

STRENGTHENING THE THERAPEUTIC ALLIANCE  
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A thesis submitted in partial fulfillment of the requirements  
for the degree of

Master of Counselling (MC)

City University of Seattle  
Vancouver BC, Canada site

Date  
August 10, 2018

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### **Abstract**

The purpose of this paper is to create a practical tool for counsellors (as part of a larger, existing toolkit) to strengthen the therapeutic alliance between client and counsellor. This primary tool will consist of a checklist that includes common factors, identifies elements that build a strong therapeutic relationship, highlights qualities important to being an effective therapist, and incorporates lessons learned and best practices in psychotherapy. This checklist should not be considered a mandatory requirement and its specific details should not be used without allowing for flexibility, refinement, customization and alteration at the discretion of the counsellor. Each client is different and therefore a general prescriptive approach is not adequate. Instead, this checklist should be seen as a general guide and helpful assistance that can and should be altered in order to suit the needs and requirements of each individual client and therapist.

It is well-known that most counsellors have heavy workloads and therefore a succinct one-page and flexible checklist as presented could be helpful in strengthening the therapeutic alliance.

## Chapter One

### Preamble

I often wish there was a panacea that would allow us as therapists to possess the magic recipe that would cure all psychological and mental health issues in our clients. It's the holy grail of some academic researchers and practising psychotherapists: finding universal factors, tools or approaches that work with all clients and deliver to all clients the results they seek.

I, however, do not believe such a holy grail exists. I do not believe we will ever discover a set of universal factors that would allow all psychotherapists to successfully treat every client. Instead, I believe each client requires and deserves a customized approach to therapy that meets his or her individual needs.

This does not mean no common factors in psychotherapy exist or that we cannot refer to common guidelines in the treatment of our clients. In this paper, I argue that such common factors do exist and that we can use them as part of a flexible guideline approach to treatment.

Such common factors are not set in stone but are instead flexible, open to adaptation and alteration, based again on the specific needs of each of our clients. I see such common factors only as a flexible guideline rather than rigid rules set in stone. While I sometimes wish there was such a panacea, a set of "golden rules" upon which all psychotherapy could exist, such an approach is fantasy.

For in producing a set of "golden rules," we would be in fact sacrificing reality to a state of fantasy, surrendering the subjective and unique individual experiences of our

clients to a normative standard. We would, in a very real sense, be playing the role of God or a supernatural entity.

In this thesis, I argue instead that each individual on our planet Earth is unique, that each is born with a different sense of life experiences and circumstances and that these complex experiences do not necessarily lend themselves to the application of a set of simple, common, psychotherapeutic factors. Indeed, studies show that even identical twins have their own unique thumbprints (O'Connor, 2004) and will conceive of the world differently, whether to a large or small degree.

Nonetheless, on a practical and practicing level, it would be useful for psychotherapists to have a set of guidelines that lead to effective therapy; these guidelines would consist of some commonalities or strength-based approaches that would help further develop and build on the therapeutic alliance, providing both therapist and client with a more beneficial and rewarding outcome.

Dating from the 1960s, the number of psychotherapy approaches has grown approximately 600 percent (Miller, Duncan & Hubble, 1997). It is estimated that there are now more than 200 therapy models and 400 techniques (Bergin & Garfield, 1994). Saul Rosenzweig's (1936) paper "Some Implicit Common Factors in Diverse Methods of Psychotherapy" initiated one of the first attempts to coalesce many of these differing and often competing approaches, identifying common factors they all shared. Barry Duncan (2002) summarizes Rosenzweig, noting that since "all approaches appear equal in effectiveness, there must be pan-theoretical factors in operation that overshadow any perceived or presumed differences among approaches" (p. 34).

But in his 1936 article, Rozenzweig also highlights the critical role of the therapist in assisting the client. He writes that “observers seem intuitively to sense the characteristics of the good therapist time and again in particular instances, sometimes being so impressed as almost to believe that the personality of the therapist could be sufficient in itself, apart from everything else, to account for the cure of many a patient by a sort of catalytic effect” ( p.414). Rosenzweig argues that perhaps it is not so much the therapeutic method but rather the demeanour and “characteristics of the good therapist” that makes for success across a range of different and differing approaches to therapy.

So what are these common factors and can they truly represent some essence shared by all psychotherapeutic approaches? The literature is replete with references to common factors, yet there is, as of yet, no set agreement on what constitutes these specific common factors. Laska and Wampold, (2014) argue that the most important common factor is the client. And they go further by noting that “there is no such thing as a ‘common factor’ treatment” (p.2). By contrast, other authors identify different types of common factors that focus specifically on therapy and the interaction between therapist and client. Tracy et al., for example, identify three general categories of factors, the first related to the bond or therapeutic alliance between therapist and client, the second related to the meanings and interactions communicated between therapist and client, and the third related to the therapy process itself and its essential structure. Goldfried (1982) detailed five specific factors they argued all psychotherapies had in common: 1) new behaviours and corrective actions suggested by the therapist; 2) a therapist’s feedback on the client’s situation and behaviour; 3) the expectation by the client that the therapy will

be effective; 4) establishment of a solid therapeutic relationship; and 5) continuing testing in the real world by the client of strategies developed in therapy. Others suggest the quality of the client's participation in the therapeutic relationship is the single most important determinant of outcome (Orlinsky, Grawe, & Parks, 1994). Carl Rogers considered the "core conditions" of effective psychotherapy – empathy, respect, and genuineness (Horvath & Lurborsky, 1993). The most helpful alliances are likely to develop when the therapist establishes a therapeutic relationship that matches the client's definition of empathy, genuineness and respect (Duncan, Solovey & Rusk, 1992).

Lambert (1992) outlined another set of common factors: 1) extra-therapeutic factors; 2) therapy relationship factors; 3) model and technique factors; and 4) expectancy, hope and placebo factors. In yet another interpretation of common factors in psychotherapy, Duncan and Miller (1997) describe a "unifying language" (Ch.2) based on what all therapists do that contributes to successful clinical work. The key here is that clients identify the importance of being cared for, respected and being understood by the therapist (Lambert, 1992).

Having noted a range of common factors described in the literature – with also no agreement on what are the 'true' common factors -- let us note that it is extremely difficult to even compare psychotherapeutic approaches in terms of efficacy. Many of the experiments attempting to demonstrate that one therapeutic approach is better than another have been shown to be non-replicable, statistically insignificant and prone to the psychotherapeutic biases of the experimenter, also known as "allegiance bias." In explaining this "allegiance bias," Hengartner (2018) writes:

In their meta-analysis, Leichsenring and Rabung (2011), both devoted to psychoanalysis, concluded that long-term psychodynamic therapy is markedly superior to short-term modalities such as CBT. Conversely, Smit et al. (2012), found no evidence for the superiority of long-term psychoanalysis related to their primary outcome of recovery as well as to all of their secondary outcomes comprising target problems, general psychiatric symptoms, personality pathology, social functioning, overall effectiveness, and quality of life. Finally, a meta-analysis conducted by Tolin (2010) concluded that CBT was superior to (short-term) psychodynamic therapy for depression and anxiety disorders (pg.2).

Hengartner notes that “allegiance bias” is pervasive in much of the literature and is but one component of the replication crisis in psychology. He writes that “reported associations are systematically inflated and many published results do not replicate, suggesting that the scientific psychological literature is replete with false-positive findings” (Aarts et al., 2015; Pashler and Harris, 2012; Yong, 2012) (pg.1). The key question then becomes: if one cannot even determine the relative effectiveness of one psychotherapeutic method over another or their equal or equivalent value, how can one derive “common factors” that all such therapies supposedly share?

Indeed, criticisms of the common factors approach can be found throughout the literature. Critics argue that rather than common factors, it is the therapeutic relationship itself that seems to be the best predictor of outcomes (Bachelor & Horvath, 1999). Much

of this suggests that common factors have not been scientifically validated and that much of the commonality amongst therapeutic methods can be credited to the collaboration between the therapist and client/patient and based on the strength of the therapeutic relationship (Hofmann & Weinberger, 2007, p.107). Laska and Wampold (2014) also make note that it is important to specify common factors that make psychotherapy effective. But is this even possible? Psychotherapy exists within the complex social world and perhaps its effects and implications are simply not measurable within the bounds of science. See for example the criticisms of psychology and the social sciences in general by the mathematician and complexity researcher Nassim Nicholas Taleb. As a study by Nosek, Cohoon, Kidwell and Spieson (2016) found there was an inability to reproduce studies published in leading psychology journals. This confirms my idea that it is difficult to replicate the results of any one particular study because psychotherapeutic factors vary enormously. Furthermore, it is difficult or nearly impossible to replicate the findings of laboratory experiments in the complex social world.

My aim in this paper, then, is not to engage in a debate over whether or not such common factors exist. As many of us practicing psychotherapy are aware, the current replication crisis in psychology and other social sciences suggests that much of the literature is in a current state of flux and that a range of bedrock beliefs and approaches are being questioned for their scientific validity; however, at a very practical level, I do not believe empiricism is necessary in the service of improving the therapeutic allegiance between client and therapist. Rather, I believe it is more important to take the advice and lessons learned from myriad practicing counsellors over many years. Can we use this advice as a practicing wisdom, as general guidelines and guidance for counsellors on the

path to strengthening the therapeutic alliance? I set out to do exactly this in the pages that follow.

Again, I emphasize this approach does not consider such factors as set in stone. These factors and the resulting checklist I aim to create are to be considered helpful suggestions rather than a mandatory decree; they must be flexible and customizable – and the present requirements and circumstances of the therapist and his or her client must always be taken into account. With all this said, I do believe we can derive and outline common factors that can be helpful in guiding the therapeutic relationship and in making it stronger and more effective.

### **The Qualities of a Checklist**

Checklists are often used in a range of industries to better ensure quality delivery of service, and the maintenance of high standards, effectiveness and safety. For example, in the medical profession, doctors, nurses and surgical specialists use checklists to ensure proper procedures are followed and critical steps are not missed accidentally or as the result of tiredness, inattention, etc. In the airline industry, pilots use checklists to ensure that they are performing at the highest standard and in a safe, authorized manner. All these professionals use checklists to avoid relying only on memory (which can often fail us, especially in stressful or time-demanding instances). Instead, checklists offer a proven path forward. As Atul Gawande writes in *The Checklist Manifesto*:

Good checklists...are precise. They are efficient, to the point, and easy to use even in the most difficult situations. They do not try to spell out everything –a checklist cannot fly a plane. Instead they provide reminders of only the most critical and important steps—the ones that even the

highly skilled professional using them could miss. Good checklists are above all practical.

Gawande's last point is critical, and something I hope to consider throughout this paper. Any checklist designed for counsellors must not dictate terms of use, but rather be a practical and useful tool that will be used, as required, by the counsellor. It is also important to note not all checklists are of equal value -- there are good checklists and bad checklists. Bad checklists, as Gawande writes, could be described as too long, hard to use, impractical, or spell out too many steps, treating the person using it as an incompetent. Good checklists provide reminders of only the most critical and important steps – the ones that even the highly skilled professionals using them could miss.

Gawande further notes that there can even be a stigma or an embarrassment about using checklists. There are those who believe that to use a checklist suggests that one is not up to task and not able to perform at the required level without an “aid.” Some might even consider it a type of cheating – as if one is supposed to have the memory of a computer. Yet it has been shown that even the smartest professionals and those considered experts in their field do make mistakes and miss things. It is human fallibility but also a reflection of our modern world. As Gawande writes, the “volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely, or reliably.”

Gawande describes checklists as often taking two formats, either a READ-DO or a DO-CONFIRM. With a DO-CONFIRM checklist, the team members perform their jobs from memory and experience, often separately. But then they stop to run the checklist and confirm that everything that was supposed to be done was done. With a READ-DO

checklist, people carry out the tasks as they check them off, one by one. This type of checklist is like following a recipe, Gawande suggests. In terms of counselling, and again with practicality in mind, the type of checklist, whether DO-CONFIRM or READ-DO, might vary according to the preference of the therapist, the client and the environment in which counselling is undertaken. For example, in my own experience as a novice therapist, I might tend to make use of both formats simultaneously, one to frame my counselling sessions as they take place in real time (READ-DO), and the other to use upon reflection after my sessions (DO-CONFIRM).

To summarize, a good checklist should contain the following key characteristics. It should be:

- Short and precise
- Deal efficiently with key issues
- Flexible and adaptable
- Customizable by the counsellor and with regard to each and every client
- Accompanied by an introductory and explanatory note in order to explain its benefits and to de-stigmatize the idea of using a checklist.
- Based on real –world best practices from counsellors in the field rather than on theoretical discussions conducted by non-practitioner academics
- Acceptable to a range of methodologies -- given the “allegiance bias” and the difficulty of demonstrating the superiority of one method over another, the checklist should encompass and be open to many different psychotherapeutic methods, allowing for its use by as many psychotherapists as possible.

As discussed above no single factor can be attributed solely to the strength of the therapeutic alliance; instead, there are many common factors, including placebo and extra-therapeutic approaches that can, implemented together, strengthen the relationship between counsellor and client. My next chapter will focus more specifically on what these components are and how they assist in developing an effective therapeutic relationship. Consideration of how the therapeutic alliance is made strong is critical in developing a useful and practical checklist for the counselling profession.

## **Chapter Two**

### **The Therapeutic Relationship**

Much of the literature, in discussing, common factors, focuses on the importance of the therapeutic relationship. The therapeutic relationship encompasses a range of variables some focused on the client, others focused on the counsellor and still others focused on them both. As written in the previous chapter, there are five specific factors identified by Goldfried (1992) that are contained within all psychotherapies.

These are similar to Lambert's (1992) description of four therapeutic factors (extratherapeutic, common factors, expectancy or placebo and techniques) as the principal elements for improvement in psychotherapy. Miller et al. (1997) expanded the use of the term common factors to include four specific factors: client, relationship, placebo and technique as contained within the therapeutic alliance. Lambert estimates that the impact of psychotherapy is 40 percent related to client factors, 30 percent related to client-counsellor relationship factors, 15 percent related to placebo and 15 percent related to the therapy model and technique. What all such analysis appears to have in common is the strong emphasis on the necessity and health of the therapeutic relationship.

Consequently, in this chapter, I will focus on the therapeutic relationship as a reference point for most common factors. A therapeutic relationship includes client components, therapist components and shared client-counsellor components; I will assess all of these in order to identify the key qualities that strengthen the therapeutic relationship. These qualities can then be used and referenced as part of an effective checklist.

The therapeutic relationship or working alliance is the primary mechanism facilitating treatment (Sugarman, Nemiroff & Greenson, 2000 in Pledge, 2004). The working alliance refers to the positive relationship established between the client and the therapist. It is the vehicle that facilitates change. The development of a propitious therapeutic alliance is deemed central to positive therapy outcomes in individual therapy (Horvath & Luborsky, 1993). A growing number of studies have found that the client's ratings of the alliance are more highly correlated with outcome (Horvath & Luborsky, 1993).

Rapport and relationship are so important to help clients push through challenging or difficult issues. The initial stages of counselling include establishing this rapport, engaging the client, managing confidentiality, and establishing norms – in other words, building and strengthening the therapeutic alliance.

The therapeutic relationship relies on collaboration not authority. As a therapist, one must encourage the client's active participation, respecting their opinions, perspectives, experiences and their view of the world and themselves. Harlene Anderson has described collaboration as a specific mode of relationship defined by mutuality and reciprocity, a participatory and purposeful activity and exchange flowing in many directions (Anderson, 1997). In a collaborative relationship participants take a position of respect and curiosity, each one positions herself as someone who can learn from the other and with the other. Collaborating is a way of connecting, a way of creating bonds that invite agency and a sense of belonging (Anderson, 2012).

Such an approach fosters a more authentic interaction between counsellor and client, helping to establish the norm that conversations with a counsellor can be different

– safer than perhaps conversations a client might have with parents, employers and others, who may be more judgemental of and have less rapport with the client. The client is given permission to be different in a therapeutic relationship, exploring new ways of behaving and these implicit messages of safety and non-judgement help build a strong rapport. Having a basis of authenticity and respect for the client furthers this approach. The therapist's authenticity and empathy allows clients to participate in the relationship with honesty, allowing themselves to be vulnerable; this is often very different from the way clients might interact with others in their lives.

### **The Client**

As Miller notes, “the client is actually the single, most potent contributor to outcome in psychotherapy.” The client is the most important contributor to outcome in psychotherapy because the client will have extra-therapeutic factors that may influence their lives outside the therapeutic alliance (Miller et al., 1997.p.25). These factors might include optimism, faith, supportive family and friends. Miller et al. notes that 40 percent of therapeutic improvement can be attributed to such client factors.

A therapist must consider such client-related factors as part of engaging with the client. For example, it would be important to consider if the client is comfortable and feels safe in participating in a therapeutic dialogue with the counsellor. Clients are seeking assistance for something that is troubling them and may find the counselling process intimidating or the client might be ashamed about the need to seek help. I believe that it is very important for the therapist to treat the client with unconditional positive regard -- as hard as that ideal may be to uphold. As therapist, it will be difficult to remain perfectly positive and supportive for any length of time (Bankart, 2007). Nonetheless, I

believe the therapist must seek to do the best they can with the resources provided to them. Helping the client feel comfortable in the session is critical (Pledge, 2004). Inquiry questions to help the therapist connect with client could help. Does the client have previous experiences with therapy? Are they optimistic about how therapy might assist them? These expectations could either help the therapeutic sessions move forward or could become potential obstacles.

In a typical first interview with a child or adolescent, for example, it's important to focus on less sensitive topics to help ease any anxiety (Pledge, 2004). The counsellor can help set the tone for client-related factors to positively impact the client both inside and outside of therapy. This can also be useful when counselling highly sensitive and/or anxious clients. Observations from individual therapy suggest that difficulties in therapy arise when clients are not comfortable in the counselling environment. This results in less self-disclosure, and emotional and interpersonal responsiveness from the client (Alexander & Anderson, 1994; Saunders & Edelson, 1999).

Another factor to consider is a client's stage of change – their present situation and feelings. For example, does the client feel any resistance to attending counselling? Are they being mandated to attend counselling to change some aspect of their behaviour such as an addiction problem or are they coming to counselling voluntarily? Prochaska and DiClemente (1984)'s six distinct stages speaks to a client's motivational readiness to make positive changes in their life:

- Pre-contemplation (Not yet acknowledging that there is a problem behavior that needs to be changed)

- Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)
- Preparation/Determination (Getting ready to change)
- Action/Willpower (Changing behavior)
- Maintenance (Maintaining the behavior change)
- Relapse (Returning to older behaviors and abandoning the new changes)

These factors can assist in determining the motivational readiness of the client, and consequently, better assist the counsellor to build rapport. If the client is not ready to make positive changes or is happy enough with their life as it is, counselling will likely not be as effective or may not be necessary.

Yet another client-related factor that can affect the therapeutic relationship is a client's attachment style. For example, research in attachment theory has shown that clients' attachment patterns influence the quality and development of the therapeutic alliance over time (Daniel, 2006). Attachment theory proposes that an individual's prior interactions with attachment figures, that is a child's early interactions with caregivers, develop into templates that will guide the way they form connections and perceive their relationships with others (Zorzella, Muller & Classen, 2014). Attachment has emerged as an important factor associated with therapy process and outcome (Davila & Levy, 2006). This factor doesn't specifically have much to do with the counsellor, but instead affects the client directly, and through this, his or her relationship with the counsellor. The adult attachment classification system was developed based on studies using the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) and comprises three main categories: free-autonomous (secure), dismissing (avoidant), and preoccupied

(resistant/anxious/ambivalent). The unresolved classification (disorganized) was given to individuals who demonstrated lack of resolution with respect to the loss of an attachment figure, or to other traumatic events, in the AAI (Main & Goldwyn, 1991/1998).

Alexander and Anderson (1994) described relational patterns and difficulties commonly displayed by traumatized clients from different attachment groups, which are likely to influence the developing alliance in individual therapy. Secure clients are better able to express emotions and resolve interpersonal conflicts, and they show higher self-esteem. Preoccupied clients demonstrate dependence and neediness, and they are prone to strong emotional reactions such as anxiety and anger. Dismissing (avoidant) clients exhibit discomfort with intimacy and denial of distress. Unresolved (disorganized) clients present higher levels of disorganization, distress and depression, dissociation, and difficulties with impulse control.

### **The Therapist**

Bankart (2007) writes that the theoretical orientation, therapeutic method, choice of technique and professional allegiance are variables of almost no real weight in determining the degree of success a client will encounter in psychotherapy. All psychotherapy outcome research agrees that one variable predicts the relative success of the therapeutic process: personality, personal style and ‘psychological presence’ of the therapist (Bankert, 2007, p. 18-19). A client who is working with a caring, competent and skilled practitioner with whom the client can establish a working relationship almost can’t go wrong.

Some therapists are more effective than other therapists, irrespective of the model they practice – and much of this appears to do with personality. Sensitivity and flexibility

may allow therapists to attune to the specific needs of their unique client (Miller et al., 1997). A therapist may need to be flexible and willing to change their relational stance to fit with what would be most helpful to the client. Other personal characteristics of the therapist could include humanness, sensitivity, and being non-judgmental. Some clients will prefer a formal or professional manner to a casual or warmer one. Some might appreciate more self-disclosure from their therapist or greater direction or, in contrast, a more laid-back pace and style (Bachelor & Horvath, 1999).

In client-centered therapy, the therapist's attitude is more important than the therapist's skills. To form a strong therapeutic alliance the therapist needs to consider the core conditions of effective psychotherapy: (1) genuineness, (2) unconditional positive regard, and (3) empathy (Miller, Duncan & Hubble, 1997, p.27). In Colin Sander's (2016) article, *Toward an Aesthetics of Engagement* he brings light to another perspective of a therapist's role being akin to a host/hostess. As he writes: "(t)he importance within therapeutic contexts of being hospitable, demonstrating presence, bearing witness and attending to an expanded understanding of language . . . collaborative intention has always been about fomenting beneficial relationships, creating and building upon presence within the relationship, listen and responding to co-identified needs and desires simply from a human relational perspective" (p. 2).

As Sanders notes, in a sense, we are "hosting the client." This means we must always treat the client with the respect and graciousness of a hospitable host. This perhaps best explains why psychotherapy can have successful outcomes using a range of theoretical approaches -- and, similarly, why psychotherapy can result in failure using

that same range. As Bankart (2007) indicates, it is not so much the theory that matters as it is the counsellor's commitment to the therapeutic working alliance that matters most. How does a therapist cultivate this inner work? Attention and awareness of personal boundaries, limitations and biases is necessary to be an effective clinician. Being honest with yourself regarding your concerns and fears will make you a better therapist. Using all of our experiences, our emotions, and our intellect become our psychotherapeutic tools.

Consistency in the therapist's style and personality can also be important. Therapists who remain the same in their style and tenor over the course of treatment, often create a sense of consistency that better allows for alliance growth.

### **Client and Counsellor Factors**

It is the therapeutic relationship that influences outcome and this relationship involves both client and counsellor. Together, the client and therapist establish the therapeutic alliance or partnership between the client and therapist to achieve the client's goals (Bordin, 1979 in Barry Duncan, 2002). In this interaction, the therapist himself or herself, their personality, and how the client feels about the counsellor predict the degree of improvement in the client (Gurman, 1977). We have already noted that what the client expects from treatment and their assessment of the credibility of the therapy's rationale and techniques are client-focussed factors. Yet it is also true that both therapist and client must believe in the positive and hopeful expectations of a good outcome for there to be therapeutic improvement. This belief can be strengthened by the therapist's attention to the client's goals and careful monitoring of the client's reactions to comments, explanations, interpretations, questions and suggestions. For this reason, the most helpful

alliances are likely to develop when the therapist matches the client's definition of empathy, genuineness, and respect, which Rogers considered the core conditions of psychotherapy (Miller et al., 2007, p. 28). It is a counselling approach that emphasizes the client takes an active role in his or her treatment with the therapist being non-directive and supportive. Rogers believed people are capable of self-healing and personal growth, which leads to self-actualization, an important concept in client-centered therapy. The goals of client-centred therapy are increased self-esteem and openness to experience. Client-centred therapists work to help clients lead full lives of self-understanding, and aim for a reduction in defensiveness, guilt and insecurity as well as more positive and comfortable relationships with others with an increased capacity to experience and express their feelings.

Miller et al. described the core attributes that I believe all good counsellors need to possess to build a strong therapeutic alliance: safety, warmth, empathy, good listening ability and genuine caring. Carl Rogers notes that these feelings are the "necessary and sufficient conditions to effect change in clients" (Miller et al., 1997, p 89). I feel it would be helpful to set a goal to always be mindful, present, and attentive to client needs. And if the client too matches such goals, the therapeutic alliance is greatly strengthened and the likelihood of therapy success increases.

The strength of the therapeutic relationship is a key factor in determining a successful outcome in counselling. Weak therapeutic relationships between client and counsellor will likely result in ineffective therapy. By comparison a strong therapeutic relationship can help promote significant change in the client and consequently positive outcome in the therapy. Therefore, any useful checklist for counsellors should incorporate

the best characteristics, approaches and processes to strengthening the therapeutic relationship.

This chapter highlights the importance of having a strong working alliance and therapeutic relationship. In the next chapter, I will further discuss and isolate the key qualities a counsellor should possess in order to enhance the client's perception of their therapist as competent. A client's expectations of their counsellor are an important factor that will influence positively or negatively on the outcome of psychotherapy. I will discuss below some of the ways the therapist can cultivate their effectiveness as a therapist.

### **Chapter Three**

#### **The Effective Therapist**

Given the importance of counsellor interactions in determining client outcomes, it is critical that we examine in-depth some of the most important qualities of an effective therapist. As we have already discussed, there are many qualities that a therapist might cultivate to create a strong therapeutic alliance and foster positive growth and change in the client. Those I focus on here include empathy, compassion and kindness.

High empathy counsellors appear to have high success rates regardless of theoretical orientation. Low-empathy and confrontational counselling, in contrast, has been associated with higher drop-out and relapse rates, weaker therapeutic alliances, and less client change (Moyers & Miller, 2013, p.878). In a literature review conducted by Slater and Mitschke (2011) the authors examined the qualities of positive relationship dynamics between adolescents and their school-based counsellors; they found a number of counsellor qualities that contributed positively to the working alliance between the client and counsellor. Of great importance was a counsellor's possession of high emotional intelligence. Emotional intelligence encompasses a range of qualities including the ability to competently "read" the emotions of others while simultaneously avoiding the pitfalls of empathy and emotional contagion – which we will discuss later in this chapter. Emotional intelligence aids in the client's perception that their counsellor is dependable, experienced and confident -- essential components of building a strong therapeutic alliance (Ackerman & Hilsenroth, 2003). Emotional intelligence can also assist in developing a clear communication style (Price & Jones, 1998), another key factor in successful counselling sessions.

**Empathy, Compassion and Kindness**

According to the Merriam-Webster Dictionary, empathy is “the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner.” Another description of empathy comes from the Dictionary of Conflict Resolution, Wiley describes empathy as “non-judgemental understanding of another person’s perception and viewpoint and should be distinguished from sympathy, which implies emotional identification with another person’s plight.” Authors Miller, Duncan and Hubble (1997) describe empathy as an attitude that places the client first (p. 112).

By comparison, Paul Bloom (2016) writes in his book *Against Empathy* that empathy can be both a force for good and a source of destructiveness – at the same time. He writes that even psychopaths may be empathetic and that is why they know how to torture their victims. He believes that empathy is not enough and that one needs good moral reasoning. Bloom argues that one must first empathize and then act with kindness and compassion. This process of moral reasoning requires both qualities, not just one or the other. A counsellor needs to be an empathetic ally, listening to the client. This first empathetic response will allow the counsellor to understand what the client may be feeling. But this is only a precursor to then demonstrating kindness and compassion, helping the client, making him or her feel listened to and understood.

Bloom makes clear that there can be a tipping point where empathy becomes more destructive than constructive. Bloom writes that empathy can be broken down into two types of empathy: emotional empathy and cognitive empathy. Emotional empathy, also described as emotional contagion, occurs when an individual is influenced by

another person's emotional state to the extent of taking on the other person's emotions. A disproportionate amount of emotional empathy can lead to emotional vulnerability and burnout, also known as compassion fatigue. Figley (1995) defines compassion fatigue as a state in which professionals become emotionally affected by vicarious, perceived or personal witnessing of the trauma of a client or family member. Compassion fatigue may lead to decreased motivation, lack of empathy towards clients and diminished overall performance. Small tasks can become overwhelming, and counsellors may project their anger towards others.

On the positive side, cognitive empathy can lead to a healthy understanding of what the client may be feeling and allow the therapist to relate well to the client while maintaining a detached concern. As noted by Leppma and Young (2016), cognitive empathy is the accurate perception of another person's emotional experience combined with feelings of concern for the other person's well-being while not vicariously experiencing the other person's emotional state. Skovholt and Trotter-Mathison (2016) highlighted the importance of resilience and self-care activities as protective factors for compassion fatigue and to promote cognitive empathy. Balancing self-care and client-care is a challenge for many counsellors, but is also critical to surrounding oneself with cognitive empathy and minimizing emotional empathy and its emotional contagion and compassion fatigue.

Given the evidence from the common factors literature that empathy and a strong therapeutic alliance have an important influence on psychotherapeutic outcomes (e.g., Norcross & Wampold, 2011), in principle, increasing trainee and qualified therapists' empathy for their clients could help improve the effectiveness of their clinical

work. Again, as Bloom notes, it's important to qualify the type of empathy that is desired and minimize emotional contagion.

The therapist can strengthen their empathetic response by showing their client that they are trying to understand what the client is thinking. This can be communicated by matching the client's body language and mirroring the client's verbal style, as well as by allowing the client to speak in a way such that the client feels she or he is really being heard. Practicing empathy might also mean first practicing empathy on one's self. And as the therapist's empathy develops within herself, the practice may naturally expand to include others. A study by Leppma and Young (2016) suggests six weeks of practicing loving-kindness meditation (LKM) increases empathy levels. Loving kindness is originally a Buddhist concept that actively cultivates feelings of kindness, compassion, and care toward oneself and others, and its use has been suggested as a means to enhance clinicians' self-care (Shapiro & Carlson, 2009). In another study, Shapiro, Brown, and Biegel (2007) demonstrated that "meditation may be an effective intervention for therapists in-training, reducing stress, anxiety, negative affect, rumination and significantly increasing positive mood and self-compassion" (Leppma & Young, 2016, p. 298). Another leader in mindfulness meditation, Jon Kabat Zinn found that LKM can both generate positive feelings and facilitate the letting-go of resentment and other negative emotions. LKM principles are useful for alleviating stress, boosting well-being, and improving interpersonal relationships. As Leppma and Young (2016) note, "LKM was shown to be effective in increasing several personal characteristics and resources important to counsellor wellness and efficacy such as compassion (Weibel, 2007), connectedness (Seppala, 2009), empathic response (Lutz, Brefczynski-Lewis, Johnstone,

& Davidson, 2008), environmental mastery, social support, and purpose in life (Fredrickson et al., 2008)” (p.298).

Consistent practice over time allows those who meditate to access feelings of kindness, compassion, and acceptance toward self and others, as well as a sense of connection with all other beings. It has been suggested that self-care in therapists involves self-awareness, self-regulation, and the ability to balance the needs of self and others. The ability to care for oneself has been viewed as related to the ability to be compassionate toward others (Gilbert, 2005). As such, loving-kindness meditation teaches people not to identify with negative emotions and self-judgments and to recognize their own essential nature (Shapiro & Carlson, 2009).

According to the Buddha, "You can search throughout the entire universe for someone who is more deserving of your love and affection than yourself, and that person is not to be found anywhere. You yourself, as much as anyone in the entire universe, deserves your love and affection" (as cited in Salzberg, 1995, p. 31).

Once such loving-kindness has been honed in one's self, then the circle of caring is gradually expanded to others, typically a benefactor and then loved ones, neutral people, difficult people, and ultimately the entire universe (Salzberg, 2005).

It should be noted that the criticisms of LKM include the claim that because LKM is derived from Buddhism, it may turn away those who are against religion; another criticism is that meditation can sometimes be a challenging practice with obstacles that can include craving, anger, boredom, restlessness, and doubt (Kabat-Zinn, 2005). While such criticisms should be considered by the individual counsellor, I believe the literature

and practice demonstrates the benefits of LKM is assisting the counsellor to be more empathetic – and to incorporate empathy along with kindness.

Other studies suggest that empathy can be learnt through role-playing exercises. As both counsellor and client engage in role-playing scenarios, empathy for both client and counsellor can increase. Kelm, Womer, Walter and Feudtner (2014) notes that there are role-playing studies that have helped medical students to positively cultivate empathy by practicing being a patient. This role-playing approach, however, appears to only consider a more traditional definition of empathy, failing to view empathy for both its good and bad components. Again, the strength of the LKM approach to building empathy is that it focuses on the right kind of empathy by combining it with loving-kindness because, as Bloom reminds us, both empathy and kindness are required in our relationships.

### **Emotional Intelligence**

Another critical quality of effective therapists is having high emotional intelligence. As Daniel Goleman (1995) writes, more important than high IQ, emotional intelligence is the strongest indicator of human success in terms of self-awareness, altruism, personal motivation, empathy, and the ability to love and to love others. A counsellor who develops high emotional intelligence is better able to employ their rational thought processing, control their impulses and read the emotions of others so as to apply compassion and moral reasoning in dealings with clients without getting swept away by their own emotional contagion.

Individuals with high emotional intelligence levels not only notice emotions in the tone of other people's voices, gestures, mimics, and verbal statements but also use an

empathetic approach. The individual who can manage their own emotions and understand those of others provides more constructive and positive reactions in dealing with emotional problems and social relationships (Mayer, Salovey, & Caruso, 2004).

Goleman identified a framework of five elements that define emotional intelligence: emotional self-awareness, emotional self-regulation, emotional self-motivation to make changes, empathy, and social skills that nurture relationships. He calls these abilities of intelligence -- self-control, zeal, persistence and the ability to motivate oneself -- emotional intelligence (Goleman, 1995, p. 79).

Emotional intelligence may help prevent compassion fatigue as a study by Gutierrez and Mullen (2016) found. They examined family therapy counsellors and found those counsellors with high emotional intelligence had lower levels of career burnout. A high level of burnout is related to poor job performance for counsellors (Lawson et al., 2007; Lee et al., 2007 in Gutierrez & Mullen, 2016). When counsellors experience burnout, they are likely to de-personalize their clients (Maslach, 2003), limiting their ability to develop an effective therapeutic alliance. As noted previously, building an effective therapeutic alliance is crucial to being an effective counsellor (Rogers, 1957), and accounts for the largest portion of client outcomes (Norcross & Wampold, 2009).

The American Counselling Association (2014) Code of Ethics states that it is a counsellor's responsibility to monitor his or her own risk for impairment and limit, lessen, or suspend services accordingly (Section C.2.g). In other words, it is the ethical responsibility of counsellors to monitor their risk of burnout, and in order to do so, they

need emotional self-management and regulation skills. These skills are core characteristics of emotional intelligence (Goleman, 1995).

Several researchers have employed psycho-educational strategies to increase emotional intelligence (Nellis, Quoidbach, Mikolajczak, & Hansenne, 2009). These researchers created brief training workshops on the topic of understanding emotions, identifying emotions, expressing and using emotions, and managing emotions. During the workshop, facilitators used a variety of techniques, including dramatization, experiential activities, and lectures based on the latest research findings on emotion. Findings indicated that participants did increase their emotional intelligence using these techniques. Moreover, Nelis and colleagues (2009) reported that changes remained significant at six months after the training sessions. Counsellors should attend and consider facilitating similar workshops for counselling professionals in their area to strengthen a counsellor's ability to self-regulate and manage stress and emotions as they are occurring in session or in the work environment.

Additionally, researchers have found that meditation practice can increase emotional intelligence (Chu, 2009; Lomas, Edgington, Cartwright, & Ridge, 2013; Perelman et al, 2012 in Gutierrez & Mullen, 2016). Study results indicate that greater mindfulness was associated with higher emotional intelligence. Counsellors can begin by taking small steps, such as reading the latest research on emotions or beginning a brief meditation practice that they can employ before seeing clients. Counsellors (especially those new to the counselling profession) should also consider expanding their understanding of the way emotions influence their health (i.e., increasing their cognitive-emotional aptitude), in addition to employing a wellness plan.

Given that counselling can be as difficult as it is rewarding, it is important that counsellors find effective ways of keeping themselves fit for the profession and develop an understanding of what factors may prevent burnout. The findings from all these studies indicate that such an approach both increases one's empathy and emotional intelligence levels and may help keep the wellness of the counsellor intact.

In concluding this chapter, it is important to note that empathy is a critical quality for a counsellor to have, but as Bloom makes clear, it is a particular type of empathy that is most important: cognitive empathy, one that includes a sense of detached kindness. As the research quoted above indicates, empathy on its own can, in fact, be detrimental to the client-counsellor relationship as it can lead a counsellor to emotional contagion and result in compassion fatigue and stress on the counsellor. The best empathy is one that is expressed by a counsellor that has a high emotional intelligence and that is why having high emotional intelligence is critical to being a good counsellor. Emotional intelligence helps by equipping and strengthening a counsellor's ability to self-regulate and manage stress and emotions as they are occurring in session or in the work environment. Becoming aware of emotions and correctly defining them allows the individual to better understand themselves and others. Emotions are an important component affecting and directing thoughts and behaviour (Beck, 2011).

In the next chapter, I will assess the literature and assess what current tools exist to guide counsellors and measure their performance.

## Chapter 4

### Existing Approaches

In this chapter, I will assess the existing approaches to measuring a counsellor's performance. What does the literature say about these approaches? What do such approaches cover? What are the strengths and weaknesses of each such approach? How does my focus on a checklist for counsellors differ from existing approaches and does my checklist add value to the existing performance assessment structure?

None of the current literature describes a checklist as I propose it. Instead the literature is full of alliance assessment scales and other client feedback and review mechanisms. While these assessment scales and review mechanisms are important, they serve a very different purpose from what I am proposing in a checklist.

The scales and assessments provide a feedback mechanism to understand how effective a counsellor is and how well he or she is interacting with the client but often this is *after the fact*. By comparison, my checklist is designed to be used both *during* the session and *after* the session in order to ensure best practices are being followed by the counsellor, strengthening the therapeutic alliance *during* each counselling session.

Another point of differentiation between my checklist and the assessments reviewed in the literature is that my checklist is a flexible and dynamic guide for the counsellor. My emphasis in the checklist approach is to provide *guidance* during the counselling session. By comparison, existing assessment scales focus more on performance – on measuring a counsellor's aptitude and excellence. While a checklist like mine will ultimately improve a counsellor's performance if followed, it is also there

to build a counsellor's confidence while strengthening the therapeutic relationship. It is a *guide* rather than a test or evaluation mechanism.

Finally, my checklist approach is designed to be used by the counsellor alone, not by the client. The assessments I review below often include components that can be used by both the counsellor and the client, to each assess the therapeutic alliance. Because my proposal is designed specifically to help guide the counsellor through each counselling session, it does not contain a component to be filled out by the client. As such, it is only one tool in the toolbox for counsellors. Getting feedback directly from the client is clearly critical. Therefore, the checklist I propose can be used in combination with other tools that get feedback about a counsellor's performance directly from the client. For example, combining my checklist designed for use by the counsellor with an assessment scale (like the ones described below) designed to be completed by the client could be one approach. The counsellor could then receive detailed guidance during and after the counselling session using my checklist as well as receiving direct feedback from the client through an assessment scale. Combining these approaches could be helpful in further strengthening the therapeutic alliance. In asking a client to fill out an assessment scale, however, a counsellor must always keep in mind that a client might feel pressured to provide a positive review to the counsellor. And this review might not reflect the true views of the client because the client does not want to offend the counsellor. This is why performance surveys in other settings are often anonymous, removing the pressure a client might otherwise feel to provide a positive review. Yet if a client is asked to fill out such a survey immediately after a therapy session, such anonymity is impossible.

Before describing the full details of my own checklist proposal, we must first examine the assessment approaches that currently exist. Below, I outline four popular existing scales that assess the strength of the therapeutic alliance. For each of these scales I cover the following areas:

- Brief summary of each existing scale
- Strengths of the scale
- Weaknesses of the scale
- Should my checklist include any of the scale themes/ideas?

### **1) STAR (Scale to Assess Relationships)**

A 2007 article by McGuire-Snieckus, McCabe, Catty, Hansson and Priebe determined that they could not find any instrument developed to assess the therapeutic relationship in community psychiatry – so they undertook to develop one. The authors conducted a study of therapists and patients to assess nine established scales measuring more than 100 items. The STAR scale was designed to assess the therapeutic relationship in community mental health care. The authors created a brief patient (Star-P) and clinician scale (Star-C) each having 12 items that are composed of three factors/subscales: positive collaboration, positive clinician input and non-supportive clinician input in the patient version and emotional difficulties in the clinician version. The scale includes rankings for therapist helpfulness, patient aggression and family interference.

Strengths of the scale include internal consistency and test-retest reliability. Also, the scale is brief and easy to use, has versions for patients and clinicians and includes good psychometric properties.

Regarding weaknesses of the scale, the authors make note that there needs to be future research in treatment adherence, admissions and symptom severity – and the scale does not assess these measures. Other limitations include the sample on which the scale was based was very small. The most difficult types of people to engage by therapists refused to take part in the study and consequently the scale may be more biased in representing clients eager to undertake therapy. A larger sample size would have been preferred as well and the authors note that the scale was developed in a deprived multi-ethnic inner city area and has not been tested outside the context of Western health-care systems (McGuire et al, 2007, p.93). I found many questions in STAR redundant. A statement like “I get along well with my patient” seems to mean the same thing as “my patient and I share a good rapport.” And “my clinician and I are open with one another” is most likely the result of “my clinician and I share a trusting relationship.” So the assessment statements included in STAR are often repetitive and redundant, and the survey could be made more succinct by reducing some of these redundancies.

It is worth noting that the STAR scale does include measures to assess a client’s goals, rapport, and empathy but was missing measures to assess a client’s growth, learning and insight and also does not include assessment of a therapist’s self-care – items that I feel should be assessed. A mix of negative and positively worded questions was evident, and I would include this approach in my own checklist.

## 2) Working Alliance Inventory (WAI)

The Working Alliance Inventory (WAI) by Horvath and Greenberg, 1989 and the Working Alliance Inventory-Short (WAI-S) by Tracey and Kokotovic, 1989 are widely used to measure the state of the client-therapist alliance.

Horvath and Greenberg (1989) developed the 36-item Working Alliance Inventory, influenced by Bordin's alliance theory (1979) to measure the strength of the therapeutic alliance between client and therapist. Later, a 12-item form -- the Working Alliance Inventory-Short Form Revised (WAI-SR) of the WAI -- was developed by Tracey and Kokotovic (1989). The WAI-SR has similar properties as the 36-item version but the 12 question short form requires less time to complete, and is therefore less burdensome for patients and more appropriate for repeated measurements over time in clinical practice and research.

Bordin defined the working alliance as a combination of (a) client and therapist agreement on goals, (b) client and therapist agreement on how to achieve the goals (task agreement), and (c) the development of a personal bond between the participants (Tracey & Kokotovic , 1989). Based on this definition, the WAI-SR measures these three aspects of the therapeutic alliance (goal, task, and bond). A key aspect of the therapeutic alliance is that it requires active negotiation and participation between patient and therapist. The WAI-SR is a patient-rated questionnaire. Patients rate items on a 5-point Likert scale anchored at each end with 'rarely or never' (1) and 'always' (5). The goal, task and bond domain search have scores ranging from 5 to 20. Higher scores indicate a better therapeutic alliance.

Strengths include the short time needed to complete the WAI-SR at approximately five minutes. Tracey and Kokotovic (1989) found that the 12 item questionnaire was easy to administer and it was developed to be used across theoretical orientations. Research indicates that feedback to clients and therapists based on client alliance scores can help identify and address problem areas in the alliance during therapy to the benefit of treatment outcome (Harmon et al., 2005). The WAI-SR helps both therapist and client increase the clarity of key alliance dimensions, helping focus therapist and client on efforts to improve the alliance. Tracey and Kokotovic also found that results for the short form were similar to that of the original, longer WAI (1989, p. 210).

One limitation of this approach was the small sample size used for the WAI. The WAI was initially tested on only 84 university counselling centre clients and 15 therapists who rated their work with 123 clients and administered the assessment after only one session. The client populations were predominantly white (Hatcher & Gillapsy, 2005, p.22). Tracey and Kokotovic (1989) make note that one session may not be enough time for a working alliance to develop and assess. Horvath and Greenberg (1989) view use of the WAI as most appropriate after the third, not the first, session. Assessing after the first session would not seem to give the relationship enough time to establish goals, agree on tasks, and form a mutual bond.

In comparing the 12 question scale I thought it covered all that I would want to include except for information about how the therapist is taking care of themselves in the sessions. Given that this questionnaire was focused on patient/client feedback, this exclusion is not surprising. I note that this questionnaire includes a question about the client's insight and growth: "What I am doing in therapy gives me new ways of looking

at my problem.” This type of question was missing in some of the other scales reviewed, and I feel this is an important area for any assessment or checklist to cover.

### **3) The Session Rating Scale (SRS)**

Duncan, Miller, Sparks, Claud, Reynolds, Brown and Johnson (2003) observed there was no alliance measure that currently existed for therapists to use on a daily basis with their clients; the authors developed an ultra-brief alliance measure: the session rating scale (SRS) version three based on Johnson, Miller and Duncan’s first version of the SRS, created in the early 2000s.

The authors note that SRS 3 is beneficial for use by clinicians to assess the therapeutic alliance after each therapy session so that changes in the approach and style of the therapist can be implemented if a negative experience is reported by the client (Duncan et al, 2003, p.9).

SRS is a four-item scale that allows the therapist to get a quantitative measure of the client’s assessment of the therapist-client relationship. Specifically, the SRS asks the client to use a sliding scale to assess their relationship with the therapist, whether the goals and topics cover what the client feels they need, how well the therapist’s approach fits the client’s needs, and an overall general assessment of their most recent session. Based upon the score of these measures, the therapist can determine whether the alliance is weak or strong. This enables the therapist to devote time to explore issues that will strengthen the relationship, such as shifting goals, changing their approach, etc.

One positive characteristic of SRS is that it is very short and quick to fill out with only four questions. An important point that Duncan et al. (2003) make is that the average therapist may be already overloaded with paperwork. So an assessment that is quick and

easy to review, and consequently does not add to a therapist's workload, can be very helpful and is more likely to be used by a therapist. In fact, Brown, Dreis and Nace (1999) found that the majority of clinicians did not consider any measure or combination of measures that took more than five minutes to complete, score and interpret (Duncan et al, 2003, p. 4). Duncan et al. (2003) also developed the SRS 3 using Bordin's three interacting themes (as described in the section above on WAI) using the measures for goal, task, and bond but with added focus on a client's theory of change, a measure for the level of confidence that the client feels the therapy and therapist will be helpful and the open expression of negative feelings. The last factor is supported by a study which suggests that clients who express low levels of disagreement with their therapist report better progress (Hatcher & Barends, 1996).

Research suggests that a client's rating of the alliance, as assessed in the SRS 3, is a far better predictor of outcome than is therapist's rating (Bachelor & Horvath, 1999). Conversely, clinicians who have access to outcomes data like that of SRS 3 can better identify clients who are not improving or getting worse and respond to those clients, thereby reducing the risk of dropout and negative outcome (Lambert, 2010; Miller et al., 2004).

Limitations of this study include that it is biased toward those who self-report (Boulet & Boss, 1991) as well as the relatively small samples used for analyses. Research with larger and more diverse clinical samples is needed and would further identify the strengths and weakness of the SRS, as well as its predictive ability of outcome.

The authors point out that no matter how reliable and valid a measure is, if it is not used, the benefits of alliance monitoring will not be realized, and the benefits are

considerable as evidenced by research results over the years demonstrating that as much 25 to 45 percent of outcome variance can be attributed to the alliance. More specifically, Miller, Duncan, Brown, Sorrell, and Chalk (in press) found that clients of therapists who opted out of completing the SRS were twice as likely to drop out of treatment and three to four times more likely to have a negative or null outcome.

I liked that the SRS 3 was the shortest and quickest questionnaire I reviewed, with only four questions to answer. It would be quite easy to administer and easy for the client to complete. The limitation is it is not very comprehensive but I think it provides a starting point for the counsellor to examine their therapeutic alliance. I want to ensure my checklist, in comparison, is both comprehensive and succinct. Non-comprehensive checklists in my opinion are not a particularly useful. And research indicates that given the extreme workload of most counsellors, an assessment that is too long and too time consuming to review will simply not be used by the counsellor (Brown et al, 1999). Therefore, I hope to develop a checklist that is both comprehensive and short.

#### **4) The Helping Alliance Questionnaire (HAQ)**

Developed in 1986, HAQ-1 was one of the earliest self-report and widely used measures designed to assess the therapeutic alliance (Alexander & Luborsky, 1986). It has been revised (HAQ-2) to currently have 19 assessment items and is widely used to measure the strength of the therapeutic alliance (Luborsky, Barber, Siqueland, Johnson, Najavits, Frank & Daley, 1996).

Luborsky et al. (1996) found that the HAQ as well as other measures of the therapeutic alliance have been successful predictors of outcome. HAQ-2 is an improvement on HAQ-1. HAQ-2 was revised to include 19 items and has good internal

consistency and test-retest reliability. Like the other assessments discussed, it too was influenced by Bordin's theoretical division of the alliance into "agreement on goals, agreement on tasks to achieve goals and bonds" (Luborsky et al., 1996 p. 260). Ten items focus on the collaborative relationship between client and therapist, the patient's perception of the therapist and the client's motivation.

HAQ-2 includes a mix of negative and positive items, which, as previously discussed, can be helpful in determining the strength of the alliance; for example, HAQ-2 includes the following statement for assessment: "The procedures used in my therapy are not well suited to my needs."

One key limitation of HAQ-2 is that it is more focused on collaborative work and helpfulness rather than on agreement about goals between client and therapist (Alexander & Luborsky, 1986).

HAQ-2 includes 19 items for the client and therapist to each assess. By comparison, the checklist I am proposing (in the next chapter) is designed as guidance for the therapist only, and includes 20 assessment features examining issues related to both the therapist and the client. In reviewing the patient version of HAQ-2, I found that it was missing a feature to assess the insight and learning of the client during therapy. HAQ-2 also did not include an assessment of a client's strengths. I think it is important for a therapist to better understand a client's insight, what the client has learned and what strengths the client possesses. I want to ensure that my checklist approach includes guidance for these characteristics.

And so we arrive at the final chapter, where I aim to pull together all I have explored and discussed so far and provide readers with a real, take-away product: a useful and practical checklist that counsellors can use to strengthen the therapeutic alliance.

## **Chapter 5**

### **The Checklist**

This chapter will discuss what an effective checklist, as I propose it, might look like. Based on the information gathered in the above chapters, there are many components to consider in developing a checklist that strengthens the therapeutic alliance. These components, encompassed within the checklist, can be sorted into three parts: the client, the counsellor and the therapeutic alliance or the counsellor-client relationship.

The checklist I am proposing can be used alongside any verbal or client solicited feedback via a rating and/or assessment tool. The checklist can be kept alongside the therapist as they conduct the therapy session to ensure they are considering elements that will help strengthen the therapeutic alliance.

Based on my analysis outlined the previous four chapters, I have synthesized the most relevant details into a checklist that can be used as a practical guide for counsellors. The checklist is presented in full at the end of this chapter. In developing the checklist, I have adhered to Gawande's recommendations for creating a useful checklist. This includes ensuring the checklist is succinct and easy to use. Given the heavy workload of the average counsellor the checklist must be a quick read, efficient and practical in its use. It must also summarize best practices in the counselling profession as I have outlined in previous chapters. These best practices include developing a checklist that is:

- Practical, easy to use, flexible, customizable, short and precise

- Assists in developing a therapeutic relationship that matches the client's definition of empathy, genuineness and respect
- Builds client rapport and safety based on collaboration, reciprocity and unconditional positive regard
- Highlights client-related extra-therapeutic factors such as strengths, optimism, faith, family and friends
- Meets the client where they are at in their present stage of change.
- Is sensitive to the specific needs of the client like a hospitable host or hostess.
- Ensures the client feels cared for, listened to and can or is willing to work on goals and tasks
- Helps the therapist to have a healthy awareness and use of empathy, compassion and kindness
- Ensures the therapist is actively working on self-care practices like loving kindness, meditation, emotional self-regulation, and self-awareness to nurture oneself and manage stress and emotions (components of emotional intelligence)

Based upon these best practices, I have developed the succinct and practical checklist below (see Appendix A). Again, the checklist should be used as a guide and not as a mandate and I leave it to the counsellor to determine how much or how little this checklist will be used. Since the checklist is designed only to be used by the counsellor, as I outlined in a previous chapter, a counsellor might consider using it in combination with an assessment survey that has been filled out by the client. But such surveys should be carefully administered in order to ensure the client does not feel obligated to provide a positive review of the counsellor's efforts.

Once this survey is put into use by counsellors, I do hope research is conducted to identify its strengths and weaknesses and provide recommendations for improvement. My hope for this checklist, which incorporates all we have discussed in the preceding chapters, is that its practicality and efficiency adds some value to the day to day engagement between therapists and clients, and in so doing, helps to strengthen and make real the therapeutic alliance.

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**Appendix A**  
**STRENGTHENING THE THERAPEUTIC ALLIANCE**  
**CHECKLIST**

**The client**

- Have I talked about the clients expectations of counselling? (Is there a hopeful outcome?)
- Have I considered the client's lifestyle, multicultural, structural, multi-systemic influences?
- Am I respectful in my demeanor and language? Am I attuning to the client's relational stance?
- Am I able to maintain a sense of unconditional positive regard for client (exploring biases/counter-transference/transference?)
- Have I received any acknowledgement that the client understands and is being understood or relating well in our dialogue together? Is the client engaged and collaborating?
- Have I determined where the client is at in their motivational readiness for change?
- Have I explored some of the client's extra-therapeutic factors that may help the client (social supports, hobbies, level of optimism, strengths?)
- Has the client expressed growth, learning and/or insightfulness in relation to their issues?

**The counsellor**

- Have I expressed caring for the client?
- How am I, as therapist, practising being present or mindful?
- Have I examined the type of empathy I am using (emotional contagion vs. cognitive empathy with reasoning for acts of compassion and kindness)
- What are my self-care practices? (e.g. loving kindness, meditation, yoga, other)
- How am I expanding my self awareness, self-regulation, self-motivation?
- Am I attending any training/workshops to self-regulate and manage my stress and emotions?

**The counsellor-client relationship**

- How is my rapport with the client? Has safety been established in the relationship?
- Am I maintaining consistency in my style with the client?
- Is there agreement between myself and the client on their goals and needs?
- Is there a purposeful collaboration between client and therapist? A sense of a reciprocity, receiving and giving?

