The Impact of Patients' and Therapists' Views of the Therapeutic Alliance on Treatment Outcome in Psychotherapy

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Abstract: This article reports about the role of psychotherapists in creating a good enough therapeutic alliance as the basic task for other therapeutic factors come into play. Data from a naturalistic study involving 237 patients treated by 68 psychotherapists using 10 different psychotherapy approaches were analyzed in a process-outcome research design. The results show that therapists had to adapt their alliance perspectives to patients' level of alliance ratings as treatments progressed. Treatment concepts did not play a role in outcome. The view of a similar quality of the therapeutic alliance seems to be an indispensable precondition for favorable treatment outcomes. Successful treatments were conducted more often by therapists who showed significant convergence of alliance ratings over time, whereas discrepant alliance ratings correlated significantly with unsuccessful treatments.

Key Words: Therapeutic alliance, process-outcome research, alliance-outcome relationship

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One of the most robust results in psychotherapy research is the association between the therapeutic alliance and treatment outcome for a wide range of diagnoses (Safran and Muran, 2000). A large meta-analysis of 201 alliance-outcome association studies covering more than 14,000 treatments reports a slight but highly significant relationship between alliance ratings and treatment outcome (r = 0.275) (Horvath et al., 2011). A more recent meta-analysis of 295 studies (published between 1978 and 2017) with more than 30,000 patients in face-to-face treatments revealed a similar effect size ($r = 0.278$; $p < 0.0001$) (Flückiger et al., 2018). Nevertheless, although the positive relationship between alliance and treatment outcome remains stable across numerous studies, it is on a low level. This fact raises several questions that Horvath (2018) has addressed in a recent article. As Horvath outlines, on the one hand, the use of a vast number of alliance measures in psychotherapy research reflects the importance of the helping relationship in therapy as well as several conceptual challenges with which researchers have to deal. First, Horvath does not see an authoritative consensually endorsed definition of alliance; second, the concept of alliance is increasingly unclear; and third, there is a commonsense meaning that, consciously or unconsciously, is not scrutinized.

The widely shared view of the alliance as a "common" therapeutic factor should be discussed anew among researchers in the field, as Horvath (2018) puts it. Horvath suggests several topics for a renewed debate to clarify the understanding of the therapeutic alliance, including clarification of the meanings of the underlying semantics of the different labels that are at the bottom of the different measures such as warmth, empathy, repairing alliances, and so on, and how these variables relate to each other. Also, possible distinctions should be sorted out between the relational elements that are common to all forms of therapy and those that are specific to various forms of treatment. Another problem to be addressed is the wide variety of time scales being used, which raises doubt that a simple additive relationship between what is measured at different time intervals does justice to the dynamic process of therapeutic change.

Several methodological limitations to measuring the alliance between patient and therapist are opposed to restrict a deeper understanding of what is meant by a good enough working alliance as a basis for a productive therapeutic cooperation (Lyons and Sayer, 2005; Tryon et al., 2007). Not surprisingly, growing research efforts within the past few years reflect the need to overcome the unsatisfying situation, which is characterized by mixed—and partially contradictory—research results in alliance research.

The therapeutic alliance has thus recently become a topic of methodologically sophisticated research efforts (Arnow et al., 2013; Coyne et al., 2017; Curran and Bauer, 2011; Falkenström et al., 2017; Laws et al., 2017; Zilcha-Mano, 2017; Zilcha-Mano et al., 2018). Zilcha-Mano et al. (2018) call the development in alliance research over the last few years "a revolution." This label refers to the use of advanced statistical methodologies and detailed process research efforts instead of simple correlations between alliance and treatment outcome. Recent publications underline the importance of controlling for lagged associations over time to ensure the direction of causality (Falkenström et al., 2017), to disaggregate between-person and within-person effects (Curran and Bauer, 2011), and to differentiate between "trait-like" and "state-like" components of the alliance (Zilcha-Mano, 2017).

Patients do not enter psychotherapeutic treatment as a "tabula rasa," and the alliance-outcome relationship should also be seen as a result of patients' capability to form a good enough alliance with the therapist. Severe psychological burden and chronicity of patients' problems impact the quality of the therapeutic alliance (Tryon et al., 2007; Tschuschke et al., 2018). On the other side, therapists' basic interpersonal skills predict the formation of better patient-rated alliances (Heinonen et al., 2014); therapists' ability to form a strong alliance across patients seems to predict outcome (Zilcha-Mano, 2017). Current discussion in the literature leaves no doubt that there are differently effective psychotherapists and that some therapists are continuously more helpful than others (Anderson et al., 2009; Baldwin and Imel, 2013; Berglar et al., 2016; Blatt et al., 1996; Firth et al., 2015; Huppert et al., 2001; Jung et al., 2015; Kaplowitz et al., 2011; Kuyken and Tsivrikos, 2009; Safran and Muran, 2000; Tschuschke and Greene, 2002; Wampold and Brown, 2005; Willutzki et al., 2013).

Particularly therapists' characteristics seem to be a crucial point in forming or repairing a good enough therapeutic alliance. The research team of Dennis M. Kivlighan, Jr., found therapists' attachment styles to be predictive for agreement with their patients on the quality of their working alliance (Kivlighan and Marmarosh, 2016; O'Connor et al., 2018). Hartmann et al. (2015) found therapists' experience of a "distressed practice" to be the best predictor of therapist-patient divergence in alliance ratings, and Heinonen et al. (2014, p 475) concluded that "therapists' professional self-confidence and work enjoyment, along with their self-experiences in personal life, consistently predicted their alliances, but were less salient for patient ratings of alliance."

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The similarity of patients' and therapists' ratings of the alliance seems to mirror a common, although not communicated, feeling on the part of both patients and therapists—a shared understanding of the therapeutic process and its progression. This in turn seems to fuel hope and inspires an even deeper cooperation. Laws et al. (2017) investigated the similarity of patients' and therapists' ratings of the alliance with regard to the treatment outcome for 357 patients with depression. Higher alliance convergence was associated with greater symptom loss at 3-month follow-up. Patient/therapist alliance discrepancy/similarity early in treatment did not predict outcome, but convergence between patients' and therapists' ratings over the course of therapy did predict outcome. Marmarosh and Kivlighan (2012) reported on several studies that investigated difference scores between patients' and therapists' separate alliance ratings of the working alliance. They underlined the importance of convergence (agreement) in counseling, but criticized several methodological shortcomings of simple difference scores (no identification of elements that are responsible for the difference, combination of data from distinct people, no exploration of the direction of any differences in the ratings) and argued in favor of polynomial regression and response surface analysis. Horvath (2018) criticized alliance investigations using a wide variety of time scales: "...there is no evidence to suggest that there is a simple additive relationship between what is measured at different time intervals" (p 512). According to Horvath and others, micro and macro perspectives as well as some perspectives between micro and macro seem to be useful, but they illuminate different time segments that can hardly be brought together.

The aim of the present study is to investigate patients' and therapists' perspectives on the therapeutic alliance across the whole duration of treatment and to link the convergence/divergence of the ratings with treatment outcome. Building on research results from several studies, we expected to find

- an increasingly higher rating of the alliance (by patients and therapists) to be correlated with a better outcome and
- a convergence in the ratings on both sides (patients and therapists) to be correlated with a better outcome.

METHODS

Study Population

Therapists using 10 different types of outpatient individual psychotherapy throughout nine major cities in Switzerland took part in the study (Tschuschke et al., 2015, 2016). The PAP-S study is a naturalistic study conducted across Switzerland, with 379 patients with a wide variety of *DSM-4* diagnoses (American Psychiatric Association, 1996). Generalizing the findings of the PAP-S study (see details in Von Wyl et al., 2013) would be premature, because some major types of psychotherapy were not included, such as behavior, cognitive behavioral, person-centered therapy, and systemic approaches (representatives of these types declined to participate in the study).

There were no restrictions on patient inclusion regarding diagnosis, age, and so on. Therapists agreed to ask all patients entering into voluntary psychotherapeutic treatment in their practices to participate. Each cooperating patient signed a written informed consent form. The form included the warranty that all participants were free to withdraw from the study at any time and without any justification. Also, each patient was assured of having the right to not participate in the study and to receive psychotherapy from the same therapist. A research application was submitted to the ethical committees of each of the Swiss cantons involved before the start of the project; all of the applications were approved by the ethical committees in the affected seven Swiss cantons (Tschuschke et al., 2015). The PAP-S study was conducted under the auspices of the Swiss Charter for Psychotherapy (von Wyl et al., 2013).

Measures

Independently trained assessors made diagnostic assessments and conducted tests using (among others, see below) the Structural Clinical Interview for *DSM-4* Axis I Disorders (SCID-I) and Axis II Disorders (SCID-II).

Outcome Battery

The outcome battery consisted of three tests that were administered by independent, trained psychotherapists (not identical with the patients' therapists and not involved in the study as therapists). Patients completed the Brief Symptom Inventory (BSI) (Franke, 2000), which covers a broad range of psychological symptoms and nine subscales; the Global Severity Index (GSI) was calculated based on the mean value of the 53 items of the BSI. The scales of the BSI, which is a short version of the Symptom Check-List (SCL-90-R), have satisfactory high internal consistencies, ranging between 0.70 and 0.89, and 0.96 for the GSI (Cronbach's alpha). Concurrent or convergent validity was estimated by high positive correlations with a number of clinical self-rating scales (Geisheim et al., 2002).

Patients also completed the Outcome Questionnaire (OQ-45.2) (Lambert et al., 2002), which is a measure for capturing symptom load, interpersonal relationship functioning, and quality of social integration. The internal consistency of the German-language version ranges between 0.59 and 0.93 for the different scales (Cronbach's alpha), and convergent or concurrent validity was estimated by positive correlations of 0.45 (with the German version of the SCL-90-R) and 0.76 (with the German version of the Inventory of Interpersonal Problems).

Finally, the German version of the Beck Depression Inventory (BDI-II) was used as an established measure of the severity of 21 depressive symptoms (Hautzinger et al., 2006). Internal consistency across the scales is excellent (Cronbach's alpha, ≥ 0.84); retest reliability is consistently 0.78 after 3 weeks and after 5 months. Convergent and discriminant validities range between 0.68 and 0.89 for several established depression measures such as Inventory to Diagnose Depression (German version), Patient Health Questionnaire-9 (German version), and Montgomery-Åsberg Rating Depression Scale (German version) (Kühner et al., 2007).

The three tests in the outcome battery were administered within the first probationary sessions before the start of treatment (t1), immediately after the last psychotherapy session (t2), and at follow-up 1 year after the completion of psychotherapy (t3).

Process Measures

Patients and therapists rated the therapeutic relationship (alliance) after each fifth session using the Helping Alliance Questionnaire (HAQ) independently of each other and without knowing each other's ratings (Alexander and Luborsky, 1986; Bassler et al., 1995; Luborsky et al., 1996; De Weert-van Oene et al., 1999). The HAQ was administered in the patient version (HAQ-P; $\alpha = 0.88$) as well in the therapist version (HAQ-T; $\alpha = 0.89$). In the present data analysis, we applied the factorial solution by De Weert-Van Oene et al. (1999), which divides the 11 items into two subscales: alliance (patient version [HAQ-A-P; $\alpha = 0.90$], therapist version [HAQ-A-T; $\alpha = 0.87$]) and treatment satisfaction (patient version [HAQ-TS-P; $\alpha = 0.79$], therapist version [HAQ-TS-T; $\alpha = 0.80$]). The alliance subscale was used in this study as a measure for the quality of the therapeutic relationship (alliance) as experienced by patients (HAQ-A-P) and therapists (HAQ-A-T).

Patients also filled out the OQ-45.2 after each fifth session. The OQ-45.2 was used as an outcome measure at pre, post, and follow-up but also as a process measure assessed each fifth session across treatment.

Thus, the process of the therapies was mapped by measurements after each fifth session by completing the HAQ (patients and therapists) and the OQ-45.2 (patients). One hundred therapies of the 237 had a

duration of at least 90 sessions and served as the empirical basis for this study.

Analogous to the study by Laws et al. (2017), the data were also analyzed in different steps. In a first step, a difference score model between patient and therapist ratings was used to create a measure of dyadic alliance differences at each measurement point (each fifth session). As in the Laws et al. study, in the second step, a linear growth model of dyadic alliance discrepancy or convergence over the total duration time of treatment was calculated. In a third step, the correlation between the quality of treatment outcome and results of the linear growth model was considered.

Statistical Analyses

In a first step, outcome was calculated on the basis of pre-post or pre–follow-up analysis (if available) using simple *t*-tests for each outcome measure. Treatment outcome was defined in two different ways. In a first step, a general outcome for each of the 237 psychotherapies was operationalized using the strategy of multiple outcome criteria (Ajzen and Fishbein, 1980; Fishbein and Ajzen, 1975). Rather than use a single outcome criterion, we combined the outcomes from all three different outcome measures, so as to measure up to the complexity of therapeutic effects. For this, *T*-score transformations for each score of each outcome measure (GSI, OQ-45.2, and BDI) at each measurement point (pre, post, or follow-up) were made. *T*-scores were then summed up across the three outcome measures each at pre (t1) and post/follow-up (t2/t3), and the total at t2/t3 was subtracted from the total at t1, resulting in a final "outcome *T*-score." *T*-score sum at premeasurement (t1) served also as a measure of the patient's initial severity of psychological problems before treatment. Given repeated and multiple measurements, this approach precludes an alpha error inflation, and items from differently scaled tests can be integrated in a single indicator into a coherent metric by linear transformations (Schmidt et al., 2003). The multiple outcome criterion was chosen analogous to a large German study (TK Study) that assessed the treatment effects of thousands of patients in cognitive-behavioral and psychodynamic therapies (Wittmann et al., 2011). Mixed model analyses were then used to identify variables that predicted outcome.

The nested data structure (some therapists treated different patients) made it necessary to calculate mixed model analyses with different variables as a dependent variable (mixed model analysis and fixed effects), with a number of independent variables as fixed factors, and with therapists as random factors.

In a second step, treatment outcome was calculated for an estimation of successful versus unsuccessful therapies. For this, the outcome measures data were calculated on the basis of a two-fold criterion for determining improvement in a patient, based on both statistical reliability and clinical significance (reliable change index [RCI] and cutoff score) (Jacobsen et al., 1984; Jacobsen and Truax, 1991). Success was defined by either a change score greater than the RCI and still greater than the cutoff score of the particular test (responder), or by a change greater than the RCI and less than the cutoff score of the particular test (remission). Treatment failure (no success) was defined by a change score less than the RCI and still greater than the cutoff score of the particular test (no change), or by a deterioration.

All statistical calculations were carried out using IBM SPSS Statistics 23.0.

Treatment alliance ratings by patients and therapists were rated with regard to similarity or dissimilarity (convergence/discrepancy) by three intensively trained blind raters. Their average interrater reliability was 0.75 (Cohen's kappa). Alliance patterns were rated as "convergent" if variations of patients' and therapists' ratings had a narrow covariation/trend over the course of therapy (mean values did not differ significantly) or their alliance curves converged over the treatment duration. "Discrepant" patterns were significantly different ratings by patients and therapists or discrepant ratings as the therapy progressed.

RESULTS

Of the total sample ($N = 379$), complete data for pre-post or pre–follow-up assessments were available for 237 patients (Table 1) treated by 68 therapists, each of them providing psychotherapy to approximately 2 to 5 patients on average. Patients per therapist ranged from 1 to 8. Table 2 shows demographic characteristics of the therapists.

The 10 cooperating institutes/types of psychotherapy contributed differing numbers of cases and different numbers of therapists to the study. Basic demographic variables such as patient age and sex did not differ substantially between types of psychotherapy. Table 1 shows the typical 2:1 sex distribution (female to male patients). Noticeable is the relatively high educational level of the patients: Approximately 60% of patients in the total sample had at least a university entrance diploma. Regarding *DSM-4* diagnoses, 81.3% of the patients had an Axis I diagnosis (mood disorder, anxiety disorder, or adjustment

TABLE 1. Demographic Data (Total Sample; $N = 237$ Patients)

	***n* (%)**
Sex	
Female	161 (67.9)
Male	76 (32.1)
Age	
Mean	39.8
Chronification, psychiatric/psychotherapeutic treatment within 2 y before entering study ($n = 233$)	
None	160 (68.7)
Outpatient	66 (28.3)
Inpatient	7 (3.0)
Marital status ($n = 236$)	
Single	127 (53.8)
Married	60 (25.4)
Separated/divorced	44 (18.6)
Widowed	5 (2.1)
Living with a partner	96 (40.5)
Children	
None	144 (60.8)
1 child	26 (11.0)
2 children	46 (19.4)
3 children	17 (7.2)
More than 3 children	4 (1.7)
Education ($n = 235$)	
Schooling completed	3 (1.3)
Elementary school	14 (6.0)
Training qualification	78 (33.2)
University entrance diploma	36 (15.3)
College or higher education	45 (19.1)
University degree	59 (25.1)
Employment situation ($n = 237$)	
Full-time job	103 (43.5)
Part-time work	77 (32.5)
In training	19 (8.0)
Unemployed	8 (3.4)
Certified unfit for work	8 (3.4)
Retiree	10 (4.2)
Homemaker	12 (5.1)

TABLE 2. Therapists' Characteristics

Age		Sex			Professional Experience	Theoretical Orientation (*n*)			
M	*n*	Female	Male	Percent	*M*	Body Oriented	Humanistic	Psychodynamic	Integrative
53.7	68	48	20	70:30	12.6	30	22	13	3

disorder), and 34.9% had an Axis II diagnosis. Table 2 reveals that also the relation of female to male therapists was approximately 2:1. With an average of 12.6 years of professional experience, therapists were very experienced.

General treatment outcome across the whole sample—across types of psychotherapy—varied considerably in relatively higher ranges, with an average effect size of 0.86 (Cohen's *d*) achieved by an average of 41 psychotherapy sessions. Institutes/types of psychotherapy did not differ substantially in outcome.

A mixed model analysis with several potentially predictive variables as independent variables and treatment outcome as a dependent variable used therapists as a random factor (because of the nested data structure, as some therapists treated different patients) (Table 3). The analysis did not reveal a significant Wald *Z*-score, thus demonstrating that the person of the therapist did not contribute significantly to the model.

Alliance as a Predictor of Outcome

Table 3 shows the results of a mixed model analysis with the different treatment approaches, patient's sex, patient's and therapist's average alliance ratings across treatment, and patient's initial level of psychological distress as fixed effects. The analysis revealed that only patients' initial level of psychological distress ($p < 0.0001$) and patient's alliance ratings (averaged across all sessions) highly significantly predicted treatment outcome ($p < 0.002$). All other independent variables did not predict treatment outcome. Other basic demographic variables (age, education level, chronification, and therapist's professional experience in years) were also not predictive. The person of the therapist did not contribute to the model. Approximately only 2% of the outcome was explained by the person of the therapist.

Alliance Convergence/Discrepancy and Treatment Outcome

Figures 1 and 2 show the average alliance ratings by patients and therapists in 46 convergent versus 47 discrepant alliance ratings over the course of treatment. Convergent alliance ratings became more similar as psychotherapy progressed (Fig. 1), in particular with therapists approaching their patients' rating levels on average.

Both continuously discrepant ratings and later converging ratings were initially characterized by an early gap. Treatments with alliance convergence were characterized by therapists' alliance ratings that continuously approached the rating levels of their patients, whereas treatments with alliance discrepancy were marked by a stable gap between patients' and therapists' alliance ratings as treatment progressed. Convergent alliance patterns were clearly characterized by therapists approaching their patients' rating levels. With alliance discrepancy, patients' ratings tended to approach the level of their therapists' alliance ratings slightly, but without reaching them in the end.

Patient-therapist pairings showed drastic differences in terms of trends. Convergent pairs increased and discrepant pairs decreased their average alliance ratings over the course of therapy (Fig. 3).

If treatments with alliance convergence/discrepancy were combined with treatment outcome (outcome was defined by RCI and cutoff criteria, treatment failure was defined by deterioration or no change, and success was defined by responding to treatment), converging and discrepant patterns could be explained to a large degree by outcome ($\chi^2 = 6.486$; $n = 93$; $p < 0.011$). Of the 55 successful therapies, 34 showed alliance convergence (61.8%), and 26 of the 38 nonsuccessful therapies (68.4%) showed alliance discrepancy.

Figure 4 shows another perspective of the convergence/discrepancy alliance ratings. In successful treatments ($n = 100$ therapies), the difference

TABLE 3. Dependent Variable: Treatment Outcome (Mixed Model, Fixed Effects)

Estimates of Fixed Effects							
						95% Confidence Interval	
Parameters	Estimate	SE	*df*	*t*	*p*	Lower Bound	Upper Bound
Intercept	−171.72	25.71	179.67	−6.680	0.000	−222.44	−120.99
Therapy 1 (humanistic)	7.14	9.49	61.36	0.752	0.455	−11.84	26.11
Therapy 2 (psychodynamic)	2.27	9.90	62.66	0.229	0.819	−17.52	22.06
Therapy 3 (body oriented)	3.70	9.43	63.42	0.392	0.696	−15.15	22.54
Therapy 4 (integrative)	−4.87	5.00	49.12	−9.74	0.335	−14.91	5.18
Sex (patient)	−4.18	3.75	199.39	−1.12	0.266	−11.56	3.21
Initial symptom burden	0.52	0.07	199.69	8.02	0.000***	0.40	0.65
Alliance (patient)	11.08	3.59	198.05	3.08	0.002**	3.99	18.17
Alliance (therapist)	6.44	4.00	168.46	1.61	0.109	−1.46	14.35

Test of Random Effects					
Parameters	Estimate	SE	Wald *Z*	*p*	Explained Variance
Residual	569.19	63.83	8.917	0.000	
Therapist	15.46	34.40	0.449	0.653	15.46/747.137 = 0.02 (approximately 2%)

**$p < 0.01$; ***$p < 0.001$; variance of treatment outcome = 747.137.

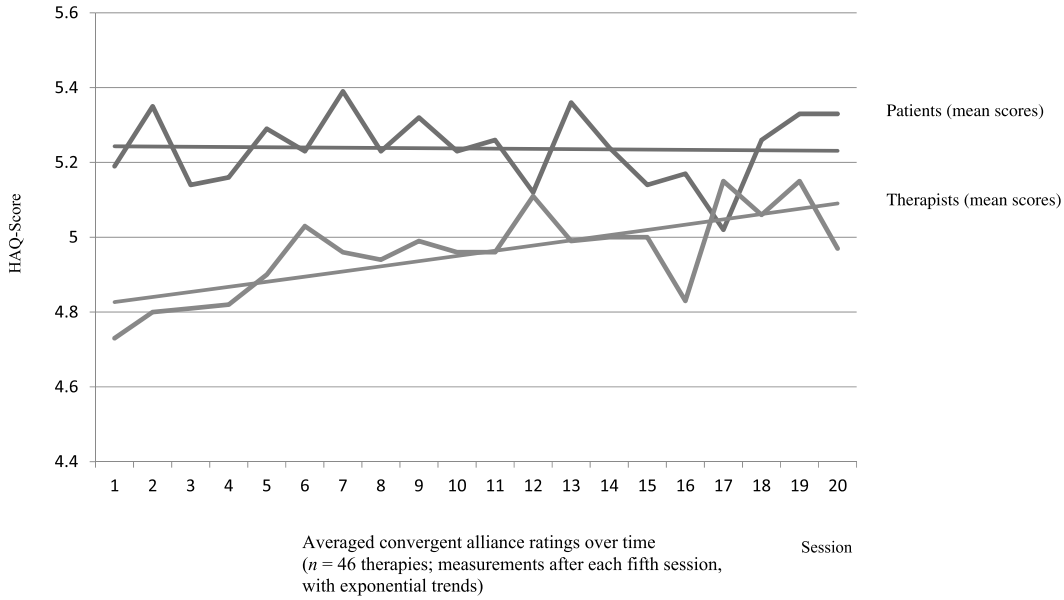

FIGURE 1. Averaged convergent alliance ratings over time (n = 46 therapies; measurements after each fifth session, with exponential trends).

between patients' and therapists' alliance ratings diminished continuously over the course of therapy. Patients' and therapists' ratings converged continuously and tended toward zero as treatment progressed.

This was not the case for unsuccessful treatments (n = 100 therapies). Although there was a very slight convergence over time, the gap between patients' and therapists' alliance ratings remained substantial compared with the diminishing gap between patients' and therapists' ratings in the successful treatments.

DISCUSSION

This study reports on the relevance of the therapeutic alliance for treatment outcome in psychotherapy. Data from 237 psychotherapeutic treatments with 68 therapists working with 10 different types of psychotherapy were investigated regarding several facets of the therapeutic alliance. We found no differences between different types of psychotherapy with regard to the working alliance.

Besides the degree of patiens' psychological symptom burden when entering treatment, it was the patients' average perceived quality of the therapeutic alliance that had a significant impact on treatment outcome. No other variable, such as patients' chronicity of their psychological problems, their age, sex, or educational level, or therapists' degree of professional experience or type of psychotherapy, predicted treatment outcome.

Thus, the patients' personality and their ability to experience a good enough working relationship can significantly contribute to the therapeutic alliance, as the literature also describes (Accurso et al., 2015; Barber et al., 2001; Connors et al., 2016; Crits-Christoph et al., 2009;

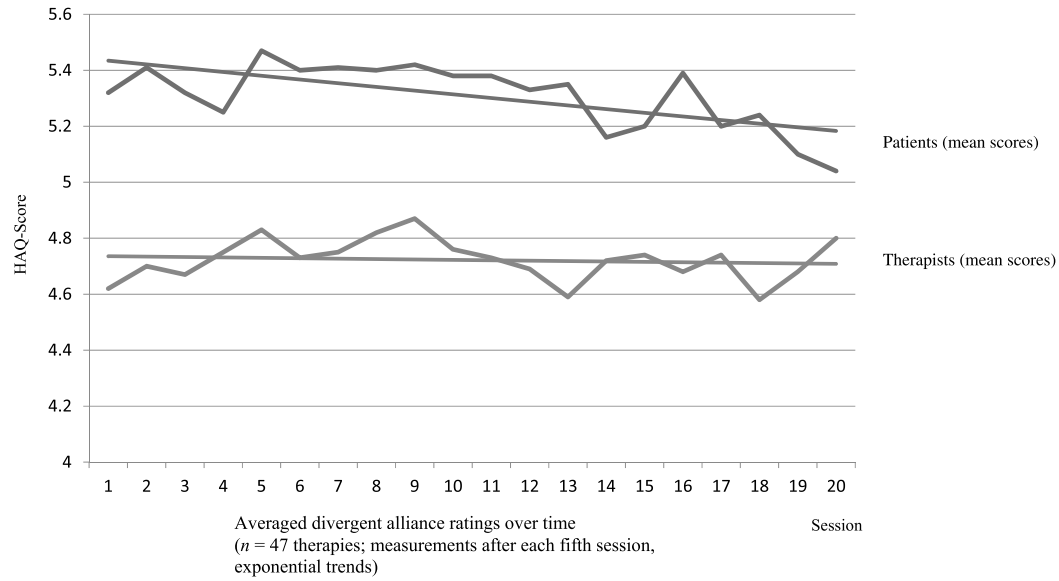

FIGURE 2. Averaged divergent alliance ratings over time (n = 47 therapies; measurements after each fifth session, exponential trends).

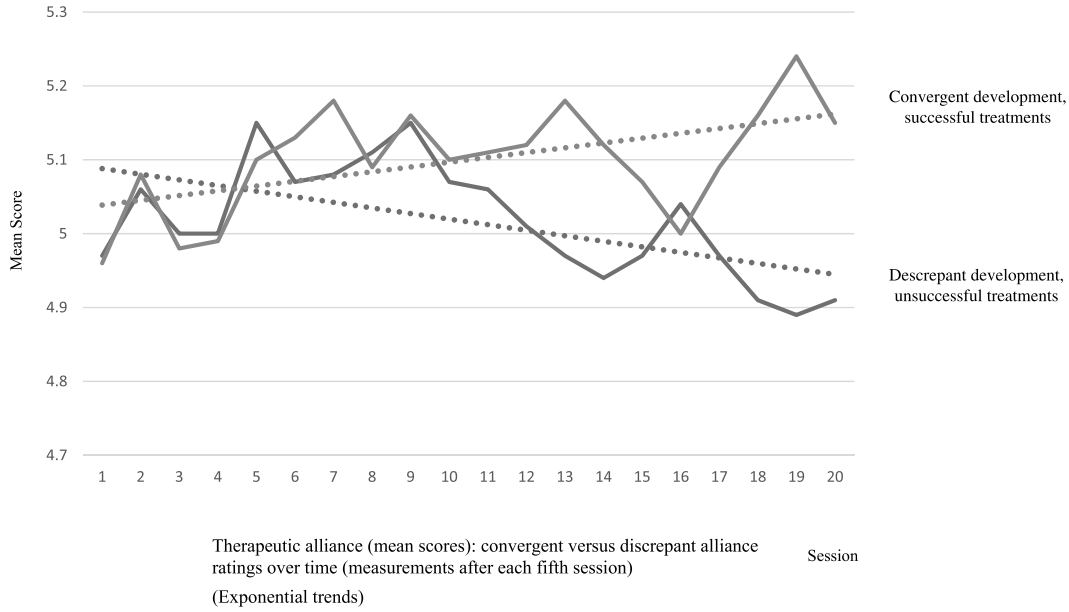

FIGURE 3. Therapeutic alliance: convergent versus discrepant alliance ratings over time (measurements after each fifth session, exponential trends).

Falkenström et al., 2016; Hendriksen et al., 2014; Iacoviello et al., 2007; Zilcha-Mano et al., 2014). Therapists' alliance ratings (averaged across the whole treatment) did not predict treatment outcome per se. Our study data reveal associations that have hardly been discovered in previous research. The importance of therapists' view of the therapeutic alliance can only be understood if it is seen in its relationship to their patients' ratings. Only the therapeutic alliance experience of the therapists across treatment permits discovery of the very relationship of the alliance with treatment outcome. As can be seen from 100 successful and 100 unsuccessful treatments (Fig. 4) from diverse concepts, only converging alliance ratings on the part of therapists are highly correlated with treatment outcome. This result suggests that the therapeutic alliance is primarily the professional ability and competency of therapists to empathize appropriately with their patients.

As can be seen from Figure 2, a lasting discrepancy in patients' and therapists' ratings of the treatment alliance during the course of treatment indicates a less favorite basis for a productive cooperation in psychotherapy. The quality of the therapeutic alliance seems basic for any working psychotherapy and seems to trigger therapeutic processes that set therapeutic changes into motion. Our results suggest that if patient and therapist are not able to generate a good enough working alliance relationship, for example, if they view the quality of their cooperation as poor, they do not create a platform for constructive psychotherapeutic work. Thus, the therapeutic alliance is presumably a necessary precondition for other relevant change factors to come into play rather than a therapeutic factor in itself. This perspective would suggest that the therapeutic alliance is a moderator of treatment outcome.

Our first hypothesis could not be supported. As our data indicate, a better treatment outcome cannot simply be explained by a continuously higher rating of the alliance by both patient and therapist. Instead, a better outcome seems to be correlated with the therapists' competency to approach their patients' level of alliance experience. Similarly, it does not seem to be a simultaneous convergence in the ratings from both sides, patients and therapists, that is correlated with a better treatment outcome; thus, the data also do not support our second hypothesis.

What is particularly interesting in our results is the fact that psychotherapies with convergence in patient-therapist therapeutic alliance ratings were clearly characterized particularly by the ability of therapists to approach their patients' ratings of the alliance and that in therapies with alliance discrepancy, the therapists did not approach their patients' ratings. Does this mean that therapists, as the professional part of the dyad, have to adapt to their patients' views and abilities in order to form a necessary basis for a productive cooperation? Or does this result argue for a necessary ability of psychotherapists to identify with their patients' view and to approach their patients' experience of the ongoing mutual cooperation (Hartmann et al., 2015; Kivlighan and Marmarosh, 2016; O'Connor et al., 2018)?

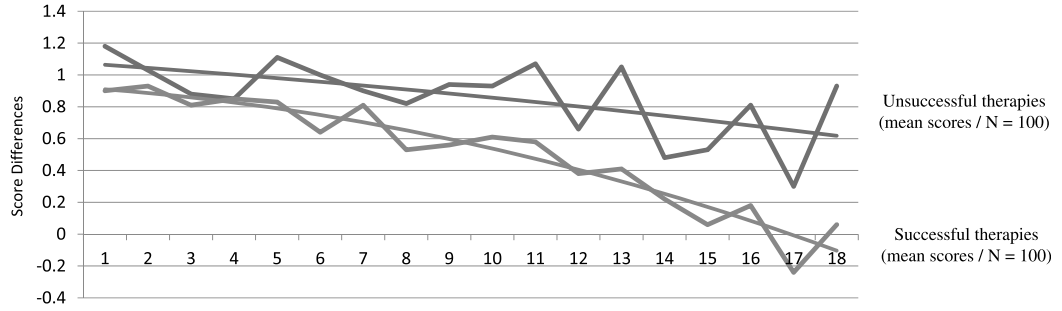

FIGURE 4. Therapeutic alliance: score differences in patient and therapist alliance ratings over time in successful and unsuccessful therapies (measurements after each fifth session).

Patients in psychotherapies with alliance discrepancy seemed to have been trying to approach their therapists' level of alliance ratings, as Figure 2 suggests, whereas their therapists' ratings of the therapeutic alliance seemed to stay at the same or similar low level.

Another impressive result concerns the relationship between alliance convergence ratings and treatment outcome. Successful therapies are characterized by continuously converging therapists' ratings of the alliance experience with their patients' ratings over treatment duration, whereas this is not the case with unsuccessful treatments.

The results of this study bring up several hypotheses. A good enough quality of the therapeutic alliance in psychotherapy is obviously a *conditio sine qua non*. It is not productive to view the therapeutic alliance from only the patient's or the therapist's side. Although both patient and therapist have their own impressions of the quality of their common therapeutic working atmosphere, the therapeutic alliance in psychotherapy must probably be seen as an inseparable unit of simultaneous emotional impressions on the part of both patient and therapist of a common, well-working therapeutic environment, a conglomerate of positively toned emotional assessments by both parties regarding their cooperation at the same moment. It appears that only this kind of agreement generates the necessary precondition for therapeutic factors come into play.

This perspective of the therapeutic alliance would imply that it is not sufficient and not constructive to view patients' positive assessment of the therapeutic alliance as a predictor of outcome in psychotherapy alone. If the therapist makes a discrepant rating of the therapeutic alliance at the same time, in line with the results of our study, the therapist's divergent impression (from the patient's impression) of the therapeutic alliance climate would highly probably lead to a less favorable treatment outcome. As the study results suggest, it is most likely that successful treatment outcomes need convergence between patients' and therapists' ratings—and increasingly more positive ratings—of the therapeutic alliance and seemingly even more effort on the part of therapists.

The findings of this study clearly point to the significance of psychotherapists in establishing a working atmosphere that allows therapeutic factors to emerge. Previous research shows that psychotherapists differ in their effectiveness (Baldwin and Imel, 2013; Berglar et al., 2016). As Safran and Muran (2000) claim, an "ongoing negotiation between two different subjectivities is at the heart of the change process" (p 15). The results of the present study argue strongly for the fact that the professional part in the therapeutic dyad—the therapist—seems to be the even more crucial part of the dyad and that it is not true to insinuate that the patient works on the same level. "The heart of the change process" (Safran and Muran, 2000, p 15) goes far beyond the negotiation of the two individuals involved.

Limitations and Strengths of the Study

The limitations of this study are several. It did not control for lagged associations over time to ensure direction of causality (Falkenström et al., 2017), did not disaggregate between-person and within-person effects (Curran and Bauer, 2011), and did not differentiate between "trait-like" and "state-like" components of the alliance (Zilcha-Mano, 2017). Also, we were not able to use polynomial regression and response surface analysis as this was suggested by Marmarosh and Kivlighan (2012).

There are several strengths of this study. It did not use difference scores, which have been criticized by Marmarosh and Kivlighan (2012). Objective ratings of the alliance ratings by blind raters with a sufficient interrater reliability ensured discovery of whether there was a significant convergence over time, thus taking into account the dynamic change of the alliance impressions of two parties involved; this allowed us to determine whose ratings were responsible for the differences (or diminishing differences) between the ratings of patients and therapists. Second, the study was based on independent data from both sides of the therapeutic dyad (Lyons and Sayer, 2005). Third, the argument by Tryon et al. (2007) that length of therapy is a factor that may moderate patient-therapist rating differences does not apply to our results, in that only therapists' ratings merged toward their patients' ratings, thus influencing treatments to be successful in the end. Another point made by Tryon et al., referring to possibly different patient-therapist alliance ratings that might be moderated by the type of therapeutic treatment that patients receive, can be cleared up. Because the data in this study were generated from 10 different types of therapy, the resulting effects were gained across all types of conceptual orientation and were thus of a general nature.

CONCLUSIONS

In summary, rather than being a therapeutic factor in itself, a good therapeutic alliance would be an indispensable precondition for therapeutic change. Both patient and therapist have to work out a common wavelength. As the present results suggest, in particular it seems to be the therapist's basic task to develop an understanding of the patient's psyche by being able to approach the level of the patient's impression of the therapeutic alliance—more than it is the patient's task to approach the level of their therapist's view of the therapeutic alliance. If this is so, such a pattern seems to launch the effectiveness of psychotherapy.

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DISCLOSURE

The results described have not been previously presented. Dr. Tschuschke, Dr. Koemeda-Lutz, Dr. Agnes von Wyl, Dr. Aureliano Crameri, and Peter Schulthess report no disclosures or potential conflicts of interest.

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