The Key to Successful Counselling: The Working Alliance in Practice

Sarah Penny

University of Calgary

The Key to Successful Counselling: The Working Alliance in Practice

Research has shown that the working alliance is essential for successful therapeutic outcomes (Castonguay, et al., 2006; Horvath, 2006; Bordin, 1979). As relationships are believed to be “a major avenue for bringing about change” (Johnson & Wright, 2002, p. 257), there has been much emphasis placed on the importance of studying and utilizing the working alliance in counselling practice. The focus of this paper will be on the working alliance, its usefulness in the counselling environment and my integration of this concept into my own work as a counsellor. This paper will begin by reviewing the literature related to the working alliance, and then proceed to describe my own integration of the working alliance construct. It will conclude with a description of the micro-skills model, introduced in the course Developing and Sustaining a Working Alliance, at the University of Calgary.

The working alliance (also referred to as the therapeutic alliance) can be defined as the professional relationship between client and counsellor. It encompasses three main components as outline by Hiebert & Jerry (2004): mutually agreed upon goals, mutually agreed upon tasks necessary to reach those goals, and a collaborative relationship of trust and respect. Emphasis must be place on the importance of this alliance, because without these components, the counselling process will not be successful (Bordin, 1979).

**Literature Review**

Presently, it is widely accepted in the counselling community that the therapeutic alliance is important in facilitating client change (Horvath, 2000) Although there has been a constant attempt to examine the client-counsellor relationship throughout the history of the mental health profession (Johnson & Wright, 2002), there has been differing views on its effect on the client. The following section will discuss the literature on the development of the working alliance and present the differing views of its importance held by various theorists.

**Freudian View of the Alliance**

Freud’s major focus around the counselling relationship was on the client’s attachment to the analyst. The client’s neurotic attachment to the analyst resulted in transference, which is “made up of client impulses and fantasies, which are revived in treatment” (Johnson & Wright, 2002, p.257). Freud also identified a “positive and reality-based component of the relationship” between client and therapist, which allowed both to work together against the client’s neurosis (Horvath & Symonds, 1991, p.139). Freud theorized that this alliance allowed the client to gain the confidence and strength necessary to deal with painful material produced in therapy (Horvath, 2000). Thus, Freud emphasized the therapeutic alliance in much of his work, since interpreting transference is a major therapeutic task in psychoanalysis (Horvath, 2000). This early research on the working alliance was vital in laying the foundation for many theorists to further evolve the concept.

**Behaviorist View of the Alliance**

Early behaviourists emphasized role of techniques in counselling, instead of the importance of counsellor-client relationship in counselling (Horvath, 2000). Behaviour therapists did not necessarily view the working alliance as an effective tool for therapeutic change. Rather, it has been seen as a “neutral stimulus” within counselling (Lejuez et al., 2006, p. 456). However, a number of contemporary behaviourists argue that the role of the working alliance is indeed essential to successful outcomes in therapy (Hyer, Kramer & Sohnle, 2004; Brown & O’Leary, 2000), and ignoring it may even be inconsistent with the practice of behaviour therapy. Lejuez et al.’s (2006) study of the therapeutic alliance and behavior therapy found that “basic behavioral principles at the core of behavior therapy are fundamental both to the development of a strong therapeutic alliance and to the provision of more specific behavioral applications that are based on these principles” (p.468). For example, a behavior therapist can use the therapeutic alliance as a tool during treatment by supporting and verbally praising the client while he or she is working on a skill. If the therapist wants to reinforce a behavior in the client, such as completing assigned homework, the therapist may reward the client’s completed homework with warmth and verbal praise, meanwhile strengthening the therapeutic alliance through verbal interactions. Thus, even in theories that are not fully supportive of the idea of the working alliance being an effective therapeutic tool, there still exists support of its benefits.

**Rogerian View of the Alliance**

Carl Rogers, founder of client-centered therapy (1957), theorized that therapist-offered conditions were only tool necessary for client change. He believed that there exist necessary and sufficient conditions to create change in a client, including the therapists’ unconditional positive regard, genuineness, and empathy towards the client. Rogers proposed that if these therapist-created conditions existed, “constructive personality change will follow” (p.241). Roger’s contributions greatly emphasized the importance and strength of the working alliance, as he proposed it was the key to success in therapy. However, his notion of the client-counsellor relationship was unilateral, as the therapist was fully responsible for creating the conditions for client change. It has been found that the client’s perception, not the counsellor’s is in fact that most important factor in determining a successful therapeutic alliance (Horvath, 2000).

In 1979, Bordin brought many of the ideas on the working alliance theories together to create “pan-theoretical reformulation of concept of working alliance” (Horvath, 2000, p.167). He proposed that alliance is a ‘here-and-now relationship’, and is bi-directional, meaning the client and counsellor are both actively involved. He viewed the alliance as made up as three components, bonds, tasks and goals (Horvath, 2000). Bonds are interpersonal attachments, such as trust between client and counsellor. Tasks are agreements on what is to be done in order for the client to reach his or her goals. Finally, goals are the expected outcome from the therapeutic process. Bordin seemed to identify the important elements of therapy (a strong alliance between client and counsellor) as well as the actual ingredients necessary for clients to meet their goals (tasks and bonds). He made a significant contribution to the working alliance as it is presently known.

**Current Literature on the Alliance**

Current literature has provided studies demonstrating the effectiveness of the working alliance (Arnd-Caddigan, 2012; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Gelso & Carter (1994) found that every therapeutic relationship, “regardless of theoretical approach, consists of three components: a working alliance, a transference configuration and a real relationship” (p. 296). According to the authors, the working alliance is the joining of the client’s reasonable self and the therapist’s analyzing self. Within this alliance, goals are created and tasks to reach those goals are agreed upon. The transference configuration is made up of the client’s transference and the therapist’s countertransference. The authors suggest that through the transference -based emotional reactions to the client, the therapist can gain a greater understanding of the client. Finally, the real relationship is the actual, authentic relationship between therapist and client. This relationship has two defining features: genuineness and realistic perceptions. Genuineness is the ability to be open and authentic. Realistic perceptions are perceptions that are not due to transference, that is, reality-based, accurate perceptions. The three components of the therapeutic relationship interact with one another, and overlap at times. Most importantly, the working alliance is influenced by both transference and the real relationship, and can therefore help therapists to better understand the working alliance. Horvath and Symonds (1991) found that the quality of the working alliance is a good indicator of the success of the therapy. They also found that the quality of the alliance could be measured as early as the third session, and this measure is a reliable predictor throughout the therapeutic relationship. These findings emphasize the importance of establishing a strong working alliance, especially from the beginning of therapy.

**Hiebert’s Definition of the Alliance**

The definition of the working alliance I will be using comes from the course “Developing a Working Alliance” at the University of Calgary. It can be characterized as the construct that describes the relationship between client and counsellor. According to the literature in this course, a strong working alliance develops when there is agreement on goals, agreement on the tasks needed to meet those goals, and mutual respect between the client and counsellor (Hiebert, 2001). This model of working alliance is a factor that “strongly affects counselling outcomes” (Hiebert & Jerry, 2004, p.1).

Both client and counsellor collaborate and are responsible for the successful outcome of therapy. They each bring their expertise to the dyad: the counsellor is the expert on the change process, and the client is the expert on his or her own experiences (Hiebert & Jerry, 2004). Specific skills, also known as micro-skills, are used by the counsellor to develop and sustain the working alliance. These skills will be discussed in further detail later in this paper.

The main goal of counselling is to utilize the strength of the working alliance to help reach the therapeutic goals. The counselling process begins at the initial stage, phase 1, where the main task is to establish goals and tasks (Hiebert & Jerry, 2004). In this stage, the client and counsellor develop an idea of where the client would like to be (goals). Together, they also decide on the necessary actions (tasks) that must be taken to reach the place the client would like to be. It is important to note that this is a collaborative effort, where both client and counsellor’s input are equally important. It is during this stage that a trusting relationship forms.

The second phase focuses on reaching the goals that were created in the first phase. This involves activities such as “problem-solving, skill-training, personal coping strategies or self-management” (Hiebert & Jerry, 2004, p.4). When the client has reached his or her goals, the next step is to begin the termination phase of therapy, and discuss how the client can maintain these goals. It is important to note that throughout this process, the working alliance is continually being maintained. Once it develops and strengthens in the first phase, it is necessary for the therapist and client to continually maintain this alliance, by checking in, and paying attention to the real relationship (Gelso and Carter, 1994).

**My Integration of the Working Alliance**

In terms of my own future practice as a counsellor, I intend to emphasize the importance of the working alliance in my interactions with clients. In my limited experience of counselling, I take a feminist-based approach. The majority of both my training and experience has come from working as a volunteer on the Toronto Rape Crisis Centre crisis line, where I support survivors of sexual violence. Coming from a feminist perspective, I believe that the clients are the experts on their own lives, and know what is most important for them. I fully intend to support and foster their inherent knowledge of their needs, rather than come from an authoritative, “therapist-knows-best” approach. Feminist therapy focuses on anti-oppression and empowering the client. Anti-oppression is practiced through an egalitarian relationship and the valuing of the client’s perspective. I believe that in order to create meaningful client change, it is imperative that the counsellor and client work together in a supportive and mutually respectful alliance. The view that the clients are the experts on their own personal experience is in line with the basic tenets of the working alliance (Hiebert, 2001). The therapist is seen as the expert on the counselling process, which is why I am utilizing the theory of the working alliance to my advantage. I believe the elements of a strong working alliance, which include agreement on goals, agreement on tasks needed to accomplish those goals and mutual respect (Hiebert, 2001) are the key to successful outcomes in counselling. Since the working alliance model posits that the client’s perception of the alliance is the most important indicator of success, I will also be sure to check-in regularly with my clients to gain their perspective of our alliance.

**Bachelor’s Three Types of Perceived Alliances**

In her research on the working alliance, Bachelor (1995) described three types of perceived alliances: nurturant, insight-oriented, and collaborative. These alliances resulted in “therapist facilitative attitudes, client-improved self-understanding and client involvement, respectively” (p.323). I believe these are all important elements to promote within the alliance, and in the following section, I will describe each term, and explain how I intend to promote each type of alliance.

The nurturant alliance is based on a client’s perception of a respectful and non-judgemental counselling relationship, which involves empathy and attentive listening by the therapist. Client members of this group in Bachelor’s study indicated that they felt at ease with their therapist, and were better able to self-disclose. Other important elements of the nurturant alliance include a competent therapist, the use of diverse methods, feedback, and the ability to intervene at the appropriate time. The use of questions and providing guidance to the client were also noted as useful. I believe that taking a nurturing approach to counselling is useful in many ways. In my work on the crisis line, the callers are often in great distress, and looking for someone to listen to them, and empathize with their situation. Many of our callers lack other sources of support in their lives around their experiences with trauma, so I believe providing them with nurturant support is of utmost importance. At the beginning of a call, many callers will ask if the line is confidential, and if they are safe to talk. I always assure them that the conversation is completely anonymous, and their information will be kept confidential. I do this so I can begin to build trust with the caller, so he or she will feel more comfortable disclosing to me. Something that stood out for me in our training as counsellors on the line was an exercise where we had to disclose something personal to a stranger (another counsellor with whom we were not yet familiar). I found it difficult to disclose a personal detail of mine to someone I had just met. I also remember my partner being very kind, supportive and empathic. This made the disclosure somewhat easier. The point of this exercise was to remind us as counsellors how difficult it can be to disclose painful secrets to a stranger on the other end of the line. I also learned that when I was met with an empathetic ear, I felt supported and less anxious once I disclosed. This was something I took into my work on the line. When working with individuals who have experienced violent traumas, a nurturing approach is important to allow them the space and safety to tell their story. I have also found other elements of the nurturant alliance to be useful while counselling survivors. A question I am often asked on the line is, “am I normal?” No matter what issue the caller is referring to, I always provide them with validating, supportive feedback. This is where I feel the nurturing approach is especially useful, because the client is often seeking some nurturing and acceptance through this question.

The insight-oriented alliance is based on the client’s perception of “improved self-understanding gained through clarification of significant client material” (Bachelor, 1995, p. 327). Clients in this group sought a better understanding of themselves, and their problematic functioning. They gained insight in therapy through self-disclosure and therapist exploratory work. The clients were able to partake in “free, uninhibited self-expression and disclosure of intimate feelings” (p. 327). I believe the ability for a client to gain insight into their inner workings , and to better “know” themselves is key to creating change. Without awareness of their patterns in behaviors and thoughts, it would be nearly impossible for them to change their problematic behaving and thinking. In my own experience, many callers on the crisis line simply need to vent their frustrations. By allowing them space to explore their feelings, many have gained insight into where their problematic behavior manifests itself. For example, one caller who had experienced a violent break-in and rape in her apartment was having trouble returning to work as a teacher. The incident had occurred six months prior to our phone conversation, and after some counselling and support from her friends, she wanted to move on with her life, and return from sick leave. However, she felt terrible anxiety at the thought of returning to work, and was having trouble understanding why. I sensed the caller needed to “talk out” her experience, and as she did, the topic moved towards her mother, who was having trouble understanding her daughter’s situation. The caller suddenly realized that it was her mother’s wish, not hers, for her to return to work. She explained to me that her mother was putting a lot of pressure on her to “return to normal” in order to move on with her life. This insight allowed her to realize she was not yet ready to return to work, and needed further counselling. She also realized that her mother was not being supportive of her healing process. Had I been seeing this woman in a long-term face to face counselling environment, I would have suggested the idea of setting some goals, such as communicating to her mother her need for time to heal, as well as a strategy to allow her to feel safe at work. In this sense, I would be utilizing the working alliance by supporting the client’s expertise on her own experiences (realizing she needs more time to heal) and thus, building trust, while setting goals and establishing tasks to reach those goals.

The final type of alliance identified by Bachelor is the collaborative alliance. This alliance involves the client’s active participation in therapy. Moving away from Roger’s (1957) belief that the therapist is fully responsible for client change, the collaborative alliance views the therapist and client as equally responsible for client change. The therapist’s role is also quite active in this alliance, by proposing topics for further discussion, or helping clients to see alternate perspectives on their situations. From my feminist perspective of the equality based relationship, I believe collaboration is essential for developing a strong working alliance. With my knowledge of the change process, and my belief in the client’s potential to reach his or her goals, I believe a successful working alliance can be created.

Although Bachelor (1995) presents three distinct types of alliances, I believe all three types together make for the strongest alliance. Elements of nurturant, insight-oriented and collaborative alliances each are important for fostering a positive and successful client-counsellor relationship. In my future practice as a counsellor, I intend to incorporate all three types of alliances. I also will work to establish a good working alliance early in the counselling relationship, since establishing the alliance at the beginning of therapy is vital to a successful outcome (Horvath, 2000). In the following section, I will discuss counsellor variables that influence the working alliance.

**Horvath’s Counsellor Variables**

Horvath 2000 article discusses the importance of the working alliance in the counselling environment, and factors that may influence it. The author presents a number of counsellor variables that influence the working alliance: the therapist’s training, the therapist’s unresolved early relationship issues, and attention paid to the relationship within the therapeutic setting.

**Amount of Counsellor Training**

In regards to the amount of training a counsellor has obtained, Horvath states that the amount of training is not directly related to the ability to form a good therapeutic relationship. I agree with this notion, as I believe a large part of being a good counsellor stems from an individual’s natural ability to relate to others. However, I do acknowledge that formal training is important, as Horvath states that counsellors with less training are more likely to misjudge the therapeutic relationship. Therefore, I believe it is important to receive training specifically on creating and managing the therapeutic alliance (such as this in the present course). In order to continually develop as a professional, I intend to enrol in continuing education courses and seminars throughout my career.

**The Therapist’s Relationship Issues**

In terms of the therapist’s own relationship issues, I believe it is useful for counsellors to explore their own issues before counselling their own clients. Although it may not be essential for every counsellor in training to receive their own personal therapy, I believe it could be of benefit to many. This way, the therapist can become aware of his or her own major issues and triggers, and not allow them to impede upon their professional work. Furthermore, the counsellor may need training herself in relationship-building skills. If she has trouble building healthy relationships with those in her personal life, it is likely to impact her ability to create strong professional relationships (Horvath, 2000).

**Attention to the Client-Counsellor Relationship**

Finally, Horvath identifies attention to the client-counsellor relationship as an important factor in the working alliance. Although it may be uncomfortable for the client and/or counsellor to discuss issues that are occurring in the present moment between them (for example, a client’s anger at the therapist for a flippant comment she made last week, or a counsellor’s anger at a client for his continual lateness), it is essential that these issues are addressed in order to have a healthy functioning working alliance. Horvath (2000) posits that it is important to address issues as soon as possible. If timely attention is not paid to such issues, they may simmer in the background, and eventually cause a major rupture in the alliance. Furthermore, having the chance to address issues happening in the relationship in real-time is a tool for therapeutic growth for the client, as he or she can practice interpersonal skills, such as confrontation.

**Micro-skills**

In the course “Developing a Working Alliance”, Hiebert (2001) introduces a set of micro-skills counsellors use to communicate with clients, and to produce specific results in clients. It is important to discuss these skills in a paper on the working alliance, because they are the tools that create and maintain a healthy working alliance, and allow it to move from the initial stage of therapy to reaching the goals. In this section, I will discuss these skills, and how they can be effectively used to contribute to a strong working alliance. The micro-skills skills are categorized in three groups: skills for enhancing meaningfulness, skills for engaging people, and skills for clarifying and providing feedback (Hiebert, 2001).

**Skills for Enhancing Meaningfulness**

Skills for enhancing meaningfulness are used to provide structure to the counselling sessions. Skills in this category include overviewing, transitions and summarizing. Overviewing allows the client to know what is to be expected during a session, or in the next part of a session. The counsellor will put forth an idea of what he/she would like to discuss, for example, “Today I’d like to take some time to talk about how you are dealing with your depression”. This also gives the client a chance to speak up if that topic does not sit well with her.

Transitions are used to mark the change in topics during a session. This allows both client and counsellor to keep track of where they are in the session, and also to give the client notice that the topics are changing, and why they are changing. This will help to avoid confusion and also to structure the session by breaking topics up into “frames”. For example, a counsellor may say, “We’ve spoken about your depression, now I’d like to focus on your anxiety”.

Finally, summarizing allows both client and counsellor to have a re-cap on what was discussed during the session, or previous portion of the session. It can also help to highlight the “bottom line” (Hiebert, 2001), or main points of the session. For example, a counsellor may say, “So we’ve discussed you depression, and your anxiety, and you’ve related both to your current working situation”. This can be useful to keep on track of the progress the client is making as well, by highlighting the important realizations from the session.

**Skills for Engaging People**

Skills for engaging people are used to “initiate and maintain client involvement or engagement in the process” (Hiebert, 2001, p.7). These skills are important to gather information, and promote client skill practice, such as cognitive, affective or behavioral activities. The skills in this category include open and closed questions, and declarative probes. Open questions are used to gather information from the client. Unlike closed questions, they cannot be answered with a yes or no. They work to encourage the client to share thoughts or feelings openly and freely, without being biased by the question. An example is a therapist asking, “How do you feel when you experience depression?”

In contrast, closed questions are those that can be answered with a yes or no answer. They are also used to obtain conformation about something. For example, “Has your doctor given you medication for your depression?” They can also be used to check in with the client after an overview, transition, or summary, to ensure the client is on the same track as the counsellor. For example, “We spoke about your depression, and now I’d like to talk about your anxiety. Is that alright with you?” This gives the client the opportunity to provide her thoughts and feelings about the change in topic, thus adding to the collaborative nature of the working alliance.

Finally, declarative probes are another way to obtain information from the client, without using a question. They can also be referred to as “polite commands” (Hiebert, 2001, p.9). An example could be, “Please tell me more about your panic attacks”. This allows the client space to elaborate on a topic.

**Skills for Clarifying and Providing Feedback**

Skills for clarifying and providing feedback work to provide clients with information about what they are communicating. These skills involve reflecting meaning, and reflecting affect. Reflecting meaning allows the counsellor to reflect back the content or meaning of what the client is saying. In this way, the counsellor can check-in with the client to make sure she’s on the right track. It also allows the client to hear back what she has just communicated. This could be an opportunity for her to hear something in a new way, or from an alternate perspective she has not yet considered. For example, a counsellor might say, “So it seems like your anxiety is triggered mostly while you are walking to work”. Hearing this statement reflected back at her could help the client to realize the link between her job and her anxiety.

Reflecting affect helps clients to know that the therapist hearing the emotions behind her words. For example, “You seem to be anxious at the thought of changing jobs”, lets the client know that the therapist accurately understands how she is feeling. It also provides an opportunity for the client to correct the therapist if she did not accurately capture the client’s feelings in that moment.

These skills help to build and strengthen the working alliance, by allowing both client and counsellor to have input in the counselling process, as well as build trust in their relationship. I will continue to practice and use these skills while counselling, as I believe they lead to effective therapeutic change.

**Conclusion**

In conclusion, I have discussed the literature on the working alliance, my integration of the alliance into my practice as a counsellor, and the micro-skills I will use to create strong working alliances. I believe all these elements are essential for a successful career in helping clients to reach their goals. I will continue to practice these skills, and reflect upon the importance of the working alliance in counselling.

References

Arnd-Caddigan, M. (2012). The therapeutic alliance: Implications for therapeutic process and therapeutic goals. *Journal of Contemporary Psychotherapy 42,* 77-85.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counselling Psychology, 42*(3), 323-337.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, research and practice, 16(3), 252 – 260.

Brown, P. D., & O'Leary, D. K. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology, 68*(2), 340–345.

Castonguay, L., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? Psychotherapy: Theory, Research, Practice, Training, 43(3), 271-279.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counselling and Development, 41*(4), 296-306.

Hiebert, B. (2001). Creating a working alliance: Generic interpersonal skills and concepts. Calgary, AB: University of Calgary.

Hiebert, B. & Jerry, P. (2004). The working alliance concept. Calgary. AB: University of Calgary.

Horvath, A. O. (2006). The alliance in context: Accomplishments, challenges, and future directions. Psychotherapy: Theory, Research, Practice, Training, 43(3), 258-263.

Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology, 56*(2), 163-173.

Horvath, A.O. & Luborsky, L. (1993). The role of therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*(4), 561-573.

Horvath, A.O. & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, (38)*2, 139-149.

Hyer, L., Kramer, D., & Sohnle, S. (2004). CBT with older people: Alterations and value of the therapeutic alliance*. Psychotherapy: Research, Practice, Training, 41*(3), 276–291.

Johnson, L. & Wright, D. (2002). Revisiting Bordin’s theory on the therapeutic alliance: Implications for family therapy. *Contemporary Family Therapy 24*(2).

Lejuez, C., Hopko, D., Levine, S., Gholkar, R. & Collins, L. (2006) The therapeutic alliance in behavior therapy. *Psychotherapy: Theory, Research and Training, (42)*4, 456-468.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Consulting Psychology, 21*(2), 95-103.