From a Distance: Establishing, Developing, and Deepening the Therapeutic Alliance

C. Cutler Dozier Jr. and Kari L. Fletcher

Abstract: We describe challenges when developing a therapeutic alliance—the dynamic and collaborative relational bond developed between therapist and client in a virtual environment during COVID-19. We offer adaptive strategies that can be used when establishing, developing, and deepening the therapeutic alliance when working virtually. Using a case study, individual vignettes illustrate the importance of establishing, developing, and deepening a therapeutic alliance. We introduce reflection and consultation adaptive strategies that may be effective when working virtually with clients. We also offer additional recommendations for strengthening clinical experiences while working with clients in a virtual environment.

***Keywords*:** therapeutic alliance, telehealth, computer mediated communication, COVID-19, psychotherapy

Introduction/Background

As Norcross (2014) asserts, "of the multitude of factors that account for success in psychotherapy, clinicians of different orientations converge on this point: The therapeutic relationship is the cornerstone" (p. 114).

Within the therapeutic relationship, the role of the *therapeutic alliance* cannot be overstated. Briefly defined, the therapeutic alliance is the dynamic and collaborative relational bond developed between therapist and client (Horvath & Luborsky, 1993). While different theoretical models frame this concept in slightly different ways, in this narrative the therapeutic alliance shall broadly refer to the collaborative and dynamic relationship formed between therapist and client, both informed by and pertaining to a wide spectrum of client and therapist characteristics (Horvath & Luborsky, 1993; Vasquez, 2007). The therapeutic alliance has been consistently linked with variability in psychotherapy outcomes—independent of specific treatment modalities—and has been identified as one of the most important factors in the clinical practice of psychotherapy (Martin, et al., 2000; Norcross & Lambert, 2018).

The alliance is considered so important that the concept was taught and emphasized throughout the first year of my MSW program. Even though clinical practice was not scheduled until the second year, I (Dozier) still remember my field instructor's comment at the beginning of my foundational social work practicum in 2019. After I had said, half-jokingly, that I felt I had been thrown into the deep end of a pool, "Just wait until your clinical practicum," she quipped. However, neither she nor I could have foreseen that not only would the proverbial water for the clinical practicum be deep, it would be more like an ocean than a swimming pool.

The literature is divided as to the extent telehealth affects the development of the alliance. According to Simpson and Reid's (2014) quantitative literature review, "studies overwhelmingly supported the notion that the therapeutic alliance can be developed in

psychotherapy by videoconference” (p. 280). In some studies, however, the strength of the alliance is disputed. Findings by Norwood et al. (2018) suggest that “meta-analyses showed that working alliance in [videoconferencing psychotherapy] was inferior to face-to-face delivery” (p. 797).

The therapeutic alliance consists of many factors that contribute to its effectiveness. Several studies have identified empathy, understanding, communication, and collaboration as factors that may positively contribute to the development of the therapeutic alliance (e.g., Ackerman & Hilsenroth, 2003; Elliott et al., 2018; Hilsenroth & Cromer, 2007; Horvath, 2001; Lavik et al., 2018). Clinician empathy also appears to be vital in securing successful client engagement and follow-up after the initial period of psychotherapy (Hilsenroth & Cromer, 2007). As any clinician knows, empathy is not only about the words expressed but how they are expressed including vocal tone, physical posture, and facial expression—all methods of communication that help facilitate attunement. Furthermore, empathetic attunement is one aspect of therapeutic presence, a critical component to building a therapeutic alliance. Other aspects of presence include putting oneself in the position of the client, seeing life through their eyes—or as with my first client, through their camera.

One way to conceptualize communication is to frame it as a system wherein client and therapist can offer feedback to one another. According to a systematic review conducted by Hilsenroth and Cromer (2017), feedback interventions wherein the therapist offered information to the patient about their symptoms, their course of treatment, and psychoeducation were strongly correlated with a strong therapeutic alliance. As a correlative, concise communication in the form of feedback from the client to the therapist has also been linked to the development of a strong alliance. With regard to telehealth, Grondin et al. (2019) cite “richness of the medium, the immediacy of feedback, transmission quality, and the content of the communication” (p. 3) as four main features that impact computer-mediated communication.

Several studies have also indicated that collaboration between client and therapist is essential to the development of the therapeutic alliance (e.g., Ackerman & Hilsenroth, 2003; Hilsenroth & Cromer, 2007; Horvath, 2001; Lavik et al., 2018). Collaboration can take various forms across the phases of client and therapist interaction including working together to identify goals and mutually working toward treatment outcomes; these are central to Bordin’s (1979) seminal definition of the therapeutic alliance.

According to findings by Simpson and Reid (2014), “of key importance in the development of the therapeutic alliance using telehealth is the attitude a therapist holds toward the use of video therapy and the way in which this influences their behavior” (p. 291). As a fairly tech-savvy millennial, I held a positive attitude toward the prospect of working virtually with clients. I felt I could comfortably manage the telehealth platform and confident I could solve any technical difficulties which might arise. In contrast to several studies cited by Simpson and Reid (2014) in which it was found that therapists were skeptical about the ability to develop a therapeutic alliance via videoconference, I did not share such skepticism. Of course, I would have preferred meeting in person with my first clients.

Establishing, Developing, and Deepening the Therapeutic Alliance: My Work with "John"

Part 1: Establishing a Therapeutic Alliance

Note: This case serves as an amalgamation of my experiences with several clients. This vignette does not include actual client dialogue, but rather dialogue has been created by this writer based on sentiments expressed by at least two or more clients.

My first intake session with a client for my clinical practicum was scheduled to be conducted through telehealth due to the COVID-19 pandemic. I had long imagined what my first client contact would be like. Would I be able to join with my client? Would they sit facing me or would I sit slightly adjacent? What would my attunement look like? Never once had I asked myself, "Where will their camera be positioned?" or "Will my audio come through clearly?" How have I perceived the impact of telehealth on the delivery of psychotherapy—specifically, how did telehealth hinder or facilitate the development of the therapeutic alliance between me and my client during the pandemic? How did the factors cited as critical to the establishment of a therapeutic alliance play out for me?

"John" is a man in his mid-40s who sought therapy in the midst of the COVID-19 pandemic. He had previously undertaken therapy several years earlier for chronic depression, anxiety, and a history of pervasive and complex trauma in childhood. Having a relatively small social circle prior to the onset of the pandemic, John reported experiencing almost daily anxiety and feeling increasingly isolated. Along with the anxiety, John described symptoms of an agitated depression and anxiety which was exacerbated by fears of contracting COVID-19 when out in public, resulting in feelings of anger and frustration towards other people not following social distancing guidelines.

Things got off to a rocky start during our introductory session when the first words out of John's mouth were, "I can't hear you." I unmuted, apologized, and said, "I didn't realize I was on mute, can we begin again?" John nodded and then proceeded to explain that he had been dealing with chronic depression for so long he could not remember a period when he had not experienced depressive symptoms. In addition, he reported the pandemic had dramatically increased his social isolation and anxiety. After gathering the relevant diagnostic criteria, and expressing empathy, I attempted to offer some credible hope about how our work together could be helpful to him. I said, "There are some tools and techniques that I think can be useful for addressing your anxiety and depression which I'd like to introduce to you." John seemed willing.

But then, about 20 minutes into the first session, *his* audio cut out for two minutes. I could see John's mouth moving, and I gestured toward my ear to indicate I was unable to hear him. This continued for what felt like an eternity until he noticed his audio had dropped. I saw him fiddle with his device, and then his voice came back again. He repeated what he said, but instinctively I knew I would never be able to hear the exact words he spoke, in the same tone, and with the same feeling. He repeated the words I had not heard because of the technical rupture but did not re-create his facial expressions and body language—all the cues that signaled deep emotions—

they were permanently lost. This resulted in a palpable sense of frustration with the technology on both our parts. However, his frustration seemed deeper, possibly related to the same feelings of anger he described at the beginning of our conversation. Our communication continued to be fragmented throughout the first session. My lack of expertise with regard to the technical aspects of the telehealth platform may well have led my client to doubt my clinical prowess. In short, I feared the very start of establishing a therapeutic alliance had already become compromised. At the end of the session, when I posed my standard question, “Is there anything I said or did that bothered you that you want to tell me about?” John responded, “I don’t like the technology,” and then quickly added, “but I know it’s not your fault.” We had a connection, albeit tenuous.

Upon reflection after our session ended, I realized that the unexpected problems I encountered delivering therapy over a virtual platform were compounded by my novice status as a practitioner. With John being one of my first clients, I had no baseline of comparison for the level of connection that is usually established after a first session—whether in person or virtually. In the findings of Békés et al. (2021), half of 150 therapists surveyed felt a lower level of connection with their online patients compared to that with in-person patients. But lower than what? I had no in-person client experience to gauge my performance against. Perhaps I needed to recalibrate expectations for myself.

Through consultation, I gained further insight into the tenuous therapeutic alliance established between John and me during our first session. Beyond the “typical” tasks associated with getting started (e.g., setting a therapeutic frame, building rapport), I found it helpful to think about the distinction between the content (what was being said, such as “Can you hear me?”) versus process (what was being thought, as in “Can our connection become a reliable one when our technology tells us otherwise?”) (Budman et al., 1992; McWilliams, 2004). Beyond the role technology may have played hindering the development of our therapeutic alliance initially, I came away from this conversation feeling as though, all things considered, I did a “good enough” job of conveying to John during our session that I had been listening, intently focusing upon his concerns, inviting his reactions to our work, and conveying understanding toward him (McWilliams, 1999).

Beyond unpacking the tenuous therapeutic alliance formed during my first session with John, during consultation I began assessing what adaptive strategies might help engage John within a virtual context as we would never physically be in one another’s presence. The concept of *social presence*—where the development of a “sense of being with one another” (Biocca et al., 2003, p. 1), and of experiencing a sense of safety, comfort, and ability to take risk (Barnett-Queen et al., 2005)—resonated with me. Extending this to a virtual environment, it would be an *online social presence*, where an emotional connection is felt by way of computer mediated technology (Sung & Mayer, 2012; Tu & McIsaac, 2002) and reinforced by an array of affective interpersonal, relationship, and technology skills (Sung & Mayer, 2012).

Part 2: Further Developing and Deepening the Therapeutic Alliance

Before our second session, I spent time conceptualizing John’s case and conferred with my clinical practicum site supervisor. I concluded that developing a positive working alliance with

John would require me to proceed more slowly than I had during our first session. I resolved to listen more, say less, and attune to his cues indicating a willingness to move forward. My hope was that this approach would communicate my empathy and understanding and result in John's full commitment to a set of goals and initial first tasks—essential elements of a positive working alliance (Ackerman & Hilsenroth, 2003; Elliott et al., 2018; Hilsenroth & Cromer, 2007).

In any other time, behavioral activation, an evidence-based treatment for severe depression (Dimidjian et al., 2011), would seem like a straightforward and viable direction to move toward. John's social isolation was clearly enacting a heavy toll on his daily functioning and exacerbating his long-standing depression. Helping John engage in meaningful behavioral tasks and move toward prosocial connection with others seemed like an obvious first step. The complicating factor: John was in the high-risk category for COVID-19, and cases were on the rise. My alternative plan, therefore, was to begin to enhance my client's sense of self-compassion, beginning with self-care, while working with him to jointly set psychotherapy goals.

During our second session, I focused upon listening empathically and seeking to understand more about John as a person and with regard to his history, while remaining continually aware of my own attunement. At first this approach seemed to resonate with John: He disclosed more about his history of trauma and the invalidating family environment he experienced while growing up. John expressed interest in joining a social group, a task we both knew would have to be delayed because of the pandemic. He also lamented about how hard it was for him to enjoy even simple daily activities such as going to the mall because of his fear of contracting COVID-19 and the anger he felt toward other shoppers.

When John talked about difficulties associated with his current situation, I attempted to first empathize with, then normalize his anxiety surrounding the pandemic by letting him know that I too get anxious in crowded environments. We were physically disconnected from one another, but because of the pandemic, we were, in one aspect, emotionally aligned. According to Geller (2020):

> Therapists' anxiety and fear, as well as grief and loss in relation to the pandemic, can be activated by clients' shared distress, eliciting countertransference issues and interfering with the ability to be fully present and responsive to their clients' fears. (p. 5)

However, in this case, my own anxiety surrounding the pandemic had enabled me to respond more empathically to my client's situation. As Chen et al. (2020) notes, "therapists and patients are 'in it together' in ways that make it clear that we are all 'more human than otherwise'" (p. 9).

This sense of "being in it together" did not last long as the session audio became fragmented. This literal disconnection fragmented momentarily my empathetic attunement. Its rupture also seemed to frustrate John. I quickly regained my equilibrium, but my responses were then met by John saying in a slightly irritated voice, "you're breaking up a little bit." Geller (2020) asserts, "clients can attribute delays or glitches in the technology to a therapist's characteristics or lack of

presence, rather than the actual technological issues" (p. 6). Although my lack of presence was due to technical difficulties, it is entirely possible that on an emotional level, John faulted me for not being present.

The technical glitches also generated feelings of frustration in me—not toward John, but with the transmission quality of the telehealth delivery mode—one of the four main factors cited by Grondin et al. (2019) that affect the impact of a virtual session. Two essential elements to a strong working alliance were hindered. Communication between us was being stifled and collaborative progress delayed. As a new therapist, this was surprising and disconcerting. I addressed my own feelings in session by using grounding techniques and by purposefully directing attention to my present moment experience.

After the session concluded, I continued to empathize with John and, through tapping into my own feelings of frustration at the technical hindrances, discovered a gateway to greater compassion for the continual struggle John was experiencing. To prepare for our next session, I resolved to be more intentional in crafting my online therapeutic presence. According to Simpson and Reid (2014), techniques that contribute to effective telehealth therapy include "being more deliberate and overt in non-verbal responses, such as purposefully exaggerating voice inflections and changes in tone, as well as gestures and mannerisms" and "asking more questions in order to clarify the meaning attached to clients' facial expressions and body language" (p. 292). These techniques were similar to the behavioral adjustments I would need to make throughout my work with John in order to ensure proper delivery of telehealth therapy.

At my next consultation, I reflected upon my continued attempts to further develop and deepen my therapeutic alliance with John by exploring aspects of transference and countertransference (Teyber & Teyber, 2017). To some degree, I was convinced that technology had contributed to John's transference in that his feelings, attitudes, and ways of being in relationships colored his subjective experience of working with me. Similarly, my countertransference of my own experienced intersubjectivity and relational style shaped my working with John (Kahn, 1996; McWilliams, 1999; Teyber & Teyber, 2017). At this rate, technology's interfering more so than facilitative presence within our work threatened both our potential for growth together (Kahn, 1996) as well as the potential to benefit from future here-and-now moments of connection vis-à-vis corrective emotional experiences and other therapeutic milestones of the treatment relationship (Teyber & Teyber, 2017).

In addition to exploring my therapeutic alliance with regard to aspects of the transference-countertransference dynamic during my second session with John, during consultation I revisited ways that I might continue engaging John within a virtual context. Expanding upon the "online social presence" and the connection I sometimes felt when working with John, as our work together progressed, I found it helpful to think about the care I had taken toward creating a *holding environment*—an intentional space where John could feel consistently supported and nurtured (Winnicott, 1971). Its cyber equivalent is a *virtual holding environment*, a space where "supportive relationships can be developed and maintained through the use of technology over time" (Fletcher et al., 2014, p. 90). As my work with John continues and eventually draws to a

close, it is my hope that the initial focus on the technical aspects of navigating our relationship online fades and our therapeutic alliance deepens, facilitating our work together.

Discussion

Over the next several months, John and I continued to meet on a weekly basis. I implemented a routine at the beginning of each session of first ensuring we could hear each other. We also developed contingencies for instances when the video display froze. As we negotiated issues related to meeting over telehealth, our working relationship developed. As communication improved, collaboration soon followed. We worked toward identifying four primary treatment goals that were realistic given the current limitations imposed by COVID-19. John shared with me his progress completing tasks we had identified, and together we solved for obstacles impeding progress. We had moments of levity, and a few times, even laughter. My confidence as an emerging therapist grew, and our working alliance deepened. While we still encountered technical issues, we learned to relegate them to their proper negligible place in our relationship.

As an intern working during the restrictions imposed by the COVID-19 pandemic, my only clinical experience with clients has been virtual in nature. Lacking experience developing a therapeutic alliance with clients in person, I have no personal comparison to measure my progress against. I share my insights as learning for other novice practitioners who begin their career in an online environment.

As a relatively new psychotherapist, I must confess that integrating what I have learned into my virtual work with John and other clients during this pandemic remains daunting, albeit less so over time. Through my field placement practicum and consultations offered within the MSW program, I am able to reflect on the criticality of the therapeutic alliance and its development within a virtual holding environment. In preparing for sessions, I consider adaptive strategies which will deepen our working alliance within this unique context.

Conclusion

Using the case of John, I have described the development of our therapeutic alliance over several months using telehealth during the pandemic, beginning with initial bumpy and fragile sessions to today's trusted, collaborative bond. Initially during my work with John, I was unprepared for and therefore surprised at the deleterious impact of technical difficulties during my first virtual session. I did not appreciate the impact the simple loss of audio or the freezing of video for a few minutes had. It, in some ways, compromised that important first impression, hindering my ability to communicate my empathy with John and establish trust.

During my second session with John, I was better able to establish an emotional alignment with John over anxiety about the pandemic. I empathized with, then normalized his anxiety by letting him know that I too get anxious in crowded environments because of COVID-19. When our audio connection then failed, I used mindfulness practices to ground myself in the present moment and proceed mindfully. Our relationship was forming.

As my work with John has progressed, I have learned to mitigate issues arising from transmission quality and delay in feedback through heightening my therapeutic presence, adapting my communication style through the use of shorter sentences and more frequent questions, and recalibrating my expectations for the session's goals. Over the next several months, our working alliance deepened. When technical issues arise, we now have routines for addressing them; consequently, they do not impede our work.

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About the Authors**:** Cutler Dozier, MSW, LGSW is Outpatient Psychotherapist, Edina, MN and Kari Fletcher, PhD, LICSW was Professor, MSW Program Director, and Military Practice Coordinator, School of Social Work, University of St. Thomas, St. Paul, MN.