Building The Alliance: Teaching Emerging Therapists The Skills To Develop Relationships

by

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Abstract

This capstone project critically examines the pedagogy of relational skills in counselling training programs. While the history ofthe therapeutic alliance demonstrates a consistent, reliable correlation between a strong relationship and positive client outcomes, current training models often fail to prioritize the development of these skills. This paper contrasts the limitations of traditional didactic approaches with the necessity of embodied, experiential learning. It further explores how the reliance on academic achievement and subjective expert interviews in candidate selection may reinforce colonial structures and fail to predict clinical efficacy. Recommendations are made for a radical shift in training and accreditation: moving toward objective, evidence-based selection of candidates, mandatory experiential modules for rupture and repair, and a commitment to decolonizing the path to licensure.

Keywords: Therapeutic Relationship, Working Alliance, Relational Skills, Counselling Pedagogy

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Chapter One: Introduction

Overview of the Topic

The nature of the relationship between therapist and client has been a topic of inquiry for those in the field since the very beginning of the psychotherapeutic endeavour. At the outset, psychoanalysts believed that in order to facilitate the healing process a detached demeanour was appropriate (Hale 1995). The analyst was expected to park their true persona at the door and adopt a clinical outlook. However, as time passed and the profession matured, it was acknowledged that the act of sitting with another person and exploring the most vulnerable aspects of their lived experience is inherently relational (Schore, 2014). It became evident that allowing the therapist's personality to be expressed did not present an obstacle to progress, but rather an opportunity to deepen the relationship with the client. This paved the way for the modern notion of the therapeutic relationship as a vector of healing. The profession now accepts as a given the possibility that the therapeutic relationship can offer a "corrective emotional experience" (Alexander, 1950; Constantino & Constantino, 2017), and there is an impressive amount of research data that situates the therapeutic relationship as one of the common factors of effective therapy (Lambert & Barley, 2001).

Norcross and Lambert (1998) stated: "The value of a treatment is inextricably bound to the relational context in which it is applied". This reminds us that we cannot separate the process of treatment from the human interaction that occurs between the two parties involved. Herein lies one of the great conundrums that faces the field of clinical psychology. Practicing psychotherapists have expended a great deal of time and energy in codifying and manualizing the processes by which they help their clients to overcome their psychological distress, resulting in an ever-growing array of modalities. However, it is impossible to take into account the personalities of the therapists who will attempt to enact those modalities. The unique qualities, or combination of qualities, that each practitioner, and indeed each client, brings to the table ensures that outcomes are unpredictable, even when the same interventions are applied. A desire to understand at a granular level the process by which effective therapy is delivered has led to the common factors approach, and this is where the importance of the therapeutic relationship has come to light (Horvath & Bedi, 2002).

While the managed care model focusses on 'proven' treatments and prioritizes modalities that can be easily manualized and delivered in a uniform manner, with quantifiable outcomes (Wampold, 2009), this approach often contradicts the experience of clinicians who understand that the nuances of each particular case must be accounted for in order to reach a successful outcome. As Gordon Paul (1967, p. 111) succinctly put it: "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?". As therapists, we are called on to adapt therapy 'to the individual patient in ways that demonstrably and probably enhance treatment success' (Norcross & Lambert, 1998). Research, discussed in Chapter 2, has shown that it is impossible to eliminate the influence of the individual therapist on the outcome of therapy-some therapists consistently achieve better outcomes than others. In fact, when therapists are ranked according to effectiveness in achieving positive client outcomes, the likelihood of significant symptom reduction for a client who sees a therapist in the top 10% is twice that of a client who sees a therapist in the bottom 10% (Anderson et al., 2016). To offer our clients the best care possible, we need to understand why this is. We now know that therapist effects actually account for more variance in client outcomes than modality, meaning that the client's choice of therapist has a greater impact on their healing journey than the therapist's theoretical orientation (Crits-Christoph & Mintz, 1991). Research into therapist effects, discussed in Chapter 2, indicates that the essential qualities that high-performing therapists bring are good interpersonal skills and the ability to form strong relationships (Anderson et al., 2016). These qualities are highly inter-related. Good interpersonal skills are grist to the mill of bond formation.

Knowing the importance of interpersonal skills and relationship development skills, one might expect to find them at the heart of therapy training programs. Indeed, one might even expect that candidates would be screened for them prior to admission. However, it appears that an emphasis on the therapeutic relationship has not manifested in our learning institutions, in spite of our understanding of its importance to successful therapeutic outcomes (Constantino et al., 2017). A number of possible reasons for this have been put forward, including time constraints. The perception that relational skills training is a lengthy process might lead to its deprioritization in favour of more expedient, content-based modules (Constantino et al., 2017). There may also be a preference to stick rigidly to the Empirically Supported Treatments (Constantino et al., 2017). The Task Force on Evidence-Based Relationships and

Responsiveness has called on learning institutions to provide emerging therapists with the training they need to develop relationship-building skills: "Mental health training and continuing education programs are encouraged to provide competency-based training in the demonstrably and probably effective elements of the therapy relationship" (Norcross et al., 2018, p.).

Purpose Statement

The impact of the therapeutic relationship on positive client outcomes is well known within the field of psychotherapy. The core premise of this paper is that we need to do a better job of preparing graduate therapists for the real work of developing strong bonds with their clients. A number of questions naturally arise: How did we arrive at the current conclusion regarding the importance of the therapeutic relationship? What role does the therapist play in the creation of the relationship? Is it possible to teach the skills that effective therapists use to develop a bond with their clients? This paper pursues three primary objectives: 1) to synthesize the evidence demonstrating the therapeutic relationship's effect on psychotherapy outcomes; 2) to investigate the core mechanisms and therapist behaviors that foster an effective therapeutic bond; and 3) to analyze the key pedagogical considerations in training emerging therapists in the essential relational competencies. These objectives are guided by the central research question: 'How can we teach emerging therapists the relational skills to reliably create effective therapeutic alliances?' Ultimately, this paper argues that training programs have an ethical and pedagogical obligation to teach specific relational competencies that will enable therapists to build effective healing relationships with a diverse range of clients.

Intended Audience

The pedagogical critique at the heart of this paper is aimed primarily at educators responsible for preparing student therapists for client-facing work. The call to action is to integrate relational skills training into curricula from the very outset. While educators are the primary audience, this paper is also relevant for therapists at all career stages. To that end, it provides a thorough review of the research that underpins the primacy of the therapeutic alliance. Therapists have a duty to provide the best possible care to clients, and the research shows that doing so requires careful attention to the relational aspects of the work.

Contribution to the Field

The inspiration for this capstone came from my first-hand experience as a Masters in Counselling student. The realization that we would receive no formal instruction around the development of the therapeutic alliance was more than a little surprising to me. Further, I have regularly observed my fellow students fretting over which interventions to use, which modalities to employ, and which training courses to pursue. Never do I hear anyone discussing the importance of the therapeutic alliance or ways one might go about developing it intentionally, which is notable given the conclusion of the Interdivisional Task Force on Evidence-Based Relationships and Responsiveness that "the psychotherapy relationship makes substantial and consistent contributions to patient outcome independent of the specific type of psychological treatment" (Norcross & Wampold, 2019, p.).

Research has indicated that greater attention needs to be paid to the way in which student clinicians learn to create therapeutic alliances (Quinn et al., 1997). Given the ethical obligation conveyed by the BCCAC Code of Ethical Conduct (2023) to provide competent caring through evidence-informed practice, coupled with the available evidence for the role of the therapeutic alliance in positive outcomes (Fluckiger et al., 2018), the case for improved training for emerging therapists is strong. On this basis, any attempt to strengthen this case has merit and may eventually lead to better client experiences and better outcomes overall.

Further to responsible caring, the BCACC Code of Ethical Conduct (2023) calls on clinicians to observe integrity in relationships. Specifically, clinicians should "manage relationships intentionally" (p.). However, the primary purpose of the Code of Ethical Conduct is to address situations that might negatively impact the client and, by extension, the profession of counselling. For example, abuses of power, conflicts of interest and multiple relationships are discussed within the Standards of Clinical Practice (2023), but expectations around how to manage relationships intentionally are notably absent, a gap that seems noteworthy in the context of this paper. Ideally, the BCACC would offer guidelines to members about what the intentional management of relationships looks like in practice. I believe that this paper, and others like it, can serve as a clarion call for the BCACC to become a stronger advocate for the primacy of the therapeutic alliance.

Reflectivity and Positionality Statement

I am a middle-class, well-educated male of European descent. I was born in Ireland but moved to the US where I lived from ages one to five. The majority of my childhood, teenage years and early adulthood were spent in Ireland, and this is the culture I most closely identify with. I studied for a Masters in Aeronautical Engineering at the University of Bristol in the UK, and I have travelled extensively and experienced numerous different cultures. I bring a deep-seated curiosity to this work and a desire to find the optimal route to positive outcomes for my clients whilst also satisfying that part of me that seeks meaning and purpose. I have resided on the traditional and unceded territories of the xwma8kwayam (Musqueam), S�w�wu7mesh (Squamish), and salilwata+ (Tsleil-Waututh) Nations since 2007. I recognise that my background and unique set of experiences has endowed me with a particular view of relationality that might not coincide exactly with that of my colleagues or clients. This project can help me to identify blind-spots and biases or assumptions that are hindering my development in the relational realm.

One of the pivotal in-class moments that I experienced while completing academic credits for my Masters in Counselling came during our Counselling Psychology Theory class with Dr. Ron Manley. One day, Dr. Manley told us about the work of Norcross and Wampold (2011) and the research behind the conclusion that the relationship in therapy mattered at least as much, if not more, than the chosen modality. This struck me as something of a revelation. I was surprised I had never learned this before, as it seemed like one of the things one would expect to know about therapy, that you need to feel a certain kinship with your therapist. While I had previously focused intently on the merits of various modalities I found myself distracted by the knowledge that there was no guarantee that choosing the 'right' modality and applying it judiciously would lead to a positive outcome. After Dr. Manley had divulged the wonderful truth about the inherent relationality of the therapeutic endeavor, I assumed we would subsequently refer to the working alliance often. I even had hopes that we would have a class dedicated to relationality at some point. Alas, it was not to be. The therapeutic alliance was referred to rarely, if at all. There was no class, or instructor, to champion the cause of the working alliance, and I found myself more than a little surprised by this. If we are about to embark on a career in which relationality would play such a central role, surely we should devote a significant amount of time and energy to learning the

skills to excel as relationship builders? My personal experience with relationality is a little bit complicated, but worth sketching out briefly. Growing up in Ireland, I lived in a society that was incredibly sociable. Having an active social life in my teens and early adulthood was a priority of mine above all else, career included. Irish people are typically out-going and gregarious, but openly discussing feelings and emotions is not the norm. Mental pathologies are discussed only in either jocular terms or hushed tones. Even learning difficulties went unacknowledged at my school, and probably most others.

In hindsight I understand that Ireland taught me a great deal about how to interact on a superficial level, but very little about how to think about relationships on a deeper level, much less address relational ruptures in a constructive way. I became a person who could very easily adapt to social situations, and I have always made friends wherever I go. Nevertheless I have frequently struggled to find truly satisfying relationships. I have a sensitive side and I have had to acknowledge the fact that I am both an extrovert and an introvert. Navigating the early stages of relationship building can be anxiety provoking for me. I often notice the contrast between my wife and I in this regard. My wife is Canadian and one of the most affable and charming people you could ever hope to meet. We met when she struck up a conversation with me on a quiet street in East Van, quite out of the blue. My wife can, and regularly does, light up the room with her presence. She makes people feel safe and welcome, and they gravitate to her because of that. I often tell my wife that if relating to people was a sport, she would be an Olympian. I envy her easy way with people, but I also realize we are very different people, with different needs. I have a misanthropic side, for example, that she utterly lacks.

I dealt with anxiety at certain times in my childhood, which I never discussed with anyone, and hence never even had the verbiage to express. Anxiety crept into my social life too, of course, and I used alcohol to deal with it. In my forties, self-exploration and self-reflection allowed me to understand myself a great deal better than I did previously. I believe this helps me to relate to others, but it also helps me to realize that I need to be more intentional in the way I approach relationality. This is the crux of my capstone from a personal perspective, the realization that I need to acknowledge and accept that I can get better at creating deep bonds with my clients.

Definition of Terms

If the intended outcome of encouraging more conversations about the importance of the therapeutic relationship is to be realized, it is important that a shared understanding of the central concepts and themes is achieved. The following is a list of terms that will be used throughout this paper. Some concepts defy easy classification, and it is possible to find differing definitions within the literature. This will be discussed later in the paper. The definitions provided are those that specifically inform the writing of this paper. Where a robust definition has been encountered in the literature it has been quoted directly. Readers are encouraged to seek further information and clarification of terms used but not explicitly defined within this paper.

Common Factors

Also referred to as 'nonspecific' or 'universal' factors, common factors are the therapeutic elements of effective treatment interventions, which exist across all modalities (Horvath & Greenberg, 1989). These are the specific aspects of the therapy process that lead to symptom amelioration and are independent of theoretical orientation. The concept arose from the discovery that all modalities are relatively equal in terms of effectiveness, pointing to the existence of common factors (Wampold, 2009). The factors typically named are empathy, warmth, congruence and the therapeutic relationship (Lambert & Barley, 2001).

Congruence

One of Carl Rogers {1957) 'necessary and sufficient conditions' of effective therapy, Rogers posited congruence as the ideal quality of a therapist who is able to be present in the therapy space as a genuine and integrated person, without facade. Congruence indicates a high correlation between the therapist's own view of themselves in the relationship and an observer's. In terms of the relationship, congruence occurs when both participants in the dyad perceive that the other is acting in accordance with the negotiated agreements about the nature of the relationship (Lichtenberg et al., 1998).

Empathy

Another of Carl Rogers (1957) 'necessary and sufficient conditions', empathy is the quality of temporarily attuning to, and caring about, the experience of another as if it were your own,

thereby allowing it to have an affective impact (Hill, 2014). In Rogers own words, empathy is the therapist's "ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view" (Rogers, 1980, p.).

Facilitative Interpersonal Skills {FIS)

Both a construct and an assessment tool used to measure a specific set skills and capacities of the therapist that allow for the cultivation of a bond between client and therapist. These include: verbal fluency, emotional expression, persuasiveness, positive regard, hopefulness, empathy, alliance bond capacity, and rupture responsiveness. (End with an in-text citation)

Positive Regard

Another of Carl Rogers (1957) 'necessary and sufficient conditions' of effective therapy, positive regard refers to a position of consistent, non-judgemental warmth directed towards the client. It creates an atmosphere of acceptance and safety within which the client can divulge their innermost thoughts.

Rupture

A strain or disconnect in the alliance between client and therapist which disrupts the progress of therapy and may lead to cessation. Ruptures are generally considered an expected and unavoidable part of the treatment process. They represent negative process and are critical to therapeutic outcome, especially when they are successfully addressed and resolved (Ackerman & Hilsenroth, 2003).

Therapeutic Bond

Described as "the positive interpersonal attachment between therapist and client of mutual trust, confidence, and acceptance" (Lambert & Barley, 2001, p.), the bond allows for revelation of the client's innermost truths. If the relationship encompasses all aspects of client/therapist interactions, including scheduling and billing, for example, then the bond is specifically the emotional and affective part.

Working Alliance/ Therapeutic Alliance/ Helping Alliance

A collaborative and conscious relationship that develops between the client and the therapist during therapy (Horvath et al., 2011). Also conceptualized as "the foundation upon which treat-

ment is built and a mechanism of change" (Page & Stritzke, 2015, p. 12). The therapeutic alliance and its elusive definition will be discussed at length throughout this paper. The above terms will be used interchangeably.

The Therapeutic Relationship and Theoretical Orientations

While it may seem obvious to many within the profession that there is no person-to-person psychotherapy without an alliance of some description, part of the intent of this paper is to further normalize, or popularize, the explicit statement of this fact within our learning institutions. It is important to emphasize the ubiquity of the therapeutic relationship within psychotherapy as it applies across all modalities, orientations and clinical approaches. While there is no one theoretical orientation that uses the therapeutic relationship exclusively as the vector of change, we can look to Relational-Cultural Therapy for an example of a framework that acknowledges the centrality of the client-therapist relationship and encourages therapists to hone their relationship-building skills (Frey, 2013). It should also be acknowledged that client-centered therapy makes the therapeutic relationship a core pillar of treatment, calling on therapists to offer their clients empathy, unconditional positive regard, and congruence (Rogers, 2003). In fact the overlap between the client-centred approach and the space occupied by the therapeutic relationship is impressive, and many of the concepts espoused in client-centered therapy find a comfortable home within that space. Other modalities that foreground the therapeutic relationship include relational psychoanalysis, inter-subjective systems theory, attachment-based therapy and emotion-focused therapy. However this paper will avoid side avenues into analyses of theoretical orientations in favour of a thorough dissection of the therapeutic relationship from a pedagogical point of view.

Outline of the Capstone Project Chapters

The goal of chapter one is to provide background and context for a discussion of the importance of the therapeutic relationship in the attainment of optimal therapeutic outcomes. The author's perception of the underemphasis of the importance of the therapeutic relationship in pedagogical settings is discussed and the associated problem space is delineated.

Chapter two will provide a comprehensive review of the available literature on the therapeutic relationship, looking back at the foundational writings on the theme, and moving forward to

encompass the extensive research on the topic. Meta-analyses which collate the results of multiple research studies will also be reviewed in order to offer the broadest overview of the available evidence for the effect of the therapeutic alliance on therapeutic outcomes. The specific behaviours and skills of therapist who build strong alliances will be outlined, including empathy, collaborative behaviors, adaptive responses, and the ability to navigate rupture and repair cycles. The possible ways in which relational skills can be taught will be explored, including a discussion of didactic versus experiential training. An overview of established training methodologies and frameworks is also included. Finally, the topic of candidate selection will be raised, and a critique of current screening techniques will be presented.

Chapter three will offer a discussion on the findings uncovered in the literature review and also address further questions that arise as a result of the enquiry into the topic of the therapeutic relationship. Recommendations as to how emerging therapists might be better served in gaining relationship building skills will also be outlined.

Chapter Two: Literature Review

Introduction

In this chapter I will offer a review of the available literature on the role of the therapeutic relationship in facilitating the therapeutic process and the mechanisms at work, followed by a review of the relevant literature concerning pedagogy and the teaching of relational skills. We will see that there is a large body of work that contributes to our current understanding of the importance of the relationship in a therapeutic setting. In order to establish credibility for the premise that we should place more focus on the teaching of relational skills, it is important to understand how we arrived at our current understanding of the role of the therapeutic alliance. While it may seem intuitive that social creatures like humans would find comfort, solace and ultimately healing in each other's company, as clinicians we need to be guided by more than intuition. The ethical guidelines under which clinical counsellors operate in British Columbia require us to offer 'evidence-informed practice' (BCACC, 2023) and thus we need a firm bedrock on which to lay the foundations of the work we do in collaboration with our clients.

Further to this goal of underpinning the value of the therapeutic relationship, it is also important to survey the available knowledge on the mechanisms by which the alliance facilitates change in clients, and also the attitudes and behaviours that lead to the development of strong interpersonal bond between client and therapist. These could be described as 'relational interventions'-a term that, while useful for research, may be perceived as overly clinical in a pedagogical context. This fundamental tension between the research goal of establishing evidence-based practice and the subjective, idiosyncratic nature of human relationships highlights the inherent challenges in this field of study, which will be further explored later.

How should our learning institutions-those with the responsibility to train the next generation of emerging therapists-incorporate our research-based understanding of the role of the therapeutic relationship into course design? While one of the primary goals of this literature review is to examine the research that proponents cite to support a relational approach to therapy, I am also concerned with the way in which the research findings on the importance of the therapeutic relationship inform the design of curricula. If we are sufficiently confident that the relationship matters, then what do we do with this knowledge? As ethical counsellors, guided to offer the best in evidence-based treatment to our clients,

what are the ways in which we can help our clients to derive the maximum benefit from the therapeutic relationship? And from a systems perspective, Is it even possible to teach emerging therapists the skills required to reliably develop good therapeutic relationships with their clients? To address these questions, the following pages will synthesize the literature on the working alliance's importance with research on effective pedagogy in clinical training.

Background and Significance of the Therapeutic Alliance

Stating the importance of the therapeutic relationship may seem relatively obvious to contemporary therapists, given the rich canon of work that supports such a position. However, as stated in my positionality statement, my personal experience has been that teaching institutions do not sufficiently ground student learning in this understanding and do not provide a framework within which students can hone their alliance development skills. As numerous meta analyses have indicated, the therapeutic relationship is one of the primary avenues by which therapeutic goals (for example self-awareness, growth, or healing) are achieved (Lambert & Barley, 2001). Assuming that the goal of learning institutions is to produce graduates who are adequately equipped to engage productively in their chosen profession, it would stand to reason that a skill as influential on outcome (i.e. relationship development) would be, at the very least, regularly discussed. The author is once again forced to reflect on the disparity between the ideal scenario and the lived reality.

Definition and Conceptual Evolution

Early psychoanalysts, inspired by Freud (1913), were concerned with the notion of transference. Transference, as Freud saw it, occurred as the patient (the accepted term at the time) started to have feelings about the therapist. Freud framed these feelings in terms of historical relational patterns being replayed in the therapeutic space. In transference "feelings, attitudes, and behaviors belonging rightfully in those earlier relationships are displaced onto the therapist" (Geise & Carter, 1994) and this acts to distort the therapeutic interaction. He recognized that it was necessary for the client and therapist to have a collaborative bond that would form the bedrock of the entire therapeutic process. This he referred to as 'positive' or 'unobjectionable' transference (Freud, 1940) and saw it as the collegial connection that is based on the actual interactions between analyst and client in the therapy room (Horvath & Symonds, 1991). Freud invoked a militaristic analogy when he described the therapeutic

relationship as the route by which client and therapist teamed up against a common enemy-the client's neurosis (Freud, 1958}. He also posited that the support provided by the relationship helped the client to persist with the therapeutic process, despite the difficulty inherent in working through the challenging material that often arises (Freud, 1913}. He was acutely aware of the power of the therapeutic relationship, and the risk that a rupture in that relationship posed. He acknowledged that "even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient was disturbed.....the personal emotional relation between doctor and patient was after all stronger than the whole cathartic process" (Freud & Strachey, 1963, p. 27). Coming from one of the most historically influential figures in the field, this is a powerful statement and one that would eventually be validated through research efforts outlined later in this chapter.

There is an innate tension within Freud's position on the therapeutic relationship which can be edifying as we attempt to formulate a coherent picture of the whole. On the one hand he acknowledged that 'unobjectionable transference' was a prerequisite of the work, a foundation stone that needed to be put in place before the important work began. On the other hand, he saw the threat posed by unhelpful forms of transference, including eroticized transference. In this tension lies the possibility that the very thing that could help the client to heal, could also cause the client a further wound.

The definition of the helping relationship between therapist and client has undergone multiple iterations since Freud proposed the concept of transference. Elizabeth Zetzel (1956} brought clinical precision to the concept when she coined the term 'therapeutic alliance'. This term is now used interchangeably with the terms 'working alliance' and 'helping alliance', as well as the term 'therapeutic relationship' -the preferred umbrella term in this text. Coming from the psychoanalytic tradition, Zetzel adopted the Freudian concept of the ego, and framed the alliance as the healthy part of the client's ego opening up to the analyst in order to collaborate on therapeutic tasks (Horvath & Bedi, 2002}. Zetzel posited that the alliance "precedes analytic processes and is both different and distinct from the emerging transference neurosis" (Roth, 2014, p.852}. She believed that the client looked to the analyst for a secure attachment akin to the parent-child bond, where the analyst would be able to provide attunement and adaptive responses (Roth, 2014). Zetzel's work was consequential because it began the process of attempting to dissect the therapeutic relationship into it's constituent parts, a process that

would serve to provide the therapeutic community with a deeper insight into the alliance and how it can be enlisted to facilitate healing (Gelso & Carter, 1994). Her work helped to explain the willingness of patients to continue the work of analysis despite the fact that doing so can be psychologically disturbing (Horvath et al., 2011), and it ultimately served to underpin the research that would lead us to a deeper understanding of the significance of the therapeutic alliance.

Greenson's Working Alliance

Ralph Greenson built upon Zetzel's work and wrote a seminal text which contained the first reference to the 'working alliance' (Greenson, 1967). The purpose of this text was to instruct therapists on how to deliver effective psychoanalysis. Traditionally, psychoanalysis was seen as a two-pronged approach encompassing transference and interpretation. Greenson proposed a third prong; the working alliance, which he described as "the reasonable and purposeful part of the feelings the patient has for the analyst" (p.192). Greenson also referred to the 'real relationship' between patient and therapist, which he saw as the part of the patient-therapist relationship that exists outside of the transferential aspect. Through this lens, the relationship is a multifaceted thing, and the therapist needs to be able to distinguish between those moments when the patient is replaying their typical relational patterns through transference and those moments when patient and therapist are connecting in a genuine, open and honest manner (Gelso & Carter, 1994). In effect, Greenson called on therapists to act upon and express their authentic and genuine human feelings towards the patient in order to create the real relationship. Greenson's work was another important step towards a more human approach to therapeutic interactions that stood in stark contrast to the neutral demeanour that was traditionally espoused by influential psychoanalysts. In the early days of psychotherapy, this detached stance was seen as analogous to the clinical detachment of physicians and was presumed to confer legitimacy on the nascent field of psychotherapy (Hale, 1995, p. 8). It is important to acknowledge the significance of this shift and the fact that the impact of the clinician-patient alliance on outcomes is now also being examined in other care provision settings (Wampold & Fluckiger, 2023).

Bordin's Tripartite Model

Bordin (1979) made one of the most significant and enduring contributions to the field of therapeutic relationality when he proposed a tripartite model of the working alliance. This model

encompasses: 1) agreement on goals 2) consensus on tasks and 3) development of a bond. Bordin (1979) himself assumed that clients would arrive at therapy with some preconception about the reason they decided to seek help, possibly arrived at with the help of other health service providers. Assuming a suitable fit exists between client and therapist, early exploration of the reasons for treatment will lead to mutual agreement on therapeutic goals. Bordin further asserted that the tasks prescribed would depend largely on the orientation of the therapist, but that the agreement of the client on the appropriateness of the tasks was central to a positive outcome. Client hope for the potential of treatment, or 'expectancy effect', has been posited as one of the common factors of effective therapy (Lambert & Barley, 2001) and has been compared to the placebo effect (Wampold & Fluckiger, 2023).

Bordin hoped to further decouple the working alliance from the strictly psychoanalytic foundation favoured by his predecessors in order to establish a pantheoretical perspective (Horvath & Greenberg, 1989). Bordin (1979) hypothesized, however, that the nature of the working alliance might differ based on the 'genre' of psychotherapy being practised. In a task-oriented framework, for example, a client might be asked to track specific events like panic attacks and this would lead to a different therapeutic alliance than one found in a humanistic or client-centered framework, which prioritizes deep inner reflection. Bordin's model has become preeminent among researchers and academics looking at, and writing about, the therapeutic alliance. It represents one of the first attempts to create a common language to describe the interpersonal framework within which treatment can be delivered. Indeed, the Working Alliance Inventory, one of the primary tools used in research to assess and measure the strength of the therapeutic alliance, was based on Bordin's model (Horvath et al., 1981). One of the key strengths of the WAI is that it was designed to evaluate working alliances regardless of the theoretical orientation of the clinician (Martin et al., 2000). This aligns with Bordin's belief in the pantheoretical nature of the working alliance (Bordin, 1979).

A 2023 article noted that 70% of the research studies carried out in the previous ten years looking at the therapeutic relationship had used a form of the WAI (Wampold & Fluckiger, 2023). There are three subscales within the original WAI, corresponding to the three facets of the tripartite model, and each subscale consists of 12 items ranked on a 7-point Likert scale (Martin et al., 2000). There are multiple versions of the measure which can be completed by either the therapist, the client, or an

observer. As we shall see later, the most reliable rater of the alliance is the client (Horvath & Symonds, 1991). One of the weaknesses of the WAI when completed by clients is that they tend to conflate the subscales that reference goals and tasks (Horvath & Bedi, 2002). It appears that the nuance between the goal setting phase and the task planning phase is typically lost on clients.

Luborsky's Biphasic Theory

As the years progressed and therapeutic modalities proliferated from the psychoanalytic loam, it became increasingly evident that taking a common factors approach was crucial to facilitate wider access to the benefits of a relational outlook (Fluckiger et al., 2018). Lester Luborsky (1976) was a key proponent of the pantheoretical approach and is often cited for his work on what he termed the 'helping alliance'. Luborsky took the earlier work of psychoanalysts like Zetzel and proposed a more granular model of the client-therapist alliance. In his view the temporal aspect of the relationship needed to be acknowledged-the fact that the helping alliance, like all human relationships, evolves over time (Horvath et al, 2011). Luborsky (1976) saw two important phases in the development of the helping alliance. First, a 'Type I' alliance is established, where the therapist enlists the trust of the client (Fluckiger et al., 2018). We can think of this phase as the time when the therapist establishes credibility with the client through expressions of genuine warmth and support (Horvath & Bedi, 2002}. As mentioned previously, the client's sense of hope in the process of therapy is an important part of a successful collaboration with the therapist (Lambert & Barley, 2001). Establishing that hope is one of the key outcomes of the first phase and opens the door to the pursuit of therapeutic transformation. Luborsky posited the 'Type II' alliance as the second phase of an effective collaboration, where the client's faith in the process of therapy grows, and the client enters fully into the cooperative relationship (Bailey & Ogles, 2023). The second phase builds on the trust established in the first phase. The client is now ready to allow themselves to be guided by the therapist, and productive conversations can begin.

Luborsky's biphasic view of the helping alliance might feel intuitive, because it correlates with our predisposition to trust those with whom we have established relationships more than, for example, those we have just met. However, research into Luborsky's model has led to doubts about its validity-in particular the eventual emergence of the Type II alliance (Davis, 2011). Using the Helping Alliance

Questionnaire (HAq-I), which Luborsky himself spearheaded the development of (Lubrosky et al., 1996), researchers attempted to uncover the typical trajectory of the therapeutic alliance. They found that there was no significant difference in the rates of growth of the Type I and Type II alliances over time as predicted by Luborsky-both tend to grow steadily as therapy progresses. The study did note, however, that the HAq-I may not be sensitive enough to accurately track the Type II alliance.

Contemporary Views on the Therapeutic Alliance

Although the nature and role of the therapeutic relationship has been written about at length since the advent of psychotherapy, we have continued to see new theoretical viewpoints emerge. In recent decades the effect of the working alliance on positive client outcomes has been widely acknowledged and accepted within the field of psychotherapy (Horvath and Bedi, 2002). This is confirmed by the many studies, research papers and meta-analyses on the topic that have been published, as we shall see in a following section. Recent studies have built upon the earlier work of theorists like Zetzel, Bordin and Luborsky and have tried to provide a more nuanced view of the therapeutic alliance (Fluckiger et al., 2018).

The dynamic nature of the alliance has been an area of particular focus, and studies have sought to track changes in the alliance as therapy proceeds, in an attempt to correlate ratings at various stages with outcomes (Zilcha-Mano et al., 2016; Florsheim et al., 2000). We have also seen efforts to investigate the alliance in the context of modern innovations such as telehealth and remote counselling (Berger, 2017). Early indications are that clients feel that the alliance created virtually is just as effective as that created in-person. Furthermore, we have seen a deeper interest in the mechanisms by which the therapeutic alliance brings about amelioration of psychic distress (Kazdin, 2007). Researchers have been drawn to the question of whether the relationship is a facilitator that helps deliver effective interventions-like grease in the cogs-or if it is itself a healing salve for clients (Martin et al., 2000).

Jeremy Safran and Christopher Muran are among the most prolific and innovative authors on the topic of the therapeutic relationship in recent times. Further adding to our conceptual understanding of the therapeutic alliance, Safran & Muran (2006) posited the notion that the alliance is a process of negotiation rather than just collaboration-a 'constantly shifting, emergent property of the therapeutic relationship'. This reference to the temporal aspect of the alliance echoes Luborsky's work and reminds

us that the alliance is never static but exists in a state of flux. Safran & Muran (1996) have also done particularly interesting work in the area of 'rupture and repair', which has taught us that disconnects between therapist and client are not only commonplace, but are potentially an avenue by which the alliance can be deepened. Safran & Muran (2006) have also written an important critique of what they see as a possible overstatement of the importance of the role of the therapeutic alliance. They point out that the effect size of the alliance is not particularly impressive, and is actually surpassed by the therapist allegiance effect, which tracks the therapist's belief in the effectiveness of their chosen theoretical framework. Effect size in the context of the therapeutic alliance is discussed in greater detail in a later section.

Researching the Therapeutic Alliance

Freud's writing on transference captured his hypothesis about what was taking place in the therapy room, and from this proceeded a wealth of further hypotheses and theorizing. However, our current understanding of the therapeutic alliance is the result of purposeful research efforts, which grew out of a desire to validate the hypotheses of the pioneers in the therapeutic endeavour. The fact that research efforts have propagated so widely and yielded so much rich material is, in and of itself, a telling indicator of the importance of this field. One must assume that if early research had shown that the therapeutic alliance had little or no effect on therapeutic outcomes, an epistemological dead-end would have been reached and further investigation would have been difficult to justify or raise funding for. In fact, we see that research efforts to widen our breadth of knowledge continue apace to this day. Recent meta-analyses have been able to draw on as many as 295 independent studies into the therapeutic alliance (Fluckiger et al. 2018). In the last five years the Journal of Clinical Psychology has published more than 280 articles about the alliance. We also see that research is exploring new avenues and responding to new trends within the profession. For example, the alliance in telehealth and remote scenarios is being investigated (Berger, 2017) as well as cultural adaptation of alliance measurement tools (Owen, 2016). Suffice to say that, year on year, our understanding of the mechanisms by which the therapeutic alliance influences client outcomes is becoming clearer and more nuanced. Before we delve deeper into the research on the therapeutic alliance, it is worth addressing some of the issues surrounding the way in which research is conducted.

Research Challenges

The first significant challenge for researchers is establishing a clear operational definition of the therapeutic alliance. In spite of all that has been written and theorized about the TA, there is no universally accepted definition. On top of this, different measurement tools use different definitions, which complicates the performance of meta-analyses. The very foundations of our investigation into the TA are based on definitional ambiguity and this fact must serve as a qualifier for everything that follows. Horvath et al. {2011, p.10) noted that there are "nontrivial differences among authors about the meaning of the term alliance", and when it comes to the measurement tools used to conduct research the differing definitions are intrinsic to those tools. The very fact that multiple tools have been developed speaks to the fact that researchers have fundamentally different outlooks on how the alliance should be conceptualized. Ideally, there would be a broad consensus and agreement on which tool would become the de facto standard. At this point however, there are more than 80 different measures that have been used in research studies {Horvath, 2016). Nevertheless, Horvath and Symonds {1991, p.140) stated that the "intercorrelation among these measures is substantial". This suggests that while foundational differences might exist between measurement tools, they are all ultimately trying to measure a common underlying phenomenon.

A key variable in the research is the question of who is assessing the alliance. Should we ask the therapist about the strength of the alliance, or the client? Or perhaps an observer? Obviously there will be a degree of variation across these three unique viewpoints. One might assume that the client's assessment is the most salient, and indeed research has shown that client reports are a better predictor of treatment outcome than either therapist or observer reports {Horvath & Symonds, 1991). Despite this finding many studies use therapist assessment. Using therapist ratings offers an efficiency of scale, given that a single therapist can provide data on multiple client relationships, whereas the majority of clients will have just one therapeutic relationship. Gathering data is typically the most challenging aspect of any research effort, and strategies which can mitigate this are bound to be adopted in a certain number of studies.

The point at which the relationship is assessed is another variable that needs consideration when conducting research because assessing the relationship at different points may yield differing

results. For example, there tends to be a greater difference between the therapist's assessment and the client's assessment early on, but things tend to come into greater alignment as the relationship matures (Horvath et al., 2011). It has also been noted that client's perception of the relationship tends to be more stable over time, whereas therapists and observers notice more fluctuations (Martin et al., 2000). This means that from a client's point of view, if the relationship is strong early on, it is likely to continue to be strong as therapy proceeds.

The Therapeutic Alliance as a Predictor of Psychotherapy Outcome

There is now a significant collection of studies looking at the effect of the alliance on therapeutic outcomes. As a result, we have a sizeable body of evidence that indicates a moderate but robust association between therapeutic alliance and positive client outcomes. One of the key tools that has solidified this conclusion is the meta-analysis. Multiple meta-analyses have been conducted that aggregate the results of specific sub-sets of the available studies in order to find overarching trends. Therefore, interrogating these meta-analyses is crucial to firmly establish the evidence base for this capstone's focus on relational skills training.

One of the earliest meta-analyses on the therapeutic alliance was performed by Horvath and Symonds {1991) and it looked at the results of 24 studies on the working alliance using 20 distinct datasets. Selection criteria stipulated that eligible studies had to reference either the "working", "helping" or "therapeutic" alliance. Also, the studies had to use a quantifiable measure of the alliance, coupled with a later measure of the outcome. Further, the studies were exclusively based on individual therapy, as opposed to couples, family or group therapy. It is notable that 15 different rating scales were used to measure the alliance in the 24 qualifying studies. The authors were able to group rating scales into 'families' and they found that results of studies using scales from the same family were consistent, but results between families looked slightly different. This may point to the different conceptualizations of the alliance underpinning the various instruments (Fenton et al., 2001). The finding serves as a potent reminder of the fundamental challenge researchers face when attempting to quantify something as enigmatic as a human relationship.

Returning to the meta-analysis by Horvath and Symonds (1991). The researchers looked at studies that used therapist assessments, client assessments and observer assessments of the strength of

the therapeutic relationship. They noted that clients' and observers' ratings of the working alliance more closely correlated with outcomes than therapists' ratings. That is, when clients or observers rated the working alliance as strong, this was predictive of a positive outcome. The authors described the association between a good working alliance and a positive outcome as 'moderate but reliable'. (Effect size will be discussed in the following section).

A later meta-analysis performed by Martin, Garske, & Davis (2000) synthesized the results of 79 independent studies. Inclusion criteria for this meta-analysis were taken directly from the Horvath and Symonds meta-analysis discussed previously. Of the qualifying studies, 51 used client ratings, 20 used observer ratings and 18 used therapist ratings. The data show that the majority of studies were using the most reliable predictor of outcomes: client assessment. It should be noted, however, that some studies used more than one rating source. Consistent with the findings of the previously mentioned meta-analysis, this meta-analysis also found a moderate but consistent relation between therapeutic alliance and treatment outcome. Further, this meta-analysis found that the effect remained relatively consistent regardless of who rated the alliance, the point at which it was rated, the outcome measure or the treatment provided, a finding that suggests an even more robust and generalized effect than was indicated by earlier research. The results of this meta-analysis solidified the understanding of the correlation between the therapeutic relationship and treatment outcome, regardless of theoretical orientation. While the mechanism by which the alliance facilitates beneficial outcomes is not discussed, the authors state that "if a proper alliance is established between a patient and therapist, the patient will experience the relationship as therapeutic, regardless of other psychological interventions" (p. 446).

The results of these meta-analyses, which were subsequently augmented by further meta-analyses (Horvath & Bedi, 2002) firmly established the importance of the alliance for positive client outcomes. To fully appreciate the clinical significance of a 'moderate but reliable' association, it is important to discuss effect size. Interrogating effect size is a crucial step towards understanding the priority that should be placed on an enhanced focus on the pedagogy of relational skills in our therapist training programs.

Effect Size

The effect of a strong therapeutic relationship on outcome is often described along the lines of 'moderate but robust', meaning it has a noticeable effect that has been replicated multiple times, and is shown to be reliably effective across all theoretical orientations. Effect size, *r,* is a common way that variable effects are referenced and compared. In the case of the therapeutic alliance, the effect size reported by Martin, Garske, & Davis (2000) was 0.21, which is somewhere between what would be considered a small and a medium effect size. It lands at the lower end of the range of previously published effect sizes of 0.21 to 0.25. However, when Horvath et al. {2011) published a further meta-analysis based on 200 research reports they found a notably higher effect size of 0.28. By comparison, the average effect size for therapy in general is around 0.80-0.85, whereas the average effect size for the modality is surprisingly low, around 0.0-0.20 (Norcross & Wampold, 2018). However, because of the difficulties associated with studying and measuring something as innately subjective as the dyadic therapeutic process, we should be slow to make definitive statements about the relative contributions of the alliance and the modality. Notably, the lower end of the alliance effect size range (0.21) almost overlaps with the upper range of the modality effect size range (0.20). Hence the following statement from the third interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness: 'The therapy relationship accounts for client improvement (or lack of improvement) as much as, and probably more than, the particular treatment method' (Norcross & Wampold, 2018).

Critiques of Research on the Therapeutic Relationship

Researching an area as enigmatic as human relations presents significant challenges, making it difficult to precisely quantify the therapeutic alliance's effect size on client outcomes. Nevertheless, the substantial body of evidence discussed here has established that the alliance has a moderate, reliable, and positive impact on therapy success. It is important to acknowledge, however, that there are legitimate criticisms of the research into the therapeutic alliance that has thus far been conducted. One of the most pointed is the question of causation vs. correlation, i.e. how can we say with certainty that the bond between client and therapist was the cause of the client's positive outcome? The studies used to measure the working alliance tend to be correlational in nature-we do not see many randomized controlled trials, for example. Indeed it is hard to envisage an effective RCT where one group is granted a strong therapeutic relationship which is denied to a second group. It is inherently difficult to completely

remove the relational factor from a person-to-person interaction: how do we apply a modality without a trace of relationality? And how will clients respond to such a situation? Will some find the therapist offensively cold, thereby creating an adversarial relationship?

Cujipers et al. (2019) remind us to exercise humility when presenting the role of the therapeutic relationship, for we believe, rather than know, that a strong therapeutic relationship leads to positive client outcomes. They note that our current understanding of the role of the therapeutic alliance is based on a correlational relationship between alliance and outcome rather than a definitively causal relationship. We are reminded that the bar to establishing a causal relationship is much higher; "a temporal relationship, a dose-response relationship, the exclusion of other potential mediators, supporting experimental research, and an explanatory theoretical framework" (Cujipers et al., 2019, p.223) are the pre-requisites of true causality.

Although the value of the therapeutic relationship in predicting positive client outcomes has been firmly established (Fluckiger et al., 2018), it is important to bear in mind that the effect size is on the low to moderate end, as discussed in chapter two. Safran and Muran (2006) have raised questions about the possibility that we are overemphasizing the role of the therapeutic relationship. They note that it has been shown that the therapist allegiance effect plays a more substantial role in outcome variation than the therapeutic alliance (Robinson et al., 1990). Therapist allegiance effect occurs where a therapist's preference for and belief in a specific modality is predictive of positive client outcomes.

Kazdin {2007) has usefully framed this conversation in terms of the mechanisms, mediators and moderators of therapeutic change. A mediator is something that causes change and RCTs can show us that psychotherapy is a mediator of change. A mechanism is the way in which a mediator causes change, and this is where things become somewhat opaque in therapy, because we have struggled to understand the mechanisms by which our interventions cause change. A moderator is something that plays a role in the process and influences the outcome. For example, gender may be a moderator where we observe a variation in the outcomes experienced by male and female patients. When it comes to the therapeutic relationship, we don't yet know if it is a mechanism, a mediator or a moderator of positive outcomes.

The Person of the Therapist

One of the challenges raised by the research findings on the therapeutic relationship is the question of the proportional input of the client versus that of the therapist in building the relationship. It would seem apt to ask: Is there a set of clients who are simply more relationally gifted than others, and tend to bring out the best in the therapist? Or, conversely, is there a set of therapists who have superior relationship building skills from which their clients ultimately benefit? In the context of a paper that seeks to investigate the possibility of teaching relationship building skills to emerging therapists it is important to consider the role that therapist characteristics and relationship building skills play in the development of the therapeutic alliance. Anderson et al. (2009) pointed out that studies designed to eliminate therapist-related variables through the 'careful selection of therapists and rigorous training and supervision in the provision of a manualized treatment' have typically found that certain therapists consistently achieve better results than others. In other words, it has proven extremely difficult to provide a homogeneous treatment experience when multiple therapists are involved. The individuality of the therapist has consistently proven to be a variable that is impossible to suppress.

With the importance of the therapeutic alliance firmly established through research and replication, recent studies have looked into adjacent areas like the influence of the therapist on the alliance. Del Re et al. (2012) performed a meta-analysis of 152 studies using the Patient-Therapist Ratio (PTR) as a measure of the contribution of client characteristics versus therapist characteristics. The PTR is based on the number of clients that each therapist is currently working with. The assumption is that when the PTR is high and a single therapist has many patients, client characteristics account for most of the variance in outcomes, whereas when the PTR is low and each therapist has a small number of clients, therapist characteristics account for most of the variance in outcomes. Del Re et al. (2021) found that "the therapist's contribution to the alliance was a statistically and clinically significant predictor of outcome". They went on to assert that some therapists are more effective at developing therapeutic relationships, and the clients of these therapists tend to have more positive outcomes.

Therapist expressions of empathy has been regularly highlighted as an important aspect of the work of alliance building. Horvath & Bedi (2002) raised the issue of client openness to such expressions of empathy, and noted that there can be variation in client responses. They advocated for flexibility in

the therapist's approach to account for client variation. However, such flexibility, and the moment-to-moment awareness of client reactions, requires a level of attunement that individual therapists will possess to varying degrees. In the context of pedagogical inquiry, we must question the extent to which such therapist characteristics can be taught to those for whom it is not innate. A deeper analysis of this topic is presented in a later section.

One of the most promising confirmations of the contribution of the person of the therapist comes from a longitudinal study which rated the interpersonal behaviours of postgraduate psychotherapy trainees and subsequently tracked their client outcomes over the next five years (Schottke et al., 2017}. The primary tool used to rate interpersonal skills is a measure known as the Therapist Related Interpersonal Behaviour (TRIB} assessment. Two versions of the measure were used to assess candidates: one for interpersonal behaviours in group situation (TRIB-G} and one for interpersonal behaviours in one-on-one settings (TRIB-1}. The TRIB-G was rated by observers using videotaped interactions and the TRIB-1 was carried out through structured interviews. TRIB items were selected based on a pantheoretical view of the characteristics of effective therapists. The authors noted that effective interpersonal skills are marked by "clear and positive communication, empathy, and communicative attunement in social relationships, respectful and warm interpersonal behavior, the respectful management of criticism, and a willingness to cooperate" (p. 648}. Candidates were trainee therapists who had completed a masters in psychology and who had committed to further training in cognitive behavioural therapy {CBT} or psychodynamic therapy (PDT). Assessing interpersonal behaviours prior to training allowed the authors to examine whether such an assessment taken before training in a specific modality would predict client outcomes after training. Further to this, the authors stated their objective to 'develop and evaluate a standardized behavioral assessment protocol for psychotherapy training programs'. The results showed that those therapists with higher scores in the observer-rated TRIB-G assessment prior to training consistently achieved better client outcomes. However, this was not the case with the TRIB-1 assessment. The positive correlation between TRIB-G score and outcome was found to be independent of therapist gender, theoretical orientation and amount of supervision the therapist had received. The authors did not offer a theory as to the disparity between TRIB-1 and TRIB-G

predictive effects, but it suggests that observable behaviours provide a better assessment of interpersonal skills than a structured interview.

These findings alone provide ample justification for the premise of this paper and highlight the need to make concerted efforts to teach emerging therapists the skills to develop stronger therapeutic relationships. The following section will provide a deeper examination of the specific skills that contribute to the formation of strong therapeutic bonds.

The Behavioral Components of Alliance Formation

While it is helpful to know that the therapist's contribution to the therapeutic alliance is significant, it would be even more helpful to have a granular understanding of the actions that the therapist is taking in order to develop the alliance. Research has identified several areas which consistently contribute to effective alliance formation. These include: empathy (Elliot et al., 2011) communication skills-both verbal (Horvath & Bedi, 2002) and nonverbal (Elliot et al., 2011)-collaborative behaviours (Norcross & Lambert, 2018, p.311), and adaptive responses (Norcross and Wampold, 2019, p.395). Let us look deeper into each of these areas.

Empathy

Perhaps the most widely agreed upon aspect of effective therapy is a stance of empathy towards clients. Research has cemented the primacy of empathy in the therapeutic alliance. A 2011 meta-analysis found that empathy is a moderately strong predictor of therapy outcome (Elliot et al., 2011). Carl Rogers wrote extensively on the topic of empathy and his definition is still widely quoted: "To sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (Rogers, 1957, p.829). It is interesting to note the separation that is built into this definition. The therapist is called upon to recreate the client's experience without getting so caught up in the pretence as to lose objectivity. For example, in the case of a depressed client we must be able to imagine what it's like to feel lethargic, anhedonic and hopeless without succumbing to those feelings. There must be at least one person in the room who is able to chart a way forward.

Elliott et al. {2011) described empathy as "a higher-order category, under which different subtypes, aspects, and modes can be nested". They specifically noted the subcategories of empathic rapport, communicative attunement, and person empathy. Empathic rapport captures the therapist's

attempt to provide a compassionate space for the client and a sense that they understand what it is that the client has experienced or is experiencing. Communicative attunement calls on the therapist to follow closely the client's attempts to elucidate their experience in a way that signals to the client that the therapist is making a genuine effort to do so. This can be signalled both verbally, through relevant reflections for example, and non-verbally, through eye contact or posture. Person empathy refers to the therapist's attempt to understand the fullest, broadest picture of the client's experience by taking into account contextual factors including formative experiences and impactful relationships. This is a stance that is often associated with a psychodynamic approach.

Communication Skills

Verbal Communication Skills. In a research study on therapist effects involving 25 practicing therapists, Anderson et al. (2009) found that verbal fluency-described as "the extent to which the participant [i.e. therapist] is verbally comfortable and at ease in communicating" (Anderson et al., 2020, p.4)-is one of the facilitative interpersonal skills (FIS) that allow therapists to effectively bond with clients. Verbal communication skills are typically considered to be the basis of effective client engagement and rapport building (Hill & Lent, 2006). Of course, much of what takes place in the therapy room relies on verbal communication, but for the purposes of this paper a specific subset is proposed that includes reflections, validations and questioning techniques. While the positive effect of FIS on client outcomes has been demonstrated through research, there appears to be little research specific to the efficacy of reflections, validations and questioning techniques. These appear to have been adopted as 'standard practice' amongst therapists because they are germane to the goal of creating an environment where deeply personal material can safely be shared without fear of shame or embarrassment (Hill, 2014, p.193).

The skill of reflecting is one that bears some examination, since it occupies a singular place in the person-centred approach. Crudely performed, the reflection can feel like a parroting of the client's own words. This would be better described as a restatement-a paraphrasing which seeks to clarify the content or meaning (Hill, 2014, p.162). The reflection, however goes beyond this. Hill (2014) described an effective reflection as a 'manifestation of empathy'. Elliot et al. (2023, p.958) looked at the effectiveness of 'empathic reflections', which they described as "responses primarily intended to convey

the therapist's empathic understanding of the client". They noted that the reflection attempts to add depth to the clients original statement. From Rogers' (2003) perspective, the reflection is not a declarative statement, but rather an attempt by the therapist to test their understanding of the client's experience. To this end, therapists may choose to couch their reflections in tentative language (Elliot et al., 2011) such as 'It sounds like...' or 'If I'm understanding correctly...'. In my own work I describe my reflections as offerings to the client, which they are welcome to run with or cast aside as they choose. I tell them that my goal is to 'flesh out' my perception of their inner world.

Non-Verbal Communication Skills. Much of human communication takes place not in the verbal space of words and sentences but in the non-verbal space that surrounds them (Hill, 2014, p.142). There are a multitude of ways in which we add nuance to what is spoken through, for example, gesture and tone. We might think of non-verbal communication as a form of signalling that augments the verbal, and typically arises from subconscious processes. The pertinent question is: can we teach emerging therapists to not just attend to the non-verbal communication of clients, but to attend to their own? This section will begin by examining the literature on the effect of non-verbal communication in therapy.

From an alliance development perspective, non-verbal communications can be an effective way to build rapport and develop the therapeutic bond (Hill, 2014). One study compared the effect of verbal and non-verbal cues in establishing conditions of empathy, positive regard, and genuineness (Tepper & Haase, 1978). Both trained therapists and clients participated in the rating process. While the complex interplay between the verbal and the non-verbal was noted, results indicated that non-verbal cues such as posture, vocal intonation, eye contact and facial expression, were significantly more effective in communicating these core conditions than verbal output. In the case of genuineness, they turned out to be in the region of 23 times more effective. It appears that trying to convey one's genuineness through verbal means is essentially futile.

A separate study looked exclusively at eye contact and trunk lean and how these related to perceptions of therapist empathy (Dowell & Berman, 2013). 144 undergraduate students rated videotaped sessions of 4 qualified therapists engaged in brief, unscripted role-play sessions with pseudo clients. Each session was enacted 4 times with varying combinations of high/low eye-contact, and forward/upright trunk posture. The results indicated that perceptions of empathy and credibility of

treatment were enhanced by the either high eye-contact or a forward leaning posture, and perceptions of the quality of the relationship were enhanced just by the maintenance of strong eye-contact. This finding is of immense pedagogical use as it presents specific, observable, and-most importantly-teachable behaviors that can form the basis of a relational skills curriculum.

There is an appropriate research basis for a focus on non-verbal communications in the therapy room. To neglect the non-verbal space is therefore to disregard one of the most effective means by which we can develop a healing bond with our clients. One of the key challenges in teaching non-verbal skills is the intricate nuance of interactions themselves. Hill (2014) enumerated multiple categories of non-verbal communication, some of which naturally lend themselves to the goal of creating interpersonal connection, such as kinesics (or body movements), eye-contact, facial expressions, body posture, proxemics (or use of space), touch and para-verbal behaviours. Eye-contact is a prime example of the nuance inherent in non-verbal communication: in western cultures strong eye-contact denotes a position of focussed listening, whereas other cultures might find it disrespectful (Hill, 2014).

Collaborative Behaviours

The goal of collaboration in therapy is to offer clients a sense of agency in the healing process. Rather than just provide answers to our clients, we want them to engage proactively in the exploration of their internal world and the search for a path forward (Hill, 2014). A prescriptive, expert-led approach can sideline our clients, when their full participation is essential. An insight that emerges from the client's own psyche will always be more impactful than an insight served to them by the therapist (Bailey & Ogles, 2023). This collaborative stance is captured in Bordin's tripartite model of the therapeutic alliance which recommends therapists work with clients to establish a clear consensus; first of all on the goals of therapy, and secondly on the tasks through which those goals will be achieved (Bordin, 1979).

In practice there are a number of ways that the therapist can invite collaboration. From a theoretical viewpoint we can look to 'collaborative empiricism', sometimes used in the delivery of cognitive-behavioural therapy (Dattilio and Hanna, 2012). This acts as a framework to facilitate collaborative efforts like goal setting and treatment planning. The tasks offered are drawn from a CBT context but in each case the collaborative aspects are emphasized. For example, client and therapist might collaborate on hypothesis testing, where they engage in evidence gathering to counteract negative

self-reflections. On a session-by-session basis, collaboration might involve reconnecting to the goals and tasks at regular intervals and inviting the client's reappraisal. There are also measures that can be employed in the service of collaboration, such as the Session Rating Scale (SRS) (Duncan et al., 2003). The SRS is a short, 4-item questionnaire designed to elicit feedback from the client regarding the therapeutic alliance and the preceding session.

Collaboration helps to foster the therapeutic relationship (Dattilio and Hanna, 2012). It is another of the foundational interpersonal behaviours that allows us to create deeper bonds with our clients. From a pedagogical perspective the SRS and the work that has been done on collaborative empiricism give us the building blocks for training programs that can teach the crucial skill.

Adaptive Responses

As mentioned in chapter one, effective therapy takes multiple variables into account in order to tailor treatment to each specific client. Therapists need to be adaptive in the way they approach individual cases, and avoid the temptation to offer 'cookie-cutter' approaches that fail to recognize the unique constellation of factors that each case presents (Norcross & Lambert, 1998). While verbal/non-verbal communications and collaborative behaviours lend themselves to some level of manualization, it is not clear that this is the case for adaptive responses.

A key study conducted by Anderson et al. {2009, p.759) gives an insight into adaptive responses by assessing the impact of the therapist's facilitative interpersonal skills. The study defined FIS as the ability to "perceive, understand, and communicate a wide range of interpersonal messages", as well as the ability to persuade clients to adopt the solution that is being offered. Therapists partaking in the study were rated on a Likert scale based on the following qualities: verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus. Crucially, the test cases offered to therapists were specifically chosen to be on the challenging side: clients were either negative and self-focussed or other-focussed and highly dependant. In this way it was possible to witness the range of therapists' adaptive responses. The study determined that therapist gender and theoretical orientation were irrelevant to client outcomes. Initially, it appeared that age was a contributing factor in positive outcomes, with older therapists achieving better results. However, upon further analysis it was discovered that experience, rather than age, was contributing to better outcomes-older therapists had

simply spent more time developing the skills that allowed the relationship to flourish. Further discussion of the role of experiential learning is undertaken in a later section on alliance training.

Rupture and Repair

In their work on the area of 'rupture and repair', where a disconnect arises between therapist and client which threatens the therapeutic relationship, Jeremy Safran and Christopher Muran have given us a roadmap to deal with one of therapy's potential potholes. Such is the likelihood of a so-called rupture in the working alliance that it is important to prepare trainee therapists, not just to address the rupture, but to recognize it in the first place. However, Safran and Muran {1996) share with us the profoundly hopeful conclusion that ruptures in the alliance, when carefully repaired, can actually make the alliance stronger. The analogy of the broken bone that heals stronger than before springs to mind. Ruptures are described as 'problems in quality of relatedness' or 'deteriorations in the communicative process'. The events that signify the rupture do not necessarily need to be severe or even particularly obvious. They can in fact be subtle and easily overlooked. Ruptures are important to address, however, as they can compromise treatment or lead to cessation (Safran and Muran, 2006). It is important to acknowledge that both parties, client *and* therapist play a role in the rupture, and it may be worthwhile to explore their respective roles while finding the way back to a place of harmonious alliance (Bailey & Ogles, 2023, p.72). This reminds us that the therapeutic relationship can act as a proxy for relationships elsewhere in the client's life (Hill, 2014, p.258). Through this experience of moving successfully from rupture to repair in the therapy room, the client can internalize new possibilities for how relational difficulties can be navigated elsewhere. This reminds us that the relationship itself can be a mechanism of change.

Two broad categories of rupture have been documented: confrontation and withdrawal (Safran and Muran 2000). This dichotomy has proven useful from a research standpoint as it is typically obvious which category individual ruptures belong to (Safran & Muran, 2006). Confrontation ruptures are typically easy to identify as they are marked by the expression of negative sentiments about the therapist or the treatment process. In order to repair confrontation ruptures, it is important to first of all acknowledge and openly explore the source of the disconnect (Ackerman & Hilsenroth, 2003). It has been found that the gesture of taking responsibility by the therapist can be validating and impactful for

clients (Constantino et al., 2017). The use of metacommunication is also advised-encouraging frank discussion of the state of the therapeutic relationship. This is another powerful form of collaboration which can deepen the bond between client and therapist (Moesender et al., 2019). Rigidity and a strict adherence to theoretical orientations has been found to be an impediment to repair (Ackerman & Hilsenroth, 2003). This reminds us of the ability of effective therapists to provide adaptive responses to intricate and complex relational scenarios.

The second category of ruptures, withdrawal ruptures, are marked by negative sentiments which are not expressed verbally but instead acted out through 'withdrawal, distancing or avoidance' (Ackerman & Hilsenroth, 2003). This second category is more difficult to detect because it relies on therapists noticing the absence of particular markers (e.g. verbal engagement or eye contact) rather than the presence of particular markers (e.g. verbal outbursts). This is a situation where the therapist's ability to pick up on non-verbal cues will be tested. Withdrawal may be a sign that the client doesn't feel safe to express the reasons for discontent, and the therapist's task is to foster a feeling of safety in the client. The goal is to encourage reluctant clients to open up about their true feelings (Bailey and Ogles, 2023).

Addressing a difficult turn in the therapeutic relationship can lead to a deepening of the bond between client and therapist, but the question remains: how do we teach therapists the skills to effectively navigate rupture and repair? To this end, Safran and Muran (1996) designed a rupture resolution model with exactly this in mind, and this could be used as the cornerstone of a relational skills development program.

Alliance Training in Therapist Education

We have seen thus far that a great deal of research has been done into the therapeutic relationship and a moderate but consistent effect on client outcomes has been firmly established. This knowledge will serve as the launching pad from which we will set out to try and understand what our teaching institutions can do to operationalize this understanding. In the following section we will seek to uncover the available literature on the training of new therapists as well as literature on pedagogy more generally, which can help us to think about how relational skills may be taught effectively.

Explicit And Tacit Knowledge

From a strictly pedagogical point of view, it would seem instructive to consider the question of whether there are categories of epistemology that are more and less teachable. To this end, we can think about the difference between explicit and tacit knowledge. Courses teaching explicit knowledge are so ubiquitous in our learning institutions that providing examples would be essentially redundant. Philosopher Michael Polanyi wrote extensively on tacit knowledge-knowledge and understanding that is, by its very nature, difficult to codify and is, as a result, routinely neglected (Hadjimichael, 2024). Conversely, we might say that the propensity of certain fields to be codified and manualized ensures that they are the ones incorporated into systems that rely on standardized testing. The exemplar of this is the Western schooling system (elementary and secondary), exported and adopted throughout the English speaking world, which still teaches essentially the same subjects that it did 100 years ago, despite the advancements in many areas, including psychology and technology (Teschers et al., 2024). It appears that it is more resource intensive to teach so-called 'soft' skills such as intuitive judgement, cultural competence and social navigation because it requires mentorship and engagement with the actual process-the 'doing' of the thing (Hadjimichael, 2024).

Carl Rogers, whose writing has given so much to the humanistic approach to psychology, expressed his belief that it was not possible to train therapists didactically in some of the attributes (from the oft-quoted 'Necessary and Sufficient Conditions of Therapeutic Personality Change' (Rogers, 1957)) that are required to facilitate positive psychological change. These specific attributes of the therapist that Rogers referred to are: congruence, unconditional positive regard, and empathy. Rogers posited that these qualities are developed experientially, through the practice of attempting to offer them to clients. He stated his belief that this experiential learning stage should be provided during professional training "but usually is not" (Rogers, 1957, p. 827). Rogers acknowledged the lack of empirical evidence for his hypothesis, writing with characteristic congruence and openly admitting the limitations of his subjective perspective. He spoke of his "radical point of view" (Rogers, 1957, p. 831), which had been arrived at through years of practice. He also stated his belief that one does not need "special intellectual professional knowledge" (Rogers, 1957, p. 831) in order to perform the role of therapist-including

knowledge about psychology. This view is indeed radical when seen from the point of view of the British Columbia Association for Clinical Counsellors (BCACC) which requires a Master's degree of all applicants.

Didactic Versus Experiential Learning

In therapy training there is typically a bifurcation between the didactical and the experiential aspects. The didactical take place in the traditional classroom setting where knowledge is imparted in a top-down manner from lecturer to students who are expected to participate more or less passively. The experiential can look more ad-hoc, where students engage in, for example, one-on-one conversations, small group consultations, or larger group encounters. This latter approach requires the full engagement of the student in a process designed to create the necessary conditions for maximum self-reflection (Baker et al., 1990).

In terms of the therapeutic alliance, it is germane to consider how much can be taught didactically and how much requires an experiential approach. An experiential approach has been recommended as the optimal way to teach the so-called 'helping skills' (Hill & Lent, 2006), those competencies of the practicing therapist that promote positive client outcomes, of which the conscientious construction of the therapeutic alliance is one. This makes sense when we think of the helping skills as areas of tacit knowledge, areas in which practitioners "know more than they can tell" (Polanyi, 1966). We can also view this from an anthropological perspective by considering how knowledge in pre-literate communities was transmitted. It is unlikely that Stone Age communities arranged youth in neat rows and bestowed knowledge upon them in the manner of a modern classroom. But undoubtedly knowledge was effectively transmitted from generation to generation. Polanyi {1958) referred to the process of 'mimesis' whereby novices mimic the actions of masters: 'By watching the master and emulating his efforts...the apprentice unconsciously picks up the rules of the art, including those which are not explicitly known to the master himself'.

We can relate the concept of mimesis to the realm of therapy training by considering training methods which allow students the opportunity to observe a therapist proficient in facilitative interpersonal skills. This method is referred to as 'modelling' (Hill, 2014, p. 355) and it has been shown to be a more effective training method than either instruction or feedback (Hill & Lent, 2006). It appears that the efficacy of this method is actually enhanced when students admire or look up to the therapist

demonstrating the skills (Kazdin, 2013). Ultimately, the goal in training new therapists should be; enabling them to deeply imbibe the facilitative skills such that they are no longer merely mimicking the skills of the competent therapist, but 'using them in a flexible, client-centred manner' (Hill & Lent, 2006). This speaks to the ideal that, rather than a 'one-size-fits-all' approach, the therapeutic process should be tailored to the individual client (Norcross & Wampold, 2018). Therapists need to be flexibly responsive to the traits, preferences and goals of each client, both from the perspective of theoretical orientation and interpersonal engagement. Numerous terms have been used to describe this process of tailoring treatment to the individual including attunement, individualizing, personalizing, therapy fit and treatment adaptation, among others. Another often-used term-'responsiveness'-seems to capture the concept succinctly. Stiles et al. (1998, p. 439) described responsiveness as 'behavior that is affected by emerging context, including perceptions of others' characteristics and behavior. Insofar as therapist and client respond to each other, responsiveness implies a dynamic relationship between variables, involving bidirectional causation and feedback loops'. In the clinical setting, this can take a number of different forms. The therapist might adapt their use of relational skills, for example using more self-disclosure to enlist the trust of a reticent client, or toning down empathic reflections for clients for whom expressions of empathy are too intrusive. The therapist might educate a solution-focused client on cognitive distortions, or take a psychodynamic approach with a self-reflective client. There are multiple other dimensions in which the therapist might adapt their approach, including 'attachment style, racial/ethnic culture, therapy preferences, religious/spiritual commitment, reactance level, stage of change, and coping style' (Norcross & Wampold, 2018).

Alliance-Focused Training

It is important to note that while the thesis of this paper rests on a perceived lack of relational skills training in therapy and counselling training programs, there is not, in fact, a lack of training frameworks that could be adopted. Several frameworks have been designed to train therapists in the interpersonal skills necessary for creating strong working alliances with clients, most notably Robert Carkhuff's Human Relations Training model, Allen Ivey's method of Microcounseling, and Norman Kagan's Interpersonal Process Recall. They began to emerge in the late 1960s as adherents of Carl Rogers' client-centred approach sought to challenge his belief that certain interpersonal skills could not

be taught. The goal of these frameworks was to break down Roger's 'necessary and sufficient conditions' of effective therapy and create systematic training programs geared specifically towards the teaching of relational skills. It is interesting to note that all three programs favour an experiential approach over a didactic approach. This aligns with the pedagogical theories discussed earlier, and also the conclusions of Hill and Lent (2006) regarding the superiority of experiential training over didactic for the acquisition of counselling skills.

Carkhuff believed that "one sustained facilitative relationship by truly helpful people may reverse a lifetime of retarding relationships" (2010, Introduction section). He created Human Relations Training (HRT), also known as Intentional Didactic Experiential Training (IDET) which offered a framework for therapists to follow as they work deliberately toward creating an alliance with clients (Carkhuff, 1969). Detailed information about HRT was difficult to access and the following is a synthesis of the sources that could be located. A three stage process is described which aims to make Rogerian concepts like empathy, respect, and genuineness concrete, observable, and systematically teachable. The first stage is Self-Exploration. The goal is to help trainees explore their experience from their own internal frame of reference, in the belief that this process of inner exploration will be beneficial to subsequent attempts to facilitate this process in others (Hill, 2014). Facilitators model the basic skill of empathy, through the use of non-verbal attending and reflection of feelings. Carkhuff (2010} provided clear instructions on the specifics of non-verbal attending, including the use of posture and eye-contact.

The second stage of the HRT model is Understanding. Here, trainees are taught to use more advanced skills in order to respond to clients, such as self-disclosure, interpretation, immediacy, confrontation (or challenge), and genuineness (Hill, 2014). These techniques are more specifically geared towards deepening the alliance. Carkhuff (2010) described self-disclosure as the therapist using their own experiences to foster deeper understanding in clients. Interpretation (also referred to as 'personalizing') requires the therapist to make conceptualizations of client's deficits (Carkhuff, 2010). Immediacy has been defined as therapists "inquiring about or disclosing immediate feelings about the client, herself or himself in relation to the client, or the therapeutic relationship" (Hill, 2014, p. 299). Confrontation allows the therapist to bring the client's attention to discrepancies within their own

statements, in the hope of facilitating greater self-acceptance (Hill, 2014). Genuineness is typically transmitted through non-verbal means mentioned previously such as posture and eye-contact.

With a solid, trusting bond established, the third stage begins, where change-focussed interventions can be applied, such as guidance, problem solving and behavioural techniques (Hill & Lent, 2006). The goal here is to help the client translate their understanding into concrete action and behaviour change. This stage relates less to the therapeutic relationship and more so to the tasks of goal-setting and process discovery.

A second important program is Ivey's (1971) Microcounselling (MC), which focusses on teaching a similar set of skills as HRT, but differs in the conceptual presentation of the concepts. In this case the skills are conceptualized as a pyramid where the skills that are easier to adopt are placed at the bottom and more advanced skills are placed higher up. At the start of the program, trainees are given an initial interview to assess a baseline for relational skills. Skills are then presented in manualized form before trainees observe a qualified clinician enact them in real time. Trainees are then taped as they attempt to use the skills themselves in a client session. These sessions are then reviewed alongside supervisors which allows trainees to get valuable feedback on where skills were successfully utilized and where there is room for improvement. This process can be repeated, giving the trainee the opportunity to engage in iterative improvement.

The third program of note is Kagan's (1984) Interpersonal Process Recall (IPR), which takes a unique stance by assuming that all candidates possess innate interpersonal capabilities, but struggle to enact them due to performance anxiety. The overall goal of the program is to remove this specific impediment to trainee efficacy. Kagan believed that people embody two conflicting forces, namely, a need for human contact and a fear of human contact which typically results from childhood experiences (Andreescu, 2009). Kagan (1980) believed that there are two ways in which therapists unconsciously prevent themselves from connecting with clients. Either they will act as if they lack the skills to do so, or they will get so engrossed in their own internal processes that they will miss important messages coming from the client. IPR requires the participation of three individuals: a client, a therapist and a 'recall worker' (or 'inquirer') (Spivac, 1974). The training process requires the therapist and recall worker to review recorded counselling sessions with the client. Trainees are encouraged to reflect on their

moment-to-moment thoughts and feelings during the session in the company of the recall worker. They are also encouraged to notice what they like, dislike and fear about themselves in the session. The recall worker is expected to remain neutral and focus on facilitating the trainee's exploration of the interactions captured in the session. They act more like a therapist supervisor than a didactic teacher, as is the case in HRT and MC, "expanding the therapist's range of awareness" (Hill & Lent, 2006, p157). IPR does not involve any scoring or rating scales, but instead relies on open-ended questions to facilitate trainee exploration (Belser, 2017). The process allows the trainee to engage in focussed, non-judgemental reflection of in-session performance with a view to refinement of techniques in future sessions.

Regarding the efficacy of these programs, Hill and Lent (2006) noted that early narrative reviews posited that warmth and empathy could be effectively taught by such programs, but also pointed out methodological issues such as vaguely defined skills, crude rating scales and inadequate control conditions. Hill and Lent (2006) further observed that despite the initial interest in the possibilities offered by helper training, research quickly stalled, and the focus moved towards the field of supervision instead. It wasn't until the 2000s that some focus returned to the area of helping skills training. Hill's Model was influenced by aspects of HRT, MC and IPR, specifically the 3 stage framework of HRT. Deliberate Practice (DP) is another training methodology that lends itself to the development of relational skills (Belikova et al. 2025). DP has been used in diverse fields to facilitate the development of tacit knowledge through guided, experiential learning. Research on DP is limited at this time, but the indications are that it is an effective way to teach relationship building skills such as immediacy.

Chapter Three: Discussion and Application

Introduction

The purpose of this third and final chapter is to integrate the findings from chapter two and offer a broader, critical view on the pedagogy of relational skills. This chapter will explore simple, evidence-based relational skills that can be readily taught, challenge the common selection process for new students, and analyze the implications of a decolonized approach to training. The chapter will conclude by providing actionable recommendations for training institutions, regulatory bodies, and future research.

Basic Interventions in Relational Skills Development

This paper is a call to action for institutions charged with training emerging therapists to critically examine their training and ensure relational skills are appropriately prioritized. Ideally, relational skills would be taught in a highly focused, experiential format that combines instruction and observation with rigorous practice, immediate feedback, and targeted work on the trainee's self-awareness and internal processes (Hill et al., 2007). In programs currently lacking in relational skills development, a comprehensive course redesign is the ideal. Nevertheless, training programs can begin to prioritize relational skills immediately by integrating three foundational, evidence-based practices into their existing curriculum.

Collaborative Goal Setting

Chapter two discussed collaborative behaviours embodied by the therapist which can lead to the deepening of the therapeutic relationship. Teaching student counsellors to focus on the goals for therapy and to invite the client to take an active part in their creation is an achievable pedagogical goal. Doing so aligns with Bordin's model of the ideal working alliance which calls for collaboration on goals and also the processes by which those goals are achieved. Furthermore, by inviting the client to be an active co-creator of their own goals, the therapist fosters a sense of agency and self-efficacy, reinforcing that the client is a partner in their own healing, not merely a passive recipient of treatment.

Querying the State of the Alliance

Given the dynamic and ever-evolving nature of the therapeutic relationship, emerging clinicians should embody this fact by regularly querying the current state of the alliance. This can be an internal

process, one that occurs in the private recesses of the therapist's own mind, and it can also take place explicitly, where the therapist invites the client to offer their thoughts on the state of the alliance. The unwillingness of the client to be forthcoming with honest disclosure due to people-pleasing tendencies is an obvious stumbling block in this exercise. However, this may lead the therapist to open a discussion about what it means to talk openly about the state of relations, and how this could be useful elsewhere.

Verbal Parsimony

An earlier section discussed the value of therapists using verbal parsimony, or more precisely, limiting the number of words spoken in session (Hill et al., 2016). Simply put, we have reason to believe that emerging therapists who use fewer words in session have better outcomes. If instructors urged emerging therapists to 'speak less', this could be an easy and effective way to elevate the quality of therapy sessions and ultimately improve therapist effectiveness. This represents a straightforward intervention in principle: we are not asking the trainee to integrate additional knowledge or acquire complex new skills, we are just asking them to prioritize brevity over verbosity. This aligns with a client-centred approach to counselling which prioritizes the material brought forward by the client over the interventions of the therapist (Hill, 2014, p.167).

Purposeful Rupture

Safran and Muran {2000} have provided deep insights into the phenomenon of rupture and repair in the therapeutic relationship, and have also emphasized that ruptures, when successfully repaired, can lead to a deepening of the relationship (Moeseneder et al., 2019). Given our ethical mandate to provide the best in evidence-based treatment to our clients (BCACC, 2023, p.11), it would seem apt to ask: should we seek to foment ruptures in the therapeutic relationship? There is a belief that therapists should actively challenge the client to prevent the therapy space from becoming *too* comfortable for both parties (Dattilio & Hanna, 2012). Leong (1999) explored this concept, reframing confrontation not as an aggressive act, but as an invitation for clients "to consider their beliefs in relation to reality". Writing from a Singaporean perspective, Leong contended that it can be productive to confront a client's 'script beliefs' (Stewart, 1996) those beliefs about the world that are transmitted from parents to children. One example offered is the notion that one must "strive toward excellence", a common belief that is inculcated in Singaporean children. Leong noted the tension between the impulse

to confront this script belief with a client who is depressed after failing an exam, for example, and the possibility that doing so will lead to guilt and confusion. While this may be true, therapists should be cognizant of the role of discomfort in the therapeutic process (Stewart, 1996).

For emerging therapists, it is easy to default to a position of trying to make our clients feel as comfortable as possible. They are often coming to us in a state of anguish or distress and our intuition as caring professionals is to create a space that feels fundamentally safe and caring. Change, however, is frequently uncomfortable because it calls on us to face the unknown (Samuelson & Zeckhauser, 1988). Clinicians need to have the capacity to hold both the client's need for safety and the understanding that facing change may compromise that sense of safety, at least temporarily (Ribeiro et al., 2013). In weighing the need to challenge clients, therapists should always tread carefully, keeping in mind the risk of cessation. Knowing that engaging in therapy is better than no therapy at all (Wampold, 2001, p.66), it behooves the ethically-minded clinician to always prioritize the continuing engagement of the client.

The challenge in teaching purposeful rupture is creating the conditions that allow trainees to embody the skill, not just understand it. This requires a pedagogical model where the careful alignment of instruction, observation, practice and feedback would be optimal. The most effective method would be to create simulated rupture scenarios where the 'client' is a faculty member, or a student from a more senior cohort. The client could work with a script designed to precipitate a confrontational situation. For example, the client might be upset with the direction therapy is going in: "I feel like you're not getting me. You just keep saying the same thing back to me. This is a waste of my money." Alternatively the client might withdraw by avoiding eye contact and giving one word answers. This gives trainees an opportunity to sit in the discomfort of a rupture without becoming defensive. They can practice managing their own sympathetic nervous system activation, staying curious, and overriding their instinct to either placate or argue. Recording these practice sessions would allow for feedback sessions in the mold of IPR, where inquirers can facilitate the student's exploration of their moment-to-moment thoughts and feelings during the confrontation. This creates a feedback loop where student's growth and development is augmented by their own in-session experiences. In addition to these high-stakes simulations, programs that require students to build pseudo client-therapist relationships with a number of different cohort members would provide those students with the opportunity to practice not

only the skills necessary to build relationships, but also to experiment with the rupture and repair cycle in a supported environment.

Selection of Candidates

The preceding sections have focused on how to train emerging therapists, but the ability of any program to graduate effective clinicians is fundamentally dependent on the innate qualities of the candidates it admits. From an ethical standpoint, it is arguable that the field's primary goal is to maximize positive client outcomes, which makes the selection of candidates critically important. Research has clearly identified the most significant predictor of a therapist's future success: their pre-existing relationship-building skills (Schottke et al., 2017). Therefore, prioritizing the selection of candidates who already possess these innate skills is the most direct path to fulfilling the profession's ethical mandate (Anderson et al., 2009). This approach also responsibly stewards the finite resources of the applicants themselves, who, if unlikely to succeed, deserve to know as early as possible so they can consider other career options (Hill et al., 2016).

The typical strategy for selecting candidates involves an expert panel interview and a review of academic achievement (Schottke, 2017). However, studies have shown that expert interviews have little or no predictive value in terms of client outcome or supervisor rating of therapist competence (Hackman et al., 1970). There is simply no evidence that trainee therapists selected by experts become effective therapists. However, according to a study by Hill et al. (2016) applicant trait empathy can predict a number of effective therapeutic capacities after training is completed. These include helper- and client-rated session quality, helper-rated self-efficacy, and a reduction in the number of words spoken in session. In the study, empathy was measured using three of the four subscales from the Interpersonal Reactivity Index (IRI), including Perspective Taking, Fantasy, and Empathic Concern. Given that the IRI demonstrates robust validity (Davis, 1983), and internal consistency (Davis, 1980) it would appear to be a useful tool for screening therapy training candidates.

There were a number of other measures used in the study by Hill et al. {2016) aimed at predicting trainees' trainability such as the Natural Helping Measure, the Prior Helping Experiences Measure, and the Reading of Mind in Eyes Test. These are designed to measure candidates' innate disposition toward helping others, their previous experience in helping others, and their innate ability to

identify emotions by looking at the eyes of another. While one might expect that such measures would offer an insight into the suitability of candidates for the role of therapist, none of them proved to have any predictive value. The authors noted that while there was ethnic diversity amongst participants, they were drawn exclusively from "one large public Mid-Atlantic university" (Hill et al., 2016, p. 56), and all in their early 20s. Clearly there was a lack of age diversity, and it is possible that this cohort was also lacking in cultural and class diversity. It would be helpful to see this study repeated with a cohort drawn from a number of helper training programs. The authors also noted a general lack of studies that predict outcomes of helping skills training and caution against premature pronouncements based solely on the results of this single study. However, they were willing to make recommendations for the screening tools that could be justifiably used at this time. These include: applicants self-reported empathy, self-rated and client-rated session quality, number of words spoken in session, and confidence in ability to use helping skills.

It is important to note, however, a potential limitation of the screening approach outlined above: the possibility that applicants who score poorly on the Interpersonal Reactivity Index but possess growth potential will be excluded. A key theme of this treatise hinges on the trainability of relational skills. The suggested framework may select candidates who are already good, but exclude those with an untapped capacity to improve their interpersonal skills. An alternative and more sophisticated approach would allow candidates to demonstrate their growth potential during a prerequisite relational skills training course. This approach would not only serve to provide students with enhanced training opportunities, but also allow faculty to gauge candidates' trainability-their ability to integrate feedback, engage in self-reflection, manage their own defensive reactions, and demonstrate measurable growth over time.

The evidence is unequivocal: traditional methods of therapist selection, such as the expert panel interview, are unreliable predictors of therapist effectiveness. In stark contrast, a robust body of research demonstrates that a candidate's pre-existing relational skills-whether measured as Facilitative Interpersonal Skills (Anderson et al., 2016) or trait empathy (Hill et al., 2016)-are the single most important predictors of their ability to achieve positive client outcomes. Therefore, if one believes in an ethical imperative to improve client care, this demands a radical shift: selection must move away from

subjective interviews and towards the objective, evidence-based assessment of these foundational relational capacities.

Decolonizing the Path to Accreditation

Today, the major governing bodies in Canada are making concerted efforts to acknowledge the necessity to infuse the work of counselling with a cultural sensitivity that respects the diverse backgrounds of our clients and the complicated colonial histories of the places in which we work and reside. For example, the BCACC has explicitly integrated an Indigenous Cultural Safety and Humility Standard, calling on counsellors to "examine their own colonial assumptions" and commit to reconciliation {BCACC, 2023). The Canadian Counselling and Psychotherapy Association {CCPA) has made concerted efforts to foreground cultural competence and "address the needs of Indigenous counsellors, psychotherapists, clients, families, and communities" {CCPA, n.d.). Their website hosts an excellent collection of relevant resources. These are laudable and necessary steps toward a more equitable profession.

However, a profound tension exists between these efforts and the mechanisms of accreditation enforced by these organizations which rely heavily on standardized, prescriptive academic pursuits and the navigation of systems heavy in colonial bureaucracy. Consequently, in order to join the pre-eminent counselling bodies in Canada one needs to meet a high academic bar, and this overwhelmingly favours middle class members of the dominant culture. Without ever naming decolonization, Carl Rogers created a powerful argument in favour of the decolonization of therapist training: "Intellectual training and the acquiring of information has, I believe, many valuable results-but becoming a therapist is not one of those results" {Rogers, 1957, p.831). In theory, one could be illiterate and still become an effective therapist.

As therapists, we are called on to deal in the ephemeral. The cognitions, emotions, and somatic sensations of our clients are the shifting sands that we tentatively navigate. In order to do so skillfully we need to embody more than just verbal reasoning skills. The somatic, non-verbal and para-verbal aspects of this work are incredibly important, and yet not easily explained. Similarly, concepts like empathy are difficult to wholly convey in words. While the didactic approach represents an efficient assembly line for manufacturing new therapists, it is a colonial system that is poorly adapted to the task of teaching

students the soft skills so vital to relationship building. By prioritizing academic achievement over embodied ways of knowing, the current system reinforces the very colonial structures it criticizes. Decolonizing the path to accreditation requires fundamentally restructuring the way we train therapists by creating new methods of assessment that honor and validate embodied, relational mastery over mere academic performance.

Recommendations

Recommendations for Training Institutions

The research question at the heart of this paper queries whether it is possible to teach relational skills to emerging therapists. While a previous section outlined relational skills that can be easily integrated into existing curricula, these measures alone are insufficient. Given the primacy of the therapeutic relationship in successful client outcomes, as established in chapter two, a more thorough course re-design is recommended in programs where no dedicated relational skills modules currently exist. We have seen that there are frameworks in existence like Human Relations Training and Microcounselling that are designed to address this need. Whether institutions choose to adopt a pre-existing format, integrate elements of pre-existing formats, or design a module from scratch, a mandatory, supervised, experiential training module is strongly recommended. A focus on areas mentioned earlier such as communication skills (both verbal and nonverbal), collaborative behaviours, and adaptive responses would be foundational for the success of new therapists, and likely contribute to their confidence and self-efficacy.

Chapter two offered an in-depth look at Bordin's tripartite model of the therapeutic relationship which prescribes consensus on goals, agreement on tasks, and the establishment of a bond. Although each facet has its own nuances, the beauty of this framework is its simplicity at the highest level. It would be a straightforward matter to integrate the model as more than just a theory, but a way in which client cases can be discussed and conceptualized. The power of the therapeutic relationship needs to be acknowledged right from the outset of training and referenced frequently as training progresses. Bordin's tripartite model gives us an ideal touchstone to help training programs to achieve this goal.

Our understanding of the inevitability of ruptures in therapeutic relationships, elucidated in chapter two, means that trainees need to be equipped with the requisite skills to navigate these

potentially stressful and activating events. From a social systems perspective, interpersonal conflict is inherently stressful, and brings with it the threat of group exclusion, a potential death sentence to our prehistoric ancestors. Each of us attends to conflict differently, based on our own particular biopsychosocial context. This needs to be acknowledged in training programs, so that trainees can begin the inner work of interrogating their own conflict style. The pedagogical goal, therefore, is to teach trainees how to consciously override the innate fight-flight-freeze response in favor of a more adaptive, analytic approach to repair (Hill et al., 2020). This level of self-regulation, however, is not a didactic skill; it is an embodied one that can only be developed through intensive supervision, experiential group work, and the trainee's own therapy.

Recommendations for Regulatory Bodies

The BC Association of Clinical Counsellors (BCACC) calls on members to "embody integrity in relationships" by "managing relationships intentionally" (BCACC, 2023, p.11), but neglects to outline the specific, observable competencies that would demonstrate this standard. This omission is notable given the association's endorsement of "evidence-informed practice" (BCACC, 2023, p.10). Given the body of evidence supporting the role of the therapeutic relationship, it is incumbent upon regulatory bodies to move beyond abstract ethical statements. To this end, they could collaborate with researchers and training institutions to create a new, evidence-based framework of observable relational skills. In researching the therapeutic relationship, measurement of Facilitative Interpersonal Skills (FIS) has been used to determine the therapists' efficacy in creating therapeutic alliances. A framework of observable relational skills is proposed as a pedagogical tool that translates the qualities identified by the FIS into a concrete, demonstrable set of behaviours that can be taught, practiced, and assessed.

Once established, the assessment of these observable skills should be designated as a mandatory requirement for program accreditation. This would create a powerful, top-down incentive for training institutions to prioritize relational skills development. Ultimately, ensuring that new registrants possess these proven capacities is not merely a bureaucratic step; it is an ethical imperative for any governing body mandated to protect the public and ensure the quality of care.

Recommendations for Future Research

One of the key criticisms of the research into the therapeutic relationship is that it has only proven a correlation between strong therapeutic relationships and positive client outcomes. This is a valid critique, and one that can only be addressed by moving beyond correlational studies to comparative efficacy trials. Specifically, a randomized controlled trial comparing the client outcomes of trainees who receive mandatory, experiential relational skills training against a control group receiving standard training would provide the field with invaluable data. While the resources required would be significant, the vast body of evidence correlating the therapeutic relationship with client success creates an ethical and scientific obligation to pursue the causal proof that only a randomized controlled trial can provide.

Personal Reflection

This has been a challenging journey for me from a personal standpoint. I have had to spend many, many hours crafting a paper of sufficient quality to allow me to progress towards my goal of doing the work of therapy. I feel conflicted about this because I doubt that this exercise will serve me nearly as well as spending that time immersed in an experiential learning environment would have. I firmly believe that my future clients would have been better served if I had been able to follow this latter course. Time spent partaking in guided, supervised small group experiential learning scenarios, would undoubtedly have enabled me to grow as a clinician in ways that would have led to better outcomes for my clients. As I continue to watch my peers slog through the mires of interventions and orientations, beset by self-doubt and imposter syndrome, I remain somewhat dumb-founded as to how we came to this situation, where an accredited learning institution is failing to equip its graduates with the skills to consistently provide one of the acknowledged cornerstones of the therapeutic endeavour-the relationship.

I can, however, hold in mind the counter-balancing thought that this process has helped me to uncover and deeply imbibe some valuable lessons. The very act of spending so much time thinking and writing about the therapeutic relationship will surely act as a reliable bulwark against any future failure to deeply consider the state of the alliance in each and every case. I believe this process will leave such an impression that I will be forced to reckon with the here-and-now bond that my client and I will collaborate on. The concept of the therapeutic alliance has moved from an academic theory to a central, guiding principle in my understanding of the therapeutic process.

Conclusion

It is important to remember that our clients are not just objects we perform operations on, but rather peers whom we walk alongside and relate to with a level of intimacy that is unusual in today's society. We know that therapeutic relationships that begin strongly, from the client's perspective, tend to remain that way (Martin et al., 2000), so it is important that we as therapists prioritize the establishment of a strong relationship early in the process. Numerous descriptions of the therapeutic relationship have been provided within this paper but few surpass the simplicity of: 'the collaborative bond between therapist and patient' (Krupnick et al., 1996). Slightly more verbose but nevertheless compelling is: 'an emergent quality of partnership and mutual collaboration between therapist and client...not the outcome of a particular or typical intervention' (Horvath et al., 2011). Synthesizing these ideas, we learn that the collaborative bond is not something the therapist alone builds, but something that grows from a genuine, reciprocal partnership.

In my emerging therapist peer group, I hear plenty of talk about modalities and interventions, but never do I hear anyone speak about the relationship and how one might go about deepening it. It is possible that mine is an outlier experience, but I believe that the therapeutic relationship should be foregrounded to such a degree in our institutions that it would not be possible to have this experience. I have come to believe that students should be so immersed in relational discourse that it becomes a touchstone in every conversation regarding a client. I can think of no more apt quote than that of Carl Rogers (Rogers & Kramer, 1995): '...in my early professional years I was asking the question, How can I treat or cure or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?'. The work of therapy takes place in the all-too-human space that exists between two people, and we can take comfort in the knowledge that our clients can experience positive outcomes, despite our imperfect understandings of the exact mechanisms involved.

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