

RESEARCH ARTICLE

Counsellor behaviours that predict therapeutic alliance: From the client's perspective

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The therapeutic alliance has been shown to be a robust predictor of counselling outcome. However, the specific counsellor behaviours that relate to the alliance have not been clearly and consistently identified, and prior attempts to identify these variables have not been typically based on client-derived conceptualizations of the alliance. A total of 79 adult counselling clients participated in a study examining the relationship between 15 client-identified counsellor behaviours and the strength of the therapeutic alliance. Correlational analyses revealed that 11 of the 15 behaviours moderately to strongly correlated with the strength of the alliance, and hierarchical regression analyses found that three particular counsellor behaviours (making encouraging statements, making positive comments about the client, and greeting the client with a smile) accounted for 62% of the variance in alliance scores. The findings suggest that seemingly small, strengths-fostering counsellor micro-behaviours can play a key role in strengthening therapeutic alliances. Given the role that alliance plays in positive counselling outcomes, it is suggested that these behaviours be tactfully implemented early on in the counselling process.

Keywords: therapeutic alliance; counsellor behaviour; client's perspective

Introduction

Of all factors that have been shown to predict positive counselling outcomes, the therapeutic alliance is among the most consistent and robust (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). While many definitions of the alliance have been offered (e.g., Bordin, 1979; Gelso & Carter, 1985; Horvath & Bedi, 2002; Luborsky, 1976; Meissner, 2007), we define the alliance as the client and counsellor's subjective experience of working together towards psychotherapeutic goals in the counselling context, including the experience of an interpersonal bond that develops while engaged in this endeavour.

Despite the large body of knowledge generated by this inquiry on the alliance, specific counsellor behaviours that relate to the alliance have not been clearly and consistently identified (Ackerman & Hilsenroth, 2003; Horvath, 2001; Horvath,

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2006; Horvath & Bedi, 2002). Castonguay, Constantino, and Holtforth (2006) have argued that future research on the alliance needs to especially focus on counsellor behaviours to improve understanding of how the alliance develops and how to train counsellors to foster the alliance. Horvath (2006) has noted that identifying evidence-based alliance-fostering counsellor behaviours has been difficult in the past due to the variety of existing definitions and theoretical conceptualizations of the alliance. Furthermore, Ackerman and Hilsenroth (2003) have argued that counselling and psychotherapy research in general would benefit from a close evaluation of counsellor characteristics that relate to the alliance.

Few prior attempts to identify counsellor behaviours (e.g., see Ackerman & Hilsenroth, 2003; Thomas, Werner-Wilson, & Murphy, 2005) have been typically based on observations made by practitioners or researchers rather than by clients themselves (Henkelman & Paulson, 2006). This is unfortunate since the client's perspective of the alliance is often found to be a better predictor of outcome (see Horvath & Bedi, 2002; Zuroff & Blatt, 2006).

Adapting one's therapeutic style to match the client's preference will likely result in stronger alliances (e.g., Duncan et al., 2003; Lambert, Okiishi, Finch, & Johnson, 1998; Lazarus, 1993; Norcross & Beutler, 1997), yet few conceptualizations of the alliance are based directly on the client's perspective of it. Indeed, clients' and counsellors' perspectives of the alliance can diverge significantly (Bachelor & Salamé, 2000; Fitzpatrick, Iwakabe, & Stalikas, 2005), and there is evidence that client-directed counselling (counselling that is driven by direct client feedback) is highly effective in establishing a strong early alliance (Duncan & Miller, 2000; Duncan et al., 2003). Thus, educators and counsellors may lack the empirical evidence necessary to maximize their potential for developing strong alliances and improving counselling outcomes.

While some research has begun to focus on practitioner *characteristics* that contribute to alliance development (e.g., Ackerman & Hilsenroth, 2003; Thomas et al., 2005; Watson & McMullen, 2005) and on the client's perspective of the alliance (e.g., Bachelor, 1995; Bedi, 2006; Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005; Bedi & Duff, 2008, 2009; Duncan et al., 2003; Fitzpatrick, Janzen, Chamodraka, & Park, 2006; Mohr & Woodhouse, 2001), very little of this research has investigated the statistical relationship between the client's perspective on counsellor behaviours and the strength of the alliance, instead focusing on the identification of alliance factors and processes. Consequently, there is a deficiency in our knowledge about whether or not the counsellor behaviours that clients *think* relate to the development of the alliance *actually do* relate to the development of the alliance. A systematic investigation of the possible measurable relationship between client-identified counsellor behaviours and alliance strength is therefore needed.

The present study examined the relationship between 15 previously identified client-identified counsellor behaviours (see Bedi & Duff, 2008) thought to be helpful in alliance formation and the strength of the therapeutic alliance for counselling clients from several major western Canadian metropolitan centres: Vancouver, Victoria, Edmonton, and Calgary. Two hypotheses are made in relation to this: (a) that a positive linear relationship exists between the frequency of each of these behaviours and the strength of the alliance, and (b) that a subset of behaviours will particularly predict the strength of the alliance.

Method

Design

A cross-sectional, correlational design was used to examine the relationship between 15 client-identified formation factors (see Table 1) and alliance strength.

Participants

An *a priori* power analysis was performed using effect size estimates that are reported in Ackerman and Hilsenroth's (2003) review of studies on counsellor characteristics that relate positively to the alliance. Based on these studies, an effect size of $R^2 = 0.25$ was considered a conservative estimate of the anticipated effect size of the present study. Given 15 predictor variables, a minimum sample size was calculated to be 73. In this study, 79 adult counselling clients from the Western Canada region participated.

Participants were recruited using posters and flyers distributed in visible areas at community-based counselling agencies, post-secondary counselling centres, support agencies, community centres, and private practitioners' offices in several major cities in Western Canada. Advertisements were also posted through online classifieds that served the Western Canada region. Advertisements for the study offered prospective participants a chance to win one of four \$100 CDN cash gift prizes in exchange for participation. Prospective participants were screened for eligibility by telephone or email. Qualifying participants included those who (a) were at least 19 years of age, (b) had had at least three sessions with their current or last counsellor or psychotherapist, (c) had received counselling or psychotherapy services within the last 30 days, (d) were willing and able to complete a 20-minute online questionnaire, and (e) had completed a grade 10 education (or equivalent). The rationale for these eligibility criteria was to recruit adults who (a) had been in counselling or

Table 1. Counsellor behaviours identified in prior research (i.e., Bedi, 2006; Bedi & Duff, 2008) as related to the alliance.

Variable
_____ asked me questions.
_____ made encouraging comments.
_____ identified and reflected back my feelings.
_____ was honest (i.e., he/she shared negative information truthfully).
_____ made positive comments about me.
_____ validated my experience (e.g., he/she said that my reaction was understandable and reasonable, and that it was okay to feel this way).
_____ made eye contact with me.
_____ greeted me with a smile.
_____ referred to details we had discussed in previous sessions.
_____ sat still (i.e., did not fidget).
_____ sat facing me (i.e., sat directly across from me).
_____ told me about similar experiences that he/she had.
_____ let me decide what to talk about.
_____ provided verbal prompts (e.g., "uh huh," "hmm-mmm").
_____ kept the administration (e.g., fees, scheduling of appointments, paperwork) outside of our sessions

psychotherapy long enough to have potentially established a functional therapeutic alliance, (b) were more likely to be able to accurately recall events that occurred during counselling or psychotherapy, (c) were willing and able to complete the questionnaires and (d) were able to understand the level of language used in the questionnaires.

Measures

Therapeutic alliance critical incidents questionnaire (TACIQ)

Derived from the 74 common factors identified by clients as critical to the development of the alliance (see Bedi, 2006), the TACIQ is a 15-item likert-type questionnaire designed specifically for use in the proposed study (see the Appendix). In the TACIQ, participants are asked to indicate the frequency with which each of the 15 critical incidents occurred over the last three sessions with their counsellor. Selection of items for the TACIQ was based on the results of Bedi and Duff (2008), in which clients were asked to rate the perceived relative impact that 74 different factors had on the development of the working alliance that they had established with their counsellor. Items were selected for the TACIQ based on a high median rating of importance and a high degree of consensus on that rating.

Working Alliance Inventory, Short Form, Revised (WAI-SR; Hatcher & Gillaspy, 2006)

Based on the original Working Alliance Inventory (WAI) developed by Horvath and colleagues (Horvath, 1981; Horvath & Greenberg, 1987, 1989), the WAI-SR is a short version of the WAI and was developed using more sophisticated factor analyses and a much larger sample than had been used in earlier WAI studies (Hatcher & Gillaspy, 2006). The WAI-SR is a valid measure of the alliance, correlating highly with the WAI and other alliance measures and demonstrating adequate reliability (Hatcher & Gillaspy, 2006). The WAI-SR was selected because of its strong theoretical rationale and its parsimony, the latter of which would help reduce the chance for participants to experience research fatigue (see Hill & Lambert, 2004) and drop out of the study prematurely.

Procedure

An Internet-based service was used to administer all questionnaires. Internet-based studies in psychology have been shown to be an efficient, valid, and reliable alternative to laboratory-based studies, yielding results that are consistent with traditional data collection methods (e.g., Buchanan & Smith, 1999; Gosling, Vazire, Srivastava, & John, 2004; Riva, Teruzzi, & Anolli, 2003).

A website address was given to qualifying participants either over the phone or via email, through which participants were directed to a secure, encrypted online version of the questionnaire and could provide informed consent. Each participant was given a unique, randomly assigned verification code, consisting of a string of random characters. Participants were prompted to enter this code before beginning the online questionnaire. The verification code was used to prevent repeat responders, to ensure that data entered online was from a screened participant,

and to ensure participants' confidentiality. All questionnaires were administered online, including a series of demographic questions. To control for primacy and order effects, the TACIQ and WAI-SR were administered in randomly varying order.

Results

Descriptive analyses. All analyses were performed using SPSS 16.0 for Mac. Participant descriptive statistics are presented in Table 2. Descriptive statistics of the service received by participants are presented in Table 3.

Reliability analyses. The WAI-SR demonstrated excellent internal consistency (Cronbach's $\alpha = 0.90$), and all inter-item correlations were at least adequate¹ ($r \geq 0.3$). All items correlated well with the total scale ($r > 0.47$). The Goal, Task, and Bond subscales of the WAI-SR also appeared to have good internal consistency, with Cronbach's alpha of 0.82, 0.85, and 0.80, respectively.

The TACIQ demonstrated good internal consistency, (Cronbach's $\alpha = 0.80$). However, items 2, 8, 12, and 14 on the TACIQ appeared to be candidates for removal from the scale.² Moreover, inter-item correlations for these items were

Table 2. Participant descriptive statistics ($N = 78$).

	<i>N</i> (%)	<i>M</i> (<i>SD</i>)	<i>Mdn</i>
Gender			
Male	25 (32.1)		
Female	53 (67.9)		
Marital status			
Never married	41 (52.0)		
Married/common-law	24 (30.8)		
Divorced/separated	13 (16.7)		
Highest level of education completed			
Elementary	1 (1.3)		
High school	21 (26.9)		
Diploma	20 (25.6)		
Undergraduate degree	32 (41.0)		
Graduate degree	4 (5.2)		
Ethnicity			
European	54 (69.2)		
First Nations/Aboriginal	5 (6.4)		
South Asian	2 (2.6)		
Other Asian	9 (11.5)		
Other	2 (2.6)		
Method of recruitment			
Flyer at counselling office	25 (32.1)		
Flyer elsewhere	19 (24.4)		
Online classified advertisement	34 (43.6)		
Age		34.0 (10.4)	32
Number of days since last session		10.0 (7.9)	7
Number of sessions with current counsellor		21.1 (26.8)	11
Number of counsellors seen in lifetime		3.3 (2.4)	3

Note: Sum of percentages may not equal 100% due to rounding.

Table 3. Descriptive statistics of service received by participants ($N=78$).

	N (%)
Reason for counselling	
Addiction issues	12 (15.4)
Anger issues	12 (15.4)
Anxiety/stress	44 (56.4)
Career issues	9 (11.5)
Depression	44 (56.4)
Educational issues	9 (11.5)
Post-traumatic stress disorder	21 (26.9)
Relationship issues	37 (47.4)
Other	15 (19.2)
Payment of service	
Full coverage by health care plan	19 (24.4)
Partial coverage	15 (19.2)
Out-of-pocket	19 (24.4)
No-charge service	24 (30.8)
Location of service	
Community agency	19 (24.4)
Hospital or clinic	10 (12.8)
Private practice	29 (37.2)
University/college counselling centre	20 (25.6)
Counsellor gender	
Male	25 (32.1)
Female	53 (67.9)
Counsellor education	
Bachelor's degree	4 (5.1)
Master's degree	39 (50.0)
Doctoral degree or MD	16 (20.5)
Unknown	19 (24.4)

Note: More than one reason for counselling could be selected; sums of percentages may not equal 100%.

generally low ($r < 0.3$), and all four items correlated poorly with the total scale, which is below the recommended cutoff of 0.3 (see Briggs & Cheek, 1986).

Correlational analyses. To test the first hypothesis that there is a positive linear relationship between each of the predictor variables and the criterion variable, Pearson correlation coefficients were computed. Correlations between each of the 15 predictor variables, the WAI-SR total scores, and the WAI-SR Goal, Task, and Bond subscales are presented in Table 4.³ The correlation between the WAI-SR and the composite TACIQ score was large (cf. Cohen, 1988) and statistically significant ($r = 0.750$, $\alpha = 0.01$, 2-tailed), supporting the overall construct validity of the TACIQ. Four predictors (items 2, 8, 12, and 14) were not highly correlated with WAI-SR scores and were not statistically significant ($\alpha = 0.05$, 2-tailed), indicating that they were not linearly associated with the alliance. All other predictors were at least moderately correlated with the WAI-SR and were statistically significant ($p < 0.01$, 2-tailed), with nearly all correlations being greater than 0.4. All WAI-SR subscales correlated well with the composite TACIQ score ($r \sim 0.6$), and most

Table 4. Pearson correlation matrix of measured variables ($N = 78$).

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1. WAI-SR	–																			
2. TACIQ	0.750**	–																		
3. TACIQ-Q1	0.478**	0.690**	–																	
4. TACIQ-Q2	0.197	0.226*	0.086	–																
5. TACIQ-Q3	0.348**	0.559**	0.393**	0.123	–															
6. TACIQ-Q4	0.667**	0.707**	0.348**	0.320**	0.341**	–														
7. TACIQ-Q5	0.592**	0.639**	0.301**	-0.070	0.411**	0.454**	–													
8. TACIQ-Q6	0.481**	0.787**	0.555**	0.053	0.488**	0.482**	0.554**	–												
9. TACIQ-Q7	0.425**	0.532**	0.417**	-0.002	0.369**	0.253*	0.455**	0.425**	–											
10. TACIQ-Q8	-0.067	0.009	-0.005	-0.227*	-0.171	-0.171	-0.137	0.048	-0.209	–										
11. TACIQ-Q9	0.508**	0.536**	0.165	0.101	0.408**	0.531**	0.435*	0.214	0.422**	-0.116	–									
12. TACIQ-Q10	0.689**	0.692**	0.354**	0.220*	0.171	0.728**	0.408	0.436**	0.214	-0.029	0.501**	–								
13. TACIQ-Q11	0.388**	0.521**	0.632**	0.016	0.213	0.166	0.356**	0.357**	0.346**	0.044	0.062	0.224*	–							
14. TACIQ-Q12	-0.002	0.292**	0.234*	-0.021	0.174	0.003	-0.075	0.332**	0.027	-0.019	-0.072	-0.018	0.059	–						
15. TACIQ-Q13	0.473**	0.573**	0.578*	-0.099	0.132	0.344**	0.292**	0.477**	0.349**	0.108	0.254*	0.419**	0.605**	-0.033	–					
16. TACIQ-Q14	0.178	0.307**	-0.041	-0.026	-0.090	0.175	0.186	0.210	-0.075	0.154	-0.070	0.191	-0.032	0.227*	-0.034	–				
17. TACIQ-Q15	0.550**	0.726**	0.591**	0.206	0.403**	0.525**	0.427**	0.543**	0.246*	-0.016	0.367**	0.649**	0.306**	0.166	0.320**	-0.037	–			
18. WAI goal	0.900**	0.633**	0.441**	0.212	0.357**	0.649**	0.525**	0.410**	0.425**	-0.208	0.480**	0.588**	0.344**	-0.0677	0.384**	0.028	0.465**	–		
19. WAI task	0.882**	0.602**	0.409**	0.130	0.220	0.584**	0.520**	0.324*	0.493**	-0.110	0.461**	0.557**	0.334**	-0.0485	0.360**	0.133	0.375**	0.785**	–	
20. WAI bond	0.739**	0.663**	0.362**	0.117	0.286*	0.439**	0.442**	0.494**	0.136	0.190	0.339**	0.601**	0.296*	0.1437	0.486**	0.310**	0.543**	0.466**	0.432**	–
<i>M</i>	45.26	56.14	4.06	2.23	3.55	3.90	4.31	3.85	3.56	4.27	3.86	3.90	4.21	3.419	4.50	2.49	4.05	14.29	14.90	16.01
<i>SD</i>	8.52	8.41	1.04	1.14	1.12	1.06	1.06	1.03	1.09	0.85	1.19	0.98	0.93	1.28	0.92	1.7	1.06	3.54	3.33	3.29
Reliability (α)	0.90	0.80												0.82	0.85			0.82	0.85	0.80

Notes: WAI-SR = composite score of working alliance inventory, short form, revised (WAI-SR); TACIQ = composite score of therapeutic alliance questionnaire (TACIQ); TACIQ-Q1 = TACIQ item 1; TACIQ-Q2 = item 2, etc.; WAI goal = WAI-SR goal subscale; WAI task = task subscale; WAI bond = bond subscale; α = cronbach's alpha. Item scores on the WAI-SR range from 1 (seldom) to 5 (always), and on the TACIQ from 1 (never) to 5 (always). Total scores range on the WAI-SR from 12 to 60, and on the TACIQ from 15 to 75.

* $p < 0.05$, two-tailed. ** $p < 0.01$, two-tailed.

predictor variables that were correlated with the WAI-SR were also moderately correlated with all WAI-SR subscales ($r \sim 0.5$). Those predictors that did not correlate with the overall WAI-SR score also did not correlate strongly with the WAI-SR subscales. Due to this lack of correlation and the poor reliability of items 2, 8, 12, and 14, it was determined that these predictors would not be suitable for inclusion in the regression model and were excluded from subsequent analyses.

Hierarchical multiple regression analysis. Hierarchical regression was employed to test the second hypothesis by determining how well each of the counsellor behaviours predicted therapeutic alliance. The remaining 11 predictor variables (after exclusion of the four non-correlated predictors) belonged to either the category of validation or of presentation/body language (see Bedi, 2006, for a description of these categories). Based on prior research (i.e., Ackerman & Hilsenroth, 2003; Bedi, 2006; Bedi & Duff, 2008; Crits-Christoph, Connolly Gibbons, & Hearon, 2006; Fitzpatrick et al., 2006; Horvath & Bedi, 2002; Najavits & Strupp, 1994), variables related to validation were strongly expected to predict alliance scores. Therefore, the first block (step one) contained all variables closely related to validation. Because of secondary support for variables related to presentation/body language as likely predictors of alliance (e.g., Ackerman & Hilsenroth, 2003; Horvath & Greenberg, 1989; Kivlighan, Clements, Blake, Arnez, & Brady, 1993; Lichenberg et al., 1988), the second block (step two) contained all remaining variables to examine the predictive contribution of presentation/body language to the regression model. The results were then examined, and all variables that were not statistically significant were removed from the regression model (step three). All blocks were input using the *Enter* method in SPSS (see Table 5).

A preliminary hierarchical regression was then computed to visually and statistically inspect the data for multivariate outliers. One extreme case was identified by inspection of a regression standardized residual histogram and

Table 5. Strategy for hierarchical regression variable entry after exclusion of non-correlated predictors.

Block	Variable
1	_____ asked me questions.
	_____ made encouraging comments.
	_____ identified and reflected back my feelings.
	_____ was honest (i.e., he/she shared negative information truthfully).
	_____ made positive comments about me.
	_____ validated my experience (e.g., he/she said that my reaction was understandable and reasonable, and that it was okay to feel this way).
2	_____ made eye contact with me.
	_____ greeted me with a smile.
	_____ referred to details we had discussed in previous sessions.
	_____ sat still (i.e., did not fidget).
Excluded	_____ sat facing me (i.e., sat directly across from me).
	_____ told me about similar experiences that he/she had.
	_____ let me decide what to talk about.
	_____ provided verbal prompts (e.g., “uh huh,” “hmm-mmm”).
	_____ kept the administration (e.g., fees, scheduling of appointments, paperwork) outside of our sessions

scatterplot of standardized predicted values against standardized residuals. Cook's distance for this case ($D = 0.27$) was higher than for most other cases, indicating that it was likely impacting skew. Inspection of the corresponding responses suggested that the participant was either non-serious or had not read reverse-coding directions carefully, as the participant's answers to the reverse-coded items were very low compared to the participant's answers on the other items. Data associated with this case were therefore regarded as unreliable, and it was excluded from subsequent analyses.

With the outlier removed, the regression analysis was recomputed. The tenability of regression assumptions was assessed prior to further analysis or interpretation, with favourable results (these findings available from the first author). It was concluded that the necessary assumptions had been met and that multiple regression analysis was appropriate. The results of the final regression analysis are presented in Table 6.

Post hoc statistical power was calculated for the regression model in each step of the hierarchical analysis. Power for the model at step one was 0.99 ($\alpha = 0.01$, two-tailed, $R^2 = 0.58$, $N = 78$, $dfs = 6$, 71), at step two was 0.99 ($\alpha = 0.01$, two-tailed, $R^2 = 0.67$, $N = 78$, $dfs = 5$, 66), and at step three was 0.99 ($\alpha = 0.01$, two-tailed, $R^2 = 0.62$, $N = 78$, $dfs = 8$, 66). All obtained values are considered adequate.⁴

Discussion

The strong correlation ($r = 0.71$) between the WAI-SR and the TACIQ supports the construct validity of the TACIQ as a measure of the therapeutic alliance from the client's perspective. This finding also suggests that the constellation of behaviours included in the TACIQ is closely related to the therapeutic alliance. The comparable magnitude of correlations between the TACIQ composite scores and each of the WAI-SR subscales ($r \sim 0.6$) indicates that the TACIQ is not particularly related to any WAI-SR subscale, suggesting that the behaviours included in the TACIQ represent a global alliance. Moreover, the similar magnitude of correlations between each predictor variable and each WAI-SR subscale ($r \sim 0.5$) indicates that not any one WAI-SR subscale is more substantially related to any counsellor behaviour than any other subscale. That is, no particular subscale emerged as being markedly more related to any specific behaviour.

The findings support the conclusion that there is a positive association between the frequency of each of the 15 behaviours and the strength of the alliance; that is, these particular counsellor behaviours co-occur reliably with solid therapeutic alliances. Five counsellor behaviours (i.e., asking questions, making encouraging comments, identifying and reflecting back the client's feelings, making positive comments about the client, and validating the client's experience) were moderately to strongly correlated with therapeutic alliance and belong to a superordinate category of counsellor behaviours described by clients in prior research as *Validation* (Bedi, 2006). This is also consistent with previous research (i.e., Bedi, 2006; Bedi & Duff, 2008) in which clients rated factors related to validation as most important to the development of the alliance. Coupled with previous research where clients identified these behaviours as *antecedents* to alliance development (Bedi, 2006; Bedi & Duff, 2008), the present findings are in line with the notion that these behaviours cause an increase in alliance strength. However, this study was not designed to infer causal

Table 6. Hierarchical multiple regression of counsellor behaviours on therapeutic alliance ($N = 78$).

Step and variables	B	$SE\ B$	β	t	95% confidence interval of B		R^2	Adj. R^2	ΔF	dfs
					Low	High				
Step 1							0.58**	0.54**	16.26**	6, 71
___ asked me questions	0.56	0.77	0.08	0.74	-0.97	2.11				
___ made encouraging comments	1.77	0.99	0.22	1.80	-0.20	3.73				
___ identified and reflected back my feelings	1.02	0.857	0.12	1.19	-0.69	2.73				
___ was honest	0.96	0.72	0.13	1.33	-0.48	2.40				
___ made positive comments about me	3.14	1.20	0.36	2.61*	0.75	5.54				
___ validated my experience	0.44	0.92	0.05	0.48	-1.39	2.27				
Step 2							0.67**	0.62**	3.68**	5, 66
___ asked me questions	0.36	0.74	0.05	0.49	-1.12	1.83				
___ made encouraging comments	1.79	0.92	0.22	1.95*	-0.05	3.61				
___ identified and reflected back my feelings	-0.94	0.95	-0.114	-0.99	-2.84	0.96				
___ was honest	0.18	0.76	0.03	0.23	-1.35	1.70				
___ made positive comments about me	2.99	1.13	0.34	2.65*	0.74	5.25				
___ validated my experience	-0.05	0.96	-0.01	-0.05	-1.96	1.86				
___ made eye contact with me	1.02	1.03	0.12	0.99	-1.03	3.06				
___ greeted me with a smile	2.10	0.81	0.26	2.60*	0.49	3.72				
___ referred to details we had discussed in previous sessions	0.79	0.73	0.10	1.09	-0.66	2.24				
___ sat still (i.e., did not fidget)	0.44	0.98	0.05	0.45	-1.55	2.41				
___ sat facing me (i.e., sat directly across from me)	0.78	1.00	0.08	0.78	-1.22	2.78				
Step 3							0.62**	0.60**	1.35	8, 66
___ made encouraging comments	1.94	0.86	0.24	2.24*	0.21	3.68				
___ made positive comments about me	3.32	0.93	0.38	3.59**	1.47	5.16				
___ greeted me with a smile	2.63	0.65	0.33	4.02**	1.32	3.93				

Notes: B = unstandardized regression coefficient; $SE\ B$ = standard error of unstandardized regression coefficient; β = standardized regression coefficient; t = value of t test; R^2 = squared coefficient of determination; Adj. R^2 = R^2 adjusted for sampling error; ΔF = change in Fisher's F statistic; dfs = degrees of freedom.

* $p < 0.05$, two-tailed. ** $p < 0.01$, two-tailed.

relationships between variables, but rather to identify linear relationships between predictor and criterion variables. Research methods that can infer causal relationships must be used in the future in order to make the assertion of causality with confidence.

Another six counsellor behaviours (i.e., making eye contact, greeting the client with a smile, referring to details discussed in previous sessions, being honest, sitting still without fidgeting, and facing the client) were also moderately to strongly correlated with the therapeutic alliance and appear to be most related to physical attending skills. They may represent an underlying dimension of counsellor nonverbal communication of attention on the client. While it is still unclear whether these behaviours increase in frequency as a result of a strong alliance, prior research seems to support the idea that positive focus on the client plays a significant role in the development of the therapeutic alliance (Ackerman & Hilsenroth, 2003; Crits-Christoph et al., 2006; Najavits & Strupp, 1994). The finding that the counsellor behaviours of referring to details from previous sessions and being honest are positively related to alliance is also supported by prior research (Ackerman & Hilsenroth, 2003).

Four counsellor behaviours (i.e., telling the client about similar personal experiences, letting the client decide what to talk about, providing verbal prompts, and keeping administration outside of session time) were not correlated with alliance. Issues of sampling error and moderating variables aside, these findings could be demonstrative of a discrepancy between what clients believe is important in the development of the alliance and what factors are measurably related. The finding that counsellor self-disclosure was not linearly related to alliance is mirrored by the mixed results of prior research, which has found that counsellor self-disclosure can be both positively and negatively related to alliance (Ackerman & Hilsenroth, 2001; Bachelor & Horvath, 1999). Clients' perception of the helpfulness of counsellor self-disclosure has been shown to modulate the impact that the disclosure has on alliance (Hanson, 2008), and therefore a direct, linear model of the relationship between the frequency of counsellor self-disclosure and alliance may not be appropriate. The remaining noncorrelated behaviours may also exemplify a discrepancy between what clients believe are related to the alliance and what empirically relates to the alliance (i.e., illusory correlations; Chapman, 1967; Fiedler, 2000). For example, clients may hold a stereotyped but incorrect belief that counsellors who form strong alliances also provide frequent verbal prompts and keep administration outside of session time.

The combination of the counsellor behaviours of making encouraging comments, making positive comments about the client, and greeting the client with a smile may be interpreted as behaviours that communicate a sense of positive regard or liking towards the client. The communication of positive regard towards the client is an action that has been previously argued to be the primary basis of effective counselling and psychotherapy (e.g., Rogers, 1957). Indeed, prior research supports the idea that positive regard promotes the development of the therapeutic alliance (Ackerman & Hilsenroth, 2003; Crits-Christoph et al., 2006; Najavits & Strupp, 1994; Thomas et al., 2005). It may also be that communicating positive regard elicits positive feelings in clients, which, as Fitzpatrick et al. (2006) found, may then lead to enhancement of the therapeutic alliance.

Implications of findings

The findings of the present study have implications for both counselling research and practice. First, the results demonstrate that some empirical relationship exists between what clients *think* plays a role in alliance development and what actually *does* play a role, giving some credence to the client as an insightful and knowledgeable agent. The present findings demonstrate that clients can accurately identify some statistically significant and helpful experiences in the counselling process. Indeed, routinely eliciting the perspective of the client on the alliance during counselling has been shown to improve the alliance and increase positive outcomes (Miller, Duncan, Sorrell, & Brown, 2005).

The findings also suggest that validation plays an important role in the therapeutic alliance. Based on the results alone, it remains unclear whether validation occurs as a result of a strong alliance, or if a strong alliance is the result of the counsellor validating the client. Nonetheless, the act of validation (communicating to someone that his or her experience is valid) conveys a sense of understanding, non-judgement, and respect towards the client, which Bordin (1979) suggested was a fundamental antecedent to alliance development. When appropriate, validation of the client should be an integral part of any counselling practice, as its effect likely extends beyond the alliance (Duncan, Miller, & Sparks, 2007). Counsellors are therefore encouraged to validate the experience of clients whenever possible, and counsellors should probably be trained to emphasize validation during the early stages of counselling.

Non-verbal behaviours that communicate a sense of focus or attention on the client also appear to be related to the alliance, and might be used by counsellors to maximize the potential of developing a strong alliance. Although the data are not able to identify whether these behaviours *cause* the alliance to improve, it seems unlikely that enacting these behaviors will cause the alliance to deteriorate. Clients are likely to benefit from the efforts of any counsellor who nonverbally communicates focus and attention on the client (Teyber, 2006), and the alliance may improve as a result.

Last, the results suggest that communicating positive regard towards clients by way of the three particular client-identified behaviours (i.e., making encouraging comments, making positive comments about the client, and greeting the client with a smile) is a strong predictor of alliance. Given that the alliance is a strong predictor of outcome (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000), communicating positive regard towards clients via these behaviours could be seen as a potentially important contributor to positive counselling outcome. While it remains uncertain, based on research design issues, whether or not these behaviours will actually cause alliance development (and consequently positive outcomes), it seems intuitively unlikely that they would impede alliance development. This assertion is supported by decades of the successful practice of person-centred counselling, which emphasizes positive regard as a core feature of effective counselling (e.g., Rogers, 1957). However, the findings make a unique contribution to counselling research by identifying a specific method of communicating positive regard towards clients (i.e., through three specific behaviours) that has a strong predictive relationship with the therapeutic alliance. Both counsellors-in-training and experienced practitioners are generally encouraged to establish a strong therapeutic alliance early in counselling (Teyber, 2006), and as a result of the present study,

educators may now also instruct students to incorporate these behaviours into empirically supported practice.

It should be mentioned here that although the results indicate an unlimited linear association between the identified counsellor behaviours and the alliance, the practical reader will note that constant and unscrupulous repetition of these behaviours will probably not improve the alliance; on the contrary, practitioners who make positive comments too frequently or at inappropriate times may find that the alliance develops poorly or does not develop at all. The results must therefore be interpreted in light of clinical experience and prior research, both of which suggest that particular behaviours can have a positive impact on the alliance when timed properly, used appropriately, and implemented with skill (cf. Ackerman & Hilsenroth, 2001; 2003; Bachelor & Horvath, 1999; Vasquez, 2007). Moreover, there is an interpretive component to each of the measured counsellor behaviours, such that different clients may interpret the meaning of any particular behaviour differently. Practitioners are cautioned to use clinical and practical judgement when implementing any of these behaviours, such that the impact of the behaviour on each client is carefully weighed and assessed before being used. The same cautionary measures must be taken when educators are training new counsellors in alliance-building processes, given that new counsellors may be less attuned to the subtleties of relationship building in the counselling context.

Limitations

There are a number of important limitations to the present study. The causal effect between variables obviously cannot be evaluated using this cross-sectional design. The proposed study also does not control for the effect of confounding or third variables, and the findings are limited to inferences that grant the potential effect of third variables possible.

Second, the screening and sampling method used in the present study narrowed the variability of participants, limiting the generalizability of the findings, since self-selection biases may artificially skew the results. For example, participants were highly experienced in counselling, probably above average. Purposive samples are also not random, and therefore statistical inference methods that are based on random population samples cannot be used with complete confidence, and the generalizability of the results are therefore called into some question.

Third, certain characteristics of the sample further limit generalizability. For example, the majority of the sample was also female (70%), which is reflective of the general gender distribution of the population of those who seek counselling (see Benton, Robertson, Tseng, Newton, & Benton, 2003). With a mean number of 21.2 ($SD = 28.7$) sessions, a median of 11 sessions of counselling, and a median of three counsellors seen during their lifetime, participants' counselling experience likely represents a subset of clients slightly more experienced than the average client.

Most participants in this study also identified themselves as being of European ethnicity (74.5%). However, clients of European descent may experience the alliance differently than clients of other ethnic heritages (Vasquez, 2007). This potentially places restrictions on the generalizability of the results to clients of non-European ethnicity. It may also be that the findings are reflective of Western cultural values, which emphasize both verbal and nonverbal expressions of liking and respect

through the use of smiling, eye contact and positive comments (behaviours that are mirrored by the present results). It is possible that the results would not be replicated in a more culturally and ethnically diverse sample than the one used in the present study. For example, Chinese cultural values are such that eye contact is not typically maintained with authority figures as a sign of respect (Hwang & Wood, 2007), and therapists who attempt to make frequent eye contact may actually impede alliance development. Future research should be conducted that better elicits the expertise of clients of diverse ethnic and cultural heritage.

Fourth, the validity of all questionnaire-based research is threatened by self-report bias. Given that all communication with participants was via telephone or email and that the questionnaire was administered online, the anonymity afforded to participants in the present study likely minimized the potential for self-report bias to impact data systematically. A more insidious threat to the validity of data collected in self-report retrospective studies is *hindsight bias*, or the tendency for participants' outcome knowledge to influence their memory of the event (Villejoubert, 2005). However, there is evidence that hindsight bias tends to be minimized when participants have a good deal of experience with the task being remembered (Christensen-Szalanski & Willham, 1991).

Last, the WAI-SR is based on Bordin's (1979) conceptualization of the alliance, and therefore measures a type of therapeutic alliance that closely matches his conceptualization. Given that the results are derived from the WAI-SR, they can only be extended to situations in which Bordin's conceptualization of the alliance is an accurate reflection of the alliance developed (as mentioned previously, this conceptualization may not be appropriate for ethnic minority clients; see Vasquez, 2007). Moreover, the TACIQ asks participants to give general approximations of the frequency of occurrence of each behaviour (e.g., questions can be answered as "sometimes" or "very often") rather than asking participants to specify the number of times that the behaviour occurred or having observers count their frequency. The accuracy with which the frequency of the behaviour was actually measured is therefore uncertain, and the results must consequently be interpreted with caution.

Future directions

Future possible studies that eliminate the issues that arise from the use of retrospective recall may use a longitudinal design in which the frequency of counsellor behaviours is reported by clients at the end of each session. To bolster the accuracy of these observations, trained observers could also rate the frequency of counsellor behaviours either through direct observation or the observation of videotaped sessions. Frequency ratings of clients and observers could be compared to assess for inter-rater agreement.

Future research should also attempt to identify the direction of causal influence between counsellor behaviours and the therapeutic alliance. While some research has attempted to demonstrate the causal effect of alliance on outcome by controlling for participant characteristics and early therapeutic change (Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland, 2000; Barber et al., 1999; Klein et al., 2003), and despite the present findings, it remains unclear whether the alliance is *caused* by certain counsellor behaviors, or that these behaviours are increased as a result of the development of the alliance, or that both alliance and these behaviours are

reciprocally influenced by one another (as suggested by Fitzpatrick et al., 2006). Another possibility is that a third, unknown factor influences or causes the association between these behaviours and alliance. Research that attempts to establish this causal effect should be based on prospective designs.

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Notes

1. Inter-item correlations greater than 0.3 are considered adequate (Field, 2005).
2. Field (2005) suggests that researchers consider removing items from a scale if their removal would increase alpha by a value greater than 0.02.
3. An outlier case (discussed later in this article) was removed prior to conducting this analysis; consequently, the sample size used in the calculation of this table was 78.
4. By convention, a value of power greater than or equal to 0.80 is considered to be adequate (Cohen, 1988).

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Appendix. Therapeutic alliance critical incidents questionnaire

Instructions: Below is a series of statements that describe some of the things that may happen during counselling. As you read the sentences, mentally insert the name of your therapist (counsellor) in place of _____ in the text. For each statement, please take your time to think carefully of your own experience *over the last three sessions only* with your therapist (counsellor) and then fill in the appropriate bubble.

Important: The rating scale is not the same for all the statements. **PLEASE READ CAREFULLY!**

- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. | _____ made eye contact with me. | <input type="checkbox"/> |
| | | Never | Sometimes | Fairly Often | Very Often | Always |
| 2. | _____ told me about similar experiences that he/she had. | <input type="checkbox"/> |
| | | Never | Sometimes | Fairly Often | Very Often | Always |
| 3. | _____ asked me questions. | <input type="checkbox"/> |
| | | Always | Very Often | Fairly Often | Sometimes | Never |
| 4. | _____ made encouraging comments. | <input type="checkbox"/> |
| | | Never | Sometimes | Fairly Often | Very Often | Always |
| 5. | _____ greeted me with a smile. | <input type="checkbox"/> |
| | | Always | Very Often | Fairly Often | Sometimes | Never |
| 6. | _____ identified and reflected back my feelings. | <input type="checkbox"/> |
| | | Always | Very Often | Fairly Often | Sometimes | Never |
| 7. | _____ referred to details we had discussed in previous sessions. | <input type="checkbox"/> |
| | | Always | Very Often | Fairly Often | Sometimes | Never |
| 8. | _____ let me decide what to talk about. | <input type="checkbox"/> |
| | | Never | Sometimes | Fairly Often | Very Often | Always |

9. _____ was honest (i.e., he/she shared negative information truthfully).

Always **Very Often** **Fairly Often** **Sometimes** **Never**

10. _____ made positive comments about me.

Never **Sometimes** **Fairly Often** **Very Often** **Always**

11. _____ sat still (i.e., did not fidget).

Never **Sometimes** **Fairly Often** **Very Often** **Always**

12. _____ provided verbal prompts (e.g., “uh huh,” “hmm-mmm”).

Always **Very Often** **Fairly Often** **Sometimes** **Never**

13. _____ sat facing me (i.e., sat directly across from me).

Never **Sometimes** **Fairly Often** **Very Often** **Always**

14. _____ kept the administration (e.g., fees, scheduling of appointments, paperwork) outside of our sessions.

Never **Sometimes** **Fairly Often** **Very Often** **Always**

15. _____ validated my experience (e.g., he/she said that my reaction was understandable and reasonable, and that it was okay to feel this way).

Always **Very Often** **Fairly Often** **Sometimes** **Never**