The Psychotherapeutic Process from the Therapists' Perspective: Personality, Therapeutic Alliance and Theoretical Orientation

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Abstract

Introduction: *The therapeutic process is largely dependent on the psychotherapist. The therapist's view on the process, however, is a difficult task to unfold, given the complexity of the concept. As a result, one can only describe the therapist's view on different components of the therapeutic process.*

Objectives: *To explore the therapeutic process from the therapists' perspectives: therapeutic alliance; the perception on the client and on himself during therapy; the psychotherapist's theoretical orientation. To devise a personality profile for the therapists in the present sample and to explore the correlation between these different variables.*

Methods: *The participants in the study are psychotherapists accredited in Romania (N=137), with various theoretical orientations, who filled in the following instruments: The Helping Alliance Questionnaire HAq2, The Big Five Inventory (BFI), Theoretical evaluation Self-Test, The therapeutic process from the therapist perspective. The sample was composed of psychotherapists officially accredited, from the Register of Psychologists in Romania. The inclusion criteria were represented by the existence of an official accreditation and the specialization (psychotherapy).*

Results: *The results show that therapists had the highest scores on the following BFI scales: Openness, Agreeableness and Conscientiousness. The therapeutic alliance varies depending on the theoretical orientation, but the source of this variability cannot be identified in this study. Therapeutic alliance is also correlated with the perception on having results at the end of the therapeutic process. When it comes to the personality factor of Neuroticism, it seems that it varies proportionately with negative countertransference, and the Openness factor correlates with the Humanistic theoretical orientation.*

Conclusions: *Through this study one can observe in which manner psychotherapists develop an image of the psychotherapeutic process and of themselves in this setting. This image is shown to be a cumulus of various elements of the psychotherapist as a person/ professional and different psychotherapy elements.*

Keywords: psychotherapy, working alliance, psychotherapists, clients, countertransference, psychotherapy practice research

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I. Introduction

In this study, the psychotherapeutic process is explored from the therapists' perspective. The therapists have also undergone an analysis which resulted in a general personality profile to better understand what characteristics are associated with the participants in this sample (psychotherapy professionals from Romania). This analysis also includes elements of the therapeutic process, such as: therapeutic alliance and the role it plays in mediating the relation between the results of a psychotherapy cycle from the therapists' perspective and their theoretical orientation.

Illustrating the therapists' perspective of the therapeutic process can be a difficult task, as a result of their continual professionalization, their focused views on their psychotherapy school and their personal values. Therefore, one might only describe their perspective on different elements of the therapeutic process, not on the therapeutic process as a whole. The research on the therapeutic process implies the study of all the factors involved in the interaction between the client and the therapist. If psychotherapy is seen as a treatment for a condition, implemented by therapists by following certain psychological principles, then the therapist factor can be considered primordial in the therapy equation. As opposed to the medical intervention, where the doctor prescribes a pharmacological form of treatment, psychotherapists further influence the treatment with their level of expertise, professional experience and even their adherence to a certain therapeutic model and their own personality characteristics. The results obtained by the client in therapy may vary depending on the therapist (Walwyn, Roberts, 2010).

The therapeutic alliance from the therapists' perspective

The therapeutic alliance, or the working alliance as it is called by some, is one of the most important components of the therapeutic process, as through it, the client and the therapist can build the relationship considered necessary for change to occur in therapy. The therapeutic alliance is one of the central factors that explain the positive results of a treatment. This fact was studied for 30 years in researches which associated the concept of alliance and the different components of the therapeutic process (Horvath & Bedi, 2002; Horvath, Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000, apud Re, Flückiger, Horvath, Symonds, Wampold, 2012). In the meta-analysis by Horvath et al., the therapeutic alliance was found to be a predictor for the treatment result and it was responsible for 8% of the results variability (Horvath, et al., 2011, apud Re et al., 2012). The therapeutic alliance was conceptualized as a relation of collaboration between the client and the therapist (Bordin, 1979; Hatcher, Barends, 2006, apud Re et al., 2012). Even if the definition of this concept is not a standard one, the researchers seem to have reached a consensus when speaking about it, both from a temporal perspective and a theoretical one. And that consensus is about the elements that form the therapeutic alliance: the relationship between the client and the therapist and the agreement on the objectives of therapy (Hatcher & Barends, 1995, 2006; Horvath, 2002, apud Re et al, 2012).

The therapeutic process from the therapists' perspective

Guiding a therapy process can be a complex action that may imply professional interventions and also authentic reactions to each client's material. Therapists are always in a rhetoric regarding the subjects that are discussed in therapy and how they should be treated. Research on the therapeutic process investigated over time what actually happens in therapy, but the most recent studies bring in the foreground the personal experiences the client and the therapist have in sessions and also between them (Hartmnan, Orlinsky, Weber, et al., 2010, apud Arnd-Caddigan, 2012). The image that a therapist has on the therapeutic process and the conversations he imagines having with the client indicate that even thinking about the therapeutic process is not an individual phenomena. If imagination uses elements from the exterior, the elements themselves play a role in the imagined event (Arnd-Caddigan, 2012). Similar to Arnd-Caddigan's study, in which participants who's verbatim were imagined conversations, the participants from this study had to recreate a part of their therapeutic activity in a different setting than their actual office.

Personality and psychotherapy

Eysenck was one of the first researchers to operationalize personality types as conglomerates of action tendencies of a person (Eysenck, 1952, apud Crețu, 2012). Eysenck was also the one who proposed a factorial model as a solution for structuring personality factors. The Big Five Model is a factorial model that succeeded to transculturally replicate 5 factors (Digman, 1990; Piedmont, McCrae, Costa, 1991, apud Crețu, 2012). Some personality traits can be a factor in choosing one's theoretical orientation or one's practice

model. How these characteristics influence therapy as a whole, alliance and therapeutic results is explored in the present study.

II. Objectives

The main objective of the present study is to explore the therapeutic process from the psychotherapists' perspective: therapeutic alliance, the perception on the client and on oneself during therapy, own theoretical orientation; to devise a personality profile for the therapists in the present sample and to explore the correlation between these different variables.

Hypotheses

1. The perception on the therapeutic alliance varies based on the theoretical orientation of the therapist.
2. Neuroticism varies proportionately according to countertransference.
3. The perception on the results of therapy is a predictor for the perception on the therapeutic alliance.
4. The Humanistic theoretical orientation correlates with the Agreeableness factor.

III. Methods

Variables

The constructs measured in this research are: perception on the therapeutic process; therapeutic alliance; personality and theoretical orientation of the therapist.

The perception on various elements of the therapeutic process: A construct measured through the scales *session's impact* (the perception on the insights of the client or the degree in which the therapist considers that during sessions there were moments which allowed for a change in the client), *the therapist's perception of the client* (with the subscales *therapy resistance* – a negative reaction of the client regarding the therapeutic process, as interpreted by the therapist, translated in a lack of adhesion to the process vs. *collaboration* – a positive reaction of the client, understood as a relationship based on cooperation), *the self-perception of the therapist* (*countertransference* – thoughts and feelings a therapist may have in the course of the therapeutic sessions, which can impact the therapist positively or negatively – *positive countertransference vs. negative countertransference*) and the *therapy results from the therapist's perspective* (the perception on the results of therapy at the end of the therapeutic process).

The therapeutic alliance is a construct measured through the questionnaire: The Helping Alliance Questionnaire HAq2, therapist version; it is the relation based on help established between the psychotherapist and the client during the psychotherapy sessions, from the therapist's perspective. In the present study, therapeutic alliance and working alliance are used to describe this variable.

The therapist's personality: is the construct measured through The Big Five Inventory that outlines the five prototype factors: Extraversion, Neuroticism, Openness to experience, Agreeableness and Conscientiousness.

The theoretical orientation of the therapist: is the construct measured through the Theoretical Orientation Test, it represents the theoretical approach of the therapist from the perspective of the psychotherapeutic orientation found in the instrument (Psychodynamic, Biologic, Family, Ecosystem, Cognitive, Pragmatic and Humanistic).

Instruments

1. The therapeutic process from the therapist perspective

The instrument was devised solely for this research and its aim is to measure the subjective aspects of the therapists' experiences during psychotherapy sessions. The scales of the instrument are:

a) *The impact of the sessions*: it measures the degree in which the client manifests himself in therapy and the existence of therapeutic insights. The Cronbach Alpha reliability index is 0.835.

b) *The therapist's perception of the client*: measures to what degree the therapist perceives his client as an actively implicated partner or as being resistant to therapy. A low score to this scale indicates a high resistance to therapy and a high score indicates a collaboration stance from the client. The Cronbach Alpha reliability index is 0.752.

c) *The therapist's perception on himself*: measures countertransference in therapy. A low score indicates a negative countertransference, whereas a high score indicates a collaboration stance. The Cronbach Alpha reliability index is 0.871.

d) *Psychotherapy results*: it measures the perception on the existence of results at the end of the therapeutic process. The Cronbach Alpha reliability index is 0.761.

2. Theoretical evaluation Self-Test (Daniel Coleman, 2000)

This instrument was devised to measure the theoretical orientation of psychotherapists. The test items are self-reporting and the participants evaluate the measure in which they agree with the statements by using a Likert scale from 1 to 7, where 1 means to strongly disagree and 7 means to strongly agree. The subscales of the test refer to the following orientations: Psychodynamic, Biological, Family, Ecosystems, Cognitive, Pragmatic, and Humanistic. In the preliminary fidelity and validity assessment, Coleman (2004) indicated through a factorial analysis that the main factors of the test were responsible for 87% of the variation of the items. The mean value of the Cronbach Alpha index for the 6 factors was 0.65 (Coleman, 2004, apud Coleman, 2007). In the revalidation study of the instrument, the factorial structure was largely replicated, except for 3 items which behaved differently. In the study they identified a 5-factor model and the mean value of the Cronbach Alpha for the 5 scales was 0.64, with variations from 0.54 to 0.72 (Coleman, 2007). After the translation and adaptation in the Romanian language, the Cronbach Alpha indexes for each scale were: Psychodynamic 0.578, Biological 0.623, Family 0.744, Ecosystem 0.515, Cognitive 0.709, Pragmatic 0.378 and Humanistic 0.594. The low internal consistency index does not allow the researcher to use the scale Pragmatic orientation in the analysis.

3. The Helping Alliance Questionnaire HAq2 (L. Luborsky, J.P. Barber, L. Siqueland, S. Johnson, L.M. Najavits, A. Frank, D. Daley, 1996)

This instrument was devised to measure the perception on the working alliance from the perspective of both the psychotherapist and the client. It consists of 19 items and their evaluation is on a Likert type scale from 1 to 6 where 1 is strongly disagree, 2 is disagree, 3 is partially disagree, 4 is partially agree, 5 agree and 6 means strongly agree. HAq2 was tested on 246 patients diagnosed with cocaine addiction, based on DSM III-R. The scale had a good reliability, of 0.90 for the client version and 0.93 for the therapist version in the second session. Also it had a high convergent validity with California Psychotherapy Alliance Scale (0.80 client and 0.94 therapist version in the second session). Following the process of translation and adaptation into Romanian, the Cronbach Alpha index for this scale (therapist version) was 0.766.

4. The Big Five Inventory (BFI) (Oliver P. John, 1991)

The Big Five Inventory was developed to measure, in a short period of time, the prototype components of the Big Five model. The instrument has 44 items, structured in short phrases, which allow a high internal consistency, as opposed to singular adjectives. The evaluation of the statements is based on a scale from 1 to 5 where 1 means strongly disagree and 5 is strongly agree. In the analysis of the samples from the US and Canada, the Cronbach Alpha index varies from 0.80 to 0.90 with a mean of 0.85 (Rammstedt, John, 2005, apud John, Naumann, Soto, 2007). Following the process of translation and adaptation into Romanian, the Cronbach Alpha index for each scale is: Extraversion 0.735, Agreeableness 0.798, Conscientiousness 0.836, Neuroticism 0.843 and Openness 0.737.

Demographics

Several questions were designed to illustrate various demographic aspects of the sample: age, gender education and professional indicators: certification, specialization, experience, etc.

Sample

The participants in the study are psychotherapists accredited in Romania (N=137). This group was composed as follows: 19 men and 118 women. Other relevant characteristics for this analysis are: the specialization stage (Romanian official ranking): under supervision N=47, autonomous N=46, specialist N=32, principal N=12; the methods of psychotherapy in which they were trained, Adlerian: N=10, Transactional Analysis: N=2, EFT: N=1, Person Centered: N=2, Cognitive Behavioral: N=33, Ericksonian: N=12, Experiential Psychotherapy of Unification: N=18, Integrative: N=29, Positive: N=2, Psychoanalysis: N=7, Psychodrama: N=4, Jungian Analytic: N=3, Systemic Couple and Family: N=9, Brief Solution-focused: N=3 and Gestalt: N=2. The last level of completed formal education was: Bachelor degree: N=15, Master's degree: N=110 and PhD: N=12. Their professional experience varied from 1 to 22 years, M= 8.31 years.

Recruitment procedure

The participants were recruited via virtual platforms between 05-20-2018 and 06-12-2018. The sample was composed of psychotherapists officially accredited in the Register of Psychologists in Romania, found on the Romanian College of Psychologists official

page. The inclusion criteria were represented by the existence of official accreditation and the specialization (psychotherapy).

IV. Results

Based on the fact that in this study the scales used are of Likert type, the variables in this study can be considered ordinal because they do not hold an equal distance between each value. The ordinal data does not meet the requirements of the parametric tests, such as the normality of data, therefore when testing the hypotheses, I will use nonparametric tests. The program utilized for the analysis is SPSS version 20.

Descriptive statistics

Table 1. Crosstab Extraversion score, Agreeableness, Conscientiousness, Neuroticism, Openness

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
BFI_SCORE_EXTRAVERSION	137	20.00	38.00	29.4015	4.25555
BFI_SCORE_AGREABLENESS	137	22.00	45.00	37.5620	4.71522
BFI_SCORE_CONSCIENTIOUSNESS	137	21.00	45.00	36.3942	5.47905
BFI_SCORE_NEUROTICISM	137	8.00	37.00	17.4015	5.47516
BFI_SCORE_OPENESS	137	28.00	50.00	42.1679	4.23495
Valid N (list wise)	137				

In table 1, one can find the description of a personality profile of the respondents based on the mean of the score obtained for each scale. The participants in the study had the highest scores concerning the following variables: Openness, followed by Agreeableness and Conscientiousness. The lowest score was at Neuroticism. The low score of Neuroticism is in accordance with their professional training but it can also be interpreted as a desirability factor.

Hypotheses testing

1. *The perception on the therapeutic alliance varies based on the theoretical orientation of the therapist*.

To test this hypothesis, I used linear regression where the dependent variable, the helping alliance score is explained by the scores of the theoretical orientation scale (Humanistic, Biologic, Family, Psychodynamic, Cognitive and Ecosystem).

Table 2.1. Regression coefficients HAq2 scores and Theoretical Orientation (TO) scores

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.433[a]	.187	.150	7.20329

a. Predictors: (Constant), TO_SCORE_HUMANISTIC, TO _SCORE_BIOLOGICAL, TO _SCORE_FAMILY, TO _SCORE_PSYCHODYNAMIC, TO _SCORE_COGNITIVE, TO _SCORE_ECOSYSTEMS

In table 2.1 one can observe that the variation of HAq2 scores according to TO scores is explained by 18.7%.

Table 2.2. Anova Test for the prediction model – HAq2 and TO

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1553.497	6	258.916	4.990	.000[b]
	Residual	6745.365	130	51.887		
	Total	8298.861	136			

a. Dependent Variable: HAQ_SCORE
b. Predictors: (Constant), TO_SCORE_HUMANISTIC, TO_SCORE_BIOLOGICAL, TO_SCORE_FAMILY, TO_SCORE_PSYCHODYNAMIC, TO_SCORE_COGNITIVE, TO_SCORE_ECOSYSTEMS

The significance test indicates a multiple regression coefficient that is statistically significant ($F=4.990$, $p<0.001$), and the prediction based on the calculated model is not a random one.

Table 2.3. Regression equation coefficients – HAq2 and TO scores

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	58.954	5.939		9.927	.000
	TO_SCORE_PSYCHODYNAMIC	.137	.152	.077	.902	.368
	TO_SCORE_BIOLOGICAL	-.049	.165	-.026	-.300	.765
	TO_SCORE_FAMILY	.080	.152	.046	.526	.600
	TO_SCORE_ECOSYSTEMS	.004	.215	.002	.017	.987
	TO_SCORE_COGNITIVE	.509	.143	.319	3.563	**.001**
	TO_SCORE_HUMANISTIC	.586	.240	.211	2.441	.016

a. Dependent Variable: HAQ_SCORE

The only predictor for the working alliance is the Cognitive theoretical orientation $\beta = 319$, $t(3.563)$, $p<0.01$. The alliance varies depending on the other theoretical orientations but the source of this variation cannot be indicated. An explanation is that Cognitive practice is overrepresented in this sample (N=33) which

may lead to the high scores obtained on the Cognitive orientation scale. HAq2 does not measure the actual quality of the working alliance but the perception that the therapist has on the alliance. It is possible that the participants of Cognitive orientation overestimate their therapeutic alliance with the clients, as opposed to their counterparts of other theoretical orientation. A possible explanation of this overestimation may reside in the directive mode of practice and the specific model of interaction of this orientation. Even if the definition of the working alliance is similar regardless of orientation, there still are some conceptual differences which may slightly distinguish them and these differences can be associated with the variations of perception. There is a possibility that each therapist, according to his training background, will define the working alliance differently.

2. *Neuroticism varies proportionately according to countertransference*.

Table 3. Correlations perception on himself in therapy and Neuroticism score

Correlations

			BFI_SCORE_NEUROTICISM	THERAPEUTIC_PROCESS_SCORE_PERCEPTION_HIMSELF
Spearman's rho	BFI_SCORE_NEUROTICISM	Correlation Coefficient	1.000	**-.438****
		Sig. (2-tailed)	.	**.000**
		N	137	137
	THERAPEUTIC_PROCESS_SCORE_PERCEPTION_HIMSELF	Correlation Coefficient	-.438**	1.000
		Sig. (2-tailed)	.000	.
		N	137	137

** Correlation is significant at the 0.01 level (2-tailed).

The perception the therapist has on himself indicates a negative correlation with the Neuroticism score. As the score of the scale was lower, the countertransference was stronger in therapy. The Spearman correlation index illustrated in Table 3 is -0.438, $p<0.001$. Countertransference is largely defined as thoughts and feelings of the therapist, in the psychotherapy session, that can be relevant to the client's experience and, as a consequence, may inhibit or encourage the client's reaction (Fonagy, 1998). Langs distinguishes two types of countertransference, the one attributed to the client and the one that results from the neurotic reaction of the analyst (Langs, 1976, apud Fonagy, 1998). In this situation, the countertransference is an accumulation of feelings and reactions of the therapist, pointed to the client without the possibility of determining if they appeared as a reaction to the client's actions or as a result of the therapist's interpretation. Neuroticism is that tendency of the individual to experiment feelings such as anxiety, hostility, impulsivity, etc. (John, Naumann, Soto, 2008). The possibility for a therapist to develop a negative countertransference to the client can be illustrated in the correlation index calculated for this sample.

3. *The results of therapy are a predictor for the perception on the therapeutic alliance*.

Table 4.1. Regression coefficients Therapy results score and HAq2

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.388[a]	.150	.144	7.22730

a. Predictors: (Constant), THERAPEUTIC_PROCESS_SCORE_RESULTS

Table 4.2. ANOVA test for the prediction model – Therapy results and HAq2 score

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	1247.283	1	1247.283	23.879	.000[b]
	Residual	7051.579	135	52.234		
	Total	8298.861	136			

a. Dependent Variable: HAQ_SCORE
b. Predictors: (Constant), THERAPEUTIC_PROCESS_SCORE_RESULTS

Table 4.3. Regression coefficients – Therapy results score and HAq2

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	61.621	5.226		11.792	.000
	THERAPEUTIC_PROCESS_SCORE_RESULTS	.738	.151	.388	4.887	.000

a. Dependent Variable: HAQ_SCORE

The variation of the HAq2 scores depending on the scores obtained for the results of therapy is explained in proportion of 15% (Table 4.1.). The significance test indicates a statistically significant multiple regression coefficient of ($F= 23.879$, $p<0.001$)

and the prediction based on this calculated model is not a random one.

The perception of having results at the end of therapy is a predictor for the perception of the therapist on the helping alliance (β = 0.388, t=4.887, p<0.001). The retrospective aspect of the answers for the studied scales can determine linear relations between the finality of the therapeutic process and what actually happened in therapy. In this kind of analysis, one cannot evaluate the concepts of therapeutic alliance and therapy results per se, but only the perception of the therapist on them. And this perception does not follow the same timeline as the real events. What this relation may actually illustrate is the possibility of an alteration of the perception of the therapeutic alliance as a consequence of the therapeutic closure. A retrospective can be considered, an analysis of actions from the past starting from the present and following a gradual deepening into past events. This analysis can indicate a relation between the two concepts from the therapist's perspective but, most importantly, it can indicate the way in which the perception of some processes may be structured when they are placed in the past and remembered in the present moment.

4. The Humanistic theoretical orientation correlates with the Agreeableness factor.

Table 5. Humanistic theoretical orientation and Agreeableness correlations

Correlations

			TO_SCORE_HUMANISTIC	BFI_SCORE_AGREABLENESS
Spearman's rho	TO_SCORE_HUMANISTIC	Correlation Coefficient	1.000	**.253****
		Sig. (2-tailed)	.	**.003**
		N	137	137
	BFI_SCORE_AGREABLENESS	Correlation Coefficient	.253**	1.000
		Sig. (2-tailed)	.003	.
		N	137	137

** Correlation is significant at the 0.01 level (2-tailed).

Therapists with a humanistic orientation are usually associated with characteristics such as: altruism and compliance, characteristics that are a part of the Agreeableness factor in the Big Five Model. To test this hypothesis Spearman correlation was carried out between the scores obtained by the participants at the Humanistic orientation scale and the Agreeableness score. The Spearman coefficient was r = 0.253, p<0.01. Although the correlation is not a strong one, it may indicate an inclination to these types of characteristics.

V. Discussion

The main objective of this study was to explore the therapeutic process from the therapist's perspective and to reveal personal and professional characteristics of the specialists who accepted the invitation to participate in this study.

The research does indicate that there is a variation of the therapeutic alliance scores depending on the theoretical orientation. HAq2 in this design does not measure the quality of the working alliance; instead it allows the researcher to grasp a part of the therapists' perception of it. The results also indicated that the therapists with Cognitive theoretical orientation overestimated their working alliance with their clients as opposed to their counterparts. This overestimation can be a result of the different definitions that a therapist may give to the therapeutic alliance according to the theoretical formation he attended but also given the large number (as opposed to other methods of therapy) of participants with cognitive practice (N=33). The perception on the therapeutic alliance may contain different elements when one shifts from the client's perspective to the therapist's view and vice versa.

Hartman, Orlinsky, Joos and Zeeck (2015) explored the therapists' perception on the therapeutic alliance and the differences in opinion between the therapist and the client regarding the alliance. The authors focused mainly on the component of the therapeutic alliance represented by the bond that the two actors share. The study used in its analysis a sample of 26 Psychodynamic therapists and 98 clients diagnosed with major depression, treated in clinical and nonclinical environment. The results indicated an underestimation of the therapists when it comes to clients' therapeutic alliance evaluation. This type of error in perception was more acute when the therapists were in a distressed practice pattern (scale in the study) as opposed to an efficient practice pattern (Hartmann et al., 2015). The Psychodynamic orientation of the psychotherapists in Hartmann's et al. study can also be a factor that influenced their perspective on the therapeutic alliance. If one brings in discussion the *unconditional positive regard* postulated by Rogers then the relationship may be viewed quite differently (Rogers, 2014). When the therapist underestimates the image that the client has on their alliance, then he might have at least two approaches: the therapist can be more engaged or can be

discouraged. Hartman's et al. study is an example on how different therapists with different orientations may view differently an element of the therapeutic process. Even if the researchers do not state that they are exploring the alliance from a theoretical orientation point of view, one may ask himself if this has not played a part in evaluating one's alliance as it did in the present study, even if the evaluation may be based on different kinds of errors.

The working alliance was also associated with the perception of having good results at the end of therapy. The answers had a retrospective facet and this facet can determine linear relations between the finality of the therapeutic process and what actually happened in the therapist's office. There may be an actual correlation between the two concepts but, most importantly, this analysis illustrates how a perspective is structured on elements that make up the therapeutic process.

Countertransference was measured through a series of affirmations in relation with the emotional reactions of the therapist to the client: *"I liked to work with this client"* (item example from the perception on oneself). Langs (1976) distinguishes between two types of countertransference: the one attributed to the client and the one resulted from the neurotic reaction of the therapist (Langs, 1976, apud Fonagy, 1998). Neuroticism is that tendency of the individual to experiment feelings like: anxiety, hostility, impulsivity, etc. The result of the analysis indicated that a therapist who tends to experiment such feelings can have a negative reaction to the client (specific for a certain type of countertransference). Research in the therapeutic process area also focuses on the intimacy that this kind of relationship implies. Rogers (1961) describes the therapeutic relationship as *"at least one party has the intent of promoting the growth, development, maturity, improved functioning, and improved coping with life of the other"* (p. 40, apud Rodgers, 2011, p. 266). In Rodgers IPA (Interpretative Phenomenological Analysis) based study, the two main clusters found in therapists' verbatim were: *understanding the phenomena* and *utilizing the transference* in therapy. It is a certainty that countertransference might occur in therapy and how one understands the phenomena and uses it, as in Rodger's study, may be an indicator of different personality characteristics.

Personal characteristics of the therapists are also an important factor in the quality of the alliance and the results of the therapy. In the study "Therapist mindfulness, alliance and treatment results", the variables alliance and therapy results are partially explained by the dispositional mindfulness of the therapist; the personal characteristics like warmth, acceptance and authenticity have an important role in forming the therapeutic alliance (Ackerman & Hilsenroth, 2003, apud Ryan et al., 2012). The personality profile of the therapists from this sample, based on the Big Five model, was composed of: Openness, Agreeableness and Conscientiousness. This profile can be associated with the formal training of the therapist but also with a series of personal characteristics that may be favored choosing this type of profession. The answers are however marked by a high level of desirability and an impossibility to dissociate oneself from the psychotherapist role when answering.

Psychotherapy is a complex process that can be viewed differently depending on who the person perceiving it is. Even if what happens in this healing space is something measurable, the way it is viewed varies based on characteristics such as personality or even how one perceives his client.

Limits

- The low number of participants.
- The overrepresentation of certain theoretical orientations of therapy like: Cognitive (N=33) and Integrative (N=29).
- Low fidelity indexes for the Theoretic Orientation Scale.
- The difficulty to explore the validity of the instruments through confirmatory factor analysis, as a consequence of the distribution of answers. As a result of the type of answers provided, one-dimensional and maybe desirable, the factorial solutions obtained were inconclusive for the utilized instruments.

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