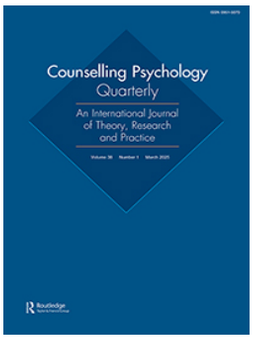

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"The therapist responded to my coaching": patients' perspectives on coaching communications in psychotherapy

David Kealy[a], Sarah Woolgar[a], Elizabeth Li[b,c], James McCollum[d] and George Silberschatz[d,e]

[a]Department of Psychiatry, University of British Columbia, Vancouver, Canada; [b]Research Department of Clinical, Educational and Health Psychology, University College London, London, UK; [c]Anna Freud Centre, London, UK; [d]San Francisco Psychotherapy Research Group, San Francisco, CA, USA; [e]Department of Psychiatry, University of California San Francisco, San Francisco, CA, USA

ABSTRACT

Patients in psychotherapy may inform, orient, and redirect their therapist according to their particular problems, goals, and needs––conceptualized by Control-Mastery Theory as the patient coaching the therapist. Yet there has been limited research on patients' subjective experiences of engaging in coaching communication. This study used an online survey to obtain patients' perspectives on the degree to which they coached their therapist and the effects and implications of having done so. Of 248 participants who had received psychotherapy, 123 provided text responses for qualitative analysis regarding their experience of coaching communication. Thematic analysis was employed to extract themes from these narratives. Major themes included the use of coaching to orient the therapist to desired goals and preferred intervention approaches, and to redirect the therapist when necessary. Themes regarding the impact of coaching included positive experiences when coaching was well received and negative experiences when therapists ignored the patient's coaching. Findings from this preliminary investigation suggest that coaching communication may be an important feature of the therapeutic process for many patients, with implications for therapist responsiveness and therapy outcomes. Moreover, the findings indicate that patients' coaching communication is a worthy subject for future psychotherapy research.

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Psychotherapy process; patient communication; therapist responsiveness; therapeutic alliance; control-mastery theory

Introduction

Psychotherapy is commonly regarded as a collaborative process that involves a mutual agreement between therapist and patient on the nature of their work together (Dattilio & Hanna, 2012; Wiseman et al., 2012). Indeed, the concept of the therapeutic alliance is built upon the notion of therapists and patients seeking to reach an agreement on the goals and tasks of therapy within a collaborative bond (Bordin, 1979; Summer & Barber, 2003). While some approaches may give more prominence to relational aspects of the alliance, consensus and collaboration are widely recognized across theoretical orientations – and evidenced through empirical research – as

CONTACT David Kealy david.kealy@ubc.ca

important to the outcome of psychotherapy (Flückiger et al., 2018; Tryon et al., 2018). However, the patient's role in actively influencing this collaborative effort, indeed in shaping the direction of the therapeutic process, has received relatively limited attention.

The availability of empirically supported therapy models for specific psychological conditions (Carr, 2009) has contributed to an emphasis on the therapist's delivery of technical interventions. Although the patient is widely seen as a collaborator in these treatments, the therapist is typically positioned as the one implementing specific prescribed tasks (e.g. cognitive restructuring, transference interpretations, mindfulness teaching) that define the therapy model and purportedly address the patient's problems. Investigation beyond specific therapy models is increasingly shifting toward therapist effects (Constantino et al., 2017; Johns et al., 2019), highlighting the influence individual therapists have in determining the outcome of psychotherapy. Yet, patients exert considerable influence on their therapies, at the very least through the problems and unique complexities they present with, and by way of their individual characteristics that render them more or less amenable to a particular therapeutic approach. Patients may go even further––via their communications and behaviors––to actively and agentically shape the therapeutic process, with some perspectives arguing that the patient is a key agent driving the therapeutic process (e.g. Anderson & Goolishian, 1992; Bohart, 2006; Rogers, 1951; Silberschatz, 2005; Weiss, 1993).

Control-Mastery Theory (CMT; Silberschatz, 2005; Weiss, 1993) posits that patients enter therapy with a largely unconscious or implicit "plan" that consists of their goals and obstructions, along with associated traumatic experiences underlying their problems. According to CMT, the patient is highly motivated to work in therapy to obtain evidence – through insights and experiences – that challenges and disconfirms the pathogenic beliefs that hinder their pursuit of important goals and fuel troublesome psychological symptoms (Gazzillo, 2023; Weiss, 1998). One way patients achieve this is by *testing* the veracity of their beliefs within the therapy relationship. While such tests may not be consciously planned by the patient––theorized to emerge instead from an implicit level of mental functioning––they can significantly influence the course of therapy and its outcome (Gazzillo et al., 2019; Silberschatz, 2008). For example, a patient who believes that she is thoroughly uninteresting to others may test this belief by proposing to the therapist that they reduce the frequency of sessions. A therapist who readily agrees to do so may be experienced by the patient as confirming her pathogenic belief (e.g. "I am not interesting enough for the therapist to continue working with me"). Conversely, a therapist who explores the request further, expresses concern, or advocates for maintaining the current schedule may provide evidence that challenges the belief (i.e. indicating the therapist's interest in her). Research has shown that when a therapist's response "passes" the patient's test, indicators of therapeutic progress can be observed both immediately following the testing sequence and at post-treatment (Fimiani et al., 2023; Gazzillo et al., 2024; Silberschatz, 2017; Silberschatz & Curtis, 1993). Thus, by testing pathogenic beliefs, the patient's search for corrective experiences – even when operating at an unconscious level – may have a great bearing on how their therapy will turn out.

Another way patients may shape their therapies is by communicating aspects of their plan to the therapist, through a process referred to as *coaching* (Bugas & Silberschatz,

2005). According to CMT, patients are motivated to position the therapist in such a way that help them overcome obstacles to their goals. They may therefore coach the therapist by providing information about their goals, the problems they wish to address, their pathogenic beliefs, and the traumatic experiences they hope to master. Patients may also coach therapists on the attitudes, styles, or behaviors they find most helpful within the therapy relationship. Coaching may sometimes be conscious and direct, as in the patient stating, *"I'd like to be more assertive and I'm hoping you can help me with that."* However, CMT suggests that coaching may also occur at an implicit or unconscious level, often conveyed indirectly in the form of an allegory, metaphor, or story (Bugas & Silberschatz, 2005; Rodomonti et al., 2021). For example, a patient might say, *"I've always admired people who could speak up for themselves; my friend is like that – she could always ask her teachers directly for help with any problem she was having."* Although phrased indirectly, such a statement would not require a great deal of inference to appreciate the patient's wish for the therapist to help with assertiveness.

Coaching communications may be either pro-active or reactive. In pro-active coaching, the patient orients the therapist to their plan at the outset, or to emergent goals as therapy unfolds; this form of coaching is relatively independent of therapist behaviors (Bugas & Silberschatz, 2005). In contrast, reactive coaching occurs in response to therapist behavior. Here, the patient may coach the therapist to discourage a particular line of intervention, to correct the therapist's understanding, or to guide the therapist toward a more constructive way of relating or working from the patient's perspective (Bugas et al., 2023). According to CMT, both types of coaching can help prepare the therapist to pass the patient's tests and optimize their responsiveness to the patient's needs for insight, learning, and corrective experiences (Rodomonti et al., 2021).

Patients' implicit communications aimed at influencing the therapist's work have been noted by authors from various theoretical orientations. Writing from a psychoanalytic perspective, Casement (1985) described and illustrated patients' efforts to signal the therapist's errors and guide them toward more appropriate therapeutic directions, often doing so unconsciously through the associations and narratives they verbalized. Similarly, Langs (1975) proposed that patients' associations may contain important messages to the therapist about their perceptions of potential threats to the analytic frame and treatment process, largely through indirect allusion and presumably outside the patient's conscious awareness.

From a relational perspective, patients may alert therapists to potential difficulties in the therapeutic alliance not only by direct confrontation but through subtle communications that risk being overlooked as compliance with treatment. These markers of withdrawal are interpreted as signals of a ruptured alliance that provide the therapist an opportunity to investigate, repair, and determine a more suitable response (Eubanks et al., 2021; Muran et al., 2021). Such acknowledgements of the patient's propensity to communicate – even at an unconscious or implicit level – for the purpose of influencing the course of therapy align closely with the concept of coaching.

Further alignment is evident in the humanistic assumption that patients possess and attempt to enact a fundamental self-healing motive in psychotherapy, emphasizing their agency in advancing therapeutic work (Bohart, 2006). Interview-based research, in which patients are asked to recall and explain moment-to-moment processes in therapy sessions, suggests that patients proactively direct the interaction and at times covertly

manipulate the therapist toward desired responses (Rennie, 2001). Further qualitative studies based on in-depth interviews have revealed patients to experience themselves as self-directed agents in their therapeutic work, viewing their own agency as central to having benefitted from therapy (Gibson & Cartwright, 2013; Hoener et al., 2012). Indeed, a meta-analysis of qualitative research found 62 studies referring to patients regarding themselves as active agents who influence their therapies both overtly and covertly, regulating their engagement and activity according to their needs and objectives (Levitt et al., 2016). Taking this further, CMT proposes that even the patient's apparently regressive, provocative, or hindering behaviors may reflect an agentic motive to overcome their difficulties by posing tests that seriously challenge the therapist (Gazzillo et al., 2022). These tests may indeed be hard for the therapist to navigate effectively without attention to coaching communications that hint at the patient's goals, obstacles, and therapeutic needs.

Empirical research on patients' coaching communications has only recently begun to emerge. One challenge for such research, particularly regarding implicit coaching, is the inference required to determine whether a communication reflects coaching – intended to shape the therapist's responsiveness to suit the patient's needs – or some other aspect of the therapeutic process, such as testing (Gazzillo et al., 2019) or displays of progress (Rodomonti et al., 2021). It may be especially difficult to ascertain occurrences of implicit coaching, conveyed indirectly or through allegory, without having first developed a formulation of the patient's goals, challenges, and concerns.

Nevertheless, a recent investigation using session transcripts from three separate therapy cases demonstrated that patients' coaching communications can be reliably distinguished from non-coaching material through the use of case formulations (Bugas et al., 2023). A case study of a failed psychotherapy case, also using session transcripts, employed ratings of the patient's coaching communications to reveal that the therapist's poor responsiveness to patient coaching may have contributed to premature termination and lack of improvement (Kealy et al., 2022). In this case, the patient engaged in coaching both pro-actively – alerting the therapist to her difficulties and needs – and reactively, in an attempt to correct the therapist's errors and guide him toward her concerns and priorities.

One body of research that partially maps on to direct forms of coaching is the literature on preference accommodation, which examines the degree to which patients' verbalized preferences are responded to and facilitated. Meta-analytic review of studies on patient preferences in psychotherapy found a robust effect for allowing patients to shape their therapies through the expression of preferences, in that accommodating patient preferences is associated with improved outcomes (Swift et al., 2018). These studies highlight patients' contributions to determining certain aspects of their therapies, indicating the value of heeding them.

Recent research has examined therapists' responses following patients' coaching in a study of 98 session transcripts from six cases of brief psychotherapy, using trained raters to assess coaching communications as defined by CMT (Gazzillo et al., 2024). The procedures for this study included the development of reliable formulations for each case, along with independent identification of coaching communications in segments throughout each therapy. Mixed model statistical analyses were used to show that, across the six cases, the therapist's ability to follow the patient's coaching was associated with

subsequent indicators of the patient's progress as rated by separate independent judges. Thus, the more therapists seemed to follow the patient's coaching in one segment, the more patients showed signs of improvement in the following segment within a therapy session.

Although research supports the existence of patient coaching and associated patient communications in psychotherapy, there remains a need for further investigation to better understand such phenomena. One largely overlooked area is the patient's vantage point with regard to their attempts at coaching their therapist. The degree to which patients see themselves as playing an active role in guiding their therapists through coaching communications – whether pro-actively or reactively – is unclear. Similarly, research is lacking as to patients' experiences of how their coaching communications are received and responded to by therapists. The present study was intended as a preliminary qualitative investigation into patients' perspectives on coaching in psychotherapy. Using questions with open-text response formats, an online sample of individuals who have received psychotherapy was asked whether they had coached their therapist and about the subsequent impact on their experience of therapy. Specifically, individuals who had sought publicly-funded mental health treatment were sampled, as patients in these settings could be expected to have a diversity of social, psychological, and health concerns––with potential implications for their treatment––to inform their providers about. A thematic analytic approach (Braun et al., 2021) was then applied to survey responses to determine themes related to patients' impressions of coaching within the therapeutic process.

Method

Participants and procedures

Participants were UK-based adults recruited online through the Prolific Academic crowdsourcing site. Recruitment was targeted specifically to individuals who were pre-screened as having previously sought mental health services through the UK's National Health Service (NHS). The NHS provides mental health care––including psychotherapy––to individuals from various socio-demographic and economic backgrounds, at no direct financial cost to service users. These participants responded to an online posting regarding a larger survey study concerning their perceptions and emotional responses regarding a range of past and present experiences. The study was approved by the Behavioural Research Ethics Board of the first author's university (certificate H20–02776), and all participants gave informed consent before proceeding with the study. A total of 357 people initiated the survey; see Figure 1 for a flowchart outlining the sampling process of the study. After screening for completeness and integrity of responses (i.e. using attention checks and duration of responding), 333 valid respondents were retained. Further screening into the present study used the question "Have you ever received counselling or psychotherapy?", offering categorical yes/no response options. Affirmative responses were indicated by 248 respondents, who were then included in the present investigation about coaching in psychotherapy. Among this sample of $N = 248$, the majority (76%; $n = 189$) reported currently experiencing a mental health problem, the most common being unspecified

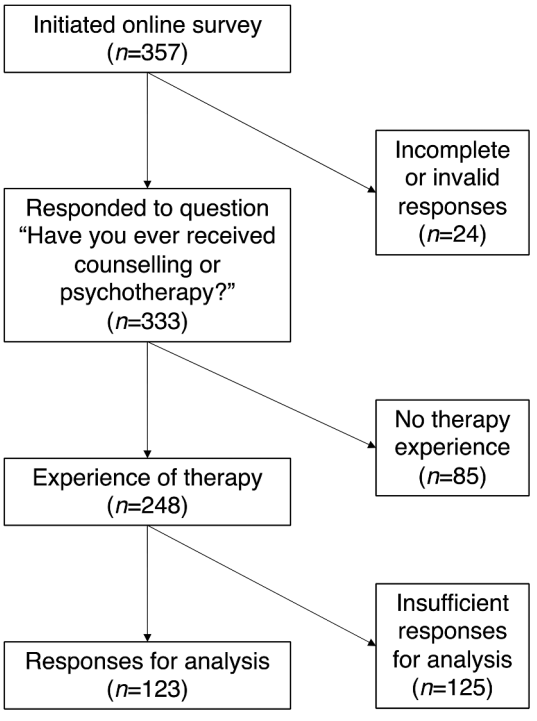

Figure 1. Sampling process for study participation and data analysis.

depressive or anxiety symptoms (71%; $n = 175$). Demographic information about the sample is presented in Table 1.

Materials

Fixed-response questions were used to obtain information about participants' demographic characteristics and timing and duration of therapy experience (see above). For the present study, questions and prompts were designed to elicit descriptions of respondents' experiences of their own coaching behavior in therapy, along with impressions of therapists' responses, the impact on therapy, and the timing and frequency of coaching communication. A brief, layperson definition of coaching in psychotherapy was included. Participants were provided with open-text response boxes and invited to describe in as much detail as they wished. Responses to the following questions and prompts were analyzed:

(1) Were there ever times in the therapy where you needed to "coach" the therapist in how to help you? In other words, did you ever need to let the therapist know, either directly or indirectly, what he/she should focus on, or to do things differently with you? Please describe in detail:
(2) Please describe how the therapist responded to your "coaching" of him/her, and what impact this had on your experience of therapy:

Table 1. Demographic information for participants who had received psychotherapy, $n = 248$.

Variable	
Age	*M (SD)*
(years)	33.6 (11.7)
Gender	% (*n*)
Female	64% (159)
Male	31% (76)
Non-binary or other	5% (13)
Ethnic identity	
Caucasian	87.5% (217)
Asian	2.4% (6)
South Asian	2.4% (6)
African	2.4% (6)
Multiple or other ethnicities	5.2% (13)
Sexual orientation	
Heterosexual	64.5% (160)
Gay or lesbian	3.6% (9)
Bisexual	22.6% (56)
Asexual	2% (5)
Queer or other orientation	7.3% (18)
Employment	
Full-time employment	44.4% (110)
Part-time employment	16.1% (40)
Student	14.5% (36
On disability benefits	11.7% (29)
Stay-home parent	3.2% (8)
Retired	1.6% (4)
Not employed, seeking work	5.6% (14)
Not employed, not seeking work	2.8% (7)
How long ago were you in therapy?	
Currently	15.7% (39)
Within the past year	25% (62)
Between 1–5 years ago	39.9% (99)
More than 5 years ago	19% (47)
Duration of therapy	
Less than 10 sessions	43% (107)
Between 10–50 sessions	50% (123)
More than 50 sessions	7% (18)

(3) Please indicate when and how often this happened (e.g. beginning/middle/end; once/a few times/many times):

Data analysis

A preliminary evaluation was conducted by reviewing whether responses included sufficient information for analysis. Single-word or brief phrase responses, such as "no" or "not applicable" – without further elaboration or contextual information – were excluded, along with blank responses. Any response providing description beyond these minimal replies was included for qualitative analysis, leaving a final sample for analysis of $N = 123$. Responses to the three questions/prompts were collated and analyzed as a single narrative per participant. The length of included responses varied, ranging from one to several sentences, with an average of 72 words per participant.

Thematic analysis (Braun & Clarke, 2012) was used to develop and organize themes in participants' responses, in line with expert recommendations for qualitative inquiry using

online surveys (Braun et al., 2021). To ensure the integrity of the analysis, additional guidelines for qualitative research were consulted throughout the analytic process (Levitt et al., 2017). The research team comprised psychotherapists and psychotherapy researchers at varying career stages, including members with graduate-level training in qualitative methods (DK, SW, EL). Team members reflected upon and discussed potential biases throughout the analytic process (see Reflexivity Statement below). Two members of the research team (DK and SW) led the analysis and management of procedures to enhance trustworthiness. These research team members each spent time with the data, independently reading and reviewing all responses, making notes to aid their reflections about participants' narratives. Next, these team members investigated patterns of meaning, conferring to discuss prospective clusters based on the explicit meanings in participants' responses. Themes and sub-themes––reflecting patterns that capture important aspects of participants' experience––were then developed to create a coding scheme. The lead researcher (DK) assigned themes to each narrative; the second researcher (SW) assigned themes independently to each narrative, before convening to discuss discrepancies with one another. Themes were supported by multiple quotes from participants, and a single response narrative could reflect more than one theme or sub-theme. To ensure rigor and trustworthiness, the team revisited original responses to reassess the context of supporting quotes within participants' entire narratives, mitigating potential interpretive bias in the initial analysis. The lead researcher (DK) then organized themes with exemplar quotes for each, in order for the full research team to evaluate the representativeness of the themes. Consensus was achieved through discussion with the full research team, reviewing explicit meanings in participants' narratives and checking for correspondence with assigned themes and subthemes.

Reflexivity statement

All researchers involved in this study were practicing psychotherapists; some were established psychotherapy researchers (DK, GS, JM) and others were early-career therapists who were completing graduate or post-graduate research training (SW, EL). Members of the research team have previously theorized and examined the phenomenon of patient coaching in psychotherapy. Thus, in collecting, reviewing, and analyzing the data, team members convened to reflect on and discuss the potential for this bias––and that related to our position as psychotherapist researchers––to influence our interpretation of the data. We also conferred to verify our interpretation and categorization of explicit meanings of participants' responses.

Results

Four main themes, each comprising at least two subthemes (for a total of ten subthemes), were developed from respondents' narratives. The first theme, labelled *orienting the therapist*, refers to participants' perceptions of having communicated to shape the goals, focus, or techniques of their treatment. A second theme, labelled *impact of coaching*, reflects participants' impressions of how their communications were received and responded to. The remaining themes, *minimal coaching* and *frequency of coaching*, reflects the incidence of coaching being limited for some participants and occurring at

particular junctures for others, respectively. Table 2 presents each theme and subtheme, along with the corresponding number of contributing responses.

Orienting the therapist

The majority of participants described engaging in coaching communication for the purpose of shaping their therapies to be aligned with their personal goals, preferences, or needs. These descriptions indicated coaching to be a means by which patients could increase the likelihood of their therapist understanding their concerns and working with them in a desired way. One component of orienting the therapist was reflected in the subtheme *clarifying goals for therapy*. Participants felt they needed to help the therapist develop a clearer sense of what the patient was trying to achieve in therapy, both at the outset of treatment and once therapy was underway.

> I had discussions with my therapist at the beginning . . . to determine what we would focus on. We discussed what was impacting me the most and agreed to work towards improving the negative impact. (33, female)

> I had to describe my intrusive thoughts to them when they did not really "get" it. I had to explain a couple times in the first session but after that they understood and adapted long term. (18, female}

Exemplifying this subtheme, these quotes indicate patients' attempts to define the focus of their work with the therapist, ensuring the agenda for therapy was aligned with the patient's goals.

In some instances coaching was described as a form of reminding or influencing the therapist – both explicitly and implicitly – regarding the issues that the patient wanted or needed to focus on in their work together.

> Yes I did [coach the therapist]. I had to identify different things each week that the counsellor would talk about with me. (33, female)

> There have been many times during my various therapy/counselling sessions over the years when I've been struggling with something and I've either needed to bring it up as something that needed to be addressed/discussed or to remind the person that I've asked for help with something but haven't gotten any. (23, female)

> I pushed my therapist to focus more on my issues with my Dad and my childhood. (23 non-binary)

Table 2. Themes of patients' perceptions of coaching communications in psychotherapy, $N = 123$.

Theme	*Subtheme*	*n*
Orienting the therapist	Clarifying goals for therapy	28
	Redirecting the therapist's focus or approach	48
Impact of coaching	The therapist's response resulted in positive collaboration	31
	The patient's input was ignored	14
	Unsatisfying outcome as the therapist neglected the patient's coaching	30
Minimal coaching	Perceptions of the therapist as expert	12
	Patient deference or lack of confidence	16
Frequency of coaching	Occasional or key moments	40
	Regularly to orient or redirect the therapist	21
	The patient's input was explicitly welcomed throughout therapy	15

These accounts reflect the agentic nature of coaching to clarify therapeutic goals, in that patients were motivated to persist in communicating their objectives throughout treatment, keeping the therapy on track with their intended focus and therapeutic needs.

Another subtheme related to orienting the therapist was labelled *redirecting the therapist's focus or approach*. This subtheme reflected patients' use of coaching to correct the course of their therapy upon recognizing that the therapist was addressing an issue of lesser importance, or employing interventions that the patient found unhelpful or objectionable. These participants thus felt motivated to alert the therapist that the current direction was not working from the patient's perspective, in the hope that the therapist would be able to change course and become better aligned with their needs.

> I had to tell them when I felt they were focusing on issues that I wasn't there to discuss. Sometimes I could tell they were asking textbook questions and didn't really get me or my problem. (39, female)

> I let them know that the techniques and tips they were giving me did not help and felt like they didn't apply to how I was feeling or would deal with the situation. (20, female)

Beyond informing the therapist about unhelpful tasks or processes, coaching aimed at redirecting seemed to link patients' discontent with their individual needs and preferences not being honored, as indicated by the following accounts.

> They would leave long awkward silences for me to fill. I've thought very deeply about my issues and can make my own thinking space when I need to so this made the sessions feel very awkward. I told them this, in roughly these words. (43, non-binary)

> I did feel that often the issue that I saw the therapist for was not the issue we spoke about in the sessions. I did once or twice raise the issue that I wanted to speak about, but I was not very confident with it. My therapist listened to me, but did not allow the session to be steered in that direction. (42, female)

The redirection subtheme also contained descriptions of coaching aimed at changing the therapist's focus of intervention, or the technical strategies involved in pursuing their goals. These communications included clues as to the kind of direction they wanted their therapy to take, in some instances suggesting areas of exploration or technical approaches they thought might be useful. While some individuals were able to specify particular types of therapy interventions, such as cognitive behavioural techniques, others provided guidance for an overall atmosphere they hoped the therapist could help create in their sessions. Taken together, these descriptions indicated that coaching represented the patient's attempt at rejuvenating a therapy that was no longer responsive – from the patient's perspective – to their concerns and sensitivities.

> I felt like the therapist was not paying attention to what was troubling me. The therapist did not want to talk about what had happened to me in my earlier years, and instead wanted to focus on the present time and future. I felt and did mention that what happened to me during my younger life needed to be talked about and dealt with, because I know that is what has impacted my adult life so badly. (56, female)

> A therapist I saw for a few months was very focused on my childhood and family when I said I had immediate issues I wanted to talk about first. (27, female)

Such accounts reflect patients' determination to influence their therapist to focus the issues that were of most importance, lest the therapy continue along an unhelpful path. Participants also described coaching to redirect a therapist's technical approach, with the aim of achieving a better fit in terms of therapeutic tasks and processes, exemplified by the following quotes.

> I felt like I needed more practical advice, and asked for more practical advice and feedback on the problems I was discussing. I also felt at times they were not really listening to me at times. (34, female)

> Sometimes I needed to know deep reasons for my behaviour and she was giving advice on how to overcome but I really wanted to know why I'm doing that so I kindly asked if we can find out the real problem instead of solving it with cognitive therapy (33, female)

> I needed them to "hold" my feelings rather than try to fix them through problem solving. (51, female)

Impact of coaching

Among participants who indicated they coaching their therapists, many provided descriptions of their perceptions of how this had an impact on their treatment. For these participants, coaching was clearly intended to have an effect on the way their therapist worked with them. We found one subtheme related to impact to refer to the positive effects of coaching, labelled *therapist's response resulted in positive collaboration.*, Responses in this category indicated that therapists were experienced by several participants as having been receptive to coaching in a manner which advanced the treatment. As portrayed in the following descriptions, these participants felt seen and heard by a therapist who welcomed their input as to what they needed and wanted in their therapy.

> The therapist responded to my coaching by taking my lead and then asking me questions that were relevant to what I initiated the session with. (51, female)

> I asked her to try and find another way to help me apart from mindfulness, as certain aspects of it such as concentrating on my body actually made the symptoms of my anxiety worse and made me feel panicky. The therapist listened to my perspective and found different techniques to try and help me. (51, female)

Moreover, participants perceived their therapeutic process to have improved as a consequence of their therapist's response to their coaching, resulting in a sense of the therapy becoming more productive. As the following accounts illustrate, patients seemed to feel encouraged by their therapist's receptivity to coaching, experiencing a strengthening of the therapeutic relationship. Thus, the degree to which coaching communications were received and integrated by the therapist corresponded to patients' experiences of therapy relationships that were attuned and helpful.

> She was very receptive and curious to learn more. It meant we had better understanding and I felt more comfortable talking to her. (21, female)

> There were a few times when I tried to get across the idea that the standard CBT concept of "repeatedly doing something in small steps to get myself accustomed to it" didn't ever really seem to work. Some suggested activities were not ones I could easily complete, nor ones that I could consistently do, and often even if I did do something repeatedly it wouldn't ease the issues I was having. We were able to adjust the suggested activities that I tried out, and to focus more on the patterns of thinking rather than the sort of exposure therapy that comes from doing something repeatedly. (24, male)

Another aspect of the impact of coaching referred to a relative lack of reception among therapists, contributing to the subtheme, *the patient's input was ignored*. These participants reported that their coaching did not seem to register with the therapist, with the therapist either showing no response to the patient's communication or simply continuing in their approach, unmodified, despite apparently having taken in the patient's perspective.

> I tried to discuss new goals a few times which seemed to be well received, but with time I realized these were not being factored in and dealt with in sessions as requested. (33, female)

> I felt like the therapist was too focused on CBT instead of trying to get to the root of the problem so I suggested we try something else. The therapist seemed to ignore my suggestion and thought just focusing on CBT would be beneficial. (29, male)

A further impact of coaching referred to the negative effects of therapists' insufficient responsiveness to the patient's attempts to shape their therapy. Indeed, several participants' descriptions informed the subtheme labelled *unsatisfying outcome as the therapist neglected the patient's coaching*. These outcomes included loss of faith in the therapist's ability to be helpful, a lack of confidence in the utility of therapy, and a deterioration in the quality of the therapeutic relationship. In this way, the therapist's unwillingness or inability to receive or integrate the patient's coaching became a source of demoralization, potentially contributing to the patient's limited therapeutic outcome and stalled recovery.

> There were times where the therapist seemed to decide on one thing as the root of all my anxiety, it was not the main issue I was struggling with but she would often focus on this. It became difficult to steer the session back to what I wanted help with. I just tried to steer the conversation back onto what I wanted to discuss with her, however she would always go back to her own line of thinking and questioning. (19, female)

> I didn't exactly coach them but I tried to talk about something I thought was important and was laying heavily on my mind and had been for a number of years. My concern was dismissed instantaneously without being questioned about what exactly it was. After that I didn't have the heart or will to try and steer the conversation again. (48, male)

As the above accounts illustrate, the therapist's dismissal of a patient's coaching efforts could be a frustrating experience, leaving the patient resigned to work in ways that weren't fully satisfying. Indeed, as the following quotes indicate, some participants felt deeply discouraged, leading to doubt about the therapeutic endeavor overall.

> She put down any suggestion I had even though I could tell she was misunderstanding me and my conditions. It affected my confidence in both the treatment and my ability to get better. I felt like I was being ignored by the people who were supposed to try to help. (25, female)

> When I asked them to focus on something else other than the issue I was attending about, they wouldn't change topic/direction. I felt that their inflexibility was deflating, demotivating, and made me connect less with them. (56, male)

For some individuals, the therapist's limited receptiveness to their feedback––and in some instances, a defensive response to it––resulted in the decision to terminate therapy despite their goals remaining unattained. The therapist's antipathy to coaching was a signal for these patients that their therapeutic needs would likely remain unmet within this relationship, and that they may be better served by leaving rather than to continue to coach toward an elusive desired way of working.

> I told therapist they were pushing me too fast. They did not agree with me and this damaged my relationship with them . . . I stopped going shortly afterwards. (37, female)

> The therapist clearly took this criticism as an insult, or it pushed one of their buttons, and they responded with unrelated and uncharitable complaints e.g. "I'm not here to solve your problems for you". I was distinctly unimpressed and decided not to see them anymore. (43, non-binary)

Minimal coaching

A minority of participant responses indicated a lack of or minimal coaching in their therapies. These participants did not endorse having attempted to orient or redirect the therapist regarding their goals or desired therapist actions. Several indicated that this was the case because they felt no need to provide any guidance to their therapist, contributing to the subtheme labelled *perception of therapist as expert*. These participants expressed feeling trust in their therapist to know what should be done in their therapy, on the basis of the therapist's knowledge, competence, or understanding of the patient. Hence, from the perspective of these patients, coaching was not necessary to assist their therapist in meeting their therapeutic needs.

> I just went with the flow that the therapist took. I didn't generally push for a particular approach myself. I trusted them to find the best way forwards, with my input where necessary of course. (24, non-binary)

> No (I didn't coach the therapist), he knew exactly what to do. (55, male)

> No, I had a good relationship with my therapist and she had a deep understanding of me. (35, female)

Another set of descriptions referred to a different rationale for not engaging in coaching during therapy. These participants did not coach their therapist due to feeling deferential or unqualified to provide direction, reflected in the subtheme labelled *patient deference or lack of confidence*. Although these participants' descriptions also alluded to therapists being seen as expert, they also emphasized the patient's relative lack of knowledge or confidence in being able to influence the agenda of their therapy or communicate their needs and preferences to the therapist. Thus, in contrast to descriptions of minimal coaching due to the therapist's competence or expertise, these participants seemed resigned to not having a right to speak up about the direction of their therapy.

> I don't have the confidence to (coach the therapist), even when the therapist said things that I thought were wrong. (35, male)

> No, I would usually focus on whatever my therapist wanted to focus on during the session. I was discharged because my therapist didn't think her therapy was the right type for me. [24, non-binary]

> No [I didn't coach the therapist], I was fairly naive to the whole process and let them guide me. (29, female)

In addition to accounts of resignation at their deference, some participants retrospectively considered that their treatments might have improved if they had overcome their reluctance to coach their therapist, as illustrated by the following quotes.

> I should have but I didn't [coach the therapist] – many sessions were me struggling to figure out what to say. (28, male)

> I didn't have the self-confidence to coach my therapist, but I feel like I would have had a better experience if I explained I didn't like her approach to getting me to open up. (28, female)

Frequency of coaching

In line with the concise and direct nature of our question, participants' responses indicating frequency of coaching were relatively brief. However, these accounts were clustered in three subthemes referring to the temporal dimension or "when" aspect of patients' coaching communications: (1) *occasionally or at key moments;* (2) *regularly to orient or redirect the therapist*; and (3) *input was explicitly welcomed throughout therapy*. Of the participants who described coaching their therapists, the majority reported this to have occurred *occasionally or at key moments* in their therapy ("a few times throughout therapy"). For some this was at the beginning of treatment ("at the start") while others coached during the middle phase of therapy ("in the middle when I started to get to know my therapist more"). A minority of participants felt they needed to coach *regularly to orient or redirect the therapist*. For these patients, relatively frequent coaching seemed necessary to ensure therapy stayed on course ("many times throughout the process"). Another set of descriptions indicated that the patient's *input was explicitly welcomed throughout therapy*. These participants, also representing a minority, felt they were engaged in coaching communication almost continuously in their therapeutic work ("this happens continuously throughout my sessions"). Moreover, they regarded this frequency of coaching as something their therapist encouraged; they felt a natural entitlement to give voice to their needs and preferences within the therapy relationship.

Discussion

The present study offered a preliminary investigation into patients' perspectives on their potential engagement in coaching activities in psychotherapy. Qualitative analysis of patients' accounts indicated two key ways in which coaching communications appeared to orient their therapist toward an optimal treatment experience. One such form of coaching reflected the patient's effort to outline and clarify their goals for therapy. This

involved proactively identifying issues for the therapist to focus on, ensuring that the therapy would be guided by the patient's main concerns and goals. Another form of coaching involved redirecting therapists away from interventions or topics that did not align with the patient's goals, needs, and preferences. In this way, coaching served to realign the therapist's focus, techniques, or style, helping to optimize the therapeutic process.

Participants described varying levels of engagement in coaching activities. While some noted coaching their therapist at key moments or during specific phases of therapy, others reported more regular coaching to keep therapy on track. In contrast, some individuals refrained from coaching either because they felt it wasn't needed or due to a lack of confidence. Participants also gave accounts of the outcomes of their coaching efforts, noting that therapist acceptance of and responsiveness to coaching was facilitative of positive outcomes. However, many participants reported that their therapists ignored or rejected their coaching attempts, resulting in negative experiences such as a damaged therapeutic relationship, dropout from treatment, or a lack of progress.

The indication that patients may alert and orient their therapists to their goals, challenges, and therapeutic needs aligns with the notion of proactive coaching (Bugas et al., 2023). CMT suggests that patients entering therapy are motivated to overcome their difficulties, and to equip their therapists to help them do so. Patients may thus reveal important aspects of what they need help with, including underlying factors that reinforce their challenges, and provide clues as to how the therapist might be useful in facilitating their therapeutic plan. Participants in the present study shared experiences of explicitly informing their therapist about areas of focus and therapeutic approaches that may or may not suit their needs. However, CMT suggests that this kind of coaching may also occur in implicit ways, beyond the patient's conscious awareness of their orienting intent. The patient's story told during the intake or early engagement phase––presented simply as a narrative of the patient's experiences––may illustrate important themes related to therapeutic objectives and preferences. By describing a previous relationship, particularly one involving a helping professional, the patient may unwittingly cue the therapist to ways of relating that could either help or hinder their present therapeutic endeavor. Qualitative research regarding patients' experiences of therapy sessions suggests that patients may retrospectively recognize such implicit motivations to shape their therapy, reflecting an agency to influence the therapist's responsiveness toward their needs (Rennie, 2001).

Like proactive coaching, communications made in reaction to the therapist's behaviour also serve to guide the therapist regarding what the patient seeks help with or toward tolerable or even ideal therapeutic tasks and behaviours. Reactive coaching, therefore, acts as a form of re-directing or re-orienting the therapist to the patient's plan (Bugas et al., 2023). In other words, when the therapy deviates from the patient's goals or needs, such coaching aims to correct and instigate or restore the therapist's optimal responsiveness (Bacal & Herzog, 2003). Participants in our study described themselves directly telling their therapist about areas they did not want to work on, or about undesired interventions. Their coaching communications were an attempt to correct what they felt was the therapist's veering off course, aimed at resetting or restoring a potentially productive therapeutic process. Misalignment of therapeutic goals, tasks, or bond has been conceptualized as a rupture in the therapeutic alliance (Eubanks et al., 2021). Given the link

between alliance quality and treatment outcome (Flückiger et al., 2018), ruptures that are unattended to may be detrimental to productive therapy (Li et al., 2024). Yet research has shown that patients often provide "markers" or cues in their utterances and behaviours that signal alliance ruptures, thereby facilitating therapists' investigation and repair of such misalignments in a manner that improves treatment outcome (Eubanks et al., 2018). Reactive coaching may encompass such markers of rupture, as patients attempt to let the therapist know what is not working for them. At the same time, these communications can include suggestions to the therapist as to possibilities for realignment or repair. Thus, reactive coaching may reflect the patient's initiative to instigate repair of an alliance rupture amid re-orientation to their therapeutic goals and needs.

The consequences of therapists' attention and inattention to coaching seem evident in our participants' accounts. When patients perceived their therapist as receptive to and applying their coaching communications, they reported experiencing a greater sense of collaboration and partnership. These participants viewed the therapist's receptiveness to coaching as a sign of their availability, understanding, and adaptability, which ultimately enhanced the patient's sense of trust. This perception of the positive impact of coaching accords with research demonstrating that therapist interventions rated as aligned with the patient's coaching are associated with evidence of the patient's immediate improvement (Gazzillo et al., 2024). Conversely, participants whose therapist was seen as oblivious or impervious to their coaching efforts developed negative views of the therapist and therapeutic process. For these individuals, the therapist was experienced as inflexible and discouraging, contributing to a sense of demoralization or disengagement. Indeed, several participants indicated having dropped out of treatment in response to the therapist's lack of attention to their coaching. Repeated disregard for coaching may jeopardize the therapeutic relationship in what could be considered an extended, treatment-threatening rupture. Although some patients may continue to coach the therapist in an attempt to repair such a scenario, there appears to be a limit beyond which patients may disengage entirely, resulting in premature termination (Kealy et al., 2022).

Interestingly, descriptions of relatively minimal coaching activity reflected participants' impressions that such activity was not called for in the therapy they experienced, albeit for two distinct reasons. One perspective positioned the therapist as sufficiently expert and responsive so as to obviate the need for the patient's coaching. These participants felt comfortable trusting the therapist to lead the way, though presumably at some point they had communicated enough of their concerns and goals, providing a clear focus for treatment. While also reflecting an assumption of the therapist's expertise, the other perspective was marked by a sense of deference to the therapist's authority and the patient's lack of confidence in being able to exert much influence in therapy. These participants acknowledged having had wishes for different therapeutic experiences but chose to withhold their input, possibly out of a belief that such disclosures would be rebuffed or perceived as inappropriate or even offensive by the therapist. Previous studies have shown that many patients avoid expressing their negative reactions to therapist interventions (Farber, 2003), with process research indicating various aspects of patients' deference, including fear of criticizing the therapist, concern about the therapist's expectations, and feelings of indebtedness to the therapist (Rennie, 1994).

While these latter findings may appear at odds with certain CMT assumptions––specifically, the idea that patients are motivated to influence therapy to overcome their

difficulties––they may reflect instead the primacy of safety for patients' therapeutic progress. According to CMT, patients need to perceive a sufficient degree of safety to lower their defenses and increase therapeutic engagement (Silberschatz, 2008; Weiss, 1998). Patients who are deferential or withholding may sense that it is not safe to fully and explicitly coach their therapist, a perception shaped by the therapist's actual behavior and/or by the patient's own pathogenic beliefs that warn against expressing controversial disclosures. In contrast, several participants described feeling encouraged to coach their therapist regularly, if not throughout the entire therapy, as a way of maintaining their influence and refining the therapeutic process. Their therapists might have actively sought and utilized patients' input to positive effect, in line with research demonstrating a robust effect of goal consensus and collaboration on therapy outcomes (Tryon et al., 2018). It is possible that for some patients, signals of the therapist's attunement and collaborative potential may well engender further coaching.

Several limitations of the present study must be acknowledged. First, participants were recruited via online questionnaire and had sought psychotherapy through publicly funded mental health services in the UK. These individuals may not represent the broader population of psychotherapy patients, such as those paying for therapy in a private practice context. Second, half of the initial sample either did not respond or gave negligible responses to our questions about coaching. While this could suggest limited awareness or recognition of coaching communications, it is also possible that some participants completed the survey quickly, with minimal reflection or narrative detail. Additionally, our online survey inquiry may also have been too far removed from some individuals' actual therapy experience, potentially limiting their ability to connect with or relate to the concept of coaching communication as described. Furthermore, we did not collect information about the type of therapy participants had received. It is conceivable that perceptions of coaching and related experiences vary across different therapeutic models and contextual factors. It is possible, for example, that some patients may feel discouraged from coaching in highly structured task-focused therapies. Alternatively, patients may feel a need to coach more vigorously––with an urgent need to convey their preferences––in therapies that emphasize the therapist's knowledge base and technical expertise. Such variation in therapy context may interact with patient features to influence the frequency and character of patients' coaching.

Future research could attempt to overcome these limitations by sampling more diverse populations of patients across a range of therapy orientations. Interview-based inquiry could also allow for deeper and more comprehensive descriptions of patients' experiences of coaching, with approaches such as the interpersonal process recall method (Larsen et al., 2008) facilitating moment-to-moment illumination of patients' perspectives on their coaching and their therapist's responsiveness through retrospective review of session material. Finally, further development of reliable, observer-based assessment of coaching (Bugas et al., 2023) would enable a deeper investigation into coaching communications that may occur beyond the patient's awareness.

As a preliminary exploration of patients' perspectives, the present study indicates that patients may seek to proactively coach the therapist to clarify their treatment goals, yet may also communicate in an effort to redirect the therapist's focus or technical strategy. Most importantly, patients reported experiencing positive therapy relationships and outcomes when their therapist acknowledged and integrated their coaching

communications. Conversely, when coaching efforts were ignored or refused, patients noted having experienced a deteriorated therapeutic relationship and diminished trust in the therapist. These findings highlight a need for therapists to pay close attention to potential coaching communications and integrate their implications for therapeutic process with a given patient.

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Notes on contributors

David Kealy, Ph.D. is an Associate Professor in the Psychotherapy Program at the Department of Psychiatry, University of British Columbia. In addition to teaching and researching psychotherapy and mental health concerns, he maintains a private practice in Vancouver, Canada.

Sarah Woolgar, MA is a doctoral candidate in the Counselling Psychology Program at the University of British Columbia, and a therapist in private practice in Vancouver, Canada.

Elizabeth Li, Ph.D. is a psychologist, educator, and researcher with the University College London and Anna Freud Centre. She teaches and conducts research on developmental psychopathology and psychotherapy.

James McCollum, Ph.D. is a psychologist, educator, and researcher with the San Francisco Psychotherapy Research Group. He is in private practice in San Francisco, California.

George Silberschatz, Ph.D. is a psychologist and Clinical Professor in Psychiatry at the University of California, San Francisco School of Medicine, president of the San Francisco Psychotherapy Research Group, and a past president of the international Society for Psychotherapy Research. In addition to his research and teaching activities he maintains a private practice in San Francisco.

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