (“the client arrived late to several appointments” and “the client was late to the first, third, and fourth appointments”). A higher concordance rate indicates more credibility that the CISs identified are important to the hindrance or weakening of the alliance (Butterfield et al., 2005).

Given that it was the intent of this study to collect only one incident from each participant, it was anticipated that the initial concordance rate would be higher than in more open-ended critical incident studies that allow any number of incidents to emerge throughout an interview. However, as the answers to the critical incident prompt collected from participants were typically a paragraph comprised of several sentences, there was still discernment required on the part of coders to extract a single representative CIS. Thus,

concordance rate provides a helpful indicator of the level of agreement between coders during this process.

Coders compared their CISs and, in the case of discrepancy between the two, agreement on what comprised the CIS or how to describe the critical incident was reached through discussion and consensus. When, for any reason, the coders were unable to reach consensus on how to extract and phrase a CIS, they consulted with the auditor to achieve a final decision. As the CISs were extracted from questionnaires completed by participants (rather than from a recorded and transcribed interview), there was a concrete record of each participant's own words and thus no need for interview fidelity checks and no question of descriptive validity. In preparation of CISs for the consensus list, extracted CISs were slightly edited. This included elimination of awkward or grammatically incorrect wording, adjustment for a uniform level of detail across the CISs, and adjustment for uniformity of grammar and verb tense across the CISs.

The auditor reviewed the consensus lists of CISs as they were reached. He questioned certain CISs or made suggestions for alternative coding, helping to ensure a consistent and appropriate level of detail. The primary coders reviewed the auditor's suggestions and determined which to incorporate.

Redundancy and Exhaustiveness. After CISs were extracted, they were examined for redundancy. A list of redundancy criteria helped to guide the primary coding team in determining whether or not the CISs were redundant. CISs were judged as redundant if they met one or more of the following criteria: a) duplication of wording within a CIS (e.g. "the therapist didn't listen to me" and "the therapist didn't listen to me"), b) repetition of main concept (e.g. "the therapist sat back in his/her chair" and "the therapist leaned back"), c)

describing same occurrence with different verb tense or grammar (e.g., “the therapist yelled” and “the therapist was yelling”), d) similarity of main concepts (e.g., “the therapist’s office had stiff, uncomfortable seats” and “there were only uncomfortable chairs in the therapist’s office”), or e) a hierarchical relationship, such as one CIS representing a more specific occurrence of the other (e.g., “the therapist wore casual clothing” and “the therapist wore jeans and a t-shirt”). Redundant instances of CISs were eliminated, with all similar instances being condensed into one representative CIS. Thus, while data were collected from 86 participants, there were fewer CISs in the final list.

Redundancy is desirable, as it indicates the extent to which the data have been exhaustively collected, providing a measure of content validity. A general guideline for sample size in the CIT is to continue collecting data until redundancy appears (Woolsey, 1986). Yet, the level of redundancy reached is flexible. Generally, repetition of incidents adds more clarity and precision to the description of the behaviors being studied (Flanagan, 1954), in this case incidents that male clients view as critically hindering or weakening to the therapeutic alliance. Flanagan (1954) offered the example that three or four repetitions of each incident would allow for a very precisely descriptive list of behaviors.

The pattern of repetition of incidents may present somewhat differently in the current study than one would expect if adhering strictly to Flanagan’s (1954) CIT because the current study focused on the single incident each participant experienced as most detrimental to formation of the alliance, rather than allowing each participant to list as many incidents as he could name that were damaging to the alliance. The sample size was for the current study was not determined by repetition alone. Data collection continued to the maximum number

of participants allowed by time and funding constraints, resulting in a moderate sample size of $N = 86$.

Post hoc redundancy checks were conducted, to assess for redundancy as a function of sample size and allow conclusions to be made about the level of saturation likely obtained. In the manner of Bedi, Davis, and Williams (2005), redundant CISs were assessed in batches of five interviews. Five interviews were randomly selected and the number of repetitive CISs extracted from these was calculated, then another five were selected, and so on. Also as in Bedi, Davis, and Williams (2005), a retrospective analysis of category creation was conducted. In batches of five randomly selected participants, the category each participant's CIS was sorted into was noted. This allowed for the determination of after how many participants each category was first utilized.

Categorization by researchers. Each researcher in the primary coding team independently sorted the CISs into categories. As recommended by Flanagan (1954) and Butterfield et al. (2009), each researcher sorted the CISs in small batches, reading three randomly selected CISs, categorizing these, then moving on to the next three. When deciding whether to merge, split, or create new categories, each researcher kept the aim of the study in mind (Butterfield, Borgen, Maglio, & Amundson, 2009): to generate a list of incidents that male clients reportedly experience as most detrimental to the formation or strengthening of the counseling alliance. As the sorting of CISs is a subjective process (Flanagan, 1954; Woolsey, 1986), researchers kept notes on their categorization process (including the point at which each new category was created), noting the reasons for splitting or merging of categories or creation of subcategories. This allowed for a richer description and interpretation of the data.

When both of the coders completed their independent sorting of the CISs, they met to form a consensus sort based on their own sort data and the sort data of the three participants. As the coders did not have access to the participants for consultation regarding consensus, it was at the discretion of the coders to find a consensus category structure that most closely represented as many of the three participant co-researchers' sorts as possible. They referred to the brief category descriptions provided by the participants to help them better understand how the participants conceived their category structures. They also had access to contextual information about the incident, as provided by the critical incident questionnaire. Context of the incident was sometimes helpful in accurately interpreting and representing the incident (Woolsey, 1986; Butterfield et al., 2009). To help clearly delineate the participants' sort data, the coders created a detailed comparison and contrasting of the three sorts. Differences between the sorts were noted and resolved through consensus. Brief descriptions of each consensus category were generated.

Independent Replications of Sorting. Two undergraduate research assistants and two graduate research assistants independently sorted all of the CISs into the consensus category structure. CISs were printed on index cards, randomized, and sorted in batches of 3 at a time (approximately 5% of total CISs, recommended by Andersson & Nilsson, 1964; Butterfield et al., 2009). As research assistants coded each batch, researchers noted the point at which the assistants began to use a category (sort the first CIS into a category).

This process allowed for several measures of interjudge reliability. First, it allowed for calculation of average match rate, a measure of how frequently the assistants sorted the CISs into the same categories as the original consensus coding of the primary coding team. A match rate of 75-85% indicates adequate interjudge reliability (Andersson & Nilsson,

1964; Ronan & Latham, 1974). Also, Cohen's kappa and Krippendorff's alpha were used to calculate the level of agreement between each assistant's sort and the consensus sort, to measure the significance of the agreement as compared to that expected on the basis of chance alone.

In addition, the sort replication allowed for validity checks. As a content validity check, researchers noted the point at which the assistants began to use a category. Ronan and Latham (1974) suggest checking what percentage of categories has been utilized when 75% of the data have been sorted. If 90% of total categories have been utilized by that point, this suggests that data collection was not stopped too early. As an additional check of content validity, the number of additional categories that began to be used when the last six CISs (approximately 10% of total) were sorted was measured. Ronan and Latham (1974) suggest that if not more than two categories are first used when the final 10% of CISs are added, this suggests that sufficient data have been collected to represent the range of possible CISs.

Representation rate. A representation rate was calculated for each category. This describes the percentage of the total number of CISs that are included within each category. While Flanagan (1954) recommended that categories contain roughly equal amounts of CISs, Woolsey (1986) countered this suggestion and cautioned that artificially constructing equal categories may distort the data. This study focused on creating categories that represent the data as fully and accurately as possible, without regard to similarly sized categories, so larger variation in representation rate was anticipated.

Participation rate. A participation rate was calculated for each category. This represents the percentage of individuals contributing at least one critical incident to each category (Bedi, Davis, & Williams, 2005). Some have argued that a higher participation rate

indicates a higher relative strength of the category (Borgen & Amundson, 1984; Butterfield et al., 2009). Butterfield et al. (2009) recommend a participation rate of at least 25% to establish each category as viable. However, a more apt description of participation rate suggests that it is merely an indication of how uniformly a category was experienced across participants; it may be interpreted as a guide as to how broadly relevant the category may be (Bedi, Davis, Williams, 2005). A low frequency of experience of the category does not indicate less importance of the category; it may be extreme or unusual but very important to those who experience it (Andersson & Nilsson, 1964; Bedi, Davis, Williams, 2005).

In the traditional CIT, participants are allowed to list as many critical incidents as they have experienced. In the current study, participants were asked to name a single incident that they experienced as most critical. Thus, each participant could only contribute an incident to a single category, decreasing the utility of participation rate to indicate the broad relevance of categories. However, participation rate for this study specifically shows the percentage of participants who contributed an incident to a given category (calculated using pre-redundancy CISs), as opposed to representation rate which shows only the percentage of post-redundancy CISs in each category.

Results

To confirm the homogeneity of the sample, comparisons were made between the data first collected ($n = 45$) and the data collected about two years later ($n = 41$). No significant differences were found by age, ethnicity, occupation, relationship/partnership status, level of education, time living in the United States, place of mental health treatment, mental health care provider's (MHP) education level, MHP's gender, reason for seeking treatment, number of sessions, time in counseling or psychotherapy, number of MHPs, or alliance strength.

Given the lack of differences beyond chance between data collected at the two time points, results will be reported for the participants as a whole ($N = 86$), unless otherwise noted.

The data from 10 participants did not meet criteria for formulating a viable critical incident. Therefore, a total of 76 critical incident statements (CIS's) were extracted before redundant CIS's were eliminated. On first attempt, the primary coders extracted the same CIS from 60.47% of participants and agreed that there was no valid critical incident from 4.65% of participants (total initial similarity = 65.12%). For 5.81% of participants, the coders did not initially agree on whether there was a valid critical incident, and for 29.07% of participants, the coders did not initially extract an equivalent CIS (although some overlap frequently occurred). This indicates a moderately consistent initial understanding of critical incidents across the two coders. After discussion and further review of participants' responses to the critical incident questionnaire, the coders were able to reach consensus on nearly all critical incidents; the auditor was only consulted on three participants' (3.49%) critical incidents to help reach consensus. The auditor's other suggestions were incorporated into CIS extraction in the following ways: three CIS's were adjusted to be more concrete and behavioral, words were deleted or changed in four CIS's to avoid compound statements, extraneous words were deleted from two CIS's to increase clarity, minor wording changes were made to three CIS's to increase clarity, wording was changed on two CIS's to more broadly applicable terminology (i.e., "my addiction" changed to "my issues"), and verb tense on one CIS was adjusted for consistency with other CIS's. After the consensus list of incidents was finalized, the CIS's were examined for redundancy. When redundant statements had been eliminated, 56 statements remained. These 56 statements are listed

within the consensus category structure in Table 1. See the section below titled Exhaustiveness for more details on the redundant incident statements.

The average Flesch-Kincaid grade reading level of the 56 CIS's, as calculated by Microsoft Word 2010, was 10.3. This reading level was consistent with the requirement of the study that each participant have at least a 10th grade education. This indicates that the vocabulary and sentence structure used in the statements was likely understood by the participants who sorted them.

Individual Categorization Structures

The first primary coder had a total of 16 categories, while the second primary coder had a total of 14 categories. They had a similar average number of critical incidents per category (first coder $M = 3.50$, $Mdn = 3.00$, $SD = 2.39$; second coder $M = 4.00$, $Mdn = 4.00$, $SD = 2.00$). A more detailed comparison of the coders' sorts is available in Appendix U.

Each of the three participants sorted the CIS's into 7, 28, and 8 piles respectively. Mean number of CIs per pile for each participant were 8 ($Mdn = 8$, $SD = 3.51$), 2 ($Mdn = 1$, $SD = 1.33$), and 7 ($Mdn = 5.5$, $SD = 5.31$). A detailed comparison of how the three participants sorted the CIS's is presented in Appendix W.

For the two coders, the mean number of categories was 15 ($Mdn = 15.00$, $SD = 1.41$) and the mean number of CIS's per category was 3.73 ($Mdn = 3.00$, $SD = 2.20$). For the participants, the mean number of categories was 14.33 ($Mdn = 8.00$, $SD = 11.85$) and the mean number of CIS's per category was 3.91 ($Mdn = 3.00$, $SD = 3.78$). There was no statistically significant difference between the mean number of categories used by participants and that used by coders, or between the mean number of CIS's per category for participants and that of coders. Therefore, on average, the coders and participants structured

the critical incidents into a similar number of categories with a similar number of statements comprising each category.

Consensus Categorization Structure

Several steps were used in the process of reaching the consensus category structure. First, the coders compared the three participant's sorts on the basis of category titles, category descriptions, and the CIS's contained in each category (see Appendix V for each of the three participants' categorization structures). They looked for similar category titles, then confirmed or disconfirmed similarity of categories on the basis of category descriptions and CIS's contained therein. The coders noted any categories that did not have any similar categories among other participants' sorts. They also noted the number of categories in each participant's sort.

Next, the coders incorporated their own sorts, one at a time, following the same comparison process used with the participants' sorts (see Appendix X for each of the two coders' categorization structures). Once all five sorts had been examined, they checked for any remaining categories not matched to a similar category; only one remained.

The coders then gave a tentative name to each grouping of similar categories to clearly explain the similar meaning between them, using the participants' words (from category titles or category descriptions) to the greatest extent possible. They avoided relying on researchers' titles or descriptions. At this point, 17 tentative category groupings existed.

Next, the coders made a list of the CIS numbers contained in each category within each group of similar categories. Then, they went through each grouping and placed a circle around any statement number that appeared three or more times in that group. They placed a triangle around each number that appeared twice. Given that there were five sorts, a

statement could appear once (no repetition), twice (some/minimal repetition), or three to five times (considerable repetition).

On a list of the statements, coders marked next to each statement the groupings in which it appeared at least twice (as indicated by the circle/triangle system explained above). Each statement appeared repeatedly in at least one grouping. For each statement that appeared repeatedly in only one grouping, the statement number was recorded under the tentative name of that grouping.

Next, the coders looked at each statement that appeared repeatedly in two groupings. In each case, they examined both category groupings to determine which one was a better fit for the statement. They determined this based on a number of factors: 1) how well the wording of the statement fit with each tentative category name, 2) whether multiple participants sorted the statement in this category grouping (the representation of two or more participants sorting in a grouping was given more weight than the two coders sorting the statement into a given category grouping), 3) sorting majority (i.e., if sorted into one category by three sorters and another category by only two), and 4) the meaning of the statement as informed by context from the raw questionnaire data. For each CIS, the coders made detailed notes on why it was placed in one category over another (see Appendix Y).

The coders eliminated any categories that had no critical incidents sorted into them at this point. Fourteen tentative categories remained. They examined two categories that had only one CIS in them and determined these could be combined with other categories. For this decision, they referred to where else participants had sorted them (even if only one participant had sorted it into a given category grouping). For detailed notes on how and why tentative categories were combined, refer to Appendix Y. The coders examined the one

category with only two CIS's and determined that it represented a concept not captured in any of the other categories, so it remained a distinct category. There were then 12 categories.

Finally, the coders used the CIS cards to review the tentative categories. They grouped the cards according to the consensus categories. Together, they looked at the CIS's in each category and generated a category description based on what the cards had in common as related to the category title. During this process, some category titles were adjusted for clarity and one CIS was moved to a different category because coders could not see any thematic match with the category it was in (see Appendix Y for further details and explanation of actions taken).

The final category structure contained 12 categories. The category titles were initially named:

- Not the Right Fit,
- Counselor/Psychotherapist Characteristics and Behavior,
- Communication Difficulties,
- Unprofessional Mistakes,
- Need to Build Trust,
- No Choice,
- Unsure of Therapist/Therapy,
- Client Not Putting in Work,
- Not Doing His/Her Job,
- Counselor/Psychotherapist Presuming,
- Pushy Counselor/Psychotherapist, and
- Time Problems.

After two undergraduate research assistants attempted to replicate the consensus sort structure by sorting the CIS's into these categories, the category titles and descriptions were slightly revised in an effort to promote clarity and increase reliable replication of the sort structure. The revised category titles are:

- Not the Right Fit,
- Unexpected Actions/Personality of Counselor/Psychotherapist,
- Communication Problems,
- Unprofessional,
- Client Needs to Build Trust,
- No Choice,
- Unsure of Therapist/Therapy,
- Client Not Putting in Work,
- Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues,
- Acting on Assumptions About Client,
- Pushy Counselor/Psychotherapist, and
- Time Problems.

These category titles were used for subsequent sort replications. See Table 1 for brief descriptions (those used by the graduate research assistants during sort replication) of the categories and a listing of which incidents fell into each category. Categories are described in further detail below and indicate categories of variables thought to harm or impair the development or maintenance of the therapeutic alliance with men.

Critical Incident Categories

Not the Right Fit. This category describes incidents centering on a big discrepancy between the client and the counselor/psychotherapist, as experienced by the client. In some cases, these are differences relating to counselor/psychotherapist characteristics (e.g., “I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence.”) or life experiences (e.g., “I felt that my counselor/psychotherapist couldn't know how I felt/thought because she was a woman who had undergone child bearing.”). In other cases, they relate more directly to the psychotherapeutic process; the approach of the counselor/psychotherapist does not match the expectations of the client (e.g., “The counselor/psychotherapist asked questions that I felt weren't important.”).

Unexpected Actions/Personality of Counselor/Psychotherapist. This category encompasses incidents in which the client encountered some highly unexpected behavior of the counselor/psychotherapist. These include behaviors such as an unexpected visible display of emotion, unwanted interaction outside of the counseling room, and a business e-mail related to psychotherapy; it also includes the counselor/psychotherapist showing an all-business personality.

Communication Problems. This category is about trouble communicating. The incidents describe the counselor/psychotherapist failing to explain in advance about plans for treatment, about how the client is expected to behave during session, or about fees associated with services. It also describes the experience of a client struggling to understand the information the counselor/psychotherapist is conveying.

Unprofessional. In this category, the CIS's describe the counselor/psychotherapist acting in ways that conflict with how the client perceives a mental health care professional should. In each incident, the counselor/psychotherapist apparently erred by being deceptive,

disorganized, inconsiderate, untimely, or avoidant about office or psychotherapy procedures. In sum, the client perceived the behavior of the counselor/psychotherapist as ethically or professionally questionable. Unlike the incidents described by Unexpected Actions/Personality of Counselor/Psychotherapist, this category contains incidents classified by participants not just as surprising but as inappropriate or wrong.

Client Needs to Build Trust. The experiences listed here describe the client's lack of trust interfering with giving or receiving information related directly to his treatment. In these incidents, the client's lack of trust seems to be standing in the way of psychotherapeutic progress, and the client felt the alliance was hindered by this blockage. In almost every incident, the client is resisting sharing information with the counselor/psychotherapist, either information he himself feels compelled to share or information the counselor/psychotherapist is asking him to share.

No Choice. This category describes situations where the client had no say in an important aspect of psychotherapy. In these incidents, the client was mandated to see a counselor/psychotherapist, forced to change to a different counselor/psychotherapist after establishing a therapeutic relationship, or forced to continue receiving treatment that he did not believe was reducing his symptoms. It can be challenging for a client to feel he has a stake in the outcome of psychotherapy when he has no part in major decisions relating to treatment, thus impairing the alliance.

Unsure of Psychotherapist/Psychotherapy. In these incidents, the client is hesitant. He is unconvinced that he should engage in counseling/psychotherapy and uncertain whether to have faith in the counselor/psychotherapist. Presuppositions or past experiences seem to be influencing the client's expectations. Unlike the category Client Needs to Build Trust,

these incidents do not revolve around conveying information related to treatment but rather to the institution of counseling/psychotherapy and the role of a counselor/psychotherapist.

Client Not Putting in Work. This category assigns responsibility to the client for hindering or weakening the alliance. It contains examples of the client not following through on his commitments in psychotherapy. This may relate to coming to appointments, work in session, or assigned homework.

Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues. Throughout the incidents in this category, the client believes the counselor/psychotherapist is failing in his/her duties as a counselor/psychotherapist. The client feels his issues are not being adequately addressed. The client believes the counselor/psychotherapist is not choosing to spend enough time on the client and working with his issues, is not working hard enough to understand the client's issues, or is not addressing them in a way that feels productive to the client.

Acting on Assumptions About Client. This category describes examples of the client thinking that the counselor/psychotherapist has prematurely made up his/her mind about the client's actions or experiences. The counselor/psychotherapist assumed that he/she knew what the client had done, what the client was feeling or thinking, or what the impact of the client's behaviors was. Then the counselor/psychotherapist enacted these assumptions on the client. It is also implicit in these incidents that the client felt the assumptions of the counselor/psychotherapist were incorrect.

Pushy Counselor/Psychotherapist. In this category are incidents of the counselor/psychotherapist pushing his/her agenda on the client. This may involve insisting on a tight time schedule, insisting on a particular approach to treatment, or pressuring the

client to involve others in session. Unlike the category Acting on Assumptions About Client, the CIS's in this category do not explicitly refer to the client's experience of the counselor/psychotherapist making decisions based on assumptions about the client.

Time Problems. This category describes occasions when the client felt he needed more time than the counselor/psychotherapist could provide. The client describes feeling rushed or the counselor/psychotherapist bringing up an issue when there is no time to address it.

One could argue that, in an effort to achieve a more parsimonious solution, some of the above categories should be combined given their conceptual similarities or overlap. However, a smaller number of categories may be less likely to represent how participants view the relationships between the incidents. Using the conceptual structure of the researcher/practitioner, there appears to be some overlap between certain categories (such as between Not the Right Fit and Unexpected Actions/Personality of Counselor/Psychotherapist or between Unsure of Therapist/Therapy and Client Needs to Build Trust). However, as the consensus category structure was based heavily on the sort structures of participants, it is likely that these categories are seen as more distinct when using the conceptual structure of the client/participant. The consensus category structure is a 12-category solution, which falls between the mean (14) and median (8) number of categories created by participants. The situation of the consensus number of categories between the mean and median number of participant categories supports the consensus category structure as representing a "typical" understanding of the clients sampled. Some overlap between categories may also be a result of the compromise necessary to blend five individual sort structures into one consensus structure.

Category Characteristics

Representation rate (after redundancies eliminated) and participation rate (based on each participant's pre-redundancy CI) of each category were calculated. These are included in Table 1, along with each category's name and the listing of critical incidents comprising each category. The category with the highest representation rate (17.86%) was Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues, and the categories with the lowest representation rate (3.57%) were No Choice and Client Not Putting in Work.

The average detrimentality rating of each category, as rated by participants who consented to follow-up interviews, is shown in Table 2. This shows that, on average, most of the categories were generally experienced as slightly damaging or less ($M \leq 2.00$) and that the category Client Needs to Build Trust was typically experienced as most detrimental. These low means could be interpreted as indicating that participants, on average, viewed the categories of incidents as slightly detrimental to the working relationship. However, there was great variability in how participants viewed each category of incidents. Descriptively, Unexpected Actions of Counselor/Psychotherapist was the least detrimental to the men in this study while Client Needs to Build Trust was the most detrimental to the men in this study. A comparison of the means detrimentality ratings of the categories revealed that Client Needs to Build Trust is not significantly more detrimental than any of the other categories at the $p < .05$ level. At the slightly more liberal level of $p < .10$, Client Needs to Build Trust is significantly more detrimental than only one the least detrimental category – Unexpected Actions/Personality of the Counselor/Psychotherapist (*Cohen's d* = .44). For a more detailed portrayal of the category detrimentality ratings, refer to the frequency tables (Appendix Z).

Conformity to Masculine Norms Inventory

The CMNI was administered only to participants at the second data collection point. Thus, all details listed relating to scores on the CMNI pertain only to participants whose data was collected at the second time point ($n = 41$). As an estimate of internal consistency of the CMNI, coefficient alpha for the total score was .88. For the eleven masculinity norms subscales, alphas were Winning = .83, Emotional Control = .91, Risk-Taking = .88, Violence = .86, Power Over Women = .77, Dominance = .50, Playboy = .77, Self-Reliance = .82, Primacy of Work = .63, Disdain for Homosexuals = .89, and Pursuit of Status = .72. The alphas for the Dominance and Primacy of Work subscales are low, but the alphas for all of the other subscales and the total score indicate reliability ranging from acceptable to high (Peterson, 1994). Variation in CMNI total or subscale scores was not found to have any significant relationship to the likelihood of any given participant's CIS being categorized in any given category.

The means and standard deviations of the CMNI scales were as follows: Winning ($M = 12.22$, $SD = 4.22$), Emotional Control ($M = 13.32$, $SD = 5.70$), Risk-Taking ($M = 15.54$, $SD = 4.47$), Violence ($M = 11.29$, $SD = 4.15$), Power Over Women ($M = 6.93$, $SD = 3.39$), Dominance ($M = 5.24$, $SD = 1.56$), Playboy ($M = 10.93$, $SD = 4.78$), Self-Reliance ($M = 6.22$, $SD = 2.90$), Primacy of Work ($M = 10.07$, $SD = 2.62$), Disdain for Homosexuals ($M = 14.85$, $SD = 5.26$), Pursuit of Status ($M = 10.51$, $SD = 2.58$), and Total Score ($M = 117.12$, $SD = 18.62$). Compared to the mean scores of 752 male college students, mostly Caucasian (Mahalik et al., 2003), the mean scores from the current study were this many standard deviations from the means of Mahalik et al. (2003): Winning 0.92 below, Emotional Control 0.28 below, Risk-Taking 0.29 below, Violence 0.27 below, Power Over Women 0.82 below,

Dominance 0.32 below, Playboy 0.19 below, Self-Reliance 0.15 below, Primacy of Work 0.34 above, Disdain of Homosexuals 0.43 below, Pursuit of Status 0.55 below, Total Score 0.70 below. To summarize, most of the mean scores in the current study fell below the means from Mahalik et al. (2003), indicating that the men sampled in the current study demonstrated less conformity to most masculine gender norms than men from the previous study.

In a similar manner to the recommendations for clinical use made in Mahalik, Talmadge, Locke, and Scott (2005), the normative data from Mahalik (2004) was used to transform participants' raw CMNI scores to T-scores. The 8,037 men sampled in Mahalik (2004) most frequently reported being Caucasian (58.2%), single (36.7%), heterosexual (54.8%), and their highest level of education as currently attending college (38.4%). These demographics are reasonably similar to those of the current sample (74.42% White/Caucasian, 69.77% single/never married, 56.98% highest level of education completed was high school, and 24.42% identified their current occupation as student). Mahalik et al. (2005) provide guidelines for interpreting CMNI T-scores. These guidelines were used to interpret the mean T-score for each subscale and the total score, as an indicator of how closely the participants in this study conform to traditional masculine norms. On average, the participants in this study demonstrated moderate nonconformity to the Winning norm ($M = 43.74$), moderate nonconformity to the Emotional Control norm ($M = 47.22$), moderate conformity to the Risk-Taking norm ($M = 50.04$), moderate nonconformity to the Violence norm ($M = 49.47$), moderate nonconformity to the Power Over Women norm ($M = 44.91$), moderate nonconformity to the Dominance norm ($M = 47.84$), moderate nonconformity to the Playboy norm ($M = 46.80$), moderate nonconformity to the Self-Reliance norm ($M =$

47.68), moderate conformity to the Primacy of Work norm ($M = 50.84$), moderate nonconformity to the Disdain for Homosexuality norm ($M = 48.37$), moderate nonconformity to the Pursuit of Status norm ($M = 48.08$). Overall, the sample demonstrated moderate nonconformity to masculine gender norms (CMNI Total Score $M = 45.73$).

Subsample Comparisons

This study included both participants currently in counseling or psychotherapy and participants who recently ended counseling or psychotherapy. As previously noted, most participants reported they were currently receiving counseling or psychotherapy at the time of their data collection appointment (90.70%), while some reported they recently ended counseling or psychotherapy (9.30%). Given the small sample sizes, comparisons between subgroups should be considered exploratory and are expected to have limited statistical power. There was no significant difference in ratings of alliance strength between men who were currently receiving counseling and those who recently ended counseling or psychotherapy. For men from the second data collection point, there was no significant difference in CMNI total scores based on whether or not participants were still in treatment. CIS's from men currently in counseling or psychotherapy most often fell into Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues (19.12%) or Time Problems (13.24%), while CIS's from men who recently ended counseling or psychotherapy tended to fall more in Not the Right Fit (25.00%), Client Needs to Build Trust (25.00%), or Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues (25.00%).

As noted above, there was a broad range of number of sessions reported ($min = 1$, $max = 699$). To compare the possible effect of number of sessions, the sample was roughly divided into thirds by session number. Some men (34.12%) reported a relatively small

number of sessions (six or less) with their current or most recent mental health professional, others (28.24%) reported a moderate number of sessions (seven to 19), while still others (37.65%) reported a relatively large number of sessions (20 or more). Whether participants reported a small ($n = 29$), medium ($n = 24$), or large ($n = 32$) number of sessions had no significant relationship with their ratings of alliance quality. Number of sessions also showed no significant relationship with participants' total CMNI scores. Descriptively, CIS's from men with a smaller number of sessions most often fell in Client Needs to Build Trust (15.38%), Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues (15.38%) or Time Problems (15.38%), while CIS's from men with a moderate number of sessions tended to fall in Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues (30.00%) or Client Needs to Build Trust (15.00%), and CIS's from men with a larger number of sessions tended to fall in Not the Right Fit (20.69%), Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues (17.24%), or Time Problems (17.24%).

It is possible that certain categories of incidents may be more salient to persons of certain ethnic backgrounds. The small percentage of non-white participants sampled by this study do not allow for effective comparisons to be made by ethnicity. However, the frequency of contributions by members of each ethnic group to each category of incidents were noted. As the contributions of White/Caucasian/European/European American/Anglo Saxon participants are most represented by the description of client contributions to categories previous listed, following are listed the client contributions to each category from participants of all other self-identified ethnicities. Of the total CISs from African American/Black American participants ($n = 2$), 50% fell in Communication Problems and 50% fell in Time Problems. Of the total CISs from American participants ($n = 1$), 100% fell

under Not the Right Fit. Of the total CISs from Asian participants ($n = 1$), 100% fell under Not the Right Fit. Of the total CISs from Hawaiian participants ($n = 1$), 100% fell under Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues. Of the total CISs from participants identifying as Mixed ethnicity ($n = 1$), 100% fell under Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues. Of the total CISs from Native American participants ($n = 2$), 50% fell in Client Not Putting in Work and 50% fell in Time Problems. Of the total CISs from participants who identified as both White/Caucasian/European/European American/Anglo Saxon and Native American ($n = 2$), 50% fell under Acting on Assumptions About Client and 50% fell under No Choice.

Credibility of Data

Six of the nine recommended credibility checks from Butterfield et al.'s (2009) enhanced critical incident technique were deemed most important and relevant to the current study and thus were conducted (i.e., independent extraction of critical incidents, participant cross-checking, independent judges placing incidents into categories, measures of redundancy, calculation of participation rate, and examination of theoretical validity). Three checks were not included, and an explanation follows. Firstly, it was not necessary to assess for descriptive validity, in the sense of fidelity to the participant's words, as questionnaires (not interviews) were used to collect data. This allowed for researchers to refer to a written record of each participant's description of the critical incident (written by the participant himself). Follow-up interviews gave participants the opportunity to speak to the accuracy of the representation of their experience at both the incident statement and category levels. Secondly, *interviewer* fidelity to the critical incident technique was not assessed by an expert in the critical incident technique, as data were not collected through interviews. However, at

least two researchers were present at each data collection appointment to aid in accountability for maintaining procedure protocol, and an auditor experienced in the critical incident technique assessed the consensus list of extracted critical incidents for fidelity to the technique. Thirdly, experts in the field of counseling or psychotherapy were not consulted for their opinions on the usefulness of the results. It is the assumption of the primary researcher, as previously explained, that the subjective experiences of clients have higher intrinsic value toward understanding what hinders or weakens alliances with them. In this study, clients, rather than mental health professionals, were treated as the primary experts, and a subsample of them were consulted instead.

Exhaustiveness. When the 76 CIS's were examined for redundancy, 11 statements were determined to be duplicated. Six redundant statements occurred twice, two occurred three times, two occurred four times, and one occurred five times. The remaining 45 statements (59.21%) occurred only once. Thus, 20 redundant statements were eliminated, as all repetitious occurrences of a statement were combined into one. For seven CIS's, the full wording of one of the original 76 CIS's was kept; it was determined that the wording of one statement was sufficient to encompass the meaning of the other duplicate statements. For four statements, the wordings of multiple CIS's from the original 76 were combined into one statement; to capture the meaning of all of the incidents, it was necessary to combine them. To recap, 31 of the 76 statements were replicated at least once (40.79%). This indicates an adequate level of saturation for such an exploratory study, with a level of saturation equal to or greater than some published CIT research (e.g., Bedi, Davis, Arvay, 2005). Given that only the single most critical incident was gathered from a moderate size sample, a high level of saturation was not anticipated. Most CIT research does not restrict the number of critical

incidents participants could provide, but this did not fit the intent of this research to examine the list of the quintessential critical incidents. It is likely a larger group of participants would need to be surveyed and/or a similar number of participants would need to be allowed to provide as many critical incidents as they are able in order to gather the full range of critical incidents that male clients experience as hindering or weakening the alliance. On the other hand, this study does provide evidence that at least a moderate level of saturation can be achieved when asking each participant to only provide the single most critical incident (whereas previous research with critical incidents had no such restrictions).

In a retrospective category formation analysis, 11 of the 12 categories were represented within 45 participants. The 12th category was represented within 50 participants. Therefore, incidents were collected from 26 more participants than was needed for full category representation. Using this criterion indicates that enough data was collected to support the content validity of the *categories* (i.e., more participants would likely not have resulted in the creation of new categories). During the post hoc redundancy check, 21 repetitious statements occurred within 85 participants. The 22nd repetitious statement occurred with the last participant. This suggests that more data would likely need to be collected for a complete list of *incidents* that male clients experience as detrimental to the alliance.

During confirmatory sorting into the finalized category structure, for one undergraduate sort replicator the last category was first utilized when the last 5% of the incidents were sorted. For the second undergraduate sort replicator, the last category was never utilized. For one graduate sort replicator, the last category was first utilized when 65% of the incidents had been sorted. For the second graduate sort replicator, the last category

was utilized when 45% of the incidents had been sorted. The dramatic difference between the percentages for the undergraduate and graduate sort replicators indicates that one or both of the following factors contributed to more of the categories being utilized earlier in the sort: 1) some category titles and descriptions were reworded for increased clarity between when the undergraduate sorts occurred and when the graduate sorts occurred and 2) the counseling graduate students' greater understanding of counseling processes and more extensive academic training and experience. In contrast to the aforementioned measures of exhaustiveness (which use different criteria), the fact that all four sort replicators used at least 90% of the categories by the time 75% of the incidents had been sorted would suggest that the full range of critical incidents was likely collected (Ronan & Latham, 1974). With the addition of the final 10% of incidents to the confirmatory sort, an average of less than one (0.25) new category was utilized. According to the guidelines suggested by Ronan and Latham (1974), this suggests that the categories collected represent in a reasonably comprehensive manner the incidents that male clients experience as hindering or weakening the development of an alliance.

Perhaps the discrepant measures of exhaustiveness may be understood as indicating that many of the categories (but not all) were adequately repetitious, thus only leaving a few types of incidents needing further research. In other words, the measures of exhaustiveness (at the category level) indicating adequate data were collected could indicate that several of the categories of incidents were exhaustively researched. Yet, the measures of exhaustiveness (at the incident level) indicating that adequate data were not collected may point to the need for further data collection to capture every potential incident in the other known categories or to learn of categories of incidents yet undiscovered.

Clarity of Consensus Categorization Structure. The first undergraduate independent sort replicator had a match rate of 39.29%, while the second had a match rate of 44.64%. The first mental health counseling graduate student replicator had a match rate of 57.14%, while the second had a match rate of 55.36%. The average match rate between the four independent replicators when sorting into the consensus category structure was 49.11%. This indicates a less than adequate level of inter-judge reliability (Andersson & Nilsson, 1964; Ronan & Latham, 1974). This shows that the category structure might not be easily understood and applied by fellow researchers; it likely does not represent the simplest way (for researchers) of relating the incidents men understand as hindering or weakening to alliance formation. So, further refinement in future research is needed. However, the low match rate may be due in part to having student researchers replicate the sort when the consensus category structure was largely based on participants' understanding. The low match rate may also be influenced by the researchers who replicated the sort having less experience with counseling than those who constructed the individual and consensus sorts. The four replicators were neither participants nor is it likely that they had experiences or an understanding of psychotherapy in any way similar to the participants. Were participants to sort the CIS's into the consensus category structure, it is expected that they would have a higher match rate, as the category structure was designed with the aim of representing the understanding of clients (not of researchers).

Cohen's kappa between the first undergraduate independent replicator's sort and the consensus categorization scheme ($K = .38$) was found to be significantly greater than chance at the $\alpha = .05$ level. Cohen's kappa could not be calculated for the second undergraduate replicator since one of the categories was not utilized in that resort. Cohen's kappa between

the first mental health graduate counseling graduate student replicator's sort and the consensus categorization scheme ($K = .55$) was found to be significantly greater than chance at the $\alpha = .05$ level. Cohen's kappa between the second mental health graduate counseling graduate student replicator's sort and the consensus categorization scheme ($K = .51$) was found to be significantly greater than chance at the $\alpha = .05$ level. Although no widely accepted guidelines for acceptable magnitude of kappa are available, these kappas indicate a fair to moderate level of agreement according to Landis and Koch (1977), although they still do not meet the high standards for generalizability proposed by Carletta (1996).

Krippendorff's alpha between the first undergraduate replicator and the consensus sort was .38 and between the second undergraduate replicator and the consensus sort was .39. This indicates a low level of agreement between both undergraduate replicators' sorts and the consensus category structure (Krippendorff, 2004). Krippendorff's alpha between the first graduate student replicator and the consensus sort was .55 and between the second graduate student replicator and the consensus sort was .51. This indicates a low level of agreement between both graduate replicators' sorts and the consensus category structure; Krippendorff (2004) recommends a minimum alpha of .667. Such low levels of agreement suggest the consensus category structure was not as well understood by the replicators as it should have been – noting again that the sort replicators were student research assistants not client participants.

Follow-up interviews. Forty participants agreed to participate in follow-up interviews. Only 20 participants could be reached after three phone calls; these 20 were interviewed and their feedback follows. During the interviews, the overwhelming majority of participants (95.00% of those interviewed) indicated that the CIS derived from their

questionnaire data did accurately represent their experience. In addition, only 35.00% said something was missing from the particular incident statement (i.e., something would need to be added to completely capture the critical incident), and only 20.00% suggested changes to the incident. See Appendix AA for detailed notes on participant feedback on the CIS's.

All (100%) of the participants interviewed indicated that the category names and descriptions were clear and made sense to them. The majority of participants interviewed (70.00%) stated that the category their critical incident was sorted into captured the meaning that the incident had for them. In response to the follow-up question, "Does the name of the category your experience was sorted into capture your experience and the meaning it had for you?" one participant responded "It exactly did" while another responded "It all adds up." These responses lend further testimonial validity to the consensus category structure. For a full listing of follow-up feedback from participants, see Appendix AA.

For the 30.00% of participants who indicated that their incident would fit better in another category, the coders evaluated how to adapt the consensus category structure to incorporate the participants' feedback. Four CIS's (7.14%) were moved to new categories based on the added information provided by participants during follow-up interviews. This is in accordance with the recommendations of Butterfield et al. (2009) to use the follow-up interviews as an opportunity to confirm whether the CIS's have been placed into appropriate categories and, if one has not been appropriately placed, generally to honor the participant's wishes and make the appropriate change. Minor wording changes were made to one CIS and one category description based on participant suggestions, but all category titles were kept intact. For detailed notes on the consensus process of incorporating feedback on the category structure, see Appendix BB.

Theoretical validity. Generally, many of the categories from the current study can be related to existing alliance and gender theories. There are those, however, that fall outside the realm of existing theory. The current study's findings are rich with qualitative data and could be explored on many levels and from many perspectives. To cover every possible interaction of the current study's findings with existing theory is beyond the scope of this paper. The following will highlight some important ways of understanding the findings as informed by the theories described earlier in this study.

In the present study, a greater percentage of critical incidents related to client contributions to the alliance than in previous similar studies related to the alliance (Bedi, 2006; Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005; Bedi & Richards, 2011; Fitzpatrick et al., 2009; Fitzpatrick et al., 2006). This supports Bordin's (1994) supposition that research on alliance strains needs to reach beyond the actions or failings of the counselor/psychotherapist. This was the first study to collect critical incidents associated with the alliance from an all-male sample. Perhaps male clients take greater personal responsibility for their contributions to or hindrance of the alliance. This may be related to certain masculine gender norms. For example, men are often expected to handle pain and adversity on their own. Also, men are expected to strive for and maintain power and status. These factors combined may push male clients to take a more active role in their treatment.

Certain categories of incidents clearly correspond to existing alliance theory. The category of Client Needs to Build Trust could be understood in relation to Bordin's (1979) proposed alliance component of Bond; the client's lack of trust is hindering the formation of a bond. Likewise, the category Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues could be understood in relation to Bordin's (1979) proposed alliance

component of Task; the counselor/psychotherapist is not in agreement with the client on the Task. Not the Right Fit describes differences between the client and the counselor/psychotherapist; these differences hindering the alliance may be interpreted as barriers keeping a burgeoning alliance from transitioning into Luborsky's (1976) Type II alliance. The discrepancies between counselor/psychotherapist and client are too broad for the alliance to move forward into a collaborative state. Perhaps the category Unprofessional could be understood as a counterpoint to the professional type of alliance described by Mohr and Woodhouse (2001).

The category No Choice also relates strongly to masculine gender norms. This category describes disempowerment of the client, a lack of choice in basic elements in psychotherapy. This stripping away of the autonomy of the client and his power to independently make decisions stands in stark contrast to the power and status prized as part of traditional masculinity. Along these lines, though to a lesser extent, the category of Pushy Counselor/Psychotherapist could be construed as a threat to the power and independence of the client.

The category Unsure of Psychotherapist/Psychotherapy may be connected to the social pressure against men seeking help. One incident in this category describes a male client's hesitation about being in psychotherapy. Others describe a client's predisposed mistrust of the counselor/psychotherapist. It is possible that the negative messages men hear about seeking help influence the associations they have with counseling/psychotherapy, thus biasing them against the counselor/psychotherapist or the process of counseling/psychotherapy before they ever set foot in a psychotherapy office.

Other categories, such as Unexpected Actions/Personality of Counselor/Psychotherapist, Communication Problems, and Time Problems, may be too broad at the category level to compare with theory. Running throughout these categories at the CIS level are threads of experience that tie into the tapestry of masculine gender norms. Some relate to shame over misunderstandings, others to how power and control are managed, and still others demonstrating confusion by men about how to interact given their lack of understanding of actions/characteristics associated with the feminine.

There are yet other incidents that seem to push the boundaries of existing alliance theory. Several incidents (e.g., “The counselor/psychotherapist had limited availability” and “The counselor/psychotherapist insisted that we continue sessions even though there was no way I could pay for it, and I accumulated huge debt”) seem to relate to practical or business aspects of the relationship between counselor/psychotherapist and client. Such aspects are not typically incorporated into alliance theory. While they may relate to alliance constructs such as collaboration or a shared understanding of tasks, they may have a less direct relationship, perhaps mediated by or interacting with other important contributors to or detractors from the alliance.

Discussion

This study adds to the small but growing literature on the male client’s perspective of counseling and psychotherapy. The critical incidents reported by men and the categories arising from them offer a partial answer to the question of what male clients understand to be most detrimental to the formation of the alliance. According to the results of this study, incidents that can hinder or weaken the therapeutic alliance with men can be classified into the following 12 categories: Not the Right Fit, Unexpected Actions/Personality of

Counselor/Psychotherapist, Communication Problems, Unprofessional, Client Needs to Build Trust, No Choice, Unsure of Psychotherapist/Psychotherapy, Client Not Putting in Work, Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues, Acting on Assumptions About Client, Pushy Counselor/Psychotherapist, and Time Problems.

Two categories of incidents stood out as the largest (by representation rate): Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues (17.86% of all CISs) and Not the Right Fit (16.07% of all CISs). Overall, incidents were most likely to fall into one of these two categories. Broadly speaking, any specific occurrence men saw as harmful to the alliance was most likely to relate to a lack of focus in session on issues important to the client, a lack of progress made on the client's presenting concerns, a perceived lack of shared personal characteristics between the client and counselor/psychotherapist, or a disparity between the client's desired approach to the problem and the approach being utilized by the counselor/psychotherapist.

The men in this study, as a group, did not see any one category as particularly more harmful to alliance development than any other category. While surprising actions of the counselor/psychotherapist were experienced as the least detrimental to the alliance, on average, and the need for the client to be more trusting and forthcoming with information was experienced as the most detrimental, on average, there was no significant difference in detrimentality even between these two types of incidents. Yet, the variability among detrimentality ratings within a given category suggests a more complex trend. As found in this study, an incident that is viewed as of little significance by one client, or perhaps is even experienced by him as helpful to the alliance, may be experienced by another client as extremely hindering the alliance. While no category of incidents stands out as damaging for

all the clients sampled here, this should not be taken as an indication that the incidents were of little importance. For the male client who experiences that type of incident as harmful, it may make a great deal of difference to the strength of the alliance.

Fitzpatrick et al. (2009) found that clients in less severe distress tended to report one type of incident as critical, while clients in more severe distress tended to report a different type of incident as critical. Different types of incidents appeared to be more important to the client depending on what types and severity of issues they were addressing in counseling/psychotherapy. This trend may also have influenced the participants in the current study. While severity of issues was not measured, there was a wide array of presenting concerns listed by participants. Perhaps this contributed to the discrepancy of detrimentality ratings. For a few participants, perhaps those being treated for a particular disorder, a certain category of incidents may be viewed as particularly detrimental. For the rest of the participants, perhaps those being treated for different issues, that category of incidents could be seen as unimportant to the alliance or perhaps even helpful.

Besides the twelve category consensus structure put forth in this study, other category structures may also be considered. This study took a postmodern approach (i.e., multiple truths) toward addressing the research question, assigning high value to the experience of the client. It is possible that another category solution, perhaps one that is a better fit for the perspective of researchers, could be formulated if a different stance were taken. Maintaining the postmodern approach, it is possible that a more parsimonious category structure (one with fewer categories) may be more representative of the client's experience. The support for this are the smaller category structures (7 and 8 categories) of two out of three participants and the median number of categories used by participants (8). The mean number of categories

(14.33) is larger, as it is pulled higher by the much larger outlier number (28) of categories used by the third participant. The final category structure was also influenced in part by the larger number of categories (12 and 14) used by the coders.

In response to the lower median number of categories used by participants and the lower than expected interjudge reliability of the consensus twelve-category structure, structures with a smaller number of categories were subsequently conjectured. Two potential eight-category structures were proposed, one by the auditor and one by a primary coder. Based on observed overlap of category descriptions and/or incident content, they proposed combining certain categories. The auditor proposed the combination of 1) Unexpected Actions/Personality of Counselor/Psychotherapist with Unprofessional, 2) Client Needs to Build Trust with Unsure of Psychotherapy/Psychotherapist, and 3) Acting on Assumptions About Client with Pushy Counselor/Psychotherapist and with No Choice. The primary coder proposed the combination of 1) Client Needs to Build Trust with Unsure of Psychotherapy/Psychotherapist, 2) No Choice with Pushy Counselor/Psychotherapist, 3) Not the Right Fit with Unexpected Actions/Personality of Counselor/Psychotherapist, and 4) Communication Problems with Acting on Assumptions About Client.

There is considerable overlap between these proposed structures. They both agree on the combination of No Choice with Pushy Counselor/Psychotherapist and the combination of Client Needs to Build Trust with Unsure of Psychotherapist/Psychotherapy. Broadly, the categories No Choice and Pushy Counselor/Psychotherapist describe threats to client autonomy. The categories Client Needs to Build Trust and Unsure of Psychotherapist/Psychotherapy describe the client's uncertainty about whether to trust the counselor/psychotherapist and fully engage in treatment. Both eight-category structures also

leave as uncombined Client Not Putting in Work, Time Problems, and Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues; thus, it is likely these categories represent distinct types of incidents. Another possible way to conceptualize the structure of the categories would be to create supercategories, under which the existing categories would be grouped. Unfortunately, such a structure could be difficult for independent sorters to understand and utilize and may disallow many tests of intersorter reliability.

Links With Past Research

Similar to Bedi and Richards (2011), the current study investigated what incidents male clients viewed as important to the formation and strength of the alliance. While Bedi and Richards (2011) examined how male clients categorized incidents that were *helpful* to forming and strengthening the alliance, the current study examined what incidents male clients viewed as *hindering* to forming and strengthening the alliance. A comparison of the findings of these two studies reveals similarities and differences between what men see as hindering the alliance and their conceptualization of what strengthens the alliance.

Several categories from the current study have a clear parallel in the categories from Bedi and Richards (2011). Most notably, there is an inverse relationship between Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues (the largest category in the current study) and Bringing Out the Issues (the largest category in the previous study). When a counselor/psychotherapist focuses on issues important to the male client, it strengthens the alliance, but when a counselor/psychotherapist does not focus on these issues, it weakens the alliance. Klingemann and Gomez (2010) found that quite often the issues focused on in treatment are different than the issues identified by male clients as primary

concerns. For counselors and psychotherapists hoping to improve the strength of their alliances with male clients, this may be an especially important area to focus on.

Other categories also reveal important similarities. Client Not Putting in Work from the current study is similar to Client Responsibility from the previous study. This indicates a consistency in male clients viewing their own contributions as important to the alliance, and it stands in contrast to the finding from Bedi (2006), where a sample of mostly (77.5% women) tended to assign responsibility for strengthening the alliance to the counselor/psychotherapist. Another pair of similar categories is No Choice from the current study and Choice of Professional from the prior study. In both studies, male clients conceptualized the choice of their mental health care professional as having an impact on alliance strength. These similarities in client responsibility and client choice indicate that elements of the Client/Practitioner Agency axis from the previous study are represented in the current study as well. This desire for male clients to be involved in treatment choices and progress towards their goals may be related to the “big wheel” and “sturdy oak” male gender norms (David & Brannon, 1976). For male clients, taking an active role in psychotherapy may represent a compromise between accepting help and maintaining a position of authority and responsibility for their own well-being.

Further similarities may be noted at the incident statement level. For example, “The psychotherapist told me that it is my decision when psychotherapy would end” (helpful incident) is the partner to “I had to switch to a new counselor/psychotherapist” (hindering incident). “The psychotherapist was a woman” (helpful incident) shares some common ground with “The counselor/psychotherapist was a woman who wore tight clothing” and “I felt that my counselor/psychotherapist couldn't ‘know’ how I felt/thought because she was a

woman who had undergone child bearing” (hindering incidents). Again, “The psychotherapist explained the process of psychotherapy (e.g., how it works, how many sessions we can have, how to cancel a session)” (helpful incident) seems in opposition to “The counselor/psychotherapist did not give me enough information about plans for continued therapy” (hindering incident). Finally, “The psychotherapist taught me skills” (helpful incident) contrasts with “I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues” (hindering incident). As noted above, many of the incidents that men in the current study described as hindering the alliance were opposite of what men in Bedi and Richards (2011) described as helping the alliance.

Not all categories from one study are reflected in the other. Categories from the previous study that do not have clear parallels in the current study are Non-verbal Psychotherapist Actions, Emotional Support, Office Environment, Practical Help, and Information. This could mean that just because something is identified by men as helpful to the alliance, it does not necessarily mean that its absence (or the opposite of what was named as helpful) will be perceived as hindering the alliance (i.e., not all helpful and hindering variables lie on a continuum). It should be noted that at the incident level, there were hindering incidents that described non-verbal actions of the counselor/psychotherapist, indicate a lack of practical help, and that indicated a lack of communication information. Ergo, the categories most unique to helpful factors were Emotional Support and Office Environment. So perhaps the presence of strong emotional support and a particular office environment are thought to help the alliance, but their absence may not necessarily hinder the alliance with male clients. Also, the theme of the Non-affective/Affective axis was not clearly reflected in the current study. Categories in the current study that do not have parallel

categories in the previous study are Not the Right Fit, Unexpected Actions/Personality of the Counselor/Psychotherapist, Communication Problems, Unprofessional, Client Needs to Build Trust, Unsure of Psychotherapist/Psychotherapy, Acting on Assumptions About Client, Pushy Counselor/Psychotherapist, and Time Problems.

The number of categories without parallels between the two studies may suggest considerable differences between how male clients conceptualize what helps the alliance and how they conceptualize what hinders it. However, the differences may also be explained in other ways. For example, the differences may exist at the categorical level in how participants conceptually grouped items, but not at the incident level. Also, in the current study more so than the previous study, researchers were involved in the formation of the category structure. So, the differences at the category level may be in part due to differences between how researchers conceptualize incidents and how participants conceptualize them. Also, in the previous study, critical incidents collected from both men and women were sorted by men. So differences at the incident level may reflect differences between what female clients view as important to alliance-formation and what male clients view as important to alliance-formation.

Bedi (2006) poses the questions of “whether alliance development is understood to be a discontinuous process (i.e., a strong alliance may have distinct factors in it and therefore is not merely more of the things present in weaker alliances)” (p. 34). The findings from the current study, when paired with the findings from Bedi and Richards (2011), would suggest that it is neither a completely continuous nor completely discontinuous process. As described above, there are several categorical parallels between the two, but there were also several unique categories of incidents found in each.

Another noteworthy comparison can be made with the findings of Bedi, Davis, and Arvay (2005). While that study found that participants did not view collaboration as particularly important to alliance-building, the men in this study appeared to view the lack of collaboration as detrimental to the alliance. A theme runs throughout the incidents and categories of the current study: male clients want to be clearly communicated to and included in the process of what to discuss, when to meet, what treatment approach to use, and whom to include in treatment. Men viewing collaboration as important to the alliance supports the element of collaboration in oft-applied theories of alliance (Bordin, 1979; Luborsky, 1976) and indicates that these theories are at least somewhat inclusive of what is important to male clients.

Some comparisons can also be drawn between the participants in this study and those in Bedi (2006). Unlike participants in that study, men in this study did not describe office environment as critical to the alliance. The previous sample was comprised mostly of women; perhaps the office environment is more important to women than men in relation to alliance formation. Or, perhaps the office environment can contribute to strengthening the alliance but has little impact on hindering or weakening it.

Similar to the participants in Bedi (2006), who identified the presence of basic counseling skills as critical to strengthening the alliance, the participants in this study identified the lack of basic counseling skills as damaging to the alliance. Some examples of incidents that address this point are, “The counselor/psychotherapist would avoid eye contact with me, looking away or directly over my head,” “The counselor/psychotherapist did not elicit more explanatory responses from me pertaining to my issues,” and “The counselor/psychotherapist put words in my mouth (i.e., told me what I felt/thought).” One

interpretation is that the first of these incidents refers to lack of eye contact, the second to ineffective use of probes, and the third to inaccurate reflections.

As in Bedi (2006), techniques were perceived as contributing fundamentally to the alliance. Clients in the current study described several incidents (thought to hurt the alliance) that pertained to the treatment strategy used by the counselor. Some examples are “The counselor/psychotherapist and I did ‘weird’ exercises to address my issues that I felt were a waste of time,” “I got the same advice several times, and I did not feel anything was solved,” “The counselor/psychotherapist suggested medication and did not offer another alternative,” and “The counselor/psychotherapist had me write down information I didn’t want to reveal.”

Bedi (2006) also notes that alliance formation may begin “before the counselor fully engages with the client, as clients may develop predispositions or impressions on the basis of the counselor’s attire, the counselor’s nonverbal gestures, the counselor’s greeting, the office environment, and the reception staff” (p. 32-33). The results of the current study suggest influences on the alliance may begin even earlier. A couple of incidents that support this are “My attitude about previous counselors/psychotherapists was not positive, so I assumed the worst about my counselor/psychotherapist before I met him/her” and “Prior to any session, the counselor/psychotherapist sent me an e-mail asking me to sign an agreement that I would pay for a session if I didn’t show up.”

Fitzpatrick et al. (2009) note that clients reporting positive incidents often reported “interventions that offered them something that they found special or something they had wished for, a wish that was often unspoken to the therapist” (p. 661). They also note that both of the two negative incidents they collected referred to unexpressed wishes that were not met. The results of this study support the notion that incidents experienced by clients as harmful to

alliance formation are associated with unmet, and often unexpressed, wishes. Many of the incidents described in this study (e.g., “The counselor/psychotherapist never really related to my issues by talking about his/her own,” “The counselor/psychotherapist suggested medication and did not offer another alternative,” and “I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues.”) refer to something the client wished for from the therapist but did not receive.

In Fitzpatrick et al. (2009), clients’ major contributions to the alliance were described as active receptivity and productive self-disclosure. In the current study, both of these points are mirrored. For example, “I did not want to have somebody tell me what was wrong or what my issues were” and “I put off or simply ignored advice and suggestions from my counselor/psychotherapist” illustrate a lack of receptivity on the client’s part. “I lied about the duration of time between stressful events and my behaviors” and “I admitted a lot of information, but there were things I didn't want to acknowledge” both describe a perceived lack of important self-disclosure on the client’s part.

Applications

Horvath and Bedi (2002) illuminated the need for research to investigate possible counselor contributions to the alliance. Bedi and Richards (2011) reported on possible therapist contributions to the alliance with male clients. In addition to the client contributions and the collaborative incidents, the current study derived a possible list of therapist detractors from the alliance with male clients.

Even before a male client meets his psychotherapist, there may be factors in place to hinder alliance development. It is likely the client wants a choice about whether to seek counseling/psychotherapy, whom to see for it, and what type of treatment to receive. Not

providing this choice may set up the pending therapeutic alliance with early difficulties to overcome. Ideas the man has about what will happen in psychotherapy may contribute to negative assumptions about the psychotherapist and initial tension about being in psychotherapy, hindering alliance development. It is likely the male client will need an extended number of sessions to build trust in the person of the counselor/psychotherapist and in the treatment process. To nurture an alliance, it seems important to male clients that a clear focus on presenting concerns be established early in treatment and consistently maintained, but the client may need to build up to sharing certain aspects of his concerns.

The client may judge the suitability of the counselor/psychotherapist to meet his needs on how well the counselor/psychotherapist can relate to his experiences; counselor/psychotherapist self-disclosure may play an important role in building alliances with men. The client may also monitor how closely the psychotherapist's approach to his problems matches how the client himself believes his problems should be approached. With alliance maintenance in mind, it may be especially important to collaborate with male clients on treatment planning. Flexibility on the part of the counselor/psychotherapist is advised; some male clients can take the insistence of the counselor/psychotherapist on a certain approach as a major detriment to the alliance. In addition, the client will hold the counselor/psychotherapist to his own understanding of professional standards for a mental health care professional. In the interest of avoiding damage to the alliance, it probably behooves the counselor/psychotherapist to be careful, courteous, honest, respectful of the client's time, and considerate of the client's financial situation.

As befits the masculine normative expectation that men should be able to handle any situation, male clients typically want to know what to expect. This extends to scheduling,

time management, fees, treatment approach, mannerisms and behaviors of the counselor/psychotherapist, and likely to other areas as well. To allow for healthy alliance development, it seems that practical matters such as fees and scheduling should be negotiated in advance and any other expectations the counselor/psychotherapist has should be made clear. In anticipation of this eventuality, the counselor/psychotherapist should be vigilant for signs that anything has shocked or confused the client, as such incidents could impact the alliance.

Perhaps related to the masculine norms that drive men to maintain status and value independence, a male client may hold himself accountable for his own part in the alliance while being easily frustrated if the counselor/psychotherapist points out any perceived shortcomings of the client. Thus, rather than the counselor/psychotherapist telling the client what he/she perceives, a more fruitful approach may be to give the client the opportunity to comment on his own behavior and the potential repercussions. In this and in other aspects of psychotherapy, the male client probably typically prefers the opportunity to speak his own mind. When the counselor/psychotherapist does venture to label the client's thoughts, feelings, and behaviors, it will likely benefit the alliance to check on the accuracy of these labels. If the client perceives the counselor/psychotherapist jumping to inaccurate conclusions, this can damage the alliance.

The findings of this study also suggest that it is important for a counselor/psychotherapist to be flexible in his/her practices and approach, in order to avoid hindering or damaging the alliance. As the variability in detrimentality ratings of the categories suggests, what one male client perceives as extremely damaging to the alliance, another male client may actually perceive as helpful to the alliance. Given that, it would

appear essential for mental health care providers to maintain flexibility with their male clients and to check in with each client about how he perceives the development of the alliance.

In addition to the ways the findings from this study may be applied by mental health care practitioners, they may also be of interest to educators and theoreticians. Educators of counselors/psychotherapists may apply the findings by using the categories of incidents as a guide to acquaint their students with possible pitfalls in building an alliance with male clients. Theoreticians may treat the consensus category structure as an experiential framework of the alliance framed by the client's perspective. This may be used to expand upon existing theories of the alliance.

Limitations

While the findings of this study offer much insight into the perspective of male psychotherapy clients, it should be noted that the generalizability of the results are limited by the characteristics of the sample. Overall, the men in this study demonstrated moderate nonconformity to masculine norms. Consequently, findings from the current study may not be easily generalizable to men who strongly conform to traditional masculine gender norms. However, given the stigma attached to men seeking help, it may be that most men who seek treatment through counseling/psychotherapy show moderate nonconformity to masculine norms. Also, the men in this study were primarily White/Caucasian, single/never married, and still in treatment at the time data was collected. It is possible that different incidents or further incidents may be considered critical to the alliance by men of color, married/partnered men, or men who have already discontinued treatment. Self-selection bias may also limit the generalizability of the results. It is possible that the men who volunteered to participate in

this study may have a different set of characteristics than the larger population of men in counseling/psychotherapy.

It should be noted that the critical incidents in this study refer to counseling and psychotherapy in a broad sense. During screening interviews, potential participants were asked, “Have you received individual counseling or psychotherapy in the last 30 days?” No criteria for the terms “counseling” or “psychotherapy” were given, so it was up to the person being screened to determine what this meant. On the demographics form, participants indicated seeing a variety of professionals (counselor, social worker, psychologist, psychiatric nurse, psychiatrist, and residential director). Therefore, any use of the terms “counselor/psychotherapist” in the results should be interpreted as applying to all of these professions and “counseling/psychotherapy” is understood to mean services provided by any of these professionals.

Some may note as a point of concern the relatively low reliability scores generated during replication of the consensus category structure. It was previously mentioned that the individuals who replicated the consensus category structure were students and researchers, while the consensus category structure was designed primarily on the basis of client participants’ sorts. Furthermore, it should be taken into account that with a hybrid consensus category structure (informed by both researcher and participant individual sorts), lower than typical reliabilities would be expected no matter who attempted to replicate the category structure. In other studies, typically researchers replicate category structures designed by other researchers. In this study, it was not possible to recruit any one person to replicate the category structure who would encompass a similar understanding of all the individual sorters (both male and female, both researchers and participants).

This study did not directly assess for the chronicity and severity of participants' mental health issues. The only indication of severity of presenting concern was that all the participants in this study were receiving some form of outpatient treatment. So this study cannot speak to how hindering alliance factors relate to symptom severity.

Although this study allowed for inclusion of a full range of alliance strengths (by not excluding participants on the basis of a given alliance strength), it is possible that it did not capture the experiences of men in every potential strength of alliance. The mean participant-reported alliance rating on a single-item, 10-point scale was 7.37, indicating strong alliances on average. The categories may not accurately represent the experiences of clients with weaker alliances.

It is possible that recall bias influenced the formulation of incidents by participants. As the incidents participants reported were derived from their memories of counseling/psychotherapy, they could be influenced by the conclusions clients drew about their therapeutic relationships, their emotional reactions to the events of counseling/psychotherapy, and anything that happened in the intervening time between the incident and data collection. Since events associated with stronger negative emotions tend to be recalled in greater detail (Bluck & Li, 2001; Kensinger, 2007; Storbeck & Clore, 2005), those participants who were not particularly distressed by the incident at the time it occurred may not have recalled it with as much accuracy. During data collection, many participants initially struggled to recall damaging incidents, noting that they had a very strong alliance with their current or most recent counselor/psychotherapist. Often, it was helpful for researchers to explain to participants that although the alliance may currently be strong, there could have been incidents that initially hindered the alliance or subsequently temporarily

weakened it. The current strength of participants' alliances may have not only made it difficult to recall incidents that had been detrimental to the alliance but also have colored their memory of such incidents. Incidents that at the time they occurred may have been severely distressing and damaging to the alliance may have, in light of later alliance strength, been minimized. This could have contributed to certain categories of incidents being rated by most participants as having no effect on the alliance. Also, some categories of incidents were rated as helpful by many participants. It may be that it was working past the incidents that was helpful to the alliance (see Safran et al., 2001 for a description of how repairing alliance ruptures can improve the alliance); thus, participants could have been confusing the immediate impact of the incident on the alliance with the long-term impact of addressing the incident. Another potential drawback of relying on participant recall to generate incidents is that it limits the list of available incidents to those within the participant's awareness. This is another reason the list of CIS's should not be considered exhaustive, as other incidents outside of participants' awareness could have impacted the alliance.

There are certain limitations of this study that are tied to the method used for data collection and analysis. This study relied on the CIT, a nonexperimental method, so no causality can be established between the CISs and the weakening of the alliance. Also, the CIT only investigates specific and concrete incidents, but this may overlook other types of incidents, such as those that interact with or build upon other factors and internal events that cannot be observed.

Great effort was made to incorporate the perspectives of clients, yet the consensus category structure was conceptualized by researchers. The CIT calls for some amount of subjective interpretation during the analysis of CIS's. The interpretations made in this study,

while informed by the category conceptualizations of a small sample of participants, were guided by the understanding of the two primary coders and the auditor. Other researchers, with different backgrounds, experiences, and expertise, may have categorized the incidents differently.

This study left some relationships among the data collected unexamined. For example, it did not examine whether counselor/psychotherapist gender has any relationship to client conformity to masculine norms or look at which categories a client's incidents are most likely to fall into given the gender of his counselor/psychotherapist. It is possible that certain trends in the data may have been missed by not exploring all of the relationships between data points.

This study sought to incorporate the perspectives of men with a wide range of experiences in counseling/psychotherapy. While this in some ways a strength of the study, in other ways it is a limiting factor. For example, only a small number of participants in the study reported having terminated counseling/psychotherapy at the time of data collection. So, the results primarily represent the perspective of men currently in treatment and may not generalize well to men who have unilaterally terminated.

Only collecting one most hindering incident from each participant may also have indirectly made the results less broadly applicable. Bedi (2006) points out that choosing to exclude incidents with a low participation rate can lead to omitting influences on the alliance that are rare. As any given participant could contribute an incident to only one category, participation rate did not hold the same meaning in the current study. Participation could neither be used as an inclusion criteria nor as an indication of how broadly experienced a category of incidents was. Thereby, it is possible that many of the incidents collected were

rare experiences, not necessarily generally experienced or generally relevant. This is another factor that may have contributed to the unexpectedly low mean detrimentality ratings of the categories. Also, collecting only the single most hindering incident does not address the possibility that the accumulation of many small incidents over time may have had a greater impact on the alliance than any one incident (i.e., a pattern of microaggressions may hinder or harm the alliance more than a single critical incident).

While data describing the incident that most helped or strengthened the alliance were collected from each participant, those data were not described in this study. Helpful or positive incidents were not extracted and examined as they may have detracted from the focus of this study—the incidents that most hinder or harm the alliance. However, if the helpful incidents had been extracted, including both a helpful and hindering incident for each participant may have offered an interactional context for certain hindering incidents (i.e., showed how the helpful and hindering incidents interacted within the same alliance).

The questionnaire format of data collection allowed for limited follow-up questions and probes. During data analysis, the primary coders acknowledged certain points that could have been further clarified. A more open-ended system of data collection (such as semi-structured interviews) would have allowed for greater depth and clarity of incident description. It is uncertain how the lack of further information influenced the results.

Directions for Future Research

It is hoped that the findings of this study will not only contribute to the clinical understanding of how to avoid hindering alliances with male clients, but also spur further related research in this area. One way these findings may be incorporated into future research designs would be to use the categories of incidents describe by men in this study to

help design a measure of alliance hindrance that closely represents the male client's perspective. While these categories are tentative, they do provide for the exploration of constructs that may be outside of the imagination or experience of researchers. The omission of such constructs from existing measures of alliance may contribute to inaccurate or incomplete representation of the client's experience of the alliance. Future studies could contribute to measure refinement by correlating categories of critical incidents to existing measures of alliance and of other related constructs.

This study was designed for preliminary exploration of the male client perspective on alliance hindrance. To further establish the validity of the constructs encompassed by the critical incident categories put forth here, future studies should replicate the results and adapt the methodology. A larger sample of men may help to confirm these categories and illuminate any remaining undiscovered categories. Allowing clients to review their own videotaped sessions before naming incidents would allow researchers to confirm that the incidents described by participants did specifically and concretely occur.

A meta-analysis of what incidents male clients view as critical to the alliance may reveal further gender-related trends. However, most studies exploring the client's perspective on the alliance do not break down incident or category contributions by gender of participant. Therefore, a helpful first step toward such a study would be for future alliance researchers to provide the gender proportions of participants in relation to incidents and categories.

Future studies could include both hindering and helpful incidents for the same participant. This would allow for examination of interaction between such incidents within the same alliance. Additionally, if participants were allowed to list any number of helpful

incidents and any number of hindering incidents, the results could include the ratio between the two lists of incidents for each participant. This may offer further context to the incidents and to any ratings of alliance strength collected. In addition to allowing participants to describe any number of helpful and hindering critical incidents, researchers could also ask participants to rank order the incidents described. This would provide some indication of how relatively helpful or harmful any incident was perceived to be by the participant describing it.

The generalizability of this study's results is limited by certain homogenous aspects of the sample. The understanding of male clients' perspective garnered by this study could be furthered and expanded on by future studies sampling different homogenous groups of men or a more varied group of men. Some groups not well represented by this study are men of color, men of who have terminated counseling/psychotherapy, men with weak alliances, and men with severe symptoms that warrant inpatient treatment. Such studies would also allow for observation of trends specific to certain subsamples of male clients, such as differences in total number of sessions with a given mental health care provider or the salience of particular categories of incidents to a certain group of clients.

To fully incorporate the categories presented in this study with alliance theory or broader theories of psychotherapeutic process, further research is needed. Future studies should go beyond simply naming the categories of incidents. Other avenues to explore include how the incidents impact the alliance, why they impact the alliance, how these incidents interact with other influences on the alliance that are outside of the participants' awareness, how homogeneously the incidents are experienced, and how the categories of

incidents relate to one another. Other methodologies, such as narrative analysis or concept-mapping, may lend themselves more to exploring these aspects.

In order to illuminate the differences between the client perspective and the practitioner perspective on categories of alliance formation, practitioners could be invited to participate in categorization of critical incidents. A future study might invite both clients and counselors/psychotherapists to create categories from critical incidents generated by clients. This would allow for a direct comparison between how practitioners categorize the incidents and how clients categorize them.

Conclusion

In culmination, this study illuminates as distinct and valuable male clients' experiences of critical points in alliance formation. Practitioners' familiarity with these incidents may allow them to more effectively and efficiently recognize or prevent damage to the alliance, or in some cases to address potentially damaging factors before they influence the alliance. The contributions of this study may help mental health care providers to forge alliances with men that are more clearly understood by both parties, better-maintained, and longer-lasting. The critical incidents from this study both confirm existing alliance theories and push beyond them to incorporate heretofore unexamined detractors from the alliance. Incorporation of this study's results into the understanding of the psychological community holds the promise for research that better captures the viewpoints of male clients and gender-informed treatment that better meets their needs.

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Table 1

Category Names, Descriptions Used by Graduate Research Assistants During Sort Replication, Representation Rates, Participation Rates, and Incident Content

Category Name	Category Description	Representation Rate (%) ^a	Participation Rate (%) ^b	Critical Incidents
Not the Right Fit (Number of CISs = 9)	There were differences between who the client was as a person and who the counselor/psychotherapist was as a person. Or, there were differences between the kind of counseling/psychotherapy the client was expecting and the kind of counseling/psychotherapy he was getting. They were not seeing eye to eye	16.07%	13.16%	<p>7 I thought the counselor/psychotherapist might have misdiagnosed me and so be trying treatment that was ineffective.</p> <p>13 The counselor/psychotherapist never really related to my issues by talking about his/her own.</p> <p>17 The counselor/psychotherapist put me off (e.g., we were interrupted by his/her cell</p>

phone calls, the counselor/psychotherapist told me "I have a lot going on right now with other clients").

21 The counselor/psychotherapist did not agree with me.

29 I felt my relationship with my counselor/psychotherapist was formal and rigid.

41 I felt that my counselor/psychotherapist couldn't "know" how I felt/thought because she was a woman who had undergone child bearing.

45 The counselor/psychotherapist was a woman who wore tight clothing.

5 I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence.

47 The counselor/psychotherapist asked questions that I felt weren't important.

<p>Unexpected Actions/Personality of Counselor/Psychotherapist (Number of CIs = 4)</p>	<p>The client was caught off guard by the personality of the counselor/psychotherapist, the way the counselor/psychotherapist showed emotion, or how the counselor/psychotherapist interacted with the client outside of the counseling room.</p>	7.14%	5.26%	<p>38 The counselor/psychotherapist began to cry.</p>
				<p>14 Prior to any session, the counselor/psychotherapist sent me an e-mail asking me to sign an agreement that I would pay for a session if I didn't show up.</p>
				<p>32 The counselor/psychotherapist had a stoic nature (i.e. very staunch and formal, not very personable, straight to business).</p>
				<p>2 The counselor/psychotherapist walked me from where I was sitting in the reception area to the door of his/her office.</p>

Communication Problems (Number of CISs = 4)	The counselor/psychotherapist did not explain to the client in advance about fees, plans for treatment, or office etiquette. Or, the client had trouble understanding the counselor/psychotherapist.	7.14%	5.26%	<p>12 The counselor/psychotherapist did not give me enough information about plans for continued therapy.</p> <p>16 I had a hard time understanding the counselor/psychotherapist because of a language barrier.</p> <p>49 The counselor/psychotherapist asked me to move my dirty shoe off his/her couch.</p> <p>4 The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent.</p>
Unprofessional (Number of CISs = 5)	The counselor/psychotherapist was deceptive, disorganized, inconsiderate, untimely, or avoidant about office or therapy procedures.	8.93%	6.58%	<p>6 The counselor/psychotherapist had people watch one of my sessions when he/she said no one was going to watch.</p> <p>25 The counselor/psychotherapist wrote down the wrong time on his/her calendar/my appointment card.</p>

				39 The counselor/psychotherapist insisted that we continue sessions even though there was no way I could pay for it (and I accumulated huge debt).
				52 I had to wait longer than I felt I should have to see the counselor/psychotherapist.
				53 The counselor/psychotherapist would avoid eye contact with me, looking away or directly over my head.
Client Needs to Build Trust (Number of CISs = 7)	The client was not being open/honest or accepting what the counselor/psychotherapist had to say. The client needed to build trust in the counselor/psychotherapist or in the process of counseling/psychotherapy.	12.50%	13.16%	19 I did not want to have somebody tell me what was wrong or what my issues were.
				24 I was unable to bring up a subject because it seemed to conflict with earlier things I had told the counselor/psychotherapist.
				46 The counselor/psychotherapist had me write down information I didn't want to reveal.

50 In the first few sessions, I was a bit reluctant to open up.

55 I admitted a lot of information, but there were things I didn't want to acknowledge.

42 A subject came up that I didn't like to talk about/wasn't comfortable talking about.

54 I lied about the duration of time between stressful events and my behaviors.

<p>No Choice (Number of CISs = 3)</p>	<p>The client did not get a choice about whether to see a counselor/psychotherapist, whether to change to a different counselor/psychotherapist, or what type of treatment to receive.</p>	<p>3.57%</p>	<p>3.95%</p>	<p>44 I had to switch to a new counselor/psychotherapist.</p>
				<p>40 I was forced to see a counselor/psychotherapist.</p>
				<p>31 The counselor/psychotherapist wouldn't change my medication.</p>

<p>Unsure of Psychotherapist/ Psychotherapy (Number of CISs = 3)</p>	<p>The client was not certain about counseling/psychotherapy or the counseling/psychotherapist. He may have made unfair assumptions, he may have been biased by his previous experiences in counseling/psychotherapy, and he doubted the character of the counselor/psychotherapist or the process of counseling/psychotherapy.</p>	5.36%	3.95%	<p>3 I was not sure if the counselor/psychotherapist was telling me the truth.</p>
				<p>20 My attitude about previous counselors/psychotherapists was not positive, so I assumed the worst about my counselor/psychotherapist before I met him/her.</p>
				<p>51 When I came into counseling/psychotherapy, I wasn't sure I wanted to be there and was uptight.</p>
<p>Client Not Putting in Work (Number of CISs = 2)</p>	<p>The client did not follow through on appointments or homework.</p>	3.57%	5.26%	<p>18 I failed to make it to a few sessions.</p>
				<p>37 I put off or simply ignored advice and suggestions from my counselor/psychotherapist.</p>

<p>Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues (Number of CISs = 9)</p>	<p>The counselor/psychotherapist did not talk about the client's issues, did not make progress on the client's issues, did not provide the client with appropriate tools or alternatives for addressing his issues, or pay enough attention to the client and his issues.</p>	17.86%	21.05%	<p>9 I had something to talk about, and we didn't talk about it.</p>
				<p>34 The counselor/psychotherapist and I spent too much time having conversations not related to solving my issues (e.g. talking about cats, talking about TV, other tangents the counselor/psychotherapist went off on).</p>
				<p>36 The counselor/psychotherapist and I did "weird" exercises to address my issues that I felt were a waste of time.</p>
				<p>43 The counselor/psychotherapist suggested medication and did not offer another alternative.</p>
				<p>56 The counselor/psychotherapist did not give answers that could help me overcome and achieve personal goals.</p>

8 The counselor/psychotherapist did not elicit more explanatory responses from me pertaining to my issues.

22 I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues.

35 I got the same advice several times, and I did not feel anything was solved.

15 Sometimes the counselor/psychotherapist would not take my calls.

<p>Acting on Assumptions About Client (Number of CISs = 3)</p>	<p>The counselor/psychotherapist was jumping to conclusions about the client's thoughts, feelings, or behaviors. The counselor/psychotherapist was making assumptions about the client and pushing those assumptions on the client.</p>	<p>5.36%</p>	<p>6.58%</p>	<p>33 The counselor/psychotherapist drew a picture of the damage and destruction my issues were causing to others.</p> <p>11 The counselor/psychotherapist put words in my mouth (i.e., told me what I felt/thought).</p>
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				27 The counselor/psychotherapist accused me of doing something wrong.
Pushy Counselor/Psychotherapist (Number of CISs = 3)	The counselor/psychotherapist pressured the client about how sessions should go. The counselor/psychotherapist insisted on his/her approach, timeline, or whom to involve in counseling/psychotherapy.	5.36%	3.95%	26 The counselor/psychotherapist suggested that his/her way - his/her philosophies and method of healing - were the only way that would work. 30 The counselor/psychotherapist pressured me to bring my mother to a session. 23 The counselor/psychotherapist repeatedly pointed out the time.
Time Problems (Number of CISs = 4)	The client felt the counselor/psychotherapist did not have enough time to meet his needs. Or, either the counselor/psychotherapist or the client was still bringing things up when there was no time to address them.	7.14%	11.84 %	1 The counselor/psychotherapist had limited availability. 28 There was not enough time for the session (i.e. we didn't get the work done that I expected).

48 The
counselor/psychotherapist
hurried me (e.g., through
questions, in conversation).

10 The
counselor/psychotherapist
asked a thought-provoking
question as I was walking out
the door.

Note: ^a Participation Rate: the percentage of participants who contributed an incident to a given category. ^b Representation Rate: the percentage of the total number of CISs contained by a given category (calculated after redundant statements were combined).

Table 2

Category Detrimentiality

Category Name	Mean Detrimentiality Rating ^{a, b}	Standard Deviation
Client Needs to Build		
Trust	2.05	1.57
No Choice	2.00	1.86
Client Not Putting in		
Work	2.00	1.30
Time Problems	2.00	1.38
Unsure of		
Therapist/Therapy	1.85	1.14
Counselor/Psychotherapist		
Didn't Work Hard		
Enough on Client's Issues	1.80	1.61
Communication Problems	1.80	1.51
Not the Right Fit	1.75	1.12
Pushy		
Counselor/Psychotherapist	1.65	1.50
Acting on Assumptions		
About Client	1.60	1.35
Unprofessional	1.60	1.54
Unexpected		
Actions/Personality of		
Counselor/Psychotherapist	1.45	1.32

Note: ^a Mean calculated from participants who rated categories during follow-up interviews ($n = 20$). ^b 0 = this was helpful or positive to our working relationship, 1 = this was not damaging to our working relationship or had no effect on it, 2 = this was slightly damaging to our working relationship, 3 = this was moderately damaging to our working relationship, 4 = this was very damaging to our working relationship or 5 = this was extremely damaging to our working relationship.

Appendix A

Recruitment Poster

Men, Get Paid to Speak Your Mind!

Do you know what it's like to be a man in counseling or psychotherapy? We want to hear from you!

To be eligible, you must:

- 1) Be 18 years of age or older
- 2) Have had an appointment with a counselor or psychotherapist within the last 30 days
- 3) Be able to travel to Western Washington University to participate

You will be asked to fill out some questionnaires. This should take about one hour. For completing the study, you'll be paid \$15.

If you would like to participate or find out more information about this study, please call Dr. Bedi's Research Lab at Western Washington University at (360) 650-3376 or e-mail Psych.Research1@wwu.edu. Please include in your message that you are calling or writing about the "men's counseling study."

Appendix B

Recruitment Poster Distribution Letter

[on letterhead]

Date

Name
Address

Dear _____:

Our research team at the Department of Psychology at Western Washington University is currently researching working relationships between counselors/psychotherapists and clients. As part of the recruitment for our latest project, we are respectfully requesting your assistance. **In particular, we hope that you are willing to share recruitment information about the study with your male clientele (see attached flyers).** Participants will be asked to describe an incident that was detrimental to the working relationship with their counselor or psychotherapist.

This thesis research project is being completed by Mica Richards under the supervision of Dr. Rob Bedi, Department of Psychology, at Western Washington University. Should you have any questions about this study, please contact Dr. Bedi's research lab at (360) 650-3376 or by e-mail at Psych.Research1@wwu.edu.

We realize that this is a demand on your time but sincerely hope that you are able and willing to share this information with your clients without too much inconvenience. With many thanks.

Sincerely,

Mica Richards
Mental Health Counseling Graduate Student Researcher
Department of Psychology
Western Washington University

Appendix C

Initial Contact and Screening Form

Initial Phone Contact and Screening

Date of Screening Interview: _____

Thank you for contacting us for information about our research study on counseling and psychotherapy. The study is being conducted at Western Washington University. **What is your name?** _____ **(Repeat Name)**, we are interested in finding out what men who have recently participated in counseling or psychotherapy believe can hurt a good working relationship between a counselor or psychotherapist and a client.

If you choose to participate, you will be asked to complete two questionnaires and write briefly about an experience you believe hurt the establishment of a good working relationship with your counselor or psychotherapist or damaged the working relationship you had already established with your counselor or psychotherapist. For your participation, you will receive \$15. YOUR PARTICIPATION SHOULD TAKE ABOUT ONE HOUR AND NEEDS TO BE COMPLETED DURING A SINGLE APPOINTMENT. Five dollars of this is intended to offset your costs of traveling to the university (e.g., gas, bus fare, parking) and \$10 to thank you for your time spent in support of our research. Any information that we collect today will be kept confidential and stored in a locked filing cabinet that is accessible only by our research team. If you are selected for our study, we also will be assigning you a participant number to further protect your identity.

In order to participate, we have a few criteria. Please answer the following questions with either a “yes” or “no.” Thank you.

- Are you male?
- Are you 18 years of age or older?
- Do you have at least a grade 10 education?

We are interested in the experiences of both men who are currently in counseling or psychotherapy and those who have recently ended therapy.

- Have you received individual counseling or psychotherapy in the last 30 days?

If participant answers yes: May we contact your current or most recent counselor or psychotherapist to verify you have had an appointment in the last 30 days? Yes No
If we schedule an appointment with you, we'll ask you to sign a form at that appointment to let us contact your counselor or therapist to verify your most recent appointment date. (Note: If participant says no to this question, they are still eligible to make an appointment to participate.)

A.) I'm sorry, you are not eligible for our study. Thank you for your time. Please feel free to let others know about our study.

B.) Sounds like you are eligible. Would you like to schedule an appointment to participate?

Appointment Date: _____ Appointment Time: _____

Assigned Primary RA: _____

Assigned Secondary RA: _____

Thank you for scheduling an appointment. We'll need to send you directions to the lab. Will you be traveling to your appointment by bus or by car? BUS CAR

(Note: If participant is walking to the appointment, BUS directions will be most helpful.)

What e-mail address or mailing address would be the best place to send you directions?

E-mail/Mailing Address: _____

We'll be contacting you a day or two before your appointment to remind you of it. Please let us know how we can contact you.

Telephone #1: (hm/wk/cell/other): _____

Telephone #2 (hm/wk/cell/other): _____

Can we leave messages? (where and conditions):

E-mail address (if different than above): _____

And for our records, are you a student at Western Washington University? Y / N (please circle)

If a WWU student, please note whether he prefers \$15 cash or 1 hour research credit.

How did you find out about our study? (If more than one answer, ask how they first learned about it.) _____

Assigned Participant Number: _____

Participant Name: _____

Appendix D

Appointment Reminder Letter

(Date)

(Address)

Dear (name)

Thank you for agreeing to participate in our study. Enclosed are driving and bus/walking directions to the clinic where the study is taking place.

Your appointment is for (date) at (time).

Please call or e-mail if you have any questions. The lab phone number is (360)650-3376 and our e-mail is psych.research1@wwu.edu.

We look forward to seeing you!

Mica Richards
Mental Health Counseling Graduate Student Researcher

Appendix E

Driving Directions to Experiment Room

Directions to Research Room, AIC 137 (East Wing)**If you are driving NORTH on I-5:**

1. Take Exit 252 to Samish Way.
2. Turn left as you come off the freeway
3. Then take a left turn at the traffic light (*if you don't, you'll end up on the freeway again*), continuing over the freeway. **Note:** *The next two traffic lights are very close together.*
4. As soon as you go through the **first** of the two traffic lights, **immediately** get in the left-turn lane at the **second** traffic light.

If you are driving SOUTH on I-5:

1. Take Exit 252
2. Turn right at the light at the end of the freeway off-ramp.
3. Get into the far left turn lane as soon as possible.

From either direction, you're now at the corner of Samish Way and Bill McDonald Parkway.

1. Turn left at the light, onto Bill McDonald Parkway. (*You'll see a 76 gas station on one corner and a Blockbuster Video store on another*).
2. Stay on Bill McDonald Parkway for approximately one mile. (*After you pass Sehome High School on the left, the road curves to the right. Up ahead on the right, at the bottom of a hill, you'll see Buchanan Towers, a multi-story brick residence hall*).

Before 4:30 (M-F) you will need to stop at the Campus Services Building for a parking permit:

3. Go past Buchanan Towers, continuing up the hill to the traffic light. (*The building immediately on your right at the traffic light is the Campus Services Building*).
4. Go through the traffic light and drive about 200 yards until you see the Campus Services Building parking lot entrance on your right.
5. You can either pull up to one of the "drive through" kiosks in the parking lot (open until 8 PM) and purchase a parking permit there, **or** go inside the Campus Services Building (open only until 4:30 PM). Once inside the building's front door, you'll see a "Visitor Information" counter immediately to your right, where you'll need to pick up your parking permit. You may have to wait in line. Parking permits are \$2/hour.

At either the Parking Lot Kiosk or the Parking/Visitor Information Counter:

- **Ask for a parking map and directions to your assigned parking area** (*most likely 12-A*) and to the Academic Instruction Center.
- Please park exactly where your parking permit indicates. If you park elsewhere, you are likely to receive a parking ticket (which start at \$25).

After 4:30 (M-F) and on weekends you can park in 12-A for free or pay \$1/hour to park in 17-G

If parking in 12-A:

3. Immediately after Buchanan Towers, take a right onto South College Drive. Then take a right into the second Parking Lot on the Right marked 12-A. (Note: Do not park in carpool spaces)
4. At the north end of the parking lot, you'll see a tunnel with a footpath that goes under the street where you turned at the stop sign. Walk through the tunnel.
5. After you come out the other side of the tunnel, follow that path to the building with the sky bridge—which is the Academic Instructional Center. You'll see it directly ahead of you as soon as you come out of the tunnel.
6. Walk under the sky bridge, and take a right. There are several entrances to the East Wing. Go to the entrance with the sign that says "Counseling Training Clinic" with an arrow pointing right.
7. Come through the double doors and you'll see an elevator on your right.
8. Take the elevator down to the first floor. As you leave the elevator, turn left around the corner. The door to Room 137 will be on your left.

If parking in 17-G:

3. Immediately after Buchanan Towers, take a right onto South College Drive. Then take a right at the stop sign onto East College Way.
4. After the road curves to your left, you'll see a parking lot on your left with an opening that says "EXIT ONLY."
5. Continue to the next parking lot opening on your left, where you'll see a sign that says "17-G" parking lot. Take a left into the 17-G.
6. Follow the signs to the Counseling Training Clinic entrance.
7. Come through the double doors and you'll see an elevator on your right.
8. Take the elevator down to the first floor. As you leave the elevator, turn left around the corner. The door to Room 137 will be on your left.

Note: Can pay by Visa/MC/Cash

If you have any questions, please give us a call: **360.650.3376**.

Appendix F

Bus/Walking Directions to Experiment Room

**Bus/Walking Directions to Western Washington University
Research Room
ACADEMIC INSTRUCTIONAL CENTER (East Wing), ROOM 137**

Western is on the WTA BLUE (105, 107, 190) Line, with buses stopping every 15 minutes on weekdays, between Bill McDonald/Samish Way and Downtown, via WWU. The GREEN (232), GOLD (331), RED (401) and PLUM (512, 525, 540, 541) Lines connect at the Downtown Transit Station, which means you can get from other parts of town to WWU with just one transfer.

From downtown Bellingham, take bus 105, 107, 190 or 14 to WWU. **DO NOT GET OFF AT THE VIKING UNION. Stay on the bus until the WADE KING RECREATION CENTER stop**, cross at the crosswalk (toward the Recreation Center, which is the large building right at the corner).

If you're still on the bus when it gets to the Campus Services Building, you've gone too far. Get off the bus. There is no sidewalk back to campus on that side of the street. The safest way to get back is to walk to the signal, cross carefully at the crosswalk, and head back to campus. It's approximately a 7-minute walk back to the Rec Center area.

Once you have crossed the street, walk northeast to the large new building just past the flag poles. The building is called the Academic Instructional Center. You'll see the "West Wing" sign first, and you'll want to walk to your right, around to the front of the West Wing. Continue on the sidewalk to the East Wing, where our lab is. As you walk in front of the West Wing, you'll see a sky bridge joining the 2 wings. Continue on the sidewalk toward middle of the East Wing. You'll see a sign up ahead that says "Counseling Training Clinic" with an arrow pointing to a set of double glass doors in the East Wing (on your right). Go through the 2 sets of double glass doors, and you'll see an elevator on your right as soon as you get in the building. Take the elevator down to the first floor. As you leave the elevator, head left around the corner. The door to Room 137 will be on your left.

Buses returning to downtown Bellingham stop on the east side of Bill McDonald Parkway (across the street from where you got off). All buses go downtown EXCEPT the 90A and 90B.

Note: Buses do not run as frequently on the weekends, for more information go to <http://www.ridewta.com/> or call 360-676-RIDE.

Appendix G

Data Collection Procedure Protocol

Procedure Protocol Sheet

Participant Number: _____ Participant Initials: _____

Telephone Number: _____ Date: _____

Data Collector: _____

Pre-Procedure Checklist

- Stuff to bring:**
 - 2 pens
 - Watch
 - money to pay the participant (\$15 for CI description or \$25 for CI sorting)
 - 1 procedure protocol (orange)
 - 2 informed consent forms (pink for describers, purple for sorters)
 - 1 participant payment form – non-students only (green)
 - 1 referral form (green)

- For describers only:**
 - 1 Questionnaire 1 [demographic] (yellow)
 - 1 Questionnaire 2 [CI] (yellow)
 - Conformity to Masculine Norms Inventory (yellow)
 - 2 pages blank paper

- For sorters only:**
 - 1 sorting task instruction form (blue)
 - 1 summarized sorting task guidelines poster (blue)
 - 1 set of sorting record forms [20 big, 10 small] (white)
 - 10 category description forms (white)
 - XX index cards w/incidents
 - 40 envelopes
 - 40 slips of nicely cut scrap paper (white)

- Get to lab 30 minutes early to collect materials, check voicemail, and answer the phone in case the participant calls for directions or to inform you of lateness. When gathering

materials, take along the participant's screening form so you can refer to him by name. Fifteen minutes before the appointment, go to the research room or clinic to meet the participant.

- Greet the participant and engage in small talk and ice-breakers.
- Does the participant look like he feels comfortable and safe?
- Verbally introduce each form, summarizing its purpose. Have the participant read the instructions and ask you any questions.
 - For Informed Consent, read aloud to the participant and have him follow along on his copy, then ask for and answer any questions before the participant signs.
- Carefully review the participant's handwriting as he completes each form. If necessary, explain you are having some difficulty reading his handwriting and request that he take his time and write as neatly as possible. Clarify illegible words/phrases.

Procedure Order for Describers

- Informed Consent
- Questionnaire I (demographics)
- Questionnaire II (critical incident)
- Conformity to Masculine Norms Inventory
- Payment Form and payment
- Provide Resource List

Procedure Order for Sorters

- Informed Consent
- Sorting Task

- Review for handwriting clarification and to be sure items are sorted according to instructions
- Ask participant for a brief description of each pile (more about the label, what the statements in the pile have in common).
- Payment Form and payment
- Provide Resource List

Post-Procedure Checklist

- Reflect. What did you do well? What might you have done differently? Now that you've completed another participant appointment, what else have you learned or what other wisdom have you gained?

Notes to self / Procedures to self / Client Comments

-
-
-
- E-mail Mica that the participant was completed.
 - For describing participants, code questionnaire data into SPSS and Word file.
 - For sorting participants: 1) Document sort data on sorting record forms (short-hand is fine). 2) Place original pile labels into an envelope and staple it to the back of the sort forms. 3) Document the sort into Word. [It is quickest to cut and paste the entire CI].
 - Make sure all forms are secured in a locked cabinet.

Appendix H

Informed Consent Form – Incident Description

PHASE 1 CONSENT FORM

Project Title: **Gaining Perspective: Incidents That Damage the Therapeutic Alliance as Described by Male Mental Health Clients**

Purpose and Benefit:

This study will help people to learn about what can hurt a good working relationship between a counselor or psychotherapist and a client. We want to learn from men what has hurt their working relationships with their counselors and psychotherapists. Clients and their counselors and psychotherapists have lots of different experiences, some that help their working relationships and some that hurt their working relationships. It is important to study what hurts their working relationships because it will help teach counselors and psychotherapists how to build better working relationships with men. Past research has shown that it is much harder to help a client make progress if he has a poor working relationship with his counselor or psychotherapist. So, helping people to recognize what hurts these working relationships should help make counseling and psychotherapy more effective.

I UNDERSTAND THAT:

- 1) To take part in this study I must be a man at least 18 years of age who had individual counseling or psychotherapy in the last 30 days.
- 2) This research study will involve completing three questionnaires. It is estimated that the questionnaires will take approximately one hour.
- 3) There is minimal risk/discomfort anticipated with participation in this study. These risks/discomforts include the time required to complete the questionnaires and to travel to the university. Another risk is that I may find that I am not happy with the quality of services I am receiving from my mental counselor or psychotherapist.
- 4) Possible benefits to my participation include learning more about what is important to me in counseling or psychotherapy and helping others to learn what is important to forming counseling or psychotherapy relationships with men.
- 5) In exchange for my participation, if I am a WWU student, I will be awarded one hour of research credit. If I am a non-student, I will be paid \$15. This amount is intended to help pay for me to get to the appointment (for example, my gas, bus pass, or parking permit) and to thank me for my time.
- 6) Being a part of this study is my choice. I can choose not to complete any particular item on the questionnaires if answering that item would be upsetting to me. If I decide to be part of this study, I may decide to stop at any time without telling anyone why. If I do decide to stop and I am a non-student, I will still be paid \$5.00 to help pay for me getting to the appointment and will also be paid \$5.00 for each half-hour that I participate. So, if I participate for 30 minutes, I will receive \$5.00 + \$5.00; if I participate for 45 minutes, I will receive \$5.00 + \$5.00; and if I complete the study, I will receive \$5.00 + \$10.00. If I

decide to stop and I am a WWU student, I will receive credit for the time I spent completing the study, rounded down to the nearest quarter hours (i.e., .25 credit for 15 minutes, .5 credit for 30 minutes, .75 credit for 45 minutes). If I decide to stop being part of the study, the answers I give will not be used for this study or any other study.

- 7) All of the information I give will be kept confidential. My signed consent form will be kept in a locked cabinet separate from the questionnaires and other information. My name will be separated from the answers I give. The researchers will put a number on my questionnaires to help them know the questionnaires all came from the same person. Only the researcher in charge and her assistants will be allowed to see my answers and forms with my name on them.
- 8) All the information I share about the experience that hurt my working relationship with my counselor or psychotherapist will be described in one sentence. If the experience I describe is very similar to what other men have experienced, all of our experiences may be described in one sentence. Men in the first part of this study will be asked if they want to help with the second part of the study. Of all the men who agree, three of them will be randomly picked to help. Each of the three men, on his own, will look at the sentences describing the experiences of all the men in the study and group them according to what they have in common. No names and no information that could let people know who exactly they are about will be in the sentences.
- 9) The results of this study will probably be shared in these ways: they may be published in an article, presented at a meeting or conference, and used in classes to teach counselors or psychotherapists. If you or another participant want to see a short description of the results, that person can let the researcher know at his appointment or call the lab at 360-650-3376 to let them know. Any many in the study who asks to see a short description of the results will be sent one after the study is over.
- 10) The answers I give will and forms I fill out will be kept on file for seven years. Seven years after the study is over, all forms filled out by men who take part in this study, answers given by men who take part in this study, and computer files describing their answers from this study will be destroyed. Paper forms will be shredded and electronic data will be erased.

If you have questions or comments regarding this study, please contact Rob Bedi, the faculty advisor of the researcher in charge. You can contact him by e-mail at psych.research1@wwu.edu or by telephone at 360-650-3376. If you have any concerns about taking part in this study or want to know about what rights you have as someone taking part in a study, you can contact the Janai Symons, WWU Research Compliance Officer, at (360) 650-3082 or by e-mail at janai.symons@wwu.edu. If you are hurt or experience problems while taking part in this study or because you were a part of this study, please let the researcher in charge of the study know or tell the WWU Research Compliance Officer.

I have read the above description and agree to participate in this study.

Participant's Signature

Date

Participant's PRINTED NAME

We will be doing follow-up interviews to help make sure the researchers honestly and clearly represent the experiences shared by men in this study. It should only take about ten minutes on the phone to answer these questions. No money will be paid for the phone interview, but we will be very grateful for your help.

May we call you for a brief follow-up interview? Yes No

Are you interested in being contacted about future studies? Yes No

A few men will be randomly picked to come back for the second part of the study. They will be asked to sort sentences describing men's experiences in counseling or psychotherapy. They will be paid for the time they spend on the second part of the study. Are you willing to come back for the second part of the study? Yes No

I agree that the answers I give today may be used in future research studies if the researchers do not use my name with my answers and take out any information that could let someone know who gave those answers. _____
(initial here)

I agree to let the researchers contact my current or most recent counselor or psychotherapist to confirm that I had an appointment with him or her sometime in the 30 days before I made an appointment to participate in this study. _____
(initial here)

NOTE: Please sign both copies of the form and retain the copy marked "Participant."

Researcher
Copy

Participant
Copy

Appendix I

Release of Last Date Seen by Mental Health Professional

COVER PAGE

From: Psychotherapy Research Lab of Dr. Rob P. Bedi, Western Washington University

Fax # of Sender: _____

To: _____

Fax # of Recipient: _____

of pages sent (including cover page): _____

CONFIDENTIAL FAX

The following fax contains confidential information. Its contents should be viewed only by the intended recipient. If you are not the intended recipient, please deliver to the intended recipient without reading its contents. If you believe this fax has reached you or your agency in error, please contact the sender at (360) 650-3082.

Release of Information

Client Name: _____

Date of Request: _____

I hereby grant permission for

(mental health care provider's name and/or agency)

to release the following requested information to Dr. Rob P. Bedi, of the Psychology Department of Western Washington University:

Date I was last seen for individual counseling or psychotherapy.

Signature of client_____
Date_____
Dr. Rob P. Bedi_____
Date

Appendix J

Informed Consent Form – Incident Sorting

PHASE 2 CONSENT FORM

Project Title: **Gaining Perspective: Incidents That Damage the Therapeutic Alliance as Described by Male Mental Health Clients**

Purpose and Benefit:

This study will help people to learn about what can hurt a good working relationship between a counselor or psychotherapist and a client. We want to learn from men what has hurt their working relationships with their counselors and psychotherapists. Clients and their counselors and psychotherapists have lots of different experiences, some that help their working relationships and some that hurt their working relationships. It is important to study what hurts their working relationships because it will help teach counselors and psychotherapists how to build better working relationships with men. Past research has shown that it is much harder to help a client make progress if he has a poor working relationship with his counselor or psychotherapist. So, helping people to recognize what hurts these working relationships should help make counseling and psychotherapy more effective.

I UNDERSTAND THAT:

- 1) To take part in this study I must be a man at least 18 years of age who has had counseling or psychotherapy in the last 30 days.
- 2) This portion of the research study will involve sorting statements describing how the working relationships men have with their counselors or psychotherapists have been damaged. I will be sorting the statements according to what I see they have in common. It is estimated that the sorting will take approximately two hours.
- 3) There is minimal risk/discomfort anticipated with participation in this study. These risks/discomforts include the time required to complete the questionnaires and to travel to the university. Another risk is that I may find that I am not happy with the quality of services I am receiving from my counselor or psychotherapist.
- 4) Possible benefits to my participation include learning more about what is important to men in counseling or psychotherapy and helping others to learn what is important to forming counseling or psychotherapy relationships with men.
- 5) In exchange for my participation, I will be paid \$25.00. This amount is intended to help pay for me to get to the appointment (for example, my gas, bus pass, or parking permit) and to thank me for my time.
- 6) Being a part of this study is my choice. I can choose not to complete any part of the study if completing that part would be upsetting to me. If I do decide to be part of this study, I may decide to stop at any time without telling anyone why. If I do decide to stop, I will still be paid \$5.00 to help pay for me getting to the appointment and will also be paid \$10.00 for each completed hour of participation. So, if I participate for 60 minutes, I will receive \$5.00 + \$10.00; if I participated for 90 minutes, I will receive \$5.00 + \$10.00; and if I complete the task, I will receive \$5.00 + \$20.00. If I decide to stop being part of the study, the answers I give will not be used for this study or any other study.

- 7) All of the information I give will be kept confidential. My signed consent form will be kept in a locked cabinet separate from the sorting results and other information. My name will be separated from the notes on how I sort the statements. The researchers will put a number on my forms to help them know they all came from the same person. Only the researcher in charge and her assistants will be allowed to see my answers and forms with my name on them.
- 8) The results of this study will probably be shared in these ways: they may be published in an article, presented at a meeting or conference, and used in classes to teach counselors or psychotherapists. If you or another participant want to see a short description of the results, that person can let the researcher know at his appointment or call the lab at 360-650-3376 to let them know. Any many in the study who asks to see a short description of the results will be sent one after the study is over.
- 9) The answers I give will and forms I fill out will be kept on file for seven years. Seven years after the study is over, all forms filled out by men who take part in this study, answers given by men who take part in this study, and computer files describing their answers from this study will be destroyed. Paper forms will be shredded and electronic data will be erased.

If you have questions or comments regarding this study, please contact Rob Bedi, the faculty advisor of the researcher in charge. You can contact him by e-mail at psych.research1@wwu.edu or by telephone at 360-650-3376. If you have any concerns about taking part in this study or want to know about what rights you have as someone taking part in a study, you can contact the Janai Symons, WWU Research Compliance Officer, at (360) 650-3082 or by e-mail at janai.symons@wwu.edu. If you are hurt or experience problems while taking part in this study or because you were a part of this study, please let the researcher in charge of the study know or tell the WWU Research Compliance Officer.

I have read the above description and agree to participate in this study.

Participant's Signature

Date

Participant's PRINTED NAME

I agree that the answers I give today may be used in future research studies if the researchers do not use my name with my answers and take out any information that could let someone know who gave those answers. _____

(initial here)

NOTE: Please sign both copies of the form and retain the copy marked "Participant."

Researcher
Copy

Participant
Copy

Appendix K

Demographics Questionnaire

Questionnaire 1**Participant Information**

To ensure confidentiality, please do not put your name on this questionnaire. For each question below, you will be asked to either check a box () or fill in a blank (_____). Please take your time and answer each question completely. Please write as neatly as possible. If you have any questions or comments while you are completing this questionnaire, please let us know.

I. Basic Information

1.) How did you find out about this research study? (Please check only one box)

- From my mental health professional
- Through a posted flyer (specify where): _____
- Through an online forum (specify which): _____
- Through Experimentrix: _____
- Other (please specify): _____

2.) Approximately how many counseling/psychotherapy sessions have you had with your current or most recent mental health professional?

_____ sessions.

3.) Are you currently receiving counseling/psychotherapy?

- Yes No

If not, how did your most recent counseling/psychotherapy end?

- Completed agreed upon number of sessions
- Therapist and I agreed goals had been reached
- Unable to continue attending (transportation, scheduling, payment issues)
- Unsatisfied with services, stopped attending
- Other, please specify: _____

4.) On a scale of 1 to 10, please rate the quality and strength of the working relationship between you and your current mental health professional

(please circle only one number):

1	2	3	4	5	6	7	8	9	10
Extremely negative and/or extremely weak			Average				Extremely positive and/or extremely strong		

II. Demographics

5.) Please indicate your gender.

Male Female Other (please specify): _____

6.) What is your birthdate? _____. That would make you _____ years and _____ months old.

7.) Please indicate your current partnership status.

Single / Never Married or Partnered Married or Partnered
 Divorced or Separated Widowed

8.) Please indicate the highest level of your education that you have completed.

Elementary School
 Junior High School
 High School / GED
 Technical Degree
 Associate's Degree
 Bachelor's degree
 Master's degree
 Ph.D., M.D. or equivalent doctoral degree

9.) Please indicate your current occupation (includes full-time student).

10.) How would you describe your ethnicity?

_____.

11.) How long have you lived in the U.S.? _____ years and _____ months.

III. Characteristics of your Counseling or Psychotherapy

12.) How many mental health professionals have you received individual counseling/psychotherapy from throughout your life (including the current one)?

13.) With your current or most recent mental health professional, how long have you been receiving counseling or psychotherapy?

_____ years, _____ months, and _____ weeks

14.) With your current or most recent mental health professional, how are you paying for services?

- The services are free Self-paying the entire cost
 Full coverage by healthcare plan Partial coverage by healthcare plan

15.) Where are you currently receiving or where did you most recently receive counseling or psychotherapy? (please check only one box)

- Private practitioner's office
 Community agency
 University/college clinic or counseling center
 Hospital
 Other (please specify): _____

16.) What is your current or most recent mental health professional's highest education level?

- Not sure
 Diploma/Certificate
 Bachelor's degree (B.A./B.Ed/B.Sc./B.SW)
 Master's degree (M.A./M.Ed/M.Sc./M.SW)
 Ph.D
 M.D

- 17.) What is your current or most recent mental health professional's profession?
- Counselor
 - Social worker
 - Psychologist
 - Psychiatric nurse
 - Psychiatrist
 - Other (please specify): _____
- 18.) What is your current or most recent mental health professional's gender?
- Male Female Other (please specify): _____
- 19.) Please check the **one** box that best describes the single, most important reason that you most recently sought counseling or psychotherapy (please check one box only).
- Anxiety or stress Self-esteem Trauma
 - Depression Relationship issues Other (please specify below):
 - Alcohol/drug use Anger management _____
 - Career concerns Educational concerns _____
- 20.) What type/style/theory of counseling or psychotherapy are you currently receiving or did you most recently receive?
- _____

Appendix L

Critical Incident Prompt and Follow-up Questions

Questionnaire 2**Factor that Helped Form or Strengthen the Working Relationship**

Please think back over the meetings that you had with your current mental health professional, paying particular attention to the working relationship that was developing between you and the mental health professional. [Please take a few moments to remember this clearly and put your thoughts in context] *What was the single most important thing that helped form and strengthen this working relationship?* We are most interested in specific behaviors and other observable things. This can be something that either you or the professional did, something you did together or something else that happened within or outside the sessions. *Please describe the behavior or event completely and in as much detail as possible.*

Before answering, **please remember that we are asking about factors that helped form or strengthen your working relationship with the mental health professional– not factors that helped you get better or resolve the issues that brought you to counseling or psychotherapy in the first place (i.e., you can have a good working relationship with your mental health professional but still not be making much progress).** Please only mention something that helped form or strengthen the working relationship. If you are unsure about whether something is about the working relationship or progress, please discuss this with the research assistant.

Question 1: *What was the most important thing that helped form and/or strengthen the working relationship? Please describe it completely and in as much detail as possible.*

[there's more space on the next page]

Q3.) If this was something the mental health professional did, what were you doing at the time?

Q4.) If this was something you did, what was the mental health professional doing at the time?

Q5.) Approximately, in what session did this occur or first occur? (e.g., 1st, 2nd, 3rd etc.)

Q6.) In the particular session in which it did occur, did it happen early in the session, in the middle of the session, or near the end of the session?

? **Early in the session**

? **Middle of the session**

? **Late in the session**

? **Not applicable**

Q7.) In only one sentence, please summarize what happened that helped form or strengthen the working relationship with your mental health professional?

Q8.) If someone were secretly watching when this happened, what would they see and hear?

Q9.) What led up to this and/or happened right before?

Q10.) What happened after this?

Q11.) Please describe how you were feeling after this happened.

***** Please remember that not all of the following questions will apply to what you mentioned. Please only answer those questions that are relevant, and put “N/A” if a question does not apply to your situation.*****

Q12.) How many times did this occur?

Q13.) For how long did this occur?

Q14.) In what percentage (%) of sessions did this occur? (0% to 100%)

_____ %

Q15.) How would you feel or react if this happened again the next session?

Q16.) What would you be thinking if it happened again the next session?

Q17.) If this stopped happening, how would you feel and react, and what would you be thinking?

Q18.) How did this help in forming or strengthening the working relationship with the mental health professional?

Q19.) Why did this help in forming or strengthening the working relationship with the mental health professional?

Q20.) Instead of this, what could you or the professional do to weaken or hurt the working relationship?

Factor that Weakened or Hurt the Working Relationship

*Now please let us know the single most important thing that weakened or hurt the formation and/or strengthening of the working relationship? We are most interested in specific behaviors and other observable things. This can be something that either you or the professional did, something you did together or something else that happened within or outside the sessions. *Please describe the behavior or event completely and in as much detail as possible. Please take your time and write as neatly as possible.**

Before answering, please remember that we are asking about factors that weakened or hurt the formation and strengthening of the working relationship with the mental health professional – not factors that directly prevented you from resolving the issues that brought you to counseling or therapy (i.e., you can have a poor working relationship with your mental health professional but still be making progress). Please only mention something that weakened or hurt the formation or strengthening of the working relationship here. If you are unsure about whether something is about the working relationship or progress, please discuss this with the research assistant.

Question 1: *What was the most important thing that weakened and/or hurt the formation and strengthening of the counseling or therapy relationship? Please describe it completely and in as much detail as possible.*

[there's more space on the next page]

***For all subsequent questions in this section (Questions 2 to 20) refer to your response to question 1. ***

Q2.) Was this something that you did, that the mental health professional did, that you did together, or something else that occurred within or outside of the sessions?

- Something I did
- Something the professional did
- Something we did together
- Something else from within the session
- Something else from outside the session

*** Please note that not all of the following questions will apply to what you mentioned. Please only answer those questions that are relevant, and put “N/A” if a question does not apply to your situation. ***

Q3.) If this was something the mental health professional did, what were you doing at the time?

Q4.) If this was something you did, what was the mental health professional doing at the time?

Q5.) Approximately, in what session did this occur or first occur?

Q6.) In the particular session in which it did occur, did it happen early in the session, in the middle of the session, or near the end of the session?

? Early in the session

? Middle of the session

? Late in the session

? Not applicable

Q7.) In only one sentence, please summarize what happened that weakened or hurt the working relationship with the mental health professional?

Q8.) If someone were secretly watching when this happened, what would they see and hear?

Q9.) What led up to this and/or happened right before?

Q10.) What happened after this happened?

Q11.) Please describe how you were feeling after this.

*** Please remember that not all of the following questions will apply to what you mentioned. Please only answer those questions that are relevant, and put “N/A” if a question does not apply to your situation ***

Q12.) How many times did this occur?

Q13.) For how long did this occur?

Q14.) In what percentage (%) of sessions did this occur? (0% to 100%)

_____ %

Q15.) How would you feel or react if this happened again the next session?

Q16.) What would you be thinking if it happened again the next session?

Q17.) If this stopped happening, how would you feel and react, and what would you be thinking?

Q18.) How did this weaken or hurt the working relationship with the mental health professional?

Q19.) Why did this weaken or hurt the working relationship with the mental health professional?

Q20.) Instead of this, what could you or the professional do to strengthen the working relationship?

Appendix M

Sample Conformity to Masculine Norms Inventory

This is the SAMPLE CONFORMITY TO MASCULINE NORMS INVENTORY. It contains the directions given to persons completing the inventory, the format of the inventory, and some sample items. The full CMNI is 94 items and takes between 10-15 minutes to complete.

Instructions: The following pages contain a series of statements about how men might think, feel or behave. The statements are designed to measure attitudes, beliefs, and behaviors associated with both traditional and non-traditional masculine gender roles.

Thinking about your own actions, feelings and beliefs, please indicate how much **you personally agree or disagree with each statement** by circling SD for "Strongly Disagree", D for "Disagree", A for "Agree", or SA for "Strongly agree" to the left of the statement. There are no right or wrong responses to the statements. You should give the responses that most accurately describe your personal actions, feelings and beliefs. It is best if you respond with your first impression when answering.

- | | | | | | |
|-----|--|----|---|---|----|
| 1. | It is best to keep your emotions hidden | SD | D | A | SA |
| 2. | In general, I will do anything to win | SD | D | A | SA |
| 3. | If I could, I would frequently change sexual partners | SD | D | A | SA |
| 4. | If there is going to be violence, I find a way to avoid it | SD | D | A | SA |
| 5. | I love it when men are in charge of women | SD | D | A | SA |
| 6. | It feels good to be important | SD | D | A | SA |
| 7. | I hate it when people ask me to talk about my feelings | SD | D | A | SA |
| 8. | I try to avoid being perceived as gay | SD | D | A | SA |
| 9. | I hate any kind of risk | SD | D | A | SA |
| 10. | I prefer to stay unemotional | SD | D | A | SA |
| 11. | I make sure people do as I say | SD | D | A | SA |

Appendix N

Critical Incident Sorting Task Instructions – Long Form

Sorting Task Instructions

You will be given a stack of cards. On each card is printed a sentence. The sentences describe how the working relationship a man has with his counselor or psychotherapist can be hurt. Each card describes one way this relationship can be hurt.

First, please read all of the cards. This study is trying to learn from men what most damaged or hurt the working relationships they've had with their counselors or psychotherapists. Think about what the sentences on the cards tell you about that.

After you have read all the cards, think about how they relate to each other. Can you think of some things certain sentences on the cards might have in common with sentences from other cards? What do they have in common about the way they describe what hurt men's working relationships with their counselors or psychotherapists? Please sort the cards into piles, grouping them together according to what you see they have in common and how they relate to each other.

As you add sentences to your piles, you will probably decide to change how you're grouping the sentences. You might move a few sentences from one pile to another, you might decide to put two or three piles together into one pile, or you might split a pile into two or more separate piles. It's helpful to make changes as you think of new things the cards have in common or how they're different.

As you're sorting, or after you're done sorting, please make a label for each pile of cards. We'll give you paper and a pen to make a label for each. The label for each pile should be a word or a few words that describe the sentences in that pile. It's okay to make a label and then decide to change it. Please take your time when placing the final labels on your piles and write as neatly as possible. When you've labeled all the piles, please take one last look to make sure that all of the cards in each pile have something in common and the label for the pile clearly describes what that is.

You can make as many different piles as you'd like, and you can put as many cards as you like into each pile, with a couple of exceptions. Usually, people don't put more than a third of the cards into one pile since there are some differences among the sentences on the cards. Also, you should not end up with every card in its own pile, since we want you to place the cards in groups according to what they have in common.

There are no right or wrong answers; we are interested in whatever way you make sense of the cards. If you discover more than one way that the cards can be sorted, please show us the one that makes the most sense to you or is the easiest one for you to understand.

If you have any questions, please do not hesitate to ask; we are here to help you.

Appendix O

Critical Incident Sorting Task Guidelines

Sorting Task Guidelines

1. Every card describes something that hurts the working relationship, NOT something positive or helpful.
2. Please DO NOT put each card in its own pile. There can be a few piles with just one card in them, but you cannot have [total # of items] separate piles.
3. Please DO NOT put all the cards into one large pile.
4. Please DO NOT create a miscellaneous pile (a mishmash of things that don't seem to fit anywhere else). Every card should be placed in a pile with other cards it has something in common with or in its own pile, if it's not at all like any other card.
5. Each card can only be placed in one pile.
6. Please make sure you group the cards according to how they relate to each other and not according to how you may or may not have experienced them in your own counseling or psychotherapy.

Appendix P

Category Record Form - Long

Participant: _____ (RA: _____)

Category #: __ of __

Category Name:

Description	(raw CI #)	Description	(raw CI #)
1.		17.	
2.		18.	
3.		19.	
4.		20.	
5.		21.	
6.		22.	
7.		23.	
8.		24.	
9.		25.	
10.		26.	
11.		27.	
12.		28.	
13.		29.	
14.		30.	
15.		31.	
16.		32.	

Appendix Q
Category Description Form

Category Name: _____

Category Description: _____

Category Name: _____

Category Description: _____

Category Name: _____

Category Description: _____

Category Name: _____

Category Description: _____

Appendix R

Payment Form

Participant Payment Form

Gaining Perspective: Incidents That Damage the Therapeutic Alliance
as Described by Male Mental Health Clients

Principal Investigator: Mica Richards, Department of Psychology,
Western Washington University

I hereby confirm that I received \$ _____ for participation in the above-mentioned research study on the date noted below.

Participant Name: _____

Participant Signature: _____ Date _____

Witness Name: _____

Witness Signature: _____ Date _____

If the participant withdraws early from the research study, please note how long the participant participated: _____ hour(s) and _____ mins.

The participant should be provided with \$5.00 to offset transportation costs + \$10.00 for each completed hour of participation. Participants who complete the incident description portion of the study will receive a total of \$15. Participants who complete the sorting portion of the study will receive a total of \$25.

Appendix S

Resource List

RESOURCE LIST

Suicide Prevention/Crisis Services Hotline (24 hour hotline): 1-800-584-3578

Domestic Violence and Sexual Assault Services: 360-715-1563 (24 hours)

Whatcom Counseling and Psychiatric Clinic: 360-676-2220/1-888-311-0120
3645 E McLeod Rd., Bellingham 24-hour emergency service available

Rainbow Activity Center: 360-752-2577
213 E. Champion St. weekdays; drop-in center, services for people with mental illnesses

Brigid Collins Family Support Center: 360-734-4616, 8:00-4:30 M-F
1231 N Garden Street, #200

National Alliance on Mental Illness (NAMI): 1-800-782-9264

Washington State Mental Health Division: 1-800-446-0259

Alcoholics Anonymous: 360-734-1688

Narcotics Anonymous: 360-647-3234

Low cost counseling services

“Counsel Program”: 360-752-4542

Call Diane (at Whatcom Counseling and Psychiatric Clinic) and ask about the “Counsel Program”

WWU Counselor Training Clinic: 360-650-3184

Interfaith Community Health Center: 360-676-6177
(Must be a medical patient here, but if you are not and qualify for low income, you can apply to a program called “Access to Mental Health Services.” If this is the case, call 1-888-693-7200.)

Local counselors:

*Counselors listed **may** be able to provide services for a reduced fee **or** on a sliding scale basis.

Julia Blunt: 360-441-6275

Lauren Davies: 360-647-7905

Jordan Feigal: 360-734-2664, ext. 21

Laurel Holmes: 360-920-0009

Victoria Lord: 360-756-9696

Jason Quick: 360-393-2272

Marlene Sexton: 360-758-4295

Appendix T

Follow-Up Interview Procedure

Participant Number: _____ Participant Name: _____

Date of First Call: _____ Message Left (circle one): Y / N

Date of Second Call: _____ Message Left (circle one): Y / N

Date of Third Call: _____ Message Left (circle one): Y / N

Participant's CI:

Category Containing Participant's CI:

Contact participant to let him know he has been selected to participate in a follow-up interview.

Hello _____, my name is _____. I'm calling from Dr. Bedi's psychotherapy research lab at Western Washington University. I'm calling to follow up on the information you provided for the study on what male clients in counseling or psychotherapy understand to hinder or weaken the working relationship they have with their mental health professional. I'm going to share with you the words we used to summarize your experience and how it was sorted into a category with other similar incidents. I'd like to get your feedback on how well this reflects your experience. Do you have a few minutes to spend on this now?

If not, when would be a good time for me to call back? _____

If so, say to participant:

Now I will read to you a single sentence we used to describe what you wrote about on your questionnaire. These words may describe only what you wrote about or may describe what you and others who had similar experiences wrote about.

Read CI to participant, then ask the following questions. Record answers verbatim.

1. Does this accurately describe what happened that held back or weakened the working relationship with your counselor or psychotherapist? Y / N

Comments: _____

2. In the sentence describing your experience, is anything missing? Y / N

Comments: _____

3. In the sentence describing your experience, is there anything that needs to be changed?

Y / N

Comments: _____

4. Do you have any other comments?

Read to client:

The experience that you wrote about and the experiences that other participants wrote about have been sorted into groups. This is to show different ways that those experiences held back or weakened the working relationships that men had with their counselors or psychotherapists. Each group, called a category, has been given its own name to describe what kinds of experiences are in that category.

Read list of category names to participant.

5. Do the category names make sense to you? (If they don't, include explanation.) Y / N

Comments: _____

Tell participant:

The sentence describing your experience was sorted into the category named

_____.

6. Does the name of the category your experience was sorted into capture your experience and the meaning it had for you? Y / N

Comments: _____

7. If your experience does not seem to fit in this category, in which other category do you think it belongs? (You may need to reread the participant the list of category names).

Tell participant: Now I will read the category names to you one at a time and ask you to assign a rating to each. Please indicate how much this type of event harmed or weakened the working relationship you have or had with your most recent mental health professional. The scale ranges from 0 to 5; a rating of 0 means that type of event was helpful or positive to your working relationship, 1 means that type of event was not damaging or had no effect, 2 means that type of event was slightly damaging, 3 means it was moderately damaging, 4 means very damaging, and 5 means extremely damaging. Again, please rate each item I read on a scale from 0 (*this was helpful or positive to the working relationship with my mental health professional*) to 5 (*this was extremely damaging to our working relationship*).

Not the Right Fit

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Counselor/Psychotherapist Characteristics and Behavior

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Communication Difficulties

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Unprofessional Mistakes

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Need to Build Trust

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

No Choice

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Unsure of Therapy/Therapist

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Client Not Putting in Work

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Not Doing His/Her Job

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Counselor/Psychotherapist Presuming

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Pushy Counselor/Psychotherapist

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Time Problems

0.....	1.....	2.....	3.....	4.....	5.....
helpful or positive	not damaging/ no effect	slightly damaging	moderately damaging	very damaging	extremely damaging

Thank you for your time. We'll use your feedback to help make sure that we've honestly and clearly represented your experiences and the experiences of other men in this study.

Appendix U

Detailed Comparison of Coders' Sorts

The initial categorization structures of the primary researcher coders were similar, but differed in some notable ways. To distinguish between the coders' structures, from here on out they will be referred to as Coder A and Coder B. The coders had several categories with moderate to considerable thematic and content overlap, as indicated by the category titles and descriptions. The coders also had other categories with overlapping CIS's.

The descriptions of Coder A's category Had to Do Something and Coder B's category Lack of Choice in Counselor/Psychotherapist both refer to the client being forced to do something. They show that the client had no say in a major element of psychotherapy. Additionally, these categories contain exactly the same CIS's. In title, description, and structure, these are the most similar categories between the two coders.

Coder A's categories of Counselor/Psychotherapist Didn't Do Something and Unsolved Issues and Coder B's categories of Counselor/Psychotherapist Not Responsive to Client and Not Addressing Issues are amongst the most similar across the two coders. These four category titles suggest that the counselor/psychotherapist is being assigned responsibility and their descriptions show that they point to the client or the client's issues not getting proper attention. Throughout these four categories' descriptions, the counselor/psychotherapist is described as not being aware of or responding to the client's needs; thus the counselor/psychotherapist was seemingly ineffective at helping the client. As in the Unsolved Issues and Not Addressing Issues categories, this may involve not getting at the client's issues or veering off topic. The two categories of Coder B's that contain the most similar CIS's to Coder A's category of Counselor Didn't Do Something are Counselor/Psychotherapist Not Responsive to Client and Not

Addressing Issues. These two categories of Coder B contain seven of the 10 incidents in Coder A's category. Coder B's categories Counselor/Psychotherapist Not Responsive to Client and Not Addressing Issues also have some overlap with Coder A's Unsolved Issues.

Coder A's category of Client Not Opening Up is similar to Coder B's category of Client Holding Back in that the titles similarly indicate the client not opening up as a form of holding back. These categories describe the client not talking about certain information, being reluctant to open up, and withholding information from the counselor/psychotherapist. While the titles and descriptions of these categories highlight a thematic similarity between them, they also contain many different CIS's.

Coder A's category of Counselor/Psychotherapist Characteristics and Behavior is similar to Coder B's categories of Counselor/Psychotherapist Forthright and Counselor/Psychotherapist Openly Emotional. These three categories' titles share a theme of describing the characteristics of the counselor/psychotherapist. In their descriptions, the counselor/psychotherapist is variously described as formal, emotional, straight forward, and not personable. Most similar in critical incident content to Coder A's category of Counselor's Characteristics is Coder B's category of Counselor/Psychotherapist Forthright, containing four of the seven incidents in Coder A's category.

Coder A's category of Uncertainty and Coder B's category of Client Not Trusting Counselor/Psychotherapist describe similar misgivings of the client. The client is uncertain about elements of psychotherapy and unsure whether to trust the words and guidance of the counselor/psychotherapist. These categories also share considerable CIS overlap.

Both Coder A's category of Time and Coder B's category of Time Constraints describe issues of time, as clearly indicated by the titles. Similar language is used in their descriptions,

such as the phrase “limited time for client/session.” The CIS’s in Coder A’s Time are subsumed under Coder B’s Time Constraints, which also contains two additional statements that Coder A sorted into Overpowering Counselor.

Coder A’s category I Didn’t Do Something and Coder B’s category Client Resisting Process both contain incidents related to the client not fully engaging and participating in counseling/psychotherapy. Coder B’s Client Resisting Process contains two of the three CIs from Coder A’s I Didn’t Do Something, along with several other incidents.

Coder A’s categories of Counselor/Psychotherapist Seeming Something Else Is Important and Interesting Questions at the Wrong Time are like Coder B’s category of Counselor/Psychotherapist Not Respectful of Client in that similar language is used within their descriptions. Interesting Questions at the Wrong Time was like Counselor/Psychotherapist Not Respectful of Client because they both mention poor timing of questions.

Counselor/Psychotherapist Not Respectful of Client is also like Counselor/Psychotherapist Seeming Something Else Is Important because they imply the counselor/psychotherapist is not focusing on the client, not respecting the client, or is indicating something else has priority over the client. Similar phrases such as “devalues client’s time” and “not giving them the time” appear in their descriptions. There are some similarly coded incidents in these categories: Coder B’s category of Counselor/Psychotherapist Not Respectful of Client contains two of the three incidents in Coder A’s Counselor Seeming Something Else Is Important, along with several other incidents.

Coder A’s category of Greed and Coder B’s category of Money Issues both center on a theme of money. Both categories describe the client being concerned with issues related to

paying for services from the counselor/psychotherapist. Additionally, they share two incident statements, 4 and 39.

Each coder also has categories that are not like any of the other's categories. With the categories of Telling Client Something They Don't Want to Hear, Honesty, Overpowering Counselor/Psychotherapist, Counselor Is a Woman, and Mistakes, Coder A conceptually grouped some incidents differently than Coder B. Telling Client Something They Don't Want to Hear is both thematically unique and different in what critical incidents it contains (these five incidents were sorted into four different categories by Coder B). Coder B's Impersonal Relationship and Communication Difficulties center on different concepts than any of Coder A's categories. The two incidents sorted into Counselor Is a Woman by Coder A were sorted into separate and unrelated categories by Coder B. None of the three incidents in Coder A's Honesty were sorted together by Coder B. Only two of the incidents in Coder A's Overpowering Counselor/Psychotherapist were sorted together by Coder B (in Time Constraints).

Coder A has more categories that contain only one incident. These single statement categories are Greed (statement 4), Interesting Questions at the Wrong Time (statement 10), and Mistakes (statement 25). The only single statement category for Coder B is Counselor/Psychotherapist Openly Emotional (statement 38).

Appendix V

Detailed Comparison of Participants' Sorts

There were several similarities in how the participants constructed, labeled, and described their categories. For example, the first participant's category Not the Right Fit of Personalities was similar to one of the third participant's categories (I Am in the Wrong Place) and several of the second participant's categories thematically. They all addressed the need for the client and counselor/psychotherapist to have approaches or personalities that are well-matched. Similar phrases in category descriptions included "counselor has mismatched approach/personality for client" from the first participant, "client needed someone engaging in a different way" from the second participant, and "not individualized, one-size fits all" from the third participant. At the CIS level, Not the Right Fit of Personalities overlapped with four of the second participant's categories (I Did Not Trust the Counselor, Mismatched Personalities, Inconsiderate, and Not Comfortable) and three of the third participant's categories (I Am in the Wrong Place, Not on the Same Page, and My Heart Is Not in It).

Another pair of similarly themed categories was the first participant's Closed-minded Approach/Ignorant Client and the second participant's Patient Ignorant. In addition to the similarity of the category titles, the phrase "patient doesn't understand why it needs to happen, therapist didn't explain" from one participant's category description could related to "client...is not open to the language of psychology" from the other participant's category description. They both seem to highlight the client's lack of familiarity with the therapeutic process. In both cases, the counselor/psychotherapist does not appear to be communicating about the process in a way that makes sense to the client. The third participant did not share a thematically similar category.

Another similar pair of categories was Too Soon to Be Helpful from the first participant and Timing of Questions from the second participant. The phrase “timing of questions that catch our attention can have an adverse effect on relationship” from the second participant’s category description is similar to “too soon to be helpful...too soon/before it’s really there” from the other participant’s category. The second participant’s category contained only one statement, so it may represent a small part of the larger concept represented by the first participant’s category; they both appear related to timing of psychotherapeutic interventions.

Several small categories of the second participant—Hindering Communication, I Don’t Feel Like I’m Being Heard, and Hurt Feeling—could be subsumed under one larger category of the first participant’s—Communication Glitches/Problems. As suggested by their titles, these categories relate to the harm done by miscommunication between the client and the counselor/psychotherapist. The phrases “can’t have counseling without speaking the same language” from the second participant’s category description and “client not clearly hearing approach of counselor/psychotherapist” from the first participant’s category description capture the element of miscommunication. The following phrases describe the resulting harm: “client feeling personally attacked by a counselor” (from the first participant), “counselor did something that hurt client’s feelings” (from the second participant), and “when a client doesn’t feel like they are being heard it upsets them” (also from the second participant). At the CIS level, two of the third participant’s categories can be tied to this group of categories. Not on the Same Page and My Heart Is Not in It hold five CIS’s in common with the first participant’s Communication Glitches/Problems. Additionally, My Heart Is Not in It shares two CIS’s with the second participant’s Hurt Feeling and two statements with I Don’t Feel like I’m Being Heard.

Another example of thematically similar categories between all three participants follows. One category of the first participant's (Unprofessional Mistakes/Habits) was similar to one of the third participant's (Oh No, Not Again) and a few of the second participant's (Wrong/Unprofessional/Illegal, Therapist Not Sensitive Enough, and Inconvenienced). Wrong/Unprofessional/Illegal has a similar title to Unprofessional Mistakes/Habits, and both of these category descriptions put the responsibility for the incident on the counselor/psychotherapist. The word "mistakes" appeared in the descriptions of both Inconvenienced and Unprofessional Mistakes/Habits. Similar phrases between category descriptions were "not business savvy" and "what makes people uncomfortable, no one will want to go there" from the second participant, "mistakes made by counselor which may hurt future relationship with client" from the first participant, and "early signs that you're going in a different direction that won't work" from the third participant. At the CIS level, Wrong/Unprofessional/Illegal is similar to Unprofessional Mistakes/Habits. As a whole, these categories appear to refer to actions taken by the counselor/psychotherapist that are perceived by the client as errors.

There is further evidence of commonality between the participants' sorts. Need to Build Trust/Issues Opening up to Others from the first participant is like a few categories of the second participant (Difficulty Facing Certain Things, I Did Not Trust the Counselor, and Fear). The first and second participant's categories had similar category descriptions; for example "need for client to be more trusting of others" from the first participant is like "lack of trust between counselor/psychotherapist and client" from the second participant, and "client avoiding conflict resolution" from the second participant is like "wall put up by client when approaching difficult subjects" from the first participant. Difficulty Facing Certain Things and Need to Build

Trust/Issues Opening up to Others also shared a couple of CIS's. The third participant's category of Not on the Same Page also has some overlap with these categories. While it does not share a clear thematic match through title or category description with the others, it shares some similarly sorted CIS's with the other participants' categories here.

Another of the first participant's categories (Client Not Ready for Psych Therapy) was similar to two of the third participant's categories (My Heart Is Not in It and Blame) as well as two of the second participant's categories (Doesn't Really Want to Be There and Not Comfortable). There was considerable CIS overlap between Blame and Client Not Ready for Psych Therapy; some incidents from My Heart Is Not in It were also shared with this category. The phrase "client has an inability to let go of personal secrets" from the first participant was like "client's fault for not talking about issues" from the third participant and from the second participant "when a client is not comfortable it hinders therapeutic process because [of] all [the] info that is withheld." Also, the phrase "client...not ready to put in the work it takes to move forward with counseling" from the first participant is like "patient doesn't want to be in session, doesn't take sessions seriously" from the second participant and from the third participant "concerns the client doesn't want to go with it...you lose faith in it." These categories all pertain to the client not opening up to the counselor/psychotherapist about important issues and how this hinders the client's ability to make progress in psychotherapy.

One of the third participant's categories (Exit-Stage Right) was like two of the second participant's categories (Not Doing His Job and I Believe We Should Talk About What I Want). From the third participant's description, "counselor/psychotherapist [is] not giving [the] client anything...nothing [is] being solved, so why be there...client has a reason to leave because [the] counselor/psychotherapist [is] not giving something" is like "shouldn't be a counselor, lack

proper training to help clients” and “patient feels that counselor/psychotherapist has an inability to bring up subject matter,” both from the second participant’s descriptions. These categories assign responsibility to the counselor/psychotherapist for bringing up important issues and helping the client to make psychotherapeutic progress; they imply it is the client’s right to receive these services.

Another pair of similar categories is the second participant’s Presumptuous and the third participant’s This Is Not a Two Way Street. Although these do not share any similarly sorted critical incidents, they do share similar category descriptions. “[It’s] not right to presume things that may be wrong about the client” from the second participant is similar to “[the] counselor [is] telling [the] client things they don’t want to hear, [the] client...should have some say” from the third participant. These categories protest the counselor/psychotherapist pushing her/his ideas on the client without giving the client a chance to voice his perspective.

One of the third participant’s categories (Rude Counselor) relates to a few of the second participant’s categories (Controlling, Unreasonable, and Inconsiderate). While the third participant’s category only has one incident and the second participant’s categories are also quite small, there seems to be a theme of client dissatisfaction with the counselor’s manner running throughout them. This can be seen in the similarity of the category titles as well as similarity in category descriptions. “[When the] patient feels controlled by [the] counselor/psychotherapist, it causes a shut down and causes dis-cooperation” from the third participant’s category is like “counselor has a big ego, [is] delusional, has power” from the second participant. These categories point to disempowerment of the client and a feeling that the counselor/psychotherapist is abusing her/his position of power.

There is additional overlap in how certain CIS's were sorted together that does not become apparent until the categories are analyzed at the statement level. For example, both the second and third participants each have several smaller categories that together form a CIS grouping similar to one larger category of the first participant. The second participant sorted statements 48, 15, and 23 together (Time Problems), statements 40, 6, and 39 together (Wrong/Unprofessional/Illegal), and statements 52 and 14 together (Therapist Not Sensitive Enough); the first participant sorted all of these together with a few other incidents in Unprofessional Mistakes/Habits. The third participant sorted together statements 40 and 52 (Oh No Not Again), statements 15, 48, and 14 (I Am in the Wrong Place), statements 53 and 25 (Not on the Same Page), as well as statements 4, 26, and 39 (My Heart Is Not in It); again, all of these incidents were found in the first participant's Unprofessional Mistakes/Habits.

In many cases, while CIS's were sorted together by multiple participants, the connection between the statements is not necessarily apparent. For example, statements 17 ("The counselor/psychotherapist put me off [e.g., we were interrupted by his/her cell phone calls, the counselor/psychotherapist told me 'I have a lot going on right now with other clients'].") and 45 ("The counselor/psychotherapist was a woman who wore tight clothing.") were sorted together by all three participants. On the surface there is no apparent connection between them through a researcher's/practitioner's lens, yet the participants saw them as related enough to fall in the same category. The three categories these statements were respectively placed in by participants were named Not the Right Fit of Personalities, Inconsiderate, and I Am in the Wrong Place.

Even given all the above similarities between the participants' sorts, there were also several differences in how participants named and described their categories. For example, the second participant had several categories that did not relate thematically to either of the other

participant sorts. These were Time Problems, Emotionally Unattached/Unwilling Emotionally, Ungenuine, and Therapist Dissatisfaction. Also, the second participant had many more categories with only one incident (15) than the other two participants put together (zero for the first and one for the third). Another singularity in the three participants' sorts is that the third participant had a significant order for most of his categories. The order was as follows: 1) Oh No Not Again, 2) I Am in the Wrong Place, 3) This Is Not a Two Way Street, 4) Not on the Same Page, 5) My Heart Is Not in It, 6) Rude Counselor, 7) Exit – Stage Right. He said that his eighth category of Blame could come in anywhere in this sequence. The participant described his categories as steps of a process, having consequences and most likely leading up to the client leaving counseling.

At the CIS level, there were also differences between the participants' sorts. Each of statements 4 ("The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent."), 5 ("I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence."), and 6 ("The counselor/psychotherapist had people watch one of my sessions when he/she said no one was going to watch.") were not sorted with similar incidents by any two participants. This would seem to indicate the participants have a very different understanding of the meaning of these incidents. In the second participant's sort, statements 51, 27, and 20 were sorted together in the category Fear. None of these items were sorted together by the other participants. In the second participant's sort, statements 2 and 30 were sorted together in the category Controlling. These items were not sorted together by the other participants. In the second participant's sort, statements 56 and 22 were placed together in Not Doing His Job. These statements were not sorted together by any other participant. In the

first participant's sort, statements 30, 41, and 20 were placed together under Closed-minded Approach. In no other sort were any of these statements sorted together.

Appendix W

Participants' Individual Categorization Structures

Table W1

Participant 1 Category Names, Descriptions, and Incident Content

Category Name	Category Description	Critical Incidents
Closed-Minded Approach/Ignorant Client (Number of CISs = 3)	client has past maternal issues and is not open to the language of psychology	30 The counselor/psychotherapist pressured me to bring my mother to a session. 41 I felt that my counselor/psychotherapist couldn't "know" how I felt/thought because she was a woman who had undergone child bearing. 20 My attitude about previous counselors/psychotherapists was not positive, so I assumed the worst about my counselor/psychotherapist before I met him/her.
Communication Glitches/ Problems (Number of CIs = 8)	client feeling personally attacked by counselor, client not clearly hearing approach of counselor/psychotherapist	49 The counselor/psychotherapist asked me to move my dirty shoe off his/her couch. 11 The counselor/psychotherapist put words in my mouth (i.e., told me what I felt/thought). 16 I had a hard time understanding the counselor/psychotherapist because of a language barrier.
{Too Soon to Be} Helpful-Connecting Techniques (Number of CISs = 6)	counselor cares too much, reaching out for a connection too soon/ before it's really there	44 I had to switch to a new counselor/psychotherapist

10 The counselor/psychotherapist asked a thought-provoking question as I was walking out the door.

34 The counselor/psychotherapist and I spent too much time having conversations not related to solving my issues (e.g. talking about cats, talking about TV, other tangents the counselor/psychotherapist went off on).

38 The counselor/psychotherapist began to cry.

28 There was not enough time for the session (i.e. we didn't get the work done that I expected).

2 The counselor/psychotherapist walked me from where I was sitting in the reception area to the door of his/her office.

Unprofessional
Mistakes/Habits

(Number of CISs = 12)

small mistakes made by counselor which may hurt future relationship with client, hindsightedness by counselor/psychotherapist.

4 The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent.

14 Prior to any session, the counselor/psychotherapist sent me an e-mail asking me to sign an agreement that I would pay for a session if I didn't show up.

6 The counselor/psychotherapist had people watch one of my sessions when he/she said no one was going to watch.

39 The counselor/psychotherapist insisted that we continue sessions even though there was no way I could pay for it (and I accumulated huge debt).

48 The counselor/psychotherapist hurried me (e.g., through questions, in conversation).

15 Sometimes the counselor/psychotherapist would not take my calls.

52 I had to wait longer than I felt I should have to see the counselor/psychotherapist.

40 I was forced to see a counselor/psychotherapist.

53 The counselor/psychotherapist would avoid eye contact with me, looking away or directly over my head.

25 The counselor/psychotherapist wrote down the wrong time on his/her calendar/my appointment card.

23 The counselor/psychotherapist repeatedly pointed out the time

26 The counselor/psychotherapist suggested that his/her way - his/her philosophies and method of healing - were the only way that would work.

Client Not Ready for Psych. Therapy.
(Number of CISs = 8)

client has an inability to let go of personal secrets, not ready to put in the work it takes to move forward with counseling.

22 I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues.

8 The counselor/psychotherapist did not elicit more explanatory responses from me pertaining to my issues.

9 I had something to talk about, and we didn't talk about it.

37 I put off or simply ignored advice and suggestions from my counselor/psychotherapist.

<p>Not the Right Fit of Personalities (Number of CISs = 13)</p>	<p>counselor has mismatched approach/personality for client</p>	<p>27 The counselor/psychotherapist accused me of doing something wrong.</p> <p>54 I lied about the duration of time between stressful events and my behaviors.</p> <p>18 I failed to make it to a few sessions.</p> <p>33 The counselor/psychotherapist drew a picture of the damage and destruction my issues were causing to others.</p> <hr/> <p>7 I thought the counselor/psychotherapist might have misdiagnosed me and so be trying treatment that was ineffective.</p> <p>36 The counselor/psychotherapist and I did "weird" exercises to address my issues that I felt were a waste of time.</p> <p>21 The counselor/psychotherapist did not agree with me.</p> <p>45 The counselor/psychotherapist was a woman who wore tight clothing.</p> <p>32 The counselor/psychotherapist had a stoic nature (i.e. very staunch and formal, not very personable, straight to business).</p> <p>29 I felt my relationship with my counselor/psychotherapist was formal and rigid.</p> <p>24 I was unable to bring up a subject because it seemed to conflict with earlier things I had told the counselor/psychotherapist.</p> <p>3 I was not sure if the counselor/psychotherapist was telling me the truth.</p>
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47 The counselor/psychotherapist asked questions that I felt weren't important.

13 The counselor/psychotherapist never really related to my issues by talking about his/her own.

56 The counselor/psychotherapist did not give answers that could help me overcome and achieve personal goals.

5 I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence.

17 The counselor/psychotherapist put me off (e.g., we were interrupted by his/her cell phone calls, the counselor/psychotherapist told me "I have a lot going on right now with other clients").

Need to Build Trust/
Issues Opening- Up to
Others

(Number of CISs = 6)

need for client to be more trusting of others, wall put up by client when approaching difficult subjects

51 When I came into counseling/psychotherapy, I wasn't sure I wanted to be there and was uptight.

55 I admitted a lot of information, but there were things I didn't want to acknowledge

50 In the first few sessions, I was a bit reluctant to open up.

42 A subject came up that I didn't like to talk about/wasn't comfortable talking about.

19 I did not want to have somebody tell me what was wrong or what my issues were.

46 The counselor/psychotherapist had me write down information I didn't want to reveal.

12 The counselor/psychotherapist did not give me enough information about plans for continued therapy.

43 The counselor/psychotherapist suggested medication and did not offer another alternative.

31 The counselor/psychotherapist wouldn't change my medication.

35 I got the same advice several times, and I did not feel anything was solved.

1 The counselor/psychotherapist had limited availability.

Table W2

Participant 2 Category Names, Descriptions, and Incident Content

Category Name	Category Description	Critical Incidents
Not Doing His Job (Number of CISs = 2)	Shouldn't be a counselor/psychotherapist, lack proper training to help clients	56 The counselor/psychotherapist did not give answers that could help me overcome and achieve personal goals. 22 I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues.
Unreasonable (Number of CIs = 1)	Counselor has a big ego, delusional, has power	26 The counselor/psychotherapist suggested that his/her way - his/her philosophies and method of healing - were the only way that would work.

Timing of Questions (Number of CISs = 1)	Sometimes questions that catch our attention can have an adverse effect on relationship between counselor/psychotherapist and client	10 The counselor/psychotherapist asked a thought-provoking question as I was walking out the door.
Disconnect in Understanding (Number of CISs = 1)	Description of categories positive or negative, helps to pair a client with a counselor/psychotherapist with an experience similar to client.	41 I felt that my counselor/psychotherapist couldn't "know" how I felt/thought because she was a woman who had undergone child bearing.
I Believe We Should Talk About What I Want. (Number of CISs = 1)	patients feel that counselor/psychotherapist has an inability to bring up subject matter	9 I had something to talk about, and we didn't talk about it.
I Did Not Trust the Counselor (Number of CISs = 4)	these instances damage was done by a lack of trust between counselor/psychotherapist and client	37 I put off or simply ignored advice and suggestions from my counselor/psychotherapist. 50 In the first few sessions, I was a bit reluctant to open up. 3 I was not sure if the counselor/psychotherapist was telling me the truth. 47 The counselor/psychotherapist asked questions that I felt weren't important.
Important to Client and Didn't Happen (Number of CISs = 1)	Counselor didn't agree with client that developed feelings that hurt the client. Subject matter that's important to the client.	21 The counselor/psychotherapist did not agree with me.
Time Problems (Number of CISs = 5)	People communicate in the medium of time and excess of time conflict interferes.	48 The counselor/psychotherapist hurried me (e.g., through questions, in conversation).

		<p>28 There was not enough time for the session (i.e. we didn't get the work done that I expected).</p> <p>1 The counselor/psychotherapist had limited availability.</p> <p>15 Sometimes the counselor/psychotherapist would not take my calls.</p> <p>23 The counselor/psychotherapist repeatedly pointed out the time.</p>
<p>Not Comfortable Engaging (Number of CISs = 1)</p>	<p>Client needed someone engaging in a different way</p>	<p>5 I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence.</p>
<p>Patient Ignorant (Number of CISs = 1)</p>	<p>patient doesn't understand why it needs to happen, therapist didn't explain</p>	<p>46 The counselor/psychotherapist had me write down information I didn't want to reveal.</p>
<p>Therapist Not Sensitive Enough (Number of CISs = 3)</p>	<p>minimize what makes people uncomfortable, no one will want to go there if you don't have a good vibe, not business savvy</p>	<p>33 The counselor/psychotherapist drew a picture of the damage and destruction my issues were causing to others.</p> <p>52 I had to wait longer than I felt I should have to see the counselor/psychotherapist.</p> <p>14 Prior to any session, the counselor/psychotherapist sent me an e-mail asking me to sign an agreement that I would pay for a session if I didn't show up.</p>
<p>Difficulty Facing Certain Things (Number of CISs = 2)</p>	<p>detrimental to helpfulness of therapy, client avoiding conflict resolution</p>	<p>55 I admitted a lot of information, but there were things I didn't want to acknowledge.</p> <p>19 I did not want to have somebody tell me what was wrong or what my issues were.</p>

Hurt Feeling (Number of CISs = 2)	counselor did something that hurt client's feelings	49 The counselor/psychotherapist asked me to move my dirty shoe off his/her couch. 4 The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent.
Ungenuine (Number of CIs = 1)	Felt counselor/psychotherapist was being ungentle	38 The counselor/psychotherapist began to cry.
Mismatched Personalities (Number of CISs = 2)	certain personalities lend themselves to working well together	32 The counselor/psychotherapist had a stoic nature (i.e. very staunch and formal, not very personable, straight to business). 29 I felt my relationship with my counselor/psychotherapist was formal and rigid.
Hindering Communication (Number of CISs = 1)	can't have counseling without speaking the same language	16 I had a hard time understanding the counselor/psychotherapist because of a language barrier.
Inconsiderate (Number of CISs = 4)	business is feelings, you need to be considerate of your clients feelings	45 The counselor/psychotherapist was a woman who wore tight clothing. 12 The counselor/psychotherapist did not give me enough information about plans for continued therapy. 34 The counselor/psychotherapist and I spent too much time having conversations not related to solving my issues (e.g. talking about cats, talking about TV, other tangents the counselor/psychotherapist went off on). 17 The counselor/psychotherapist put me off (e.g., we were interrupted by his/her cell phone calls, the counselor/psychotherapist told me "I have a lot going on right now with other clients").

Therapist Dissatisfaction (Number of CISs = 1)	dissatisfaction of counselor/psychotherapist, client switches to another. Might be afraid of new counselor/psychotherapist	44 I had to switch to a new counselor/psychotherapist.
I Don't Feel Like I'm Being Heard (Number of CISs = 3)	when a client doesn't feel like they are being heard it upsets them making counselor's/psychotherapist's job harder	8 The counselor/psychotherapist did not elicit more explanatory responses from me pertaining to my issues. 35 I got the same advice several times, and I did not feel anything was solved. 36 The counselor/psychotherapist and I did "weird" exercises to address my issues that I felt were a waste of time.
Presumptuous (Number of CISs = 1)	not right to presume things that may be wrong about the client.	11 The counselor/psychotherapist put words in my mouth (i.e., told me what I felt/thought).
Emotionally Unattached Unwilling Emotionally (Number of CISs = 1)	important to connect on an emotional title because discussing emotional topics, need to respond emotionally	53 The counselor/psychotherapist would avoid eye contact with me, looking away or directly over my head.
Fear (Number of CISs = 3)	fear can get in the way of facing things you're there to face and in the way of gaining resolution to problems/ better life	51 When I came into counseling/psychotherapy, I wasn't sure I wanted to be there and was uptight. 27 The counselor/psychotherapist accused me of doing something wrong. 20 My attitude about previous counselors/psychotherapists was not positive, so I assumed the worst about my counselor/psychotherapist before I met him/her.
Doesn't Really Want To Be There	patient doesn't want to be in session, doesn't take sessions seriously	18 I failed to make it to a few sessions.

(Number of CISs = 1)		
Psychology is a Limited Science (Number of CISs = 1)	tell patient you're crazy and we're right, when patient is not confident they're being treated properly	7 I thought the counselor/psychotherapist might have misdiagnosed me and so be trying treatment that was ineffective.
Controlling (Number of CISs = 2)	When a patient feels controlled by counselor/psychotherapist, it causes a shut down and causes dis-cooperation	2 The counselor/psychotherapist walked me from where I was sitting in the reception area to the door of his/her office. 30 The counselor/psychotherapist pressured me to bring my mother to a session.
Not Comfortable (Number of CISs = 4)	When client is not comfortable it hinders therapeutic process because all information that is withheld	54 I lied about the duration of time between stressful events and my behaviors. 24 I was unable to bring up a subject because it seemed to conflict with earlier things I had told the counselor/psychotherapist. 42 A subject came up that I didn't like to talk about/wasn't comfortable talking about. 13 The counselor/psychotherapist never really related to my issues by talking about his/her own.
Wrong Unprofessional Illegal (Number of CISs = 5)	Fucked Up! When people have control over you it's messed up. Respect the value of human life when you mess with it.	40 I was forced to see a counselor/psychotherapist. 6 The counselor/psychotherapist had people watch one of my sessions when he/she said no one was going to watch. 31 The counselor/psychotherapist wouldn't change my medication.

		39 The counselor/psychotherapist insisted that we continue sessions even though there was no way I could pay for it (and I accumulated huge debt).
		43 The counselor/psychotherapist suggested medication and did not offer another alternative.
Inconvenienced (Number of CISs = 1)	the counselor/psychotherapist should be able to minimize inconvenience, not make mistakes, be on point	25 The counselor/psychotherapist wrote down the wrong time on his/her calendar/my appointment card.

Table W3

Participant 3 Category Names, Descriptions, and Incident Content

Category Name	Category Description	Critical Incidents
Oh No Not Again (Number of CISs = 4)	early signs that you're going in a direction that won't work, counselor/psychotherapist goals diff than clients	40 I was forced to see a counselor/psychotherapist. 20 My attitude about previous counselors/psychotherapists was not positive, so I assumed the worst about my counselor/psychotherapist before I met him/her. 52 I had to wait longer than I felt I should have to see the counselor/psychotherapist. 2 The counselor/psychotherapist walked me from where I was sitting in the reception area to the door of his/her office.

I Am in the Wrong Place (Number of CIs = 10)	Counselor/psychotherapist has a system in place that doesn't work for client, not individualized, one-size fits all, form letter	15 Sometimes the counselor/psychotherapist would not take my calls.
		48 The counselor/psychotherapist hurried me (e.g., through questions, in conversation).
		17 The counselor/psychotherapist put me off (e.g., we were interrupted by his/her cell phone calls, the counselor/psychotherapist told me "I have a lot going on right now with other clients").
		13 The counselor/psychotherapist never really related to my issues by talking about his/her own.
		41 I felt that my counselor/psychotherapist couldn't "know" how I felt/thought because she was a woman who had undergone child bearing.
		1 The counselor/psychotherapist had limited availability.
		14 Prior to any session, the counselor/psychotherapist sent me an e-mail asking me to sign an agreement that I would pay for a session if I didn't show up.
		50 In the first few sessions, I was a bit reluctant to open up.
		45 The counselor/psychotherapist was a woman who wore tight clothing.
		51 When I came into counseling/psychotherapy, I wasn't sure I wanted to be there and was uptight.

Not on the Same Page
(Number of CISs = 14)

client thinking structured differently than counselor's/psychotherapist's, counselor not listening

46 The counselor/psychotherapist had me write down information I didn't want to reveal.

53 The counselor/psychotherapist would avoid eye contact with me, looking away or directly over my head.

9 I had something to talk about, and we didn't talk about it.

34 The counselor/psychotherapist and I spent too much time having conversations not related to solving my issues (e.g. talking about cats, talking about TV, other tangents the counselor/psychotherapist went off on).

55 I admitted a lot of information, but there were things I didn't want to acknowledge.

16 I had a hard time understanding the counselor/psychotherapist because of a language barrier.

25 The counselor/psychotherapist wrote down the wrong time on his/her calendar/my appointment card.

24 I was unable to bring up a subject because it seemed to conflict with earlier things I had told the counselor/psychotherapist.

32 The counselor/psychotherapist had a stoic nature (i.e. very staunch and formal, not very personable, straight to business).

11 The counselor/psychotherapist

<p>My Heart Is Not in It. (Number of CISs = 14)</p>	<p>personal likings to each other not working, concerns the client doesn't want to go with it. Different worries build in the process of counseling/psychotherapy. So many things pile up, you lose faith in it.</p>	<p>put words in my mouth (i.e., told me what I felt/thought). 21 The counselor/psychotherapist did not agree with me. 3 I was not sure if the counselor/psychotherapist was telling me the truth 42 A subject came up that I didn't like to talk about/wasn't comfortable talking about. 47 The counselor/psychotherapist asked questions that I felt weren't important.</p>
		<p>4 The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent. 26 The counselor/psychotherapist suggested that his/her way - his/her philosophies and method of healing - were the only way that would work. 12 The counselor/psychotherapist did not give me enough information about plans for continued therapy. 36 The counselor/psychotherapist and I did "weird" exercises to address my issues that I felt were a waste of time. 8 The counselor/psychotherapist did not elicit more explanatory responses from me pertaining to my issues. 29 I felt my relationship with my counselor/psychotherapist was formal and rigid.</p>

		31 The counselor/psychotherapist wouldn't change my medication.
		39 The counselor/psychotherapist insisted that we continue sessions even though there was no way I could pay for it (and I accumulated huge debt).
		5 I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence.
		38 The counselor/psychotherapist began to cry.
		30 The counselor/psychotherapist pressured me to bring my mother to a session.
		27 The counselor/psychotherapist accused me of doing something wrong.
		10 The counselor/psychotherapist asked a thought-provoking question as I was walking out the door.
		49 The counselor/psychotherapist asked me to move my dirty shoe off his/her couch.
Rude Counselor (Number of CISs = 1)	Counselor/psychotherapist is too frank, impersonal, could have said something a different way	23 The counselor/psychotherapist repeatedly pointed out the time.
Exit – Stage Right (Number of CISs = 3)	Counselor/psychotherapist not giving client anything so why am I here, nothing being solved, so why be there, try something else. Client has a reason to leave because counselor/psychotherapist not giving something	56 The counselor/psychotherapist did not give answers that could help me overcome and achieve personal goals.

		35 I got the same advice several times, and I did not feel anything was solved.
		44 I had to switch to a new counselor/psychotherapist.
<hr/>		
This is Not a Two Way Street (Number of CISs = 3)	Relationship has to be both ways, try to work with one another. Counselor/psychotherapist telling client things they don't want to hear, client has a right to be a part of treatment plan and should have some say. Pushing topics client was not ready for.	33 The counselor/psychotherapist drew a picture of the damage and destruction my issues were causing to others.
		19 I did not want to have somebody tell me what was wrong or what my issues were.
		43 The counselor/psychotherapist suggested medication and did not offer another alternative.
<hr/>		
Blame (Number of CISs = 7)	Not responsible, client's expectation wasn't met, wanted more faster, client blamed counselor for things that didn't happen. excuses for not showing up, clients fault for not talking about issues	22 I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues
		28 There was not enough time for the session (i.e. we didn't get the work done that I expected).
		37 I put off or simply ignored advice and suggestions from my counselor/psychotherapist.

54 I lied about the duration of time between stressful events and my behaviors.

18 I failed to make it to a few sessions.

7 I thought the counselor/psychotherapist might have misdiagnosed me and so be trying treatment that was ineffective.

6 The counselor/psychotherapist had people watch one of my sessions when he/she said no one was going to watch.

Appendix X

Coders' Individual Categorization Structures

Table X1

Coder A Category Names, Descriptions, and Incident Content

Category Name	Category Description	Critical Incidents
Counselor Didn't do something (Number of CISs = 10)	The counselor/psychotherapist is not giving, doing something to or for the client in and out of therapy	<p>9 I had something to talk about, and we didn't talk about it.</p> <p>13 The counselor/psychotherapist never really related to my issues by talking about his/her own.</p> <p>12 The counselor/psychotherapist did not give me enough information about plans for continued therapy.</p> <p>56 The counselor/psychotherapist did not give answers that could help me overcome and achieve personal goals.</p> <p>15 Sometimes the counselor/psychotherapist would not take my calls.</p> <p>31 The counselor/psychotherapist wouldn't change my medication.</p> <p>43 The counselor/psychotherapist suggested medication and did not offer another alternative.</p> <p>8 The counselor/psychotherapist did not elicit more explanatory responses from me pertaining to my issues.</p> <p>22 I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues.</p>

		7 I thought the counselor/psychotherapist might have misdiagnosed me and so be trying treatment that was ineffective.
Client not opening up (Number of CIs = 4)	The client didn't want to talk about something or reluctant to open up	46 The counselor/psychotherapist had me write down information I didn't want to reveal. 42 A subject came up that I didn't like to talk about/wasn't comfortable talking about. 50 In the first few sessions, I was a bit reluctant to open up. 55 I admitted a lot of information, but there were things I didn't want to acknowledge.
Unsolved Issues (Number of CISs = 4)	Not addressing client's issues by off topic issues, too much of the same advice or useless questions	36 The counselor/psychotherapist and I did "weird" exercises to address my issues that I felt were a waste of time. 34 The counselor/psychotherapist and I spent too much time having conversations not related to solving my issues (e.g. talking about cats, talking about TV, other tangents the counselor/psychotherapist went off on). 47 The counselor/psychotherapist asked questions that I felt weren't important. 35 I got the same advice several times, and I did not feel anything was solved.
Telling Client something they don't want to hear (Number of CISs = 5)	Telling client something about their issues or disagreeing with client that the client doesn't see as wrong	19 I did not want to have somebody tell me what was wrong or what my issues were. 21 The counselor/psychotherapist did not agree with me. 33 The counselor/psychotherapist drew a picture of the damage and destruction my issues were causing to others.

		27 The counselor/psychotherapist accused me of doing something wrong. 11 The counselor/psychotherapist put words in my mouth (i.e., told me what I felt/thought).
Counselor is a Woman (Number of CISs = 2)	Women are different than men in many aspects	41 I felt that my counselor/psychotherapist couldn't "know" how I felt/thought because she was a woman who had undergone child bearing. 45 The counselor/psychotherapist was a woman who wore tight clothing.
Had to do something (Number of CISs = 2)	Client did something they seemed not to have wanted to	44 I had to switch to a new counselor/psychotherapist. 40 I was forced to see a counselor/psychotherapist.
Counselor seeming something else is important (Number of CISs = 3)	Not giving the client the time for them during/ for their session.	17 The counselor/psychotherapist put me off (e.g., we were interrupted by his/her cell phone calls, the counselor/psychotherapist told me "I have a lot going on right now with other clients"). 52 I had to wait longer than I felt I should have to see the counselor/psychotherapist. 53 The counselor/psychotherapist would avoid eye contact with me, looking away or directly over my head.
Greed (Number of CISs = 1)	Counselor/psychotherapist wants money for a service you would think would be for free	4 The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent.
Counselor's Characteristics (Number of CISs = 7)	Counselor/psychotherapist is emotional, rigid, formal, over confident, not personable, clean	29 I felt my relationship with my counselor/psychotherapist was formal and rigid. 38 The counselor/psychotherapist began to cry.

		<p>32 The counselor/psychotherapist had a stoic nature (i.e. very staunch and formal, not very personable, straight to business).</p> <p>5 I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence.</p> <p>2 The counselor/psychotherapist walked me from where I was sitting in the reception area to the door of his/her office.</p> <p>14 Prior to any session, the counselor/psychotherapist sent me an e-mail asking me to sign an agreement that I would pay for a session if I didn't show up.</p> <p>49 The counselor/psychotherapist asked me to move my dirty shoe off his/her couch.</p>
Honesty (Number of CISs = 3)	Client lying or not telling the whole truth, or counselor/psychotherapist lying.	<p>24 I was unable to bring up a subject because it seemed to conflict with earlier things I had told the counselor/psychotherapist.</p> <p>54 I lied about the duration of time between stressful events and my behaviors.</p> <p>6 The counselor/psychotherapist had people watch one of my sessions when he/she said no one was going to watch.</p>
Overpowering Counselor (Number of CISs = 5)	Counselor/psychotherapist is pressuring, forcing, insisting, repeatedly telling or asking the client something.	<p>26 The counselor/psychotherapist suggested that his/her way - his/her philosophies and method of healing - were the only way that would work.</p> <p>23 The counselor/psychotherapist repeatedly pointed out the time.</p> <p>39 The counselor/psychotherapist insisted that we continue sessions even though there was no way I could pay for it (and I accumulated huge debt).</p>

		30 The counselor/psychotherapist pressured me to bring my mother to a session.
		48 The counselor/psychotherapist hurried me (e.g., through questions, in conversation).
Uncertainty (Number of CISs = 3)	Client unsure about elements of counseling/psychotherapy	3 I was not sure if the counselor/psychotherapist was telling me the truth. 51 When I came into counseling/psychotherapy, I wasn't sure I wanted to be there and was uptight. 20 My attitude about previous counselors/psychotherapists was not positive, so I assumed the worst about my counselor/psychotherapist before I met him/her.
Interesting Questions @ the wrong Time (Number of CISs = 1)	as the client leaves they are asked questions that seem important	10 The counselor/psychotherapist asked a thought-provoking question as I was walking out the door.
Mistakes (Number of CISs = 1)	Counselor/psychotherapist gave client wrong information by mistake	25 The counselor/psychotherapist wrote down the wrong time on his/her calendar/my appointment card.
Time (Number of CISs = 2)	Counselor/psychotherapist had limited time for client	1 The counselor/psychotherapist had limited availability. 28 There was not enough time for the session (i.e. we didn't get the work done that I expected).
I didn't do something (Number of CISs = 3)	Client not fully participating in counseling/psychotherapy	18 I failed to make it to a few sessions. 37 I put off or simply ignored advice and suggestions from my counselor/psychotherapist. 16 I had a hard time understanding the counselor/psychotherapist because of a language barrier.

Table X2

Coder B's Category Names, Descriptions, and Incident Content

Category Name	Category Description	Critical Incidents
Counselor/Psychotherapist Forthright (Number of CISs = 6)	Counselor/psychotherapist was straightforward, got down to business, made direct requests or observations	<p>27 The counselor/psychotherapist accused me of doing something wrong.</p> <p>33 The counselor/psychotherapist drew a picture of the damage and destruction my issues were causing to others.</p> <p>14 Prior to any session, the counselor/psychotherapist sent me an e-mail asking me to sign an agreement that I would pay for a session if I didn't show up.</p> <p>32 The counselor/psychotherapist had a stoic nature (i.e. very staunch and formal, not very personable, straight to business).</p> <p>49 The counselor/psychotherapist asked me to move my dirty shoe off his/her couch.</p> <p>5 I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence.</p>
Client Holding Back (Number of CIs = 3)	Client withholding information from counselor/psychotherapist	<p>50 In the first few sessions, I was a bit reluctant to open up.</p> <p>55 I admitted a lot of information, but there were things I didn't want to acknowledge.</p> <p>24 I was unable to bring up a subject because it seemed to conflict with earlier things I had told the counselor/psychotherapist.</p>

<p>Client Not Trusting Counselor/Psychotherapist (Number of CISs = 4)</p>	<p>Client doesn't trust counselor/psychotherapist to be competent, honest, understanding, etc.</p>	<p>41 I felt that my counselor/psychotherapist couldn't "know" how I felt/thought because she was a woman who had undergone child bearing.</p> <p>3 I was not sure if the counselor/psychotherapist was telling me the truth.</p> <p>7 I thought the counselor/psychotherapist might have misdiagnosed me and so be trying treatment that was ineffective.</p> <p>20 My attitude about previous counselors/psychotherapists was not positive, so I assumed the worst about my counselor/psychotherapist before I met him/her.</p>
<p>Difference of Opinion (Number of CISs = 2)</p>	<p>Client and counselor/psychotherapist disagree about some aspect of treatment</p>	<p>21 The counselor/psychotherapist did not agree with me.</p> <p>26 The counselor/psychotherapist suggested that his/her way - his/her philosophies and method of healing - were the only way that would work.</p>
<p>Counselor/Psychotherapist Not Respectful of Client (Number of CISs = 6)</p>	<p>Counselor/psychotherapist not respectful of client boundaries, devalues client's time, may involve being deceptive, poor timing, bullying</p>	<p>46 The counselor/psychotherapist had me write down information I didn't want to reveal.</p> <p>10 The counselor/psychotherapist asked a thought-provoking question as I was walking out the door.</p> <p>6 The counselor/psychotherapist had people watch one of my sessions when he/she said no one was going to watch.</p>

		<p>17 The counselor/psychotherapist put me off (e.g., we were interrupted by his/her cell phone calls, the counselor/psychotherapist told me "I have a lot going on right now with other clients").</p> <p>30 The counselor/psychotherapist pressured me to bring my mother to a session.</p> <p>52 I had to wait longer than I felt I should have to see the counselor/psychotherapist.</p>
<p>Money Issues (Number of CISs = 2)</p>	<p>Client feels unfairly charged or is concerned about not being able to afford services</p>	<p>39 The counselor/psychotherapist insisted that we continue sessions even though there was no way I could pay for it, and I accumulated huge debt.</p> <p>4 The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent.</p>
<p>Counselor/Psychotherapist Not Responsive to Client (Number of CISs = 8)</p>	<p>Counselor/psychotherapist is either not aware of or is choosing not to respond to client's needs/wants; this includes discomfort/displeasure with services or practices of counselor/psychotherapist.</p>	<p>45 The counselor/psychotherapist was a woman who wore tight clothing.</p> <p>2 The counselor/psychotherapist walked me from where I was sitting in the reception area to the door of his/her office.</p> <p>36 The counselor/psychotherapist and I did "weird" exercises to relieve stress that I felt were a waste of time.</p> <p>35 I got the same advice several times, and I did not feel anything was solved.</p> <p>31 The counselor/psychotherapist wouldn't change my medication.</p>

		<p>43 The counselor/psychotherapist suggested medication and did not offer another alternative.</p> <p>22 I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues.</p> <p>15 Sometimes the counselor/psychotherapist would not take my calls.</p>
Counselor/Psychotherapist Openly Emotional (Number of CISs = 1)	Counselor/psychotherapist demonstrably expresses emotions during session	38 The counselor/psychotherapist began to cry.
Impersonal Relationship (Number of CISs = 3)	Relationship with counselor/psychotherapist is not as warm and connected as client would desire	<p>53 The counselor/psychotherapist would avoid eye contact with me, looking away or directly over my head.</p> <p>29 I felt my relationship with my counselor/psychotherapist was formal and rigid.</p> <p>13 The counselor/psychotherapist never really related to my issues by talking about his/her own.</p>
Not Addressing Issues (Number of CISs = 5)	Time, conversation, and energy were not effectively directed at addressing the client's issues.	<p>56 The counselor/psychotherapist did not give answers that could help me overcome and achieve personal goals.</p> <p>9 I had something to talk about, and we didn't talk about it.</p> <p>8 I felt the counselor/psychotherapist was unable to appreciate the severity of my issues.</p> <p>34 The counselor/psychotherapist and I spent too much time having conversations not related to solving my issues (e.g. talking about cats, talking about TV, tangents the counselor/psychotherapist went off on).</p>

		47 The counselor/psychotherapist asked questions that I felt weren't important.
Client Resisting Process (Number of CISs = 6)	Client does not appear willing to engage in some element called for in counseling/psychotherapy - being fully present, being open about experiences/behaviors, naming problems, following through on treatment plan.	54 I lied about the duration of time between stressful events and my behaviors. 51 When I came into counseling/psychotherapy, I wasn't sure I wanted to be there and was uptight. 42 A subject came up that I didn't like to talk about/wasn't comfortable talking about. 37 I put off or simply ignored advice and suggestions from my counselor/psychotherapist. 18 I failed to make it to a few sessions. 19 I did not want to have somebody tell me what was wrong or what my issues were.
Lack of Choice in Counselor/Psychotherapist (Number of CISs = 2)	Client is forced to see a counselor/psychotherapist or a different counselor/psychotherapist than he would like/is accustomed to.	40 I was forced to see a counselor/psychotherapist. 44 I had to switch to a new counselor/psychotherapist.
Communication Difficulties (Number of CISs = 4)	Information between client and counselor/psychotherapist is not being clearly and accurately conveyed.	16 I had a hard time understanding the counselor/psychotherapist because of a language barrier.

		<p>11 The counselor/psychotherapist put words in my mouth (i.e., told me what I felt/thought).</p> <p>25 The counselor/psychotherapist wrote down the wrong time on his/her calendar/my appointment card.</p> <p>12 The counselor/psychotherapist did not give me enough information about plans for continued therapy.</p>
<p>Time Constraints (Number of CISs = 4)</p>	<p>Limited time for sessions or during sessions, client may feel rushed or that his issues are not being adequately addressed</p>	<p>28 There was not enough time for the session (i.e. we didn't get the work done that I expected).</p> <p>1 The counselor/psychotherapist had limited availability.</p> <p>48 The counselor/psychotherapist hurried me (e.g., through questions, in conversation).calendar/my appointment card.</p> <p>23 The counselor/psychotherapist repeatedly pointed out the time.</p>

Appendix Y

Consensus Categorization Notes

Table Y1

Notes on Coding Decisions Made During Consensus Categorization

Critical Incident Statement Number	Wording of Critical Incident Statement	Action Taken	Reason
5	I took the confidence of the counselor/psychotherapist as a threat or challenge to my own confidence.	put in category Not the Right Fit (over other potential category of Counselor/Psychotherapist Characteristics and Behavior)	this has more to do with the interaction the counselor/psychotherapist and client, how client reacted, not just counselor/psychotherapist, how client related counselor/psychotherapist characteristics to something in himself
8	The counselor/psychotherapist did not elicit more explanatory responses from me pertaining to my issues.	put in Not Doing His/Her Job (over other potential category of Client Not Putting in Work)	CIS had no thematic match with Client Not Putting in Work
11	The counselor/psychotherapist put words in my mouth (i.e., told me what I felt/thought).	put in category Counselor/Psychotherapist Presuming (over other potential category of Communication Difficulties)	coders perceived a strong thematic match between definition of "presume" and phrase "put words in my mouth"

- | | | | |
|----|--|---|--|
| 14 | Prior to any session, the counselor/psychotherapist sent me an e-mail asking me to sign an agreement that I would pay for a session if I didn't show up. | put in category Counselor/Psychotherapist Characteristics & Behavior (over other potential category of Unprofessional Mistakes) | the primary issue is not with the behavior of the counselor/psychotherapist but in the way the counselor/psychotherapist did it |
| 22 | I wish the counselor/psychotherapist had given me techniques for sensing and resolving my issues. | put in category Not Doing His/Her Job (over other potential category of Client Not Putting in Work) | this relates to something the counselor/psychotherapist didn't do not something the client didn't do |
| 23 | The counselor/psychotherapist repeatedly pointed out the time. | put in category Pushy Counselor/Psychotherapist (over other potential category of Time Problems) | put in Pushy Counselor/Psychotherapist because CIS relates to how they did it and frequency, not just behavior of pointing out time |
| 32 | The counselor/psychotherapist had a stoic nature (i.e. very staunch and formal, not very personable, straight to business). | put in category Counselor/Psychotherapist Characteristics & Behavior (over other potential category of Not the Right Fit) | about nature of counselor/psychotherapist, from raw questionnaire data we know that client was okay once he acknowledged this as counselor/psychotherapist nature not something to do with himself |
| 3 | I was not sure if the counselor/psychotherapist was telling me the truth. | put in category Need to Build Trust (over other potential category of Unsure of Therapist/Therapy) | CIS describes client not trusting counselor/psychotherapist to tell them the truth as opposed to doubting the character of counselor/psychotherapist or process of therapy |

- | | | | |
|----|--|---|---|
| 35 | I got the same advice several times, and I did not feel anything was solved. | put in category Not Doing His/Her Job (over other potential category of Communication Difficulties) | could be Communication Difficulties if responsibility is on client to bring this up, could be Not Doing His/Her Job if burden is on counselor/psychotherapist to recognize it's not working; went with majority, 3 individual sorters placed this in Not Doing His/Her Job grouping |
| 40 | I was forced to see a counselor/psychotherapist. | put in category No Choice (over other potential category of Unprofessional Mistakes) | doesn't seem unprofessional, No Choice captured meaning better |
| 42 | A subject came up that I didn't like to talk about/wasn't comfortable talking about. | put in category Need to Build Trust (over other potential category of Client Not Putting in Work) | not addressing given topic better captured by Need to Build Trust, does not necessarily indicate client not willing to do work |
| 47 | The counselor/psychotherapist asked questions that I felt weren't important. | put in category Not Doing His/Her Job (over other potential category of Need to Build Trust) | doesn't seem to relate to trust/openness of client, so put in Not Doing His/Her Job (seems to be aspect of counselor/psychotherapist's job) |
| 49 | The counselor/psychotherapist asked me to move my dirty shoe off his/her couch. | put in Communication Difficulties (over other potential category of Counselor/Psychotherapist Characteristics & Behavior) | as informed by raw questionnaire data, more of a communication issue than cleanliness of counselor/psychotherapist since client felt bad for doing this and tried to remember not to, client could have asked about it first, counselor/psychotherapist could have mentioned not to first |

- | | | | |
|----|--|--|---|
| 4 | The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent. | moved from its own category of Money Issues to combine with Communication Difficulties | this was in its own category of Money Issues, looked at where else it had been sorted: didn't fit with Client Not Putting in Work, did not put in Unprofessional Mistakes because it's not billing for time that is issue, more the client being surprised by it, counselor/psychotherapist should have shared billing policy in advance, so combined with Communication Difficulties |
| 10 | The counselor/psychotherapist asked a thought-provoking question as I was walking out the door. | moved from its own category of Devalues Client's Time to combine with Counselor/Psychotherapist Characteristics & Behavior | this was in its own category of Devalues Client's Time, looked at where else it has been sorted: doesn't fit with Client Not Putting in Work, informed by raw questionnaire data--could have been intentional technique (approach almost seems like it fits in Not the Right Fit but only considered categories where it had been individually sorted) |
| 27 | The counselor/psychotherapist accused me of doing something wrong. | moved from Client Not Putting in Work to Counselor/Psychotherapist Presuming | didn't seem to fit with category title of Client Not Putting in Work, moved when building descriptions of categories, looked at original client categories from individual sorts, moved to Counselor/Psychotherapist presuming since it had a better thematic match to the original client category descriptions |

Appendix Z

Detrimintality Rating Frequency Tables

Table Z1

Frequency of Each Detrimintality Rating for Category: Not the Right Fit

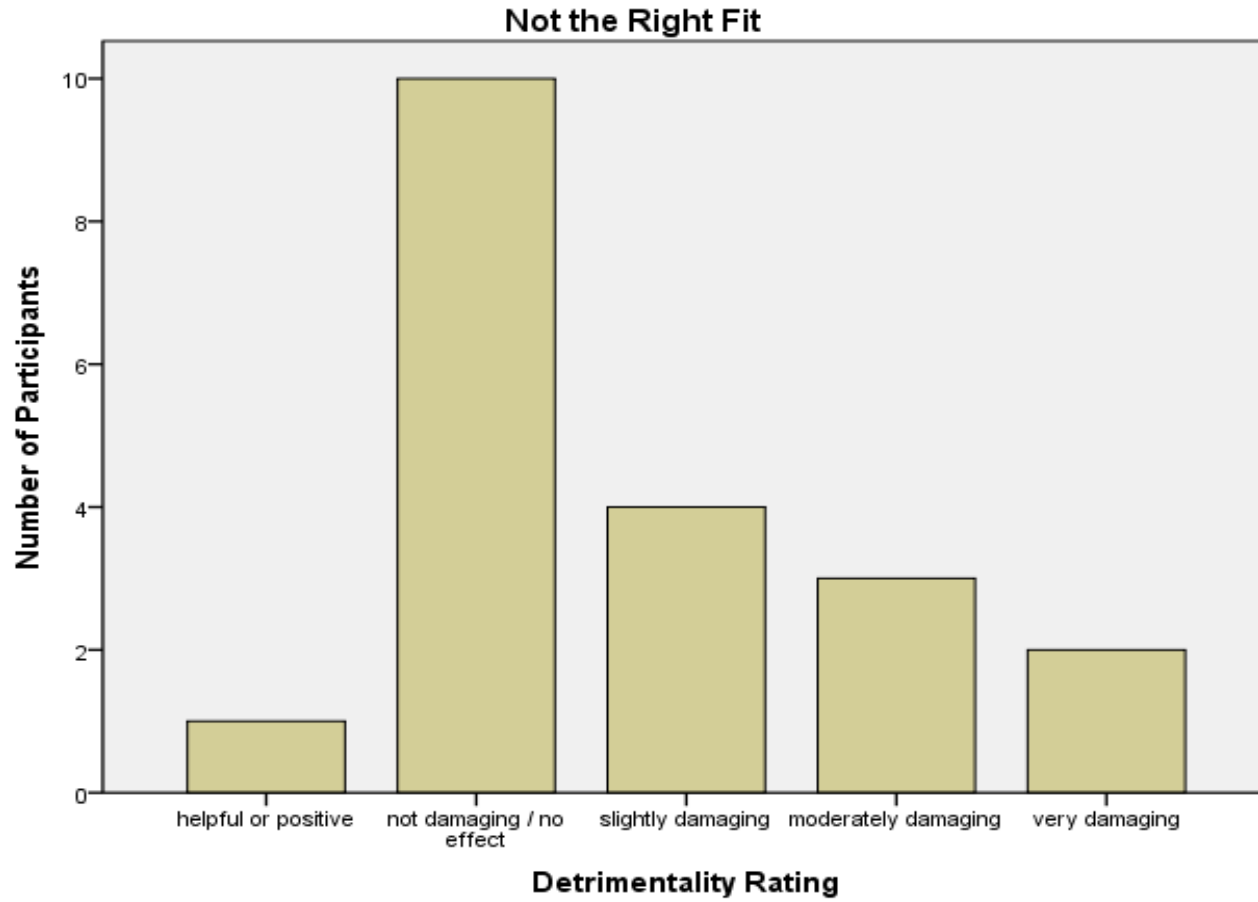


Table Z2

Frequency of Each Detrimintality Rating for Category: Unexpected Actions/Personality of Counselor/Psychotherapist

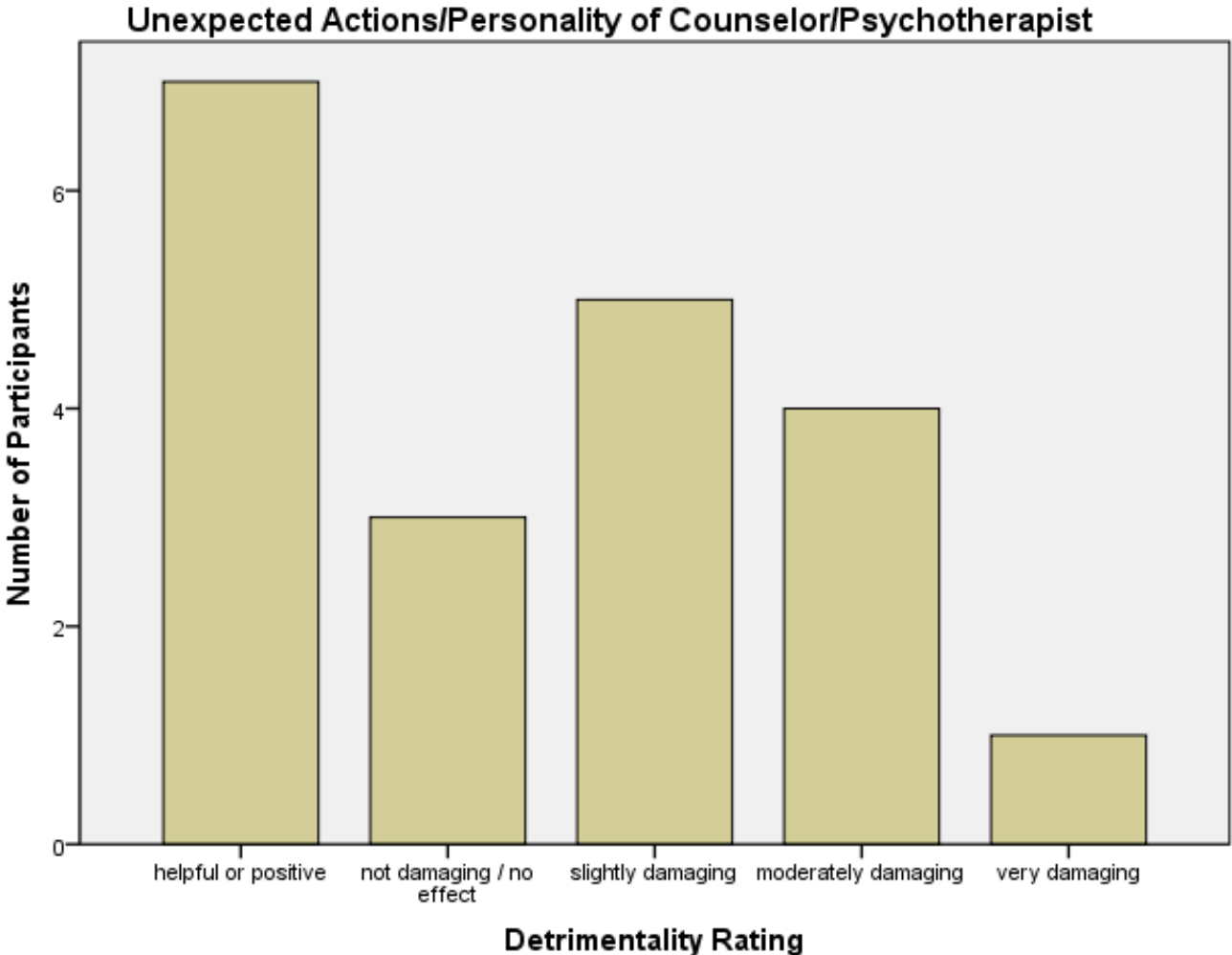


Table Z3
Frequency of Each Detrimentality Rating for Category: Communication Problems

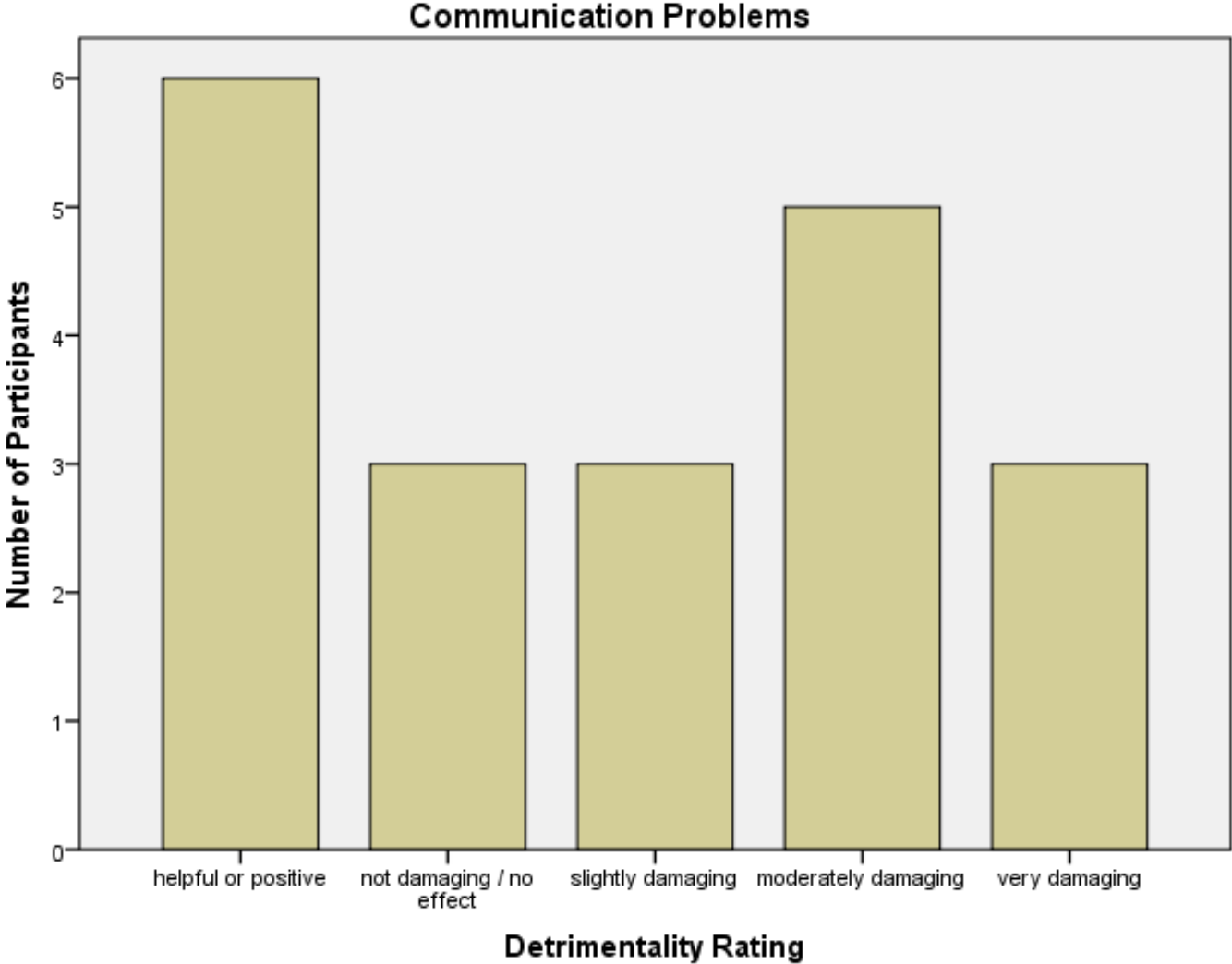


Table Z4

Frequency of Each Detrimentality Rating for Category: Unprofessional

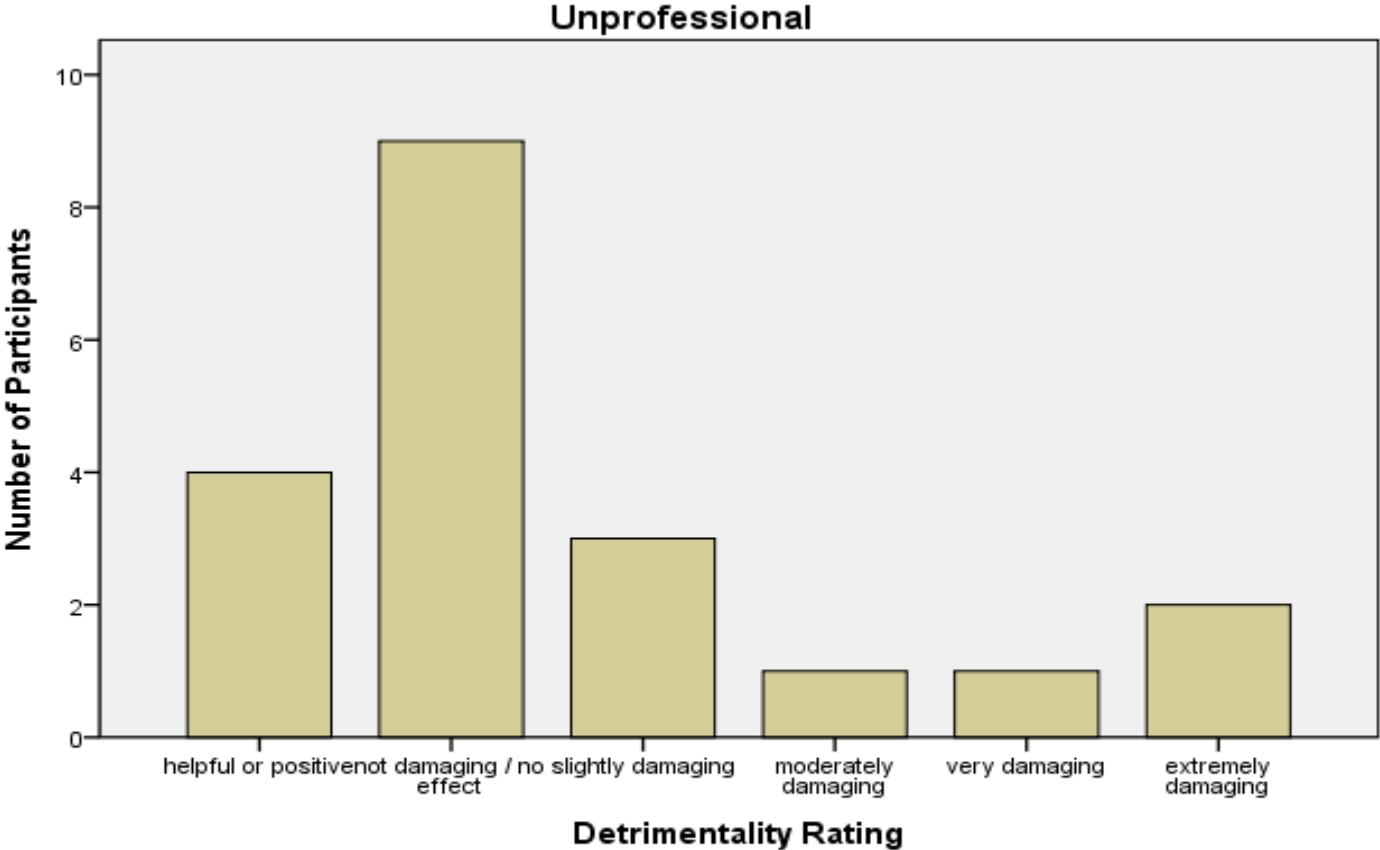


Table Z5

Frequency of Each Detrimentality Rating for Category: Client Needs to Build Trust

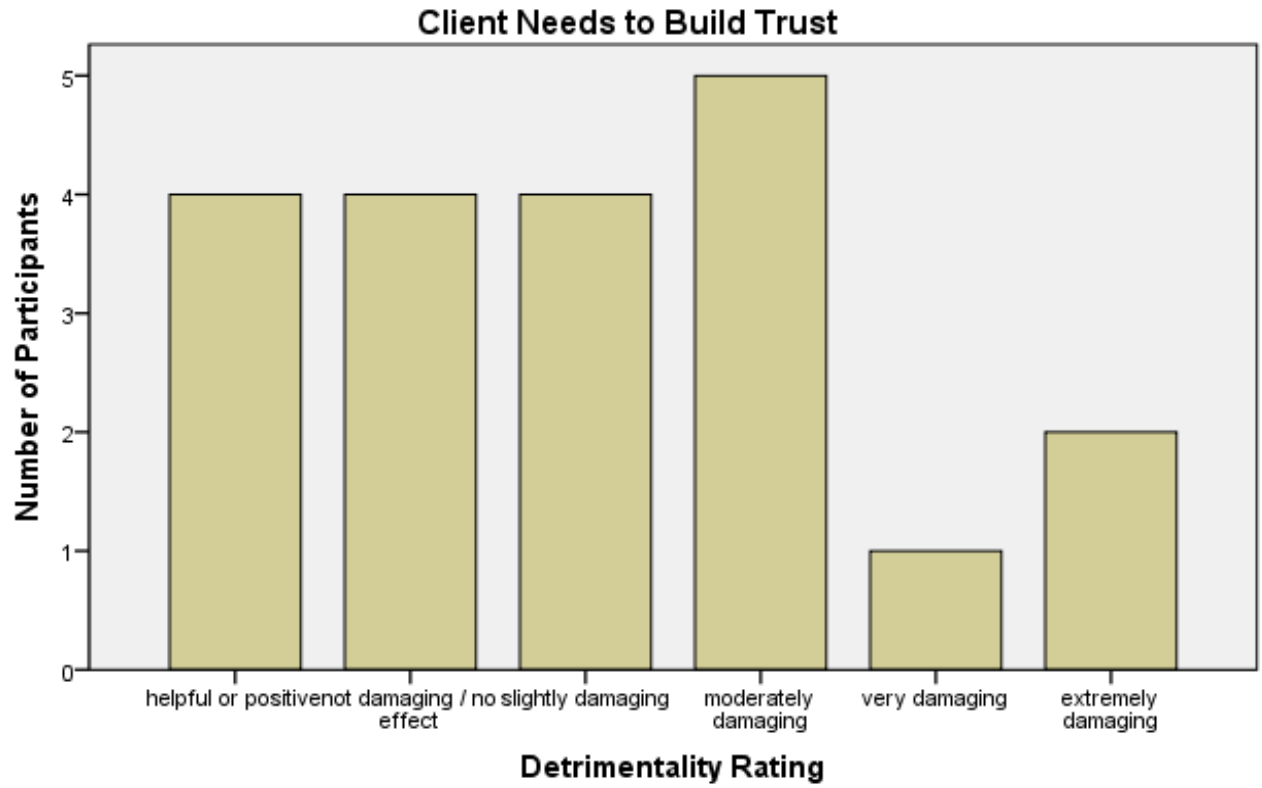


Table Z6

Frequency of Each Detrimentality Rating for Category: No Choice

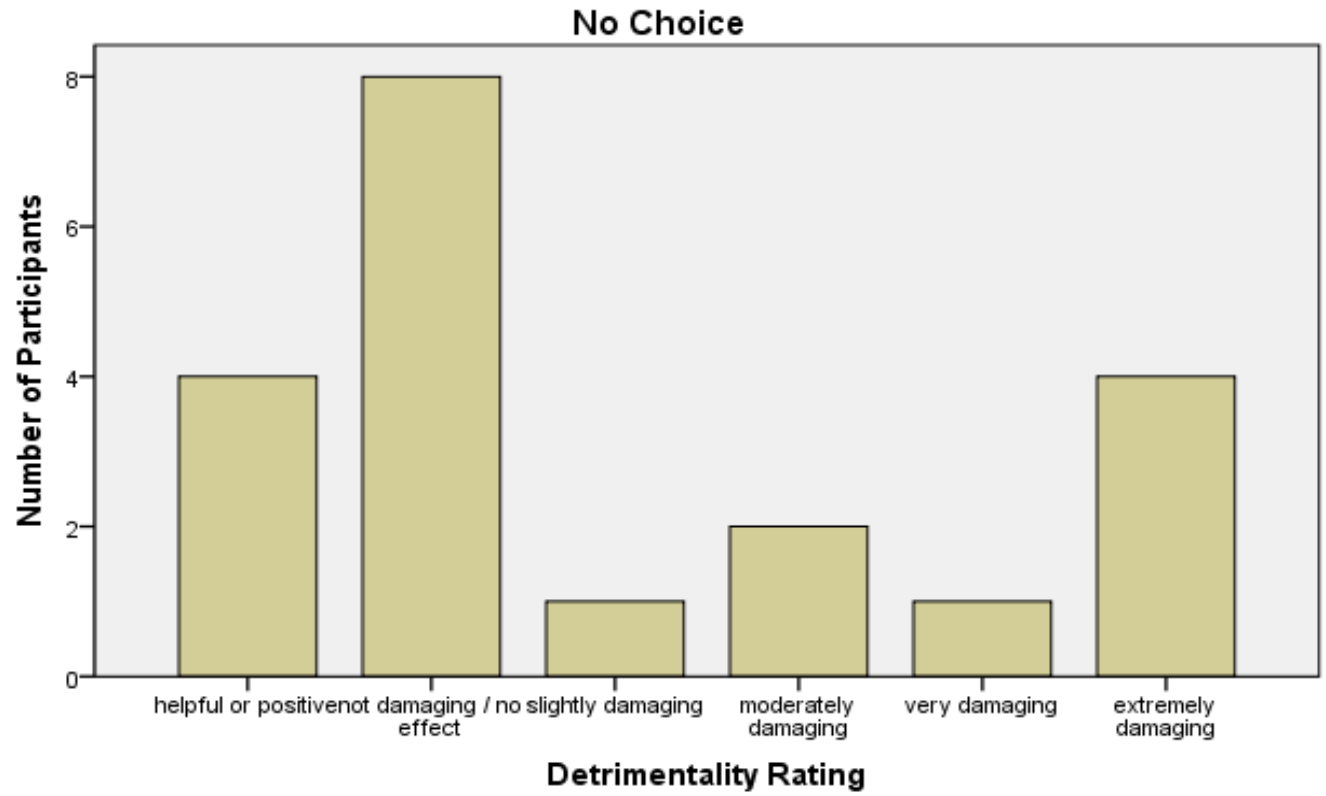


Table Z7

Frequency of Each Detrimentality Rating for Category: Unsure of Psychotherapy/Psychotherapist

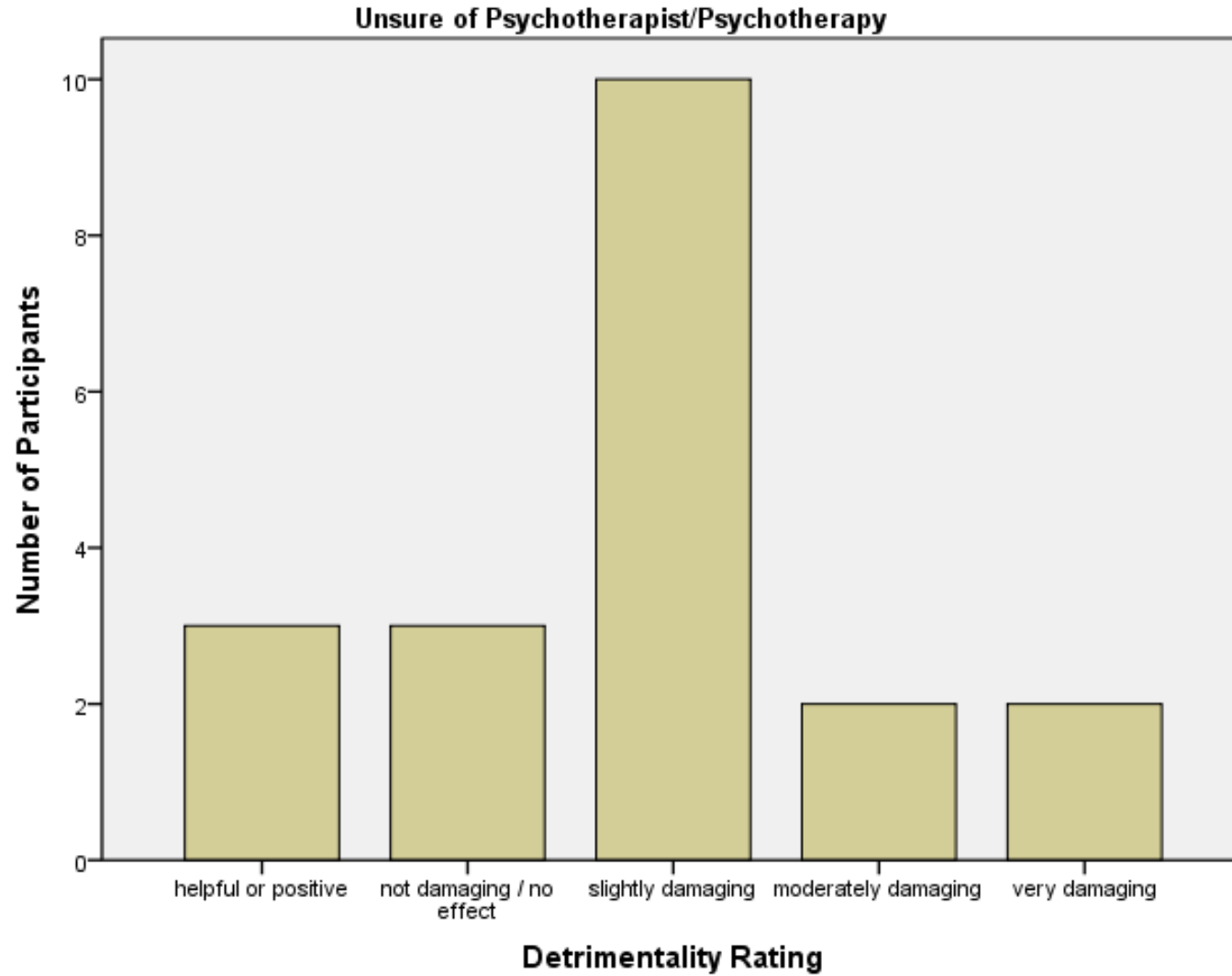


Table Z8

Frequency of Each Detrimentality Rating for Category: Counselor/Psychotherapist Didn't Work Hard Enough on Client's Issues

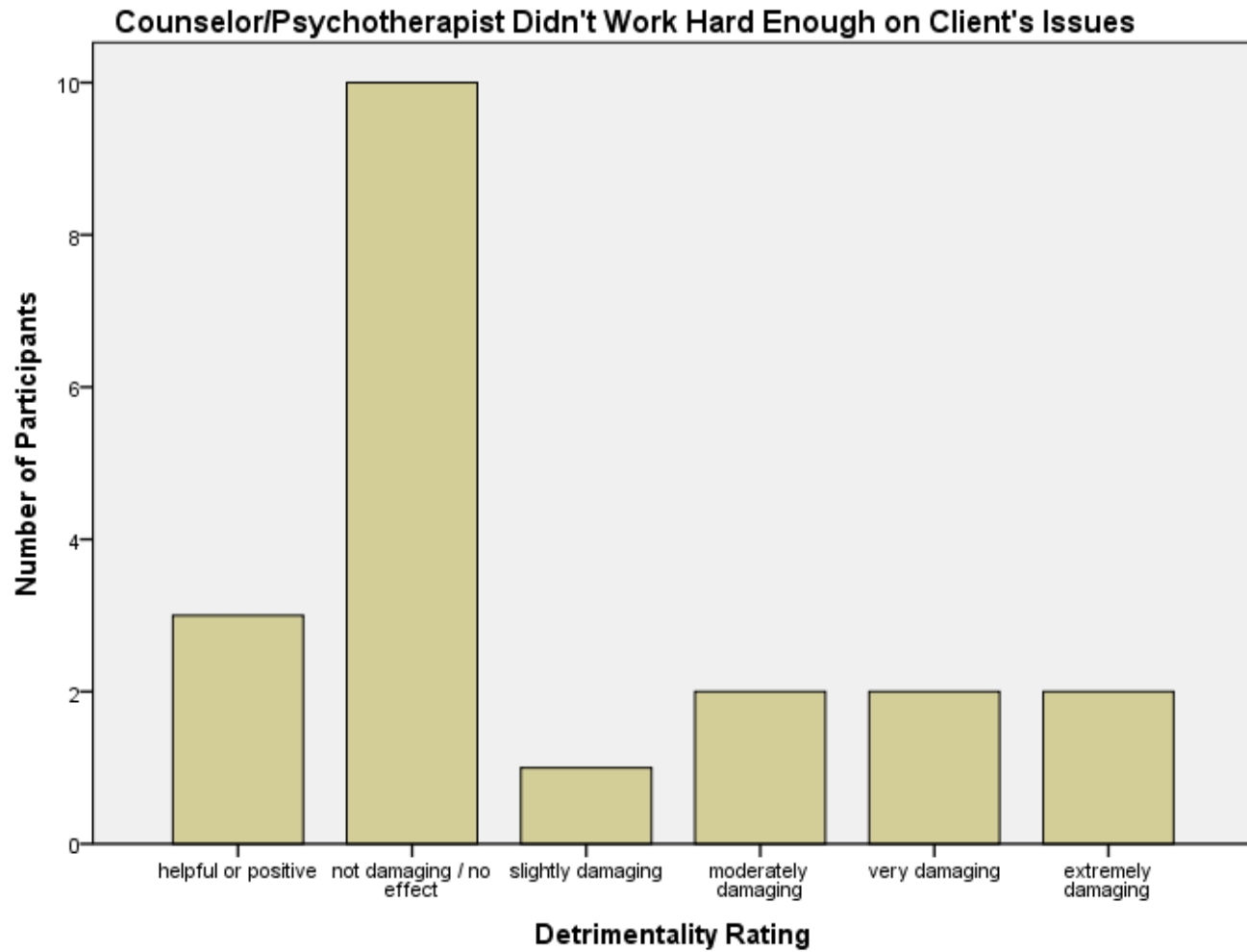


Table Z9

Frequency of Each Detrimentality Rating for Category: Acting on Assumptions About Client

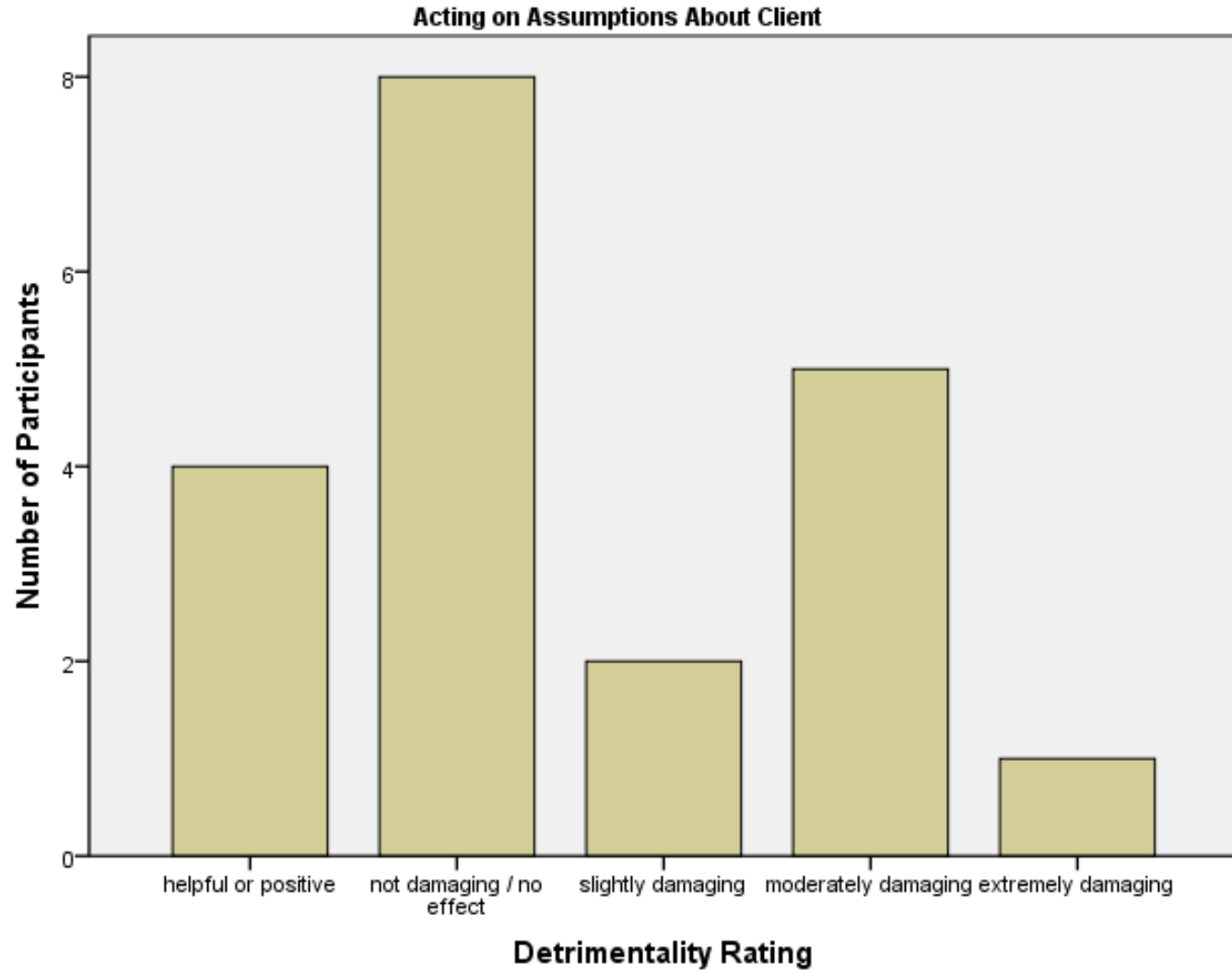


Table Z10

Frequency of Each Detrimentality Rating for Category: Not the Right Fit

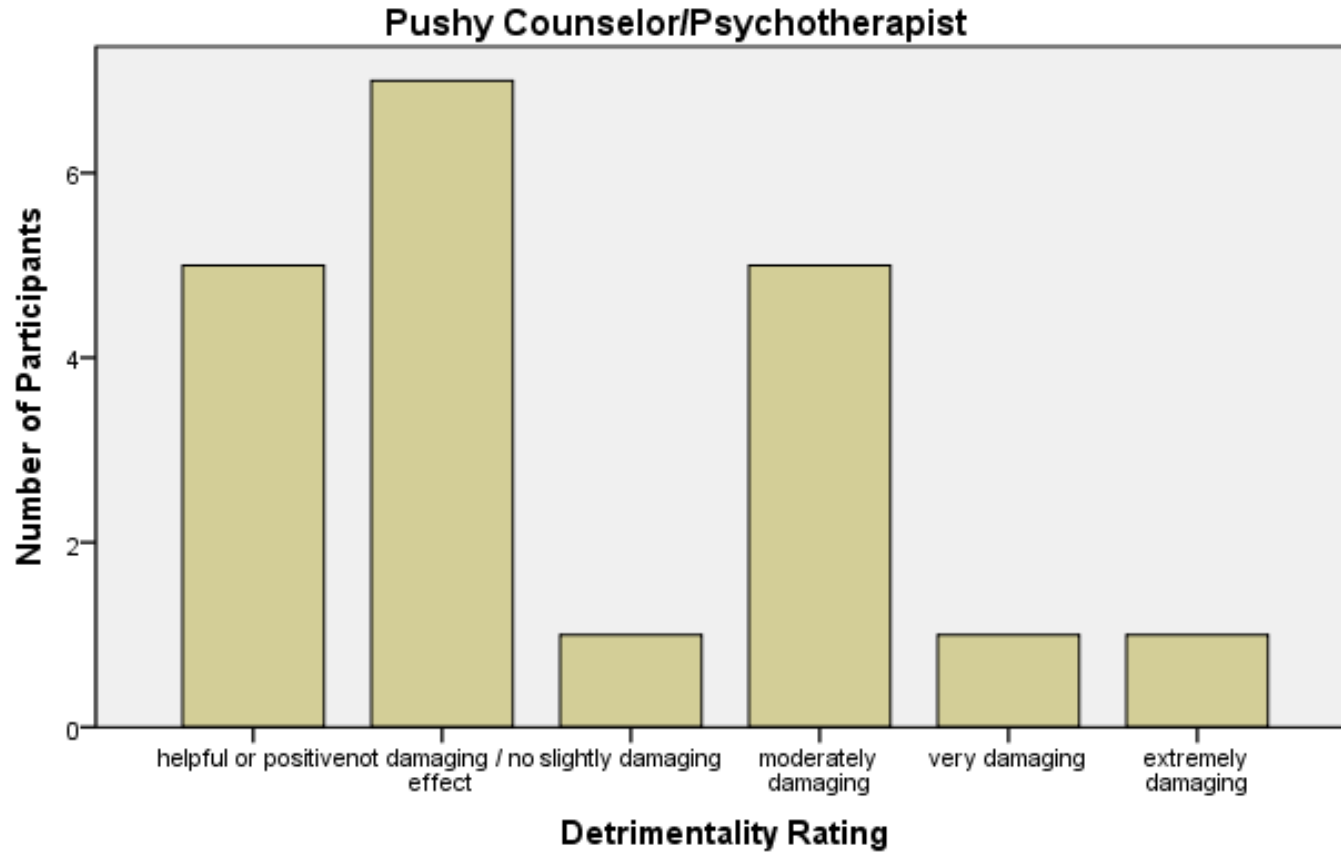


Table Z11

Frequency of Each Detrimintality Rating for Category: Time Problems

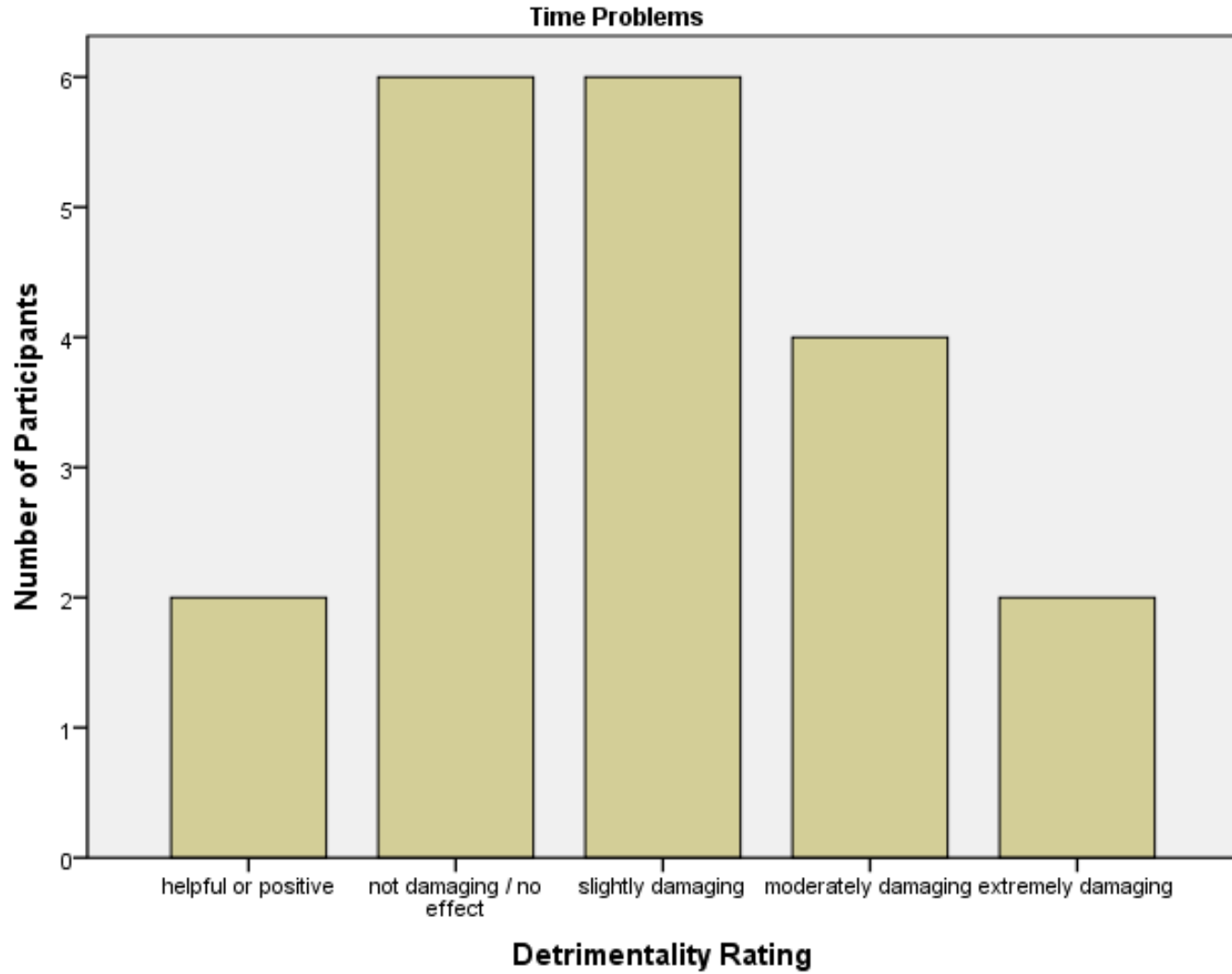
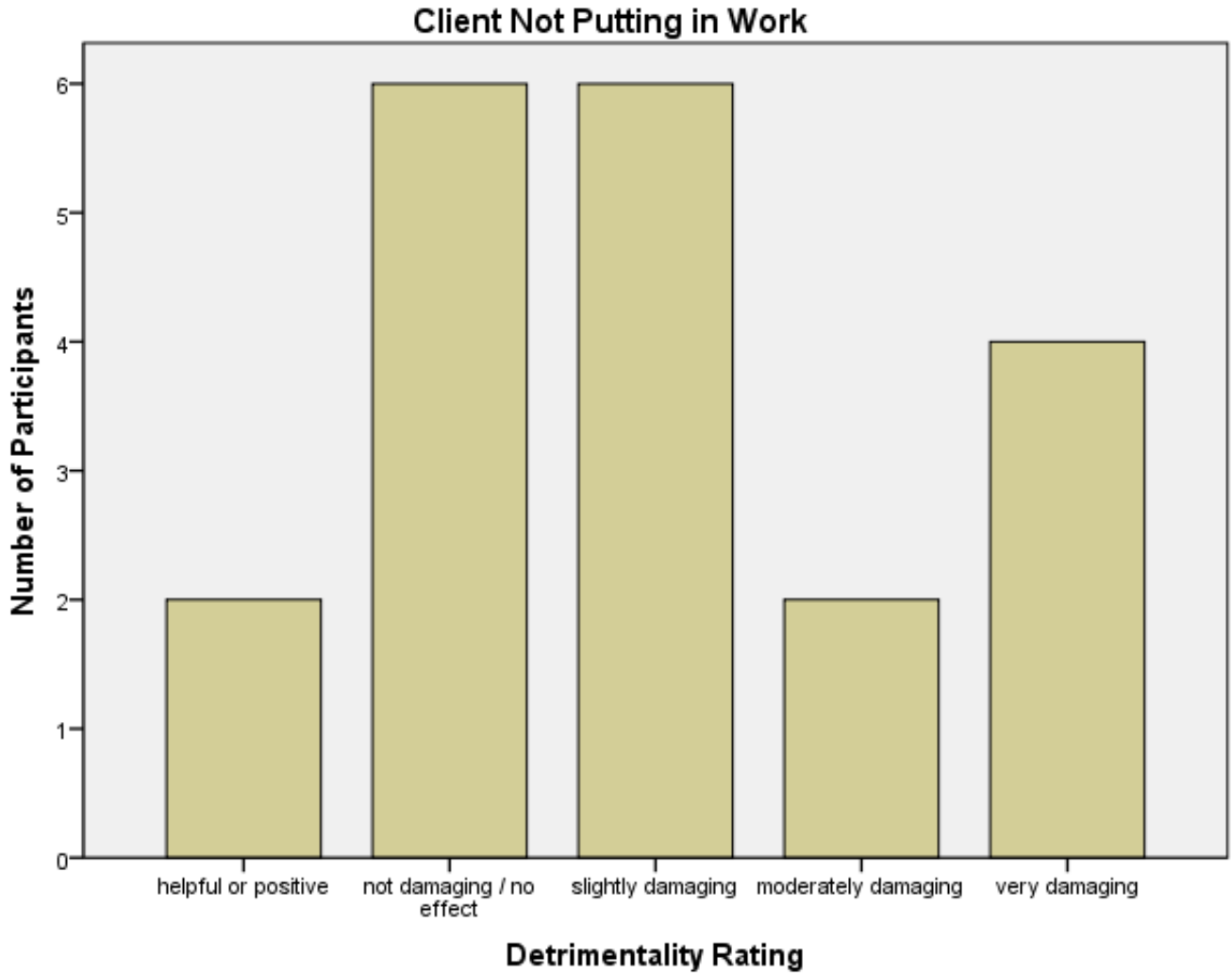


Table Z12

Frequency of Each Detrimentality Rating for Category: Not the Right Fit



Appendix AA

Participant Feedback From Follow-up Interviews

Does this accurately describe what happened that held back or weakened the working relationship with your counselor or psychotherapist?

- Summarizes it to a degree
- Psychotherapy topics he [counselor/psychotherapist] didn't want to talk about

In the sentence describing your experience, is anything missing?

- Other factors may need to be taken into account, but this is the primary factor
- I had something to talk about and I was nervous to talk about it, but we didn't.
- Sort of nebulous. Sometimes the counselor/psychotherapist has an “I don't care” attitude, [and there's] no effort put out to help me wrestle with my illness, not enough time put into diagnosing.
- It wasn't random stuff, just not what he wanted to talk about at that time.
- It sounds more negative than it was. [There] wasn't enough time to finish the question and answering it wasn't allowed. Inappropriate timing.
- Not very specific
- [I] have become very close to [the] counselor and we've had great sessions. Now he's leaving because his internship is over.
- Not very comfortable with him [counselor/psychotherapist]. [He's] kind of cold

- Just one idea, sometimes it happens and sometimes it doesn't ([since we have] both 1/2 hour and 1 hour sessions).
- Not every counselor is like [that]

In the sentence describing your experience, is there anything that needs to be changed?

- Other factors may need to be taken into account, but this is [the] primary factor.
- Nonchalant attitude. [Change to describe the nonchalant attitude of the counselor/psychotherapist.] Instead, [say] the counselor/psychotherapist was very quick to diagnose without getting to know me or my medical history first.
- [I'm] not sure how you can change it.
- [Not] unless we could change [it] to a whole different [incident]
- Include percentage of time that it occurs (participant couldn't nail down percentage).
[There are] lots of variables – [it] also matters how [the] client is doing.

Do you have any other comments?

- [I'm] still in same program, seeing [the] same Dr. [I] begged him to change it [medication]. [There was] nothing I could do, but he did lower [the] dose and it helped. [It] made a difference; I feel better.
- As soon as I brought it up, we talked about it.

Do the category names make sense to you?

- Communication Difficulties – [The] counselor/psychotherapist made no try to listen in [the] first place. Unsure of Psychotherapist/Psychotherapy – [The client] may be figuring things out, trying to learn guidelines and rights.
- No, [but they] described many counselors/psychotherapists; medical records could help us maybe.
- Communication is a two way street; [the] client needs to participate. Client Not Putting in Work - I like that one, it's true. Need to Build Trust – [It] has to begin with [the] first stage of opening up, [and it] may be somewhat superficial. [The client] may need to start with something small and contemporary to build ability to share deeper wounds. Time Problems – [It] behooves [the] client to put in effort before session, [to] prepare [him]self about what or how much to share.

Does the name of the category your experience was sorted into capture your experience and the meaning it had for you?

- [It was] not so much of a communication thing, but [about] trust. Having to pay for the letter was a put off; [it] reminds you it's about the cash.
- [It] may also fit in Not the Right Fit.
- [The category] doesn't apply to me. Everyone is doing their job, but he [counselor/psychotherapist] can't or doesn't want to listen to my concerns. [I'm] required to keep going to [counseling/psychotherapy to] keep [my] housing and benefits, so [I] have to take meds.
- I was nervous so it related more to trust. [What I didn't bring up to the counselor/psychotherapist was] kind of a big issue, [so it would have been] a little early

to talk about it. She [counselor/psychotherapist] said "I'm glad you didn't tell me about it right away" when I brought it up. [She] thought it would not be healthy to trust that much too soon.

- Peppered with that throughout many different experiences, it all adds up
- Maybe Not the Right Fit and Communication Difficulties. [The current] category may be too harsh; [instead the incident] might be [about] communication issues. Note: [Rereading] the description for Not Doing His/Her Job [current category] made him [the participant] confirm his critical incident fitting there.
- Combination of Counselor/Psychotherapist Characteristics & Behavior, Communication Difficulties, and Time Problems. [I'm] not sure you can separate the experience into all these.
- Because I didn't feel like I knew the counselor very well, [we did] not having a trusting relationship. [That] made me less likely to be up front at first.
- [It] wasn't just all the counselor. [We were] stuck in a cycle, but the counselor/psychotherapist did not help.
- [It] exactly did. The counselor/psychotherapist assumed I was going to do something violent or suicidal because of my energy.
- [It] may fit in Need to Build Trust or Communication Difficulties. [Researcher] confirmed that participant felt [current category of] Counselor/Psychotherapist Characteristics and Behavior was best fit.
- [It was] more of a lack of communication on both of our parts. The counselor/psychotherapist wanted to come up with a diagnosis and throw medication on

it. [The counselor/psychotherapist] didn't explain how they would help, and I didn't bring up that I wanted to talk about [my] issues [instead].

- No open mindedness, the counselor/psychotherapist was close-minded

Appendix BB

Notes on Incorporating Participant Follow-up Feedback

Table BB1

How Participant Feedback on Incidents and Categories Was Addressed

Statement Number	Critical Incident Statement	Notes
4	The counselor/psychotherapist wrote me a hardship withdrawal letter, and I had to pay for the time he/she spent.	Despite participant's request, this CIS was not moved from Communication Difficulties to Need to Build Trust. Participant implied the CIS broke trust, but putting it in trust category would more imply that if there already had been trust, it would have been okay with the client to pay for the letter. The participant's feedback seems to relate to the result of the CIS not the description of what weakened the relationship
9	I had something to talk about, and we didn't talk about it.	The participant wanted to change the CIS to: "I had something to talk about and I was nervous to talk about it, but we didn't." To do this, it would have to be separated from other redundant CISs that were incorporated with it (M13-30: The c/p stopped me from talking about the loss of my dad. M04-13: The c/p directed the conversation away from what was, in my mind, the most important thing to talk about.) Coders reviewed the raw data; with the info from the follow-up interview, it painted a picture of the client being stressed out because the topic was being put off. He wanted to get it over with sooner. Even with the further detail of "nervous," this still fit as redundant with other CISs. If this detail had been available in the original questionnaire, it would likely have been removed when combining for redundancy. Coders left CIS under Not Doing His/Her Job because it describes not talking about a topic important to the client, so the client's concerns are not being addressed. The connection about trusting in the process of counseling/psychotherapy was too vague to

- justify moving it to Need to Build Trust; it may fit for this participant but not the others who have CISs combined in this statement.
- 10 The counselor/psychotherapist asked a thought-provoking question as I was walking out the door. No change was made to CIS. The participant broadly suggested change but wasn't sure how it could be clarified. Coders felt "inappropriate timing" was covered by "as I was walking out the door." CIS was moved to Time Problems from C/P Characteristics and Behavior, at the participant's request. Per the participant, the CIS was an issue of timing. It could have been that the counselor/psychotherapist didn't have time to discuss the question right then.
- 11 The counselor/psychotherapist put words in my mouth (i.e., told me what I felt/thought). Participant said CIS should be changed to: "The counselor/psychotherapist was very quick to diagnose without getting to know me or my medical history first." To make this change, it would be necessary to split this incident from previously combined CI (C05-21 The c/p stated my feelings instead of letting me express my emotions.) Given the potential impact of this change on the category structure, the CIS was not separated; no changes were made.
- 28 There was not enough time for the session (i.e. we didn't get the work done that I expected). Participant wanted to change CIS. He felt it was overly simple because sometimes the sessions felt too short and other times they did not. Coders decided not to change CIS b/c when it does happen, it is an issue, and when it does not, it is not. Also, the participant's feedback described frequency rather than adding detail to the incident; the CIS as it was (and remained) implied only one occurrence, not that it happened every session.
- 31 The counselor/psychotherapist wouldn't change my medication. CIS moved from Not Doing His/Her Job to No Choice per participant request. Participant's follow-up interview provided added information that the client was required to receive treatment to keep his housing and benefits. As a result, added to the No Choice category description was "or what treatment to receive."
- 32 The counselor/psychotherapist had a stoic nature (i.e. very staunch and formal, not very personable, straight to business). Per participant's request, "cold" was added to Counselor/Psychotherapist Characteristics and Behavior category descriptors under i.e.

- | | | |
|----|--|--|
| 34 | The counselor/psychotherapist and I spent too much time having conversations not related to solving my issues (e.g. talking about cats, talking about TV, other tangents the counselor/psychotherapist went off on). | Coders decided not to add anything to CIS; participant's description of other psychotherapy topics he didn't want to talk about was already covered by "other tangents the c/p went off on." |
| 43 | The counselor/psychotherapist suggested medication and did not offer another alternative. | Participant thought CIS should be in Communication Difficulties because counselor/psychotherapist didn't explain why/how meds would help and client didn't ask to try talking about issues first. As the CIS was written, it would not fit under Communication Difficulties, but changing the wording would not fit with the other CI previously combined with this one (The c/p pushed drugs on me, even when they didn't help.). As splitting the CIs would have complicated analyses, no changes were made. |
| 47 | The counselor/psychotherapist asked questions that I felt weren't important. | The CIS was moved from Not Doing His/Her Job to Not the Right Fit at the participant's request. Participant did not give specific reasons for the move, but coders agreed it could fit in the participant's preferred category. |
| 54 | I lied about the duration of time between stressful events and my behaviors. | The CIS was moved from Client Not Putting in Work to Need to Build Trust, given the participant's explanation during his follow-up interview: the client was lying because he did not yet have a trusting relationship with his counselor/psychotherapist and so was less likely to be open with him/her. |
-