The Therapeutic Alliance: A Must for Clinical Practice

L'alliance thérapeutique : un incontournable pour la pratique clinique

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Abstract

The role of the therapeutic alliance in the success of interventions has been well demonstrated in areas related to speech-language pathology and audiology. Based on this knowledge, this article presents the theoretical foundations of the therapeutic alliance, distinguishing it from the therapeutic relationship. The central concept of shared decision making is presented, followed by factors that may influence the establishment and quality of the therapeutic alliance. A low-quality therapeutic alliance is associated with the possibility that the client will discontinue the intervention, hence the importance of paying special attention to this dimension. In situations where clinicians have difficulty establishing an alliance, it is their responsibility to identify how they may be contributing to this situation and reflect on their own actions in order to make the necessary corrections.

Abrégé

Le rôle de l'alliance thérapeutique dans le succès des interventions est bien établi dans les domaines connexes de l'orthophonie et de l'audiologie. En s'appuyant sur ces connaissances, le présent article présente les fondements théoriques de l'alliance thérapeutique, en la distinguant notamment de la relation thérapeutique. Le concept central de la prise de décision partagée est présenté, suivi des facteurs susceptibles d'influencer l'établissement et la qualité de l'alliance thérapeutique. Une alliance thérapeutique de faible qualité est associée à la possibilité que le patient mette fin à l'intervention lui étant offerte, d'où l'importance d'accorder une attention particulière à cette dimension. Dans les situations où les cliniciens ont de la difficulté à établir une alliance, il est de leur responsabilité d'identifier de quelle façon ils contribuent à cette situation et de réfléchir sur leurs propres actions afin d'apporter les correctifs nécessaires.

Over the last few decades, research in the field of speech-language pathology has increasingly focused on evidence-based practices (American Speech-Language-Hearing Association, 2005). To reduce the uncertainty surrounding clinical decisions and therapeutic choices, clinicians must actively use the knowledge deriving from both scientific research and their own clinical experience (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). More recently, the need to take clients' preferences and values into account has been recognized as being central to the clinical process (Dollaghan, 2007; Furlong, Serry, Erickson, & Morris, 2018; Schwarz, Coccetti, & Cardell, 2020). Thus, clinicians must master two types of competence. The first is *clinical competence*, that is, their mastery of all the knowledge relating specifically to their area of expertise. The second is *relational competence*, namely all the attitudes and skills required to develop a strong therapeutic alliance with the client (Wampold, 2001). Even when the intervention plan is relevant, it can only be successfully implemented when the speech-language pathologist (S-LP) manages to establish, develop, and maintain a therapeutic alliance with clients and their family. In each intervention, every day, S-LPs activate a *clinical-relational* process in their clinical work (Côté & Hudon, 2016).

In 2002, the American Psychological Association published findings on the elements characterizing the effectiveness of interventions. The therapeutic alliance was the main element cited (Norcross, 2002). The links between the quality of the therapeutic alliance and the effectiveness of interventions has been empirically demonstrated in the fields of psychotherapy and health-related professions (Hall, Ferreira, Maher, Latimer, & Ferreira, 2010; Martin, Garske, & Davis, 2000). Two meta-analyses focusing on adult clienteles have reported a modest but significant relationship between the therapeutic alliance and intervention outcomes. The first of these meta-analyses included 24 studies and reported an average effect size[1] of .26 (Horvath & Symonds, 1991), while the second included 79 studies and reported an effect size of .22 (Martin et al., 2000). Two other meta-analyses, focusing on children and adolescents (n = 49 and n = 23 studies, respectively), reported similar results (Karver, Handelsman, Fields, & Bickman, 2006; Shirk & Karver, 2003). In the medical field, the reported effect size is .11 (Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). Although these effect sizes may appear modest at first glance, in areas where so many factors can influence outcomes (e.g., severity of the disease, psychosocial stressors), their impact is significant (Rutledge & Loh, 2004). Taken together, these findings

suggest that the therapeutic alliance is more strongly associated with the results of interventions than the specific techniques and approaches used by clinicians (Manning, 2010; Norcross, 2002; Plexico, Manning, & DiLollo, 2010). In psychotherapy and intervention involving individuals or families, the therapeutic alliance has been identified as a process that is essential to change (Elvins & Green, 2008). Indeed, it is considered the vehicle for delivering effective change (Lawton, Haddock, Conroy, Serrant, & Sage, 2020).

In the field of speech-language pathology, the therapeutic alliance is also mentioned as a key factor of the success of interventions in fluency disorders (Plexico et al., 2010), aphasia rehabilitation (Lawton et al., 2020; Lawton, Sage, Haddock, Conroy, & Serrat, 2018), and child speech and language disorders (Fourie, Crowley, & Oliviera, 2011; Freckmann, Hines, & Lincoln, 2017). For example, a qualitative study involving 28 participants (19 men, 9 women) having received from 6 months to more than 12 years of therapy for stuttering identified seven characteristics that were effective in promoting successful change in this regard. The clinician's ability to build a strong alliance with his/her clients was mentioned as one of the most significant factors (Plexico et al., 2010). For the participants of this study, "the clinicians who were perceived as more competent were those who were able to promote an effective therapeutic alliance" (Plexico et al., 2010, p. 348).

Lawton et al. (2018) conducted in-depth, semi-structured interviews exploring the point of view of 22 S-LPs working with people with aphasia post-stroke. Their findings also point to the importance of the therapeutic alliance for the success of interventions. Their data highlight the relevance of developing shared expectations of therapy. They also emphasize the need to jointly define the goals of the intervention and the role of both the clinician and client in achieving these goals (Lawton et al., 2018).

The term *therapeutic alliance* is often used interchangeably with *therapeutic relationship* (e.g., Elvins & Green, 2008; Freckmann et al., 2017; Lawton et al., 2018, 2020). For example, Lawton et al. (2018) placed equal emphasis on the "importance of showing empathy" and the need to "delineate roles." However, we suggest that these two behaviours refer to distinct components of the clinical-relational process. The therapeutic relationship is a component of the therapeutic alliance rather than an equivalent term. To better guide clinical work, these concepts should be properly delineated.

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[1] An effect size is a measure of the strength of the relationship between two variables. It corresponds here to the difference between two means, divided by the standard deviation. In accordance with the guidelines published by Cohen (1988), a modest effect is set at 0.20, a moderate effect at 0.50, and a high effect at 0.80 and above.

Objectives

Based on the knowledge developed in speech-language pathology and related fields, the purpose of this article is to present the definitions of the therapeutic alliance, distinguishing it from the therapeutic relationship. The concept of shared decision making will also be exposed as another crucial component of the clinical-relational process rooted in a person-centred approach.

Definitions of Concepts

Therapeutic Alliance

The tripartite conceptualization of the therapeutic alliance introduced by Bordin (1979) stipulates that the clinician and client must come to an agreement on (1) the goals of the intervention and (2) the explicit tasks and intervention intensity required to meet them, by creating (3) an affective bond. The first two components of the therapeutic alliance, setting goals and establishing the necessary tasks, are relatively concrete and explicit (Freckmann et al., 2017). Goal setting implies a mutual understanding of the problem about which the client is consulting, and of the client's strengths and needs. Agreeing on the tasks required to meet these goals entails defining and clearly delineating the roles of each party—clinician, client, and family. Shared decision making is the process whereby clinicians and clients work together to make these decisions (Haesebaert, Adekpedjou, Croteau, Robitaille, & Légaré, 2019).

The third dimension, the development of a bond, refers to a more abstract component of the alliance, namely its emotional component (Bordin, 1979). This bond can only be created in the context of a trusting relationship between the clinician and the client. In fact, the establishment of a trusting therapeutic relationship is the first condition of the therapeutic alliance.

Therapeutic Relationship

The therapeutic relationship is the ground on which the therapeutic alliance is constructed. It involves all the feelings and attitudes that the clinician and client have towards one another and the way they are expressed (Fourie et al., 2011; Norcross, 2002). On the part of the clinician, it requires respect, listening, authenticity, and empathy, as well as a real interest in the personal experience of the client who is struggling with communication difficulties (Di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001; Kelley et al., 2014).

The therapeutic relationship develops right from the very first contacts between the clinician and the client. It is during the evaluation of the client's needs, and sometimes even the first telephone contact, that the key elements of a trusting relationship will or will not be established. In this sense, the first meetings with the client are decisive for the development of the therapeutic alliance. To foster this relationship of trust, the clinician must engage in a real partnership with the client (Dumez, 2012; Joosten et al., 2008; Plexico et al., 2010). The clinician must show openness and commitment to the client (Lawton et al., 2018, 2020; Plexico et al., 2010). A good therapeutic relationship is characterized by relational symmetry resulting from a complementarity of roles (Leahy, 2004). The S-LP is the communication disorders expert, whereas clients are the experts of their own lives and, consequently, the best placed to identify and communicate their needs, preoccupations, preferences, and so on. As stated by Weston (2001, p. 438), in the medical context, "[…] physicians still have an obligation to contribute their expertise to the discussion and to involve patients in such a way that patients can use that expertise in making their own decisions about care." By putting the client at the centre of the intervention, such a clinician–client partnership is aligned with World Health Organization guidelines. These guidelines stipulate that client autonomy and empowerment are the basic values and underlying premises for the provision of healthcare (Joosten et al., 2008). Developing and maintaining a trusting therapeutic relationship requires a person-centred approach and a real conviction of the uniqueness of each client/family (Bishop, Kayes, & McPherson, 2019; Côté & Hudon, 2016).

Shared Decision Making

Shared decision making is defined as a collaborative process whereby clinicians and clients work together to make choices regarding therapeutic actions (Elwyn, Frosch, & Kobrin, 2016; Haesebaert et al., 2019). This process has its roots in the field of ethics and respect for the rights and autonomy of people (Moore & Kaplan, 2018).

Several studies have confirmed that a significant proportion of clients wish to play an active role in decisions regarding their health (Kiesler & Auerbach, 2006). Clients increasingly recognize that they are the best judges concerning these issues and in decisions regarding interventions that affect them (O'Connor et al., 2003). For these decisions to be not only shared but also informed, it is imperative for clients to have a clear understanding of the problem in question. It is also essential for clients to have a fair understanding of the different intervention options and scientific facts supporting them. In the first place, it is crucial that the clinician share and explain to the client the path of his/her clinical reasoning. It is also important for the clinician

to discuss with the client the advantages and disadvantages of each of the therapeutic alternatives available (Légaré et al., 2010). Client values and preferences need to be clarified and openly discussed (Dollaghan, 2007). The clinician must always ensure that the client understands what is at play and not hesitate to suggest postponing the decision if further explanation is required or the client needs time to reflect (Légaré et al., 2010). The decision must be made in full knowledge of the facts.

In a systematic review of shared decision making and patient outcomes in 39 studies, Shay and Lafata (2015) noted that shared decision making was associated with affective-cognitive outcomes and, to a lesser extent, behavioural and health outcomes. Affective-cognitive outcomes include knowledge, attitudinal, and affective/emotional effects. Behavioural outcomes refer to adherence to recommended interventions and health behaviours, while health outcomes include quality of life and biological measures of health.

The process of shared decision making has the effect of increasing the client's understanding of the problem, adherence to intervention, confidence, satisfaction and, more generally, health and well-being. For example, the results of a prospective cohort study involving 83 adults with neurological disabilities showed significant correlations between goal-planning engagement, goal attainment, and functional outcomes (Turner-Stokes, Rose, Ashford, & Singer, 2015). The results of a cross-sectional survey of adults initiating biological treatment of autoimmune disease showed that persistence in treatment was longer for participants who engaged in shared decision making (Lofland et al., 2017). More generally, the results of a meta-analysis (*n* = 35 studies) confirmed that clients who were involved in shared decision making, chose a treatment condition, or received their preferred intervention showed higher satisfaction, higher completion rates, and better clinical outcomes (Lindhiem, Bennett, Trentacosta, & McLear, 2014). These results underscore the importance of shared decision making, jointly defining with the client the objectives of the intervention and the means of achieving it. This is at the heart of the therapeutic alliance. Indeed, including clients in decision making has been associated with more favourable outcomes for their health (Duncan, Best, & Hagen, 2010; Légaré et al., 2010). Shared decision making increases the quality and effectiveness of interventions (Côté & Hudon, 2016).

In Sum

The therapeutic alliance can be conceived as the organizing principle of the relational dimension of the clinical-relational process. This organizing principle is operationalized through two components: (1) a therapeutic relationship of trust (affective bond) which favours (2) shared decision making aimed at helping the clinician and client/family develop a common view of (a) the goals of the intervention and (b) the explicit tasks and intervention intensity required to meet these goals. **Figure 1** sets out and illustrates the components of the clinical-relational process constantly in play during a speech-language pathology intervention.

Figure 1

Therapeutic alliance

Therapeutic relationship (affective bond)

Shared decision making

Goals of intervention

Tasks and intervention intensity to meet the goals

Therapeutic alliance: Organizing principle of the relational dimension of the clinical-relational process
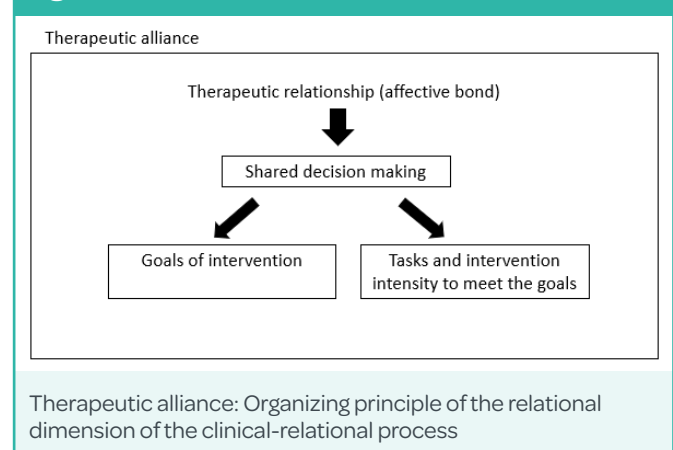
The crucial role played by the establishment of a good therapeutic alliance in the effectiveness of interventions is quite clear. However, for clinicians working with people struggling with language impairment, this can constitute a challenge (Lawton et al., 2018) because communication impairment can impact the degree of collaboration and the ability to reach consensus (Rosewilliam, Roskell, & Pandyan, 2011). The experience of S-LPs and their in-depth knowledge of communication impairment provide them with the keys to overcome these pitfalls (Hersh, 2010). Yet, the establishment of a therapeutic alliance, through a trusting therapeutic relationship including shared decision making, can be positively or negatively modulated by factors relating to clinicians or clients, as well as external factors (Baldwin, Wampold, & Imel, 2007; de Roten, 2011). The sources of variability identified in studies on language impairment are reported in **Table 1**.

Sources of Variability in the Therapeutic Alliance

Factors Relating to Clinicians

Establishing, developing, and maintaining a good therapeutic relationship is challenging. Such a relationship implies that clinicians be constantly attentive to their role and to clients' subjective experiences in order to respond with empathy. The clinician should express receptiveness to the client's point of view and intervene in ways that can generate hope (Horvarth & Bedi, 2002).

Table 1		
Factors Relating to Clinicians, Clients, and the Context of the Intervention		
	Type of clients	References
Factors relating to clinicians		
Adapt their behaviour and style of communication to degree of severity of language impairment presented by client	Adults with aphasia	Lawton, Haddock, Conroy, Serrant, & Sage (2020) Slingsby (2006)
• Persons with severe impairment, attending therapy over a long period (e.g., persons with severe aphasia) valued therapeutic empathy, enjoyment of therapy, and hope	Adults with aphasia	Lawton et al. (2020)
• Persons with mild therapy valued professional competence, therapeutic challenge, and firmness	Adults with aphasia	Lawton et al. (2020)
Adapt to individuals' relational preferences and needs	Adults with aphasia	Lawton, Sage, Haddock, Conroy, & Serrant (2018)
Propose relational proximity, not as a friend, but not too formal	Adults with aphasia	Lawton et al. (2018)
Give honest feedback on progress and recovery	Adults with aphasia	Lawton et al. (2018)
Use humour sparingly: can foster solidarity and togetherness	Adults with aphasia	Simmons-Mackie & Schultz (2003)
Acknowledge the person's lived experience	Adults with aphasia	Simmons-Mackie & Damico (2011)
Demonstrate passion for assisting the client	Adults with stuttering	Plexico, Manning, & DiLollo (2010)
Communicate clearly their understanding of the client's experience	Adults with stuttering	Plexico et al. (2010)
Listen carefully and focus on the client's unique goals and capabilities	Adults with stuttering	Plexico et al. (2010)
In paediatric context: make sure the therapy is enjoyable	Children with language difficulties	Fourie, Crowley, & Oliviera (2011)
Factors relating to clients		
Motivated to participate in shared decision-making process	Adults with aphasia	Lawton et al. (2018)
Perceive that they play an active role in the therapeutic process	Adults with aphasia	Lawton et al. (2018)
External factors		
Service delivery model prioritizing impairment-based approach and time constraints	Adults with aphasia	Lawton et al. (2018)
Limited time resources	Adults with aphasia	Lawton et al. (2018)
Relational discontinuity	Adults with aphasia	Lawton et al. (2018)
Medical model	Adults with aphasia	Lawton et al. (2018)

Supporting the process of change requires flexibility in the application of the therapeutic approach (Côté & Hudon, 2016). Adopting a flexible approach can help clinicians meet the varied needs of clients. Indeed, clients differ regarding their language impairment, but also their expectations when it comes to their relationship with the S-LP (Lawton et al., 2018). Clinicians may consider some changes to be meaningful, but clients may not value these changes (Finn, 2003). It is important for clients to have a say concerning the types of change they see as worthwhile (Manning, 2010).

However, it is important to note that while, for some clients, empathy may promote the therapeutic alliance by making them feel understood, for other clients, it can also be perceived as an intrusion (Horvath & Bedi, 2002). To have a beneficial effect on the therapeutic alliance, the empathy demonstrated by the clinician must therefore be consistent with the preferences and perceptions of clients (Constantino, Castonguay, Zack, & DeGeorge, 2010; Horvath & Bedi, 2002). Failure to recognize the client's emotions and possible criticism, and an over-focus on detail, are all possible barriers to establishing a therapeutic alliance (Karver et al., 2006).

Other strategies and behaviours are also negatively associated with the therapeutic alliance. For example, pushing clients to talk when they do not wish to do so, or being overly formal, can compromise the quality of the therapeutic alliance. This appears to be particularly true for teenagers (Constantino et al., 2010). With this clientele, it is also important to avoid strategies that are more appropriate for young children, which can be perceived with suspicion and disinterest (DiGiuseppe, Linscott, & Jilton, 1996).

Factors Relating to Clients

Clients' perception of the usefulness of the intervention and expectation of change, as well as their receptivity to and motivation to change, are considered factors that can influence the establishment of a good therapeutic alliance with the clinician (Constantino et al., 2010; Hersoug, Høglend, Havik, & Monsen, 2010; Karver, Handelsman, Fields, & Bickman, 2005; Ross, Polaschek, & Ward, 2008). If clients have had negative experiences in the past, this can make them wary of engaging in a new therapeutic relationship (Rooney, 2009). Where they are at in terms of the stages of therapeutic change and how they expect to be able to cope with their problem are some of the variables pertaining to the client in any intervention session (Manning, 2010).

Seeing the clinician as trustworthy, honest, authentic, and empathic can induce positive feelings toward the clinician and lead to the development of a supportive

therapeutic alliance (Karver et al., 2005). Some authors state that clients may be more inclined to form a therapeutic alliance with clinicians they perceive to be credible and competent (Karver et al., 2005). Strong (1968) defined a credible clinician as a person who presents him/herself clearly, with simplicity and authenticity. This kind of clinician inspires confidence (Ackerman & Hilsenroth, 2003). In a study involving adults who stuttered, clinicians who were perceived as lacking competence were described as ineffective in conveying to the client a sense of acceptance, understanding, and trust (Plexico et al., 2010).

It is true, however, that not all clients are willing to take an active part in decision making. Age-related factors, experience of health care use, acceptance of the problem, and cultural values, for example, may influence the degree to which clients wish to be involved in this process (McKeown, Reininger, Martin, & Hoppmann, 2002). Clinicians must thus have realistic expectations regarding the involvement of different clients and adjust to the role that each is willing to play in this decision-making process (Pomey et al., 2015). Take, for example, a 9-month-old child for whom a diagnosis of profound hearing loss has just been confirmed. The need to intervene will be very clear for both parents and stakeholders. Accordingly, the discussion will focus on defining the best therapeutic approach, the short- and medium-term goals of the intervention, its intensity, and the roles of the parents and clinician. By contrast, in a situation where the need to intervene may appear less obvious, such as with a client with a neurodegenerative disease, the discussion will have to address the client's expectations of the intervention. The possible benefits will be exposed while also emphasizing the inevitable progression of the disease and its consequences.

External Factors

Other persons may also influence the establishment of a therapeutic alliance between the client and the clinician, including family members, friends, and other significant figures in the client's life (Ross et al., 2008). Through the values they convey, their perceptions, and comments on the intervention, these different actors all have the potential to encourage or undermine the therapeutic alliance that develops between clients and their clinicians.

Regarding the context of the intervention, two meta-analyses focusing on adult clients receiving psychotherapy reported that intervention type did not moderate the relationship between the therapeutic alliance and intervention outcomes (Horvath & Symonds, 1991; Martin et al., 2000). Freckmann et al. (2017) came to the same conclusion in a study comparing the strength of the

therapeutic alliance between S-LPs and their clients in two clinical settings. More specifically, the therapeutic alliance was equally as strong in both face-to-face and telepractice settings and was thus not affected by the service delivery model.

Nevertheless, the intervention context appears to be the most important external factor likely to impair the therapeutic alliance (Wolter, Corbin-Lewis, Self, & Elsweiler, 2011). Constraints related to the organization of services (e.g., a limited number of appointments granted by the institution, the impossibility of meeting in the family home or the child's daycare centre) are likely to interfere with the establishment of a therapeutic alliance. This is the case when such constraints prevent action that the clinician considers relevant but is unable to apply (Lawton et al., 2018). Moreover, prioritizing a medical model may compromise the establishment of a therapeutic alliance. Such a model encourages clients to adopt a passive attitude, concurring with the clinician, who chooses the intervention that they consider best (Joosten et al., 2008). The therapeutic alliance is also largely compromised in a context characterized by frequent relational discontinuity caused by high staff turnover, due to illness, vacations, new employees, or restructuring of workloads in institutions (Légaré et al., 2013).

In summary, a low-quality therapeutic alliance is associated with the possibility that the client will discontinue the intervention and lose interest in any future intervention. The inability of clinicians to develop an effective therapeutic alliance may lead to emotions in the client such as shame, inadequacy, hopelessness, frustration, anger, guilt, embarrassment, and discouragement (Plexico et al., 2010). It is thus crucially important to pay attention to this dimension, especially during early appointments (Horvarth & Bedi, 2002). In situations where clinicians have difficulty establishing a therapeutic alliance, it is their responsibility to identify how they might be contributing to this situation rather than putting the blame on the client's characteristics. Clinicians must reflect on their own actions and make the necessary corrections. Clinical supervision is a possible avenue in such a context. Feedback is recognized as a powerful tool for professional development and learning (Van de Ridder, McGaghie, Stokking, & ten Cate, 2015).

Strategies for Establishing, Maintaining, or Improving the Therapeutic Alliance

Training at both the under- and postgraduate levels is the most frequently cited strategy for improving clinicians' ability to first develop and then maintain and improve their skills in the relational side of the therapeutic process

(e.g., Légaré et al., 2013; Rose, Rosewilliam, & Soundy, 2017; Strauss et al., 2015). Such training can be implemented to foster the development of a therapeutic alliance (Crits-Christoph et al., 2006) and manage ruptures in this alliance (Castonguay et al., 2004). Just as the initial training of S-LPs prepares them to effectively execute their clinical expertise, such training should also give equal emphasis to the relational side of therapy, or *how* therapy is implemented (Lawton et al., 2018; Manning, 2010).

Engaging clinicians in a process of reflexivity could be the way to achieve this. Applying reflective skills can allow clinicians to take a step back from their action and identify concrete ways to improve it (Mann, 2011). Reflective practice is conceived as a learning process that takes place over time, emphasizing the back and forth between action and reflection. It allows for the transformation of a clinician's practice, as a result of this learning (Lison, 2013). Clinicians reflect on their own concrete experiences, identifying the elements that raise questions for them. The clinician then analyzes these elements and seeks and validates alternatives, arriving at an understanding of the phenomenon that will allow for new experience. The cycle then begins again—reflective practice is an iterative process. This process, together with constructive feedback, facilitates awareness of what works well and what does not, and how the clinician can improve (Embo, Driessen, Valcke, & Van Der Vleuten, 2014).

Some activities, practiced individually, with a mentor or in groups, promote reflective practice. One example is the case method. What is essential, however, is feedback. Feedback is what provides access to a level of generalization that results in a change in practice over the long term. Becoming a reflexive clinician takes not only time (Larrivee, 2000) and a supportive environment (Mann, Gordon, & MacLeod, 2009), but also mentoring (Donnay & Charlier, 2008).

Communities of practice can also be supportive, enhancing the clinician's ability to develop a quality therapeutic alliance with clients and their families. Communities of practice are groups of people who share a common concern or passion. Together, they can learn to improve their practice through regular interaction with one another (Wenger-Trayner, Fenton-O'Creevy, Hutchinson, Kubiak, & Wenger-Trayner, 2014).

Conclusion

It is essential that speech-language services be based on the latest scientific knowledge and professional best practices. However, high-level clinical expertise is not

enough to ensure the effectiveness of speech-language interventions. It is also and above all the responsibility of clinicians to establish a good therapeutic alliance with their clients and their families in order to maximize the benefits of their interventions. Developing and maintaining therapeutic relationships requires a person-centred approach and a real conviction of the uniqueness of each client/family.

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Acknowledgments

Disclosures

Appendix

Here are some interesting references for clinicians who want to deepen their knowledge of the topic of this article.

Therapeutic Alliance and Therapeutic Relationship

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