The Working Alliance in Depth

THE TALKING THERAPIES UK PRACTITIONER SERIES



The Working Alliance in Depth

Bordin's alliance, relational depth, difference and diversity, and the skilled use of self.

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

This manual accompanies the The Working Alliance in Depth course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 4. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

Decades of outcome research keep returning the same finding: the quality of the working alliance predicts outcome more reliably than the therapist's chosen model. This course takes that finding seriously. It is written for practitioners who have the core skills and now want to work deliberately with the relationship itself: to build the alliance, monitor it, strain it purposefully when honesty requires, and repair it when it tears.

You will study Bordin's three components, agreement on goals, agreement on tasks, and the bond that carries them, and learn to monitor the alliance in session rather than assume it. You will practise immediacy and congruent challenge: how to say difficult, true things inside the relationship in ways that deepen rather than damage it. The second module addresses the relational questions that most exercise modern practice: working across culture, identity and power with genuine cultural humility, and the disciplined use of self, including when disclosure serves the client and when it serves only the therapist.

Substantial written lessons with key points and applied practice tasks, supported by a study tutor throughout. Ten hours of CPD with around nine months of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the

conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Explain the working alliance in Bordin's terms: bond, goals and tasks, and monitor all three in live work
- Notice strain and rupture in the alliance and repair them openly and non-defensively
- Work with what happens between counsellor and client as information about the client's wider relationships
- Use immediacy, appropriate self-disclosure and challenge in the service of the client's goals
- Adapt relational depth to the client's readiness while keeping the work purposeful
- Use supervision to examine your contribution to the relationship, including countertransference in its broad sense

PART 1

Part 1: Bordin's three components and alliance monitoring

Lessons 1 to 5 of the course.

CHAPTER 1

Bordin's three components and alliance monitoring

Edward Bordin's contribution to psychotherapy research cannot be overstated. By extracting the working alliance from the realm of vague feeling and placing it into a clear, pan-theoretical structure, he gave clinicians a practical map for what had previously been described only in metaphor. The map consists of three negotiable components: agreement on the goals of therapy, agreement on the tasks that will be employed to achieve those goals, and the affective bond that links therapist and client. Each of these elements is not a static backdrop but a dynamic, co-constructed agreement that can be revisited, clarified, and, when necessary, repaired. The elegance of Bordin's formulation lies in its simplicity and its universality; it applies equally to cognitive-behavioural, psychodynamic, humanistic, and integrative approaches, and it does so without imposing a doctrinal hierarchy. In practice, the three-part model turns the alliance from an ethereal hope into a concrete structure that can be built, measured, and, crucially, adjusted throughout the therapeutic journey.

The first component, the goal agreement, concerns the overarching purpose of the work. It is tempting for therapists to assume that the client's desire to "feel better" is sufficient, but research shows that vague goals dilute the alliance's predictive power. When the client can articulate a specific, personally meaningful aim – for example, "be able to stay in the room during conflict rather than shutting down" rather than merely "reduce anxiety" – the therapist can align interventions more precisely and the client can monitor progress with greater clarity. The second component, task agreement, refers to the concrete activities that will be undertaken to pursue the agreed goals. Whether the task involves exposure exercises, exploration of early attachment narratives, or the systematic use of a thought record, the client's understanding of why the task matters is essential. When a client recognises that repeatedly returning to a felt sense in the body is not a gratuitous repetition but a purposeful means of accessing implicit emotional material, the task becomes collaborative rather than prescriptive. The third component, the bond, is the affective dimension that sustains the

partnership. It encompasses mutual trust, respect, and a sense of genuine caring. The bond is not a background ambience; it is an active, observable process that can be nurtured through empathy, validation, and, when ruptures occur, timely repair.

The empirical weight behind this three-part model is considerable. Meta-analyses led by Lester Horvath and later extended by Christiane Flückiger and colleagues have consistently placed the alliance–outcome correlation among the most robust findings in psychotherapy research. Across hundreds of studies involving tens of thousands of participants, the correlation between alliance ratings and symptom change remains moderate in magnitude (approximately r = .30 to .35) yet remarkably stable across therapeutic modalities, settings, and presenting problems. The reliability of the alliance as a predictor is striking because it persists even when controlling for therapist experience, client severity, and treatment dosage. In other words, regardless of whether a therapist is delivering cognitive-behavioural therapy for panic disorder, psychodynamic therapy for personality disorder, or integrative counselling for relationship distress, the strength of the alliance remains a decisive factor in determining whether the client will improve.

One of the most compelling implications of this evidence base is that the alliance is one of the few levers that clinicians can deliberately manipulate with confidence that doing so will influence outcome. While many theoretical models propose mechanisms that are difficult to operationalise – for instance, the psychodynamic concept of transference or the cognitive-behavioural notion of schema restructuring – the alliance offers a concrete, observable target. This is why monitoring the alliance is not a peripheral activity but a core competence for any therapist who wishes to practise evidence-informed counselling.

Monitoring, however, reveals an uncomfortable truth: client-rated alliance and therapist-rated alliance regularly diverge, and it is the client's perspective that predicts outcome. Studies employing the Working Alliance Inventory (WAI) and its short form (WAI-S) have shown that therapists tend to overestimate the quality of the bond, especially with clients who are at risk of premature termination. This over-estimation is not a matter of intentional bias but a by-product of the therapist's reliance on surface compliance – a client who nods, attends sessions, and completes homework may appear

engaged, yet internally may feel disconnected from the therapeutic purpose. The client's rating, captured through instruments such as the Session Rating Scale (SRS) or the Outcome Rating Scale (ORS), consistently demonstrates stronger predictive validity for symptom change measured by tools like the PHQ-9 or GAD-7.

The practical upshot is that alliance monitoring must be systematic, transparent, and, above all, responsive. A therapist who merely asks, "Is everything alright?" in a perfunctory manner is unlikely to capture the nuanced discrepancies that can undermine progress. Instead, the therapist should embed brief, validated rating scales into the rhythm of the therapeutic process. For example, after each session the client can be invited to complete the SRS, which asks four items – relationship, goals, approach or method, and overall feeling – each scored on a visual analogue scale from 0 to 10. The therapist, in turn, completes a parallel rating. The scores are then compared in a collaborative debrief. When a discrepancy emerges – say, the client rates the goal item as a 4 while the therapist rates it as an 8 – the therapist can explore the source of the mismatch without judgment, thereby opening a space for repair.

A concrete worked example illustrates how this process unfolds in practice. Consider Maya, a 34-year-old woman referred for treatment of generalised anxiety and chronic low mood. She presents with a PHQ-9 score of 16 and a GAD-7 score of 14, indicating moderate to severe symptomatology. The therapist, using an integrative counselling approach, begins by establishing a provisional goal: "reduce the frequency of anxiety attacks and improve sleep quality." The first three sessions focus on psychoeducation and the introduction of a daily sleep diary as a task. Maya completes the diary diligently, and the therapist records a high bond rating on the WAI, interpreting the compliance as evidence of a strong alliance.

At the end of session three, the therapist administers the SRS. Maya rates the relationship item as 9, the goals item as 5, the approach item as 7, and the overall feeling as 6. The therapist's parallel ratings are 9, 8, 8, and 8 respectively. The stark discrepancy on the goals item prompts a gentle enquiry: "I notice you gave the goal item a lower score than I did. Could you tell me more about how you see the purpose of our work?" Maya explains that while she appreciates the sleep diary, she feels the sessions have not addressed the underlying sense that she is "stuck" in a career she no longer

enjoys, a concern that she has been hesitant to voice because she fears being labelled as a complainer. The therapist recognises that the original goal – reduction of anxiety attacks – does not capture Maya's deeper existential distress.

In response, the therapist invites Maya to co-construct a revised goal: "explore career satisfaction and develop a plan for potential change, while also maintaining strategies to manage anxiety symptoms." The task list is expanded to include values clarification exercises and a graded exposure to job-search activities. The bond is reaffirmed through explicit validation of Maya's courage in sharing her true concerns. In the next session, both therapist and client complete the SRS again; this time the goal item rises to an 8 from Maya's perspective, aligning closely with the therapist's rating. Over the subsequent eight weeks, Maya's PHQ-9 score falls to 8 and her GAD-7 to 6, reflecting clinically significant improvement. The alliance monitoring process, by surfacing the hidden misalignment in goals, facilitated a repair that directly contributed to symptom reduction.

The lesson from Maya's case is that the three components of the alliance are interdependent. A warm bond cannot compensate for a mis-aligned goal, and a well-agreed task cannot rescue a relationship that has been strained by unspoken expectations. The therapist must therefore attend to each component with equal rigour, treating the alliance as a living system that requires regular calibration.

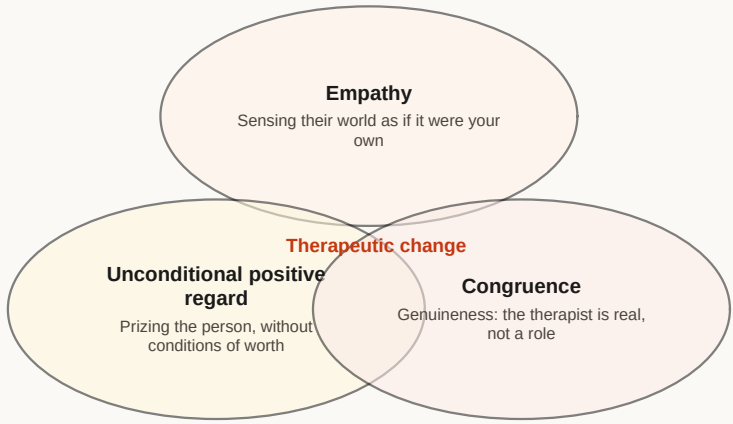
In terms of implementation, there are several practical strategies that can be woven into the fabric of routine counselling practice. First, schedule explicit alliance check-ins at natural review points – for instance, after the third session, at the midpoint of a planned series, and before termination. During these check-ins, ask three open-ended questions that map directly onto Bordin's components: "What do you feel we are working towards together?" (goal), "Which activities do you find most helpful, and are there any you would like to change?" (task), and "How would you describe our relationship at the moment?" (bond). Second, use brief rating scales not as bureaucratic add-ons but as conversational catalysts. Present the scores as shared data, and invite the client to interpret them. Third, cultivate a stance of curiosity rather than defensiveness when discrepancies arise. The therapist's instinct may be to protect the perceived integrity of the therapeutic relationship, but acknowledging a rupture openly often strengthens the bond more than

attempting to ignore it.

It is also important to recognise that alliance monitoring is not limited to formal scales. Informal observations – such as noticing a client's body language, the frequency of eye contact, or the tone of voice when discussing the therapeutic plan – can provide valuable clues. When a client begins to answer questions with monosyllabic replies, or when they consistently arrive late to sessions, these behavioural signals may indicate a weakening bond or a hidden disagreement about goals. In such moments, a brief reflective statement – "I sense that something feels off for you today; would you like to talk about what's on your mind?" – can open the door to repair.

The evidence base also suggests that alliance monitoring yields benefits beyond symptom reduction. Studies have linked higher alliance ratings to increased client empowerment, greater treatment adherence, and lower dropout rates. In a longitudinal study of community mental health services, clients whose therapists used systematic alliance monitoring were 30 per cent less likely to terminate prematurely than those whose therapists relied on intuition alone. Moreover, the alliance appears to mediate the relationship between therapist competence and client outcomes, meaning that even highly skilled therapists can achieve suboptimal results if they neglect to attend to the alliance.

In sum, Bordin's three-part model provides a clear, evidence-based framework for understanding and shaping the therapeutic relationship. The alliance is not a mystical, intangible quality; it is a set of negotiable agreements that can be articulated, measured, and repaired. The robust meta-analytic evidence confirming its status as one of the strongest predictors of outcome underscores the ethical imperative for clinicians to treat alliance monitoring as a core competency. By regularly inviting client feedback through validated tools such as the Session Rating Scale, by asking direct, collaborative questions about goals, tasks, and bond, and by responding to discrepancies with curiosity and repair work, therapists can transform the alliance from a passive backdrop into an active engine of change. The next time you sit with a client, consider the alliance not as an abstract ambience but as a concrete structure you are jointly constructing, one that you will periodically inspect, adjust, and, when necessary, mend, in order to ensure that the therapeutic journey remains on a shared, purposeful path.



Necessary and, Rogers argued, sufficient — when the client perceives them.

FIGURE 1.1 Rogers' core conditions

Person-centred therapy holds that when the therapist offers empathy, unconditional positive regard and congruence, and the client perceives them, the conditions for constructive personality change are present. They are ways of being, not techniques to perform.

Points worth keeping

- Alliance = goals + tasks + bond, and each is negotiable
- The alliance is among the most robust outcome predictors known
- Monitor it: client and therapist ratings regularly disagree

PRACTICE TASK

Write the exact sentence you would use to invite alliance feedback at the end of a session, in your own voice.

CHAPTER 2

Immediacy and congruent challenge

Immediity and congruent challenge sit at the heart of the working alliance, yet they remain the most under-used instruments in the therapeutic repertoire. The term immediacy, first articulated by Carl Rogers in his seminal work on client-centred therapy, refers to the therapist's willingness to comment on the live, unfolding relational process that is occurring in the consulting room. In practice, this means naming what is happening between therapist and client in the here-and-now, rather than waiting for the client to bring the material into the narrative. The paradox is that while immediacy is arguably the most powerful relational lever – capable of opening up otherwise inaccessible material – it also feels socially transgressive. Ordinary conversation rarely turns the spotlight on its own mechanics; to say, for example, "I notice we have both become very quiet in the last few minutes" is to breach a conversational norm in service of a therapeutic one. This breach, when undertaken with care, can unlock a cascade of insight that would otherwise remain locked behind the client's habitual defences.

The working alliance, as originally conceptualised by Bordin, rests on three pillars: goals, tasks and bond. Immediity operates primarily on the bond pillar, strengthening the affective connection by demonstrating that the therapist is attuned to the client's experience in real time. Moreover, the alliance is not a static construct; Safran and Muran have shown that ruptures and repairs are inevitable, and that the therapist's capacity to repair ruptures in the moment is a predictor of positive outcomes. Immediity, therefore, is not a decorative skill but a repair mechanism that can be deployed the instant a rupture is sensed. The chronic under-use of immediity can be traced to the therapist's fear of appearing intrusive or judgmental, a fear that is reinforced by the cultural script that therapy is a space for the client to lead, not for the therapist to comment on the process itself. Yet the very act of naming the process can convey a deep respect for the client's agency, because it signals that the therapist is listening not only to content but to the relational texture that carries that content.

The grammar of immediity is precise. It is always offered tentatively, owned personally, and framed as a description rather than a diagnosis. A therapist

might say, “I find myself feeling a little hesitant to explore that topic today, and I wonder what that hesitation might be telling us both.” Notice the use of first-person language (“I find myself…”) and the avoidance of attributing the hesitation to the client (“you are defensive”). This self-referential stance creates a safe container for the client to reflect on the therapist’s experience without feeling blamed. The description is brief, concrete, and anchored in observable behaviour – a pause, a change in tone, a shift in posture – rather than in inferred motives. By keeping the focus on observable process, the therapist reduces the risk of the client perceiving the comment as a moral judgement.

Congruent challenge is the partner of immediity. While immediity names the process, congruent challenge names the discrepancy between the client’s stated experience and their lived behaviour, always from a place of empathy and shared responsibility. The term “congruent” is drawn from Rogers’ notion of congruence, meaning that the therapist’s verbalisation aligns with their internal experience and with the therapeutic intent to promote client growth. A congruent challenge therefore presents the client’s own words side-by-side with a contradictory behaviour, without imposing a verdict. For instance, a therapist might observe, “You tell me that you feel in control of your drinking, yet you also describe waking up in the night feeling terrified about how much you have consumed. I am struck by how both statements can be true at the same time.” This formulation respects the client’s autonomy, because the therapist does not say, “You are lying to yourself,” but rather invites the client to explore the paradox.

The sequencing of empathy, immediity and challenge follows a subtle economics of relational credit. Empathy, as defined by Carl Rogers, is the accurate, unconditional, and non-judgmental reflection of the client’s internal state. It is the currency that must be banked before any credit can be spent on immediity or challenge. The therapist first establishes a robust empathic attunement, often using reflective statements that mirror the client’s affective tone. Once the client feels understood, the therapist can spend a small portion of that credit to name the present relational process (immediity) or to highlight a discrepancy (challenge). After the challenge is made, the therapist returns to empathy, inviting the client to share the emotional response that the challenge has evoked. This cyclical pattern – empathy, immediity/challenge, empathy – is a core principle in Ivey’s “process-oriented” model and is echoed in the “repair” phase of Safran and

Muran's rupture-repair framework.

The danger of premature challenge is well documented. Novice therapists often mistake the act of observation for insight, delivering a well-crafted challenge before the client has had the opportunity to feel truly heard. The result is a defensive response, a withdrawal of alliance, or a rupture that the therapist is ill-equipped to repair. Conversely, when empathy is sufficiently banked, the client is more likely to receive the challenge as a collaborative invitation to deepen self-knowledge. Ivey's rule of thumb – "if a challenge is not received, increase empathy rather than intensify the challenge" – remains a reliable guide across therapeutic orientations.

A concrete worked example illustrates the nuanced dance of immediity and congruent challenge. Maria, a 34-year-old accountant, presents with chronic anxiety, scoring 15 on the GAD-7, and reports difficulty sleeping. Over several sessions she has described a pattern of perfectionism at work, coupled with a fear that any mistake will lead to catastrophic consequences. In session five, Maria begins to speak in a rapid, clipped manner, her hands trembling as she describes a recent presentation. The therapist notes the heightened arousal and decides to employ immediity. The therapist says, "I notice that my own breathing has become quicker as you describe the presentation, and I find myself feeling a bit tense as well. I wonder what that tension might be telling us about the moment we are sharing now." Maria pauses, looks up, and replies, "I guess I'm scared that I'll mess up again, even though I'm trying to stay calm." The therapist has used immediity to name the shared physiological response, creating a bridge between therapist and client.

Having established that shared tension, the therapist now moves to a congruent challenge, still anchored in empathy. The therapist reflects, "You have told me that you want to feel confident and in control during presentations, yet you also describe feeling a knot in your stomach that tightens each time you think about speaking in front of others. I am struck by how both of those statements can coexist – wanting confidence while feeling a physical cue of anxiety. What do you think that knot might be trying to protect you from?" Maria, feeling heard and not judged, begins to explore the possibility that the knot represents a fear of judgment from colleagues, a fear that she will be seen as incompetent. The therapist then returns to empathy, saying, "It sounds like that fear is very real for you, and I can hear the sadness behind it. It must be exhausting to carry that weight every time

you present." This sequence – empathic attunement, immediity, congruent challenge, and renewed empathy – exemplifies the relational economics that sustain the alliance.

The therapeutic benefits of immediity and congruent challenge are supported by empirical research. A meta-analysis by Horvath, Del Re, and colleagues (2011) found that therapist behaviours that directly address the therapeutic relationship – including immediity – are among the strongest predictors of alliance quality and client outcome. Further, studies of rupture-repair interventions (Safran, Muran, & Côté, 2011) demonstrate that timely, empathic repairs that incorporate immediity reduce dropout rates and improve symptom reduction. Congruent challenge, when delivered from a stance of empathy, has been linked to increased client insight and motivation for change, particularly in cognitive-behavioural frameworks where discrepancy is a catalyst for cognitive restructuring.

It is essential to recognise that immediity and congruent challenge are not techniques to be deployed in isolation; they are relational gestures that must be calibrated to the client's developmental stage, cultural context, and presenting problem. For instance, a client from a collectivist background may view direct process-focused comments as confrontational, requiring the therapist to soften the language and increase the amount of empathic scaffolding before attempting a challenge. Similarly, clients with trauma histories may experience heightened vigilance to perceived criticism, making the timing of any challenge especially delicate. The therapist's cultural humility and ongoing self-reflection are therefore integral to the skilful use of these interventions.

In practice, the therapist can cultivate a habit of noticing the relational micro-climate. This habit involves three simple steps: first, attend to the client's verbal content and non-verbal cues; second, monitor one's own internal response to those cues; third, articulate the observed process in a tentative, first-person manner. The articulation can be as brief as a single sentence, but its impact is amplified when it is delivered at a moment when the client's affective state signals readiness – for example, after a sustained period of reflective listening or when a subtle shift in posture suggests an emerging rupture.

The language of immediity and congruent challenge must also respect the therapist's own authenticity. Rogers warned against "pseudo-immediity,"

where the therapist pretends to notice a process without truly feeling it. Such inauthenticity can be sensed by the client and may exacerbate mistrust. Therefore, therapists should engage in regular supervision or peer consultation to explore moments where they felt a pull to comment but hesitated, examining whether the hesitation stemmed from genuine concern for the client's safety or from personal discomfort with the transgressive nature of immediity.

A final vignette illustrates the cumulative power of these skills. James, a 28-year-old university student, repeatedly expresses gratitude for the therapist's support but habitually arrives ten minutes late to each session. The therapist, having built a solid empathic foundation over several weeks, decides to employ immediity. The therapist says, "I notice that we often start our sessions a few minutes after the scheduled time, and I wonder what that timing might be communicating for you, especially given how much you have told me about valuing punctuality in your studies." James looks down, then replies, "I guess I'm trying to avoid the moment when I have to face the topics I don't want to talk about, so I delay a little." The therapist follows with a congruent challenge: "You tell me that being on time is important to you, yet you also describe this pattern of arriving late as a way of protecting yourself from the discomfort of the session. I am struck by how both of these statements can be true at the same time. What might be happening for you in that space between the desire to be punctual and the act of delaying?" James, feeling heard and not judged, begins to explore the underlying fear of vulnerability, eventually linking the lateness to a deeper avoidance of emotional pain. The therapist then returns to empathy, reflecting, "It sounds like you are caught between wanting to honour your commitments and protecting yourself from feeling exposed. That must be a heavy tension to carry." This sequence not only clarifies the client's pattern but also re-aligns the therapeutic alliance, demonstrating how immediity and congruent challenge can transform a seemingly minor behavioural issue into a gateway for deeper work.

In sum, immediity and congruent challenge are indispensable tools for maintaining and repairing the working alliance. They require the therapist to be present, vulnerable, and willing to momentarily step outside the conventional therapist-client hierarchy. By banking empathy, spending it judiciously on process-focused comments, and then replenishing the alliance with renewed empathy, the therapist creates a dynamic, resilient

relational environment. The evidence base, from alliance research to rupture-repair studies, underscores their efficacy, while the lived experience of seasoned clinicians confirms their transformative potential. Mastery of these skills invites the therapist to move beyond the safe but static realm of content-only therapy, into the vibrant, ever-changing terrain of relational process where genuine change is most likely to occur.

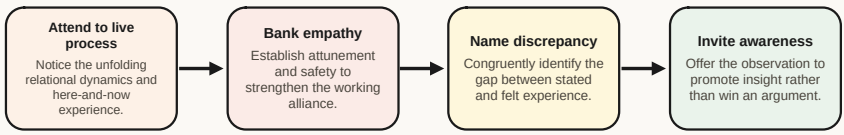


FIGURE 2.1 The Process of Congruent Challenge

This model illustrates the sequential steps for deploying immediacy to facilitate therapeutic awareness. It highlights the necessity of establishing empathy before naming discrepancies in the live process.

Points worth keeping

- Immediacy names the live process and is chronically under-used
- Challenge = congruently naming discrepancy, from alongside
- Bank empathy before challenge; the aim is awareness, not victory

PRACTICE TASK

Draft one immediacy statement for a session that has gone polite and flat, phrased so it invites rather than accuses.