

The working alliance and the short-term and long-term effects of therapy: Identification and analysis of the effect of the therapeutic relationship on patients' quality of life

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Summary

Objectives. The main issue presented in this article is the analysis of the therapeutic alliance as a non-specific factor healing various mental disorders and the effect of therapeutic alliance quality on patients' quality of life.

Material and methods. The sample consisted of 140 subjects: 85 patients participating in individual psychotherapy and 55 psychotherapists. To assess working alliance quality, the author used the Working Alliance Inventory (WAI; Horvath & Greenberg). The other measures used in the study were the Temporal Satisfaction With Life Scale (TSWLS; Pavot, Diener, & Suh) and the Psychological Well-Being Scale (PWBS; Ryff).

Results. The results showed that the actual effect of working alliance quality on short-term satisfaction with life was not statistically significant. It was found, however, that the effect of therapeutic alliance quality on psychological well-being was statistically significant and that a higher level of working alliance reported by the psychotherapist and the patient led to a greater sense of psychological well-being. The obtained values of correlation coefficients served as the basis for the hypothesis postulating a positive correlation between working alliance as well as its dimensions and the dimensions of psychological well-being.

Conclusions. The working alliance is not related to short-term effects in psychotherapy, which means that it does not increase the current feeling of satisfaction with life as well as the experience of positive affect and contentment with life. The working alliance augments the quality of life understood as lasting and healthy development. It turns out that the psychotherapeutic alliance is a determinant of psychological well-being understood more deeply than merely as fleeting pleasure and more holistically, as an intrinsic, long-term element of healthy human development. The correlation of these two factors is significant.

Key words: mental health, well-being, working alliance

Introduction

Patients who visit the psychotherapist's office are troubled by diverse internal conflicts and problems. Psychotherapy is regarded as an effective way of treating mental disorders by organizing the space in which a person can undertake to work with the difficulties causing the disorder. However, its effectiveness – understood as achieving the desired outcomes – is gradable.

Sometimes only some of the expected results are achieved, and sometimes the change is fundamental. In both cases, however, it is emphasized that if, according to the salutogenetic model [1, 2], mental health is a dynamic process of continually reacting to the demands in order to restore a certain level of organization, then every outcome that optimizes functioning is evidence of the patient's recovery taking place in psychotherapy.

The existing research results support two conclusions important for this empirical study [3]. The first of these conclusions is as follows: psychotherapy brings positive results operationalized both by objective indicators, namely the disappearance of the symptoms that the patient complained of, and by subjective ones, namely the increase in the patient's well-being [4]. The second conclusion concerns the different modalities in which therapists work and points out that, so far, there is no sufficient evidence to regard any school of psychotherapy as more effective than others [5].

Nevertheless, charges have been articulated against numerous studies that led to the above conclusions [6]. It has been pointed out that many studies were conducted in laboratory conditions, on carefully selected groups of patients and therapists who rarely resembled those really coming for help or providing it. This means that a clear and, importantly, conclusive answer to questions concerning the actual healing factors and effectiveness criteria in psychotherapy has not been given yet. The aim of the present empirical study is to bring us closer to answering these questions. Psychotherapists working with patients differing from those who took part in laboratory studies are looking for an answer to the question of which of the factors that determine the effectiveness of psychotherapy will contribute to its lasting effects. Further research is required to confirm the value of the variables considered in the literature.

The determinants of effective psychotherapy that have been mentioned include the characteristics of the psychotherapeutic process, such as the therapeutic relationship variable, also referred to in the literature as “therapeutic alliance” or “working alliance” [7, 8]. The specific events observed in the entire process of psychotherapy, particularly the experiences and attitudes of the therapist and the patient towards each other in the course of meetings as well as the undertaken actions are a significant factor in corrective experience and a vehicle of optimal change.

The main issue presented in this article is the analysis of the therapeutic alliance as a non-specific factor healing various mental disorders. This cooperation between the psychotherapist and the patient, marked by commitment and based on mutual trust, will be considered as a determinant of improvement in the quality of life, understood in several ways, currently identified as specific operationalizations of the construct of quality of life. Importantly, although it is stressed that the effectiveness of psychotherapy is significantly influenced by the quality of the therapeutic relationship and alliance –

that is, by how the relationship between the therapist and the patient develops, in Polish psychology there is little empirical material to precisely identify the obtained effects.

The model of alliance in psychotherapy

In the literature devoted to the issue of alliance in psychotherapy, it is highlighted that alliance is the most rational part of the therapist–patient relationship. For an alliance to be formed, the patient must have a directed need for recovery, some sense of helplessness or inadequacy, and a conscious need for cooperation with the psychotherapist [9]. Some authors argue that the emergence of the therapeutic alliance must be preceded by a preparatory phase in therapy, in which a stimulation of the development of such a relationship takes place [10].

Despite the fact that, as mentioned above, the alliance in therapy is considered to be a healing factor, definitional issues have not been unambiguously resolved, and a common definition has not been agreed on [11]. Given that the majority of researchers treat the alliance in psychotherapy as a non-specific factor, and given that the assessment of this kind of factor will involve a variety of therapeutic approaches, one of the best proposals enabling the assessment of alliance is the theoretical model offered by Bordin [12]. The value of this model stems both from the essence of how alliance is understood in it and from the fact that it was thoroughly analyzed by the author of the construct and has been used in a number of research studies [13].

Bordin suggests that alliance encompasses three integrated components: goals, tasks, and bonds [14]. The first two dimensions are specified at the initial meetings, which, for psychotherapists, are also sessions aimed at assessing the patient. The third dimension – though built during the entire period of psychotherapy, as it is impossible to agree on mutual trust during the first sessions – is a condition of achieving the goals and performing the tasks. Bordin emphasizes that the quality of these three dimensions of the therapeutic alliance is what the success of psychotherapy depends on. Thus understood, the therapeutic alliance ensures the patient the conditions necessary to build trust with respect to the proposed treatment, to accept it, and to adhere to the working rules agreed on in the further stages of psychotherapy.

The psychotherapeutic alliance and the effects of therapy

Thus defined, the alliance in psychotherapy is distinguished from the consultative or advisory relationship [15] and from interpersonal influence [16]. In the case of Bordin's model, it is pointed out that the patient approves the intervention agreed on and actively takes part in it. An important characteristic of Bordin's working alliance is the mutuality of agreement. The strength of the alliance in this case is therefore built by mutual consent to the undertaken actions and by maintaining a relationship of cooperation. The indicators of change are the goals achieved through specific tasks, which is possible thanks to the bond created between the patient and the psychotherapist.

The working alliance is considered to be an important determinant of the success of psychotherapy [17, 18] because it builds a framework for various strategies and

methods of work used by psychotherapists. It builds communication between the psychotherapist and the stable part of the patient's personality, helping the latter to remain in the process despite the fluctuating intensity of subjective discomfort or perceived functioning difficulties. The psychotherapist also benefits from establishing an optimal alliance with the patient because he or she has an opportunity to adapt to those of the patient's characteristics that, for various reasons, could make it more difficult for the psychotherapist to take a positive attitude towards him or her [19].

There are studies indicating that a well-formed therapeutic alliance is a predictor of positive effects of treatment, on the condition that the alliance is evaluated not only by the psychotherapist but also by the patient and when these evaluations are convergent [20]. The model of the working alliance proposed by Bordin is useful in assessing the links of the therapeutic relationship with the outcomes of treatment because it postulates precisely this kind of convergence of evaluations. The alliance is considered optimally established when the evaluations from the two parties to the process are convergent.

Important findings concerning the relationship between the results of therapy and the strength of the psychotherapeutic alliance were made by Botell et al. [21]. The researchers assessed the level of psychotherapy effectiveness using objective measures. They found significant relations between the alliance and the symptoms. With an increase in the number of sessions, the strength of the relationship between the alliance and the symptoms grew, and its direction remained inversely proportional. Likewise, the research results presented by Zuroff and Blatt [22] show that faster decrease in depressive symptoms was found in the patients who rated the quality of the therapeutic relationship as high.

There have also been voices such as Kazdin's [23], who stresses in his works analyzing the existing research findings that, despite the existence of hundreds of carefully conducted empirical studies, there is still no explanation of how and why even the best psychotherapeutic interventions cause a change.

Current research

Sass-Stańczak and Czabała [24] note that previous studies have provided grounds to believe that a good therapeutic relationship positively influences the therapeutic process and the outcome of psychotherapy. The above issues, stemming from in-depth analyses, the assumption, as well as the still numerous gaps and the still ambiguous research reports have defined the horizons of current research.

At present, it is worth asking precise questions concerning only what it is in the therapeutic relationship that makes it possible to effect a change and in what dimensions this change takes place. A substantial proportion of research devoted to the therapeutic alliance and the results of therapy is focused on assessing the relationship between them by demonstrating the absence of symptoms. Reporting a decrease in symptoms impairing the individual's functioning is important and needed, but it seems to be insufficient. The development of a healthy individual takes place not only due to the decrease or absence of negative experiences or sensations, but also, perhaps above all, because thanks to psychotherapy the individual begins to experience himself or herself

as a person having specific resources and the closest environment as supportive. It is therefore important to ask about what positive experiences, attitudes, and beliefs an individual gains thanks to this process. It is important to ask about how the therapeutic process and its important aspects, including the working alliance, enhance the quality of life: both its short-term aspect – good temporary well-being – and the more lasting one – further healthy development and psychological well-being. Looking for relations between the working alliance and well-being is consistent with the current paradigm of positive psychology, highlighting the fact that well-being results from the dialectics of various positive and negative experiences or landmark moments in life [25].

Although the psychotherapeutic alliance is the most often estimated determinant of success in psychotherapeutic treatment, little is known about the explanatory value of its components [26, 27]. What is it, then, in the entire spectrum of factors constituting the alliance between the psychotherapist and the patient, that actually heals? Is it legitimate to speak about the leading effect of one of the components of the therapeutic alliance? And if there is such a factor, what is it and how strongly does its effect differ from that of the others? Which elements contribute to the long-term outcomes of psychotherapy and which ones contribute only to the short-term outcomes? Finally, what can be treated as an outcome? Only what is objectively measurable? It seems that subjective indicators showing an increase in well-being should be taken into account too. This issue also requires broader exploration.

Another question that arises is who should be the source of information about the quality of the alliance in psychotherapy. Is the alliance to be evaluated by the patient or by the therapist? Is it possible, though certainly difficult, to draw conclusions about the quality of the alliance based on several sources at the same time, from the patient's and the psychotherapist's perspectives? It seems to be, since research results reveal that the effects of therapy depend also on the therapist's ability to develop a relationship with the patient in which he or she (the therapist) plays the role of a partner [28, 29].

To sum up, the central issue explored in the present study was the effect of therapeutic alliance quality on the quality of life. Bordin's pantheoretical model of alliance was taken into account and diverse approaches to well-being were introduced. For this purpose, an elaborate and complex model has been provided, operationalizing the possible relations between the psychotherapeutic alliance and well-being, which supplements previous research into these issues.

Well-being was operationalized in two ways, derived from different philosophical traditions: hedonistic and eudaimonic. In the first operationalization, well-being consists in the experience of pleasure and satisfaction [30] as well as subjective satisfaction with life [31, 32]. In the second one, it is a long-lasting feeling that accompanies the realization of the human potential and life in harmony with nature [33, 34]. I decided to check whether the working alliance led to an outcome in the form of short-term experience of positive affect or whether it was related to psychological well-being understood as an element of healthy human development.

Hypotheses

I tested the following hypotheses in the present study:

- Hypothesis 1 (H1): A higher level of working alliance reported by the psychotherapist and the patient results in higher satisfaction with life than a lower level of working alliance.
- Hypothesis 2 (H2): A higher level of working alliance reported by the psychotherapist and the patient results in higher psychological well-being than a lower level of working alliance.

The relations were tested also at the specific level, which means the study also investigated the strength of the relations between specific elements of the working alliance and the dimensions of quality of life. The specific hypothesis was as follows:

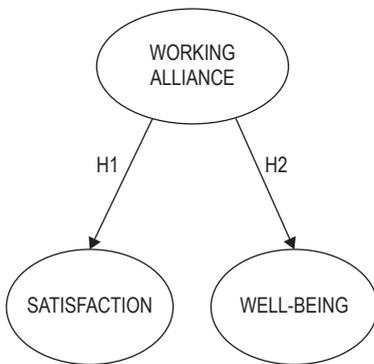


Figure 1. **Model of direct relations between the working alliance and satisfaction with life as well as well-being**

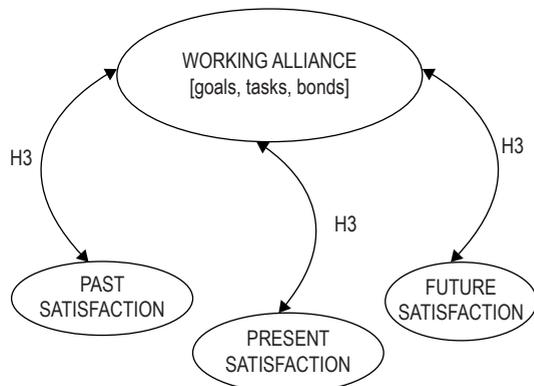


Figure 2a. **Specific model of correlations for satisfaction with life**

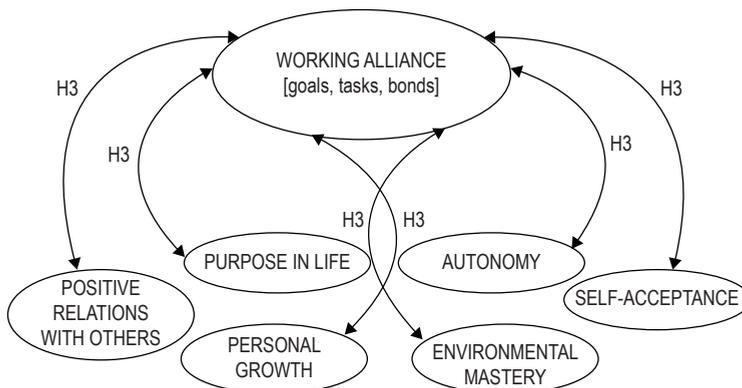


Figure 2b. **Specific model of correlations for psychological well-being**

- Hypothesis 3 (H3): Working alliance is positively correlated with the dimensions of satisfaction with life and psychological well-being.

The model of the hypothesized relations between the above constructs, tested in the study, is illustrated in Figures 1, 2a and 2b.

Method

Participants

The sample consisted of 85 patients: 57 women and 28 men, aged 17 to 70 ($M = 36.28$; $SD = 11.44$), attending individual psychotherapy. Most of them had higher (52.9%) or secondary education (38.8%) and lived in cities with a population above 100,000 (69.4%). By the time when the measurement was performed, the patients had attended between 2 (2.4%) and 960 (1.2%) sessions ($M = 53.63$; $SD = 137.68$). Sixty-one participants (71.8%) attended psychotherapy once a week, and most of the psychotherapeutic sessions (78.9%) took 50 to 60 minutes.

The type of disorder experienced by the participants in the group of patients was a variable controlled for to a limited degree. Many patients had more than one diagnosis; others were unable to give an unambiguous one. Data are therefore incomplete in this respect. The largest group were patients diagnosed with adaptation disorders (18.8%), followed by patients suffering from anxiety disorders in the form of phobias and other anxiety disorders (12.94%); mood (affective) disorders were found in 10.95% of the patients, mental disorders and behaviors caused by psychoactive substance use were found in 8.23%, and 5.88% of the patients were diagnosed with schizophrenia or schizotypal and delusional disorders. In 2.35% of the patients a previously experienced complex trauma was given as the reason for psychotherapeutic work.

The sample also included 55 psychotherapists: 41 women and 14 men, aged 28 to 58 ($M = 41.38$; $SD = 8.52$). The psychotherapists taking part in the study worked in the following modalities: psychoanalytic or psychodynamic, Ericksonian, systemic, humanistic, and Gestalt; 89.4% of all the psychotherapists in the sample were doing or had completed at least two-year training in psychotherapy. In the group of psychotherapists, the experience variable was controlled for; 55% of the participants in this group had between 1 and 5 years of work experience, and 40% had worked as psychotherapists for more than 5 years. In order to enhance the precision of the assessment of alliance in psychotherapy, I performed the measurement in psychotherapist–patient dyads.

Procedure

Invitation to take part in the study began with the presentation of the aim of the study to the psychotherapist. After obtaining the psychotherapist's consent, still before the measurement, the patient was informed about the aim of the study and asked to give consent for it to be conducted. After both individuals from the dyad had given their consent, the psychotherapist completed a questionnaire concerning the working

alliance as well as a survey with questions about demographic variables and variables associated with the context of psychotherapeutic work, such as: the number of sessions held with the patient, the frequency of meetings, or mean session length.

In the case of the patient, measurement began with completing a questionnaire concerning the therapeutic alliance; then the patient completed a battery of scales measuring quality of life, particularly emotional and psychological well-being. At the end of the measurement the participant completed a respondent's particulars survey, containing questions about sociodemographic data, such as age, sex, education, or place of residence.

In the present study, I analyzed data collected in a single measurement. Participation in the study was voluntary, and the subjects did not receive any remuneration. The study was approved by the Research Ethics Board at the Maria Grzegorzewska University in Warsaw Approval decision number: 169-2018/2019. The Research Ethics Board expressed no ethical reservations about the submitted research project.

Measures

To assess the quality of the working alliance, I used *the Working Alliance Inventory* (WAI). This measure was developed by Horvath and Greenberg [35] and adapted into Polish by Prusiński [36]; it operationalizes the psychotherapeutic alliance in accordance with Bordin's theoretical model.

There are two versions of the WAI: one for the patient and the other one for the psychotherapist. Each version consists of 36 analogous items, which the respondent rates on a Likert scale as accurately or inaccurately describing the cooperation in the patient–psychotherapist dyad being evaluated. The WAI score can be computed for three subscales. “Goals”, “Tasks” and “Bonds”; it is also possible to assess the overall quality of the working alliance by computing the total score. Each subscale consists of 12 items: six positive and six negative ones.

Psychometric validation revealed a high goodness of measurement using the WAI. The reliability of the overall score is $\alpha = 0.94$; as regards the subscales, reliability is $\alpha = 0.87$ for Goals, $\alpha = 0.87$ for Tasks and $\alpha = 0.81$ for Bonds. Confirmatory factor analysis (CFA) showed that measurement using the WAI was valid. The values of CFA indicated a good fit of the theoretical and measurement models ($\chi^2/df = 1.09$; RMSEA = 0.03), and the values of path coefficients were acceptable. A high WAI score means strong working alliance.

The remaining measures used in the present study were:

- *The Temporary Satisfaction With Life Questionnaire* (TSWLS). It is a scale developed by Pavot, Diener and Suh [37], adapted into Polish by Ciecuch and Karaś. The questionnaire measures integrated evaluation of life as a whole that existed, exists and will continue to exist. The scale consists of 15 items. TSWLS scores were used to assess the short-term outcomes of psychotherapy, understood as the current sense of satisfaction, pleasure and contentment.
- *The Psychological Well-Being Scale* (PWBS). The scale was developed by Ryff [33, 38, 39], and in the present study I used its Polish version. It measu-

res integrated well-being as a whole. Additionally, PWBS items operationalize six components of psychological well-being: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. The scale consists of 18 items. PWBS scores were used to assess long-term psychological well-being.

High TSWLS and PWBS scores mean high evaluation of quality of life in those dimensions that these measures operationalize. The reliability and validity indices of the measures justified using them in the study.

Results

Preliminary analyses

In order to test the main hypotheses, H1 and H2, postulating the direction and strength of linear relationships between the working alliance and quality of life, I built structural models with eight latent variables (the model for H1), with eleven latent variables (the model for H2), and with fifteen latent variables (the joint model for H1 and H2). Thus, I constructed three SEM models. Their graphic illustration is presented in Figures 3–5.

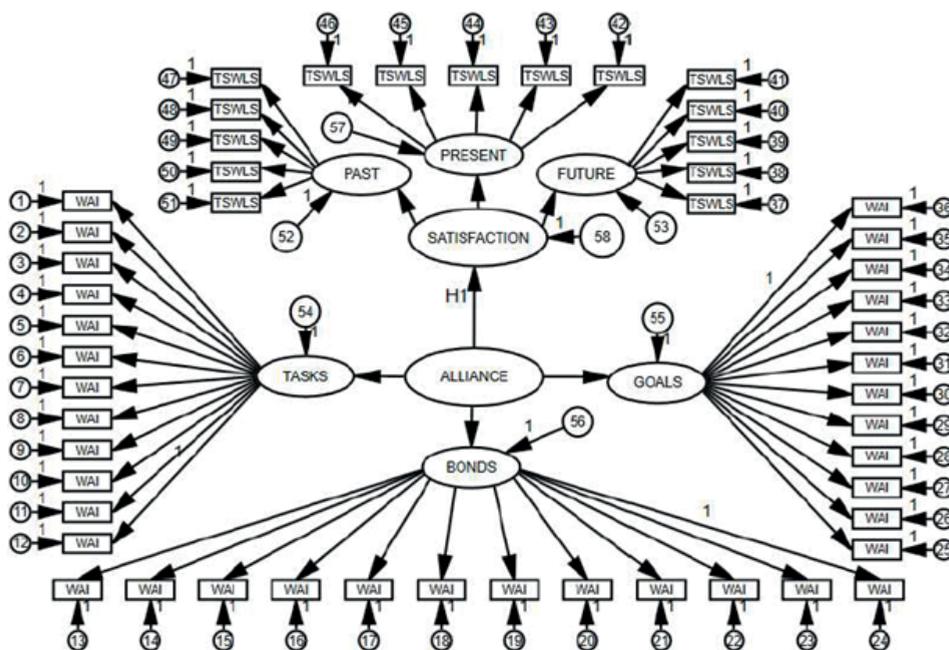


Figure 3. Structural and measurement model with eight latent variables, postulating the direction of relations between the working alliance and satisfaction with life, tested by means of SEM

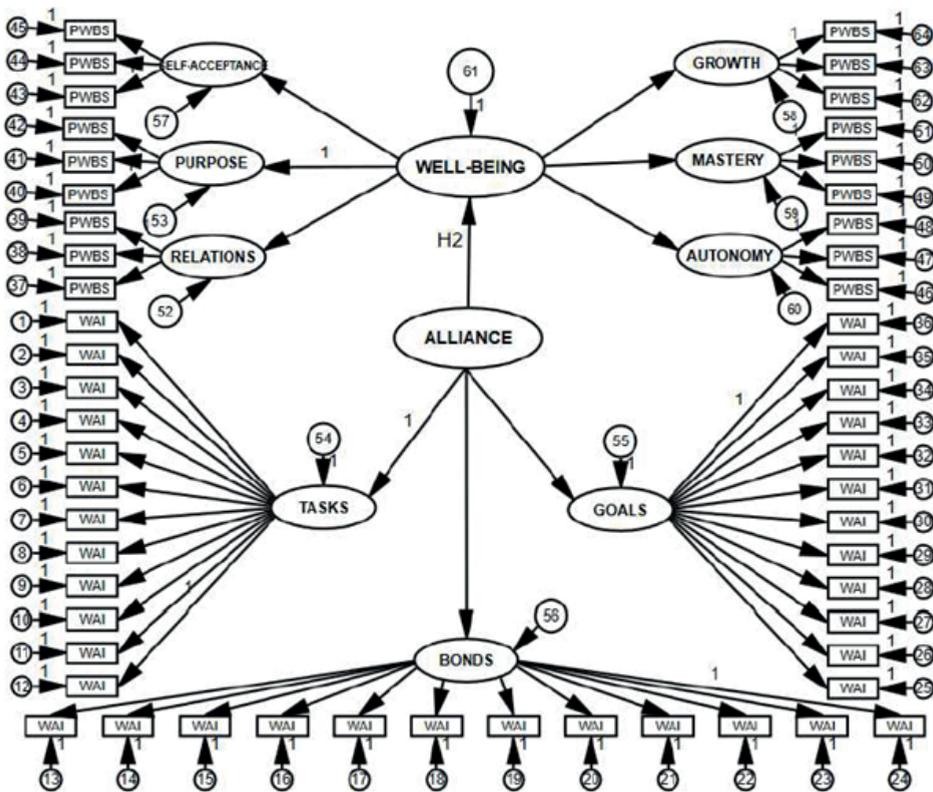


Figure 4. Structural and measurement model with 11 latent variables, postulating the direction of relations between the working alliance and psychological well-being, tested by means of SEM

In order to obtain the best estimations, so that the model would explain the analyzed phenomenon to the greatest possible extent and reflect the theory underlying it, I changed the proposed measurement model within the framework of the same structural model of relations for the entered latent variables.

The first measurement proposal assumed that the latent variables of the structural model of the working alliance would be built by the averaged sum of scores from the measurement using both versions of the WAI simultaneously (i.e., the versions completed by the psychotherapist and by the patient). In this model, the evaluation of the working alliance came from two sources at the same time: it was made both by the psychotherapist conducting the therapy and by the patient attending it.

The second measurement proposal assumed that the evaluation of the working alliance loaded into the structural model would be made only by the patient. The third structural model relied on the measurement of the working alliance exclusively by means of the WAI scale completed by the psychotherapist. The measurement model

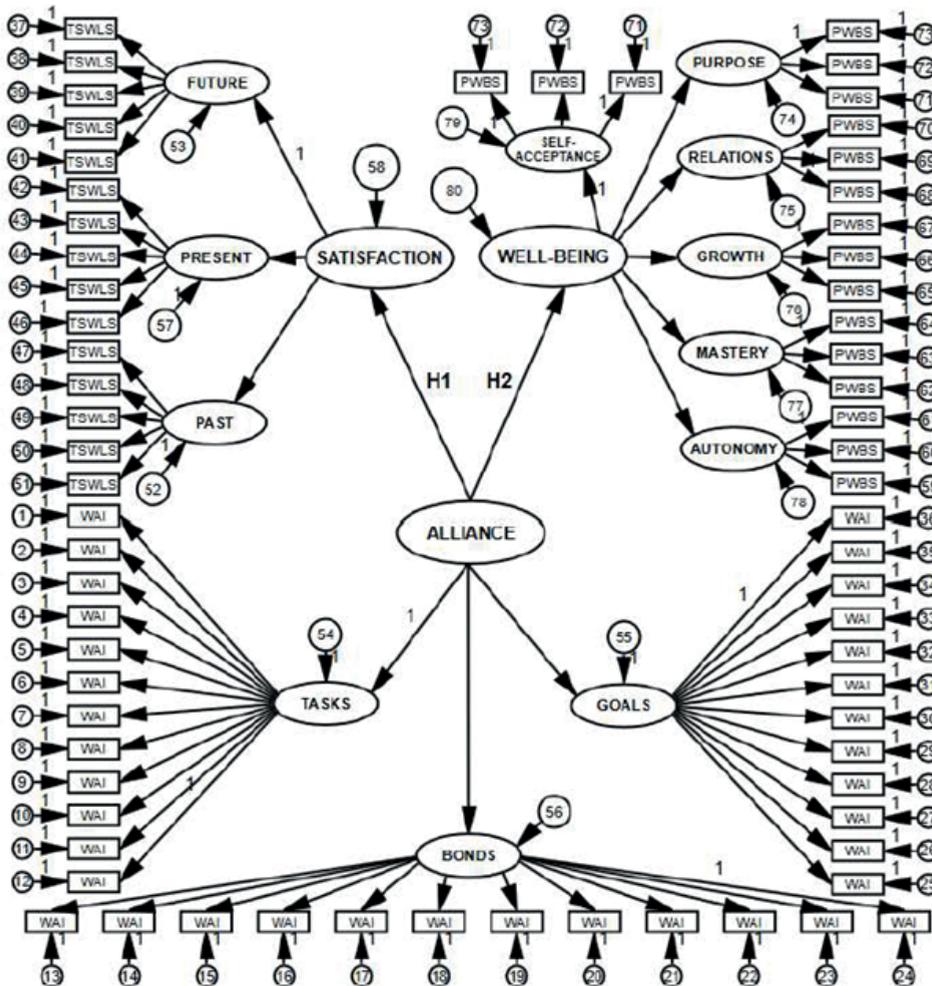


Figure 5. Structural and measurement model with 15 latent variables, postulating the direction of relations between the working alliance and satisfaction with life as well as between the working alliance and psychological well-being, tested by means of SEM

that served as the basis for the structural part concerning satisfaction with life and psychological well-being remained unchanged.

What is important, each of the structural models was additionally analyzed in the form of both full and simplified structure. The analysis of simplified SEM models is recommended by Szymańska [40]. SEM models in this form are not affected by small sample size bias, which makes it possible to avoid the risk of increasing the likelihood of Type 1 error – rejecting a correct model. This kind of model does not ignore the postulated multidimensionality of the construct in any way.

To sum up, 18 models were tested in the preliminary analyses. Before analyzing the estimation results yielded by structural equation modeling, I assessed the value of the constructed structural models with latent variables [41]. The values of fit indices for the measurement models are presented in Table 1.

Table 1. Fit indices of the tested models

Hypotheses	Model	χ^2	df	p	χ^2/df	RMSEA	GFI	CFI	
H1	Sum of evaluations	full	2075.69	1217	p<0.05	1.71	0.09	0.55	0.64
		simplified	14.33	8	p>0.05	1.79	0.1	0.94	0.84
	PA evaluation	full	2168.56	1217	p<0.05	1.78	0.1	0.53	0.61
		simplified	10.13	8	p>0.05	1.27	0.06	0.96	0.99
	PT evaluation	full	1932.28	1217	p<0.05	1.59	0.08	0.56	0.57
		simplified	11.36	8	p>0.05	1.42	0.07	0.95	0.89
H2	Sum of evaluations	full	2484.47	1367	p<0.05	1.82	0.1	0.52	0.53
		simplified	44.98	26	p<0.05	1.73	0.09	0.88	0.65
	PA evaluation	full	2349.32	1367	p<0.05	1.72	0.09	0.51	0.58
		simplified	49.38	26	p<0.05	1.89	0.1	0.9	0.93
	PT evaluation	full	2424.05	1367	p<0.05	1.77	0.1	0.53	0.39
		simplified	43.76	26	p<0.05	1.68	0.09	0.88	0.66
H1 and H2	Sum of evaluations	full	4452.36	2263	p<0.05	1.97	0.11	0.47	0.44
		simplified	144.88	52	p<0.05	2.79	0.15	0.79	0.77
	PA evaluation	full	4372.28	2263	p<0.05	1.93	0.1	0.46	0.46
		simplified	88.90	52	p<0.05	1.71	0.09	0.82	0.43
	PT evaluation	full	4295.86	2263	p<0.05	1.90	0.1	0.48	0.36
		simplified	187.13	52	p<0.05	3.53	0.17	0.73	0.53

Sum of evaluations model – the model with a measurement structure based on the averaged sum of scores obtained simultaneously on both versions of the WAI, completed by the psychiatrist and by the patient; PA evaluation model – the model with a measurement structure based on scores obtained on the version of the WAI completed by the patient; PT evaluation model – the model with a measurement structure based on scores obtained on the version of the WAI completed by the psychotherapist; χ^2 – the chi² model fit statistic; df – the number of degrees of freedom; χ^2/df – the chi² statistic divided by the number of degrees of freedom; RMSEA – root mean square error of approximation; GFI – index of variance explained by the path model; CFI – comparative fit index.

Having analyzed the fit indices of the theoretical model to the measurement model as well as having tested and interpreted the values of path parameters and variance, I concluded that the structural models jointly based on the relationships between the working alliance and both satisfaction with life and well-being were poorly fitted. They were not be considered in further analyses.

As regards the remaining models, separately estimating the relationship between the working alliance and satisfaction with life as well as psychological well-being, a few of them demonstrate fit values that are good or on the border of acceptability; it is these models that constituted the basis for further analyses.

In three cases, the test of model fit, corrected for model complexity, shows perfect fit of the model to the dataset. In many cases, the main estimator of model fit, RMSEA, for which it was assumed that the value of 0.1 and above was unacceptable and demanded the rejection of the model [42], has values that are on the border of acceptability or exceed the norm. Similarly, in some cases, GFI and CFI values are close to or above 0.9.

Based on the analyses presented above, I decided to use two models to test H1: the averaged sum model with full measurement structure, the patient's evaluation model with a simplified measurement structure, and the psychotherapist's evaluation model with both full and simplified measurement structures. The averaged sum model with a simplified measurement structure will be considered exclusively for information purposes; even though the RMSEA value exceeds 0.9, the χ^2/df statistic indicates that the model is fitted to the dataset.

To test the second hypothesis, H2, I used the following models: the averaged sum model with a simplified measurement structure, the patient's evaluation model with full measurement structure, and the psychotherapist's evaluation model with a simplified measurement structure.

Main Analyses

SEM results

Hypotheses H1 and H2, postulating the existence of cause-and-effect relations between the working alliance as the explanatory variable and satisfaction with life as well as psychological well-being as explained variables, were tested based on the results of structural equation modeling. A graph of the theoretical model has been presented before, in Figures 3–5.

The results obtained by means of SEM are presented in Table 2.

Table 2. Nonstandard and standard estimations of the tested models

Hypotheses	Model	β	Standardized β	p	R ²
H1	Averaged sum: full	0.122	0.268	0.47	0.072
	Averaged sum: simplified*	0.101	0.241	0.55	0.058
	PA evaluation: simplified	0.085	0.277	0.37	0.077
	PT evaluation: full	0.170	0.286	0.40	0.082
	PT evaluation: simplified	0.018	0.084	0.90	0.007
H2	Averaged sum: simplified	0.148	0.724	0.01	0.525
	PA evaluation: full	0.626	0.530	0.01	0.281
	PT evaluation: simplified	0.121	0.526	0.01	0.277

Averaged sum model: full – the averaged sum model with full measurement structure; Averaged sum model: simplified – the averaged sum model with a simplified measurement structure;

PA evaluation model: simplified – the patient’s evaluation model with a simplified measurement structure; PT evaluation model: full – the psychotherapist’s evaluation model with full measurement structure; PT evaluation model: simplified – the psychotherapist’s evaluation model with a simplified measurement structure; PA evaluation model: full – the patient’s evaluation model with full measurement structure. β – non-standardized path coefficient; standardized β – standardized path coefficient; R^2 – multiple correlation coefficient.

* – model presented for information purposes only

The results of SEM analysis for H1, presented in Table 2, proved to be statistically insignificant in the case of each of the considered models. The actual effect of working alliance quality on the sense of contentment and satisfaction with life is not statistically significant when the quality of the working alliance is evaluated simultaneously by a psychotherapist–patient dyad as well as when the evaluations are separate and performed either by the patient or by the psychotherapist. Path parameters cannot be subject to interpretation.

Moreover, it should be noted that the values of standardized path coefficients ($\beta_{\text{averaged sum: full}} = 0.268$; $\beta_{\text{averaged sum: simplified}} = 0.241$; $\beta_{\text{PA evaluation: simplified}} = 0.277$; $\beta_{\text{PT evaluation: full}} = 0.286$; $\beta_{\text{PT evaluation: simplified}} = 0.084$) are low and indicate that quality of life is only slightly determined by working alliance quality. The values of multiple correlation coefficient (R^2) range from 0.007 to 0.082, which means that the model explains only 0.7% to 8.2% of the variance in the explained variable.

Based on the results obtained by means of structural equation modeling, hypothesis H1, which postulated that a higher level of working alliance reported by the psychotherapist and the patient led to higher sense of satisfaction with life than a lower level of working alliance, was rejected.

The results of SEM analyses verifying H2 turned out to be statistically significant in each of the considered models. It was revealed that the effect of working alliance quality on psychological well-being was statistically significant both for joint evaluations and for separate ones.

The values of β coefficients reflecting the effect of working alliance quality on outcomes in the form of higher psychological well-being ($\beta_{\text{PA evaluation: full}} = 0.530$; $\beta_{\text{PT evaluation: simplified}} = 0.526$) turned out to be moderate and similar. The exception is the path coefficient based on the joint evaluation of the working alliance in the psychotherapist–patient dyad. This result ($\beta_{\text{averaged sum: simplified}} = 0.724$) is high.

The interpretation of the standard β coefficient of this model is as follows: working alliance higher by one standard deviation results in a rating of psychological well-being higher by an average of 0.59 standard deviations. In the case of patients as well as psychotherapists experiencing a high level of working alliance in the course of psychotherapy, there is a high level of patients’ psychological well-being, understood as an element of healthy human development. On average, the working alliance explains ($R^2_{\text{averaged sum: simplified}} = 0.525$; $R^2_{\text{PA evaluation: full}} = 0.281$, $R^2_{\text{PT evaluation: simplified}} = 0.277$) 36.1% of the variance in psychological well-being.

Based on the results obtained by means of structural equation modeling, hypothesis H2, which postulated that a higher level of working alliance reported by the psychotherapist and the patient led to higher psychological well-being than a lower level of working alliance, was confirmed.

Correlations

The third hypothesis (H3) concerning positive relations between the working alliance as well as its dimensions and the dimensions of satisfaction with life and psychological well-being was verified by the results of the test of correlations between the variables. Table 3 presents the obtained results.

Table 3 Spearman's rho correlations between the working alliance as well as its dimensions and the dimensions of satisfaction with life and psychological well-being

Variable		WA	G	T	B
SATISFACTION	PRESENT	0.21*	0.16	0.24'	0.15
	PAST	0.17	0.10	0.10	0.26"
	FUTURE	0.05	-0.02	0.07	0.13
WELL-BEING	SELF-ACCEPTANCE	0.25'	0.23'	0.21'	0.28"
	PURPOSE	0.16	0.19*	0.17	0.11
	RELATIONS	0.52"	0.44"	0.49"	0.51"
	GROWTH	0.16	0.15	0.11	0.21'
	MASTERY	0.41"	0.41"	0.42"	0.35"
	AUTONOMY	0.22'	0.18'	0.18'	0.27"

WA – the working alliance, overall averaged sum of patient's and psychotherapist's ratings; G – goals; T – tasks; B – bonds; PRESENT – satisfaction with the present life; PAST – satisfaction with the past life; FUTURE – satisfaction with the future life; PURPOSE – purpose in life; RELATIONS – positive relations with others; GROWTH – personal growth; MASTERY – environmental mastery.

* $p < 0.05$; ** $p < 0.01$

Based on the results of correlation analyses presented in Table 3, it should be concluded that only some of the correlations between the working alliance and the dimensions of satisfaction with life are statistically significant. Those that are statistically significant are low, though positive. In this respect, the results of analyses concerning the relations between the working alliance and satisfaction with life support hypothesis H3 to a small degree.

The working alliance correlates only with present satisfaction with life ($\rho_{\text{WAX-PRESENT SATISFACTION}} = 0.21$), and its dimensions correlate with the present satisfaction ($\rho_{\text{TXPRESENT SATISFACTION}} = 0.24$) and past satisfaction ($\rho_{\text{BXPAST SATISFACTION}} = 0.26$).

The results of the analysis of correlations between the working alliance and the dimensions of psychological well-being are consistent with the expectations specified in hypothesis H3 and support this hypothesis to a basic extent. The definite majority of the results presented in Table 3 are statistically significant, and the values of Spearman's rho coefficients indicate a positive and moderate relationship.

The working alliance is associated with all dimensions of psychological well-being except purpose in life and personal growth. Particularly significant is the relationship of the working alliance with positive relations with others ($\rho_{\text{WAXRELATIONS}} = 0.52$) and with environmental mastery ($\rho_{\text{WAXMASTERY}} = 0.41$).

An even greater number of significant correlations can be found at the level of dimensions of the working alliance. The goals agreed on in psychotherapy co-occur with positive relations with others ($\rho_{GxRELATIONS} = 0.44$) and environmental mastery ($\rho_{GxMASTERY} = 0.41$). The tasks set correlate positively with relations with other ($\rho_{TxRELATIONS} = 0.49$) and environmental mastery ($\rho_{TxMASTERY} = 0.42$). The number of moderate correlation values is the largest in the case of bonds. The development of bonds co-occurs with positive relations with others ($\rho_{WxRELACJE} = 0.51$), environmental mastery ($\rho_{BxMASTERY} = 0.35$), as well as autonomy ($\rho_{BxAUTONOMY} = 0.27$) and, importantly, self-acceptance ($\rho_{BxSELF-ACCEPTANCE} = 0.28$).

On the side of the explained variable, personal growth and purpose in life should be excluded from the pattern of relations between the dimensions of the working alliance and the dimensions of psychological well-being, because the values of correlations in these cases are statistically insignificant or tend to indicate a low strength of relationship.

To sum up, what served as the basis for the verification of hypothesis H3 was the values of Spearman's rho correlation coefficients. Although, obviously, these relations did not occur in all the considered cases, those described above are more than sufficient to confirm hypothesis H3 as regards the existence of correlation between the working alliance and psychological well-being, but insufficient to confirm the co-occurrence of the working alliance and satisfaction with life.

Discussion

In the present article I have addressed the important issue of long-term and short-term results of treatment using psychotherapy, with a focus on the key factor in the process: the psychotherapeutic alliance. Previous research results have often indicated that a well-established alliance yields the expected outcomes both during and at the end of treatment [24]. The majority of the studies revealed a decrease in or disappearance of the symptoms that caused suffering [21–22]. The presented research results are partly consistent with those previously reported in the literature, although, what is important, they are based on the assessment of subjectively perceived well-being. The main findings come from the testing of the first two hypotheses against SEM results.

It turns out that the working alliance is not related to short-term effects in psychotherapy, which means that it does not increase current satisfaction with life. Psychotherapeutic work in a strong alliance does not determine patients' experience of positive affect and satisfaction with life when working on the difficult issues of their own life, which make them focused on their own deficits and on the temporary nature of previous solutions, and when building adaptive ways of functioning, which in turn directs patients' attention towards looking for opportunities and building their potential.

This result is consistent with the popular assumption about what psychotherapy is. Since, as pointed out by Haley [43], the main aim of psychotherapy is for people to start functioning appropriately to the reality in which they live, the efforts of looking for appropriate life strategies may be accompanied by various kinds of experience, including discomfort. The results of the present study confirm this pattern, with the experience of various levels of pleasure and discomfort during treatment.

The study gave an interesting answer to the question about how the working alliance enhances quality of life understood as long-term healthy development. It turns out that the psychotherapeutic alliance is a determinant of psychological well-being (understood more deeply than merely as current pleasure and more holistically) as an intrinsic long-term element of healthy human development. The strength of the relationship between them is high.

Proceeding to the confirmed third hypothesis, postulating that the working alliance and its dimensions are positively correlated with specific dimensions of satisfaction with life and well-being, we should note that the obtained results of analyses allow for discussing several important relationships.

The data obtained in the analyses lead to the conclusion that the alliance in psychotherapy enhances a person's ability to enter into deep and trustful relations with others. Likewise, high and positive correlations were found for specific components of the alliance. Only slightly lower correlations were found in the analyses concerning environmental mastery. In the literature on the subject [33], authors stress that a key role in human development is played by the sense of agency and the ability to transform the environment in accordance with one's needs and values. The results of analyses show that the working alliance enhances the process of building active participation in one's life and community.

The development of two other dimensions of well-being – autonomy and self-acceptance – is also correlated, though less strongly, with the quality of the patient–psychotherapist alliance [44]. This important finding suggests that an optimally built relationship in the process of psychotherapy has an effect on and strengthens the main characteristics of mental health: a positive but also realistic attitude towards oneself, manifesting itself in the acceptance of one's own faults and virtues, as well as independence and self-directedness, enabling optimal internal regulation of behavior.

It is difficult to clearly specify what it is, in the whole spectrum of factors behind the alliance in therapy, that enhances the increase in mental health the most. We cannot speak of a stronger separate effect of any of the considered components. It can undoubtedly be said, however, that an important element of the whole strategy of building the working alliance is the quality of the bond developed between the psychotherapist and the patient. The lasting outcomes of psychotherapeutic treatment are strictly related to this dimension, which proved to be their strong predictor.

The presented research was free of some of the limitations of previous studies. The effects of psychotherapy were operationalized by means of subjective indicators: the level of satisfaction with life, temporary well-being, and psychological well-being, rather than the abatement or disappearance of symptoms [45]. The study was not conducted on carefully selected samples of psychotherapists and patients. The strength of the working alliance was measured in the natural conditions of mental health clinics, psychological counseling centers and private offices. The only requirement for participation in the study was participants' consent and a sufficiently long history of attending psychotherapy. Working alliance measurement was based on the pantheoretical model of alliance in psychotherapy, which seems to be one of the best proposals capturing the essence of the psychotherapeutic relationship. The strength of the alliance itself has

often been estimated based on two evaluations: the psychotherapist's and the patient's, which seems to significantly increase the reliability of the conclusions drawn on the basis of the performed analyses.

The results of the present study open a new perspective for understanding and measuring therapeutic alliance in Polish psychotherapy and for the possibility of controlling the impact of this alliance on the short-term and lasting outcomes of therapy. As every empirical study, the present one has its limitations. The results presented in this report do not satisfy the need for further research. Future studies require increasing the sample size in order to ensure stronger support particularly for factor analyses; both the group of patients and the group of psychotherapists must be larger. With such elaborate statistical models and with the assessment of multiple variables, the presented analyses should be regarded as preliminary and the project should be continued. The aim is not merely to increase the number of participants, but also to ensure that people with different characteristics in terms of extraneous variables are sufficiently represented. The current sample was too small and too heterogeneous to make it possible to distinguish homogeneous subgroups of subjects.

Conclusions

The working alliance is not related to short-term effects in psychotherapy, which means that it does not increase the current satisfaction with life as well as the experience of positive affect and contentment with life. The working alliance augments the quality of life understood as lasting and healthy development. It turns out that the psychotherapeutic alliance is a determinant of psychological well-being understood more deeply than merely as fleeting pleasure and more holistically, as an intrinsic, long-term element of healthy human development

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