The Matching Process Between Therapist and Client:

How to Magically Land on Therapeutic Alliance

by

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Abstract

Therapeutic alliance (TA), the quality of the connection between therapist and client, is a well-researched concept in the psychotherapy literature. Despite the immense amount of studies and discussions on TA's role as a necessary foundation for therapeutic efficacy, therapists are not trained to educate their clients about TA, and TA is not a known phenomenon to therapy seekers. As awareness of how individual and collective privileges and discriminations are determined by the dominant social structures in place grows, consideration of TA and therapist's reflexivity become crucial to practice ethically and anti-oppressively. In addition to providing an overview of the makeup of TA, this paper inquires into the influences of intersectionality theory, attachment theory, and interpersonal neurobiology through an intersectional feminist and anti-colonial lens. The failure to integrate TA into therapist education, training, practice, and communication with clients sees implications for the profession of psychotherapy and clients ' access to appropriate and efficacious mental health care. Recommendations are offered to encourage TA- and trauma-informed, person-centered, relational, and decolonial practices.

Keywords: therapeutic alliance, therapeutic efficacy, Intersectionality, Attachment, Interpersonal Neurobiology

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Chapter 1: Introduction

This Capstone aims to deepen the understanding of what contributes to a strong therapeutic relationship and to investigate the matching process between therapist and client. In this chapter, I will speak to the contemporary concerns that this Capstone is in response to, introduce the theoretical frameworks with which the existing research is analyzed, elaborate on the significance of this topic as it relates to the field of psychotherapy, state my positionality, define key terms, and provide an overview of chapters two and three.

Statement of the Issues

Although the role of therapeutic alliance (TA) has been well-researched in contributing to the efficacy of psychotherapy, the components of TA remain uncommon knowledge to both therapists—in their professional training and practice—and clients—in their search for a therapist (Norcross & Wampold, 2018). While there is often a focus on building the therapeutic relationship in therapeutic training, the degree to which clients or people seeking therapy are aware of TA's significance has seemingly not been a subject interest of academic literature. Given that TA involves the nature of people and relationships, the field of psychotherapy needs to evolve alongside the continued social and cultural evolution of the collective. From a practical perspective, the process of searching for a therapist remains most commonly through word of mouth, various directories, and via Google (American Psychological Association, 2017; Healthline, 2020; Morin, 2022). Directories present therapy seekers with pages and lists of therapists who claim to specialize in numerous problems and techniques. The information about the services is often delivered with professional jargon, which can be difficult to understand. For a person in need or new to therapy, the absence of a clear and approachable way to be matched with a therapist based on the knowledge of TA can deter therapy as an option for help; worse, it

can create unhelpful or even harmful therapeutic experiences for the client (T. Nguyen, personal communication, June 13, 2022; V. So, personal communication, June 2, 2022).

In recent years, intersectionality (Crenshaw, 2019) and trauma-informed care are both topics observed on the social and cultural landscapes in relation to mental health care. While TA has been studied in its influence on therapeutic outcome, there remains a lack of comprehensive research on the pairing of therapist and client based on their respective intersectional locations and its impact on the therapeutic experience—particularly for the client. This reflects the lack of integration of Intersectionality, queer, and feminist theories in the history of the practice and research of psychotherapy. This shortfall in the theory and research extends to the understanding of TA, influenced by the intersectional power imbalances between the therapist and client based on their racial, gender identity, social, class, ability, age, and more (PettyJohn et al., 2020). Through the Intersectionality lens, these locations represent the "locus of [one's] agency, power, disempowerment, oppression, and resistance" (Morgan, 1996, as cited in PettyJohn et al., 2020). Furthermore, the meeting of these intersectional locations is only one layer of the interaction. TA is an evolving dynamic, consistently forming bidirectionally. The mutual influence includes neurological interactivity, and right-brain-to-right-brain communications, between the therapist and client (Schore, 2014; Shewfelt, 2018; Wallin, 2017). In terms of clinical application and understanding trauma's effects on a person, these elements of TA inform not only the efficacy of the therapeutic practice but its ethics as well.

Significance and Contribution to the Field

This paper aims to examine the qualities and factors that form TA and how the matching process integrates this knowledge. This is significant as inquiring into what makes effective client-therapist pairings provides knowledge that may bridge the gap of access to care. Seeking a

new therapist can be varying degrees of overwhelming. For someone new to therapy or deeply in need, the accessibility of information on who can provide the most appropriate and fitting support becomes pivotal. The enormous amount of information about psychotherapy modalities, techniques, designations, and jargon found on many therapists 'websites and community organizations 'directories can be esoteric and inefficient for clients. Clients may find themselves doing a paralyzing amount of work to find the right therapist. Moreover, someone new to therapy landing on an incompatible match once or twice can be enough of a discouraging experience to not return to therapy (Kim & Kang, 2018; Z. Gray, personal communication, March, 2021). This is especially problematic if they feel harmed by the therapeutic process or the therapist. Clients may feel negatively reinforced, untrusting, and even traumatized by the therapeutic experience from a bad match (Kim & Kang, 2018; Qureshi, 2007). The significance of this research topic on the application of TA formation thus involves the reputation and effectiveness of the profession of psychotherapy.

In addition to the gaps in the theory and research on TA mentioned in the *Statement of the Issues* section, this topic responds to the missing application of the understanding of TA in the field: namely, the lack of psychoeducation on TA. Bachelor's (2013) study showed that the client participants demonstrated an understanding of TA dissimilar to that of the therapist participants, defining TA as merely collaboration and commitment to therapeutic goals. Furthermore, the client participants reported that their perspectives of the therapeutic bond were "unrelated" (Bachelor, 2013, p. 132). Naturally, as I had previously experienced along with others, the process of searching for a therapist is commonly done without awareness of the role of TA in therapeutic success (T. Nguyen, personal communication, June 13, 2022; L. Fox, personal communication, June 12, 2022). Furthermore, much of the public-facing information

for the therapy seekers omits the crucial pieces that contribute to TA, including the therapist's and client's intersectional location and attachment style, and the bidirectional influence of the therapeutic relationship. As discourse around social dynamics based on individuals ' intersectional identities expands, clients with intersecting identities of race, gender, and queerness have been particularly impacted. Racialized clients have expressed not feeling comfortable in sharing their experiences relating to racism because their white therapists did not address their social location nor name the differences between them and their clients (Qureshi, 2007; T. Nguyen, personal communication, June 13, 2022; V. So, personal communication, June 2, 2022). Macroscopically, the profession has historically contributed to systemic oppression under the influences of capitalism and white supremacy, through its expert culture, inaccessibility by way of unaffordability, and failure to center oppressed voices and needs (Malott & Schaefle, 2015). The efforts around decolonizing therapy have fallen on individual and grassroots communities and organizations. This process involves discussing and educating therapists about anti-oppressive practice and providing support not only with sliding scale rates but also offered by practitioners of diverse cultures, backgrounds, and identities.

The research presented in the next chapter will address this by demonstrating the profound influence of the therapist's reflexivity on alliance formation, including broaching the topic of Intersectionality in the room. The therapist's reflexivity further includes awareness of their personal attachment style and how that may play out in the therapeutic relationship, potentially benefitting or negatively impacting the client. The literature review will showcase the bidirectionality of therapy, speaking to the reciprocal influence between the therapist and the client. On this note, the research aims to discuss the necessity of normalizing and expecting trauma-informed care from mental health practitioners. The research will include the theory of

Interpersonal Neurobiology (IPNB) to illuminate the relational nature of TA as rooted in neurobiology. As the mental health professional in the dyad, the research looks to demonstrate that it is the therapist's ethical responsibility to practice with an understanding of IPNB, given therapy work is inherently relational. Furthermore, centering and discussing anti-oppressive practice is part of the process to decolonize the practice of psychotherapy (Linklater, 2014). The research on IPNB, Attachment Theory, and Intersectionality in the context of TA become exponentially relevant in working with trauma, which is especially common among communities that are continuously oppressed under various social structures.

The research and discussions presented in this paper contribute to the current body of research by privileging differences in people: racial, social, economic, relational, trauma, and neurotype, and advocating that all of these pieces are part of TA and deserving of further research. This paper intends to communicate that the awareness, understanding, and praxis of what makes TA is a responsibility of the therapist to practice anti-oppressively. In other words, in entering this work and a therapeutic relationship, there is an onus on the therapist to reconcile personal biases and views about differences and to recognize the vital role therapists play in how a therapeutic experience unfolds. This work calls for a continuous reflexive practice to name and address the systems of oppression both within and outside of the therapy space. By reckoning with this ethical duty, the focus can then be redirected to the therapeutic work and the client, making it person-centered and decolonial-in-progress.

Purpose Statements

This Capstone has four purposes. First, it aims to illuminate how, despite abundant research on TA, there remains a lack of information on TA's significance in predicting therapeutic success available for clients or people who are seeking mental health support.

Second, this capstone looks to explore the extent to which Intersectionality influences TA development and discuss the lack of understanding of Intersectionality within the literature. Third, it seeks to illustrate the role of the therapists 'and clients 'attachment styles and the bidirectional influences of TA. Finally, this capstone will explore the barriers to making industry knowledge useful and accessible for clients and therapy seekers.

This capstone provides a review of research literature based on these purpose statements and an applied method proposal. The literature review covers the makeup of TA and investigates the influences of Intersectionality, attachment styles, and IPNB-informed care on TA, which will be valuable information for therapists and research psychologists. Foreseeably, it may also benefit the clients in understanding the importance of the therapeutic relationship and help parse out their needs when looking for a therapist. The final chapter is presented with practicing therapists, therapists-in-training, educators, and researchers in the psychology and psychotherapy fields in mind as the intended audience.

Reflexivity and Positionality Statement

Reflexivity

I am both a therapist-in-training and an active client. I am fortunate to reside on the unceded territories of the Musqueam, Squamish, and Tsleil-Waututh nations, colonially known as Vancouver, BC (https://native-land.ca). Similar to the rest of the Western world, psychotherapy is a familiar notion, however still stigmatized in some areas. It is in this culture and location that I began receiving therapy as a client and training as a therapist. Before and during my training and education, I experienced the process of finding a therapist, which generated curiosity and critical examination of its opaqueness and inaccessibility. As I began engaging in conversations with friends and peers in which experiences were shared about their

processes of finding a therapist—both in continuous, positive therapeutic relationships as well as disappointing experiences—I saw that the barriers were not unique to me. Reflecting on my first experience in landing a meaningful TA with a therapist, I recognized that I was lucky. Without having searched the corners of the internet, I asked around and my friend recommended their friend, who became my therapist. We developed a TA soon after we began working together. However, as I got deeper into my therapeutic training, I became intrigued by the significance of TA, learning that it is one of the consistent factors in determining the efficacy of therapy. I also increasingly reflected on my social location. I came to be curious about the idea of working with a therapist who has more shared lived experiences and may better work with me on a variety of issues unique to my background and experiences. Even as a therapist-in-training, my process of finding a therapist has not become easier.

While I am familiar with the therapeutic approaches and language seen on therapists ' directories, websites, and biographies, TA as a phenomenon and its significance remain unspoken in my observation. Additionally, I found myself experiencing barriers that others have anecdotally shared. As there is no standardized, streamlined way to find or be matched with a therapist where I reside, I did many Google searches and combed through various directories; page after page of therapists and their biographies were read. Some websites have filters that allow users to narrow their searches, such as “issues” they look to work on, gender and ethnicity of the therapist, and languages. Inexplicably, this process continues to leave me uncertain about moving forward with any therapist. I think about those who may be in more immediate need of a therapist and have less knowledge about therapeutic jargon and TA, and the potential detriment of this inaccessible, unintuitive process of seeking mental health care. Accessibility and practicality for the clients are top of mind in researching the available journal articles and studies

focused on TA. With the breadth of interests and critical analyses of this research topic, the outcome looks to be one that can help generate ideas for a new process to land on TA.

Positionality Statement

I am a non-disabled, straight-sized immigrant settler on the traditional, unceded, and occupied lands of the Musqueam, Tsleil-Waututh, and Squamish peoples from Hong Kong with anti-racist and anti-capitalist values. Rooted in social justice and an appreciation for radical acceptance (Linehan & Wilks, 2015), I work with dedication to name oppressive systems and dominant narratives, as well as undo binary thinking that often leaves clients with shame and internal conflicts that continuously oppress them. I am experienced in working from an Intersectionality-focused lens with predominantly Black, Indigenous, and people of colour with different neurotypes, who identify as queer and have ongoing relationships with grief. Trained in Feminist Narrative Therapy, I privilege a person's survival story and relationships to their agency, emotions, boundaries, and people. As a service provider in the field of mental health care, I work with a mission to destigmatize and democratize mental health by aiming to improve its accessibility. When interacting with clients, I practice informing them that their relationships with their counsellors are one of the most important factors to therapeutic success and healing, and actively invite them to consider that when selecting a therapist to work with.

Being an immigrant and having resided as a foreigner and settler in Canada, Germany, and France, I have found myself constantly negotiating with power dynamics. This often included others 'questioning my origin, demanding an explanation when I used to say I came from Canada. In my adolescent and early young adult years, I wanted to identify as Canadian out of not wanting to be Chinese. The racism, informed by colonialism and white supremacy, experienced from having to convince people where I "came from" was obvious and deeply felt,

yet it did not motivate me to value my Hong Kong heritage more, nor did it bring me closer to my Canadian identity. Instead, it felt as though white supremacy had pushed me to a place of non-belonging. This experience is important to name because while I have put considerable effort into undoing pieces of the assimilation that followed immigration and in coping with personal experience with racism, I am oftentimes aware of my racialized appearance to others. Despite having a more nuanced intersectional identity, I am inseparable from my appearance as an Asian, cisgender, young, able-bodied female in the therapy room, whether I'm in the therapist or client role. Depending on the therapist's or client's intersectional experiences, I am aware that simply the way I appear to them can present challenges. I consider these aspects when I show up in a session as a therapist and in approaching the research into the process of landing on TA.

Due to my philosophy of practice that the personal is political, and my prioritizing of clients 'Intersectionality in my counselling practice, I acknowledge that my ideas and interpretation of research data can present several biases. These biases include my preferred method of analysis to center the voices of and represent marginalized individuals, namely 2SQTBIPoC, as a settler on Indigenous lands. Additionally, using a critical lens toward the established Eurocentric academic and research methodologies and beliefs, informed by various decolonial literature and community wisdom particularly relating to mental health (Linklater, 2014). I have an education and training background in critical thinking, literary analysis, and Feminist Narrative Therapy, meaning a qualitative research background and limited experience with quantitative or scientific research processes. I further recognize my position as a Hong Kong-born person and settler on the unceded territories of the Coast Salish nations, who inherited specific cultural values and was socialized and educated in western cultures. I have inevitable blind spots to others 'intersectional struggles, oppressive experiences, and their

sources. Unequivocally, my insights and position in this paper do not represent all identities and needs. I write as a therapy patient and therapist-in-training who has worked with clients from various intersectional backgrounds, examining the meaning of accessibility in mental health support in a culture that continues to uphold white supremacist, patriarchal, cis- and heteronormative, and ableist values and philosophies.

Definition of Terms

Attachment style/dimension: According to Bowlby's (1978) Attachment Theory, attachment style refers to the affectional and relational bond between individuals. The attachment dimensions are secure and insecure, the latter further categorized by four main styles: secure, anxious, avoidant, and disorganized attachment. It is important to consider attachment as a dimension rather than a singular, permanent style (R. Manley, personal communication, 2021).

Client: Used throughout this paper to refer to anybody seeking for and/or engaging in therapeutic services with a practitioner. While this term is used in discussing TA here, TA is not exclusive to practitioners who work with "clients". TA is also applicable in therapeutic relationships between practitioners and patients.

Intersectionality: A term developed by Black feminist and legal theorist, Kimberlé Crenshaw (2016), Intersectionality describes discrimination, challenges, and dilemmas experienced as a consequence of one's location, situated at the intersections of race, gender expression, sexuality, and ability. The term illuminates systemic and ideological frames through which power is imbalanced and prejudices legitimized (Crenshaw, 2019). Crenshaw (2016, 2019) stated that Intersectionality is a prism to shed light on dynamics that were not recognized by the law, consequently abandoning those who are impacted by multiple forces of discrimination.

Reflexivity: Part of the feminist and deconstructionist theory and practice, referring to the active reflection of "one's [own] assumptions, values, standpoint, and social locations to assess how these might influence one's views of others" (Enns et al., 2021, p. 13). In the context of this paper, reflexivity is pivotal as part of the guiding framework of Intersectionality, feminist, and queer theories. Reflexivity is considered to be an integral part of the therapist's practice, as it inevitably plays a role in alliance formation.

Rupture: A natural part of the therapeutic process and alliance development. Safran (1993) defined rupture as a "negative shift in the quality of the therapeutic alliance or an ongoing problem in establishing one" (p. 34). It can also be understood as "enactments that are shaped by dissociated aspects of both patients 'and therapists 'experiences in interaction with one another" (Safran et al., 2014, p. 213). Relationally, working through a rupture constructively contributes positively to TA.

Therapeutic alliance: Refers to the bond between a practitioner and their client/patient who are in a therapeutic relationship. Often synonymous with the terms *working alliance* and *therapeutic bond*, therapeutic alliance is formed in a positive therapist-client relationship, where "the client, as part of the therapy process, develops the capacity to form a positive, need-gratifying relationship with the therapist. [...] The therapist's task is to maintain a positive, reality-grounded stance toward the [client]" (Horvath & Luborsky, 1993, pp. 561-562). Therapeutic alliance is shortened to TA throughout this paper.

2SQTBIPoC: Refers to two-spirit, queer, transsexual and transgender, Black, Indigenous, and people of colour. This paper discusses the qualities of a therapeutic relationship using the framework of Intersectionality to illuminate how both the therapist's and client's intersectional locations contribute to the quality of the alliance. 2SQTBIPoC refers to a large population that

has historically been deemed outside of what is considered societal norms, i.e. white, Christian, cisgender, and heterosexual (Lorde, 1984). This term does not encompass all that lies beyond the "norm". Notably, terms change as decolonizing language continues to be developed and integrated.

Outline of Capstone Project Chapters

Chapter two will review the research literature on the components of TA, the significance of addressing and understanding Intersectionality and the Attachment Theory in alliance development, and the impact of trauma- and Interpersonal Neurobiology (IPNB)-informed care in a therapeutic relationship. Chapter three looks to address the problematic gap between industry knowledge and accessible information about the importance and components of TA, especially with therapists of all levels, educators, and researchers in psychotherapy and TA in mind as the target audience. In addition to examining the available research, this Capstone will acknowledge the systemic influences of settler colonialism and capitalism. Furthermore, chapter three will focus on client-centered and IPNB-informed care in exploring the implication of this research topic. The final aim is to offer a proposal of actions with the outlined research and values, in hopes of mitigating the gap of knowledge to better facilitate the process of landing on therapeutic alliance.

Chapter 2: Review of Research Literature

Chapter one introduced the objectives of this capstone in exploring the formation of therapeutic alliance (TA) and investigating the connection between ethical practice and Intersectionality-, trauma-, and TA-informed practice. It laid out contemporary problems observed due to the lack of recognition of TA's significance in spaces where people seek help. It also included a positionality statement to identify the lens through which the literature and discussions are reviewed and generated throughout the paper. This chapter will start with an overview of the theoretical frameworks that guide the literature review and the capstone at large, offering an introduction to the theories of Attachment, Intersectionality, feminism, queerness, and interpersonal neurobiology (IPNB) to demonstrate this capstone's interpretation of trauma-informed and person-centered care. A review of the research literature on the formation of alliance and the significance of TA will follow, including discussions on studies inquiring into the connections between TA and both therapists 'and clients 'intersectional locations and attachment styles. Importantly, the role of trauma in alliance development will be examined alongside research on IPNB.

Theoretical Frameworks

Attachment Theory

According to Bowlby's (1978) attachment theory, attachment style refers to the affectional and relational bond between individuals. Considering the uniqueness of the therapeutic relationship, the relational dynamic between the therapist and client is influenced by both parties 'attachment styles. Bowlby believed that attachment theory has significance in the therapeutic relationship, as one of the main aims of the therapist in the therapeutic work is to become a secure attachment figure for the client (Levy et al., 2019). Secure attachment between

the therapist and client for the therapeutic work produces a secure base, which supports the client to safely explore and better understand impactful, past, and current events and attachments (Fisher, 2017). This foundation further allows the client to examine the therapeutic relationship and how it may shed light on their relationships outside of the therapy room. Importantly, it is from this foundation the therapist and client co-create new "internal working models" that better serve the client moving forward (Levy et al., 2019, p. 180). As attachment style is changeable and earned secure attachment style is a common goal of psychotherapy, this paper adopts psychologist and professor Dr. Ron Manley's framework on attachment style: attachment is discussed and interpreted as a dimension rather than a singular, permanent style (R. Manley, personal communication, 2021).

Attachment theory further helps explain the role of the respective attachment styles of the therapist and client in the development of the TA. Specifically, the pairing of the attachment styles contributes to both parties 'agreement of the alliance, referred to as "congruence," which plays a part in determining the experience and effectiveness of therapy (O'Connor et al., 2019, p. 84). Overall, attachment theory is one of the most influential frameworks in understanding TA. A section will be dedicated to the exploration of attachment styles 'influences on TA in the *Review of Research Literature* section in this chapter.

Intersectionality Theory

Intersectionality theory, developed by Black feminist and legal theorist Kimberlé Crenshaw (1989), is one of the main guiding frameworks in this research on TA. Intersectionality's impact on TA has long been acknowledged, both in the research literature as well as among practitioners. In a TED Talk by Crenshaw (2016), she described Intersectionality as a response to the "framing problem"—problems that do not have a name cannot be seen, and

thus cannot be solved—of the law that abandons those who experience multiple levels of discrimination as a consequence of their social location. Intersectionality alludes to the challenges and disadvantages experienced by those who occupy a location based on the intersections of race, gender expression, sexuality, ability, class, age, etc. Crenshaw (2016) specified that the use of the term is a way "to deal with the fact that many of our social justice problems, like racism and sexism, are often overlapping, creating multiple levels of social injustice" (04:42). As the term has become popularized in recent times, motivated and galvanized by major social movements, particularly in 2020 and 2021, it has been commandeered to refer to one's multiplicity in identity and experience (Bense, 2020). It is paramount to note that Intersectionality here specifically attempts to acknowledge and consider the structural inequity and its impact on individuals—including both ends of power and privilege and disadvantages and marginalization (Bense, 2020; PettyJohn et al., 2020). In the realm of psychotherapy, this calls for consideration of a deep range of issues in the profession, from its largely colonial, white supremacist, and patriarchal history to the interpersonal power dynamic between the therapist and client.

Intersectionality will be invaluable as a framework in thinking about TA as this paper examines the nuances between pairings of therapists and clients. This means considering both parties 'socioeconomic and racial backgrounds, and importantly, the therapist's ability to broach the topic of Intersectionality in therapy. The power dynamic derived from the therapist's and client's social locations has long been an important factor in determining TA and consequently the effectiveness of therapy; its potential effects are particularly palpable among pairings of white therapists and racialized clients (Qureshi, 2007). Nevertheless, the therapist's duty to

address and discuss racial trauma is a rather recent conversation in the white-dominant mental health field, which has seen increased training for practitioners.

Feminist and Queer Theories. While interconnected with intersectionality theory (Crenshaw, 1989), feminist and queer theories are intentionally named as a separate framework to acknowledge the particular places they occupy in not only the larger history of politicized identities (Duong, 2012), performativity (Butler, 2009), and the "collapse" of distinction between sex and gender (Salih, 2007), but also how these pieces trickle into the therapeutic sphere and specifically the development of TA. They are vital as guiding theories in discussions on what it means to practice anti-oppressively: they recognize the socially and colonially created imbalances in power dynamics between bodies based on abilities, race, colourism, sexuality, and sexual and gender identities. Furthermore, Intersectionality, Feminist, and Queer Theories will illuminate a focus on continuous reflexive practice on the therapist's part as an indispensable process to conceptualize holding space therapeutically, effectively, and ethically.

Feminism, specifically fourth-wave feminism, and Queer theory are foundational to the development of the intersectional perspective and critical lens this paper holds, particularly the philosophy of "the personal is political" and Queer Theory's explorations of the antithesis of normativity. They will be referenced and examined together to provide a platform on which systemic powers and oppressive forces, and their relationship to the therapeutic practice and alliance, are discussed. To this end, it is important to recognize that the pioneers of the canonized feminist and queer theories are historically white folks and pursued at the expense of Black, Indigenous, and bodies of colour's fight for anti-racism. As a result, the process of fighting for these rights also perpetuated an oppressive, sexist, racist, and classist structure that ultimately prioritizes white supremacy (hooks, 2000).

Trauma- and Interpersonal Neurobiology-Informed Care

The theory of interpersonal neurobiology (IPNB) developed by Dan Siegel (2019) and Allan Schore (2014; 2021) establishes the neurophysiological effects people have on one another in an interaction. Their work on IPNB, right-brain-to-right-brain communication, and mindfulness is expansive and applicable to the topic of TA due to its relational nature, similar to attachment theory. Importantly, Siegel (2019) and his colleagues named the idea of "generative social fields," illuminating the connection between the brain, mind, and our social relational moments (p. 234). "The notion of such a set of interactive relational communications helps us to see how the 'mind 'is not only embodied in our brains and whole bodies, it is also fully extended and embedded in our relationships with one another and the world outside these bodies we inhabit" (Siegel, 2019, p. 233). In the therapeutic setting, the interpersonal piece of IPNB speaks to the interaction between the therapist's and the client's nervous system, meaning that the client's neurophysiological state plays a role in the generative field and the TA. IPNB illustrates that TA has a direct effect on the depth and quality of the exchange, thus the effectiveness of therapy in the long run.

Along with IPNB, trauma-informed care plays a crucial role in researching TA. Practicing therapy with a trauma-informed lens requires a therapist's understanding of how traumatic events and experiences may be stored in a person's system and body (Fisher, 2017; Peña, 2019). To practice anti-oppressively, trauma- and IPNB-informed care must incorporate an understanding of colonialism and systemic oppression's impact on a person's nervous system and access to and perception of safety. Stored trauma can be nuanced and extremely complicated, and oftentimes results in the client's impaired neuroception, the reflex to scan the environment to ensure safety for survival purposes (Porges, 2013, as cited in Manley, 2016). One

of the priorities of practising trauma- and IPNB-informed care is to facilitate the repair and integration of the client's autonomic and cognitive neuroception (Porges and Dana, 2018; R. Manley, personal communication, November 5, 2021; Siegel, 2019). As alliance-building involves the client's experience of safety in therapy, particularly in the context of working with trauma, the therapist's attunement to the client's neurophysiological and mental state in the moment—and the therapist's ability to co-regulate with the client—are integral (Peña, 2019; Schore, 2021; Shewfelt, 2018).

On Therapeutic Alliance

Over the past few decades, research has consistently found that the quality of the therapeutic alliance (TA) contributes significantly to generally positive therapeutic outcomes across orientations (Bachelor, 2013; Horvath & Luborsky, 1993; Martin et al., 2000). Safran and Muran (2006) described TA as "an ongoing process of negotiation between patient and therapist at both conscious and unconscious levels[,] highlight[ing] the intrinsic role that this type of negotiation plays in any change process" (p. 289). Therapeutic alliance in psychotherapy refers to the quality of the mutual connection between the therapist and the client, born when a sense of safety and security is achieved (Lavik et al., 2018). TA is rooted in secure attachment, which allows for a possible safe exploration of the client's experiences. TA's significance is in its "covenant" nature the therapist and client form together that makes the previously insurmountable "task of healing" possible (Horvath & Luborsky, 1993, p. 561). For this reason, regardless of the therapeutic approach, TA is arguably the cornerstone and the primer for the therapeutic process to take effect.

The following sections will explain the main components of TA and illustrate the intricacies within. The setup of TA will reveal that a successful TA relies heavily on the

therapist's abilities, with a major element being the practitioner's awareness of how their presence influences the dynamic. Clients 'perspectives and experiences of the TA and their therapists are included in this part of the literature review, as they are pivotal in illuminating the importance of a "congruent" experience of the TA shared by both the therapist and the client (O'Connor et al., 2019). The section will close by examining the existing measurements of the strength of the alliance and their impact on therapeutic outcomes.

A Tango of Authenticity and Professionalism

Generally, while the "professional" presentation of the therapist is important to the client, a sense of being understood as a whole person, and feeling supported and safe while experiencing the therapist as a person rather than a more powerful expert are the most crucial factors attributing to TA. The descriptor "professional" warrants more analysis and discussion, as it can have various meanings based on different cultural contexts. The first of its kind, Lavik et al. (2018) completed a meta-analysis of alliance formation processes by studying up to the first five sessions. This research provided a thorough analysis and explored the experiences of the early formation process from both the client's and therapist's perspectives. One of the main findings was that TA is mostly established in early sessions.

The five meta-themes concluded in what forms TA from the perspective of the client were: "(1) meeting a competent and warm therapist; (2) being understood as a whole person; (3) feeling appreciated, tolerated, and supported; (4) gaining new strength and hope for the future; and (5) overcoming initial fears and apprehension about psychotherapy" (Lavik et al., 2018, p. 348). From the client's perspective, it is important to feel that their therapist is professional—via their competence in both psychological knowledge and therapeutic skills, what they wear, and the physical environment of the therapy room—without eliciting an expert stance that towers

over the client, making them feel like they can be manipulated by the therapist. The environment also needs to feel safe, meaning that the client gets the sense that their therapist understands them as a person rather than another patient, who is more than the problems they discuss in a session. Further to this, the client feels bonded to the therapist if they feel seen by the therapist through the therapist's recognition of their efforts and values. Moreover, the therapist discovers the client's strengths and can mobilize their agency to engage in moving toward the client's preferred outcome. Overall, it is an authentic feeling of being supported, validated, accepted, and encouraged.

The six meta-themes derived from the articles that focus on the makeup of TA from the therapist's perspectives include: "(1) balancing technical interventions and interpersonal warmth; (2) showing a genuine desire to understand; (3) openly supporting client agency; (4) adjusting to create a sense of safety; (5) paying attention to body language; and (6) providing helpful experiences during the first session" (Lavik et al., 2018, p. 348). As mentioned above, this is one of the rare showcases of the therapist's experience of the TA formation being studied and compared to the client's viewpoint (Lavik et al., 2018). TA was predicted by the therapist's sense of their ability to both build rapport and a warm relationship with the client, which includes a genuine presence in the session where they feel they can professionally self-disclose to demonstrate their personhood while offering technical interventions. It is facilitated in cases where the therapist generates and displays a genuine desire to understand the client, can observe the client's body language, and collaboratively explore aspects of the client, including their strengths and resources. Importantly, the therapists found that if they were able to provide constructive insights in the first session, alliance development was more easily established early on in the therapeutic relationship.

Predictably, TA is harder to build if the therapist is less engaged and appears to lack emotional investment in the therapeutic conversation (Lavik et al., 2018). The therapist also tends to be more aware of their performance in terms of technical interventions while the client tends to assess the therapist's general competence in their role. The meta-analysis (Lavik et al., 2018) showed that "the quality of the personal lives and private relationships of therapists is also associated with both their own and their clients 'evaluations of the therapeutic alliance" (p. 360), illuminating the importance of therapists 'self-care and accurate assessment of their capacity. In contrast to low alliances, the therapeutic work reflects more predictors of efficacy through "more focused conversations and more emotional content" in therapeutic relationships where the alliance is high and established early (Lavik et al., 2018, p. 360). Specifically, these sessions saw a higher ratio of the client talking and listening on the therapist's part. The studies used in this meta-analysis, however, did not specify the severity of the participants 'mental health problems.

Additional findings inspected Language Style Matching (LSM) as an implicit aspect of TA, which represents the rates at which the therapist and client use function words, including pronouns, prepositions, and conjunctions (Aafjes-van Doorn et al., 2020). It was found that among efficient therapies the languages were matched, whereby the therapist accommodated the client's language style (Aafjes-van Doorn et al., 2020). However, psychotherapy is likened to tango: it is extremely challenging to determine who is leading in a verbal interaction, as it is often a "mutual adaptation," in which the influence of the language style is bidirectional (Aafjes-van Doorn et al., 2020, p. 510). Therefore, LSM is understood to be a supportive supplement to self-report data. Furthermore, it may be predicted by prior therapeutic experiences and predictive of the quality of future TA. Aafjes-van Doorn et al. (2020) stated that "the level or range of function words clients and therapists use might reflect their culture, educational level, and

upbringing, more than the dynamic response to the current situation of the conversation" (p. 519). This alludes to the importance of examining aspects of the match regarding the intersectional qualities of the individual and their influences on one's LSM.

Another implicit aspect of TA is explored in Zilcha-Mano et al.'s (2020) study, where they examined the neuropeptide oxytocin (OT)'s role in alliance formation and maintenance. OT is defined as "a biological mechanism by which bonds are formed and strengthened across species" (Zilcha-Mano et al., 2020, p. 523). They confirmed that OT levels change in psychotherapy and posited that OT synchrony is generally found between parent and child, produced by "sensitive, empathic, and synchronous parenting" (Zilcha-Mano et al., 2020, p. 528). This suggests that better-matched OT levels in a therapeutic relationship might be related to a stronger TA, thus better therapeutic outcomes. Zilcha-Mano et al. (2020) spoke to the significance of confirming these hypotheses in terms of gaining biological evidence for the "longstanding claim that the patient-therapist relationship mirrors at many levels the mother-infant attachment" (p. 529). This would further contribute meaningfully to the understanding of the "neurobiology of human attachment" (Feldman, 2017, as cited in Zilcha-Mano et al, 2020, p. 529), which is a conceptual framework that has proposed that "biological and behavioral synchronous processes established within the mother-infant bond are transferred to meaningful relationships throughout the individual's life and play an important, potentially reparatory, role" (Zilcha-Mano et al, 2020, p. 529).

The Reflexive Capacity of the Therapist

In most of the literature analyzing TA and its development, there appears to be a common thread of rhetoric that speaks to the style and quality of the individual therapist and their clinical skills as more influential in establishing alliance than their professional experience (Cheng & Lo,

2018). The unique characteristics of the therapist encompass a wide range of biological, cultural, and social factors. When matched with that of the client, they have been found to produce positive alliances, with the acknowledgment of nuances and exceptions. Importantly, it was found that the therapist's capacity and the quality of their personal relationships influence both therapist's and the client's evaluation of the TA (Lavik et al., 2018). This highlights the significance of the therapist's consistent reflection, understanding, and caring of self in offering, guiding, and participating in ethical and efficacious practices.

Congruence Requires Reflexivity. *Congruence*, the agreement on TA between the therapist and client, is imperative because therapists need to have an accurate understanding of the alliance development, as it is related to treatment success (O'Connor et al., 2019). Considering that psychotherapy is inevitably a relational activity, the therapist's reflexivity would not be complete without understanding their attachment style and ways of relating, and how these elements are actively influencing the alliance during any given session. For example, O'Connor et al. (2019) examined attachment styles 'role in TA, specifically, the agreement on the alliance between the therapist and client. The study focused on the significance of the match between the two parties based on the therapist's understanding of their own and the client's attachment style. With an accurate assessment of their respective relational styles, the therapist is better able to identify ways to improve the TA, thereby enhancing the effectiveness of the therapy. The role of congruence in the development of TA will be expanded on in the section *Attachment's Influences on Therapeutic Alliance*.

Repairing Ruptures

The therapeutic relationship is a ground where relational injuries can happen (Safran & Kraus, 2014). Often referred to as ruptures in psychotherapy, they are ideally addressed with

open communication, which allows the client to feel accepted while confronting a conflict (Safran & Kraus, 2014). For this reason, the therapeutic relationship is unique from any other type of relationship; it resembles a secure mother-child relationship, where the client is invited to collaboratively discuss strains that take place within the therapeutic relationship (Safran & Kraus, 2014). This is particularly important as a therapeutic goal for the client is to eventually be able to take the security cultivated in the TA into their relationships outside of the therapy room, with an understanding that "relationships are possible even where there is not always perfect accord" (Safran & Kraus, 2014, p. 382). Of significance, ruptures happen nearly every other session, whether the therapist is aware of it or not (Safran & Kraus, 2014). Safran and Muran (1996) defined the emergence of ruptures in the TA as the therapist's unknowing participation in "maladaptive interpersonal cycles" that exist in the client's interactions with others; when it happens within the therapeutic relationship, it may confirm the client's "dysfunctional interpersonal schemas" (p. 447).

While the relational nature of a therapeutic relationship is why TA is a continuous negotiation that renews every session, congruent with the aforementioned components that make up TA, the attunement to when ruptures happen—verbally and nonverbally—and the initiative to address it in conversation are responsibilities that belong to the therapist. Research studies (Eubanks et al., 2018; Safran & Kraus, 2014) have shown that when ruptures are addressed and repaired, the TA leads to more positive outcomes. In a meta-analysis looking at alliance rupture repair that successfully led to positive treatment outcomes, Eubanks et al. (2018) identified the key practice of being attuned to withdrawal and confrontational ruptures. They added that immediate acknowledgment of the rupture with directness is important, and is dependent on the development of alliance, empathy, and validation for the client's expression and participation in

the conversation. This process of attunement and acknowledgment further involves the therapist taking responsibility for their contribution to the rupture (Eubanks et al., 2018). Some final considerations, depending on the progress of the initial phase of the repair, including connecting the rupture to the client's interpersonal challenges or patterns outside of sessions, personal reflection to explore any negative feelings that surface, and, crucially, extending the same care one would to themselves as they would their clients in the process (Eubanks et al., 2018).

Through an anti-oppressive lens, repair is part of the process of taking accountability and is necessary for any rupture in the therapeutic space. Mingus (2019) described accountability as a proactive practice that strives for transformative justice. Mingus offered four parts to the accountability process: self-reflection, apologizing and taking responsibility, repair as a relational process, which can involve making amends, rebuilding trust, and changing one's behaviour. Within the therapeutic relationship, the ability to take accountability when the therapist has enacted low-level harm to, broken trust, or had a misunderstanding with the client is crucial to repair and demonstrates a secure relationship the therapist has with themself that they can extend it to their client. By committing to taking accountability as part of the rupture-repair process, the therapist exercises what Mingus called "a practice of interdependence, a way to care for those we love and our selves, and shows that we have done our own internal work to take responsibility for our actions" (para. 15).

Assessments of Therapeutic Alliance

Although TA is a key component in therapeutic efficacy, assessment of TA has not been adopted into most practitioners 'professional and educational training. Part of the reason is that despite the extensive research on TA, ways to accurately measure it remain scattered and not streamlined. In other words, there is yet to be a consistent method for assessing the strength of a

therapeutic relationship. As a relational and dynamic concept, TA can be perceived differently between the therapist and client (O'Connor et al., 2019). Moreover, many of the existing measurements are self-report-based and often examine the results session-to-session, or between sessions. This results in a lack of microcosmic measurements of the experience or events, such as ruptures within a session (Colli & Lingiardi, 2009; Martin et al., 2000).

A meta-analysis by Martin et al. (2000) investigated how well TA predicts therapeutic outcomes. The researchers outlined the most common scales that measure alliance strength, naming that they are "based on somewhat different theoretical understandings of the alliance and rely on different methodologies for measuring the relationship" (p. 439), illustrating the richness of what is yet to be understood about TA, how to incorporate it into practice, and further research that it calls for. Additionally, the diversity within the interpretations of TA and consequently measurements presents another barrier for practitioners to land on a reliable assessment. Nevertheless, of the measures discussed in the meta-analysis—the Pennsylvania Scales, the Vanderbilt Scales, the Toronto Scales, the Working Alliance Inventory (WAI), the California Scales, and the Therapeutic Bond Scales (TBS)—the WAI was concluded as the most versatile measurement that also captures the alliance's theoretical constructs. Furthermore, the WAI offers a score that assesses the key aspects of alliance according to a few of the frequently quoted researchers in the measurement of TA: Bordin (1979, as cited in Martin et al., 2000) and Horvath and Luborsky (1993, as cited in Martin et al., 2000). It also comes in different versions of rating for client, therapist, and observer (Martin et al., 2000). Noteworthy to mention is that this meta-analytic review included 79 studies conducted over 18 years; 30 of which originated before 1990 and the rest between 1990 and 1996—the data are from three decades and more ago. Another crucial note about this review is that the scales studied were evaluated on their correlation with

the therapeutic outcome, rather than the strength of the alliance per se.

Studies have inquired into the relationships between select assessment scales and specific aspects of TA. They include Reading et al. (2019)'s investigation on the role of Therapist Reflective Functioning (mentalization capacity) in predicting therapy success, using the WAI in conjunction with a "Session Evaluation Questionnaire" (p. 118); Mellado et al. (2017)'s examination of the variations of TA with the Vanderbilt Therapeutic Alliance Scale (VTAS); and Colli and Lingiardi (2009)'s study of the Collaborative Interactions Scale (CIS) as a transcript-based method for assessing specifically alliance ruptures and resolutions in psychotherapy. All of these studies arrived at results according to their hypotheses and claimed the reliability of the measurement tools used.

Boswell et al. (2015)'s contribution to the available assessments of TA is valuable in their discussion on implementing routine outcome monitoring (ROM) that utilizes session-to-session tracking of client progress to improve treatment outcomes. The history of ROM traces back to 1996 when researchers Howard, Moras, Brill, Martinovich, and Lutz used a more focused assessment question with an "idiographic" approach: "Is this treatment, however constructed, delivered by this particular provider, helpful to this client at this point in time?" (Boswell et al., 2015, p. 7). This article stated that ROM can help indicate to therapists when their treatment may potentially be ineffective or even harmful to the client. Echoing the congruence piece mentioned earlier, Boswell et al. repeatedly showcased the discrepancy between the therapist's and the client's view of the therapeutic outcome. Examples include when a client's self-reporting of their experience of therapy or the severity of the problem is influenced by what they may believe is in their interest, as well as a therapist's inaccurate assessment of progress. While the blame often falls on the measurements 'unreliability, the researchers have asserted that the feedback provides

material for an open conversation where the therapist can discuss the discrepancy in the client's and their respective experiences of the therapeutic process. This process is believed to strengthen the TA.

Intersectionality's Influences on Therapeutic Alliance

Pairing and Intersectionality

As discussed earlier, a therapist's reflexive capacity is a core component of TA. In this section, the role of Intersectionality (Crenshaw, 2019) and the mindfulness of it in the practice of psychotherapy will be explored. Among the literature reviewed, research findings on pairings of clients and therapists are based on varying combinations of locations and positionalities on the axes of identities. Racial, socioeconomic, age, and an admittedly dated binary perspective of gender, on both the therapist's and client's ends are presented. Several important studies (Kim & Kang, 2018; PettyJohn et al., 2020; Qureshi, 2007) revealed that addressing and understanding Intersectionality is a crucial step to establishing and creating safety in the therapeutic space, therefore an ethical responsibility of therapists. The results of omitting a discussion on the discrepancy born from the inherent power dynamic between the therapist and client, often intensified by their respective intersectional identities and locations, will be discussed. Notably, it is powerfully demonstrated through one's mere presentation of oneself in front of another person in any setting, especially a therapeutic one.

A longitudinal analysis by Cheng and Lo (2018) explored factors associated with TA. The factors include the client's insights and motivation to change, interpersonal challenges, the match of gender and ethnicity between the therapist and client, the therapists 'intersectional backgrounds, and their lengths of professional experience. This analysis examined 239 clients who shared marital status, education, and income, over a 16-session period; specifically at the

intake stage, early in the therapeutic relationship, and at treatment termination, across the span of three years (1982 to 1985). While acknowledging that other studies have found higher alliances in relationships where the ethnicity or race match, Cheng and Lo hypothesized that the therapeutic alliance is negatively associated with ethnic matching. Cheng and Lo wrote:

> Another [study] found [w]hite clients to develop significantly stronger therapeutic alliances with their therapists than African-American clients developed. At the same time, the literature comprises many studies suggesting clients 'and therapists 'racial/ ethnic similarity does not significantly affect either therapeutic alliances […] or treatment outcomes. (pp. 783-784)

The client's lack of motivation to change, interpersonal difficulties, stress, and substance use were found to negatively influence the TA, while a sense of motivation to change and the presence of client insight was associated positively with TA (Cheng & Lo, 2018). In the study (Cheng & Lo, 2018), this was interpreted as a lack of desire on the client's part to find meaning in the therapeutic relationship. Although TA appeared to be higher in pairings where the client's and therapist's genders matched, Cheng and Lo (2018) concluded that there is no significant association between ethnicity or race and TA. However, the homogeneity of their sample size—87% of clients were white and 78% of therapists were identified as male, whose ethnicities were not disclosed in the study—speaks to the unreliability in considering the results as conclusive.

On the other hand, a study by Kim and Kang (2018) focused on the effects of racial matching between therapist and client on therapeutic outcomes. They found that among the pairings with matching ethnicity or race, the therapeutic relationships were longer lasting and yielded better improvement than those of racially unmatched. While it is unclear how exactly

racial matching adds to TA, Kim and Kang spoke about the correlation between rapport and TA, which is more consistently observable among pairings that share similar experiences. This aspect appears to foster greater trust in clients, who in turn are compelled to share more. In contrast, unmatched pairings have the potential to be harmful to clients. Therapists risk perpetuating harm in the context of therapy when therapists from different racial backgrounds and experiences are matched with historically marginalized clients. This is particularly evident for those who occupy an intersectional position that situates higher in the social hierarchy and is part of the oppressive system that continues to marginalize BIPOC communities (Kim & Kang, 2018; PettyJohn et al., 2020). This pairing is particularly dangerous if the therapist fails to reflect on their location and/or acknowledge the racial differences in the room, where vulnerable and extremely personal work takes place (PettyJohn et al., 2020). One of the major findings in Kim and Kang's study is that racially matched cases displayed higher counselling efficiency than unmatched cases.

Behn et al. (2018) surveyed the levels of TA among different combinations of gender, age, and income in therapist-client pairings. The findings provided many nuances, most notably the "female effect," "youth effect," and "affluence effect" (p. 1417). Behn et al. found that although gender matching does not increase TA in already positive therapeutic relationships, initial low TA among "male" therapist and "female" client relationships improved after the fourth session. The researchers referred to this as the "female effect," alluding to Bhati (2014, as cited in Behn et al., 2018, p. 1417), who stated that TA tends to be higher among "female-female" therapist-client pairings. However, the gender matching was reported to be insignificant when the client's symptoms severity was controlled for. In addition, the TA was found to be higher in similar-aged therapist-client pairings and among dyads where the therapist was younger than the client (Behn et al., 2018). This "youth effect," however, saw the growth decline slightly session

by session (p. 1417). In regards to income levels, Behn et al. surprisingly found the TA growth to be higher among dyads where the therapist came from a higher income status than the client, "particularly when clients are from a vulnerable socioeconomic class" (p. 1417). The researchers attributed this "affluence effect" to "social trust" on the client's part in meeting with those from a higher income status (p. 1417).

Why Intersectionality-Informed Therapy Matters

The studies discussed thus far analyzed various factors positively and negatively associated with the formation of TA. Notably, the factors tended to be siloed in the method of data collection and analysis. As mentioned, racial and socioeconomic backgrounds, gender, the therapist's presentation, the client's perception, and the agreement between the perceptions are all relevant factors. In other words, Intersectionality is crucial in considering the formation of TA. *Intersectionality* refers to the unique intersecting facets of one's identities and experiences that place an individual in a position of marginalization and disadvantage in social systems that uphold power and privilege. PettyJohn et al. (2020) asserted that TA must consider the amalgamation and alchemy of both the therapist's and client's myriad backgrounds and experiences. Specifically, they argued that TA is achieved via addressing Intersectionality in therapy: "therapist transparency in addressing issues of [I]ntersectionality with client identities deepens and strengthens the therapeutic alliance and, as a result, positively affects treatment outcomes" (p. 313).

Consequences of a Lack of Intersectionality-Informed Therapy. A crucial yet nuanced piece about the therapist-client power dynamic is expanded to the systemic imbalances experienced by people facing different degrees of discrimination (Crenshaw, 2019). PettyJohn et al. (2020) acknowledged that the therapist's and client's roles are at times occupied by the

marginalized and historically oppressed under various systemic powers. Power imbalance and microaggressions, intentional and unintentional, between the therapist and client, is a result of the therapist failing to recognize and address the intersectional disparity within the relationship. This unaddressed imbalance can rupture TA. As mentioned above, the client's perception of the therapist's professionalism based on the physical environment where therapy takes place and the therapist's perceived clinical knowledge are both major influences in the client's rating of the TA (Lavik et al., 2018). PettyJohn et al. (2020)'s essay illuminated that the client's perception of the therapist's presentation is influenced by the client's sense of safety, which is shaped by their intersectional experiences. The client's sense of safety contributes to their readiness or desire to build trust with the therapist.

Therapists who do not acknowledge or reflect on Intersectionality in relation to their role in a session may be due to their lack of experience, understanding, or awareness of this dynamic (PettyJohn et al., 2020). In the existent literature, it is rare for researchers to assert that therapists hold serious responsibility acting as the authority figure and service provider in an inherently imbalanced context of helper and the helped. As mentioned earlier, without awareness and reflexivity, therapists in positions of privilege and power working with clients from historically and continually marginalized communities of intersecting identities can replicate harm that has been upheld by systemic forces in the therapeutic relationship (Kim & Kang, 2018; PettyJohn et al., 2020). PettyJohn et al. (2020)'s essay revealed that 53–81% of racialized clients reported experiencing "at least one microaggression perpetrated by their therapist, with the majority of these incidents involving therapist avoidance of culturally relevant conversations, or subscribing to common cultural stereotypes without asking clients about their own unique experiences" (p. 317). This showcases an understated impact of Intersectionality on TA and the harm perpetrated

by therapists, paralleling that of existing power structures.

In addition, congruent with Lavik et al. (2018)'s study as discussed earlier, PettyJohn et al. (2020) posited that positive TA is largely fostered in early sessions and that early formation involves cultivating a sense of safety. They explained: "clients cannot feel fully seen, understood, or accepted until certain dimensions of power are worked through" (p. 317). Furthermore, part of cultivating safety means "giving the clients space to discuss any apprehension or discomfort they may be experiencing in relation to the therapist's identity" (PettyJohn et al., 2020, p. 317). Without this process and mindfulness, TA, which stems from a healthy bond and emotional connection, can be increasingly challenging to develop over time.

Caveat. Having spoken to the measured factors contributing to TA formation and the importance of addressing Intersectionality—recognizing that it is crucial in locating the different facets of both parties 'backgrounds—some studies illustrate the unreliability of self-reporting. In a single study qualitative article by Qureshi (2007) that examined a Black client's experience working with a white therapist, the client found himself reevaluating his high rating for the therapist when he reported the therapist's hesitance to bring up race. Specifically, the therapist did not name it. The client reflected that although the therapist self-disclosed his Jewish background, allowing the client to open up about certain experiences, the therapist projected values such as binary beliefs that forgiveness is good, and anger is bad onto the conversation. The client shared that this hindered him to express and explore his anger as he wished, revealing a disparity in their therapeutic goals. Furthermore, the client's initial impressions of the therapist's position as an older white man created a dynamic where he, a Black man, felt he had no choice but to trust and respect him, and wanted to be liked and validated in return. This study analyzed many reasons the client shared in retrospect that would have led him to rate the TA as

subpar, despite having received beneficial pieces from the sessions. The interviewed client's high rating for the therapist and TA serves as a warning, not only about the format of surveys but more importantly, how positionality and perceived authority of the therapist have the potential to influence the client's perception of the therapist and their own experience of the TA (Qureshi, 2007).

The examined literature is by no means exhaustive. Some crucial distinctions and exclusion of identities and qualities have been noted as limitations to a fuller understanding of the extent of Intersectionality's impact on the formation of TA, especially considering the significance of deconstructing power and normativity in the ever-evolving social and political climate. In addition to considering the roots of these limitations as reflective of the systemic structure that exists in the colonial landscape, the limitations further warrant consideration of the valuable information and knowledge that are missed and left out of the scholarly consciousness. This will be discussed further in chapter three.

Attachment's Influences on Therapeutic Alliance

The Matching and Non-Matching of Attachment Styles

As discussed earlier when considering the components of TA, two core tenants are concerned with the connection between the therapist and client where a secure base is developed for the client, and the therapist's reflexivity is paramount (Lavik et al., 2018; O'Connor et al., 2019). In the past decade, research that examined the pairings of therapists and clients based on their attachment styles has emerged. The research yielded discussions around how the matching and non-matching pairings influence the TA, both at the beginning of the relationship as well as in the long run. After looking at how the therapists 'attachment styles and reflective functioning impacted the therapeutic outcome, Cologon et al. (2017) conclusively stated that mentalizing

ability is one of the standout characteristics that explains a therapist's effectiveness, over their varying levels of education, training, and experience. *Mentalizing* is defined as the ability to "create [a] secure and reflective interpersonal space that allows for therapeutic change" (p. 615). Furthermore, Cologon et al. noted that mentalizing is believed to mediate the therapist's personal internal working model and the client's attachment patterns within the therapeutic relationship. As a result, the therapist's "well-developed ability to mentalize" in their work protects clients from "the effects of attachment trauma and overcoming childhood difficulties" (Cologon et al., 2017, p. 623).

Perhaps counterintuitive to much of the foundational understanding of building a working alliance—mirroring the client's verbal and nonverbal language and pacing—and to the important role of psychotherapy serving as a secure base, the therapist's personal secure attachment has not been found to contribute to better working alliance (Bucci et al., 2016). Moreover, Bucci et al. (2016) found that "insecurely attached clients [also] did not have poorer working alliances" (p. 161). Among the numerous studies (Bucci et al., 2016; Degnan et al., 2016; Marmarosh et al., 2014; O'Connor et al., 2019) that looked at the role of attachment style in contributing to TA, the findings revealed that while there appears to be value in non-matching pairings of attachment styles in relation to TA, it is mostly in the early development of the working relationship.

Degnan et al. (2016) provided a systematic review of 11 studies that inquired into the impact of therapist attachment style on TA and client outcome. Only one of four studies indicated a direct impact of therapist attachment style on the therapeutic outcome (not TA, specifically), where therapist attachment security yielded better therapeutic outcomes and vice versa with therapist attachment insecurity. Echoing Bucci et al. (2016)'s finding, as mentioned earlier, only three of the seven studies that measured attachment security identified associations

between the therapist's secure attachment with positive TA (Degnan et al., 2016). The researchers of one of the seven studies explained that, rather than a securely attached therapist, a "nonintrusive and more dismissing therapist" would likely benefit insecure clients with "ambivalent and disorganized attachment experiences characterized by unresolved trauma" (p. 60). In particular, therapists with a contrasting attachment style, namely avoidant, would provide a corrective and "predictable" emotional experience, demonstrating the strength in adopting an "autonomous role" in dealing with relational injuries (p. 60).

Among the 10 of the total 11 reviewed studies that examined the impact of the therapist's insecure attachment dimensions on TA, only two showed that "anxiously attached therapists establish[ed] poorer working alliances with their clients" (p. 61). One study specified that although therapist attachment anxiety had a positive impact on the TA in its early development, its impact was negative over time. This mirrors the results found in Marmarosh et al. (2014)'s study, where the researchers posited that the initial positive impact of therapist attachment anxiety on the TA might be due to anxiously attached therapists "overly focusing on maintaining a positive relationship with the client" (p. 409). On the other hand, only one study of the 11 in Degnan et al. (2016)'s systematic review showed that therapist attachment avoidance had a negative effect on the TA. Distinctively, some of the results spoke to the client's presenting problem as a factor for matching: two studies demonstrated a more influential role in the therapist's attachment style in pairings with clients who had more "severe presentations" (Degnan et al., 2016, p. 61). One study in Degman et al,'s review found that therapist secure attachment was a predictor of better TA with "more severely impaired" clients; the other study revealed that anxiously attached therapists negatively affected the TA in pairings with clients who were more interpersonally distressed (Degnan et al., 2016, p. 61).

Marmarosh et al. (2014) suggest that among non-matching attachment style pairings, it is still crucial for the therapist to have a level of security while falling under the avoidant attachment dimension when working with anxiously attached clients. Equally, securely attached therapists who also locate on the anxious attachment dimension tend to work best (in the beginning) with avoidantly attached clients. However, when the pairing falls on further extremes on the attachment dimensions, namely pairings between a more anxiously attached therapist or client with a more avoidantly attached therapist or client, the development of TA sees a negative impact particularly in "session depth" (p. 409). The same study also indicated that matching attachment anxiety pairings might lead to negative therapeutic outcomes. O'Connor et al. (2019) studied the role of attachment in TA and, more specifically, the role of the agreement on the TA between the therapist and client in relation to therapeutic outcomes. Similarly, they found that even though there was stronger TA between more anxiously attached clients and "less anxiously attached" therapists, the therapists who continued to accurately track the agreement of the TA between them and their clients were those who still had "sufficient levels of security" (p. 90).

Congruence: The Agreement on the Therapeutic Alliance

Contrast to the benefits of non-matching therapist-client pairings based on their attachment styles, O'Connor et al. (2019) pointed to the significance of the match between the two parties based on the therapist's understanding of their own and the client's attachment style. The agreement on the TA between the therapist and client is referred to as *congruence* (O'Connor et al., 2019). With an accurate assessment of their respective relational styles, the therapist is better able to identify ways to improve the TA, thereby enhancing the effectiveness of the therapy. O'Connor et al. identified that in contrast to non-matching or non-complimentary pairings, session-to-session agreement on the TA is higher where therapist and client "match" in

their attachment style, namely, both are higher or lower in attachment anxiety or attachment avoidance. The agreement is also high where the attachment styles are "complementary," meaning one party has a higher avoidant attachment and the other has a lower anxious attachment, or one higher in attachment anxiety and the other lower in attachment avoidance (O'Connor et al., 2019).

Congruence is important because therapists need to have an accurate understanding of alliance development, which has been researched to relate to treatment success (O'Connor et al., 2019, p. 84). In O'Connor et al. (2019)'s study, treatment success correlated to high congruence was defined by the client's perceived "smoothness" of the sessions and decrease in symptoms (p. 84). Moreover, session-to-session agreement has been observed to yield a lowering in levels of "client worry and global psychological distress," as well as depression (p. 84). Although the primary hypothesis of this study that a pairing of secure–secure attachment (both lower in the same attachment dimension—anxiety or avoidance) would lead to a higher working alliance was confirmed, a pairing where both parties operated from the same insecure attachment dimension ("i.e., more avoidantly attached therapists working with more avoidantly attached clients, and more anxiously attached therapists working with more anxiously attached clients") also resulted in a higher agreement (p. 89). Furthermore, therapists with lower attachment anxiety were shown to have more accurate tracking of the client's perception of the TA and higher agreement with their clients on their session-to-session working alliance. In other words, agreement on TA or congruence may be mostly achieved by pairings where the therapist and client share a similar attachment style.

Noteworthily, the therapist's security in the attachment dimension dictates the accuracy of the relational assessments and agreement on TA (O'Connor et al., 2019). As seen in O'Connor et

al. (2019)'s research, therapists situated lower in anxious attachment tended to rate the TA lower than their clients did. On the other hand, therapists with higher anxious attachment may underestimate the bond of the relationship in contrast to the client's perspective, because they may be occupied with their feelings; they may also be insecure about the client's view of the relationship, thus demonstrating an inaccurate understanding of the TA.

Psychotherapy is Bidirectional

Therapeutic relationships are inevitably complicated and attachment style is only one among multiple factors that influence the TA (Degnan et al., 2016). Degnan et al. highlighted how the matching varied across the studies reviewed. Despite the non-matching pairing's influence on TA, a finding shows that matching pairs of low attachment avoidance saw better outcomes (Degnan et al., 2016). They concluded that it remains unclear whether matching or "mismatching" would be more optimal (p. 63). Nevertheless, the researchers asserted that a mismatch may allow the therapist to challenge maladaptive patterns, especially with insecurely attached clients. Degnan et al. emphasized the discrepant tools used across the reviewed studies and the variations even among the results that came from using the same measurement tool, alluding to the unreliability of the alliance reports. Especially in relation to clients and therapists who have insecure attachment styles, the self-report nature of the TA assessment is inevitably highly influenced by the reporter's insights, or lack thereof, and desire of how they may wish to be perceived.

Finally, it is important to remember that TA is a relational concept, it is therefore dynamic and inconstant. While the therapist's or client's attachment styles may influence the TA, the development of the alliance in turn plays a role in drawing out different attachment patterns, responses, and even opportunities for corrections in both the therapist and client (Degnan et al.,

2016). The bidirectional nature of a therapeutic relationship explains the wide range of variety in the research findings. It further serves as a reminder that evolution is an inherent part of TA and offers continuous opportunities for the therapist to monitor and implement corrective experiences where they are needed. In turn, again, this contributes to the strength of the TA.

The Role of Trauma: Experiencing Security via Therapeutic Alliance

In the context of working with trauma, the therapist's presence and ability to guide the formation of the therapeutic relationship becomes significant. There are many therapeutic approaches to treating trauma, such as co-regulation, establishing and maintaining safety and stability, respect, positive regard, compassion, inciting hope, taking client's Intersectionality into consideration, and a consistent positive therapeutic relationship (Briere & Scott, 2015).

For traumatized individuals, one of the most difficult barriers to overcome or cope with is their impaired neuroception (Porges, 2013, as cited in Manley, 2016), which refers to the reflective quality of one's brain in scanning their environment to ensure safety for survival purposes. Even people who have undergone severe trauma can generally function day-to-day by achieving a cognitive sense of safety, though the traumatic and painful memories remain in their nervous system. Porges and Siegel, leading theorists who have brought forth in-depth understandings of how trauma impacts one's neurophysiology, both speak to the goal of integration. *Integration* is when safety is experienced, felt, and secured as a state one can routinely return to—a repaired cognitive and autonomic neuroception (Manley, personal communication, November 5, 2021). Relational experiences are often at the root of trauma, whether the trauma stems from attachment injuries, abusive relationships, or harm caused to a person by another individual. Understanding the neurophysiological state of a traumatized client, TA becomes not only a crucial element of therapy, but an opportunity for corrective experiences

whereby the client can participate in co-regulation, a safe and trusting relationship, and secure attachment.

Interpersonal Neurobiology-Informed Therapeutic Presence

Siegel's (2019) work on Interpersonal Neurobiology (IPNB) and mindfulness is expansive and widely applicable. In particular, the work of Siegal and his colleagues 'idea of "generative social fields" illuminated the connection between the brain, mind, and our social relational moments. They noted:

> The notion of such a set of interactive relational communications helps us to see how the "mind" is not only embodied in our brains and whole bodies, it is also fully extended and embedded in our relationships with one another and the world outside these bodies we inhabit. (Siegel, 2019, p. 233)

To this, Siegel proposed four components of a generative field: presence, attunement, resonance, and trust (pp. 233-234). These can be considered as the foundation of a therapeutic relationship especially in the context of treating trauma. Siegel (2019) defined *presence* as showing up with open consciousness, receiving "whatever arises from within the body, including the brain, and from the world around us, including the social relationships and their inherent patterns of signals from others—patterns of sharing energy and information flow" (p. 233). When a therapist is reflecting on Siegel's definition of *presence*, the therapist is actively demonstrating a nervous system that is safe, receptive, and in the ventral state. Such therapeutic presence is thus able to create a space for co-regulation to take place.

The interpersonal piece of IPNB speaks to the interaction between the therapist's and client's nervous systems, meaning that the client's neurophysiological state plays a role in the generative field and the formation of TA between the therapist and them. Fisher (2017), using

Siegel's IPNB framework, spoke to the therapist's role as "an ally for both sides of the struggle and a facilitator of 'earned secure attachment'" (p. 13). To do so requires the therapist to interpret the client's tendencies, which often originate from attachment injuries, and trauma responses as intrapersonal rather than interpersonal. In other words, within the therapeutic relationship, the client is still able to experience their internal attachment disorder while having a figure of security and attachment present to co-regulate and accept them. This further allows them to tend to their "young wounded selves" (Fisher, 2017, p. 13). Fisher explained the process of achieving earned secure attachment in TA: when a client reflects on, or recalls traumatic experiences, having another set of securely attached brain and body present helps assure and co-create a "new story of safety, closeness, and compassion" (p. 17). The repetition of this process rewires one's perception of their sense of safety. Peña (2019) echoed the IPNB framework by connecting it to Schore's (2014) work on right-brain-to-right-brain processes: "This intersubjective field, in which affective states are exchanged between client and therapist, is essentially the grounds for deep change to occur" (Peña, 2019, p. 103). *Intersubjectivity* describes right-brain-to-right-brain communication between two people (Schore, 2014). As "subjective emotional experiences" and intersubjective processes rely on the right hemisphere, right brain processes are activated and exchanged within TA (Schore, 2014, p. 390).

To competently work with trauma, the research suggests that the therapist has a presence attuned with the client on multiple levels. From this attunement they are able to facilitate a consistently positive therapeutic relationship and provide effective trauma therapy by executing the role of a neurophysiological activation of safety. This involves activating the client's ventral vagal pathways of the parasympathetic nervous system, hence igniting their neuroception of safety (Briere & Scott, 2015; Porges & Dana, 2018). In other words, the therapist's nervous

system, level of awareness and self-awareness, and wellbeing are all significant in the process of setting up the foundation for a secure therapeutic relationship, activation of safety, and effective trauma therapy. Findings from Lavik et al. (2018) have shown that the therapist's capacity and quality of their personal relationships influence both therapist's and client's evaluation of the TA. The practitioner's consistent reflection, understanding and caring of self, therefore, are intrinsic to the definition of ethical and efficacious practices, especially in trauma therapy.

Chapter Summary

In this chapter, I discussed the available research literature on TA—what it is and what contributes and influences it. The reviewed literature included studies on the three main tenets of TA: an interplay of the therapist's authenticity and professionalism, their reflexivity, and their ability to recognize and repair ruptures. I also provided an overview of assessment tools of TA. Based on the research findings, I discussed the three theories that play a major role in alliance formation, namely the theory on Intersectionality, Attachment Theory, and Interpersonal Neurobiology. All of which speak to the bidirectionality of the practice of psychotherapy and the opportunity for therapy to be a reparative process for various forms of trauma.

In the next chapter, I will offer my observations of the available literature on TA and discuss the implications of the disconnect between the current understanding of TA, inclusive of its strengths and limitations, and clients 'access to this information on the practice of psychotherapy. I will explore some of the structural contributions to these implications and offer actionable recommendations accordingly for practitioners and educators to promote TA, with the aim to facilitate ethical, decolonial, trauma-informed, and person-centered therapeutic practices.

Chapter 3: Summary, Recommendations, and Conclusion

Summary of Findings

Chapter two provided research-based discussions on the configuration of therapeutic alliance (TA) and the theories on Intersectionality, Attachment, and Interpersonal Neurobiology (IPNB) that significantly influence alliance development. The formation of TA is relational and bidirectional between the intrapersonal and the interpersonal, with both the client and the therapist mutual in their influence of one another. Within this bidirectionality, positive TA leads to the consistent generation of opportunities for corrective secure experiences. Without monitoring and exercising one's reflexivity, the therapist risks triggering the client's traumatic experiences in therapy and potentially adding to existing harm. The therapeutic space cultivates and guides the client's repair of cognitive and somatic safety. In the context of working with trauma, the therapist takes on an ethical duty to be a step ahead of the client. The therapist is tasked with being ahead not only in the client's neurophysiological state, but in their awareness of themselves, and the conscious and unconscious "intersubjective field" between them (Peña, 2019, p. 104). Ultimately therapists are responsible for setting up a safe and positive therapeutic experience and ensuring that their intrapersonal climate has the capacity for relational therapeutic work. The research findings point to the importance of this readiness as a foundation for positive TA, thus making healing possible for the clients.

Implications

Observations Within Industry Knowledge

Appreciation. Therapeutic alliance (TA) has evidently been a well-researched subject since the early 1990s. The literature has offered a wide range of studies and discussions on the complex nature of alliance formation. The findings offered many insights that responded to the

research question and beyond the focus areas included in this paper. The research question and aim of this paper has been to investigate what makes a strong TA and arrive at a concrete understanding of the significance of TA. While a major learning is that the ethical onus falls on the therapist to establish a safe-enough therapeutic experience, the research illuminated critical introspection on the process of thinking about and discussing TA (PettyJohn et al., 2020; Qureshi, 2007). Lavik et al.'s (2018) meta-analysis on alliance formation processes pointed out that while TA is interpreted as a process that facilitates client agency, it is less stated that client agency is important in fostering TA. The discussion shed light on the influences and contributions in alliance development from the client and revealed the assumption of a causal relationship between TA and client agency (Lavik et al., 2018). Furthermore, they asserted that the emphasis on "the alliance" risks fostering the idea that TA is a "product" to be achieved, rather than "ongoing collaborative and mutual processes" that are organic and ever-evolving in a therapeutic relationship (p. 361). However, it remains critical to consider the intrinsic power dynamic within the therapist-client relationship: it is partially formed by the therapist's positionality and social location, and may affect the client's exercise of their agency within the therapeutic relationship (PettyJohn et al., 2020; Qureshi, 2007).

Limitations. One of the patterns observed in the reviewed studies is that the samples of clients consisted mostly of white clients with only single-digit-percentages of colored clients. A couple of studies were excluded from the pool of research for this capstone because of the homogeneity of the demographics. In addition, while these studies described the backgrounds of the clients, they left out the same details of the participating therapists except for their average year of experience and gender. There were also conflicting statements about what previous research has revealed. Of the reviewed studies that had race and ethnicity as variables, half of

them claimed that previous research has proven that matching is irrelevant to the therapeutic efficacy, and the other half claimed the opposite.

Throughout the literature review in this capstone genders were referenced in quotation marks in the discussion of the research findings because it was not specified whether the participants self-identified as male or female, nor did they include or identify any gender non-binary, fluid, or queer participants. The studies 'discussion of the participants based on their perceived gender, rather than self-identified gender, could have hindered meaningful nuances, especially in studies that inquired into therapist-client pairings based on the various intersecting axes. Furthermore, failing to include other gender identities in the study of TA suggests neglect of a range of gender-based experiences. While some studies offered rare insights into how individuals 'class and socioeconomic locations play out in a therapist-client dynamic, the omission of diverse gender identities, participants 'self-identified gender, and their neurotypes is common among the reviewed literature. Despite the need for further research on Intersectionality-informed therapy—inclusive of variables based on gender, age, neurotype, body size, ability, and more—the reviewed literature has provided a meaningful understanding of TA's role in molding therapeutic experience.

In examining the assessment tools for TA, it was illuminated that TA has been studied as a broad concept across research studies without a congruent focus on any particular aspect of the alliance. Degnan et al. (2016) offered that "even when the well-established WAI was used, it was scored differently across the six studies, and only three measured its individual components (goal, task, and bond)" (p. 61). Furthermore, there were contradicting results among reports using the same tool, between therapist- and client-rated alliance (Degnan et al., 2016). With regards to the association between TA and therapist attachment in particular, Degnan et al.

concluded that it was unclear which aspects of TA were the most germane to the literature.

On the Practice of Psychotherapy

The Need for Decolonial, Relational Practice. Safran and Muran (2006), two researchers who have published multiple papers on TA, offered a critical reevaluation of the concept of TA, particularly on its role concerning the change process. They questioned whether the construct of TA warrants its popularity in psychotherapy research. Tracing back to TA's psychoanalytic origins, Safran and Muran highlighted the transformative influence of relational factors in treatment across the psychotherapy field. They claimed that this influence changed TA, from what was once synonymous with *transference* in the psychoanalytic days, to a "superfluous" concept (Safran & Muran, 2006, p. 287).

Safran and Muran (2006) opened their discussion by asserting that the evidence of TA predicting successful treatment outcomes was "modest," offering therapist allegiance and the "individual therapist variables" as overlooked factors for higher correlation in the therapeutic outcomes (p. 286). They did not clarify why "individual therapist variables" was considered a separate factor from TA at large. The distinction suggests that TA, at least in this context, does not account for the qualities of the individual therapist. Safran and Muran claimed:

> …it is unlikely that studies that continue to examine the predictive validity of the alliance, or the relative or additive importance of technical and relational factors, will yield much new knowledge in the future. We do not believe that it will be particularly valuable to develop new measures of the alliance or to attempt to refine the alliance construct further either through conceptual or empirical means or some combination [...] nor do we believe that it will be particularly productive to continue to look at patent or therapist characteristics that are predictive of a good therapeutic alliance. (pp. 289 - 290)

In the same essay, they concluded that research efforts should focus on how the relational factors play into the change process and affirmed that the relational context is important in considering how the therapeutic process unfolds (Safran & Muran, 2006).

The divorcing of alliance and relationality asserted by Safran and Muran (2006) is difficult to comprehend. They claimed that individual characteristics, of clients and therapists, are unlikely to be predictive of a positive TA, while still asserting the importance of relational factors in therapeutic outcomes. Does one relate to another as a completely neutral being? Are "individual therapist variables" not factors of the "mutual influence" between the therapist and client? (Safran & Muran, 2006, p. 287). The argument for relational variables in exchange for the alliance and the investigation of the influence of individual therapist variables suggests that they are mutually exclusive. It further demonstrates the characteristics of settler colonial thinking. It suggests a belief that the personal has no bearing on the intersubjectivity in a therapeutic relationship; that the therapist's personal experiences and background are not influential at the onset of the therapeutic process. Importantly, it fails to acknowledge the wisdom that clients hold from their cultural and lived experiences (Linklater, 2014). It imagines the "intersubjective field" to be a blank slate (Peña, 2019; Schore, 2014).

Peña (2019) described the value of somatic awareness and embodied attunement to clients in entering this "intersubjective field," where right-brain-to-right-brain states are exchanged (p. 103). In contrast to Safran and Muran's (2006) suggestion that individual characteristics are irrelevant, Peña argued that as the "intersubjective field" is where deep change can occur through right-brain-to-right-brain attunement, it is only by entering it with an "embodied presence" that the therapist invites the client into their own (p. 103). This suggests the therapist doesn't simply connect with a client by entering into a therapeutic relationship through

showing up and verbally engaging the client. For change to occur on an embodied level, the process of relating involves "working with implicit messages with an orientation surrounding meeting the needs of the aspects of self that are split off, frozen, or out of explicit understanding" (Peña, 2019, p. 104).

The lack of reflexivity on the therapist's contribution to the relational factors or the TA, as illustrated in the line of thinking demonstrated in Safran and Muran's (2006) paper, is congruent with the observable lack of research on how both the therapist's and client's intersectional locations contribute to TA. It further elucidates the benefits of Interpersonal Neurobiology-informed therapeutic practices. As collective conscience grows, many are reckoning with new perspectives on their identities: how they have been and continue to be shaped by systemic powers, and where their privileges and disadvantages lie. When therapists undergo this reflection on their own identities and experiences, the recognition of their intersectional experiences and how they may influence the therapeutic relationship to have an effect on therapeutic outcomes (Cologon et al., 2017; Lingiardi et al., 2016). Reflexivity allows therapists to attune to the relational factors, or lack thereof, between themselves and clients, and to subsequently address it to build alliance as well as model secure attachment (Safran & Kraus, 2014).

From a decolonial and justice-forward perspective, the concept of TA becomes more relevant and more relational than ever. Shewfelt (2018) explained the application of Interpersonal Neurobiology in psychotherapy, "since our therapeutic models influence the kinds of changes that people make in therapy, let us move increasingly toward [...] becom[ing] more relational, collaborative, and inclusive. Relational psychotherapists focus specifically on the reparative experience of the therapeutic relationship" (para. 6). Understanding relational factors

in therapeutic outcomes might not be achievable without acknowledging the history, research, and practice of psychotherapy. Due to the white supremacist and settler colonial systems in place, it has neglected, thus discounted, the enormous influences of intersectional power imbalances between the therapist and client based on their racial, gender identity, and class (Linklater, 2014).

Connection Issues due to Dominant Structures and Capitalism. Despite the abundant research on TA within the psychotherapy field demonstrating it as a consistent factor that promotes therapeutic efficacy, this knowledge has not been relayed into mainstream, obtainable information for those seeking therapy. Based on the aforementioned systemic structures in which the psychotherapy field exists and operates, the implications ripple into the design of the existing systems for those who seek help, thus affecting the experience of the process of finding a therapist. The implications raised from the literature review on TA are made under the theoretical framework of this capstone and consider my positionality and personal and professional experience. The barriers to finding a therapist, particularly one that is more likely to be a strong match in terms of TA, have also been expressed by both other clients and therapists (J. Petry, personal communication, May 26, 2022; L. Fox, personal communication, June 12, 2022; M. Norkowski, personal communication, May 5, 2022; R. Ren, personal communication, December 11, 2021). While they are by no means universal, I believe there to be benefits in including real-life and nuanced experiences that have not been scientifically studied or academically reported on.

To recapitulate: the implications include that the systemic influences of settler colonialism and capitalism create a dominant culture of psychotherapy practice wherein discussions on relationality lack Intersectionality-based considerations. In other words, while

therapy education and training teach the importance of rapport, it is not taught alongside the theory of Intersectionality, which is arguably integral to what a therapist and client respectively "bring" into the therapy room. This problem trickles into therapists 'wrestle with self-disclosure and an insufficient understanding of what information about themselves would help clients build trust (Jolley, 2019). For example, research shows that an overlap of lived experiences between the therapist and client creates fertile ground for TA (Kim & Kang, 2018). For therapists who are working with clients coming from disparate backgrounds, the lack of education and training in addressing Intersectionality in the therapeutic relationship is a common cause of ruptures (Linklater, 2014; PettyJohn et al., 2020; Qureshi, 2007).

Furthermore, the concept of alliance, though well-researched, is not often centered or privileged in practice. The results are that clients are uneducated and not exposed to the concept of TA, both what it is and why it matters. Simultaneously, in cases where TA is not at the forefront of the therapist's awareness when meeting a client for the first time, TA is not included as part of the informed consent. Congruent with the lack of peer-reviewed data on the availability of information about TA for therapy seekers, I have observed that places where people seek help, namely meetings with general practitioners, therapist online directories, mental health apps, and counselling institutions and agencies, rarely educate therapy seekers about TA. In my conversations with friends and colleagues, the dominant experience is that clients don't feel or realize that they have the agency and power to "shop around" for a therapist (M. Norkowski, personal communication, May 5, 2022; T. Nguyen, personal communication, June 13, 2022). The power dynamic between a therapist and client is a well-known and researched phenomenon. Under this power dynamic, the client looks to the therapist as the authority, expert, and potential power figure. By not naming TA's significance and deliberately giving the client permission and

room to explore what qualities in a therapist may work best for them, the client may not realize that they hold agency and autonomy to be selective in whom they work with. Additionally, some clients, especially those who are new to therapy, may not know what they need in a therapist (V. So, personal communication, June 2, 2022). On top of the power dynamic and lack of access to the concept of TA, the wide ranges of modalities, languages, and terms within the industry often get clouded in jargon, making accessing help a barrier for clients (J. Hassell, personal communication, May 27, 2022; T. Nguyen, personal communication, June 13, 2022; V. So, personal communication, June 2, 2022).

Lastly, capitalism promotes the idea of valorizing and monetizing an individual's productivity, on which worth is perceived to be based (Biss, 2020; Odell, 2019). In the marketplace, to survive and to sell their services, therapists are motivated to embellish their offerings. Examples may include claiming that they have expertise on an issue or modality despite having minimal education and training in it. Survival under the capitalist system further motivates an increase in the number of clients or sessions over quality. The quality that gets deprioritized may be the therapeutic relationship, a feedback-informed practice, and ultimately, a low capacity for reflexivity and a tendency to burn out, or continue to work despite being burnt out.

This gap between industry knowledge and public-facing information reveals an accessibility flaw in the current mental health system. Failure to communicate pertinent information that helps inform a decision-making process means failure to support those in need (B.C. Association of Clinical Counsellors, 2010). The most common ways to find a therapist remain word of mouth, a Google search, and insurance and organization directories (American Psychological Association, 2017; Healthline, 2020; Morin, 2022).

Recommendations

Education on Interpersonal Neurobiology-Informed Care as Client-Centered Care

Toward an Integrated Neuro-Intersectional and Trauma-Informed Education and Practice. In the United States, a review of the curricula among the 776 counselling programs showed that 41% offered some type of trauma course and a mere 5% included a neurocounselling course (Montague et al., 2020). *Neurocounselling* is defined as "the integration of neuroscience into the practice of counselling by teaching and illustrating the physiological underpinnings of many of our mental health concerns" (Russell-Chapin, 2016, as cited in Montague et al., 2020, p. 10). There is an increased understanding within the research of how trauma affects one's neurobiology alongside a growing recognition of the traumatic impact of systemic oppression (Meyer, 2003; Quinn & Chaudoir, 2015). For therapy to achieve efficacy, as discussed in this Capstone, a foundational part of the therapeutic relationship is the therapist's ability to establish safety; in cases where the client experiences ongoing systems-induced trauma, it is about creating a safe-enough environment (Kinavey & Cool, 2019).

Interpersonal-Neurobiology-informed practice requires the therapist's attunement to the client's nonverbal language and promotion of the client's access to their resilient zone or Window of Tolerance (Miller-Karas, 2013; Siegel, 1999). The bidirectionality of the therapeutic relationship points to the ongoing undercurrent between the therapist and client, wherein both parties 'neurophysiological states are interacting and mutually influencing one another (Schore 2014; Schore, 2021). This "intersubjective field", according to the theory of Interpersonal Neurobiology (IPNB), is where change can take place (Peña, 2019; Schore, 2021; Siegel, 2019). While this is part of some trauma courses in counselling education programs, there has been an increase in proposals on educating about trauma throughout program curricula, rather than in

singular courses (VanAusdale & Swank, 2020). Moreover, research that came out of Scandinavia has made the case for adopting Problem-Based Learning (PBL) in master programs for psychotherapists and psychologists (Glintborg & Hansen, 2018). PBL "draw[s] on social-constructivist approaches focusing on providing conditions for students 'active construction of knowledge, working with real-life tasks, and learning in collaboration with others" (Glintborg & Hansen, 2018, p. 120). If the continuous trauma and IPNB education interweave teachings and discussions around power structures of patriarchy, colonialism, white supremacy, ableism, cis- and heterosexism, capitalism, and more, the benefits would see a holistic approach to study and understanding of personhood from a neuro-social perspective. Furthermore, it would serve as a foundation for students in counselling programs to form genuine person- and client-centered practices.

To promote integrated neuro-intersectional and trauma-informed learning, PBL can be a beneficial structure for each course within a counselling program curriculum despite focusing on different areas of the professional practice. For example, PBL can be a framework to support group discussions, clinical hypotheses, or role play using case studies beyond the usual single course on trauma. Neuro-intersectional and trauma-informed PBL would guide students through questions that inquire into the ways in which the person(s) in the case study benefits or is disadvantaged from the oppressive systems in place, namely patriarchy, settler colonialism, ableism, cis- and heterosexism, capitalism, anti-fat bias, etc. Following this step or interweaved in between can be questions and discussions on the potential neurophysiological responses the studied person may have, and how their intersectional location may factor into it.

Connecting to the notion of TA, students can be then guided through a reflection of their lived experiences as clients, or imaginings of how their role as therapists, coming from their

intersectional location and self-knowledge of their attachment patterns, may impact and establish safety with the studied person in a hypothetical session. Including scenarios of rupture and discussions on how to repair the therapeutic relationship would enrich the learning. To prepare students for their practice, it is crucial to learn how to build a secure relationship with clients while acknowledging the discomfort of ruptures and accounting for the students', i.e. the therapists', personhood. Addressing, normalizing, and practicing rupture and repair with neuro-intersectional and trauma-informed PBL through case studies as well as lectures can deepen their investment and appreciation for client-centered care.

The Body is Intersectional. Client-centered care is a term ubiquitous in the practice of psychotherapy, referencing the Rogerian values of unconditional regard, congruence, and empathy (Velasquez & Montiel, 2018). However, as this paper and reviewed literature discussed, practicing client-centered therapy involves acknowledging that the therapeutic relationship influences the client's progress in therapy. As we consider integrating the mind-body approach to efficiently work with trauma among other issues, the body that we are attempting to connect to the mind includes its neurophysiology. Furthermore, the body is inseparable from its location in the world, with its physical appearance, visible abilities and disabilities, and neurotypes, where the combinations of these attributes fall on the intersecting axis of privilege, domination, and oppression (PettyJohn et al., 2020). The body, without soliciting, is associated with various social messages, identities, and meanings, which leads to complex and often disproportionate experiences of discrimination and advantages (Mortimore, 2021). For this reason, client-centered care in the therapeutic context, especially when working with trauma, would entail an understanding of IPNB as well as Intersectionality theory.

Importantly, Intersectionality demands us as mental health practitioners to maintain curiosity and humility about our clients and their expertise in their lived experiences. Practitioners need to understand how we and the clients enter a relational dynamic with inherent power imbalances based on our respective positionalities—socially, bodily, and politically related—and that many individuals have a lifetime experience of discrimination before working with us. Clients remain the experts of their experiences with their embodied knowledge of what it means to be in relation to oppressive forces, manifested in institutions, systems, and other humans (Kinavey & Cool, 2019).

Reflexivity Resources for Therapists. In practice, personal reflection is the first step. As a practicing therapist, one must have gone through, and commit to doing so on a continuous basis, a rigorous self-reflection on their relationship to various structures, particularly white supremacy and settler colonialism, ableism, patriarchy, and cis-and heterosexism. The reflection should consist of explorations of the impact of these relationships on their "values, beliefs, politics, philosophy of life, and professional practice"—the clinical implications (S. Médiné, personal communication, January 8, 2021). Some questions can include "What aspects of personality, values, and beliefs have emerged as a result of your location in relation to this particular system of structural power?", "How might your location in relation to this system of power impact your work with clients?", and "What will you have to attend to in order to practice in a way that does not enact the harms of this particular system of structural power?" (S. Médiné, personal communication, January 8, 2021).

Another consideration to integrate into building an Intersectionality-informed practice is practicing naming one's intersectional location with clients and inviting clients to reflect on and name their own, rather than describing it for them. As discussed in this paper, clients have

reported on the importance of a felt sense of safety and being put at ease, which can manifest as the therapist taking the initiative to address the differences between them, thus the inability to fully relate, as well as feeling comfortable in talking about typically sensitive topics, such as experiences of racism and body-based discrimination (Qureshi, 2007; T. Nguyen, personal communication, June 13, 2022; V. So, personal communication, June 2, 2022). As a therapist, one can demonstrate awareness of how their presence, physical or with implicit association, may impact the client by verbalizing it while acknowledging their value in the client's lived wisdom. This may alleviate the client's burden of feeling the need to educate or explain to the therapist. By broaching this conversation, it can help the therapist redirect the focus on the therapeutic work and the client their experiences, rather than protecting the therapist's feelings—in order to protect themself. There is also value in maintaining that consent is ongoing by asking for the client's consent before diving into an impactful event or challenging them.

Advocate Therapeutic Alliance

Training Therapists to Educate Clients on Therapeutic Alliance. While the first lessons in therapy school talk about rapport with clients, TA rarely, if ever, has an entire course dedicated to it. It should be distinguished from the introduction to counselling practice because the extensive research on the topic of TA has revealed how the therapeutic relationship is a non-negotiable entry point to the possibility of change from the IPNB perspective (Siegel, 2019). To effectively work with a client's intrapersonal and interpersonal challenges, the therapeutic relationship must be a secure base for these challenges to be explored, confronted, processed, and perhaps corrected (Peña, 2019; Schore, 2014; Wallin, 2017). The security of the therapeutic relationship is the ground from which correction can be modeled and learned (Cologon et al., 2017; Degnan et al., 2016; Miller-Bottome et al., 2019). In summary, effective therapists are TA-

informed.

The power dynamic between therapist and client is intrinsic to the relationship (PettyJohn et al., 2020). This, among other reasons including aforementioned capitalism, colonial mindset, and lack of understanding of TA, warrants the question: are clients aware of the concept or significance of TA? Clients have shared that when therapists named the importance of how the clients feel about their fit or their experience of the therapists, the clients felt a sense of agency to be selective of whom they work with, and were relieved and grateful (L. Fox, personal communication, June 12, 2022; M. Norkowski, personal communication, May 5, 2022; J. Napier, personal communication, May 14, 2022). They shared a common experience with a false sense of disempowerment because the therapists are assumed to be the experts; even when the fit didn't feel right, they continued working with the same practitioners (K. Tsui, personal communication, July 23, 2022; T. Nguyen, personal communication, June 13, 2022; V. So, personal communication, June 2, 2022). A therapist's ability to address and promote TA with a client, which involves putting aside self-interest, actually demonstrates a form of secure attachment and deconstruction of the inherent power dynamic between them and their client.

To put this into practice, therapists can explicitly name the power they have in the therapeutic relationship by inviting clients to be selective in whom they work with because the therapy is for them, not for the therapists. With the therapist's encouragement, clients may feel empowered and autonomous in their search for a therapist with whom they feel more in alignment, consequently more likely to build an alliance. This further lets the client know that the therapist is not purely motivated by money, or having them become a client of theirs, which may help deconstruct the power dynamic and ease the transactional sense of the relationship. Therapists can also ask the clients about any specific qualities they look for in a therapist, in

addition to the problems or situations the clients are looking to address in therapy. With a careful assessment of the therapist's intersectional location, professional experiences and scope, and attachment tendencies, the therapist's transparency in their inaptitude and capacity shall be respectfully communicated with the client. It would be helpful for the therapist to include any recommendations of therapists, agencies, or collectives that may better suit the client's needs.

Limitations to this Capstone

Future Research in Therapeutic Alliance

In addition to incorporating IPNB and Intersectionality more interconnectedly in counselling education programming and practice, it is important to integrate the role of TA. Although the literature on TA has been increasing in interest and volume, it remains challenging to find a study that considers the aspects of identities that have been evolving and emerging into the contemporary understanding of sexual and gender identity, as well as the variety of neurotypes. Given the unfolding of knowledge around neurodiversity, the future of research on TA would benefit from including factors that majorly influence the communication, perceptions, and general experiences of therapy sessions in therapeutic dyads and relationships. For example, autism, alexithymia, delayed processing, and common yet influential tools of survival, such as masking and stimming (Young & Mosaic, 2019; Zamzow, 2021). These gaps contribute to an incomplete exploration of TA in this capstone.

Inclusion of Neurodiversity

Since beginning this capstone and completing my practicum, my experience in working with neurodivergent individuals and my purview of the vast knowledge that neurodiversity offers has deepened. *Neurodiversity* refers to "the natural diversity of human minds that acknowledges the whole spectrum of neurodiversity from neurodivergent individuals to neurotypical

individuals," and *neurodivergence* is an umbrella term to describe "individuals who have a mind or brain that diverges from what is typical or normal" (Wise, 2022). This capstone mentions neurotype as a part of one's intersectional identity that can bring about challenges and discrimination due to the neurotypical framework of most societal structures. However, it does not encapsulate the nuances in how neurodivergent and conventionally neurotypical people communicate, and the imaginably immense impact the therapist's ignorance of neurodivergence can have on a neuroatypical client's experience of the therapeutic process as well as the relationship. With the considerations of Intersectionality, attachment, and IPNB, TA- and person-centered care rely heavily on verbal and nonverbal communication, which is naturally influenced by how an individual's brain is structured. Moving forward, discussions on and advocacy for TA would benefit from the neurodiversity paradigm perspective, recognizing that "the idea of a normal or healthy brain is a social construct,", in alignment with normalizing diversity in other areas of a person's identity (Wise, 2022).

Conclusion

Guided by the theories of attachment, Intersectionality, feminism, queerness, and IPNB, this paper set out to define and explore the components of TA, and gain a clearer understanding of the relationship between peer-reviewed and industry knowledge on TA and therapy seekers ' experience in finding a therapist. The literature review in chapter two provided an overview of the rich, existing research on how TA is defined, what contributes to it, and how it impacts therapeutic efficacy. Among the various contexts that observed TA's role in therapeutic outcomes, this paper discussed research insights on the therapists 'and clients 'attachment styles and intersectional locations as variables. Drawing from the research findings, this chapter focused on the relational and bidirectional quality of these influences and the therapeutic

relationship, which motivated the recommendations. In summary, exploring TA has identified a need for more constructive attention to therapist's reflexivity, IPNB-informed, and trauma-informed education and practice.

On a personal note, I am grateful to have had the opportunity at this particular juncture of my professional development to explore a topic close to my heart. What makes a therapeutic relationship work initially seemed like an impossible question to answer. It was unsurprising to find that the research findings and discussions that presented the experiences and feedback from both therapists and clients, rather than merely from clients or therapists alone, were, in the end, the most valuable. Gaining insights into the bidirectionality of the forming and unfolding of a therapeutic relationship via neuroscience and Intersectionality theory, in particular, resonated deeply. As previously stated, my positionality and approach to this paper is one that aimed to be analytical about the existing system and practical in nature. I have centered my research question around TA because I have witnessed its importance in therapeutic outcomes in the literature and my own experience as a practitioner and client. Nonetheless, my friends, colleagues, and myself have yet to experience the benefits of knowing it as therapy seekers out in the world where we seek mental health support.

I am hopeful that, as we move toward a more inclusive, reflexive, and collaborative way of relating to one another, we allow it to permeate into the educational system and the ethics and approaches with which we practice as helpers and psychotherapists. The most impressionable piece I have come across during this research journey remains the statement "the relationship is the therapy" (Shewfelt, 2018, para 1). May the science and art of therapeutic alliance continue to inform and guide the research and development of therapeutic practice.

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