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Review Article

It's time to talk about our relationships: Exploring the role of therapeutic alliance in speech and language therapy, with stuttering intervention as an exemplar

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Abstract. The value of the therapeutic alliance as an essential component of psychotherapy has been recognised for several decades. For example, research has shown that the therapeutic alliance contributes positively to treatment outcomes and client satisfaction. In contrast, knowledge about the role of therapeutic alliance in speech and language therapy (SLT) remains at an emerging level, due in part to the discipline's primary focus on the development, use and scientific validation of specific intervention methods and techniques. This paper aims to increase speech and language therapists' (SLTs) understanding and implementation of constructive therapeutic alliances in their work with individuals with communication needs. In particular, we focus on adults who stutter, to convey the importance of fostering these alliances in clinical practice. We begin with an exploration of the meaning of the therapeutic alliance and the range of person-related and contextual variables that influence its establishment and maintenance. We continue with a discussion on what SLTs can learn from the psychotherapeutic literature on therapeutic alliance. In addition, the gaps in our knowledge that remain in terms of the need for an SLT-specific and stakeholder-informed conceptualisation of the therapeutic alliance are discussed. Finally, we provide key recommendations for fostering a therapeutic alliance with adults who stutter in order to enhance the relational competence of SLTs working in clinical practice. It is imperative and timely that the discipline of SLT redirects its attention to the role of variables beyond specific treatment techniques that influence treatment outcomes. This will ensure the design and delivery of effective stuttering interventions, and enhance treatment outcomes for those who stutter.

Keywords: Therapeutic alliance, speech and language therapy, stuttering, clinical recommendations

1. Introduction

Therapy is both science and an art, and research should reflect this by investigating the operational step-by-step techniques employed by therapists, as well as the relational processes that lead to positive outcomes (Larner, 2004). Research in the discipline of SLT has primarily focused on the experimental validation of selected treatment methods and techniques (Hansen et al., 2021). The content of clinical practice in SLT is primarily technique focused; less attention has been paid to other aspects of therapy that

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are known to influence outcomes, such as the therapeutic alliance and person-related variables. This narrow focus is problematic because it ultimately limits the ability of SLTs to help their clients.

To be an effective therapist, two types of competence must be mastered: *clinical* competence and *relational* competence (Sylvestre & Gobeil, 2020; Wampold, 2001). *Clinical* competence is the mastery of knowledge relating to a specific area of expertise (e.g., the ability to administer an assessment, or to execute a specific intervention). *Relational* competence incorporates the attitudes and skills that are necessary to establish a therapeutic alliance with a client (Wampold, 2001). A therapist's adherence to a specific treatment protocol, whilst important, is not the sole contributor to treatment outcomes. Although the focus of evidence-based practice has primarily centred on efficacy evidence, it must also include client-based evidence, such as client opinions, values and treatment preferences (Greenhalgh et al., 2014; McCurtin et al., 2019). To facilitate the collection of client evidence, therapists must develop and use their *relational* competence and build a therapeutic alliance with their clients. The discipline of SLT must therefore investigate the role of variables beyond specific treatment techniques. This will also help to align SLT with other disciplines, such as psychotherapy, that have been demonstrating the value of these variables for several decades.

2. What is therapeutic alliance?

Various terms have been used, often interchangeably, to describe the interactional and relational processes that operate during therapy. These include: *therapeutic alliance*, *working alliance*, *rapport*, *therapeutic bond* and *therapist-client relationship* (Hansen et al., 2021; Kayes & McPherson, 2012; Lawton et al., 2018a). These terms carry different meanings, with some emphasising the affective element of the relationship (e.g., *therapeutic bond*), and others placing more weight on the interactional elements of the relationship (e.g., *working alliance*) (Kayes & McPherson, 2012). The term *therapeutic alliance* is used throughout this paper as it encompasses both the interactional and relational processes that are co-constructed by the client and therapist during therapy (Green, 2006; Walsh & Felson Duchan, 2011). Importantly, the therapeutic alliance is not a static state; rather, it develops and evolves continuously over time between the individuals involved (Walsh & Felson Duchan, 2011). These individuals include the client and the therapist, but can also include other parties such as caregivers who may play an essential role in therapy (Freckmann et al., 2017).

The origins of the therapeutic alliance are grounded in psychotherapy, namely Freud's (1913) and Rogers' work (1957). Bordin presented a tripartite conceptualisation of what he termed the "working alliance", which was composed of the client's and therapist's agreement on therapy goals, the mutual agreement and collaboration on tasks to meet the goals, and the interpersonal bond between the client and therapist (Bordin, 1979, p. 252). This conceptualisation parallels more contemporary foci in healthcare such as shared decision-making and person-centred care, which emphasise the merits of integrating client treatment preferences and desired outcomes (Bomhof-Roordink et al., 2019; WHO, 2015). Bordin's conceptualization has more recently been expanded due to its increased application to a wider range of healthcare disciplines, and additional constructs such as communication, client empowerment (including power sharing and client self-efficacy), family systems and social context have been added (Elvins & Green, 2008; Göldner et al., 2017; Kim et al., 2001, Lawton et al., 2018a). Based on this prior literature, we will use the term therapeutic alliance to refer to the interactional and relational processes that are cocreated by the client and therapist throughout therapy and influenced by variables within and beyond the client-therapist dyad.

Sylvestre and Gobeil (2020) differentiated between therapeutic relationship and therapeutic alliance. They asserted that the therapeutic relationship is itself a component of the broader therapeutic alliance, and they highlighted that this relationship develops from the very first interaction between the client and therapist. The therapeutic relationship is the trusting foundational affective bond on which the therapeutic alliance is built; it consists of the attitudes and feelings that the client and therapist experience and express with one another (Fourie et al., 2011; Sylvestre & Gobeil, 2020). In order to establish and maintain this initial therapeutic relationship and the subsequent therapeutic alliance, therapists are required to adopt a person-centred care approach and implement the process of shared decision-making (Sylvestre & Gobeil, 2020). In a person-centred care approach, the clinician acknowledges each individual client in their personal context, and respects, listens to, informs and involves them in all aspects of their care (Epstein & Street, 2011). It is a form

of appreciative healthcare, in which the therapist is aware of the positive potential in their client (Roberts & Machon, 2015). Person-centred care is endorsed as an essential approach to health service delivery, with frameworks such as the *International Classification of Functioning, Disability and Health* (ICF) providing a useful roadmap for therapists to support its implementation (WHO, 2013, 2015).

Using stuttering intervention as an example, a person-centred care approach involves the therapist acknowledging the individual nature and experience of stuttering, incorporating collaborative decision-making into the intervention (such as agreement on goals and treatment choice), and using client-derived outcome measures that are specific to the client's personal goals. In their exploration of the association between therapeutic alliance and person-centred care, Hamovitch et al., (2018) concluded that the two are inextricably linked, with each influencing the other. In other words, the therapeutic alliance is both a facilitator and an outcome of person-centred care. Shared decision-making, a core component of person-centred care, has been proposed to facilitate the establishment of the therapeutic alliance (Sylvestre & Gobeil, 2020). It involves the client and therapist working together to agree on the tasks required to meet the client's personal goals through consideration of the best evidence and the client's values and preferences (Ferro-López et al., 2021; Haesebaert et al., 2019; Sylvestre & Gobeil, 2020). Elements of shared decision-making include describing treatment options to clients, including client preferences, and increasing clients' choice awareness (Bomhof-Roordink et al., 2019). Stewart (2022) advocates for the creation of a context of choice to support the therapeutic alliance when working with individuals who stutter. In line with research identifying the bidirectional relationship between the therapeutic alliance and person-centred care, it can be assumed that shared decision-making both facilitates and is enhanced by the therapeutic alliance (Hamovitch et al., 2018).

3. What variables influence the therapeutic alliance?

A range of person-related and external variables have been identified in the healthcare literature as influencing the establishment, maintenance and quality of the therapeutic alliance.

3.1. Variables relating to the therapist

While what we do as a therapist has importance, aspects of who we are and how we work with our clients also influence treatment outcomes (Kayes & McPherson, 2012). Certain interpersonal characteristics of a therapist that influence the therapeutic alliance have been identified in the psychotherapy, SLT and physiotherapy literatures. These include empathy, honesty, respect, trustworthiness, confidence, warmth, interest, openness, receptiveness, genuineness and the ability to be present (Ackerman & Hilsenroth, 2003; Miciak et al., 2018; Stewart, 2022; Van Riper, 1973; Walsh & Felson Duchan, 2011). These interpersonal characteristics are not static; rather, they develop continuously throughout the relationship with the client (Göldner et al., 2017). Emotional intelligence is the term used to describe a set of emotional and social skills that impact how we perceive and express ourselves, and maintain social relationships (Multi Health Systems, 2011). Weng et al. (2011) found that surgeons' emotional intelligence had a positive effect on client-surgeon relationships.

In the drive to provide an intervention or to meet daily appointment targets, the time necessary to enact these qualities may be lacking, resulting in poorer alliances with clients. Examination of the SLT literature, in particular studies of adults with aphasia, highlights specific behaviours of the SLT that influence the therapeutic alliance. These include giving honest feedback to the client about their progress, using humour (appropriately), acknowledging the client's lived experience, and adapting to the client's relational preferences (Lawton et al., 2018a; Simmons-Mackie & Damico, 2011; Simmons-Mackie & Schultz, 2003). Fourie (2009) argued that the interplay between the therapeutic actions of the SLT, as well as their personal and professional qualities, facilitates a positive therapeutic alliance. Through his investigation of the SLT qualities desired by a group of adults with acquired communication and swallowing disorders, Fourie developed a theory of "restorative poise" (2009, p. 988). This theory summarised the therapeutic *qualities*, such as being understanding and inspiring, and the therapeutic *actions*, such as being confident, practical and empowering, that influence the therapeutic alliance (Fourie, 2009). In essence, the SLT must bring their authentic "best self" to the interaction and avoid their own ego, fears or impatience that may hinder the therapeutic alliance (Stone-Goldman, 2013, p. 26). Studies have found that specific train-

ing of novice psychologists in therapeutic alliance techniques (centred on Bordin's (1979) three key areas of agreement on tasks, agreement on goals, and therapeutic bond) is effective in enhancing alliances with their clients (Crits-Christoph et al., 2006). This is encouraging for SLTs who feel that they may not possess the required interpersonal skills, or for less-experienced SLTs who have not yet developed the more nuanced communication skills that support the development of therapeutic alliances. Communities of practice (CoPs) offer further support to SLTs wanting to deepen their knowledge and expertise in clinical areas such as the development of the therapeutic alliance (Gauvreaua & Le Dorze, 2022). These groups of individuals, who share a common interest or clinical concern, facilitate the sharing and co-creation of knowledge through interactions with peers (Li et al., 2009).

To date, relatively little research has examined the role of SLTs in developing and maintaining the therapeutic alliance in stuttering intervention. Several studies have examined the characteristics of SLTs that both facilitate and hinder successful therapeutic outcomes (Johnson et al., 2016; Plexico et al., 2010). Adults who stutter have reported that the SLT's empathy, understanding of stuttering and its treatment, commitment to therapy, and ability to build a trusting therapeutic alliance with their clients are all facilitators to successful therapeutic outcomes (Johnson et al., 2016; Plexico et al., 2010). Conversely, failure to acknowledge individual goals, an overreliance on therapeutic technique, and reduced patience are all perceived as barriers to successful outcomes (Johnson et al., 2016; Plexico et al., 2010). These findings have implications for how we conduct therapy and call us to question our over-reliance on specific intervention techniques.

These findings align with Botterill's (2011) and Stewart's (2022) discussion on the need for SLTs to move away from an asymmetrical medical model view of the client-therapist relationship (involving the expert therapist and passive client) and towards a more collaborative and empowering one (where the client is an equal partner in the relationship). In more recent stuttering research, the therapeutic activities performed by the SLT (e.g., involvement of family members in the intervention, discussing past negative intervention experiences), and their professional and personal qualities (e.g., being empathetic, being a good listener) have been identified as core intervention components by key stakeholders, including adults who stutter and academic and clinical stuttering experts (Connery et al., 2020a; Connery et al., 2021). These findings highlight the key role SLTs play in the therapeutic process and in enhancing treatment outcomes.

3.2. Variables relating to the client

The healthcare literature has outlined a range of client-related variables that influence the establishment and maintenance of a therapeutic alliance. These include past experiences of relationships (e.g., with parents or caregivers in early childhood), pre-treatment severity of illness, insight into their difficulties, previous experiences with healthcare professionals and the expectation of change (Bernecker et al., 2014; Cheng & Lo, 2018; Hersoug et al., 2010; Paap et al., 2021). For example, a high expectation of change may lead to frustration about slow therapeutic progress and a deterioration in the therapeutic alliance. Cheng and Lo (2018) identified three key client-related variables that influence the therapeutic alliance in psychotherapy: interpersonal capacities, intrapersonal dynamics, and problem severity. A client's difficulty with forming an interpersonal relationship with the therapist, which may stem from a history of poor-quality relationships, (interpersonal capacity), or their reduced motivation to change (intrapersonal dynamics), can weaken the therapeutic alliance (Cheng & Lo, 2018; Wolfe et al., 2013). Additionally, working with clients with more severe and complex mental health difficulties can result in the formation of weaker therapeutic alliances (Cheng & Lo, 2018; Flückiger et al., 2013). It is therefore important for the SLT to be aware of such factors specific to their client. Conversations should be held at the beginning of intervention, or when the intervention is not working, to assist in gathering such knowledge.

In their research exploring the therapeutic alliance between clients and physiotherapists, Miciak et al. (2018) identified four foundational conditions that foster the alliance, including the client being present, receptive, genuine and committed. (These conditions are also required from the physiotherapist). Client-based research specific to aphasia rehabilitation has identified the client's readiness to contribute to the alliance (e.g., psychological status or awareness of difficulties) as an essential prerequisite to forming a therapeutic alliance (Lawton et al., 2018b). Individuals with aphasia typically need to adjust to immediate and significant changes in their health status. Therefore, their perceptions of the therapeutic alliance are

most likely different to that of adults who have stuttered most of their lives.

No research known to the authors has investigated the perceptions of what the therapeutic alliance means to adults who stutter. Similarly, no research has examined the role of adults who stutter in establishing and maintaining the therapeutic alliance. Research has, however, identified client-related characteristics that influence stuttering treatment outcomes. These include readiness for change, motivation to engage in intervention, sense of agency, and communication self-efficacy (Bray et al., 2003; Connery et al., 2020a; Connery et al., 2021; Floyd et al., 2007; Manning, 2010; Rodgers et al., 2021; Sønsterud et al., 2019; Turnbull, 2000). Adults who stutter are more likely to form a therapeutic alliance with a therapist they perceive as competent (e.g., communicating their understanding of the client's experience of stuttering), as this facilitates feelings of being understood, accepted and empowered (Plexico et al., 2010). SLTs play a role in the evolution of these client-related characteristics in therapy. For example, research has demonstrated that client motivation is constructed through the client-therapist interactions that occur in the clinical environment (Papadimitriou et al., 2018).

3.3. Client-therapist matching

The psychotherapy literature has explored the influence of matching therapists and clients, in terms of certain characteristics or attributes, on the therapeutic alliance. This matching stems from the idea that individuals are more likely to associate with and develop better relationships with those with a similar worldview and similar physical characteristics (Behn et al., 2018). Research has explored the influence of matching in terms of gender, race/ethnicity and age on therapeutic alliance. Overall results have been mixed, suggesting that matching in terms of shared values and attitudes may be more important to clients than matching in terms of demographic characteristics (Cheng & Lo, 2018; Gelso & Mohr, 2001; Werbart et al., 2018). Some psychotherapy research has highlighted the essential role that client-therapist personality matching plays in the therapeutic alliance (Bordin, 1979; Werbart et al., 2018). Bordin (1979, p. 252) for example, argued that the strength of the alliance is dependent on the "goodness of fit" of the two personalities with the demands of the alliance; however, he failed to fully explicate the meaning and composition of this "fit".

Although the influence of personality matching is an unexplored area in SLT, one recent study by Freud et al. (2021) compared the personality profiles of SLTs working with clients who stutter to those not working with this client group. SLTs working with clients who stutter were characterised by lower levels of Neuroticism (which is associated with emotional stability, calmness, and elevated resilience to anxiety) relative to SLTs not working with clients who stutter. Adults who stutter have been shown to exhibit higher scores on Neuroticism (which is associated with anxiety and emotional instability) when compared with controls (Freud et al., 2021; Jafari et al., 2014). Thus, a lower level of Neuroticism on the part of the clinician may facilitate a better therapeutic alliance with clients who stutter. The matching of personalities has the potential to influence the strength of the therapeutic alliance. This concept is reflected in the psychotherapeutic term, *therapeutic dance,* in which both parties connect in a way that promotes growth and change (Slavin-Mulford, 2013). In an ideal world, a client would be paired with an SLT whose personality complements their own. However, the applicability of such a vision is no doubt challenged by the pervasive under-resourcing and organisational constraints that face many SLTs in clinical practice. Nevertheless, if we choose to ignore such issues, resources will be wasted and clients will experience poorer outcomes.

3.4. External variables

A range of variables outside of the therapeutic dyad can influence the quality and strength of the therapeutic alliance. Lawton et al., (2018a, p. 558) used the term "contextual shapers" to capture the influence of organisational and family factors that can facilitate or impede the development and maintenance of the alliance between SLTs and their clients. Organisational factors such as time constraints and a target-driven culture (which currently dominates SLT and healthcare practice more generally) have been identified by SLTs as hindering the development of the therapeutic alliance (Lawton et al., 2018a). Additionally, the use of a medical model approach to service delivery compromises the therapeutic alliance as it encourages the client to be a passive recipient of care (Joosten et al., 2008; Sylvestre & Gobeil, 2020). Of note, research examining the service delivery model of telepractice has found therapeutic alliance established during telepractice to be equal and sometimes even superior to therapeutic alliance

in face-to-face psychotherapy and SLT (Chong & Moreno, 2012; Freckmann et al., 2017).

Although the impact of external factors on the therapeutic alliance between SLTs and adults who stutter has not been investigated specifically, some organisational barriers to the delivery of effective stuttering intervention have been identified. These include the prioritisation of services for other communication disorders, limited time spent with the client, and the financial cost of services (Connery et al., 2020a; Yaruss et al., 2002). A further external variable identified by SLTs as influencing the therapeutic alliance refers to the influence family members have on the client's perception of the therapeutic alliance (Lawton et al., 2018a). Through these individuals' own personal perceptions and comments on the intervention to the client, they can either facilitate or impede the therapeutic alliance (Lawton et al., 2018a; Sylvestre & Gobeil, 2020). Benefits of integrating family members, such as partners, as agents of change during stuttering interventions with adults has been demonstrated (Beilby et al., 2013); however, SLTs should be mindful of the influence of this on the therapeutic alliance, and whether it will be constructive or deleterious.

4. What can we learn about the therapeutic alliance from the psychotherapy literature?

The range of variables outside of the specific intervention technique that contribute to therapeutic change have been acknowledged in the psychotherapy literature for several decades (Cartwright & Hardie, 2012; Lambert, 2013; Wampold, 2015). While SLT cannot be considered a psychotherapy, working with clients with communication disorders such as stuttering certainly requires elements of psychological knowledge and skills, if the totality of the disorder and its implications are to be successively managed. Wampold's (2015) Contextual Model detailed three core pathways that lead to psychotherapeutic outcomes: an authentic alliance between the client and therapist, client expectations of therapy, and the specific treatment technique. Wampold (2015) argued that an initial bond between the client and therapist needs to be established prior to the employment of these three pathways. Similarly, Sylvestre and Gobeil (2020) argued for the necessity of an initial trusting affective bond between an SLT and their client, on which the therapeutic alliance can then be constructed. Lambert (2013) estimated that 40% of psychotherapy outcome variance is due to extra-therapeutic factors, which include client qualities (e.g., motivation) and environmental variables (e.g., social support); 30% is due to common factors, such as the therapeutic alliance or clinician-related variables (e.g., empathy), and only 15% is due to the specific therapeutic techniques. The important message for SLTs, who tend to be highly focused on technique, is that their mastery of clinical competence alone is not sufficient for the delivery of effective interventions. Relational competence is also required to facilitate positive treatment outcomes. Further, given the primary focus on the experimental validation of treatment techniques that currently characterises SLT research, increased attention to the measurement of other variables, such as therapeutic alliance and person-related factors, needs to be prioritised.

Numerous systematic reviews and metanalyses in the discipline of psychotherapy (and more recently physical rehabilitation) have concluded that the strength of the therapeutic alliance is related to treatment adherence, treatment outcomes and client satisfaction with treatment (Baldwin et al., 2007; Flückiger et al., 2018; Hall et al., 2010; Horvath et al., 2011; Lakke & Meerman, 2016; Martin et al., 2000). A client's perceived quality of the therapeutic alliance early in therapy (by the third session) is a significant predictor of outcome, with favourable judgements generally resulting in positive outcomes, and unfavourable judgements associated with increased dropout from therapy (Castonguay et al. 2006; Leibert, 2011). The first few sessions of therapy, therefore, represent a "window of opportunity" during which the therapist must prioritise and foster the development of the therapeutic alliance, both to reduce the likelihood of premature dropout and to maximise treatment outcomes for the client (Bachelor & Horvath, 1999, p. 139).

5. What can we learn about the therapeutic alliance from the SLT literature?

In comparison to the vast exploration of the role of therapeutic alliance in the psychotherapy literature, such studies remain at an emerging level in the discipline of SLT. Most of the research is based on theoretical knowledge that is primarily generated from psychotherapeutic approaches (Göldner et al., 2017). Despite this, research examining the

influence of the therapeutic alliance on client motivation, engagement in the therapeutic process and outcomes is becoming increasingly evident in the discipline of SLT, in particular with interventions for aphasia (Lawton et al., 2016; Lawton et al., 2018a,b; Lawton et al., 2020), paediatric speech and language disorders (Freckmann et al., 2017), cluttering (Sønsterud, 2019) and stuttering (Connery et al., 2020a,2021; Sønsterud et al., 2019). Lawton et al. (2018b) investigated people with aphasia's experiences of constructing and maintaining therapeutic alliances with speech and language therapists (SLTs). The results of their study highlighted the essential role the SLT plays in the construction of therapeutic alliance, in terms of the behavioural processes they employ including responding to their client's needs and communicating information. In fact, SLTs' own perspectives of the therapeutic alliance in aphasia rehabilitation support these findings, with a range of processes identified by this stakeholder group as being important to developing and maintaining a therapeutic alliance. These processes, including getting to know the person, showing empathy, preserving hope, promoting goal ownership, and being encouraging, are moulded by contextual factors such as the client's family and organisational drivers (e.g., time and resource constraints) (Lawton et al., 2018a).

Systematic reviews of stuttering treatment efficacy have revealed a diverse range of effective interventions, with no significant difference in outcomes (Baxter et al., 2015; Connery et al., 2020b; Herder et al., 2006). Such findings may be explained by the presence of variables beyond the intervention technique that are common to all interventions. In their investigation of the perspectives of adults who stutter on the characteristics of therapists that contribute to an effective therapeutic experience, Plexico et al. (2010) found that over 50% of the participants identified the importance of a trusting therapeutic alliance in promoting successful change. More recent research providing client- and practice-based evidence for effective stuttering interventions offers support for this argument (Connery et al., 2020a; Connery et al.; 2021). Connery et al. (2020a) explored the perspectives of international researchers and clinical experts in the field of stuttering on the components of effective stuttering intervention using semi-structured interviews. One of the three core themes identified was "a really collaborative relationship where we are both bringing our sense of expertise to this" (Connery et al., 2020a, p.6). This theme represented the client- and therapist-related attributes that are important for enhancing the therapeutic process and treatment outcomes, as well as the benefits of collaborative work and a positive therapeutic alliance in enhancing treatment outcomes. In another stakeholder-focused study, SLTs and adults who stutter both agreed that the therapeutic alliance and variables related to the client (e.g., client motivation) and the SLT (e.g., their knowledge of stuttering) are indispensable ingredients of effective stuttering interventions (Connery at al., 2021). These studies highlight the wide-ranging variables that lead to therapeutic change and the need for SLTs to be competent in the relational aspects of therapy. However, these studies do not examine the construct of therapeutic alliance in its entirety, and further explication of the specific attributes and behaviours that are conducive to a positive alliance in stuttering intervention is needed (Connery et al., 2021; Manning, 2010).

Sønsterud et al. (2019) found significant associations between the strength of the alliance and clients' motivation and treatment outcomes 6 months post-intervention for stuttering. The intervention focused on breath and body awareness, speech modification, mindfulness-based strategies and presentation skills. Results revealed that mutual agreement on therapy tasks and client-led goals were of particular importance to treatment outcomes, and that such factors contributed more to outcomes than the emotional bond. The authors cautioned that this finding does not indicate that the client-therapist bond should be neglected; rather, it provides a foundation for therapy tasks and client-centred goals to be established. Such findings may be further explained by considering the more task-based nature of SLT in comparison to psychotherapy. Sønsterud et al. (2019) argued that the bond between client and clinician may play less of a role in SLT than psychotherapy, which focuses more on the individual's internal experiences. The client-therapist bond may however have increased relevance for other intervention approaches, targeting, for example, client goals on the management of the emotional and cognitive aspects of stuttering.

6. Tools for assessing the therapeutic alliance

Routine clinical use of therapeutic alliance measures can provide therapists with information required to repair problems in the alliance and identify clients with a poor response to an intervention (Manning, 2010). Most measurement tools originate from the field of psychotherapy: Elvins and Green (2008) reviewed 32 such tools, compared to just four

identified in a recent review in the physiotherapy literature (Sánchez et al., 2020). The perspectives of a range of stakeholders must be obtained in order to adequately assess the therapeutic alliance. These include the client, their caregiver (if appropriate), and the therapist (Freckmann et al., 2017). The Working Alliance Inventory (WAI) is one self-report instrument that measures the strength and quality of the client-therapist relationship across Bordin's (1979) three components of bond, goal and task (Horvath & Greenberg, 1989). A shorter 12-item version, the Working Alliance Inventory-Short Revised (WAI-SR), was later developed; it remains one of the most frequently used measures of the therapeutic alliance in psychotherapy (Hanson et al., 2002). Both have been recommended by Sønsterud et al. (2019) as useful clinical tools for evaluating the therapeutic alliance in SLT. Using the same theoretical underpinnings, the Therapeutic Alliance Scales for Children-Revised (TASC-R) was developed for use with children and their therapists, and measures therapeutic alliance across the three dimensions of task, bond and goals (Creed & Kendall, 2005). Variations of this measure such as the TASCP (Therapeutic Alliance Scale for Caregivers and Parents) also exist to collect the perspectives of other parties (Accurso et al., 2013).

In SLT, Lawton et al. (2019) recently developed the Aphasia and Stroke Therapeutic Alliance Measure (A-STAM), including both client and therapist versions. Although no stuttering-specific measure of the therapeutic alliance exists, the clinical use of rating scales to assess the quality of the therapeutic alliance in stuttering intervention has been recommended (Plexico et al., 2010; Zebrowski & Kelly, 2002). One example is the Session Rating Scale (SRS) which consists of four interacting items in visual analogue form and in line with Bordin's (1979) classical definition of the therapeutic alliance: Relationship, Goals and Topics, Approach or Method, and Overall (Miller et al., 2002). Each item is rated from 1-10, and if the total score is lower than 36, a discussion with the client is required to identify areas requiring change moving forward (Miller et al., 2002).

7. Strategies to foster a therapeutic alliance with an adult who stutters

SLTs play a key role in establishing and maintaining the therapeutic alliance with adults who stutter. Based on the literature reviewed above, a range of recommendations to bolster this in clinical practice will now be presented. Although these recommendations are specific to intervention with adults who stutter, they also have relevance to clinical work with clients with other communication difficulties.

7.1. Position the client at the heart of therapy

Maintaining a person-centred approach and implementing shared decision-making will support the development and maintenance of the therapeutic alliance with your clients. This can be achieved by listening to an individual's personal lived experience of stuttering, acknowledging their expert role in the therapeutic process, supporting them in generating realistic goals, and including them in all aspects of decision-making.

7.2. Allow time to develop a therapeutic alliance with your client and be present in this process

Ensure your time with the client is not dominated by the administration of assessments and the implementation of specific interventions. Ensure that you allocate sufficient time, especially in the early stages of therapy, to establish a trusting relationship, through hearing the client's story, demonstrating empathy and patience, and expressing commitment to facilitating positive change with the client.

7.3. Make space for the client to talk about their past experiences of intervention, as well as their prior therapeutic alliances

For some adults who stutter, their past experiences of SLT were characterised by a lack of person-centred care, reduced knowledge and empathy on the part of the SLT, and the development of unrealistic goals (Johnson et al., 2016). A discussion about past negative experiences of therapy has been identified by adults who stutter as an essential component of effective intervention (Connery et al., 2021). Allow time, especially in the early stages of therapy, for a conversation to unfold on the aspects of previous therapy that did and did not work well. This will foster a relationship of trust and increase the likelihood of a positive therapeutic alliance being established.

7.4. *Familiarise yourself with therapeutic alliance measures*

The use of therapeutic alliance measures with clients at the end of sessions provides useful information on key aspects of the alliance such as goal-setting and collaborative decision-making. The SRS or WAI-SR are easy and quick to administer, and information collected from these instruments can be supplemented with an informal discussion on aspects of the alliance that can be improved moving forward (Hanson et al., 2002; Miller et al., 2002).

7.5. *Establish a therapeutic alliance community of practice*

Communities of practice (CoPs) are groups of individuals sharing a common interest, problem or challenge that offer a platform where the exchange of knowledge and practices (e.g., the practice of developing a therapeutic alliance) can occur through ongoing interactions as a group (Wenger-Trayner et al., 2014). A therapeutic alliance CoP would encourage SLTs to reflect on their current practice around developing alliances, better equip them to adopt new practices, and increase their confidence and motivation towards enhancing alliances with clients (Gauvreaua & Le Dorze, 2022).

7.6. *Explore the meaning of emotional intelligence and engage with training in this area*

Key elements of emotional intelligence include *self-perception* (e.g., the ability to recognise and understand one's own emotions, strengths and weaknesses), *self-expression* (the ability to communicate one's feelings, beliefs and thoughts) and *interpersonal skills* (e.g., the ability to develop relationships based on trust, empathy and compassion) (Multi Health Systems, 2011). Activities such as self-reflection on your skills, strengths and weaknesses in general, peer feedback activities, or seeking mentorship from a colleague with high emotional intelligence, would enhance your own skills in this area. Further, developing an understanding of the lived experience of stuttering as portrayed by individuals who stutter in autobiographies, blogs, poetry, film and the visual arts, can increase empathy and enrich clinical encounters (Walsh & Mallinson, 2022). Finally, the American Speech-Language-Hearing Association (ASHA) Leadership Academy webinar on emotional intelligence is a useful resource for enhancing relationships with clients, families and colleagues (AHSA, 2020).

7.7. *Reflect on the interplay between your own and your clients' personalities*

Due to the pervasive under-resourcing and organisational constraints that most SLTs are currently faced with in clinical practice, it is unlikely that client-therapist matching will be possible with your caseload. Still, there are several practical ways that the therapeutic alliance can be enhanced based on the matching literature (Werbart et al., 2018). These include attending to a client's dominant personality traits, acknowledging your feelings and reactions being triggered by these traits, reflecting on the interplay between your client's and your own personality configuration, and seeking supervision when this interplay is perceived as unhelpful.

7.8. *Re-evaluate service delivery in light of research on the therapeutic alliance*

Current stuttering care pathways and service delivery models operational in clinical practice should be reviewed to ensure the role of the therapeutic alliance is acknowledged, and that adequate time and resources are allocated for it to be established. In addition, given that the therapeutic alliance achieved via telepractice is at least of equal quality to that accomplished face-to-face, the service delivery model of telepractice may be of value to clients living in geographically remote areas.

7.9. *Apply the therapeutic alliance research findings to a paediatric population*

The therapeutic alliance is an important component of SLT for children with communication needs (Fourie et al., 2011), and discussions and recommendations of this paper are of relevance to intervention with this cohort, e.g., developing an affective bond with a child who stutters through play, recognising the child's personal goals. Additionally, your interactions with parents of children who stutter may also be enhanced through increased knowledge of therapeutic alliance and the wide-ranging variables that influence it.

7.10. Extend the construct of the therapeutic alliance to other contexts

The construct of the therapeutic alliance can be extended to other contexts involving interactional and relational processes such as relationships with students, colleagues and supervisors. Knowledge of the therapeutic alliance and its components can support your understanding of ruptures in these relationships, and identify the elements of the relationship that need repair e.g., recognising that reduced collaboration on tasks is negatively impacting a relationship with your colleague.

8. Recommendations for future research

Although psychotherapeutic constructs of the therapeutic alliance offer valuable knowledge to the discipline of SLT, the development and maintenance of alliances with clients with communication difficulties are more nuanced. This is due to clients' specific deficit in communication (which is an essential skill for developing a therapeutic alliance), and the fact that the processes involved in communication rehabilitation are different to those commonly used in psychotherapy (Lawton et al., 2018b). It is therefore fundamental that the evidence base for the therapeutic alliance specific to communication difficulties be expanded so as to include the perspectives of all key stakeholders.

Client-based evidence is an under-represented form of knowledge in the SLT literature, and this is echoed in the paucity of research examining client perceptions of the therapeutic alliance (Fourie, 2009; McCurtin et al., 2019). It is likely that there are differences in the experiences of the therapeutic alliance between different communication disorder cohorts, given the chronic nature of some conditions (e.g., stuttering) and the more acute nature of others (e.g., aphasia post-stroke). Therefore, a conceptualisation of the therapeutic alliance as it relates to specific communication disorders is warranted. This has recently been demonstrated in the aphasia rehabilitation literature, with a stakeholder-focused exploration of the experience of therapeutic alliance from the perspective of SLTs and adults with post-stroke aphasia (Lawton et al., 2018a, Lawton et al., 2018b; Lawton et al., 2020). The stuttering-specific literature would benefit from a similar stakeholder-focused exploration and conceptualisation of the therapeutic alliance. Obtaining the perspectives of both stakeholder groups (SLTs and adults who stutter) is essential due to differences in clients' and therapists' perceptions, with clients viewing the therapeutic alliance as stable and therapists indicating more change over time (Horvath et al., 2011; Martin et al., 2000). Additionally, the therapeutic alliance has been characterised by an imbalance of power between healthcare professionals and clients, with power disproportionately weighted toward therapists and highlighted by reduced collaboration and therapist-led goal-setting (Lawton et al., 2016). It is therefore essential to obtain the perspectives on what the therapeutic alliance means to both stakeholder groups, to develop a conceptualisation that can inform further research in the area and offer guidance for those working in clinical practice.

9. Conclusion

The therapeutic alliance is a multi-faceted and dynamic construct that has been recognised as an active and essential ingredient of effective psychotherapy for several decades. In more recent times, its role in healthcare more generally has gained traction, with research concluding that the strength of the therapeutic alliance is related to treatment outcomes, adherence and satisfaction. Research into the range of person-related and contextual variables that influence the therapeutic alliance highlights the complexity of this construct that goes beyond Bordin's original tripartite conceptualisation of bond, goal and task. Therapeutic alliance is a complex construct that is influenced by factors within and beyond the therapist-client dyad. Current conceptualisations of this construct in the literature have primarily evolved from the discipline of psychotherapy. They therefore fail to capture the true meaning of the therapeutic alliance as it relates to the context of disciplines such as SLT.

Despite significant advancements made in the experimental validation of SLT treatment methods and techniques, less attention has been paid to other relational aspects of the therapeutic process that influence outcomes. It is therefore essential that the field of SLT directs its attention to the investigation of variables such as the therapeutic alliance to ensure equal value is placed on the clinical and relational elements of SLT. Stakeholder-informed research exploring the conceptualisation of this construct as it applies to specific cohorts of individuals with communication needs, such as adults who stutter, is recommended.

This will support its application in clinical practice and ensure optimum outcomes for clients with communication difficulties are achieved.

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Conflict of interest

The authors have no conflict of interest to report.

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