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The effect of congruence in patient and therapist alliance on patient's symptomatic levels

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Abstract
Objective: The ability of alliance to predict outcome has been widely demonstrated, but less is known about the effect of the level of congruence between patient and therapist alliance ratings on outcome. In the current study we examined whether the degree of congruence between patient and therapist alliance ratings can predict symptomatic levels 1 month later in treatment. **Method**: The sample consisted of 127 patient–therapist dyads. Patients and therapists reported on their alliance levels, and patients reported their symptomatic levels 1 month later. Polynomial regression and response surface analysis were used to examine congruence. **Results**: Findings suggest that when the congruence level of patient and therapist alliance ratings was not taken into account, only the therapist's alliance served as a significant predictor of symptomatic levels. But when the degree of congruence between patient and therapist alliance ratings was considered, the degree of congruence was a significant predictor of symptomatic levels 1 month later in treatment. **Conclusions**: Findings support the importance of the level of congruence between patient and therapist alliance ratings in predicting patient's symptomatic levels.

Keywords: alliance; alliance–outcome association; alliance congruence; response surface analysis

The therapeutic alliance is commonly defined as the emotional bond established in the therapeutic dyad, and the agreement between patient and therapist about the goals of therapy and the tasks necessary to achieve them (Bordin, 1979; Hatcher & Barends, 2006). The quality of the therapeutic alliance is a consistent predictor of outcome in psychotherapy, with stronger alliances being associated with better therapeutic outcomes (e.g., Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Flückiger, & Symonds, 2011), even when accounting for the temporal precedence between alliance and symptoms (Falkenström, Granström, & Holmqvist, 2013; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014; Zilcha-Mano & Errázuriz, 2015). Although much is known about the alliance from the perspectives of both the therapist and the patient, little is known about the effect of the congruence between the patient and therapist perspectives of the alliance on outcome, that is, the degree to which the level of agreement between the patient and therapist perspectives of the alliance affects outcome (Horvath & Bedi, 2002). Because alliance is a dyadic process, it is reasonable to expect that it is shaped and perceived by both patient and therapist, potentially resulting in a congruence effect of alliance on outcome (e.g., Silberschatz, 2009). This expectation is at the basis of several theoretical conceptualizations of the role of the alliance in psychotherapy, which consider agreement on the components of alliance to be an important aspect of the working alliance (Bordin, 1979; Gaston et al., 1995) and crucial for the success of treatment (Pepinsky & Karst, 1964; Safran & Muran, 2000). Agreement between patient and therapist on their levels of agreement on the tasks and goals of treatment and on the strength of the emotional bond between them is expected to increase coordination between them as they work

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together to address the patient's difficulties, and to increase the therapist's ability to effectively help the patient (Marmarosh & Kivlighan, 2012).

Previous studies of the association between alliance and outcome have focused primarily on alliance as perceived by either patient or therapist (primarily by the patient). In their meta-analysis, Horvath and colleagues found that 112 of 175 independent effect sizes between alliance and outcome were based on the point of view of the patient. Across studies, therapist and patient alliance ratings were significantly correlated (e.g., Marmarosh & Kivlighan, 2012; Tryon, Blackwell, & Hammel, 2007), and therapists' mean ratings of the alliance were in general lower than those of patients (Fitzpatrick, Iwakabe, & Stalikas, 2005; Hartmann, Joos, Orlinsky, & Zeeck, 2014; Tryon et al., 2007). According to the meta-analysis by Horvath et al. (2011), although significantly different in their mean levels, both patient and therapist ratings of alliance can predict psychotherapy outcome. But because previous studies seldom combined therapist and patient alliance ratings in the same analysis (Kivlighan, 2007), the unique contribution of the patients' and therapists' reports to the alliance–outcome association is less clear. The findings of studies that examined the unique contribution of each perspective to treatment outcome were mixed, some showing that both patient and therapist alliance have a clearly marked effect on outcome (Bachelor, 2013), others that neither can predict outcome (Knuuttila, Kuusisto, Saarnio, & Nummi, 2012) nor that only one of them can (e.g., Gaston, Marmar, Gallagher, & Thompson, 1991; Gullo, Lo Coco, & Gelso, 2012; Marcus, Kashy, & Baldwin, 2009; Huppert et al., 2014). To date, very few studies have examined the effect of the congruence level of patient and therapist alliance ratings on outcome, which may explain at least some of the inconsistency in the literature.

Because alliance is a dyadic process, it is reasonable to expect that the level of congruence between the alliance ratings of patients and therapists affects outcome. Therapists' and patients' ability to build a relationship and describe it may differ. First, both partners have their own tendency to perceive interpersonal interactions based on their relationship history (Bowlby, 1982). Second, the different roles of therapist and patient may create differences in how they construe internal representations of the therapeutic relationship. The patients' perspective may be based on their beliefs and knowledge about what is helpful to them and what has worked for them in the past. For example, when trying to estimate the strength of their alliance with their therapists, patients may compare their relationship with the therapist to other close relationships in their life.

Therapists may rely on experiences with previous patients to gauge the alliance in the present relationship. Therapists may also have training and expertise in identifying aspects of the relationship that may lie outside the patients' awareness. Therefore, both patients and therapists may contribute both shared and unique perspectives when rating the alliance and the level of congruence between their perspectives may predict the patients' subsequent symptomatic levels. Thus, it may not be possible to fully understand the effect of alliance on symptoms without taking into account the contribution of each partner to the alliance and the level of congruence between them.

Previous studies suggest that therapists and patients indeed tend to hold different perspectives of the working alliance (e.g., Fitzpatrick et al., 2005; Tryon et al., 2007), and that therapeutic dyads may differ in their levels of congruence on the alliance (Marmarosh & Kivlighan, 2012). Studies that demonstrated interdependence between patients' and therapists' ratings of alliance and patients' and therapists' ratings of outcome attest to the importance of focusing on both therapist and patient alliance ratings. These findings support the assumption that patient and therapist affect each other during psychotherapy and are attuned to one another. Therefore, focusing only on the therapist or the patient precludes a complete understating of the alliance effect on outcome (Kivlighan, Hill, Gelso, & Baumann, in press). In two studies, Kivlighan (Kivlighan, 2007; Kivlighan, Marmarosh, & Hilsenroth, 2014) investigated the interdependence between patients' and therapists' alliance levels in predicting outcome, using the Actor-Partner Interdependence Model analysis (Ledermann & Kenny, 2012), and found that both patient and therapist alliance levels at a specific time point in treatment are important in order to predict outcome. Yet, some inconsistencies appear in these studies. In the initial study, Kivlighan (2007) noted that therapists' ratings of alliance correlated significantly with their patients' ratings of session outcome. But in a later work (Kivlighan et al., 2014) an opposite partner effect was reported, demonstrating that patient ratings of the alliance predicted the therapist ratings of several session outcome measures. We argue that focusing on level of congruence can contribute to our understanding of the contributions of patient and therapist perspectives of alliance on outcome and shed light on previous findings. Support for this hypothesis can be found in several studies that operationalized agreement using methods such as difference scores and profile similarity correlations, and showed that greater congruence in alliance predicted better outcome (Bachelor, 2013; Kivlighan, 2007;

Rozmarin et al., 2008). The literature, however, is not consistent regarding the effect of alliance congruence on outcome, and other studies using the same methods have found no association between alliance congruence and either outcome (Fitzpatrick et al., 2005) or the risk of dropout (Meier & Donmall, 2006).

To explain the mixed results in the literature regarding alliance congruence effect on outcome, Marmarosh and Kivlighan (2012) pointed out the problems in the ways in which previous studies operationalized alliance congruence (such as difference scores and profile similarity correlations). They argued that in order to examine the effect of level of congruence on outcome researchers should use polynomial regression and response surface analysis. Polynomial regression overcomes the deficiencies of other methods. It does not use difference scores, therefore reliability is not compromised and there is no ambiguity in interpreting the relationships between predictors and criterion variables because ratings from patient and therapist serve as separate predictors of outcome. Another advantage of polynomial regression and response surface analysis is the possibility they offer to examine questions about both the absolute level of the working alliance as rated by both patient and therapist and the direction of the differences between patient and therapist working alliance ratings, that is, whether instances in which patients rate the alliance as stronger than the therapist do differ from instances in which the patients see the alliance as weaker than the therapist do (for more details see Edwards & Parry, 1993; Marmarosh & Kivlighan, 2012).

Marmarosh and Kivlighan (2012) used polynomial regression and response surface analysis in two samples of patient and therapist dyads. They found greater session smoothness and symptom reduction when patients' and therapists' perceptions of the alliance were in agreement and high than when they were in agreement and low. Regarding the consequences of alliance disagreement, however, in one sample they found that when patients' ratings of the alliance were lower than those of their therapists, they rated sessions as being less smooth than when their ratings of the alliance were higher than those of their therapists, but in another sample the consequences of alliance disagreement were the same regardless of who rated the alliance higher than the other. Therefore, additional studies using polynomial regression and response surface are required to evaluate the effects of a high level of agreement and the consequences of alliance disagreement to further elucidate the association between patient and therapist alliance in predicting symptoms.

The present study evaluated the effect of the congruence between patient and therapist alliance rating on symptomatic levels 1 month later in treatment, using polynomial regression and response surface analysis. To further contribute to the ecological validity of the alliance-symptoms literature, the present study focused on the association between the patient's symptomatic levels and the strength of patient and therapist alliance as it occurred in applied settings. Key conditions and characteristics of treatment (e.g., therapists, patients, treatment, and contexts) in naturalistic studies may be more similar to those in clinical practice than in other research designs (e.g., Hoagwood, Hibbs, Brent, & Jensen, 1995). For example, naturalistic studies may be more representative than other study designs of the patient population at large, because in these studies patients are not excluded for reasons such as level of symptom severity, comorbidity of different disorders, and diverse presenting disorders (Kazdin, 2008; Silberschatz, in press). The present study used a naturalistic design, without including criteria that often restrict the variability that characterizes the patient population and therefore may restrict the generalizability of the findings.

The study examined the following three hypotheses based on the reviewed literature:

(a) Consistent with previous studies, there is a significant correlation between patient and therapist alliance, with patients rating the alliance higher than their therapists do.
(b) Both patient and therapist ratings of the alliance are associated with the patient's symptomatic level a month later.
(c) The level of congruence between patient and therapist alliance ratings is associated with patient's symptomatic level a month later. Specifically, the ability of the patient and therapist to share a common perspective on the alliance is associated with lower symptomatic levels a month later.

Methods

Participants

One hundred and twenty seven patients participated in the study. The sample was comprised of 87 female and 40 male patients, between the ages of 18 and 50. Patients presented with a variety of mental health issues and diagnoses, including relationship concerns, substance abuse, anxiety, depression, adjustment disorder, bipolar disorder, etc. Many patients had dual diagnoses. Exclusion criteria comprised age younger than 18 years, severe suicidality, severe substance abuse disorders, and severe

psychotic disorders. Participants were recruited from the San Francisco Psychotherapy Clinic and Training Center. Patients learned about the study either from their therapist or through flyers posted in clinic waiting rooms, and provided informed consent to participate in the study.

Therapists and Treatments

All treatments were conducted at the San Francisco Psychotherapy Research Group, Clinic and Training Center. The clinic provides low-fee psychotherapy to patients residing in San Francisco and the surrounding Bay Area. Twenty-one therapists participated in the study (16 female and 5 male) between the ages of 25 and 55. The mean number of patients treated by each therapist in the current study was 6.05 (*SD* = 3.96; range: 1–14). The main theoretical orientation was control-mastery theory, a cognitive-relational-psychodynamic approach (Sampson, 1991; Silberschatz, 2005; Weiss, 1993). All therapists attended several weekly didactic trainings in control-mastery theory throughout their participation in the study and received individual supervision twice per week by two licensed mental health professionals practicing from a control-mastery perspective. According to control-mastery theory, adverse or traumatic experiences play a central role in the development of psychopathology. Weiss (1993) described two types of traumatic experiences: shock trauma (specific catastrophic childhood events) and stress trauma (persistent traumatic experiences). To cope with these trauma experiences, children often adopt irrational theories and conclusions (namely, pathogenic beliefs), leading to self-blame and guilt (Shilkret & Silberschatz, 2005). Later in life, these irrational beliefs become the basis of psychopathologies (Weiss, 1986, 1993). According to control-mastery theory patients seek therapy to get better, and they do so by working to disconfirm their pathogenic beliefs (Silberschatz, 2012, in press). Patients have three main ways of accomplishing this in treatment: gaining new insights from the therapist's interpretations, testing the irrational beliefs collaboratively with the therapist, and benefitting from the therapeutic qualities of the relationship with the therapist (Silberschatz, 2012). Treatments in this study were open-ended, with a modal length of one year.

Measures

Therapeutic alliance. The quality of the therapeutic alliance was assessed with the 12-item Working Alliance Inventory-Short Form (WAI-SF; Hatcher & Gillaspy, 2006), using the patient (WAI-P) and

therapist (WAI-T) versions. Items were rated on a 7-point Likert scale ranging from 1 (never) to 7 (always). In the present study the internal reliability level of the WAI total score was .90 and .94, for the patient and therapist respectively.

Outcome measure. Psychological dysfunction was assessed with the 45-item patient-rated version of the OQ (Lambert et al., 1996), designed to measure patient progress over the course of therapy. Patient progress was monitored along three primary dimensions: (i) subjective discomfort (e.g., anxiety and depression: "I feel blue"), (ii) interpersonal relationships (e.g., "I feel lonely"), and (iii) social role performance (e.g., "I have too many disagreements at work/school"). Possible scores ranged from 0 to 180, with higher scores reflecting greater severity of distress. The internal reliability level of the total OQ score in the present study was .91.

Procedure

Patients receiving treatment at the clinic were asked to participate in the study. To ensure the ecological validity of the study, patients were not excluded based on *a priori* criteria, such as diagnosis or symptom severity. Cases were assigned to therapists on the basis of clinician availability, size of caseload, and various other practical considerations typical of the routine functioning of a psychotherapy clinic. At the time of data collection, all patients and therapists were involved in on-going psychotherapy. Because the study was conducted in an ecologically valid manner, the length of treatment was determined on a case-by-case basis by the patient and the therapist. Those who agreed to participate completed informed consent forms before joining the study, and their next available session was used for data collection. Patients and therapists completed the WAI immediately after one randomly chosen session in the course of treatment, and the OQ was completed by patients 1 month later in treatment. Thus, the data reported in the study reflect therapist and patient ratings on the WAI and patient OQ 1 month later in an ongoing therapy for each participating dyad. No data are available on the specific session of treatment in which data were collected, and on certain demographic variables.

Data Analysis

To examine our hypotheses we conducted a response surface analysis by polynomial regression (Shanock, Baran, Gentry, Pattison, & Heggestad, 2010) consisting of five predictors: (i) patient alliance rating, (ii) therapist alliance rating, (iii) a quadratic term

formed by squaring the patient's alliance rating, (iv) a quadratic term formed by squaring the therapist's alliance rating, and (v) a cross-product term formed by multiplying the patient alliance rating by the therapist alliance rating. Both patient and therapist alliance ratings were centered around their mean. The following regression equation was used:

$$OQ = b_0 + b_1 PA + b_2 TA + b_3 PA^2 + b_4 PA \times TA + b_5 TA^2 + e,$$

where PA represents patient alliance and TA therapist alliance (Edwards, 2001; Edwards & Parry, 1993).

We used the estimated coefficients from the regression model to calculate test values for two slopes and two curvatures along the response surface: (i) the slope of the line of agreement (which tests whether symptoms are less severe when patients and therapists agree that the alliance is strong than when they agree that the alliance is weak; $a_1 = b_1 + b_2$); (ii) the curvature along the line of agreement ($a_2 = b_3 + b_4 + b_5$), (iii) the slope of the line of disagreement (which tests whether symptoms are less severe when patient perceptions of alliance are stronger than therapist perceptions of alliance than when therapist perceptions of alliance are stronger than patient perceptions; $a_3 = b_1 - b_2$); (iv) the curvature along the line of disagreement (which tests whether symptoms are less severe when disagreement between patient and therapist ratings of alliance is weaker; $a_4 = b_3 - b_4 + b_5$). For more information see Edwards and Parry (1993) and Edwards (2001).

The data were hierarchically nested, with patients nested within therapists. To account for the resulting non-independence of assessments, and to prevent inflation of the effects, we added the therapist as a random effect to the analyses using the SAS PROC MIXED procedure for multilevel modeling (Littell, Milliken, Stroup, Wolfinger, & Schabenberger, 2006).

Table I. Polynomial regression model for patient and therapist alliance and patient-rated severity of symptoms 1 month later.

Effect	Estimate	SE	$t(59)$	p
Symptom severity intercept	62.36	3.39	18.36	<.0001
Patient alliance	−0.45	0.44	−1.03	.30
Therapist alliance	−0.59	0.30	−1.98	.05
Patient alliance[a]	0.008	0.03	0.24	.80
Therapist alliance[b]	0.002	0.02	0.09	.93
Patient × therapist alliance	−0.12	0.05	−2.39	.02

Note. S.E. = Standard error.
[a] quadratic term formed by squaring the patient's alliance rating.
[b] quadratic term formed by squaring the therapist's alliance rating.

Results

A hierarchical linear analysis, in which patients were nested within therapists, found a null and non-significant therapist effect ($\sigma^2_{\text{therapist}} = 0.00$, $p = .99$). Patients' mean OQ levels were 62.53 ($SD = 21.21$), indicating symptoms of clinical significance. Consistent with our first hypothesis, patient and therapist ratings of the alliance were significantly correlated, and patients rated the alliance higher than did their therapists. The correlation between the two informants' reports was found to be low-to-moderate and significant, $r(117) = .25$, $p = .01$, much lower than the minimal correlation level required to assume that the two scores examine exactly the same construct (McGraw & Wong, 1996). Therapists' ratings of the alliance were significantly lower ($M = 43.19$, $SD = 8.31$) than the patients' average ratings ($M = 49.55$, $SD = 7.20$), $t(94) = -6.58$, $p < .0001$. Therefore, findings suggest that therapist and patient perspectives of alliance are related but not identical, supporting the first hypothesis.

Next, we examined the second hypothesis according to which both patient and therapist ratings of alliance are related to the patient's symptomatic levels 1 month later. Findings show that therapist alliance levels were significantly correlated with patients' symptomatic levels ($r_{(98)} = -.25$, $p = .01$), whereas the correlation between patients' alliance levels and their symptomatic levels was not significant ($r_{(98)} = -.09$, $p = .35$). Similarly, when examined together in the same model, only therapist alliance made a significant unique contribution to predicting the patients' symptomatic levels ($\beta = -.27$, $t = -2.39$, $p = .01$).[1]

Next, we used response surface analysis to examine the third hypotheses regarding the effects of congruence. The results of the regression analysis are shown in Table I. The five alliance variables (patient alliance, therapist alliance, patient alliance,[2] therapist alliance,[2] and patient alliance × therapist alliance) accounted for 16.08% of the variance in patients' symptom severity 1 month later ($F_{(5,78)} = 2.99$, $p = .01$). As seen in Table I, one of the predictors was significantly and negatively related to patients' symptom severity (patient alliance × therapist alliance) and one was moderately negatively related to it (therapist alliance).

To assess the effects of patient and therapist alliance agreement or disagreement, we examined the linear combinations of effects, based on Edwards (2001) recommendations and the derived response surface (see Table II). We found a significant negative slope along the line of agreement, $B = -1.05$, $p = .02$, and a significant effect for the curvature along the line of agreement, suggesting that the line

Table II. Response surfaces for patient and therapist alliance and patient-rated severity of symptoms 1 month later.

Effect	Coefficient	SE	$t(59)$	p
Slope along $x = y$	−1.05	0.44	−2.36	.02
Curvature along $x = y$	−0.11	0.04	−2.36	.02
Slope along $x = -y$	0.14	0.60	0.24	.81
Curvature along $x = -y$	0.13	0.08	1.52	.13

Note. S.E. = Standard error.

of agreement is significantly curvilinear for symptoms severity, $B = -0.11$, $p = .02$. This suggests that although symptoms severity decreases as combined alliance increases, the decrease is more pronounced at higher levels of combined alliance. The slope and curvature along the line of disagreement were both insignificant, providing no support for either the ability of alliance disagreement or the direction of disagreement to predict symptom severity.

In Figure 1(a + b), the x-axis represents patient working alliance, the y-axis therapist working alliance, and the z-axis patient symptom severity. The line of

agreement along which patient and therapist alliance ratings are in agreement (where the patient's alliance rating = the therapist alliance rating), extends from the closest to the farthest corners of the plane. The slope of the response surface along the line of agreement shows the effect of agreement at high and low levels of patient and therapist working alliance. The significant slope and curvature along the line of agreement ($a_1 = -1.05$, $p = .02$) ($a_2 = -0.11$, $p = .02$) combined with Figure 1 shows that on average symptom severity decreases as the average patient and therapist alliance increases (given agreement between patient and therapist alliance ratings). But at the lower levels of the average patient and therapist alliance, symptom severity decreases as the average patient and therapist alliance decreases. In other words, agreement on a stronger alliance predicts lower symptoms, unless the patient and therapist agree on a low alliance, in which case the poorer the average alliance is, the lower the symptoms are (Figure 1(c)).

The line of disagreement is the line along which patient and therapist alliance ratings are opposite (patient alliance rating = −therapist alliance rating).
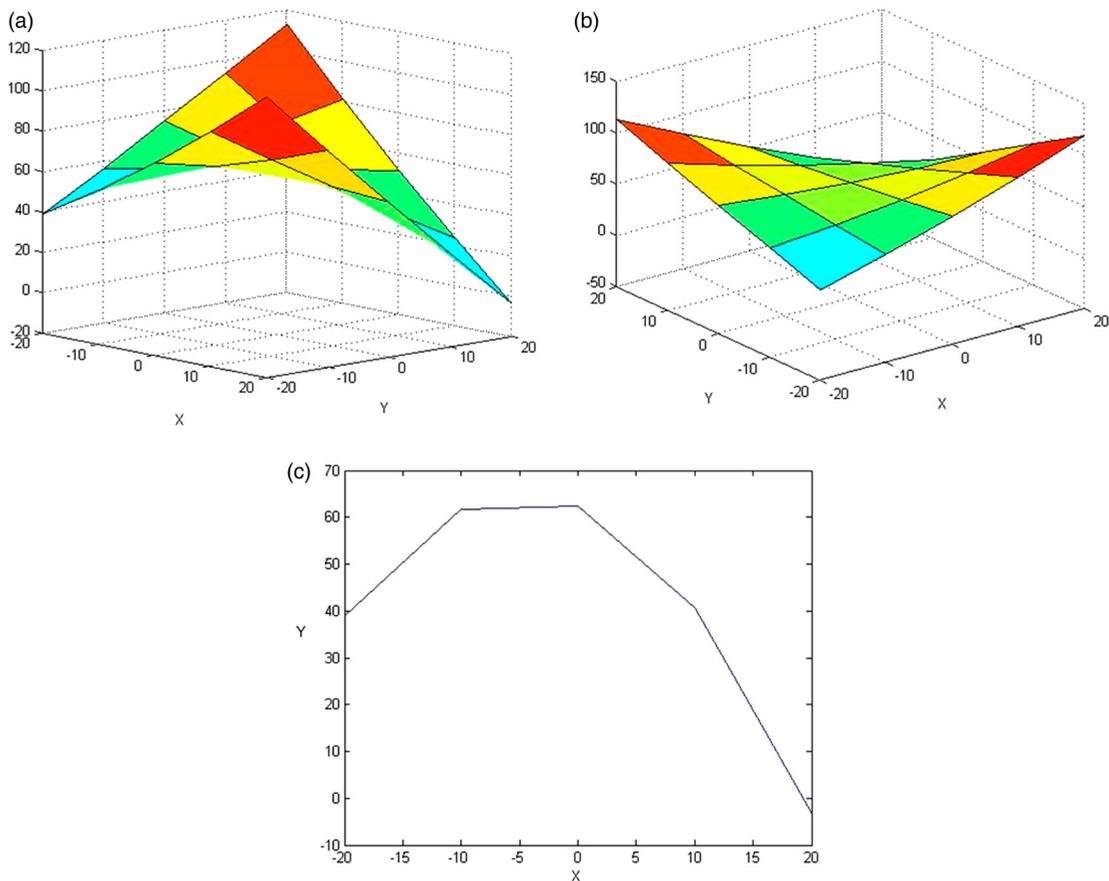

Figure 1. Patient and therapist alliance agreement and outcome. In (a) + (b) the x-axis is the patient working alliance, the y-axis is the therapist's working alliance, and the z-axis is the patient's symptom severity. In (c) x-axis is the average patient and therapist alliance (given agreement between patient and therapist alliance ratings) and the y-axis is the patient's symptom severity.

The line extends from the left to the right corner of the X–Y plane. The slope and curvature along the line of disagreement were both insignificant ($a_3 = 0.14$, $p = .81$) ($a_4 = 0.13$, $p = .13$), lending no support to either the ability of alliance disagreement or its direction to predict symptom severity.

Discussion

The findings of the present study show that the patients' and therapists' alliance ratings capture related but distinct constructs. Although patients and therapists appear to show some agreement in their perspective on the alliance, as evident from the moderate association between their alliance ratings, they also demonstrate some incongruence in their ratings, with a tendency for patients to rate the alliance as stronger than their therapists do. Whether patients' and therapists' alliance ratings were considered together or separately, only the therapists' ratings had a significant effect on the patients' symptomatic levels.

Although in the present study the patients' alliance ratings were not found to be a significant predictor of symptoms, the contribution of the patients' perspective of the alliance to their subsequent symptomatic levels was revealed when we examined the patient and therapist levels of congruence in alliance ratings. The level of congruence between patient and therapist alliances was significantly associated with the patient's symptomatic levels. Specifically, findings suggest that subsequent symptomatic levels were lowest when patients' and therapists' perceptions of the alliance were in agreement and high than when they were in agreement and moderate. This finding is consistent with those of Marmarosh and Kivlighan (2012). One interpretation of this finding is that when agreement is high and alliance is strong, the patient may feel a greater sense of safety and thus deepen the therapeutic work. It is also likely that during these periods of strong alliance the therapist can effectively use therapeutic techniques to help the patient feel better. Interestingly, when both therapist and patient agreed that the alliance was poor, the patient's symptom level 1 month later was lower than when the two were in agreement and moderate. One explanation for this result is that when both partners recognize that the alliance is problematic, the patient coaches the therapist (Bugas & Silberschatz, 2000) as a way of getting the relationship back on track. The literature on therapeutic ruptures and repairs (e.g., Safran & Muran, 2000) similarly suggests that periods of difficulty in the relationship can provide valuable opportunities for collaborative work and meta-communication, which result in improved therapeutic process (i.e., lower symptomatic level 1 month later). Support for this interpretation is also found in a recent study demonstrating that patients whose therapists rated their alliance as poorer showed better treatment outcomes several weeks later (Zilcha-Mano et al., 2015).

The current findings are consistent with previous studies demonstrating that patient and therapist alliance ratings can be partitioned into both shared and unique portions (Hatcher, Barends, Hansell, & Gutfreund, 1995). Although our findings are not consistent with previous research showing that patient alliance alone is a predictor of the patient's symptomatic levels, they do suggest that both patient and therapist alliance are important for determining symptomatic levels and are therefore consistent in this regard with Marmarosh and Kivlighan's (2012) findings and with previous findings regarding the interdependence between patient and therapist alliance with respect to patient perception of outcome (Kivlighan, 2007). It can thus be suggested that patients contribute to the dyad their own perspective of alliance, colored by their interpersonal tendencies and previous experiences and therapists contribute their own perspective, colored by their interpersonal tendencies, professional experience, and theoretical expectations (Horvath & Greenberg, 1989), and that the level of congruence between the two is important in predicting patients' subsequent symptomatic level.

The present findings suggest that higher levels of congruence combined with moderate levels of alliance quality predicted the poorest outcomes. One way to understand this finding is that agreement on a moderate level of alliance may be the least conducive to action for both therapists and patients. Whereas strong agreement on a strong alliance may provide an ideal environment for patient and therapist to collaborate, and a strong agreement on poor alliance may create an opportunity for both patient and therapist to invest the needed efforts to address their ruptures in the alliance, agreement on moderate alliance may not provide the optimal conditions for any of these effective processes. These finding suggest that alliance ruptures are not necessarily detrimental. The findings are therefore optimistic concerning the possibility of change: when both patient and therapist agree that there are problems in the alliance that must be addressed, poor alliance may not have a detrimental effect: opportunities for therapeutic change and corrective experience may follow through collaborative work (Safran & Muran, 2000; Silberschatz, 2012). Future studies should directly examine these suggestions.

Based on the current findings, we recommend a multi-perspective approach to alliance assessment

and conceptualization, taking into account both patient and therapist alliance ratings as well as their interactive effect. Such a perspective produces a better understanding of the alliance effect on outcome, and it is consistent with theoretical views of an intersubjective sphere between patients and therapists, in which both contribute their subjective perspectives to creating a shared subjectivity (Aron, 1996; Benjamin, 1990; Mitchell, 1993). In other words, the effect of the alliance on outcome may not be fully evaluated without taking into account the effect of congruence in alliance perspective between the two partners of the dyad.

The present study estimated the between-patients correlation of alliance with symptomatic levels assessed 1 month later, but did not model the temporal precedence between alliance and outcome within patients across treatment. Therefore, an alternative explanation is possible whereby the congruent effect of patients' and therapists' reported alliance may have been caused by severe symptoms (DeRubeis, Brotman, & Gibbons, 2005). In other words, it is unclear whether it is patient and therapist alliance ratings that predict the patient's symptomatic levels, or the other way around. Thus, although we used statistical models of prediction and a time interval of 1 month between the predictor and outcome, we cannot infer causality from the results. The fact that sessions were randomly chosen for each dyad may contribute to our ability to generalize the findings, but at the same time it makes it difficult to interpret the non-significant therapist effect and to determine specific phases of treatment in which the documented effects are stronger. For example, it may be that patient–therapist dyads that rated the alliance and patient symptoms late in the treatment may have been more likely to report higher quality alliance and greater congruence (Kivlighan & Shaughnessy, 1995; but see also Fitzpatrick et al., 2005) than dyads that did so earlier in the treatment. There is some evidence that alliance may affect outcome differently at different phases of treatment (Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011), and that treatment duration may moderate the alliance–outcome association (Zilcha-Mano & Errázuriz, 2015), but less is known about a potential moderating effect of time in treatment on the association between alliance congruence and outcome. Future studies should incorporate session-by-session measurement across the treatment to account for temporal precedence between alliance and symptoms, and to examine how alliance congruence may change over the course of treatment and have a different effect on outcome. Future studies should also incorporate ratings of alliance and outcome provided by an external source, as well as well as theoretically relevant third variables that may affect both alliance and symptoms. They should also examine whether the present findings can be generalized to other cohorts, with different characteristics, such as different treatment orientations and specific mental health disorders.

The present findings support the theoretical view of alliance as a dyadic construct, showing an effect of the levels of congruence between patient and therapist perspectives of alliances on patient symptomatic levels 1 month later. The findings suggest that patients' symptomatic levels were lowest when patients' and therapists' perceptions of the alliance were in agreement and high than when they were in agreement and moderate. Yet, when both therapist and patient agreed that the alliance was poor, the patient's symptom level 1 month later was lower than when patient and therapist perceptions were in agreement that alliance was moderate. If future studies that account for the temporal sequence of the documented effect support these findings, the findings suggest that the level of congruence between the alliance perspectives of the two partners of the therapeutic dyad contributes substantially to our understanding of the effect of alliance on outcome.

Note

[1] Findings did not change regardless of whether we accounted for the insignificant therapist effect.

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