Psychiatr. Pol. 2025; 59(3): 415–430
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/190513

Negotiating the therapeutic alliance: Are we going to converge with time? The effect of psychotherapy treatment duration and psychotherapist's modality on the discrepancy in alliance ratings in the psychotherapeutic dyad

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Summary

Aim. The study aimed to analyze the discrepancies in alliance ratings in a psychotherapeutic dyad – between the patient and their therapist. It was also examined if these discrepancies differed depending on the modality of the psychotherapist's work.

Material and methods. The cross-sectional study included alliance measurement in 181 psychotherapeutic dyads. Psychotherapeutic processes were investigated at different moments of treatment, from the initial phase until the final one. Three psychotherapeutic modalities were controlled for: psychodynamic and psychoanalytic, cognitive-behavioral and systemic. To verify the hypotheses, the author performed difference tests and first-degree polynomial analysis, looking for a linear trend. Square and cubic trend analyses were also performed.

Results. The assumption that patient–therapist discrepancy would decrease over the course of the psychotherapy process was not supported. The study confirmed the effect of the psychotherapist's modality on patient–therapist discrepancy in alliance quality ratings. Discrepancies were smaller in the case of cognitive-behavioral psychotherapists than in those of the systemic modality.

Conclusions. The results of the analyses show that the asymmetry in alliance perception is a permanent characteristic of the psychotherapeutic process and that changes in this respect depending on treatment duration tend to be small. A smaller patient–therapist discrepancy in alliance ratings may be a function of a quicker and more effective process of clarifying relational issues in the dyad and may stem from attunement, which forms and develops in the cognitive-behavioral modality.

Key words: therapeutic alliance, discrepancy in alliance ratings, trend analysis

Introduction

Looking for factors significantly and systematically influencing the outcomes of psychotherapy treatment, researchers increasingly more often focus on various aspects of the therapeutic relationship. In particular, they explore the therapeutic alliance because the results of existing studies point to it as a condition of effective psychotherapy. It is indicated that the patient's motivation to undertake change and to participate in the psychotherapy process depends on the quality of the established therapeutic alliance because this relationship models the patient's key attachment relationship and provides corrective experiences in a safe environment. [1–3] Alliance, however, turns out to be a changeable phenomenon over the course of psychotherapy, also due to many contextual factors defining the treatment process. Hence the need for more precise research into this issue.

Assuming that alliance is the experience of certain aspects of a relationship by two people: the patient seeking help and the psychotherapist working for his or her benefit, in the last decade scholars have been more and more intensely exploring the correspondence between these people's perceptions. Knowledge about whether there are discrepancies in alliance evaluation, how large they are, and whether there are factors that can influence them, as well as knowledge about whether the discrepancy in alliance evaluation changes with the progress of treatment, is crucial especially for the psychotherapist, who is responsible for the conditions and proper management of the psychotherapy process [4]. The question of how patients' and psychotherapists' alliance ratings evolve – that is, how they diverge from and converge with each other throughout the psychotherapy – was the issue investigated in this empirical study.

Patient–therapist divergence of perspectives

According to the relational theory of psychotherapy [1, 5], recognizing that the psychotherapeutic process is shaped by two individuals, the patient's and the psychotherapist's mutual attitudes and their views of what is happening between them are changeable and intensive [6]. Taking stock of the accomplishments regarding goals and tasks, the patient and the psychotherapist converge and diverge, and the bond between them fluctuates from strengthening to weakening [7]. These processes are often present and perceived more strongly on one side of the dyad than on the other, which is reflected in ratings. Alliance can be evaluated in different ways, and alliance ratings do not necessarily coincide.

This is because the process of constant alliance negotiation, between change and stuck periods, is a central phenomenon throughout treatment [8]. This may stem from the inevitable asymmetry of roles between the helper and the helped or from individual differences between them, inherent in this relationship [9]; it may also result from contextual factors, potentially modeling the therapeutic alliance [10]. However, Manne et al. [11] indicate that the convergence of alliance ratings is also linked with

the quality of the processes in the dyad, or that it results from the relationship rather than from the patient's or therapist's individual characteristics.

Also the results of empirical research concerning the degree of patient–therapist consensus on the evaluation of their relationship indicate that there are discrepancies in this respect between patients and psychotherapists [12]. These discrepancies are greater in the case of shorter therapies and in treatment for mild and moderate disorders compared to severe ones. In the case of patients experiencing difficulties in relationships and suffering from anxiety or personality disorders, patient–therapist consensus on the evaluation of their mutual relationship is low or, at best, moderate [13]. It has been pointed out that the severity of psychopathology is a significant factor influencing alliance quality, because chaos, instability, criticism of the relationship, and a focus on the need for control rather than on building a genuine relationship often underlie more severe disorders that patients come to be treated for [14].

Moreover, when analyzing the direction of the discrepancies, it is indicated that the subjective assessments of the psychotherapists regarding the alliance are lower [15]. This may stem from their excessive sense of responsibility and criticism regarding the achievement of treatment goals, which is reflected in cautious alliance ratings [16]; it may also stem from the underestimation of their own work, resulting from a sense of incompetence (especially in younger psychotherapists) [17]. Different views on the quality of the alliance and the lower ratings of the alliance can be reflected in the psychotherapy process by lowering understanding of the patient's actions and efforts, stiffening and formalizing the bond, which may then reduce patient engagement and ultimately hinder the achievement of the desired change in treatment [5, 15, 18, 19].

Diverse findings and numerous ambiguities appear regarding the estimation of discrepancies in ratings depending on the duration of psychotherapy. Marmarosh and Kivlighan [20] found that convergence of evaluations decreases with time. Initially, patients' and psychotherapists' evaluations of their relationships are more convergent. It was also found that larger discrepancies were observed in those stages of psychotherapy in which the patient revealed the symptoms of their disorder during the sessions [16]. However, these latter studies reached different conclusions than those of Marmarosh and Kivlighan [20]. Atzil-Slonim et al. [16] demonstrated that the discrepancy in ratings decreased over the course of psychotherapy treatment. A similar trend, with increasing consensus on alliance quality, was confirmed by Laws et al. [19]. Discovering a convergence of therapeutic alliance ratings, these researchers explained it as resulting from the patient–therapist negotiation at the beginning of the process, which gradually fades as the dyad becomes more attuned and the important relational issues are cleared up. Regardless of the actual state of the relationship, irrespective of whether it is breaking down or developing, the parties in the dyad perceive it in increasingly similar ways as they move from the consultation and initial phases of psychotherapy to the middle and final phases.

There is also a shortage of studies exploring the issue of discrepancies in a dyad depending on the psychotherapist's modality. Although the psychotherapist's manner

of working, theoretical modality and the techniques that stem from it are discussed in the literature as an alliance-modeling factor, studies more often examine their differentiating effect on alliance development [21], particularly in the early phase [22], or on alliance quality [23]. Studies on alliance usually concern one of two types of treatment: CBT or psychodynamic therapy [21, 24]. Other approaches are seldom investigated as separate treatment strategies [25], and some of them are more often explored in the context of couple or family psychotherapy than in the context of individual psychotherapy [26]. It therefore remains unknown if the convergence of alliance ratings in a psychotherapeutic dyad can also be explained by the psychotherapist's modality.

Alliance measurement model

I adopted Bordin's model of the therapeutic alliance, known as the working alliance [27]. The working alliance is understood in this model as the outcome of agreement and cooperation in a patient–psychotherapist dyad, and the category of counseling or guidance is present here to the smallest degree. The operationalization formula that includes cooperation and mutual agreement on the psychotherapy treatment process is the most appropriate in research on patient–therapist discrepancy in perspectives on the relationship. To a smaller degree, differences in alliance ratings are a consequence of the measurement technique, which Hartmann et al. [15] warned about. In the *Working Alliance Inventory* [28] (WAI), a measure based on Bordin's model, the therapist is asked to rate the therapeutic alliance rather than the patient's perspective. Moreover, the alliance is understood in a broad sense, as a triad of agreed goals, designated tasks and developed bonds, and it is assumed that these elements are universal, i.e., present in every psychotherapeutic process.

Aim of the study

Based on an analysis of the problem and a review of the literature, it seemed that especially two issues required further study. Firstly, further investigation was needed into whether treatment duration had an effect on the discrepancy in alliance ratings – namely, on how patient–therapist differences in the perception of the therapeutic alliance changed depending on the duration of the psychotherapy process. Secondly, there was a need for exploring if the psychotherapist's modality had an effect on the discrepancy in alliance ratings – for exploring if patient–therapist discrepancies in the perception of the therapeutic alliance differed depending on the psychotherapist's working technique in a given dyad. I formulated two hypotheses:

H_1: Patient–therapist discrepancy in alliance ratings will decrease over the course of psychotherapy, showing a convergence of perspectives towards an increasingly similar perception of the state of the relationship.

H_2: There are discrepancies in alliance ratings depending on the psychotherapist's modality.

Material and methods

Participants

The cross-sectional study included 170 dyads. The sample was composed of patients undergoing individual outpatient treatment in private or public practice.

The patients, diagnosed by a psychiatrist and/or psychologist based on ICD-10, suffered from adaptation disorders (n = 20; 11.8%), anxiety disorders and phobias (n = 13; 7.6%), affective disorders (n = 63; 37.1%), mental and behavioral disorders caused by alcohol-type and psychoactive substance use (n = 45; 26.5%), personality disorders (n = 15; 8.8%), and eating disorders (n = 14; 8.2%). Women (n = 74) constituted 43.5% of the sample and men (n = 96) constituted 56.5%. Patients were 18 to 80 years old (M = 36.90; SD = 11.77). Most of them had secondary (n = 77; 45.2%) or higher education (n = 88; 51.7%); 87.6% of the patients lived in cities; 64.1% were married or had a partner.

The sample of 108 psychotherapists (the initial number of 115 respondents was reduced by 7 respondents due to lack of training in psychotherapy) included 65 women and 43 men, aged 27 to 64 years (M = 43.44; SD = 9.31), working in the psychoanalytic and psychodynamic (27.1%), CBT (40.6%), and systemic (32.4%) modalities. All psychotherapists had completed or were in the process of receiving education in psychotherapy. Nearly 66.5% of the psychotherapists taking part in the study had worked in their profession for more than 5 years. Psychotherapy sessions usually took 50 minutes (M = 52.91; SD = 9.56), and their number at the time of measurement ranged from 3 to 72 (M = 22.91; SD = 18.13).

Measurement of variables

Therapeutic alliance

To assess therapeutic alliance, I administered the full version of the WAI [28] as adapted into Polish [29]. I used two versions of this measure: for the patient (WAI-PA) and for the psychotherapist (WAI-PT). Each version consists of 36 analogous items operationalizing the construct of working alliance, which the participant rates on a Likert scale as true or untrue about cooperation in the patient–psychotherapist dyad being evaluated.

Measurement reliability was $\alpha_{WAI\text{-}PA} = 0.98$ and $\alpha_{WAI\text{-}PT} = 0.97$. CFA [29] and the experimental analysis of change over occasions [30] showed that measurement using the WAI was valid.

Demographic data and the formal and contextual aspects of the psychotherapy process

I used an elaborate demographic survey (DS) to control for demographic variables (e.g., sex, age, education) and variables relevant to the subject matter of the study (psychotherapist's modality, psychotherapist's work experience, the number of sessions held, session length). The survey questionnaire was prepared in two versions: for the patient and for the psychotherapist. The latter included questions about the formal aspects of psychotherapy and the variables concerning its context.

Measurement procedure and schedule

First, the patient and the psychotherapist were informed about the purpose of the study and asked to give their consent for participation in writing. All participants gave their informed written consent, and the study was approved by the research ethics committee at the author's university (no. 169/188). Measurements always took place after a completed psychotherapeutic session. The measurement was conducted by the research assistant or the psychotherapist was asked to hand the questionnaire to the patient. The patient returned the completed questionnaire in a specially prepared envelope not allowing anyone other than the researcher to see the answers. The alliance was measured first, and then the participants completed a survey with questions about sociodemographic data as well as formal and contextual aspects of psychotherapy. Participants received no remuneration for taking part in the study. After completing the measures, they were asked to check if they had responded to all the items in the set, which is why there were no missing data.

Measurement was performed once for each dyad. The alliance was measured at different moments of the psychotherapy process. The moment of measurement of the therapeutic alliance was controlled. Measurements were taken at similar moments understood as consecutive psychotherapy sessions. Participants were selected through expert sampling. Participants were purposively selected in a subjective manner to obtain a sample representing the values of the context variables as broadly as possible (e.g., psychotherapist's modality, the number of sessions held).

Results

Discrepancies in alliance ratings and psychotherapy treatment duration

To test H_1, postulating a decrease in patient–therapist discrepancy in alliance evaluation with the progress of psychotherapy, I analyzed patients' and psychotherapists' global alliance ratings and determined the differences between them. Using the data thus prepared, I analyzed the trends by performing polynomial analyses. In accordance with H_1, I performed a first-degree polynomial analysis – a linear downward trend; I also performed square and cubic trend analyses. Table 1 presents the results of the analyses and Figures 1 and 2 sum up the findings.

Table 1. **Descriptive statistics for therapeutic alliance ratings and for patient–therapist discrepancies in alliance ratings according to the moment of the treatment process and polynomial analysis results (linear, square and cubic trends)**

Session	Alliance		P ↔ T discrepancy			Analysis of variance and polynomial analysis	
	M(P)	M(T)	M	SD	| M |		
3	148.29	155.57	-7.29	27.09	21.57		
4	161.75	165.75	-4.00	20.16	14.75		
5	182.71	181.57	1.14	27.93	19.71		
6	145.67	154.33	-8.67	15.04	9.33		
7	162.50	160.50	2.00	18.14	15.40		
8	182.00	196.17	-14.17	23.61	20.50		
10	174.44	174.89	-0.44	26.02	19.11		
11	189.50	204.00	-14.50	22.20	18.83		
12	164.33	164.50	-0.17	18.84	15.17		
13	187.33	189.67	-2.33	15.57	11.67		
14	157.20	173.00	-15.80	27.37	21.40		
15	189.54	182.23	7.31	14.34	12.23	$F (df_1, df_2)$	
16	206.00	209.33	-3.33	29.20	21.33	0.90^{*} (37, 132)	
17	168.33	163.00	5.33	10.69	10.00		
19	184.25	169.25	15.00	26.58	20.50	Linear polynomial	
20	189.29	198.71	-9.43	25.11	22.00	$C_{COMPONENT}$	$F_{DEVIATION}$
21	175.00	176.00	-1.00	14.73	11.67	0.01^{*}	0.92^{*}
24	182.50	178.50	4,00	19.13	14.50		
28	195.21	194.29	0.93	14.13	11.07	Square polynomial	
30	187.29	167.57	19.71	31.77	24.00	$C_{COMPONENT}$	$F_{DEVIATION}$
31	169.00	171,.67	-2.67	23.54	16.00	0.91^{*}	0.92^{*}
35	203.00	220.33	-17.33	18.23	17.33		
36	234.50	241.50	-7.00	5.66	7.00	Cubic polynomial	
37	180.25	174.50	5.75	14.55	11.25	$C_{COMPONENT}$	$F_{DEVIATION}$
38	200.00	203.00	-3.00	12.00	9.00	$^{*}0.11$	$^{*}0.95$

table continued on the next page

39	221.50	200.00	21.50	10.61	21.50		
40	229.00	225.00	4.00	25.46	18.00		
42	197.50	186.50	11.00	22.63	16.00		
43	210.00	207.00	3.00	4.24	3.00		
49	202.50	200.50	2.00	16.97	12.00		
50	183.00	205.00	-22.00	0.00	22.00		
53	210.00	190.00	20.00	67.89	48.00		
62	226.00	237.50	-11.50	6.36	11.50		
65	155.00	149.50	5.50	17.68	12.50		
66	221.00	218.00	3.00	15.56	11.00		
67	238.00	223.00	15.00	8.49	15.00		
70	181.50	225.00	-43,50	26.16	43.50		
72	198.25	186.00	12,25	19.91	12.25		

Session – the number of sessions followed by patient-rated and therapist-rated alliance measurement; M(P) – mean patient-rated alliance quality; M(T) – mean therapist-rated alliance quality; P ↔ T discrepancy – patient-therapist discrepancy in alliance ratings; M – mean; *SD* – standard deviation; $\left|\,M\,\right|$ – mean absolute discrepancy; F – one-way analysis of variance; $C_{COMPONENT}$ – contrast for the analyzed trend; $F_{DEVIATION}$ – deviation for the analyzed trend

* statistically non-significant test

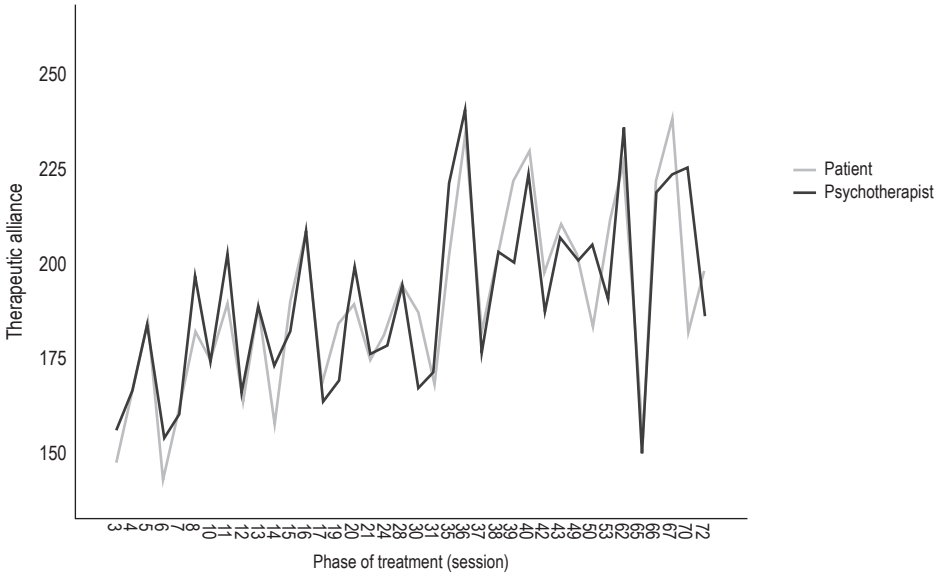

Figure 1. **Changes in patient-rated and psychotherapist-rated alliance at different moments of psychotherapy treatment**

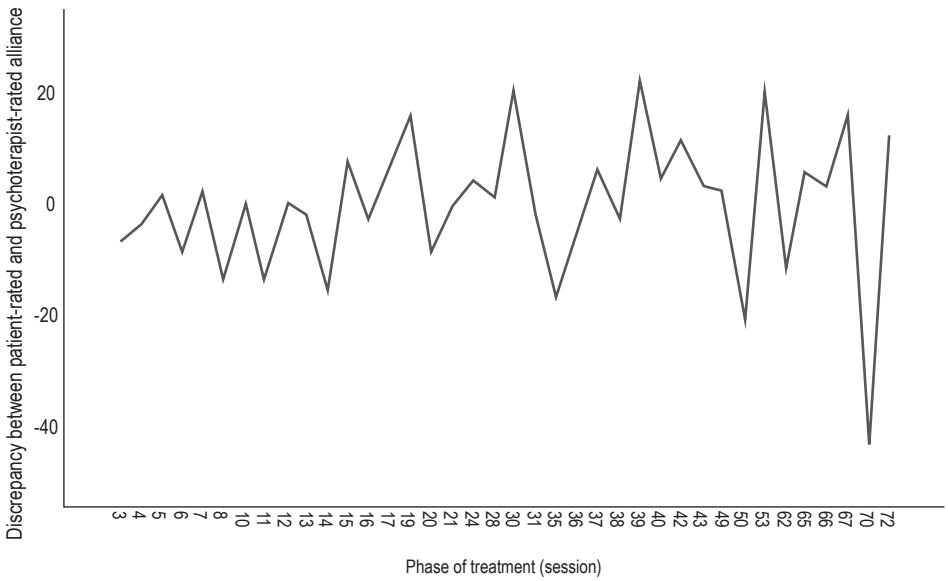

Figure 2. **Patient–therapist discrepancies in alliance ratings at different moments of psychotherapy treatment**

The results of the analyses indicate that there is a statistically significant effect of the measurement moment on patient–therapist discrepancies in alliance ratings. Although patient–therapist discrepancies were found at each measurement moment, they were usually small and their direction varied. Absolute discrepancy values show that the discrepancies are similar across numerous measurement moments. The hypothesized decrease in discrepancy is not observed.

Most importantly, discrepancies in alliance ratings do not exhibit any non-random tendency over time. The trend postulated in H_1 was not found across the levels of the factor. Contrast and deviation for the non-linear factor are statistically non-significant. A linear downward trend is not present. Changes in patient–therapist discrepancy in alliance ratings do not take the form of second – or even third-degree functions, either.

Discrepancies in alliance ratings and the psychotherapist's modality

To test H_2, postulating differences in the convergence of alliance ratings depending on the psychotherapist's modality, I performed a one-way analysis of variance (ANOVA) for independent samples. The psychotherapist's modality independent variable was operationalized on three levels: psychoanalytic and psychodynamic, cognitive-behavioral (CBT), and systemic. Analyses were performed for patient–therapist discrepancies in alliance ratings extracted from global alliance estimations. Table 2 presents the results of the analyses.

Table 2. **Descriptive statistics for patient–therapist discrepancies in alliance ratings according to the psychotherapist's modality and the result of the ANOVA**

Psychotherapist's modality	n	Alliance						F (df_1, df_2)
		M(P)	M(T)	P ↔ T discrepancy				
				M	SD	Min.	Max.	
Psychoanalytic and psychodynamic	46	176.76	178.33	-1.57	19.42	−49	35	4.25* (2, 167)
Cognitive-behavioral	69	198.09	202.96	-4.87	22.79	−62	55	
Systemic	55	171.29	164.93	6.36	24.10	−53	85	

M(P) – mean patient-rated alliance quality; M(T) – mean therapist-rated alliance quality; P ↔ T discrepancy – patient–therapist discrepancy in alliance rating; M – mean; SD – standard deviation; Min. – minimum value; Max. – maximum value; F – one-way analysis of variance

* statistically significant test

The results of the ANOVA indicated a statistically significant effect of the psychotherapist's modality on patient–therapist discrepancy in alliance ratings. Although such patient–therapist discrepancies were found at each measurement moment, they were usually small, and their direction varied. Post-hoc comparisons using the Bonferroni test revealed statistically significant differences between the cognitive–behavioral

and systemic modalities. There were no significant differences between the remaining modalities.

The largest discrepancies in alliance ratings were found in the case of systemic psychotherapy. Importantly, in the case of systemic psychotherapy, the study showed the direction of discrepancies previously suggested by research results, indicating that psychotherapists underrated alliance quality. For the remaining psychotherapeutic modalities, the result was the opposite and patient–therapist discrepancies were smaller. Hypothesis H_2 was supported, but only with regard to one postulated difference in patient–therapist discrepancies.

Discussion

The relational theory of psychotherapy, postulating that the therapeutic alliance is built by two individuals – the patient and the psychotherapist, provides a theoretical framework for research exploring the issue of patient–therapist consensus on therapeutic alliance quality. It is postulated that the central phenomenon is the continual negotiation of alliance over the course of treatment [8], and the opinions held and evaluations made concerning this matter by each of the parties in psychotherapy are changeable and differ [5, 6]. Most of the existing studies provide further empirical evidence in this regard [12, 15]. The present empirical study also revealed patient–therapist discrepancies in alliance evaluation.

However, the results of the current analyses, performed almost session by session, indicate that the asymmetry in the perception of alliance is, as it were, inherent in the psychotherapeutic process and that changes in this respect are rather small. With the progress of the psychotherapy process, operationalized as treatment duration and followed by alliance evaluation, patient–therapist discrepancies do not change significantly. This is shown by the absence of trends in the analyzed discrepancies – not only upward or downward trends, as second – or third-degree functions were not found to fit the identified pattern of discrepancies in alliance ratings either. Discrepancies in alliance ratings occurred at various moments of the examined psychotherapies.

Perhaps a continual negotiation mechanism is inherent in psychotherapy, being a special form of social exchange [8], and the needs of the patient seeking help in difficulties can never fully converge with the help offered by the psychotherapist. Observed in consecutive phases of psychotherapy, the perspectives of the individuals in a dyad do not coincide [31]. The frequent occurrence of non-linear divergences in ratings, with their temporary decreases and increases, is presumably a function of the dynamic presence of two alternating periods in psychotherapy: ones in which there are important positive changes of meanings in patients' ideas about themselves and their problems [31] and those referred to as stuck episodes, in which the emergence of new meanings is temporarily halted [32], and a function of the affective component added to these moments, strengthening both the patient's and the psychotherapist's experience.

Perhaps positive changes, defined by Horvath [33] as interpersonal events in the form of reinforcing experiences, moments of fundamental change, or specific achievements, take place only during small fragments of sessions, while the rest of the therapeutic relationship is a function of moving away from the interpersonal events that have occurred and approaching the next ones. The time of patient–psychotherapist work, with the increases and decreases in motivation, between the moments of positive changes, may be saturated with uncertainty, doubts, and criticism, especially about the relationship that reaching these achievements is based on. The discrepancies in alliance ratings may be a direct reflection of these fluctuations, which are, by their very nature, part of the above process. Similar dynamics and periods with temporarily greater discrepancies and convergences were observed by Laws et al. [19], who stressed that the patient's and psychotherapist's identical understanding of the process and identical subjective experience of the relationship is often momentary.

The direction of the found discrepancies indicates that it is not always psychotherapists, with their already discussed tendency to systematically underrate the alliance, who contribute significantly to these persistent divergences [15]. Sometimes it was patients who rated the alliance lower. Most of the psychotherapists in the study had a few years of professional experience and education behind them. This was, therefore, less likely to result in a sense of incompetence and the underestimation of their own work, which used to be given as the explanation for psychotherapists' low alliance ratings [17]. It is difficult to determine if the responsibility psychotherapists took for the achievement of goals and the performance of tasks and their resulting self-criticism [16] may have fundamentally and systematically shaped the discrepancies. What may also have been of some importance is patients' psychopathology, which was not controlled for in the present study, with a sample of patients heterogeneous in this respect.

Finally, an issue that needs discussing is whether the psychotherapist's modality influences the discrepancy in alliance ratings. In the current study – although little – this effect was found only in comparison between CBT and systemic psychotherapy. It was observed that in the case of cognitive–behavioral psychotherapists the discrepancies were smaller than in the case of systemic psychotherapists.

It could be assumed that this may be related to the fact that, as found before, cognitive–behavioral therapy offers optimal possibilities of building an alliance compared to other approaches, not only on the level of defining its goals and tasks but also on the level of bond development [21, 34, 35]. Based on the findings reported by Folmo et al. [22], it should be added that this optimization takes place not only in the early stages of alliance development but also when the development has lasted longer, beyond the first few sessions. It is argued that cognitive–behavioral psychotherapies may place greater emphasis on the crucial aspects of treatment, namely cooperation on tasks and goals [36, 37], compared to psychodynamic therapies, which may focus to a greater degree on bond – the emotional relationship between the therapist and the patient [21]. A smaller patient–therapist discrepancy in alliance ratings may be a function of

a quicker and more effective clarification of relational issues in the dyad and may stem from attunement, which forms and develops in CBT.

Clinical implications and further research

The results of the present study have clinical implications that should be noted. Psychotherapists and patients should have an understanding and awareness of the existence of discrepancies in alliance ratings at different points in the psychotherapeutic process. This may paradoxically help to build a stronger therapeutic alliance because it familiarizes the parties of the dyad with the possibility that such discrepancies exist. Research also indicates that there is an ongoing negotiation process of therapeutic alliance that occurs at different stages of the psychotherapeutic process. Additionally, knowledge of how the alliance is experienced by their patient allows the psychotherapist to properly manage the process, ensuring that cooperation is effective and that the patient does not abandon treatment. The study makes little contribution to assessing the existence of alliance ratings discrepancies due to the psychotherapist's modality.

Some further research directions also need to be identified. The study of discrepancies in alliance ratings should be carried out by performing multiple and not just point measurements of alliance in one psychotherapeutic dyad. This will identify how discrepancies in alliance ratings are shaped within one whole psychotherapeutic process. Discrepancies in alliance ratings should be investigated in groups of patients that are homogeneous due to contextual variables (e.g., patient psychopathology, pharmacotherapy). The relationship between discrepancies in alliance ratings and treatment outcomes should be investigated as there is still little knowledge in this area.

Limitations

The key limitations of this empirical study include the small samples of patients and psychotherapists based on which alliance evaluations were estimated and the lack of control for important independent variables (e.g., type of disorder, length of experience as a psychotherapist). Only three homogeneous groups were distinguished according to the psychotherapist's modality. An important factor was not included – namely, pharmacotherapy and its possible significance for therapeutic alliance evaluation. Although a universal model for understanding and measuring the psychotherapeutic covenant has been adopted, it should be emphasized that the concept of bonding can, depending on the modality, be defined differently by psychotherapists and such different understandings can be a potential source of error affecting alliance assessments.

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