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REAL RELATIONSHIP AND WORKING ALLIANCE: THEIR ASSOCIATION AND CONTRIBUTION TO THE OUTCOME OF PSYCHOTHERAPY

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Dissertação para obtenção do grau de Mestre em Psicologia – Especialização em Psicologia Clínica e da Saúde

Trabalho efetuado sob orientação de:

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UNIVERSIDADE DO ALGARVE

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Declaro ser a autora deste trabalho, que é original e inédito. Autores e trabalhos consultados estão devidamente citados no texto e constam da listagem de referências incluída.

Assinatura:

(Ana Marta Vieira Vaz)

Agradecimentos

O caminho foi longo, teve alguns obstáculos pelo meio, mas finalmente chegámos ao sítio que há tanto aguardávamos. O meu maior agradecimento vai para o Prof. Luís Janeiro. Pela ajuda, pelo conhecimento, e pela vontade que demonstrou em que eu me superasse a mim própria e evoluísse. Sinto, honestamente, que atingi um novo patamar graças a si. Agradeço-lhe imenso por tudo o que passámos juntos e que se traduz neste produto final. O meu muito obrigada!

Um grande agradecimento também à Laura que, além de ter sido uma ajuda essencial neste trabalho, nunca deixou de me apoiar. A sua presença foi constante e saber que ela estava lá não só me tranquilizou como me deu força para fazer mais e melhor. Muito obrigada!

A prova de que nem os anos, nem a distância apagam uma amizade veio com a ajuda inestimável do Rodrigo. Além de pronto a ajudar, não descansou enquanto não atingi o objetivo. Obrigada!

Contribuindo de forma direta e indireta para este trabalho, a Dr.ª Simone esteve sempre presente durante este percurso, e não podia deixar de lhe endereçar um obrigada do tamanho do mundo. Estou-lhe eternamente grata.

A todos os psicólogos e clientes que participaram neste estudo, o meu enorme agradecimento. O trabalho seria impossível sem a vossa disponibilidade e boa vontade.

Um agradecimento especial para a minha família, que acredita em mim mais do que ninguém. Apoiam as minhas decisões, sofrem comigo, celebram comigo, e nunca me deixam sozinha. Não sou nada sem vocês!

Podia enumerar uma lista de pessoas que me apoiaram durante esta etapa, e às quais também agradeço, mas há duas que merecem um agradecimento especial: a Rita e o Tiago. Sou da opinião que as amizades são como plantas, e devemos regá-las e tomar conta delas para não morrerem. As plantas deles são as mais bonitas do meu jardim. Nunca, por um segundo, duvidaram de mim ou das minhas capacidades. Mesmo quando eu própria duvidei. Obrigada por estarem sempre ao meu lado, nesta etapa e em todas as outras.

Por fim, um obrigada ao Emiel. Pelas conversas, pelas gargalhadas, pelos momentos de pausa. Por me fazeres voar para outras partes do mundo e me fazeres esquecer de coisas menos boas. Por me fazeres acreditar num futuro melhor. Salamat mahal!

Abstract

The real relationship and working alliance are considered sister concepts because even though they are separate constructs they are also interrelated. Both of them are considered to contribute significantly to the outcome of therapy, but there are still some questions regarding their relationship, like what contributes to their proximity?

To examine the association of real relationship and working alliance across studies, and confirm their separation, we elaborated a systematic review of this two constructs. Based on the results from that study, we conducted an empirical investigation with 40 ongoing therapist-client dyads, where we evaluated how real relationship and working alliance contribute to the outcome of psychotherapy, and if that contribution was influenced by the rater's perspective.

The meta-analysis confirmed the theorized association between real relationship and working alliance, revealing an overall correlation of $r = .66$. The manner in which each of them contributes to outcome confirmed their differentiation. The empirical study also showed a significant correlation between real relationship and working alliance, and that the bond subscale of the Working Alliance Inventory (WAI) had an influence in this association. Overall, real relationship seemed to predict outcome beyond the working alliance, in both client and therapist's perspectives. However, when we considered the subscales, the results depended on the perspective: for clients, genuineness was a better predictor; for therapists, realism was more important when combined with the task subscale of the WAI.

The study emphasizes the need to keep the research on the concepts of real relationship and working alliance, in order to improve the therapeutic relationship and the outcome of psychotherapy.

Keywords: therapeutic relationship; real relationship; working alliance; therapy outcome.

Resumo

A relação terapêutica é tão importante para o sucesso da terapia como a própria intervenção psicoterapêutica. Assim, é importante que a primeira seja tão estudada como a segunda. O modelo tripartido da relação terapêutica, proposto por Gelso, afirma que existem três importantes componentes que são diferentes, mas interligados: a relação real, a aliança terapêutica e a configuração transferência-contratransferência.

A relação real define-se como a relação pessoal existente entre duas ou mais pessoas, que se reflete no grau em que cada uma é genuína com a outra e percebe a outra de forma realista. Esta definição inclui duas dimensões importantes: a genuinidade e o realismo. A genuinidade é a capacidade de ser quem realmente se é, de ser autêntico no "aqui-e-agora"; o realismo é a experiência ou perceção do outro de formas que lhe são próprias, em vez de projeções do indivíduo baseadas nos seus medos ou desejos.

A aliança terapêutica foi definida de várias maneiras ao longo dos anos, mas Gelso adota a definição de Bordin porque esta coloca o enfoque no trabalho terapêutico. Assim, consideramos a aliança terapêutica como a colaboração entre terapeuta e cliente que assenta em três componentes: acordo sobre objetivos terapêuticos, consenso sobre as tarefas que compõem a terapia, e um vínculo entre ambos os participantes.

Embora a aliança terapêutica faça parte do tratamento, no sentido em que existe para realizar o trabalho da terapia, a relação real está presente sempre que duas ou mais pessoas se relacionam entre si. Por este motivo, o vínculo presente tanto na aliança como na relação real deve ser visto como um vínculo de trabalho e um vínculo pessoal, respetivamente. O facto de estes dois conceitos estarem tão interligados e, ainda assim, serem independentes, faz com que tenham sido nomeados "conceitos-irmãos".

A American Psychological Association (APA) organizou um grupo de trabalho cujo objetivo é identificar e estudar os elementos que compõem a relação terapêutica e contribuem para os resultados da terapia. Num conjunto de meta-análises reunido por Norcross e Lambert (2019), é demonstrado o contributo da relação real e da aliança terapêutica, de forma independente, para os resultados.

No nosso estudo, que está dividido em duas partes, começámos por realizar uma revisão sistemática da literatura no que a estes dois construtos diz respeito. Pretendíamos examinar a sua associação e confirmar a sua diferenciação; e observar como estes construtos podem predizer o resultado da terapia.

Tendo como base uma meta-análise realizada por Gelso et al. (2019), pesquisámos os conceitos "relação real" e "aliança terapêutica" em bases de dados científicas e definimos os

critérios de inclusão e de exclusão, o que nos levou a um total de 23 artigos. Para a realização da meta-análise, tivemos de adotar critérios mais específicos, o que nos levou a excluir 7 artigos da amostra. Esta acusou uma correlação moderada entre relação real e aliança terapêutica de r = .66, confirmando a forte associação entre os construtos, mas sem revelar a que se devia esta associação. Na revisão sistemática, os resultados mostraram: que relação real e aliança terapêutica contribuem de maneiras diferentes para os resultados, confirmando que são conceitos diferentes; a relação real parece ser melhor preditora dos resultados da terapia; poderá haver influência do avaliador no valor preditivo de cada um dos construtos. Para tentar responder às questões levantadas neste estudo, realizámos um estudo empírico.

Neste segundo estudo, propusemo-nos a responder se o fator vínculo do Inventário de Aliança Terapêutica (IAT) tinha influência na forte associação demonstrada entre relação real e aliança terapêutica; e se o avaliador (terapeuta ou cliente) dos construtos influencia o valor preditivo dos mesmos.

Nesta investigação, reunimos informação de 40 díades terapeuta-cliente, constituídas por 6 terapeutas e 40 clientes. Todos os participantes completaram instrumentos de autorrelato sobre a relação real, a aliança terapêutica, os resultados de terapia e desejabilidade social. Os instrumentos foram aplicados à distância, através da plataforma Google Forms, devido à pandemia de Covid-19 que vigorava na altura em que o estudo foi conduzido.

Foram realizadas correlações de Pearson na análise dos resultados e detetámos associações positivas e significativas entre a relação real e a aliança terapêutica. No caso dos clientes, o fator vínculo revelou uma correlação moderada e significativa com a relação real. Procedemos a uma análise posterior de significância de correlações, que demonstrou que o fator vínculo poderá estar a contribuir para as elevadas correlações entre relação real e aliança terapêutica.

Tanto a relação real como a aliança terapêutica tiveram associações significativas com os resultados da terapia. Através de regressões lineares hierárquicas, observámos que, em ambas as perspetivas (terapeuta e cliente), a relação real era o melhor preditor de resultados. Quando observadas ao nível dos seus fatores, a subescala tarefas do IAT e a subescala genuinidade do Inventário de Relação Real (IRR) demonstraram ser as melhores preditoras dos resultados da terapia.

No entanto, quando os fatores do IAT eram colocados no primeiro bloco de análise, havia diferenças ao nível dos avaliadores: na perspetiva dos clientes, a genuinidade roubava o valor preditivo das tarefas, tornando-se o melhor preditor; enquanto para os terapeutas o realismo e as tarefas, em conjunto, eram bons preditores.

Apesar de já estar estabelecido que a aliança terapêutica é um importante componente da relação terapêutica e um bom preditor dos resultados da terapia, neste estudo chegámos à conclusão de que a relação real também deve ser tida em consideração, pois mostrou ser um melhor preditor de resultados que o seu "conceito-irmão".

É necessário, contudo, algum cuidado a interpretar os nossos resultados, pois a amostra que apresentamos não é de grande dimensão, em particular no número de terapeutas, e os clientes apresentavam-se em diferentes fases da terapia, além de se encontrarem em psicoterapias diferentes.

Além disso, apesar de uma tradução que consideramos adequada, o IRR ainda não foi validado para a população portuguesa.

Este estudo vem acrescentar ao que tem sido feito no campo da relação terapêutica, não só ao nível da investigação, como ao nível clínico. Em termos de investigação, revela que o IAT talvez precise de ser revisto, porque o fator vínculo está a influenciar as correlações entre relação real e aliança terapêutica. Em termos clínicos, mostra que é necessário informar sobre a relação real e desenvolver estratégias que permitam aos terapeutas desenvolver as suas relações reais com os seus clientes e, consequentemente, melhorar os resultados da terapia.

Palavras-chave: relação terapêutica; relação real; aliança terapêutica; resultados de terapia.

Index of Contents

Index of Tables

Index of Annexes

Introduction

Throughout the years, some therapists have believed that the relationship that develops between them and their clients is the essence of effective treatment; others think that a good therapist-patient relationship provides significant leverage for the implementation of therapy techniques (Gelso & Carter, 1994). Whether the relationship is the essential ingredient of therapy, or a means to an end, it is well established that it plays an important role in therapy (Norcross & Lambert, 2019).

Norcross (2011) affirms that the therapeutic relationship makes substantial and consistent contributions to patient success in all types of psychotherapy studied (e.g., cognitive, psychodynamic, humanistic), and it accounts for why clients improve – or fail to improve – as much as a particular treatment method. Like the author himself, we also consider the relationship between client and therapist as a crucial, fundamental determinant of success, and how we create and cultivate that powerful human relationship can be guided by the fruits of research.

According to Gelso (2014), all psychotherapy relationships consist of three interlocking elements: a real relationship, a working alliance, and a transference configuration (both transference and countertransference) – what he has called the tripartite model. These elements were rooted in the psychoanalytic theory, but the author believes each of them is present across all theoretical orientations and are present from the first moment of contact between therapist and patient (Gelso, 2014). In addition, the three relationship components are independent, but they do not operate independently; these three components interact constantly and, to some extent, overlap throughout the course of therapy (Gelso & Carter, 1994). For the purpose of the present study, we will discuss only the concepts of real relationship and working alliance.

Real relationship is defined as "the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (Gelso, 2009, pp. 254–255). Two components emerge from this definition: genuineness and realism.

Genuineness is the capacity to be who one truly is, to be authentic in the here and now. It is the psychotherapy participants' authenticity with each other or the extent to which they are truly themselves as opposed to phony and fake with each other (Gelso et al., 2012). Although genuineness was first defined by Carl Rogers (1957), it was only applied to the role of the therapist. Gelso (2010) suggests that the concept of genuineness in the real relationship is bipersonal – it pertains to both participants as well as their relationship. Genuineness has a

personal characteristic of the therapist and patient as well as an experiential quality of the relationship.

Realism is the experiencing or perceiving of the other in ways that befit him or her, rather than projections of the individual based on his/her fears or wishes (Gelso, 2009). On the low end of the realism dimension, one may badly misperceive the other, for a multitude of reasons (e.g., the perceiver may see only what he or she wishes to see, or fears to see, in the other); while on the positive end of the realism continuum, one's experiencing of the other is in close alignment with who the other actually is.

Gelso (2010) separates realism and genuineness for theoretical and measurement reasons, but acknowledges that they must be closely intertwined. Perceiving and experiencing the other as he/she truly is, requires for him/her to be truly genuine; likewise, how genuine one is will be strongly influenced by the extent to which one feels understood accurately by the other.

To better understand the real relationship we also need to consider two other concepts: magnitude and valence. Magnitude refers to the amount of real relationship (how much genuineness and realism) that exists, both overall and on a moment-to-moment basis (Gelso et al., 2018). Valence concerns to how positive or negative the participants' feelings and thoughts are toward one another. Each participant may experience and perceive the other positively or negatively in terms of realism and genuineness. Positively versus negatively valenced reactions that reveal themselves in therapy include liking-disliking, loving-hating, caring-not caring, respecting-disrespecting, and should be addressed as a continuum (Gelso, 2009). For example, if one's genuine and realistic feelings toward another are negative, we could have a therapist who dislikes his/her patient, even though the patient is being genuine and the therapist sees the patient realistically. In other words, one may have a high magnitude of realism and genuineness, but still feel negatively toward the other (Gelso et al., 2018). According to Gelso and Kline (2019), a negative real relationship in the outset of treatment is considered to be responsible for premature terminations.

Realism and genuineness are the key elements of the real relationship, and this conception has been a fundamental element in current thought and empirical research on the real relationship (Gelso et al., 2018). The combination between genuineness and realism, including their magnitude and valence, results in the strength of the real relationship. Gelso (2009) proposes that a greater magnitude of realism and genuineness, and a more positive valence of these elements would result in a more effective treatment. The more positively are

the therapist and client's genuine and realistic feelings for one another, the stronger is the real relationship (Gelso & Kline, 2019).

Because it is a bipersonal phenomenon, the real relationship is constructed by both therapist and client (Gelso, 2002; Gelso et al., 2018). The therapist contributes direct and indirectly: directly through self-disclosures of thoughts, feelings, and information; indirectly through facial expressions, body language, office décor, etc. These will allow the patient to build the image of the therapist as a person. The therapist also contributes to the strength of the real relationship by being genuine with the client, and perceiving the client as he/she is, instead of as a projection of the therapist's own conflicts (Gelso et al., 2018). On the other hand, the client's enactment of his/her role also contributes to the formation and development of the real relationship: getting in touch with his/her inner experiences and communicating verbal and nonverbally who he/she is – genuineness – and experiencing and perceiving the therapist in ways that befit the therapist – realism (Gelso et al., 2018).

The term alliance can be preceded by therapeutic, working, or helping (Flückiger et al., 2018). Unlike the real relationship, that only recently was given more focus, the alliance has been studied for a long time. Although the term was not yet defined, the concept dates back to Freud and his recognition of the importance of the client's conscious attachment to the person of the therapist (Flückiger at al., 2018).

Bordin (1979) proposed a pantheoretical version of the alliance called "working alliance". For this author, the working alliance is a collaboration between therapist and client that rests on three components: agreement on therapeutic goals, consensus on the tasks that make up therapy, and a bond between both participants. For the purpose of the tripartite model, Gelso (2009, 2014) embraces Bordin's definition of working alliance because the focus is on the working aspect of the alliance – allowing it to be differentiated from other components which are not directly linked to a working collaboration.

Gelso (2009) believes that the working alliance should be seen as including all of the actions and conscious intentions of the participants that pertain directly to getting the work of therapy accomplished. While working alliance is a piece of treatment, in the sense that it exists to get the work done, the real relationship is always present anytime two or more people relate to one another (Gelso, 2009, 2014). For this reason, Gelso and Kline (2019) argue that we could consider the bond element – present in both working alliance and real relationship – as a working bond and a personal bond, respectively. Despite being theoretically separate constructs, working alliance and real relationship have been theorized to

be highly interrelated, to the point of being called “sister concepts” (Gelso, 2014; Gelso et al., 2018; Gelso & Kline, 2019).

The two elements emerge simultaneously and work together – the patient is inclined to be motivated to do the work of therapy when he/she personally connects to the therapist, and working well together creates a sense of personal relationship (Gelso & Kline, 2019).

However, there might be times when the two constructs are not in synchrony. Not all therapists feel strongly connected to their clients as persons. The real relationship might be weak at the beginning of treatment, while the working alliance may be solid. It can also happen that the real relationship may never become strong, but the work can be successful because the working alliance is strong enough. Nonetheless, Gelso and Kline (2019) believe that the work might not be as successful as it would have been if both real relationship and working alliance were strong.

What about a weaker working alliance compared to a strong real relationship? Gelso and Kline (2019) also thought about this, and concluded that it might be hard for a treatment to be successful if the working alliance is weak, because it concerns the goals of therapy, the tasks needed to attain those goals, and because the bond is directly related to the work in therapy.

One of the purposes of the Third Interdivisional American Psychological Association (APA) Task Force on Evidence-Based Relationships and Responsiveness is to identify effective elements of the therapy relationship. In doing so, Norcross and Lambert (2019) gathered meta-analyses about the working alliance and the real relationship, among others (e.g., self-disclosure and immediacy).

The working alliance has been submitted to a number of meta-analyses before, to try to understand how it can predict outcome. Horvath and Symonds (1991) conducted the first one, that revealed an overall alliance-outcome correlation of $r = 0.26$. That effect size has proven robust across psychotherapies and decades of research. The following meta-analyses’ correlations varied only slightly over the years (Horvath & Bedi, 2002: $r = 0.21$, k = 100; Horvath et al., 2011: $r = 0.28$, k = 190; Martin et al., 2000: $r = 0.22$, k = 79). The most recent meta-analysis conducted by Flückiger et al. (2018) revealed a correlation of $r = 0.278$, identical to the one conducted by the same authors in 2011, indicating that the alliance-outcome relation accounts for about 8% of the variability of treatment outcomes.

Eugster and Wampold (1996) conducted the first empirical study on the real relationship. In their study, they used an 8-item measure of the real relationship. Therapists and patients made ratings on a 6-point scale of the quality of the therapist-offered real

relationship and the patient-offered real relationship. Both therapist and patient ratings of real relationship correlated moderately but uniformly positively with session evaluation (*r* ranging from 0.28 to 0.64). This first study demonstrated that the real relationship was a promising variable in terms of its potential influence on treatment outcome. However, empirical research on the real relationship only now is giving the first steps. The main reason is because the first reliable measures are recent. Gelso et al. (2005) developed the first instrument that allowed therapists to rate the real relationship: the Real Relationship Inventory – Therapist Form (RRI-T). Later on, in 2010, Kelley et al. developed the client version – the Real Relationship Inventory – Client Form (RRI-C).

The first meta-analysis conducted by Gelso et al. (2018) revealed a moderate real relationship-outcome association ($r = 0.38$). This relation shows a larger magnitude than the working alliance-outcome relation (small, $r = 0.28$) found in the most recent meta-analysis (Flückiger et al., 2018). On the Real Relationship chapter of "Psychotherapy Relationships that Work", edited by Norcross and Lambert (2019), there is one meta-analysis that was originally published by Gelso et al. (2018) about real relationship and outcome. When they adapted their work for Norcross and Lambert's book, they performed other meta-analyses and checked the association between real relationship and working alliance. The result ($r = 0.58$, $p < .001$) supports Gelso's characterization of the constructs as sister concepts – medium to large correlation, but not identical constructs.

As stated earlier, our work in based on Gelso's tripartite model. We will not study the therapeutic relationship as a whole, but we will take the example of Gelso (2014) and "open the package of relationship" to study its components, namely the real relationship and working alliance.

The working alliance is a construct that "continues to be one of the most investigated factors leading to psychotherapy success" (Flückiger et al., 2018, pp. 317). The real relationship only recently has received more importance in psychotherapy process and outcome. This construct even gets a whole chapter for itself at the latest edition of "Psychotherapy Relationships that Work", edited by Norcross and Lambert (2019), while the working alliance already had one in the previous edition (Norcross, 2011).

One of the questions that has been asked the most concerns the conceptual overlap between the common factors. The same happens with real relationship and working alliance being called "sister concepts". Using Gelso's analogy, the question we ask is: at what level are these concepts "sisters"? Are they twins, sisters with the same parents, half-sisters, or even cousins? The question is relevant from a conceptual and clinical point of view. If two

constructs are this close, to what do we attribute this proximity? Are there any clinical advantages in keeping their independency?

The key objectives of our study are to (a) examine the association of the constructs across studies, and confirm their independence; and (b) observe how the constructs might predict outcome. In order to answer our objectives we will conduct two studies. First, we systematically review studies investigating both working alliance and real relationship. Our aim is to replicate the meta-analysis performed by Gelso et al. in 2019. Secondly, we conduct an empirical study where we evaluate how real relationship and working alliance are associated, both in the perspective of the client and the therapist, and how they can predict – together and separately – treatment outcome.

Systematic review

We performed a systematic review in order to explore the connection between real relationship and working alliance. We aimed to extend the meta-analysis performed by Gelso et al. (2019) centered on the real relationship and working alliance interdependence.

Gelso et al. (2018) conducted the first meta-analytic (N = 16) review of the association between real relationship and outcome in psychotherapy. One year later, they adapted that first work on the matter and published the chapter "Real Relationship" in Norcross and Lambert's APA book – "Psychotherapy Relationships that Work" (Norcross & Lambert, 2019). When they adapted their article, they also checked the association between real relationship and working alliance through a meta-analysis. In that secondary meta-analysis they used a subset of nine studies which, besides the correlations between psychotherapy outcomes, also included self-reported working alliance data from clients and/or therapists. The nine studies reported the correlation between real relationship and working alliance, and the meta-analysis based on the reported correlations found a significant omnibus effect (r = .58, 95% CI [.51, .64], $p < .001$).

As stated above, from the initial meta-analysis focused on the association between real relationship and outcome (Gelso et al., 2018) nine studies that also reported data from real relationship and working alliance were extracted to make a secondary meta-analysis (Gelso et al., 2019). This means that this secondary meta-analysis, centered on our research question, may be incomplete. Studies containing the association between real relationship and working alliance, but where outcome was not measured, were not included.

Thus, with our work we intend to overcome that limitation. First, we performed a systematic review to identify all the articles containing the association between real relationship and working alliance; not only the articles included in the previously mentioned meta-analysis, but also the ones which might have been neglected. Then, we replicate the meta-analysis on the association between real relationship and working alliance but, this time, with all the studies conducted until this date.

Method

Source of data

The databases Web of Science and PsycINFO were searched until the end of August 2020 using the following terms: "real relationship" AND ("working alliance" OR "therapeutic alliance"). The alliance can be referred to as "working alliance" or "therapeutic alliance"

(Flückiger et al., 2018). “Helping alliance” is not so commonly used, and even after adding this term, there were no differences in our results.

The inclusion criteria were: (a) articles were peer-reviewed; (b) written in the English language; (c) both working alliance and real relationship were measured in the study. The exclusion criteria included papers where (a) the therapeutic relationship was not the matter of study and (b) qualitative studies (e.g., review papers, meta-analysis).

Table 1

Studies Characteristics and Key Findings

Author, year; country	Design	Objectives	Participants	N	Key measures	Key findings
Gelso et al. (2005); USA	Cross-sectional	Develop and validate the RRI-T.	Therapists	210	WAI-S; SEQ – Depth and smoothness	The RRI–T total score and one or both subscale scores correlated significantly with the WAI, the SEQ Depth and Smoothness subscales, emotional insight, intellectual insight, and negative transference.
Fuertes et al. (2007); USA	Cross-sectional	Examine therapist and client ratings of the RR in relation to their WA ratings; Examine the role of therapist and client attachment in the formation of the RR.	Therapists and clients	118	WAI-S; RRI; COM	For both therapists and clients, there was a positive relationship between their ratings of the RR and the WA. With respect to progress, client and therapist ratings of the RR, and not their ratings of the WA, were predictive of their ratings of client progress.
Marmarosh et al. (2009); USA	Longitudinal	Understand how the RR relates to important process and outcome variables (attachment, WA, transference, and treatment outcome) from both the clients' and therapists' perspectives.	Therapists and clients	52	WAI-S; RRI; SCL-90-R	Clients' perceptions of the RR correlated with both therapist and client ratings of WA. Therapist ratings of the RR correlated with only therapist ratings of WA. Therapists' perceptions of the RR did not correlate with clients' perceptions of the alliance at the third session of therapy. Therapist-rated RR was the only significant predictor of outcome.
Kelley et al. (2010); USA	Cross-sectional	Develop and validate the RRI-C.	Clients	187	WAI-S	The RRI-C was positively correlated with a measure of clients' observing ego functions and WA; it was

						negatively correlated with a scale that measures clients' tendency to hide their true feelings and to change their behavior to fit in or meet others' expectations.
Owen et al., (2011); USA	Cross-sectional	Examine whether clients' perceptions of their psychotherapists' multicultural orientation (MCO) were associated with their psychological functioning, WA, and RR scores.	Clients	176	WAI-SR; RRI; SOS-10	Clients' perceptions of their psychotherapists' MCO were positively related to the WA and it significantly mediated the relationship between clients' perceptions of their psychotherapists' MCO and client psychological well-being. Clients' perceptions of the RR was not a significant mediator for the association between clients' ratings of their psychotherapists' MCO and psychological well-being, but a strong and positive association was found between clients' perceptions of their psychotherapists' MCO and the RR.
Lo Coco et al. (2011); Italy	Longitudinal	Association of the client- and therapist-rated strength of the RR to the outcome of brief psychotherapy; Extent to which the RR predicts outcome above and beyond the predictive power of the WA.	Therapists and clients	54	WAI-S; RRI; OQ-45	From the clients' perspective, both the Genuineness of the RR and the Bond scale of the WA were found to relate significantly to treatment outcome when these variables were measured early in treatment. However, neither the therapist-rated RR nor the therapist-rated WA, when measured early in treatment, were significantly associated with outcome.
Gullo et al. (2012); Italy	Longitudinal	Examine whether clients who continued longer in brief therapy reported stronger associations of RR and WA with therapy outcome than clients who received very brief treatment.	Therapists and clients	54	WAI-S; RRI; OQ-45	For clients who continued in brief therapy, in contrast to those who terminated such treatment after only a few sessions, the early RR seems to matter considerably in both therapists' and clients' eyes. The strength of the RR is associated with outcome when measured not only

		Examine whether RR and WA assessed early in treatment predicted outcome differently from that assessed later in therapy.				very early in treatment but also later.
Fuertes et al. (2013); USA	Longitudinal	Determine how the RR unfolds over the course of time-limited treatment and how this unfolding relates to the development of the client/therapist WA, client transference, and therapist countertransference. Also how these indices of the relationship fluctuate as a function of treatment outcome.	Therapists and clients	9	WAI-S; RRI; COM	The RR was strong from the beginning of therapy, and in successful cases, the RR further strengthened as treatment progressed, particularly therapists' ratings. High level of convergence in therapists' and clients' perceptions of the unfolding of the RR when the outcome of treatment was more successful. When the treatment was less successful, there was more disparity between clients' and therapists' perceptions of this unfolding process. Close relationship between RR and WA in their pattern of unfolding during brief treatment.
Hill et al. (2014); USA	Longitudinal	Investigate the use and perceived effects of immediacy in 16 cases of open-ended psychodynamic psychotherapy.	Therapists and clients	25	WAI-SR; RRI; IIP	Amount of immediacy events was related to therapists' but not clients' evaluations of session process and outcome (RR, WA and outcome).
Hill et al. (2015); USA	Longitudinal	Investigate changes over 12 to 42 months in 23 predoctoral trainees during their externship training in a psychodynamic/ interpersonal psychotherapy clinic.	Therapists and clients	191	WAI-SR; RRI; OQ-45.2	Over their time in the clinic, trainees were able to form stronger WA (as rated by both clients and therapists) and stronger RR (as rated by clients).
Kelley (2015); USA	Cross-sectional	Investigate the role of therapy practices and the therapy relationship on lesbian and gay clients' feelings about their current therapist.	Clients	116	WAI-SR; RRI	Clients' perceptions of their therapists' therapy practices, the RR, and the WA were significantly positively related to these clients' feelings about their therapists.

						The RR and the WA were strongly correlated.
Pinto-Coelho et al. (2016); USA	Longitudinal	Investigate 185 therapist self-disclosure events in 16 cases of open-ended psychodynamic/ interpersonal psychotherapy.	Therapists and clients	25	WAI-SR; RRI	Disclosures of facts were associated with lower client-rated RR and WA than were other types of TSDs. Disclosures of feelings were positively associated with client-rated RR. The stronger the client-rated WA, the more TSDs there were; the stronger the client-rated RR, the fewer factual TSDs there were.
Kivlighan et al. (2016); USA	Longitudinal	Examine the dyadic associations of clients and therapists in their evaluations of WA, RR, session quality, and client improvement over time in ongoing psychodynamic or interpersonal psychotherapy.	Therapists and clients	97	WAI-SR; RRI; OQ-45	Clients' and therapists' ratings of the WA and the RR were significantly and uniquely related to their own ratings of session quality. Client-rated WA and RR were associated with therapist-rated session quality.
Doran et al. (2016); USA	Cross-sectional	Investigate the utility and psychometric properties of the Alliance Negotiation Scale (ANS).	Clients	212	WAI; RRI	The relationship between the ANS and WAI was positive and statistically significant; the ANS and RRI were significantly positively correlated. The correlations point to a substantial overlap between the three measures.
Baumann and Hill (2016); USA	Cross-sectional	Investigate client motivations for concealing vs. disclosing secrets and how concealment and disclosure relate to therapeutic process and outcome.	Clients	115	WAI-SR-Bond; RRI; COM	Clients who concealed secrets evaluated the RR as weak; disclosure was not related to the RR. Neither secret concealment nor disclosure was a significant predictor of the WA bond.
Shafran et al. (2017); USA	Longitudinal	Examine the relationship between amount of therapist immediacy in sessions and client post-session ratings of WA, RRI,	Therapists and clients	25	WAI-SR; RRI	More immediacy in a session was related to higher client ratings of session quality for that session. Whereas more immediacy in a session was related to

		and session quality, using hierarchical linear modeling (HLM).				lower client ratings of WA early in treatment, more immediacy in a session was related to higher client ratings of WA later in treatment. No relationship was found between immediacy and RR.
Kivlighan et al. (2017); USA	Longitudinal	Examine how congruence and discrepancy in clients' and therapists' ratings of the WA and RR were related to client-rated session quality.	Therapists and clients	167	WAI-SR; RRI; SES	RR–WA discrepancy is a common occurrence at the session level. More than 50% of sessions had discrepant client RR–WA scores, and almost 45% of the sessions had discrepant therapist ratings.
Bhatia and Gelso (2017); USA	Cross-sectional	Examine how 3 elements of the therapy relationship (WA, RR, and transference) during the termination phase relate to perceived client sensitivity to loss, termination phase evaluation, and overall treatment outcome.	Therapists	233	WAI-SF; RRI; COM	Therapists perceiving a stronger WA and RR during the termination phase were also likely to view the termination phase as effective and overall treatment as successful. Only therapists' perceptions of the WA during the termination phase contributed to overall treatment outcome, when all three components were examined together.
Bhatia and Gelso (2018); USA	Cross-sectional	Examine the components of the tripartite model in terms of how they relate to one another and to the outcome of a psychotherapy session, from the therapists' perspective.	Therapists	249	WAI-SR; RRI; SES	WA, RR, transference and countertransference contributed 27% of the variance in session outcome as rated by therapists of varying theoretical orientations. From the therapist's perspective, the WA, RR and transference configuration were associated with session outcome. Only the RR and the WA predicted session outcome when all the components were looked at simultaneously in a regression model.
Morales et al.	Longitudinal	Examine client- and therapist-rated WA	Therapists	153	WAI-SR;	Although there were no therapist effects due to client

(2018); USA		and RR at Session 3 and growth in WA and RR across the course of open-ended psychodynamic psychotherapy for clients who identified as racial/ethnic minority (REM) or as White.	and clients		RRI	REM status for either client- or therapist-rated WA or RR at Session 3, there were therapist effects due to client REM status for client-rated but not for therapist-rated WA and RR changes over time.
Alessi et al. (2019); USA	Cross-sectional	Test a conceptual model through which LGBQ clients' perceptions of their therapists' affirmative practices, the WA, and the RR relate to psychological well-being	Clients	184	WAI-SR; RRI; SOS-10	The therapeutic relationship (WA and RR) was the underlying mechanism through which clients' perceptions of therapists' affirmative practices correlated with psychological well-being.
Pérez-Rojas and Gelso (2020); USA	Cross-sectional	Assess how acculturation may impact international student therapists' experiences in cross-cultural counseling.	Therapists	104	WAI-S; RRI: SES	The self reported quality of counseling relationships (RR and WA) and of counseling sessions with U.S. clients was unrelated to international counseling students' levels of acculturative stress and perceptions of cultural distance.
Doorn et al. (2020); USA	Cross-sectional	Explore therapists' experiences of video therapy after switching from in-person to video sessions during the pandemic.	Therapists	141	WAI-SF; RRI	Higher rated WA and RR were associated with more positive attitudes towards video therapy. Scores on the RR and WA were positively correlated. Neutral WA online, albeit lower than those reported in previous studies on video therapy. Relatively strong RR online, similar to levels reported in studies of in-person therapy.

Notes. RR: Real Relationship; WA: Working Alliance; WAI-SF: Working Alliance Inventory – Short Form; WAI-SR: Working Alliance Inventory – Short Revised; SEQ: Session Evaluation Questionnaire; COM: Counseling Outcome Measure; SCL-90-R: Symptom Checklist-90-Revised; SOS-10: Schwartz Outcome Scale-10; OQ-45: Outcome Questionnaire-45; IIP: Inventory of Interpersonal Problems; SES: Session Evaluation Scale.

Results

Our search resulted in 110 citations, leaving 86 when duplicates were removed. The articles were screened at abstract level, and the remaining 62 articles were screened at full text level against inclusion criteria, leading us to 23 included articles. To this date, one of the articles which we could not get access to was not sent to us by the authors. Table 1 presents all 23 studies characteristics.

After close examination of all 23 studies, and because we wanted our analysis to be as thorough as the one performed by Gelso et al. (2018), we decided that included studies should allow the calculation of the correlation between the strength of real relationship and working alliance. Studies were then excluded if they did not have the information necessary to calculate a correlation between the real relationship and working alliance.

Besides that, we also excluded studies if the data set was not independent of other studies included in the review. In those cases we used the studies that presented a more complete data set. Three studies examining the real relationship and working alliance were not included because their data sets partially overlapped with studies that were included in this review. The Gullo et al. (2012) study was not included because their sample is shared with the one of Lo Coco et al. (2011), which contained the most inclusive data set. The Hill et al. (2014) and Pinto-Coelho et al. (2016) studies were not included because their sample is shared with the one of Shafran et al. (2017), which contained the most inclusive data set.

The studies by Fuertes et al. (2013) and Morales et al. (2018) were excluded because they did not present correlations between real relationship and working alliance; the Baumann and Hill (2016) study only presented a correlation between real relationship and the Bond subscale of the Working Alliance Inventory (WAI); and the Alessi et al. (2019) study only presented correlations between the subscales of each measure (RRI and WAI) and not their totals.

From the sixteen selected studies, along with data necessary for computing standardized effect sizes (Pearson's *r*) we also extracted the sample size, and who made the ratings (client or therapist). Pearson's correlation coefficient (*r*) was the effect size measure used in this research. We used the Comprehensive Meta-Analysis V3 (www.meta-analysis.com) statistical software to conduct the analyses.

When studies contained multiple effect sizes, we followed the procedure of Gelso et al. (2018), and aggregated data within studies and then between studies, based on the specific comparisons from our different analyses. We computed Pearson's *r* and 95% confidence intervals (CI) as summary statistics. The heterogeneity among effect sizes in an analysis was

assessed using the Q-statistic (assessing whether between-study heterogeneity exceeds that expected by chance alone). All analyses used random effects models.

Statistical Analysis

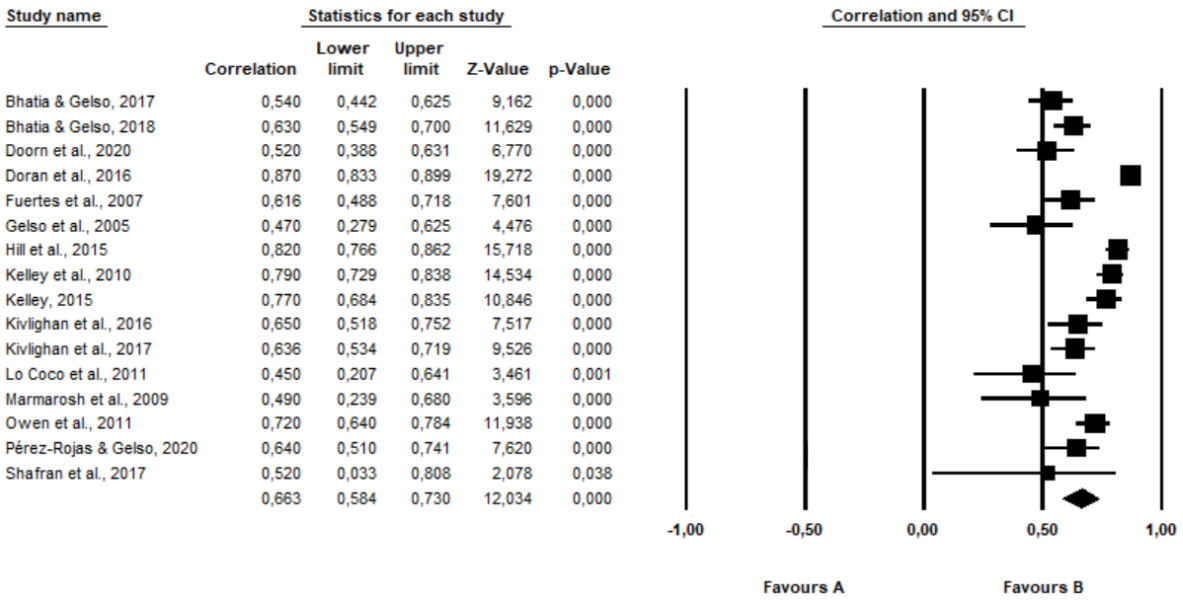
Sixteen studies were included in the meta-analysis, after the exclusion of seven studies from the review. This means an increase of 80% of studies compared to the meta-analysis of real relationship and working alliance performed by Gelso et al. (2019), and also an increase of 1119 participants.

This meta-analysis follows the criteria adopted by Gelso et al. (2018). The omnibus effect size was significant (r = .66, 95% CI [.58, .73], p < .001, N = 2189 participants). Figure 1 displays the forest plot for this analysis. These results support Gelso's characterization of the real relationship and the working alliance as sister concepts – medium to large correlation but not identical constructs.

There was significant heterogeneity across the studies (Q[15] = 132.08, p = .000), and the extent of heterogeneity was high (I^2 = 89%) representing a high variability among studies. The fail-safe N was 5514. One concern of publication bias is that some non-significant studies are missing from the analysis and that these studies, if included, would nullify the observed effect (Cooper et al., 2009). The number of studies that would be required to nullify the effect represent the fail-safe N. Because we need a large number of studies to nullify the mean effect, then there is no need to concern about publication bias. The Egger test also showed no evidence of publication bias (t = 1.45, p = .08)**.**

Figure 1

Forest Plot of Effect Sizes and Confidence Intervals for the Meta-Analysis of Real Relationship and Working Alliance



Note. "Box" size is relative to sample size, with larger boxes indicating a larger sample. "Favors A" indicates a negative correlation, whereas "Favors B" indicates a positive correlation. The last line of the table is the estimated results (random effects) for the meta-analysis.

Study Characteristics

The included articles were published between 2005 and 2020. Most analyzed studies (N = 10) were cross-sectional, while the rest (N = 6) were longitudinal. Among the longitudinal studies, working alliance and real relationship were measured after each session (N = 4); on the third and eight sessions (N = 1); on the third session and at termination (N = 1).

Because there is only one instrument to measure the real relationship, all studies used the RRI: the complete 24-item form was used more often (N = 11) than the short 12-item form (N = 5). On the other hand, although working alliance has originated a number of measures, all the studies included in our review used only the Working Alliance Inventory (WAI). The Working Alliance Inventory – Short (WAI-S; Tracey & Kokotovic, 1989) was used in 9 studies; whereas the Working Alliance Inventory – Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) was used in 6 studies. Both of them are short 12-item versions that

come from the complete 36-item WAI (Horvath & Greenberg, 1986, 1989). Only one study in our review used the complete form.

When looking at the participants included in these studies, we observe that they consist of both therapists and clients (N = 6), only therapists (N = 5), and only clients (N = 5).

The clients' eligibility criteria included being 18 years old or over, and having had at least some psychotherapy sessions: one session (N = 1); three sessions (N = 1); five sessions (N = 2); eight sessions (N = 2). Four studies recruited their participants before they started their psychotherapy sessions. One study was not clear on how many sessions the clients had already. Although some studies were not specific on their clients' eligibility criteria – aside from the minimum number of sessions – other criteria could include the nonexistence of psychotic or suicidal symptoms or not currently abusing substances.

Real Relationship and Working Alliance Predicting Outcome

Of the sixteen analyzed studies, there were ten studies where the authors tried to understand how working alliance and real relationship related to outcome. In the other six studies, outcome was not measured or it was associated with other variables (e.g., immediacy).

First of all, we need to take into account that outcome is not measured equally in all studies. Outcome can be evaluated through session quality, client progress or symptomatic evolution. Seven outcome measures were used by the authors of the different studies: session quality (Session Evaluation Questionnaire, SEQ; Session Evaluation Scale, SES); client progress (Counseling Outcome Measure, COM; Schwartz Outcome Scale-10, SOS-10); and symptomatic evolution (Symptom Checklist-90-Revised, SCL-90-R; Outcome Questionnaire-45, OQ-45; Inventory of Interpersonal Problems, IIP). These measures can be completed by the clients and/or the therapist, and they can assess outcome after each session, at the beginning and end phases of psychotherapy (pretest-posttest change), or at a certain phase of treatment. Despite all these differences between the measures, they all accounted for outcome, and we make no distinction between them.

Four studies (Gelso et al., 2005; Fuertes et al., 2007; Marmarosh et al., 2009; Lo Coco et al., 2011) concluded that the real relationship was a better predictor of outcome than working alliance. The Gelso et al. (2005) study revealed a small and non significant association between working alliance and the depth and smoothness subscales of the SEQ (Depth: $r = .14$; Smoothness: $r = .16$). On the other hand, the RRI had a positively significant association with the subscales of the SEQ (Depth: $r = .36$, $p < .01$; Smoothness: $r = .43$, $p <$

.01). Fuertes et al. (2007) found that client ratings of the real relationship predicted 14% of additional variance in their ratings of psychotherapy progress above and beyond client ratings of attachment, working alliance, and therapist empathy (adjusted R^2 = .54). Therapist ratings of the real relationship explained an additional 5% of variance in therapist ratings of client progress above and beyond attachment and their ratings of the working alliance. However, this result approached (β = .29, p < .058), but did not fully attain, statistical significance. Client and therapist ratings of the real relationship, and not their ratings of the working alliance, were predictive of their ratings of client progress. In the study by Marmarosh et al. (2009), hierarchical multilevel regression revealed that the therapist-rated real relationship was the only significant predictor of post-treatment symptoms. Besides, therapists' perceptions of realism but not genuineness, accounted for a significant amount of variance in client-rated therapy outcomes. Client-rated real relationship, especially the genuineness subscale, predicted outcome in the study conducted by Lo Coco et al. (2011), and added to the working alliance effect predicting outcome a significant increase in the explained variance (adjusted R^2 increased from .10 to .38). The working alliance did not seem to relate to treatment outcome, except for the client-rated bond element of the working alliance.

Only one study (Bhatia & Gelso, 2017) revealed a greater role of working alliance in predicting outcome. Real relationship, working alliance, and transference were examined through the therapists' perspectives during the termination phase of therapy, and were related to overall treatment outcome and other variables. Results showed that the three relational components together predicted 19% of the variance in overall treatment outcome (Adjusted R^2 = .19, $F_{(3, 216)}$ = 18.67, p < .01) during the termination phase. However, only therapist-rated working alliance during the termination phase significantly predicted treatment outcome (B = .35, p < .01).

Four studies that associated outcome to real relationship and working alliance (Owen et al., 2011; Kivlighan et al., 2017; Bhatia & Gelso, 2018; Pérez-Rojas & Gelso, 2020) did not find major differences between the two constructs in their prediction of outcome. Owen et al. (2011) found a positive significant association between client-rated psychological well-being and real relationship (r = .27, p < .001) and working alliance (r = .34, p < .001); Pérez-Rojas and Gelso (2020) also showed a significant positive association between therapist-rated session quality and real relationship (r = .47, p < .001) and working alliance (r = .42, p < .001). Kivlighan et al. (2017) examined how congruence and discrepancy in clients' and therapists' ratings of the real relationship and working alliance were related to client-rated session quality. Their main finding revealed that for both clients and therapists, at all levels of

analysis (except the therapist level for therapist ratings), session quality was highest when combined real relationship and working alliance ratings were high and lowest when combined ratings were low. Bhatia and Gelso (2018) conducted a simultaneous regression analysis to examine how working alliance, real relationship, negative transference and countertransference behaviors, as perceived by therapists, contributed to therapist ratings of session outcome. Results indicated that the four components together predicted 27% of the variance in session outcome (Adjusted R^2 = .27, $F_{(237)}$ = 23.10, p < .01). Further examination of the regression model revealed that only the real relationship and working alliance significantly predicted session outcome after adjusting for all components of the tripartite model (RRI: B = .73, p < 0.01; WAI: B = .98, p < .01).

Lastly, one study showed differences between real relationship and working alliance when the raters were different. Kivlighan et al. (2016) proved that clients' and therapists' ratings of the working alliance and the real relationship were significantly related to their own ratings of session quality. For therapist session outcome, the therapist working alliance effect was twice as large as the therapist real relationship effect. By contrast, for client session outcome, the client real relationship effect was twice as large as the client working alliance effect. These results suggest that while therapists give more weight to the working alliance, clients pay more attention to the real relationship when evaluating sessions.

Overall, the studies can be divided into four sections: real relationship is the better predictor of outcome (N = 4); working alliance is the better predictor of outcome (N = 1); the constructs do not present major differences in their relation to outcome (N = 4); the constructs predictive value is influenced by the rater (N = 1).

Discussion

Gelso et al. (2018) performed the first meta-analysis of the real relationship literature. Their focus was to report its association with outcome. When they adapted their study to Norcross and Lambert's "Psychotherapy Relationships that Work" (2019), they also performed a meta-analysis between real relationship and working alliance. However, they extracted the data from the results of their first meta-analysis. This means that the nine studies reported in Gelso et al. (2019), contain not only real relationship and working alliance, but also outcome. What about the studies where outcome was not measured?

In order to overcome this limitation, we performed a systematic review to identify all the articles containing the association between real relationship and working alliance. We gathered twenty-three studies but, because we wanted our analysis to be as thorough as the one performed by Gelso et al. (2018), we only included studies that allowed the calculation of the correlation between real relationship and working alliance. This added delimitation resulted in a total of sixteen studies, meaning we collected seven more studies than the first meta-analysis. The low number of studies can be explained by the lack of reliable instruments to measure real relationship which – with the validation of the RRI-T (Gelso et al., 2005) and RRI-C (Kelley et al., 2010) – just recently started to be empirically studied.

Our meta-analysis revealed a significant omnibus effect (r = .66, 95% CI [.58, .73], p < .001) a little above the one found by Gelso et al. (2019) (r = .58, 95% CI [.51, .64], p < .001), demonstrating a medium to large correlation. These results confirm the existence of a moderate association between real relationship and working alliance, and contribute to Gelso's characterization of the real relationship and working alliance as sister concepts.

But to what do we attribute this association? Kelley et al. (2010) investigated if the real relationship and working alliance were that different at all. To do so, they examined if the RRI-C correlated differently with the WAI subscales. They discovered that the bond subscale of the WAI was more highly correlated with the real relationship than were the other components of the WAI. This makes sense given that the bond subscale may be easily confused with the personal bond that the real relationship represents, especially in the clients' perspective. In fact, Gelso (2014) had already pointed out that three of the items of the bond tap personal feelings between therapist and client ("I believe my therapist likes me" / "I believe my client likes me"; "I feel that my therapist appreciates me" / "I appreciate my client as a person"; "My therapist and I trust one another" / "My client and I have built a mutual trust") and only one taps the work collaboration ("I'm confident in my therapist's ability to help me"/ "I'm confident in my ability to help my client"). Although that was not possible in

our review, we consider necessary to investigate the contribution of the bond subscale of the WAI in the association between real relationship and working alliance.

After confirming the association between the constructs, the results from the studies allowed us to observe the conceptual differences between them in the way that they related to outcome. Our review revealed that in the studies where both working alliance and real relationship were considered, four studies demonstrated that the real relationship is a more significant predictor of outcome than working alliance (Fuertes et al., 2007; Gelso et al., 2005; Lo Coco et al., 2011; Marmarosh et al., 2009). Only one study showed that the working alliance was a better predictor of outcome (Bhatia & Gelso, 2017). In another four studies, there were no significant differences between them (Bhatia & Gelso, 2018; Kivlighan et al., 2017; Owen et al., 2011; Pérez-Rojas & Gelso, 2020). With these results, we could say two things: first, the real relationship seems to be a better predictor of outcome than working alliance; second, if they contribute differently to outcome, they should be conceptually different.

However, one last study (Kivlighan et al., 2016) revealed that the rater of the constructs can make a difference on how they will relate outcome. These authors discovered that, for therapists, the effect of working alliance was twice as large as the real relationship for therapist-rated session outcome; and for clients, the real relationship effect was twice as large as the working alliance for client-rated session outcome. If therapists consider the working alliance to be a better predictor of outcome, and clients consider that the real relationship is the construct that has a higher predictive value, then does the rater have an influence in the constructs' association with outcome?

Both the conceptualization of the constructs and the empirical results that we found support Gelso's characterization of these constructs as "sister concepts", although we believe that they might be at a critical development phase of their "adolescence", beginning to show different patterns in their relationships. First, because real relationship is proving to be a better predictor of outcome than working alliance; secondly, because it seems like their relation with outcome may be influenced by the rater: therapists consider working alliance a better predictor, while clients think that real relationship is the one with a better predictive value.

In our next study we intend to address the questions raised by our systematic review. In the first place, can the bond subscale be the reason why real relationship and working alliance are so highly associated? And secondly, can the raters of the constructs (therapist and client) have an influence on how they relate to outcome?

Empirical study

With our first study, we intended to review the existing quantitative studies about real relationship and working alliance, in order to confirm their association – which granted them the designation of "sister concepts" (Gelso, 2014; Gelso et al., 2018; Gelso & Kline, 2019). Even though they are conceptually different, they are two of the elements of Gelso's tripartite model of the therapeutic relationship (Gelso, 2014), therefore highly related. The overall correlation found in our previous study confirms that. We may, however, question how closely these two "sister" concepts are. In the present study, we intend to investigate the proximity between real relationship and working alliance by recasting previous argumentation of the bond subscale psychometric problems (Gelso, 2014). We also expect to analyze if the differentiation between the concepts can be due to the way each of them relates to outcome, considering the influence of the rater (client vs. therapist).

According to Gelso (2014), the correlation between real relationship and working alliance can be inflated due to a psychometric problem. Namely, the overlap between the real relationship and the bond subscale of the WAI contributes to the reported proximity between the concepts. Gelso (2014) refers that after inspection of the bond subscale of the WAI, it revealed that three of the items tap personal feelings between therapist and client and only one taps the work collaboration. In the present study, our first objective is to analyze if the bond subscale is contributing to the elevated proximity between the concepts.

In our previous study, we also analyzed the results from the studies to see how real relationship and working alliance related to outcome in psychotherapy. We concluded that, despite the aforementioned association, they contribute differently to outcome. Overall, real relationship appeared to be a better predictor of outcome, compared to working alliance. However, the role of the better predictor could be influenced by the rater. In one particular case, while clients gave a bigger importance to the real relationship, therapists emphasized the role of the working alliance in the outcome of psychotherapy (Kivlighan et al., 2016). Due to the variety of studies from our review, we did not always get the perspective from both client and therapist. Our second objective with this study is to explore if the rater has an influence on the association of real relationship and working alliance with outcome. Previous studies analyzed not only the overall scores, but also the subscales of the measures (e.g., Lo Coco et al., 2011; Marmarosh et al., 2009). Like them, we will also observe closely these subscales and see if any of them could be playing an important role in each of the constructs.

Because of our objectives, and in order to make the information clearer, we divided the Results chapter into Clients and Therapists sections.

Participants

Participants consisted of 40 ongoing therapist-client dyads, with a total of 6 therapists and 40 clients.

Therapists were 1 man and 5 women between the ages of 24 and 51 (*M* = 37.17, *SD* = 11.58), and all of them were Portuguese. One of them had a doctorate, another one had a pre-Bologna bachelor degree, and the other four had a master's degree. Therapists were asked to rate in a scale of 1 (little) to 10 (a lot) the extent of their belief and adherence to the theory and techniques of different therapies: cognitive-behavioral (*M* = 3.57, *SD* = 2.29); psychodynamic (*M* = 5.86, *SD* = 2.12); humanistic (*M* = 5.57, *SD* = 1.62); systemic (*M* = 5.83, *SD* = 3.31); psychoanalytical (*M* = 5.00, *SD* = 2.31); integrative (*M* = 6.86, *SD* = 2.61); others (*M* = 4.00, *SD* = 3.42). Therapists reported the following work settings: private practice (N = 5), community mental health center (N = 1), university setting (N = 2), others (N = 1).

Clients included 9 men and 31 women, between 18 and 58 years of age (*M* = 28.90, *SD* = 10.51), where 35 of them were Portuguese, 3 were Brazilian, and 2 were Italian. Regarding marital status, 6 clients were married, 3 were divorced, 29 were single, and 2 lived in non-marital partnership. Most clients had a higher education, with 1 doctorate, 8 masters, and 16 bachelors, 14 clients completed high school, and one completed middle school.

Most clients reported that they never had therapy before (N = 27), while the others had already been in therapy once (N = 4), twice (N = 4), three times (N = 4), and five times (N = 1). Of these 13 clients, 11 used to be followed by different therapists and 2 were followed by the same therapist as they were currently seeing.

The number of sessions differs across all 40 clients, with a minimum of 4 sessions and a maximum of 200 sessions (*M* = 31.50, *SD* = 31.53). Nonetheless, like in other studies, all the clients have at least 3 sessions.

Clients' motives to seek therapy differ across all 40 clients but the most pointed out are anxiety, depression, family problems, need for self-knowledge, and need for specialized help.

Measures

The Real Relationship Inventory-Therapist and the Real Relationship Inventory-Client (RRI-T and RRI-C; Gelso et al., 2005; Kelley et al., 2010) are a 24-item measure using a 5-point scale from 1 (strongly disagree) to 5 (strongly agree) which assess perceptions of the strength of real relationship in terms of realism and genuineness. For the present study we used a short form with the 12 items that Hill et al. (2014) considered that best represented the theoretical components of the measure.

The translation of the RRI Therapist and Client Forms from English to Portuguese happened in two stages: first, the scale was translated by means of a back-translation procedure; in the second phase, one bilingual expert within the domains of psychology judged the translation. The final translation was used in the present study.

For the current sample, internal consistency reliability estimates (Cronbach's alpha) for the RRI Total scores were $\alpha = .83$ (RRI-T) and $\alpha = .70$ (RRI-C). Because the Therapist Form presented a good internal consistency, and the exclusion of items would not significantly improve the Cronbach's alpha, we did not exclude any items from this measure. The same did not happen with the Client Form which, although the overall internal consistency was acceptable, the subscales were very low ($\alpha_{Realism} = .54$, $\alpha_{Genuineness} = .53$). Therefore, we decided to exclude items 4 and 5 from the Client Form, which allowed the RRI-C to present a slightly higher consistency ($\alpha = .74$), as well as its subscales ($\alpha_{Realism} = .57$, $\alpha_{Genuineness} = .60$).

The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) is a 12-item measure that assesses client perceptions of the working alliance, and was adapted to the Portuguese population by Ramos (2008). Items are rated in a 5-point scale from 1 (seldom) to 5 (always). The therapist version is a comparable 10-item measure. The Cronbach's alpha for the WAI-T was $\alpha = .88$ and for the WAI-C was $\alpha = .89$.

The Counseling Outcome Measure (COM; Gelso & Jonhson, 1983) asks clients and therapists to evaluate clients' progress since the beginning of therapy in terms of feelings, behaviors, and self-understanding in general. The four items are rated in a 7-point scale ranging from 1 (much worse) to 7 (much improved). The items are summed as a total score. The translation of the COM followed the same procedure as the one for the RRI. The Cronbach's alpha was $\alpha = .90$ for the COM-T and $\alpha = .87$ for the COM-C.

The Marlowe-Crowne Social Desirability Scale-Short Form (MCSDS-SF; Ballard, 1992) is a 13-item self report of social desirability, and was adapted for the Portuguese population by Pechorro, Vieira, Poiares, and Marôco (2012). The MCSDS uses a true-false format to identify individuals who describe themselves as possessing culturally sanctioned characteristics considered rare in the general population to obtain approval from others. This measure has been used extensively to assess social desirability as a response tendency in studies implementing self-report formats.

Because this is the first translation of the RRI, we decided to do the same as Gelso et al. (2005) and Kelley et al. (2010) and use the MCSDS in our study to assess discriminant

validity, and therefore the measures of real relationship and outcome should be unrelated to social desirability. For the MCSDS, the Cronbach's alpha was $\alpha = .75$.

The correlations between social desirability and the RRI-C and COM-C revealed that social desirability was unrelated to real relationship (r = -.068), and outcome (r = -.191), displaying initial evidence of discriminant validity.

Procedure

Our data collection took place during the Covid-19 pandemic, so we decided to do the procedure online. Participants were contacted via email, and answered our questionnaires on Google Forms.

Therapists were contacted via email by the author, requesting them to participate in a study, and asking for their clients to participate as well. Therapists with clients who were interested in participate were sent a second email with the links of the questionnaires, as well as a brief explanation of the ongoing study.

On the first and second pages of the questionnaire, participants found the informed consent where they would read that their participation was anonymous, voluntary, and that they could interrupt it at any time without consequences. The third page required them to insert a code with the initials of the therapist, the initials of the client, and the client's year of birth, to make sure that each client and their therapist filled up the questionnaire. The next page consisted of a socio-demographic questionnaire, and the following pages contained the WAI-SR, RRI, COM and MCSDS. All questions were answered by all the participants because the website would not allow continuing to the next page if any question was left unanswered.

Therapists' questionnaires had a small difference from the ones sent to clients. Because therapists had to fill up one questionnaire per client, after they filled up the first questionnaire, we would send them a different link, where they would find only the WAI-SR, RRI, and COM. It was not necessary for them to complete again the socio-demographic questionnaire or the MCSDS, and it also became less exhausting for them.

All of our analyses were carried out recurring to the IBM SPSS Statistics for Windows (version 27.0). We performed statistical analyses like Pearson correlations, and hierarchical regressions.

Results

This chapter is divided into two sections: Clients and Therapists. In the Clients' section we present the correlations between the measures, and their comparison, and the regression analyses that might explain outcome. The therapists' section is also divided in correlations of the measures, and regression analyses.

Clients

Bond Subscale of the WAI Explains Real Relationship and Working Alliance. Table 2 presents correlations between WAI-C subscales, RRI-C subscales, and COM-C, as well as means and standard deviations.

Table 2

Means, Standard Deviations, and Correlation Matrix for Clients

	1	2	3	4	5	6	7	M	SD
1. WAI-C Total	1							52.95	6.17
2. WAI-C Goals	.898**	1						17.48	2.21
3. WAI-C Task	.904**	.731**	1					16.95	2.35
4. WAI-C Bond	.891**	.699**	.699**	1				18.53	2.31
5. RRI-C Total	.517**	.423**	.431*	.539**	1			42.55	4.05
6. RRI-C Realism	.479**	.383*	.385*	.520**	.916**	1		20.28	2.48
7. RRI-C Genuine	.446**	.375*	.388*	.437**	.873**	.603**	1	22.28	2.04
8. COM-C	.325*	.250	.324*	.298	.440**	.376*	.417**	24.75	2.77

**p < .05. **p < .01.*

The WAI-C and RRI-C demonstrate a moderate positive correlation (r = .517, p < .01). The WAI-C reveals a weak positive association with the COM-C (r = .325, p < .05), while the RRI-C presents a moderate positive association with the COM-C (r = .440, p < .01). Observing the subscales of the measures, it is possible to observe that the bond subscale has a moderate positive correlation with the RRI-C (r = .539, p < .01), and with a bigger magnitude than the total score of the WAI-C. Also, the association between the task subscale and the COM-C is equivalent to the one of the WAI-C (r = .324, p < .05). Regarding the RRI-C, the genuineness subscale correlates more to the COM-C than the realism subscale (r = .417, p < .01).

Although the correlations allow us to observe the proximity between real relationship and working alliance, it does not tell us if there are any major differences between them. In our meta-analysis we obtained an overall correlation of the real relationship with working alliance of r = .66. To better understand the proximity between the concepts, we compared the correlation between the real relationship and each of the subscales of the WAI with the overall correlation obtained in our meta-analysis.

We used the website developed by Lenhard and Lenhard (2014) called Psychometrica (www.psychometrica.de/correlation) to do the comparison of the correlations. We tested the correlations of the subscales against a fixed value – in our case, the one obtained from our meta-analysis. We insert the sample number (N), the correlation (r), and the fixed value (ρ), and the test uses the Fisher-Z-transformation to test the significance of the difference between r and ρ. The calculator provides us the test statistic (z) and the probability (p).

The correlation between WAI-C and RRI-C (r = .517, p < .01) is not significantly different from the one in our meta-analysis (z = -1.426, p = .077). The correlation between the bond subscale of the WAI-C and the RRI-C (r = .539, p < .01) compared to the one from the meta-analysis also did not reveal significant differences (z = -1.24, p = .107). On the other hand, the correlation between the task and the goals subscales of the WAI-C and the RRI-C (task: r = .431, p < .05; goals: r = .423, p < .01) were both significantly different from the correlation from our meta-analysis (task: z = -2.102, p = .018; goals: z = -2.161, p = .015).

Real Relationship and Working Alliance Predict Outcome. In order to examine the effect of the two variables in the prediction of outcome, we performed a multiple hierarchical regression analysis. In a first analysis, we only aimed to know whether the real relationship or the working alliance was the better predictor of outcome. We placed the RRI-C in the first block and the WAI-C in the second block. After that, we inverted the blocks – WAI-C in the first block, and RRI-C in the second block – to compare the results. Table 3 shows the results of our analyses.

Table 3

Multiple Hierarchical Regression Models with COM-C as the Criterion Variable (N = 40)

						Standardized coefficients		
Model	**Block**	R^2	**Adjusted** R^2	R^2 **change**	***F* change**	**β**	***t***	**Significance**
I	1	.193	.172	.193	9.109			

	RRI-C					.440	3.018	.005
	2	.206	.163	.013	.602			
	RRI-C					.371	2.168	.037
	WAI-C					.133	.776	.443
II	1	.105	.082	.105	4.480			
	WAI-C					.325	2.117	.041
	2	.206	.163	.101	4.699			
	WAI-C					.133	.776	.443
	RRI-C					.371	2.168	.037

The two variables together explain 20,6% of the variance of outcome. When the RRI-C is placed on the first block, it explains 19,3% and the WAI-C contributes with 1,3% to the model (ΔR^2 = .013, p = .443). The effect of the RRI-C is significant (β = .440, t = 3.018, p = .005), and it remains significant, even after the addition of the WAI-C in the model. The effect of the WAI-C is not significant when we consider the two variables together (β = .133, t = .776, p = .443).

If we place the WAI-C in the first block, it explains 10,5% of the variance of outcome (ΔR^2 = .105, p = .041), and its effect is significant in predicting outcome (β = .325, t = 2.117, p = .041). The RRI-C adds up 10,1% (ΔR^2 = .101, p = .037) to the model, which is a very similar value to that of the WAI-C. However, the effect of the WAI-C is no longer significant (β = .133, t = .776, p = .443) when we add the RRI-C, which becomes a more important predictor of outcome (β = .371, t = 2.168, p = .037).

We performed a second analysis in order to investigate which of the subscales of each variable gave a better contribute to the outcome. In the next multiple hierarchical regression analysis, we placed the goals, task, and bond subscales on the first block, and the realism and genuineness subscales on the second block. Afterwards, we inverted the blocks, placing the realism and genuineness subscales in the first block, and the goals, task, and bond subscales in the second block. Table 4 presents our findings.

We adopted a stepwise method in order to exclude predictors who lose their importance with the addition of more important variables. For the models where, by introducing the variables in the second block, none of the predictor variables was significant, we decided to use an enter method so we could report the statistic indicators, namely the standardized coefficients. This procedure was adopted for both Clients and Therapists' sections.

Table 4

Multiple Hierarchical Regression Models with COM-C as the Criterion Variable (N = 40)

Model	Block	R^2	Adjusted R^2	R^2 change	F change	Standardized coefficients		
						β	*t*	Significance
I	1	.105	.082	.105	4.470			
	WAI-C Task					.324	2.114	.041
	2	.205	.162	.099	4.628			
	WAI-C Task					.192	1.205	.236
	RRI-C Genuine					.342	2.151	.038
II	1	.174	.152	.174	7.979			
	RRI-C Genuine					.417	2.825	.007
	2	.206	.116	.033	.484			
	RRI-C Genuine					.339	2.003	.053
	WAI-C Goals					-.058	-.241	.811
	WAI-C Task					.200	.836	.409
	WAI-C Bond					.050	.213	.832

When the subscales of the WAI-C appear in the first block, task and genuineness are the better predictors of outcome. Together these subscales contribute to 20,5% of outcome, with a relatively equivalent weight (Task ΔR^2 = .105; Genuineness ΔR^2 = .099). However, with the addition of genuineness in the model (β = .342, t = 2.151, p = .038), the initial significance of the task subscale (β = .324, t = 2.114, p = .041) is no longer significant (β = .192, t = 1.205, p = .236).

If we put the RRI-C subscales in the first block, genuineness shows a bigger contribution to outcome (ΔR^2 = .174, p = .007) than in the previous model. The WAI subscales together only add up 3,3% to the model. None of these subscales have a significant role when we consider genuineness first. Genuineness also loses its significance in the model, when considered together with the other subscales (β = .339, t = 2.003, p = .053).

Therapists

Association Between Real Relationship and Working Alliance. Table 5 presents the correlations between the total scores and subscales of the RRI-T, WAI-T, COM-T, and means and standard deviations.

Table 5

Means, Standard Deviations, and Correlations for Therapists

	1	2	3	4	5	6	7	M	SD
1. WAI-T Total	1							42.55	4.44
2. WAI-T Goals	.939**	1						12.03	2.01
3. WAI-T Task	.917**	.887**	1					11.93	1.76
4. WAI-T Bond	.662**	.424**	.375*	1				18.60	1.43
5. RRI-T Total	.515**	.413**	.503**	.403**	1			51.35	3.77
6. RRI-T Realism	.297	.174	.292	.322*	.893**	1		25.43	1.66
7. RRI-T Genuine	.603**	.527**	.587**	.410**	.950**	.709**	1	25.93	2.40
8. COM-T	.400*	.351*	.440**	.209	.558**	.477**	.545**	23.55	2.64

**p < .05. ** p < .01.*

The WAI-T and RRI-T present a moderate positive correlation ($r = .515$, $p < .01$). The task subscale of the WAI-T revealed a higher correlation with the RRI-T ($r = .440$, $p < .01$) than the bond subscale ($r = .209$, $p > .05$). On the other hand, the genuineness subscale of the RRI-T demonstrates a higher correlation with the WAI-T ($r = .603$, $p < .001$) than the realism subscale ($r = .297$, $p > .05$).

The WAI-T also had a moderate positive correlation with the COM-T ($r = .400$, $p < .05$), but the RRI-T correlation with the COM-T was of higher magnitude ($r = .558$, $p < .01$). The task subscale of the WAI-T reveals a higher moderate correlation with the COM-T ($r = .440$, $p = .01$) than the total score, and the bond subscale correlation with outcome is almost neglectable ($r = .209$, $p > .05$). When looking at the real relationship, genuineness has a higher moderate correlation with the COM-T ($r = .539$, $p < .01$) than realism.

Real Relationship and Working Alliance Predict Outcome. To see how real relationship and working alliance work in predicting outcome, we performed a multiple hierarchical regression analysis. First, we placed the RRI-T in the first block and the WAI-T

in the second block; and then, we placed the WAI-T in the first block and the RRI-T in the second block. Table 6 displays our results.

Table 6

Multiple Hierarchical Regression Models with COM-T as the Criterion Variable (N = 40)

						Standardized coefficients		
Model	**Block**	R^2	**Adjusted** R^2	R^2 **change**	***F* change**	**β**	***t***	**Significance**
I	1	.311	.293	.311	17.160			
	RRI-T					.558	4.143	< .001
	2	.328	.292	.017	.946			
	RRI-T					.479	3.046	.004
	WAI-T					.153	.973	.337
II	1	.160	.138	.160	7.227			
	WAI-T					.400	2.688	.011
	2	.328	.292	.168	9.280			
	WAI-T					.153	.973	.337
	RRI-T					.479	3.046	.004

The RRI-T alone contributes to 31,1% of the outcome, and the WAI-T adds up 1,7% to the model, making a total of 32,8%. By itself, the effect of the RRI-T is very significant (β = .558, t = 4.143, p < .001), and this is still the case with the addition of the WAI-T (β = .479, t = 3.046, p = .004). Meanwhile, the addition of the WAI-T is not significant in the model (β = .153, t = .973, p = .337).

If we place the WAI-T in the first block and the RRI-T in the second, the WAI-T contributes with 16% of the variance of outcome (ΔR^2 = .160, p = .011), and the RRI-T adds up 16,8% (ΔR^2 = .168, p = .004). The effect of the WAI-T is significant by itself (β = .400, t = 2.688, p = .011), but with the addition of the RRI-T it loses its significance (β = .153, t = .973, p = .337). Only the effect of the RRI-T becomes significant, after its addition to the model (β = .479, t = 3.046, p = .004).

Next, we performed another multiple hierarchical regression analysis, where we placed the subscales of the RRI-T in the first block (realism and genuineness), and the subscales of the WAI-T in the second block (goals, task, and bond). Afterwards, we inverted the blocks, so block one contained the goals, task and bond subscales, and block two

contained the realism and genuineness subscales. Table 7 displays the results that we got from these analyses.

Table 7

Multiple Hierarchical Regression Models with COM-T as the Criterion Variable (N = 40)

Model	Block	R^2	Adjusted R^2	R^2 change	F change	Standardized coefficients		
						β	*t*	Significance
I	1	.193	.172	.193	9.099			
	WAI-T Task					.440	3.016	.005
	2	.326	.290	.133	7.300			
	WAI-T Task					.328	2.327	.026
	RRI-T Realism					.381	2.702	.010
II	1	.297	.278	.297	16.028			
	RRI-T Genuine					.545	4.003	< .001
	2	.327	.250	.031	.531			
	RRI-T Genuine					.447	2.524	.016
	WAI-T Goals					-.185	-.602	.551
	WAI-T Task					.351	1.111	.274
	WAI-T Bond					-.027	-.172	.865

The first analysis revealed that the task subscale of the WAI-T and the realism subscale of the RRI-T were the best predictors of outcome (R^2 = .326). The task subscale explains 19,3% and the realism subscale adds up 13,3% to the model. The effect of the task subscale by itself is significant (β = .440, t = 3.016, p = .005). When we add the realism subscale in the model, both variables contribute significantly for the prediction of outcome, although the realism has a higher effect (β = .381, t = 2.702, p = .010).

On the other hand, when we place the RRI subscales in the first block, the one that contributes more to the prediction of outcome is no longer realism but genuineness (R^2 = .297, p < .001), and all the subscales of the WAI together only add up 3,1% to the model. Even after adding up the WAI subscales, the genuineness is still a more significant predictor of outcome (β = .447, t = 2.524, p = .016) than any of the subscales.

Discussion

Our systematic review allowed us to verify the existing correlations between real relationship and working alliance, and confirm their association. Besides working together in Gelso's tripartite model of the therapeutic relationship, their association is also explained by the medium to large correlations present across different studies (e.g., Bhatia & Gelso, 2017; Lo Coco et al., 2011; Owen et al., 2011). But what about the psychometric issue, already proposed by Gelso (2014), where three items of the bond subscale of the WAI tap a personal bond – associated with real relationship –, and only one item concerns the working collaboration? Are the correlations higher because of this?

In this study, we obtained moderate correlations between real relationship and working alliance, in both clients' (r = .517, p < .01) and therapists' (r = .575, p < .01) perspectives. From the clients' perspective we observed a larger magnitude from the bond subscale of the WAI, even higher than the sample's total score (r = .539, p < .01). Kelley et al. (2010) had already reported that the bond element of the working alliance can be easily mistaken with the real relationship.

In a posterior analysis, we used the correlations of the WAI subscales and total score with real relationship, and the correlation from our meta-analysis, to examine if there were significant differences between them. We observed that neither the total score nor the bond subscale of the WAI presented significant differences against the correlation of the meta-analysis; on the other hand, both the goals and task correlations were significantly different from the fixed value. While it makes sense that the total score does not present differences against the overall correlation from the meta-analysis, the bond should not be so close to the overall correlation, nor should the goals and tasks be that different. In fact, this could mean that, if the bond subscale was removed from the measure, probably the overall correlation would be significantly lower. This supports the idea that the items of the bond subscale that concern a personal relationship, instead of a working collaboration, should be eliminated from the WAI (Gelso & Kline, 2019).

Our findings reveal that the bond subscale of the WAI is an important factor in keeping the "sisterhood" between working alliance and real relationship. But it seems like that is its only role. When we want to see how these constructs work in the prediction of outcome, the bond suddenly disappears. Unlike Lo Coco et al. (2011) who detected that client-rated bond added significantly to the prediction of outcome, we did not see any significant contribution from this factor in either perspectives. Like other authors have suggested (Gelso,

2014; Gelso & Kline, 2019; Kelley et al., 2010), we believe that it would be helpful to eliminate the items that tap the personal relationship from the measure.

The systematic review that we conducted previously also confirmed the contribution of both concepts to the outcome of psychotherapy. It showed not only that they contribute differently to outcome but also that, when both of them are taken into account, the real relationship makes more significant contributions to outcome than the working alliance. It was not possible, however, to observe a specific pattern related to the raters of these constructs. Almost two thirds of the studies that we analyzed in our review concerned either the client or the therapist perspective, while the remaining studies observed both perspectives. Even then, it was not clear if the rater perspective could moderate the association between real relationship and working alliance, and their relation to outcome. In this study, we tried to address this matter.

In our empirical study, real relationship and working alliance demonstrated moderate correlations with outcome, for both perspectives. Also, the real relationship was the better predictor of outcome, which is in line with previous studies (Gelso et al., 2005; Fuertes et al., 2007; Marmarosh et al., 2009; Lo Coco et al., 2011). It contributed with almost the double of the variance when considered alone, than the working alliance by itself. The real relationship also added significantly to the working alliance in predicting outcome, but the opposite did not occur. This would suggest that the real relationship does not necessarily need the working alliance to contribute to the outcome of psychotherapy.

When working alliance is considered in the first place, both clients and therapists appear to give a bigger relevance to the tasks that will help with therapy. After adding the real relationship to the model, clients will also emphasize the role of genuineness, while therapists will highlight realism to achieve results. Lo Coco et al. (2011) also observed that client-rated genuineness related significantly to the outcome, when it was measured early in treatment. Marmarosh et al. (2009) found that therapist-rated realism, and not genuineness, accounted for a significant amount of variance in client-rated therapy outcome.

In contrast, when the real relationship was considered first, both clients and therapists acknowledged the genuineness as being enough to predict the outcome. This means that none of the subscales of the WAI – and, therefore, the total score of the WAI – added significantly to outcome. These findings are opposite to the one of Bhatia and Gelso (2017) who concluded that, during the termination phase of therapy, therapists consider the working alliance as the only significant predictor of outcome. Once again, our findings suggest that the real relationship, particularly the genuineness, does not need the working alliance's contribution to

outcome. We could even go further and suggest that the genuineness by itself is a good enough predictor of outcome.

Our empirical findings confirm the already observed tendency that the real relationship contributes more to outcome than working alliance, and that does not depend on the rater, because both of them considered the real relationship as the better predictor. The rater only appears to influence the variables' relationship with outcome when we look closer at their subscales. Therapists believe that a realistic vision of the relationship will help to complete the tasks agreed in therapy, and both factors will contribute to a better outcome. Clients feel that, after considering the real relationship, genuineness will steal the spotlight from the tasks, and become a more important predictor of outcome. Even when looking closer at the constructs' dimensions, the real relationship subscales weigh more than the working alliance subscales.

Conclusion

With this work, we proposed to examine the association between real relationship and working alliance, and confirm their association; and observe how the constructs might predict outcome. In order to achieve our key objectives, we conducted two studies: a systematic review and an empirical study.

In the first one, we reviewed the existing literature on real relationship and working alliance. Our basis was the meta-analysis of Gelso et al. (2019) which compiled nine studies (r = .58). We increased the number of analyzed studies (N = 16), and obtained a slightly larger overall correlation of r = .66 between the constructs. We confirmed the constructs' association, but also that they are different, not only conceptually, but also by contributing differently to outcome. Although not all studies had the same results (e.g., Bhatia & Gelso, 2017), most of the studies that we analyzed indicated that, when considered with working alliance, the real relationship was the better predictor of outcome. This result is not new, but it tells us that maybe we have been giving too much importance to the working alliance, when we should be addressing the real relationship. We could say that it is understandable that this has happened, given the fact that it is easier to work on more concrete dimensions, like goals of therapy and the tasks to achieve those goals, than to work on something that we cannot observe, like being who one truly is and perceiving the other realistically. The real relationship involves personal development, while the working alliance concerns an explicit idea of negotiation between therapist and client. Of course the real relationship is not so easy to address. Therapists still need to familiarize with this construct and work on their capacity to develop a real relationship with their clients. How? Gelso et al. (2018) purpose a few therapist actions that may help to develop a stronger real relationship: to manage countertransference; to share reactions with the client; to explain to the client when not sharing; and to be consistent and constant.

After the findings from our first study, there were still some questions that we felt like were not answered: first, is the high association between real relationship and working alliance related to the bond subscale of the WAI? And second, is the way that the constructs relate to outcome influenced by the rater? To answer these questions we undertook an empirical study.

Our empirical study allowed us to explore the importance of the bond subscale for the association between real relationship and working alliance, something that has been discussed for a few years now (e.g., Kelley et al., 2010). In fact, the bond subscale of the WAI may actually be the key to their strong correlations. Although it is expected for real relationship

and working alliance to be highly correlated, the results from our studies suggest that the elimination of the bond subscale would decrease the magnitude of their association. Like we said earlier, we agree with the suggestions already given by other authors (Gelso, 2014; Gelso & Kline, 2019; Kelley et al., 2010) that the items that reflect a personal relationship of the WAI should be eliminated, and the bond subscale should only have items that pertained to the working collaboration. The correlations between the constructs might be of different magnitudes, and maybe the concerns regarding their overlap would finally be solved.

The results from our empirical study were analyzed considering the rater's perspective (client vs. therapist), and considering not only the overall scores of the measures but also their subscales. Our main finding was that the real relationship was considered, by both clients and therapists, as the better predictor of outcome compared to working alliance. This result is in line with the ones from previous studies (Fuertes et al., 2007; Gelso et al., 2005; Lo Coco et al., 2011; Marmarosh et al., 2009), and shows that the rater does not seem to influence the association of the constructs to outcome. Once again, we suggest that the real relationship should be the focus of more research.

Unlike other studies (e.g., Bhatia & Gelso, 2017; Kivlighan et al., 2016) where only the total scores of the RRI and the WAI were examined in their relation to outcome, ours went a bit further and examined how the subscales of each measure could predict outcome. Both real relationship and working alliance are constructs with different dimensions that contribute to the therapeutic relationship. By observing each of them we can actually focus on what is more relevant for the success of psychotherapy. When considering the real relationship in the first place, genuineness is the dimension that reveals to be more important for both raters. If the working alliance is considered first, both clients and therapists appear to give a bigger importance to the tasks to achieve good results.

Finally, our study also contributed to verify if the raters could influence the predictive value of real relationship and working alliance in the outcome. In our sample, we did not observe a major influence of the raters in the constructs' prediction of outcome. Only when we looked closely at the subscales of each measure did we find a difference: when the working alliance is considered first, both raters give more importance to the tasks of therapy; but after adding the subscales of real relationship, clients feel like genuineness would be more helpful to achieve results. Therapists, on the other hand, think that a realistic vision of the relationship will help to complete the tasks agreed in therapy, and the combination of the two factors will contribute to a better outcome.

We believe that the "sister concepts" are in an adolescent phase of their development (or is the research on these constructs in that phase?), because of the way that each of the constructs relates to the outcome. Like we observed in our empirical study, although real relationship was considered by both raters as the better predictor of outcome, therapists consider realism, and clients consider genuineness, as the most important dimensions of this construct.

The fact that therapists consider realism as a better predictor of outcome, within the real relationship, reminds us of the importance that all therapists try to understand the reality of the client. Although they might not be fully successful in this, because it is not possible to fully understand another human being, he/she must never give up and continually aim to understand the client's reality (Gelso, 2011). How well the therapist manages countertransference will be crucial in trying to understand the client's reality.

A client attributing a more predictive value to genuineness may be expected, considering that the literature on genuineness has focused more on the therapist (Gelso, 2011). Genuineness was first mentioned by Carl Rogers (1957) and it pertained to the therapist being aware of his/her inner experience and the extent to which the therapist's behavior reflected some truly felt aspect of that inner experience. Whereas there is general agreement that the client is expected, at his/her own pace, to share thoughts and feelings, it is still controversial how much and in what way the therapist should share his/her feelings and thoughts with the client (Gelso, 2011).

Despite our findings, we must acknowledge that our studies presented some limitations that need to be addressed. One big limitation concerns the small amount of studies regarding real relationship. Only since 2005, with the validation of the first measure of real relationship, it has been possible to conduct empirical studies on this subject. Obviously this will have an influence in the effect sizes of our meta-analysis.

Another limitation of our study regards our sample. We collected data from 40 client-therapist dyads. First of all, this sample is significantly smaller than the ones collected in other studies on the matter. Also, although clients were all different, there were only six therapists, which most likely have had an influence in our results. Future samples need to be bigger in order to account for more statistically significant results, and accurately represent a clinical sample.

Our clients were all in different stages of therapy, though they all had a minimum of three sessions, like in most studies that we encountered. Also, our study has a cross-sectional design. Considering that relationships are dynamic, and the therapeutic relationship is also

characterized by its ups and downs, we do not know exactly at which part of the relationship "curve" were the dyads from our sample, and if that influenced our data. Future research could compare groups from different phases of therapy in order to observe if the predictive value of real relationship and working alliance is the same in different stages of therapy.

We also did not account for what type of psychotherapy clients were in. Although the tripartite model of the therapeutic relationship is thought to be present across all types of psychotherapies, we could have made this distinction and look for any differences. Since the tasks are usually more associated with cognitive-behavioral psychotherapy, would they have a higher predictive value in this kind of therapy?

Two points need to be considered when it comes to the measures used in this study. First, the measures of real relationship and outcome are not yet validated to the Portuguese population. We completed the procedures for what we consider was a satisfactory translation, the internal consistency was good, and the measure was not influenced by social desirability. Still, we had to eliminate two items from the RRI-C in order to improve its fidelity. Also, even though our sample was small, the real relationship showed a bigger predictive value of outcome when compared to working alliance. We consider necessary to address the validation of this measure, especially after the results of this study.

Secondly, all the measures that we used employ a self-report format. This limits us to understand only the parts of the therapeutic relationship available to the awareness of therapists and clients. With the growing investigation on implicit measures, it would be interesting to develop one that could access the real relationship or working alliance.

Although our focus was to study real relationship and working alliance, truth is transference and countertransference are also part of the tripartite model. Like Gelso (2011) mentions, the phenomenon that they represent is always present in the therapeutic relationship, even if we are talking about cognitive-behavioral therapy. Therefore, they should also be considered when we analyze how the relationship in therapy contributes to the outcome. With that in mind, could the effect of real relationship observed in our study be moderated or explained by other variables? And if so, do these variables concern the client, the therapist, or the overall therapeutic relationship?

References

*Aafjes-van Doorn, K., Békés, V., & Prout, T. A. (2020). Grappling with our therapeutic relationship and professional self-doubt during COVID-19: will we use video therapy again?. *Counselling Psychology Quarterly*, 1-12. https://doi.org/10.1080/09515070.2020.1773404

*Alessi, E. J., Dillon, F. R., & Van Der Horn, R. (2019). The therapeutic relationship mediates the association between affirmative practice and psychological well-being among lesbian, gay, bisexual, and queer clients. *Psychotherapy*, *56*(2), 229-240. https://doi.org/10.1037/pst0000210

Ballard, R. (1992). Short forms of the Marlowe-Crowne social desirability scale. *Psychological reports*, *71*(3_suppl), 1155-1160. https://doi.org/10.2466/pr0.1992.71.3f.1155

*Baumann, E. C., & Hill, C. E. (2016). Client concealment and disclosure of secrets in outpatient psychotherapy. *Counselling Psychology Quarterly*, *29*(1), 53-75. https://doi.org/10.1080/09515070.2015.1023698

*Bhatia, A., & Gelso, C. J. (2017). The termination phase: Therapists' perspective on the therapeutic relationship and outcome. *Psychotherapy*, *54*(1), 76-87. https://doi.org/10.1037/pst0000100

*Bhatia, A., & Gelso, C. J. (2018). Therapists' perspective on the therapeutic relationship: Examining a tripartite model. *Counselling Psychology Quarterly*, *31*(3), 271-293. https://doi.org/10.1080/09515070.2017.1302409

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice*, *16*(3), 252-260. https://doi.org/10.1037/h0085885

*Doran, J. M., Safran, J. D., & Muran, J. C. (2016). The Alliance Negotiation Scale: A psychometric investigation. *Psychological assessment*, *28*(8), 885-897. https://doi.org/10.1037/pas0000222

Eugster, S. L., & Wampold, B. E. (1996). Systematic effects of participant role on evaluation of the psychotherapy session. *Journal of Consulting and Clinical Psychology*, *64*(5), 1020-1028. https://doi.org/10.1037/0022-006X.64.5.1020

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316-340. http://doi.org/10.1037/pst0000172

*Fuertes, J. N., Gelso, C. J., Owen, J. J., & Cheng, D. (2013). Real relationship, working alliance, transference/countertransference and outcome in time-limited counseling and psychotherapy. *Counselling Psychology Quarterly*, *26*(3-4), 294-312. https://doi.org/10.1080/09515070.2013.845548

*Fuertes, J. N., Mislowack, A., Brown, S., Gur-Arie, S., Wilkinson, S., & Gelso, C. J. (2007). Correlates of the real relationship in psychotherapy: A study of dyads. *Psychotherapy Research*, *17*(4), 423-430. https://doi.org/10.1080/10503300600789189

Gelso, C. (2014). A tripartite model of the therapeutic relationship: Theory, research, and practice. *Psychotherapy Research*, *24*(2), 117-131. https://doi.org/10.1080/10503307.2013.845920

Gelso, C. J. (2002). Real relationship: The "something more" of psychotherapy. *Journal of Contemporary Psychotherapy*, *32*(1), 35-40. https://doi.org/10.1023/A:1015531228504

Gelso, C. J. (2009). The real relationship in a postmodern world: Theoretical and empirical explorations. *Psychotherapy Research*, *19*(3), 253-264. https://doi.org/10.1080/10503300802389242

Gelso, C. J. (2011). *The Real Relationship in Psychotherapy: The Hidden Foundation of Change.* (1st ed.). American Psychological Association.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of counseling psychology*, *41*(3), 296-306.

Gelso, C. J., & Johnson, D. H. (1983). *Explorations in time-limited counseling and psychotherapy*. Columbia University Press.

*Gelso, C. J., Kelley, F. A., Fuertes, J. N., Marmarosh, C., Holmes, S. E., Costa, C., & Hancock, G. R. (2005). Measuring the Real Relationship in Psychotherapy: Initial Validation of the Therapist Form. *Journal of Counseling Psychology*, *52*(4), 640-649. https://doi.org/10.1037/0022-0167.52.4.640

Gelso, C. J., Kivlighan Jr, D. M., Busa-Knepp, J., Spiegel, E. B., Ain, S., Hummel, A. M., Ma, Y. E., & Markin, R. D. (2012). The unfolding of the real relationship and the outcome of brief psychotherapy. *Journal of counseling psychology*, *59*(4), 495-506. https://doi.org/10.1037/a0029838

Gelso, C. J., Kivlighan Jr, D. M., & Markin, R. D. (2018). The real relationship and its role in psychotherapy outcome: A meta-analysis. *Psychotherapy*, *55*(4), 434-444. https://doi.org/10.1037/pst0000183

Gelso, C. J., Kivlighan Jr, D. M., & Markin, R. D. (2019). The Real Relationship. In J. C. Norcross, & M. J. Lambert (Eds), *Psychotherapy relationships that work: Volume 1: Evidence-based therapist contributions*, (3rd ed., pp. 351-378). Oxford University Press.

Gelso, C. J., & Kline, K. V. (2019). The sister concepts of the working alliance and the real relationship: on their development, rupture, and repair. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *22*(2), 142-149. https://doi.org/10.4081/ripppo.2019.373

*Gullo, S., Lo Coco, G., & Gelso, C. (2012). Early and later predictors of outcome in brief therapy: The role of real relationship. *Journal of Clinical Psychology*, *68*(6), 614-619. https://doi.org/10.1002/jclp.21860

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy research*, *16*(1), 12-25. https://doi.org/10.1080/10503300500352500

*Hill, C. E., Baumann, E., Shafran, N., Gupta, S., Morrison, A., Rojas, A. E. P., Spangler, P. T., Griffin, S., Pappa, L., & Gelso, C. J. (2015). Is training effective? A study of counseling psychology doctoral trainees in a psychodynamic/interpersonal training clinic. *Journal of Counseling Psychology*, *62*(2), 184-201. https://doi.org/10.1037/cou0000053

*Hill, C. E., Gelso, C. J., Chui, H., Spangler, P. T., Hummel, A., Huang, T., Jackson, J., Jones, R.A., Palma, B., Bhatia, A., Gupta, S., Ain, S. C., Klingaman, B., Lim, R. H., Liu, J., Hui, K., Jezzi, M. M., & Miles, J. R. (2014). To be or not to be immediate with clients: The use and perceived effects of immediacy in psychodynamic/interpersonal psychotherapy. *Psychotherapy Research*, *24*(3), 299-315. https://doi.org/10.1080/10503307.2013.812262

Horvath, A. O., & Bedi, R. P. (2002). The Alliance. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work: Therapist contributions and responsiveness to patients* (pp. 37– 69). Oxford University Press.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work* (2nd ed., pp. 25-69). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199737208.003.0002

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of counseling psychology*, *38*(2), 139-149. https://doi.org/10.1037/0022-0167.38.2.139

*Kelley, F. A. (2015). The therapy relationship with lesbian and gay clients. *Psychotherapy*, *52*(1), 113-118. https://doi.org/10.1037/a0037958

*Kelley, F. A., Gelso, C. J., Fuertes, J. N., Marmarosh, C., & Lanier, S. H. (2010). The Real Relationship Inventory: Development and psychometric investigation of the client form. *Psychotherapy: Theory, Research, Practice, Training*, *47*(4), 540-553. https://doi.org/10.1037/a0022082

*Kivlighan Jr, D. M., Hill, C. E., Gelso, C. J., & Baumann, E. (2016). Working alliance, real relationship, session quality, and client improvement in psychodynamic psychotherapy: A longitudinal actor partner interdependence model. *Journal of counseling psychology*, *63*(2), 149-161. https://doi.org/10.1037/cou0000134

*Kivlighan Jr, D. M., Kline, K., Gelso, C. J., & Hill, C. E. (2017). Congruence and discrepancy between working alliance and real relationship: Variance decomposition and response surface analyses. *Journal of Counseling Psychology*, *64*(4), 394-409. https://doi.org/10.1037/cou0000216

Lenhard, W., & Lenhard, A. (2014). Hypothesis Tests for Comparing Correlations. available: https://www.psychometrica.de/correlation.html. Bibergau (Germany): Psychometrica. DOI: 10.13140/RG.2.1.2954.1367

*Lo Coco, G., Gullo, S., Prestano, C., & Gelso, C. J. (2011). Relation of the real relationship and the working alliance to the outcome of brief psychotherapy. *Psychotherapy*, *48*(4), 359-367. https://doi.org/10.1037/a0022426

*Marmarosh, C. L., Gelso, C. J., Markin, R. D., Majors, R., Mallery, C., & Choi, J. (2009). The real relationship in psychotherapy: Relationships to adult attachments, working alliance, transference, and therapy outcome. *Journal of Counseling Psychology*, *56*(3), 337-350. https://doi.org/10.1037/a0015169

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of consulting and clinical psychology*, *68*(3), 438-450. https://doi.org/10.1037/0022-006X.68.3.438

*Morales, K., Keum, B. T., Kivlighan Jr, D. M., Hill, C. E., & Gelso, C. J. (2018). Therapist effects due to client racial/ethnic status when examining linear growth for client-and therapist-rated working alliance and real relationship. *Psychotherapy*, *55*(1), 9-19. https://doi.org/10.1037/pst0000135

Norcross, J. C. (2011). *Psychotherapy relationships that work: Evidence-based responsiveness.* (2nd ed.). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199737208.001.0001

Norcross, J. C., & Lambert, M. J. (2019). *Psychotherapy relationships that work: Volume 1: Evidence-based therapist contributions.* (3rd Edition). Oxford University Press.

*Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, *48*(3), 274-282. https://doi.org/10.1037/a0022065

Pechorro, P., Vieira, R. X., Poiares, C., & Marôco, J. (2012). Contributos para a validação duma versão curta da Escala de Desejabilidade Social de Marlowe-Crowne com adolescentes portugueses. *Arquivos de Medicina*, *26*(3), 103-108.

*Pérez-Rojas, A. E., & Gelso, C. J. (2020). International counseling students: acculturative stress, cultural distance, and the process of counseling with US clients. *Counselling Psychology Quarterly*, *33*(3), 352-374. https://doi.org/10.1080/09515070.2018.1553145

*Pinto-Coelho, K. G., Hill, C. E., & Kivlighan Jr, D. M. (2016). Therapist self-disclosure in psychodynamic psychotherapy: A mixed methods investigation. *Counselling Psychology Quarterly*, *29*(1), 29-52. https://doi.org/10.1080/09515070.2015.1072496

Ramos, M. A. (2008). *Análise das Características Psicométricas da Versão Portuguesa do Working Alliance Inventory – Short Revised.* [Unpublished master thesis]. Universidade do Minho.

*Shafran, N., Kivlighan, D. M., Gelso, C. J., Bhatia, A., & Hill, C. E. (2017). Therapist immediacy: The association with working alliance, real relationship, session quality, and time in psychotherapy. *Psychotherapy Research*, *27*(6), 737-748. https://doi.org/10.1080/10503307.2016.1158884

Annexes

Annex I – Informed consent

Termo de Informação e Consentimento

1. Responsável pelo tratamento: Ana Marta Vaz e Luís Janeiro

2. Contactos: o responsável pelo tratamento pode ser contactado através do endereço de correio eletrónico a44968@ualg.pt.

3. Categorias de titulares de dados: participantes no estudo de investigação

4. Dados pessoais a tratar: dados de identificação dos participantes no estudo, processados através de meios manuais e informatizados

5. Contexto e finalidade do tratamento: processamento de dados pessoais para efeitos de realização de estudo de investigação académica ou científica com o título "O contributo da Relação Real e da Aliança Terapêutica para os resultados: a perspetiva do cliente e do terapeuta" na Universidade do Algarve

6. Fundamento jurídico: consentimento do titular dos dados pessoais

7. Destinatários: o responsável pelo tratamento procede ao tratamento por si

8. Suportes: os dados pessoais recolhidos serão objeto de posterior anonimização e processamento informatizado

9. Medidas de segurança: estão implementadas todas as medidas consideradas necessárias para garantir a segurança dos dados pessoais recolhidos e dos respetivos suportes de processamento

10. Prazo de conservação: sem prejuízo das situações excecionais de prorrogação do prazo de conservação previstos na lei, os seus dados pessoais são conservados pelo período de 5 anos ou até à retirada do consentimento

11. Direitos do titular dos dados: o titular dos dados tem o direito de solicitar ao responsável pelo tratamento o acesso, a retificação ou o apagamento dos seus dados pessoais, bem como a limitação ou a oposição à participação e a portabilidade dos dados. O titular dos dados tem ainda o direito de, a todo o tempo, retirar o consentimento, podendo sempre exercer, caso assim o considere necessário, o direito de apresentar reclamação à Comissão Nacional de Proteção de Dados (www.cnpd.pt)

12. Endereço para exercício de direitos: para solicitar qualquer informação, apresentar reclamações e pedidos de retirada de consentimento ou requerer o exercício de direitos é favor contactar a44968@ualg.pt

13. Consequências do não consentimento: a participação é voluntária – o titular dos dados não está obrigado a permitir o tratamento dos seus dados, pelo que, não consentindo, não será o mesmo objeto de tratamento por parte do investigador.

☐ Declaro que li o Termo de Informação e Consentimento

Termo de receção de informação e confirmação de consentimento para participação em estudo

☐ Declaro que pretendo participar no estudo de investigação acima identificado e no preenchimento dos respetivos questionários e tarefas, que me foram prestadas as necessárias informações relativamente aos objetivos, termos e condições de funcionamento e ao caráter confidencial do tratamento dos dados, e que as compreendi disponibilizando voluntariamente todos os dados necessários solicitados pelo investigador.

E que, em face das informações aqui prestadas e nos referidos termos e condições:

☐ Aceito participar voluntariamente no estudo conforme a informação prestada.

☐ Não aceito participar voluntariamente no estudo conforme a informação prestada.

Annex II – Client socio-demographic questionnaire

1. **Idade:** ____
2. **Sexo:** F___ M___
3. **Nacionalidade:** _____
4. **Estado civil:** Solteiro___ Casado___ União de facto___ Divorciado___ Viúvo___
5. **Habilitações académicas:**
    a. 1º ciclo do ensino básico ___
    b. 2º ciclo do ensino básico ___
    c. 3º ciclo do ensino básico ___
    d. Ensino secundário ___
    e. Licenciatura ___
    f. Mestrado ___
    g. Doutoramento ___
6. **Profissão: _____**
7. **Motivo para procurar terapia:**

    _____

    _____

    _____
8. **É a primeira vez que está em terapia?** Sim ___ Não ___
    a. **Se não, quantas vezes já tinha estado em terapia antes?**

        _____
    b. **Nas terapias anteriores, o terapeuta é o mesmo que vê atualmente?**

        Sim ___ Não ___
    c. **Se não, com quantos terapeutas já tinha "trabalhado" antes?**

        _____
9. **Considerando a terapia em que se encontra atualmente, quantas sessões já "fez" aproximadamente?**

    _____
10. **Qual a frequência das sessões de terapia?**

    _____

Annex III – Therapist socio-demographic questionnaire

1. **Idade:** ____
2. **Sexo:** F___ M___
3. **Nacionalidade:** _____
4. **Estado civil:** Solteiro___ Casado___ União de facto___ Divorciado___ Viúvo___
5. **Habilitações académicas:**
    a. Licenciatura ___
    b. Mestrado ___
    c. Doutoramento ___
6. **Anos de experiência:** ___
7. ***Setting* terapêutico:**
    a. Clínica privada ___
    b. Centro comunitário de saúde mental ___
    c. Hospital ___
    d. *Setting* universitário ___
    e. Outros ___
8. **Numa escala de 1 (pouco) a 10 (muito), por favor avalie em que medida acredita e adere à teoria e técnicas das seguintes terapias:**
    a. Cognitivo-comportamentais ___
    b. Psicodinâmicos ___
    c. Humanistas ___
    d. Sistémicos ___
    e. Psicanalíticos ___
    f. Integrativos ___
    g. Outras ___

Annex IV – Real Relationship Inventory – Client Form

Inventário de Relação Real - Versão Cliente - Reduzida (RRI-CS; Hill et al., 2014)

INSTRUÇÕES: Por favor, utilize a seguinte escala para avaliar as suas perceções de si mesmo, do seu terapeuta e do relacionamento com o seu terapeuta.

1	2	3	4	5
Discordo fortemente	**Discordo**	**Neutro**	**Concordo**	**Concordo fortemente**

1. O meu terapeuta gosta do meu verdadeiro "eu".	1	2	3	4	5
2. Sou aberto e honesto com o meu terapeuta.	1	2	3	4	5
3. O meu terapeuta parece genuinamente ligado a mim.	1	2	3	4	5
4. O meu terapeuta retrai o seu "eu" genuíno.	1	2	3	4	5
5. Aprecio as limitações e qualidades do meu terapeuta.	1	2	3	4	5
6. Nós não nos conhecemos um ao outro de forma realista.	1	2	3	4	5
7. O meu terapeuta e eu somos capazes de ser autênticos na nossa relação.	1	2	3	4	5
8. O meu terapeuta e eu expressamos um carinho profundo e genuíno um pelo outro.	1	2	3	4	5
9. Tenho uma compreensão realista do meu terapeuta como pessoa.	1	2	3	4	5
10. O meu terapeuta não me vê tal e qual como sou.	1	2	3	4	5
11. Sinto que nos retraímos muito na nossa relação.	1	2	3	4	5
12. Concordo com a ideia que o meu terapeuta tem sobre mim.	1	2	3	4	5

Annex V – Real Relationship Inventory – Therapist Form

Inventário de Relação Real - Versão Terapeuta - Reduzida (RRI-TS; Hill et al., 2014)

INSTRUÇÕES: Por favor, complete os itens seguintes relativamente à relação com o seu cliente.

Utilize a seguinte escala para avaliar cada item:

1	2	3	4	5
Discordo fortemente	**Discordo**	**Neutro**	**Concordo**	**Concordo fortemente**

1. O meu cliente e eu conseguimos ser genuínos na nossa relação.	1	2	3	4	5
2. O meu cliente aprecia o meu verdadeiro "eu".	1	2	3	4	5
3. Sinto que existe uma relação "real" entre nós, além da relação profissional.	1	2	3	4	5
4. O meu cliente e eu somos honestos na nossa relação.	1	2	3	4	5
5. O meu cliente retrai partes significativas de si mesmo.	1	2	3	4	5
6. Não existe uma ligação genuinamente positiva entre nós.	1	2	3	4	5
7. Os sentimentos do meu cliente em relação a mim parecem adequar-se a quem eu sou como pessoa.	1	2	3	4	5
8. Não gosto do meu cliente como pessoa.	1	2	3	4	5
9. É difícil para mim expressar o que verdadeiramente sinto em relação ao meu cliente.	1	2	3	4	5
10. O meu cliente tem uma perceção irrealista sobre mim.	1	2	3	4	5
11. O meu cliente e eu temos dificuldade em nos aceitarmos um ao outro tal como somos.	1	2	3	4	5
12. O meu cliente partilha comigo as partes mais vulneráveis de si mesmo.	1	2	3	4	5

Annex VI – Working Alliance Inventory – Client Form

Inventário de Aliança Terapêutica - Versão reduzida, revista (WAI-SR; Ramos, 2008)

INSTRUÇÕES: Abaixo encontrará afirmações sobre o que uma pessoa pode pensar ou sentir acerca da terapia ou do seu terapeuta. Por baixo de cada afirmação existe uma escala de 5 pontos. Para cada afirmação, considere a sua própria experiência e assinale o número correspondente. Note que a escala de resposta não é a mesma para todas as afirmações. Por favor, leia cuidadosamente e não se esqueça de responder a todas as afirmações.

1. Como resultado destas sessões torna-se para mim mais claro como será possível eu mudar.

1. Raramente 2. Ocasionalmente 3. Muitas Vezes 4. Frequentemente 5. Sempre

2. O que eu faço na terapia permite-me ver o meu problema de novas formas.

1. Raramente 2. Ocasionalmente 3. Muitas Vezes 4. Frequentemente 5. Sempre

3. Acho que o meu terapeuta gosta de mim.

1. Sempre 2. Frequentemente 3. Muitas Vezes 4. Ocasionalmente 5. Raramente

4. O meu terapeuta e eu colaboramos na definição dos objetivos da minha terapia.

1. Raramente 2. Ocasionalmente 3. Muitas Vezes 4. Frequentemente 5. Sempre

5. O meu terapeuta e eu respeitamo-nos mutuamente.

1. Sempre 2. Frequentemente 3. Muitas Vezes 4. Ocasionalmente 5. Raramente

6. O meu terapeuta e eu trabalhamos para objetivos que foram mutuamente acordados.

1. Sempre 2. Frequentemente 3. Muitas Vezes 4. Ocasionalmente 5. Raramente

7. Sinto que o meu terapeuta me aprecia.

1. Sempre 2. Frequentemente 3. Muitas Vezes 4. Ocasionalmente 5. Raramente

8. O meu terapeuta e eu estamos de acordo acerca do que eu preciso de fazer para melhorar.

1. Raramente 2. Ocasionalmente 3. Muitas Vezes 4. Frequentemente 5. Sempre

9. Sinto que o meu terapeuta se preocupa comigo mesmo quando eu faço coisas que ele não aprova.

1. Sempre 2. Frequentemente 3. Muitas Vezes 4. Ocasionalmente 5. Raramente

10. Sinto que aquilo que faço na terapia me ajudará a alcançar as mudanças que eu quero.

1. Raramente 2. Ocasionalmente 3. Muitas Vezes 4. Frequentemente 5. Sempre

11. O meu terapeuta e eu estabelecemos um bom entendimento quanto às mudanças que seriam boas para mim.

1. Raramente 2. Ocasionalmente 3. Muitas Vezes 4. Frequentemente 5. Sempre

12. Acredito que o modo como estamos a trabalhar com o meu problema é correto.

1. Sempre 2. Frequentemente 3. Muitas Vezes 4. Ocasionalmente 5. Raramente

Annex VII – Working Alliance Inventory – Therapist Form

Inventário de Aliança Terapêutica - Versão Reduzida Terapeuta - Revista (WAI-SR; Ramos, 2008)

Instruções: Abaixo encontrará afirmações sobre o que uma pessoa pode pensar ou sentir acerca do seu cliente. Por baixo de cada afirmação existe uma escala de cinco pontos. Por favor leia cuidadosamente e não se esqueça de responder a todas as afirmações.

1	2	3	4	5
Raramente	**Ocasionalmente**	**Muitas Vezes**	**Frequentemente**	**Sempre**

1. O/a meu/minha cliente e eu estamos de acordo acerca das coisas que é necessário fazer em terapia para ajudar a melhorar a sua situação.	1	2	3	4	5
2. Estou genuinamente preocupado com o bem-estar do/a meu/minha cliente.	1	2	3	4	5
3. O/a meu/minha cliente e eu trabalhamos para objetivos que foram mutuamente acordados.	1	2	3	4	5
4. O/a meu/minha cliente e eu temos confiança na utilidade das nossas atividades em terapia.	1	2	3	4	5
5. Aprecio o/a meu/minha cliente como pessoa.	1	2	3	4	5
6. Estabelecemos um bom entendimento quanto às mudanças que seriam boas para o/a meu/minha cliente.	1	2	3	4	5
7. O/a meu/minha cliente e eu respeitamo-nos mutuamente.	1	2	3	4	5
8. O/a meu/minha cliente e eu temos uma perceção comum acerca dos seus objetivos.	1	2	3	4	5
9. Eu respeito o/a meu/minha cliente mesmo quando faz coisas que eu não aprovo.	1	2	3	4	5
10. Estamos de acordo acerca daquilo em que é importante o/a meu/minha cliente trabalhar.	1	2	3	4	5

Annex VIII – Counseling Outcome Measure – Client Form

Medida de Resultados da Terapia (COM; Gelso & Johnson, 1983)

Instruções: Gostaríamos que se recordasse do acompanhamento psicoterapêutico com o/a seu/sua psicólogo/a. Por favor, complete as seguintes questões selecionando o número que melhor reflete a sua resposta. Por favor, não deixe nenhuma resposta em branco.

1	2	3	4	5	6	7
Muito Pior	**Moderadamente Pior**	**Ligeiramente Pior**	**Igual**	**Ligeiramente Melhor**	**Moderadamente Melhor**	**Muito Melhor**

1. Como se sente, neste momento, face ao início da terapia?	1	2	3	4	5	6	7
2. Em que medida houve uma mudança no seu comportamento?	1	2	3	4	5	6	7
3. Em que medida parece compreender-se melhor?	1	2	3	4	5	6	7
4. Classifique a mudança global com o acompanhamento terapêutico.	1	2	3	4	5	6	7

Annex IX – Counseling Outcome Measure – Therapist Form

Medida de Resultados da Terapia (COM; Gelso & Johnson, 1983)

Instruções: Gostaríamos que se recordasse do acompanhamento psicoterapêutico com o/a seu/sua cliente. Por favor, complete as seguintes questões selecionando o número que melhor reflete a sua resposta.

1	2	3	4	5	6	7
Muito Pior	**Moderadamente Pior**	**Ligeiramente Pior**	**Igual**	**Ligeiramente Melhor**	**Moderadamente Melhor**	**Muito Melhor**

1. Como lhe parece que este/a cliente se sente neste momento?	1	2	3	4	5	6	7
2. Em que medida, até ao momento, este/a cliente parece ter feito mudanças no seu comportamento?	1	2	3	4	5	6	7
3. Em que medida, até ao momento, este/a cliente parece ter evoluído em termos de autoconhecimento?	1	2	3	4	5	6	7
4. Classifique a mudança global deste/a cliente durante a psicoterapia.	1	2	3	4	5	6	7

Annex X – Marlowe-Crowne Social Desirability Scale

Escala de Desejabilidade Social de Marlowe-Crowne - Versão reduzida (MCSDS-SF; Pechorro et al., 2012)

Instruções: De seguida, são apresentadas afirmações que refletem atitudes e traços pessoais. Leia cada item e decida se a afirmação é verdadeira ou falsa, no que a si diz respeito.

1. Por vezes, quando não consigo o que quero, fico chateado.	Verdadeiro	Falso
2. Já me aconteceu desistir de fazer certas coisas por pensar que não tinha capacidade para as fazer.	Verdadeiro	Falso
3. Já senti vontade de me revoltar contra as pessoas com mais autoridade do que eu, apesar de saber que elas tinham razão.	Verdadeiro	Falso
4. Ouço sempre com muita atenção todas as pessoas com quem falo, sejam elas quem forem.	Verdadeiro	Falso
5. Já fingi estar doente para me safar de uma situação.	Verdadeiro	Falso
6. Já me aproveitei de outras pessoas para benefício pessoal.	Verdadeiro	Falso
7. Quando cometo um erro estou sempre disposto a admitir que o cometi.	Verdadeiro	Falso
8. Por vezes, tento vingar-me em vez de perdoar e esquecer.	Verdadeiro	Falso
9. Sou sempre simpático, mesmo se as pessoas são mal-educadas para mim.	Verdadeiro	Falso
10. Nunca me aborreci quando as pessoas tinham ideias contrárias às minhas.	Verdadeiro	Falso
11. Houve alturas em que tive bastante inveja da boa sorte dos outros.	Verdadeiro	Falso
12. Por vezes, fico irritado com as pessoas que insistem em me pedir favores.	Verdadeiro	Falso
13. Nunca disse coisas para magoar os sentimentos de outra pessoa.	Verdadeiro	Falso