SERÁ A RELAÇÃO TERAPÊUTICA SUFICIENTE? O PAPEL DE TAREFAS E RUTURAS EM PSICOTERAPIA

(IS THE THERAPEUTIC RELATIONSHIP ENOUGH? THE ROLE OF TASKS AND RUPTURES IN PSYCHOTHERAPY)

Pedro Rodrigues Ribeiro

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Dissertação submetida como requisito parcial para obtenção de

Doutoramento em Psicologia

Especialidade: Psicologia Clínica

2026

Dissertação apresentada para cumprimento dos requisitos necessários à obtenção do grau de Doutor em Psicologia, na área de especialização em Psicologia Clínica, realizada sob a orientação de David Dias Neto, apresentada no ISPA - Instituto Universitário no ano de 2026.

Em memória de Alzira dos Anjos Lameiras Rodrigues

e Anacleto José Rodrigues, aqueles que me ensinaram o papel da relação

O vosso amor permanecerá no meu coração

Agradecimentos

Nos últimos 12 anos, tenho tido o privilégio de trabalhar com homens, mulheres e crianças, cujas circunstâncias da vida os leva sentir a necessidade de apoio e auxílio para uma mudança na sua vida. Tive então a oportunidade de estar em relação, poder ser um companheiro de viagem num percurso de transformação. Como digo a todos eles, fazer esta viagem requer força e todos aqueles que transcendem estas barreiras são seres humanos cheios de recursos e de uma enorme resiliência. Carrego dentro de mim, todos os dias, a minha admiração, a vossa história e todos os momentos passados em relação. O meu agradecimento a todos.

À Dra. Graça Tavares, cujo trabalho e qualidade de relação terapêutica salvaram a minha vida e mostraram-me como poder fazer o mesmo por outros.

Ao Ispa-Instituto Universitário, cujas paredes e encontros relacionais abriram-me as portas para o meu amor pela Psicologia.

À Associação Portuguesa de Terapias Comportamentais, Cognitivas e Integrativas, por me mostrarem quem é o psicoterapeuta e como ele deve estar em relação com o outro. Obrigado por fazerem de mim uma melhor pessoa e melhor profissional.

Ao Dr. João Faria e Prof. Dr. António Branco Vasco, pessoas que moldaram a forma como estabeleço as minhas relações terapêuticas. A vosso apoio e supervisão fez-me crescer e sentir confiança em mim e no outro para, em conjunto, chegarmos a uma experiência emocional corretiva.

À Sociedade Portuguesa de Terapia Focada nas Emoções, por me mostraram o valor das emoções na relação. Aprendi que o psicoterapeuta é acima de tudo um ser humano e que o contacto relacional começa como sendo isso mesmo: pessoa, real e autêntico.

A Applied Psychology Research Center Capabilities & Inclusion, por me terem recebido de braços abertos e terem sido a minha "casa de investigação", durante estes 6 anos. Agradeço todo o apoio e as oportunidades de partilha.

Aos meus amigos, aqueles que tiveram sempre uma palavra de apoio, em particular nos vários momentos desafiantes.

À Ana Rafaela Quina e Tomás Vicente, pela ajuda e por acreditarem no valor deste trabalho.

Aos meus colegas desta viagem de doutoramento: Ana Filipa Santos, Ana Carina Valente, Margarida Jarego, Laura Maciel, Ana Daniela Aleixo, Bárbara Pereira e Vasco Costa. O meu muito obrigado.

À Rita Sebastião, cujas palavras são escassas para descrever toda a amizade, carinho e apoio ao longo destes 6 anos. Se cheguei até aqui, em muita parte foi por ti.

Ao meu orientador Prof. Dr. David Dias Neto, pelo ser humano, profissional e professor que é. Cresci como pessoa e profissional em todos os nossos encontros e mesmo quando senti que o estava a desapontar, esteve sempre presente. Sem si, isto não seria possível.

Ao maior amor, a minha mãe. A relação mais importante que tenho na minha vida.

Palavras-Chave:

Psicoterapia; Relação Terapêutica; Técnicas; Ruturas

Keywords:

Psychotherapy; Therapeutic Relationship, Techniques; Ruptures

Categorias de Classificação da tese

3300 Health & Mental Health Treatment & Prevention

3310 Psychotherapy & Psychotherapeutic Counseling

ABSTRACT

Research shows that the therapeutic relationship consistently has a moderate, positive impact on the efficacy of psychotherapy and on change. However, there is ongoing discussion about the association between the relationship and techniques in the change process, with evidence that techniques have a positive impact on both the process and the relationship. At the same time, we see an increase in the influence of identifying and repairing ruptures as a relational task and a contribution to the quality of the relationship and the efficacy of therapy. The purpose of this work is to determine whether the therapeutic relationship is sufficient and to examine the roles of techniques and ruptures in the therapeutic process, thereby expanding theoretical and empirical knowledge.

In the first study, we propose a different view of the Therapeutic Relationship by integrating the Real Relationship, Therapeutic Alliance, and Client's Attachment to Therapist in a sample of 373 adults in individual therapy. Using an exploratory principal components analysis, the results show a five-component structure, illustrating different patients' needs and perspectives on the relationship, as well as the therapist's perceptions of the relationship and their interactions with patients. We conclude with implications for research and clinical practice.

In the second study, we question the role and weight of techniques in the Therapeutic Alliance, in individual therapy. Based on the literature, we conducted a systematic review analyzing 53 articles, organized by specific therapeutic strategies and their relative weight in the alliance. Results show a total of 37 techniques: 14 had a positive impact on the alliance's effect size, and 23 didn't affect the alliance's effect size, illustrating that techniques can affect the alliance and the process outcome. We conclude with implications for research and clinical practice.

In the third study, we proceeded with the analysis of a 19-session brief intervention with an adult patient in individual therapy in a case study context. Using a reflexive thematic analysis methodology, this analysis is grounded in our perspective on the therapeutic relationship and in the identification and repair of ruptures in the alliance. The results show themes related to the patient's specific needs, the therapist's techniques, and a set of alliance ruptures, indicating a good partnership throughout the intervention and an openness and flexibility to repair ruptures in the relationship. We conclude with implications for research and clinical practice.

The contributions of these studies and works allow us to say that, regarding therapeutic process and change, the therapeutic relationship influences the change in interaction with techniques and rupture repair. We conclude with suggestions for the next steps that, ultimately, can contribute to enhancing therapists' training and research in the field of psychotherapy.

RESUMO

A investigação demonstra que a relação terapêutica tem apresentado consecutivamente um impacto moderadamente positivo na eficácia de psicoterapia e na mudança. No entanto, existe uma contínua discussão acerca da sua relação com técnicas, no contexto global de um processo de mudança, havendo evidências que técnicas apresentam um impacto positivo no processo de mudança, assim como na relação. Ao mesmo tempo, assiste-se ao aumento da influência de identificação e reparação de ruturas, tanto como tarefa relacional, quer como contributo para o aumento da qualidade da relação e da eficácia de terapia. Este trabalho pretende perceber se a relação terapêutica é suficiente e qual o papel de técnicas e ruturas, no processo de psicoterapia, contribuindo para o aumento do conhecimento teórico e empírico.

No primeiro estudo, propomos uma visão diferente da Relação Terapêutica, integrando a Relação Real, a Aliança Terapêutica e a Vinculação do Cliente ao Terapeuta, com base em uma amostra de 373 adultos em terapia individual. Por meio de uma análise de componentes principais exploratória, os resultados mostram uma estrutura de cinco componentes, ilustrando diferentes necessidades e perspetivas de pacientes quanto à relação e à forma como o terapeuta pode percecioná-la e as suas interações. Concluímos com implicações para a prática clínica e contexto de investigação.

No segundo estudo, questionamos o papel e o peso das técnicas na Aliança Terapêutica em processos de terapia individual. Com base na literatura, realizamos uma revisão sistemática, analisando um total de 53 artigos, organizados em categorias específicas de estratégias terapêuticas e de seu peso na aliança. Os resultados mostram um total de 37 técnicas, onde 14 apresentaram um impacto positivo no efeito da aliança terapêutica e 23 não apresentaram qualquer impacto no efeito da aliança, ilustrando que técnicas podem ter um impacto na aliança e no resulto do processo. Concluímos com implicações para a prática clínica e investigação.

No terceiro estudo, procedemos à análise de uma intervenção breve de 19 sessões, com um paciente adulto, em terapia individual, num contexto de estudo de caso. Usando uma metodologia de análise temática reflexiva, a análise parte dos pressupostos teóricos da nossa perspetiva de relação terapêutica e identificação e reparação de ruturas na aliança. Os resultados indicam o surgimento de temas remetentes a necessidades específicas do paciente, o uso de técnicas pelo terapeuta e um conjunto de ruturas na aliança, ilustrando uma boa aliança terapêutica ao longo das sessões, bem como uma abertura e flexibilidade para a resolução dessas ruturas na relação. Concluímos com implicações para a prática clínica e investigação.

Os contributos decorrentes destes estudos permitem-nos dizer que, no que diz respeito ao processo terapêutico, a relação terapêutica influencia a mudança em interação com as técnicas e reparação de ruturas. Concluímos com sugestões para próximos passos que podem, em última instância, contribuir para a melhoria do treino de terapeutas e da investigação em psicoterapia.

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Chapter 1

Introduction

Introduction

Psychotherapy is a complex theoretical field that has sparked ongoing debate amongst researchers. On the one hand, we established psychotherapy's efficacy by developing therapeutic models for specific interventions and testing them, demonstrating their effectiveness in achieving symptom remission, thought modification, emotion regulation, and even behavior change. We provided a list of therapeutic models, such as cognitive-behavioral therapy, that serve as the "goal standard" for psychotherapy efficacy, as we continuously develop new models. In the latest edition of "Handbook of Psychotherapy Integration", Norcross and Alexander (2019) list 500-plus models of therapy, while Prochaska and Norcross (2014) analyze 15 significant therapy systems. On the other hand, several researchers defend what is known in the psychotherapy literature as the "Dodo Bird Verdict". Inspired by Lewis Carroll's novel Alice in Wonderland, this verdict holds that unrecognized factors in any therapeutic situation may be even more important than the intervention's theoretical framework, and that these factors are what make the intervention successful (Rosenzweig, 1936). If so, every model can be effective, and efficacy is explained by something beyond theory or technique. Later known as the common factors, this approach aims to identify the core ingredients of change that all therapies share, which are now considered the primary "signal" elements of treatment (Omer & London, 1993). Despite years of research, hundreds of therapeutic models, and a list of evidence-based practices for effective interventions for different conditions, the debate still endures, as one side defends that specific models and their components achieve efficacy, and the other side defends that common factors are more important and enough to ensure efficacy and therapeutic change.

Therapeutic Relationship

One of the most popular and researched common factors is the therapeutic relationship. Across all forms of therapy, the therapeutic relationship has consistently been one of the strongest predictors of efficacy in psychotherapeutic change (Fluckiger et al., 2019). In fact, the therapeutic relationship has been centered on integrative approaches, such as the Contextual Model (Wampold & Imel, 2015), which holds that the effectiveness of psychotherapy is unrelated to the specific ingredients and that relationship factors will account for much of the variability in outcomes. If one adheres to the Contextual Model, one may believe that a large part of therapeutic effectiveness lies in the relational aspect.

Before further exploring the therapeutic relationship, it is important to define what we actually call it. The therapeutic relationship has been defined as the feelings and attitudes that therapist and patient have toward one another, and the ways these are expressed (Gelso & Carter, 1985, 1994). Both sides then create the relationship—the therapist and patient(s)—within the context of therapy, where the interaction of feelings and their expression (clearly, unclearly, directly, or indirectly) or withholding is used to facilitate change. Even now, this definition has been used as a consensual view of the relationship for different task forces on the effectiveness of therapeutic interventions (Norcross & Lambert, 2019).

Despite Gelso and Carter's work and advances in defining the therapeutic relationship, some questions were raised about how this definition was used. The most relevant criticism came from Hill (1994), specifically addressing how feelings were expressed in the relationship. In response to Sexton and Whiston's (1994) empirical review of the status of the counseling relationship, Hill stated that the lack of narrowing down the various ways of expressing feelings between the therapist and patient can condition the investigation of the complex interactions that might occur. Hill further differentiates the therapist's in-session contribution (interventions, experience) from the client's in-session contribution (tasks, experience) and the interaction between therapist and client (including the therapeutic relationship). Regarding the relationship, Hill (1994) also considers it important that it includes the communication patterns between participants, as well as the nonbond aspects of the specific rules and behaviors that two people negotiate for how they choose to be together. Although recognizing the validity of Hill's position, Gelso and Carter (1985) reinforce that the manner of expressing what is felt and perceived is a necessary part of any relationship definition.

To further enhance the "messiness" of the therapeutic relationship, we need to consider what we include and exclude as elements that establish it. Norcross and Lambert (2019), in their latest revision for the APA's Task Force on Evidence-Based Psychotherapy Relationships, included as part of the therapeutic relationship the therapeutic alliance in individual therapy, cohesion in group therapy, the Rogerian facilitative conditions, collection of real-time patient feedback, repairing alliance ruptures, facilitating emotional expression, and managing countertransference. We begin to realize that the therapeutic relationship is a complex, multidimensional entity in which different relational constructs can coexist and intertwine.

The Tripartite Model of the Therapeutic Relationship

One of the first — and arguably the most significant— attempts to establish a working model of the therapeutic relationship is the Tripartite Model of the Therapeutic Relationship. Developed by Charles Gelso, this model sought to provide a structure for the development and operationalization of the therapeutic relationship, based on the clinical theories of Ralph Greenson (1967). The refinements made by Gelso, elaboration, and the precise definition of key constructs allow the model to transcend its psychodynamic roots and achieve greater scientific merit. Thus, the model could be applied to all psychotherapy relationships, regardless of the therapist's orientation (Gelso, 2014).

This model consists of three interlocking elements: a real relationship, a working alliance, and a transference configuration (the patient's transference and the therapist's countertransference). As stated before, each of these components is theorized to be important to diverse theoretical perspectives and is present from the first moment of contact between therapist and patient, sometimes even before contact in the form of fantasies of the therapist or the patient to be (Gelso, 2014). These elements are interrelated and function separately, each influencing the others and the process and outcome. So, all elements are simultaneously present in the relationship, in the context of therapy, even when one element is more salient at a given time. First, we will explore each element and then how they relate to one another.

Real Relationship

Initially developed by Ralph Greenson (1967), the real relationship is considered the most fundamental relational concept in this model (Gelso, 2014). According to Gelso (2014), all therapeutic relationships have a real relationship component, and thus, the real relationship is universal to all forms of therapy. Recent research on the real relationship defined it as *the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that benefit the other* (Gelso, 2011; Gelso, 2014; Gelso et al., 2005; Gelso & Samstag, 2008). With this definition, it is suggested that the real relationship has two elements: Genuineness and Realism. Gelso and his colleagues improved this concept to include the extent to which genuineness and realism exist in the relationship (magnitude) and the extent to which they are positive or negative (valence). The resulting magnitude and valence will give us an index of the strength of the real relationship; both being positive would indicate a stronger real relationship.

Despite the real relationship appearing in one form or another at the beginning of psychoanalysis (Freud, 1937, 1964), it was only in the early decades of the twentieth century that many analysts began to explore the concept (Gelso, 2011). However, the real relationship did not escape controversy or criticism, namely, the reality aspect. For Horvath (2009), the term *real* can be problematic for two main reasons: first, the relationship requires an unavoidable phenomenological reality for those who experience it, and signaling this aspect may imply that other relational aspects are different. Second, from a philosophical standpoint, there can be ambiguities about what we consider "real," stemming from Plato and Nietzsche. Gelso's proposition compares the concept of "real" with the notion of "fit", implying that it is constructed as realistic and that the perception of the other is consistent with that person's self-definition (Horvath, 2009). Regarding the manner in which the patient perceives the therapist, Horvath (2009) also questions this aspect, pointing out flaws in the criteria if the therapist's self-perception is somehow distorted, and so both views do not fit.

Research indicates a meaningful relation between the real relationship and session outcome (Bhatia & Gelso, 2013; Eugster & Wampold, 1996; Gelso et al., 2005), treatment progress and outcome (Ain & Gelso, 2008, 2011; Fuertes et al., 2007; Gelso et al., 2012; LoCoco, Gullo, Prestano, & Gelso, 2011; Marmaros et al., 2009; Owen, Tao, Leach, & Rodolfa, 2011), especially when comparing with the working alliance, where the real relationship seems to make a more substantial contribution to session and treatment outcome variance (Bathia & Gelso, 2013; Fuertes et al., 2007; Lo Coco et al., 2011; Marmarosh et al., 2009). These advances were possible following the development of convenient, sound, and psychometrically valid measures from therapists' (Gelso et al., 2005) and clients' (Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010) perspectives.

Working Alliance

According to the tripartite model, the working alliance is a catalyst for psychotherapy to get done. As noted by Greenson (1967), the real relationship is part of all human encounters, and the working alliance is an artifact of psychotherapy, with the sole reason for its existence being to allow the work of therapy. The alliance emerges from the real relationship, infused by transference, and mainly composed of realistic perceptions.

Gelso and Carter (1994) defined the working alliance as *"the alignment or joining together of the reasonable self or ego of the client and the therapist is analyzing or 'therapizing' side for the work"* (p. 297). For Gelso (2011), the joining of the patient's and

therapist's reasonable sides allows each to observe, understand, and do the work of therapy in the face of many emotional obstacles and resistances that impinge on virtually all forms of therapy.

Despite the alliance's rich history and evolution, the work of Lester Luborsky and Edward Bordin has been crucial to its development and has gone beyond its psychodynamic roots. Luborsky (1976) proposed a two-phase development of the alliance: “Type I” and “Type II”. In a “Type I” alliance, the patient develops a belief in the therapist as a strong source of help, provided through a warm, supportive, and caring relationship, representing a secure holding for the beginning of the work in therapy. In a “Type II” alliance, the patient invests and has faith in the therapeutic process, sharing ownership of it. This representation of the alliance enabled application across all forms of treatment (Ribeiro & Neto, 2025).

Bordin’s perspective (1975, 1979, 1989, 1994), the one in Gelso’s consideration of the working alliance, is a collaborative stance in therapy, between therapist and patient, centered on three components: agreement on the therapeutic goals, consensus on the tasks that make up therapy, and a bond between the patient and therapist (Ribeiro & Neto, 2025). For Gelso (2014), the focus is on the *working* aspect of the alliance, contrasting it with the therapeutic alliance, which seems to address the overall relationship. This focus also allows us to differentiate the working alliance from other components not directly linked to a working collaboration. In a meta-analysis of 190 independent alliance-outcome ratings (Horvath, Del Re, Flukiger, & Symonds, 2011), the results indicated a moderate, stable median correlation coefficient of .28 across a wide range of treatments, supporting the idea that alliance is a pantheoretical concept (Gelso, 2014).

Transference-Countertransference Configuration

The last part of the tripartite model is the basis of psychoanalytic theory and also the beginning of the concepts of relationship and alliance. Regarding transference, there are controversies over its definition, ranging from classical psychoanalytic views, which are more totalistic, to more relational/self-psychological views, which are more inclusive of patient reactions. In this model, transference is viewed as the patient’s experience and perceptions of the therapist that are shaped by the patient’s own psychological structures and past, involving carryover from and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully to and in earlier significant relationships (Gelso & Hayes, 1998; Gelso & Bhatia, 2012). In a review of 16 qualitative and quantitative studies that

examined transference from nonanalytic therapies or in samples of therapists with diverse theoretical orientations, Gelso and Bhatia (2012) concluded that transference "indeed happens in nonanalytic therapies, and it does not seem to happen much less than in analytic therapies. The content of transference is also essentially the same in nonanalytic and analytic therapy, and transference does not appear to be an artifact of the analytic therapist. That is, it is not simply created by the therapist's belief in its existence. Lastly, transference is likely to show itself, perhaps increasingly [as treatment progresses], whether or not the therapist attends to it." (p. 387).

Countertransference has also been surrounded by controversy over its definition, as well as by the totalistic view that the therapist's transference encompasses all his reactions, rather than by the classic definition of the therapist's transference as the patient's transference. To integrate both views, Gelso and Hayes (2007) proposed that countertransference can be defined as *"the therapist's internal and external reactions that are shaped by the therapist's past and present emotional conflicts and vulnerabilities"* (p. 25). As for its presence in nonanalytic interventions, Hayes et al. (1998) found that eight expert therapists identified countertransference in fully 80% of their total of 127 brief therapy sessions, one patient per therapist, even when the above-described integrative definition was used.

A different look at the relationship

While acknowledging the pantheoretical proposal of the tripartite model of the therapeutic relationship, especially the real relationship and the working alliance, we also have to point out the difficulties of the transference-countertransference configuration. Not only are the definitions of the concepts not entirely consensual, as Gelso (2014) pointed out, but these components may be stronger and more prominent in a treatment such as psychoanalysis than in nonanalytic treatments, such as cognitive-behavioral therapy (Gelso, 2011), regarding how and if other interventions deal with the transference-countertransference configuration, a relational construct such as attachment seems to be more pantheoretical.

Initially developed by John Bowlby (1969), attachment theory explains the behavioural and emotional responses that bind young children to their caregivers. It explains reactions to separation and loss (Bowlby, 1973) and the development of emotional attachment after infancy (Bowlby, 1977; Ainsworth, 1989; Mallinckrodt, Gantt, and Coble, 1995). Later

studies identified three attachment patterns: secure, anxious-ambivalent, and anxious-avoidant (Ainsworth et al., 2014). These early attachment experiences become internalized, shaping the child's development of self and expectations from others (Bowlby, 1977; Bretherton, 1985), and are confirmed in future research (Egeland & Farber, 1984; Egeland & Sroufe, 1981), as working models involving beliefs about whether they are worthy of care and help from others, versus being unworthy of help and comfort (Ribeiro & Neto, 2025).

These working models and attachment system continues to influence adult social relationships (Hazan & Shaver, 1994; Cobe, Gantt, and Mallinckrodt, 1996), and are activated in any close, intimate relationships that evoke the potential for love, security, and comfort, which can include friendship, kinship, romantic relations, and the therapeutic relationship (Ainsworth, 1989; Ribeiro & Neto, 2025). Thus, the therapeutic relationship offers the possibility for the patient to re-experience and re-enact a primary attachment, including certain aspects of an old, unsatisfactory relationship with the therapist. This enactment opens the possibility for the therapist to gain a better understanding of the patient's working models and to help bring them to consciousness so they can be challenged and changed (Sperling & Lyons, 1994).

In a meta-analysis by Mallinckrodt and Jeong (2015), 1051 patient-therapist dyads were surveyed across 13 studies, examining the patient's attachment relationship to the therapist, using the Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, and Coble, 1995), and also the results of three other meta-analyses were taken into account, two associated client attachment to the therapeutic alliance (Bernecker et al., 2013; Diener & Monroe, 2011) and one with therapy outcome (Levy et al., 2011). In general, the results showed that pre-therapy patient anxiety was significantly associated with CATS Preoccupied attachment, CATS Secure attachment is associated with a positive therapeutic alliance and two other studies regarding the Real Relationship showed a positive association with CATS Secure, negatively associated with CATS Avoidant, and not significantly related to CATS Preoccupied (Fuertes et al., 2007; Moore & Gelso, 2011). Gelso (2013) recognizes that attachment theory relates to the Real Relationship and facilitates change in that "it is likely curative in itself and of itself, as several studies now suggest (Gelso, 2011, 2014), and it benefits the patient by the provision of an image of an attachment figure who is different from the transference-based Internalized Working Model." (p. 1166). We can hypothesize that the inclusion of attachment theory into the therapeutic relationship is more transtheoretical

than the transference-countertransference configuration, especially in nonanalytic interventions.

The relation between the Therapeutic Relationship and Techniques

The place of techniques in the psychotherapy process has always been a source of discussion and debate. Advocates of the common factors approach dismiss the importance of techniques, elevating the role of factors and processes that are transtheoretical to all treatments and interventions. Advocates for evidence-based practices emphasize the importance of techniques associated with interventions shown to be more effective for specific pathologies. Years of psychotherapy research have sought to clarify this and other questions about what accounts for psychotherapy outcome, and the best answer we have can be found in the work of the Third Interdivisional Task Force on Evidence-Based Relationships and Responsiveness (Norcross & Lambert, 2019). This task force offered two tentative models to explain what accounts for psychotherapy outcomes, averaging across thousands of outcome studies and hundreds of meta-analyses, while considering the percentages as crude empirical estimates and not as exact numbers (Norcross & Lambert, 2019)

The first model, summarized in Figure 1, estimates the percentage of variance in psychotherapy outcomes as a function of therapeutic factors, drawing on decades of research data without being formally extracted from meta-analytic methods.

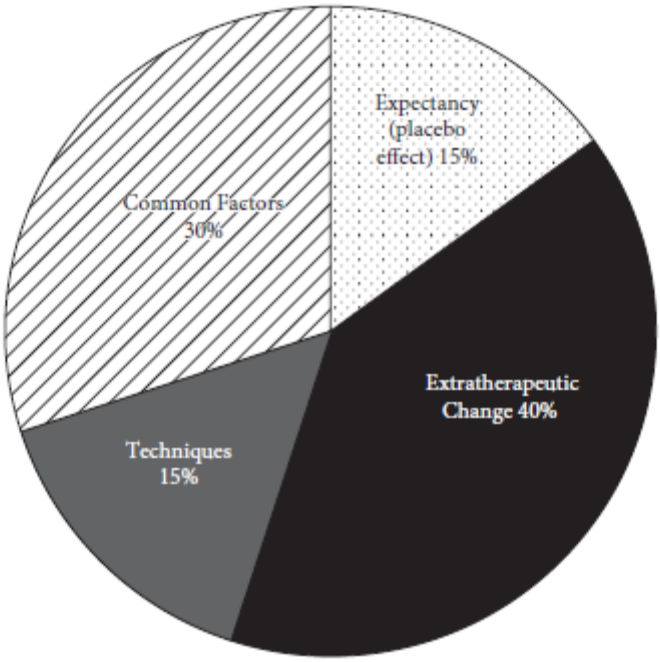

Figure 1 - Percent of improvement in psychotherapy patients as a function of therapeutic factors (Norcross & Lambert, 2019)

In this model, we see a significant percentage attributed to the patient's contributions to change outside of therapy, such as self-change, spontaneous remission, social support, and fortuitous events. Common factors accounting for roughly 30% of the change are those found in the therapeutic relationship. Not far behind are techniques, which account for roughly 15% of the change in process outcome.

A second model, summarized in Figure 2, was elaborated to account for all outcome variance in psychotherapy, starting with the unexplained variance, which decreases the amount of variance attributable to other factors.

In this second attempt, it is estimated that the patient accounts for approximately 30% of the variance, the therapeutic relationship accounts for 15%, and the treatment method, including techniques, accounts for 10%. To be sure, psychotherapy research has difficulty accounting for all the variation in success, since we are talking about a complex human activity (Norcross & Lambert, 2019). Nevertheless, it is interesting to note that the therapeutic relationship and techniques show slight variance. In fact, the second model brings them even closer together in explaining process outcomes, with Norcross and Lambert (2019) concluding that the therapeutic relationship generally accounts for at least as much of the variance in psychotherapy success as the treatment method (including techniques).

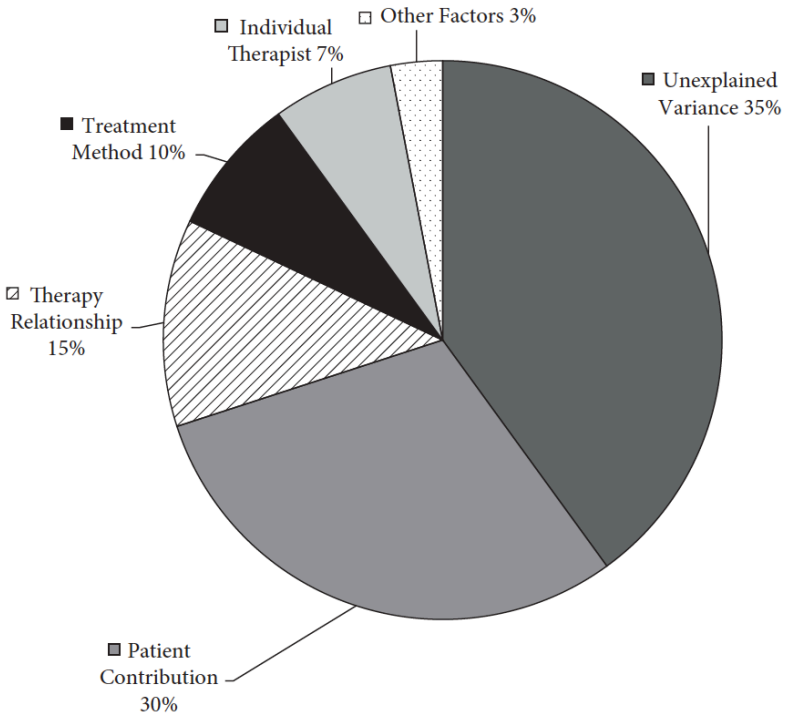

Figure 2 – Percent of psychotherapy outcome attributable to therapeutic factors (Norcross & Lambert, 2019)

When defining the therapeutic relationship, Gelso (2019) noted that, for the relationship to be meaningful, the key construct from which to differentiate is the therapist's technique. In defining the therapist's technique, Gelso describes it as the operations therapists use to move treatment forward and bring about change. These operations or techniques generally emanate from the therapist's theory and practice of psychotherapy, as well as from the therapist's approach to bringing about constructive change in the patient (Gelso, 2019). Harper and Bruce-Sandford (1981) defined techniques as tools or methods therapists use to facilitate effective therapy and positive behavior change in clients. For Safran and Muran (2003), techniques are associated with Bordin's tasks component of the alliance, being specific, overt, or covert activities that the patient must engage in to benefit from treatment. Regarding specificity, some techniques or tasks are central to psychotherapy models and their interventions. For example, in classical psychoanalysis, the patient is required to free-associate by saying whatever comes to mind without censoring. In cognitive therapy, an important task may involve homework and behavioral assignments between sessions. An essential task in Gestalt therapy requires the patient to engage in a dialogue between two different parts of the self (Safran & Muran, 2003). Techniques are typically considered part of a unique theory of psychotherapy, though, to a

degree, different from other theories, although through different forms of integration, certain forms of therapy use techniques from other theoretical models (e.g., a cognitive-behavioral therapist using a Gestalt empty-chair task).

It is recognized that, in practice, technical and relational aspects constantly interact and influence one another in a synergistic relationship. The techniques the therapist uses, and the manner in which he uses them, influence the unfolding relationship. At the same time, the therapist's feelings towards the patient will profoundly affect the techniques he chooses and the manner in which they are used (Gelso, 2019).

For Hill (2005), techniques, patients' involvement, and the therapeutic relationship are intertwined and need to be considered together in any discussion of the therapeutic process. Therapists tend to use different techniques for different intentions, and patients respond differently to different techniques/intentions (Hill et al., 1988). In this sense, techniques can set the tone for therapy and help patients explore problems, gain new insights, and determine what to do differently in their lives. Also, although various techniques could be helpful at any given time, the chosen technique will help to shape the direction and course of therapy.

Therapeutic techniques can be operationalized by type or content (e.g., reflection of feelings, interpretation, challenge, paradoxical intervention), by verbal versus nonverbal expression, and by the way they are implemented (e.g., level of empathy, warmth, and genuineness), and the quality of the technique (e.g., appropriate timing, matching the needs of the patients). They are discrete verbal and nonverbal therapist interventions, as well as the manner and quality in which they are presented (Hill, 2005).

The relationship between therapeutic techniques and the therapeutic relationship, in terms of therapeutic change processes, has been quite different, and this difference can be explained by the vision each primary therapeutic model holds of techniques and the relationship. Early psychoanalytic therapy emphasized technique over relationship, focusing on the therapist's neutrality, in which therapeutic change occurred through the development of transferential reactions toward the analyst and the analyst's subsequent accurate interpretations (Goldfried & Davila, 2005). Behavior therapy placed primary emphasis on developing techniques in which the therapist would actively and deliberately create conditions that would enable the patient to learn new ways of functioning. In this way, the relationship was considered less important as a primary vehicle of change, and the therapist's primary function was that of a "social reinforcement machine" (Krasner, 1962). In more contemporary applications of

behavioral or cognitive-behavioral therapy, the primary goal is for patients to learn more effective coping skills for life problems, with Beck's cognitive approach considered more relational, in which the therapeutic relationship serves as the context for effectively employing techniques (Goldfried & Davila, 2005). Rogers (1951) gave a greater emphasis on the therapeutic relationship over technique, maintaining that it was the therapist's affirmation of the patient that produced therapeutic change: "the client moves from experiencing of himself as an unworthy, unacceptable, and unlovable person to the realization that he is accepted, respected, and loved, in this limited relationship with the therapist…as the client experiences the attitude of the acceptance which the therapist holds toward him, he can take and experience this same attitude toward himself" (pp, 159-160).

What does research show us? Both the therapeutic relationship and technique contribute to the change process. In a study conducted by Persons and Burns (1985), the technique consisted of challenging maladaptive automatic thoughts believed to be associated with depressed mood. The results indicated that the technical intervention improved mood and that mood changes were also associated with the quality of the therapeutic relationship. In a study of cognitive therapy for depression (Burns & Nolen-Hoeksema, 1992), it was found that patients' perception of therapist empathy was associated with outcome, but homework compliance was as well. Cognitive-behavioral therapists maintain that techniques can enhance the therapeutic relationship, such as the effective use of relaxation. For Elliot et al. (2004), experiential techniques can be "viewed as building on and deepening an alliance" (p.142). A review conducted by Ackerman and Hilsenroth (2003) concluded that the technique can have an impact on the alliance, where exploratory strategies can enhance the bond between therapist and patient (Bachelor, 1991), such as accurate interpretation (Crits-Christoph, Barber, & Kurcias, 1993) and reflection, listening, and advising (Sexton, Hembre, & Kvarme, 1996).

Ruptures, Rupture Repair, and the Therapeutic Relationship

Besides the close interplay between technique and relationship, there is a supporting claim that the construction of the therapeutic relationship itself is a technique. Elliott (2004) describes the formation of the alliance as a therapeutic task in the same way that other experiential techniques, such as the two-chair dialogue, are therapeutic tasks. As Safran and Muran (2003) described: "The process of relating to the therapist in an authentic and organismically grounded fashion (common to both existential and relational psychoanalytic approaches) can be thought of as yet another therapeutic task" (p. 13). To view the therapeutic

relationship as a technique in itself, several authors focus on the most operationalized part of the relationship, the working alliance. This allows for the emergence of what is considered second-generation relationship research: rupture and its repair.

Identifying and repairing ruptures is a crucial relational task that can enhance therapy outcomes (Alldredge et al., 2021; Bengardi et al., 2025; Eubanks et al., 2018; Eubanks, 2022; Hogenhaug et al., 2024; Mahon, 2023; Muran et al., 2023). Ruptures have been associated with numerous terms, including breaches, breakdowns, challenges, derailments, deteriorations, dissociations, disturbances, disruptions, dysfluencies, failures, impasses, misalliances, misattunements, miscoordinations, misunderstandings, and resistances (Muran et al., 2023). Additionally, ruptures have been linked to other constructs, including enactments, negative process, projective identification, transference-countertransference, and vicious circles (Muran, 2019). They can be defined as any disagreement regarding how the patient and therapist work together (tasks) and to what end (goals), as well as a deterioration in the therapeutic bond (Safran & Muran, 2000, 2006). This definition is based on Bordin's (1979) pantheoretical perspective on the alliance, which opens the door to considering it an integrative variable or common factor (Wampold & Imel, 2015; Wolfe & Goldfried, 1988). While this definition can represent an explicit account of alliance ruptures, we can also implicitly define alliance ruptures, taking into account Bordin's (1979) intersubjective view of the alliance, involving an interaction of the respective subjectivities of the patient and the therapist (Muran & Eubanks, 2020; Safran & Muran, 2000), as breakdowns in how patients and therapists negotiate their respective needs.

As ruptures can be viewed as specific interpersonal behaviors, Muran and colleagues distinguished between withdrawal and confrontation markers (Muran & Eubanks, 2020; Safran & Muran, 2000; Samstag et al., 2004). Withdrawal markers include movements away from another person, towards isolation, going silent, pivoting away to discuss another topic, or speaking in abstract terms. Additionally, it may involve movements away from certain aspects of oneself to appease the other, going along to avoid conflict. Hence, withdrawal markers are movements aimed at preserving relatedness, rather than severing bonds at the expense of self-definition (Muran et al., 2023). Confrontation markers include movements directed at another person that involve control or aggression, such as criticism or manipulation. Confrontation markers are aimed at promoting agency, ignoring one's impact on another, at the expense of communion. These markers, withdrawal and confrontation, can

be seen in either patient or therapist behavior (Muran et al., 2023), emerging within a specific context, specifically the therapeutic relationship, which is co-constructed between the therapist and patient, representing interpersonal dynamics. Also, ruptures can be conceptualized as intrapersonal markers, emotional states that indicate empathic failures, interpersonal pulls, enactments, or power plays. These experiences can be important sources of information for therapists, in which they can use their emotional internal experience to guide their understanding of their patient and basic self-conscious emotional experiences, such as anxiety, anger, guilt, shame, despair, boredom, competitiveness, and seduction (Muran & Eubanks, 2020).

Rupture repair or resolution has evolved as a critical change process or change mechanism (Castonguay et al., 2019; Norcross & Lambert, 2019). Recently, Muran and colleagues developed a typology of strategies for rupture resolution, drawing on clinical, empirical, and practical literature (Muran & Eubanks, 2020; Safran & Muran, 2000). Three possible pathways were defined, beginning with some acknowledgment, implicit or explicit, by the therapist, the patient, or both, and ending with some new relational or corrective experience (Castonguay & Hill, 2012). These models are intended to be representational because the repair process is complicated.

The first two pathways are categorized as *immediate* strategies, as they involve immediate responses to the rupture and corrective actions to normalize the therapeutic process. The third pathway is categorized as an *expressive* strategy, involving the exploration of the rupture and the patient's and therapist's respective contributions, leading to clearer expression and recognition of implicit needs (Muran et al., 2023).

These pathways can intersect; efforts to reattune (pathway 1) are present in efforts to renegotiate a task or goal (pathway 2) and to explore a rupture experience (pathway 3). Efforts to renegotiate (pathway 2) can include some exploration (pathway 3), and efforts to explore (pathway 3) can result in renegotiation (pathway 2) (Muran et al., 2023). Pathway 1 involves validations of feelings or intentions, explaining a position ("What I really mean is…"), correcting a misunderstanding ("Now I understand what you are saying by…"), or supporting the truth value of an experience ("It makes sense for you to feel that way with me right now…"). These answers can recognize a feeling, redress a misattunement, resulting in reattunement. These efforts were described as *alliance-building strategies*, used in building a good alliance, consistent with what is defined in Tronick's (2007) dyadic system models, with

relevance for creating resilience for misunderstanding and optimism for (re)connection to another, challenging and correcting beliefs and expectations that another cannot understand one person. Pathway 2 involves renegotiating tasks and goals or making any necessary changes to the work or its direction. Muran and colleagues (2021) developed a rational model with three tracks for this work of renegotiation, informed by cognitive-behavioral therapy experts and task analysis (Greenberg, 2007). In track A, the therapist detects a disagreement and establishes an agreement on an alternative. The therapist can modify a task to increase the patient's agreement. In track B, the therapist clarifies an internal obstacle (thoughts or feelings) or an external obstacle (behavioral or circumstantial) that prevents the patient from completing a task or achieving a goal, and explores and establishes an alternative (Muran et al., 2023). In track C, the therapist moves from clarifying negative feelings to explaining the rationale for the work before establishing agreement on the original task or goal (Muran et al., 2023). Pathway 3 involves rupture exploration, including contributions from both the therapist and the patient, their states (thoughts and feelings), and their behavioral actions (disclosures and avoidances), toward a greater understanding of implicit needs. As such, the rupture marks an entry point to the patient's and therapist's relational world.

The most emphasized technical principle for the therapist's rupture repair is *metacommunication* (Kiesler, 1996; Safran & Muran, 2000), defined as communicating about the communication process as it unfolds. Therapists can initiate this process by making observations or questions about the patient's experience, the interpersonal field, or the therapist's experience. Metacommunication has also been described as *mindfulness-in-interaction*, bringing bare attention to therapist and patient states and actions in the here and now. Muran and Eubanks (Muran, 2019; Muran & Eubanks, 2020) suggested the potential of metacommunication to regulate the therapist's and the patient's emotions by putting words to experience and promoting awareness of their own and the other's subjective experiences. It is also a means of mutual recognition of both subjectivities and of resolving the dialectical tension experienced as they each negotiate their needs for agency and communion (Muran, 2019; Muran & Eubanks, 2020).

Aims and scope of the present research

Throughout this introduction and literature review, our purpose was not only to convey the importance of the therapeutic relationship in psychotherapy, but also to highlight the lack of agreement on the roles of therapeutic processes, especially the therapeutic

relationship and techniques. As noted by Goldfried (2005), change principles, such as the relationship or techniques, lend themselves to easier categorization as technique- or relationship-driven. Thus, therapeutic change is better understood as the ways in which each change process facilitates these more general principles. When we adopt this perspective, the question we must ask is: how do they act to produce therapeutic change? At the same time, research on identifying and repairing ruptures in the alliance, as a relational task, has demonstrated an impact on therapeutic change; in each case, the repairing of ruptures is positively correlated with a strong alliance and good process outcome(Eubanks et al., 2018; Muran, 2019; Safran et al., 2011).

There is still an ongoing debate on the role of the therapeutic relationship as a common factor (Miller, Chow, Malins, & Humble, 2023; Wampold & Imel, 2015), advocating for the "Dodo Bird Verdict" and its validity as the cause for therapeutic change and the equal efficacy of all therapeutic approaches. Others, like Chambers (2002), advise caution for the total acceptance of the "Dodo Bird Verdict" when considering the exclusion of many types of patients (e.g., children and adolescents), and treatment conditions, such as obsessive-compulsive disorder. Beutler's perspective on the "Dodo Bird Verdict" is that it is extinct. In one of his examples, Beutler and colleagues (2000) inspected the individual contributions of initial patients' qualities with comorbid depression and chemical abuse problems. The results showed that each process (patients' qualities, placebo effect, specific techniques, and the therapeutic relationship) was equally important in predicting treatment benefit.

The main questions this research seeks to answer are: Is the Therapeutic Relationship enough? What are the roles of Techniques and Ruptures in psychotherapy?

To answer these questions, we first dive into the understanding of the therapeutic relationship, specifically the interaction of relational constructs, the Real Relationship, the Therapeutic Alliance, and the Client's Attachment to the Therapist, to offer a different and integrative perspective of the Therapeutic Relationship. Then, we sought to understand the role of techniques in the therapeutic alliance and their potential impact on the alliance and on process outcomes. Our final goal was to observe how the techniques and the therapist's ability to identify and repair ruptures affect the therapeutic relationship within a brief therapeutic intervention.

With this research, we intend to contribute to this debate, not only with the possibility of having a different view of the therapeutic relationship, but also to try to clarify the position of the therapeutic relationship, driven versus technique-driven, or even a synergy between the therapeutic relationship and techniques. It is also our intention to demonstrate the difficulties of conducting psychotherapy research, where methodologies such as mixed-methods research designs are a more realistic approach for analyzing *how* processes of change function, while accounting for emerging research limitations.

Dissertation structure

The present dissertation is organized into two chapters. The second chapter comprises three papers, and the second chapter shall consist of one paper. Each paper presents a different methodological study conducted during the doctoral work and highlights a specific contribution to the dissertation as a whole.

The second chapter investigates the therapeutic relationship, the relationship with techniques, and their place in the therapy outcome. In the first study, we proposed a different theoretical perspective on the therapeutic relationship, supported by the real relationship, therapeutic alliance, and the client's attachment to the therapist. This study was carried out with a Portuguese sample of adults with experience in individual therapy, regardless of the therapy model. The results, from the patient's perspective, led to the creation of a five-factor model that expresses the patient's needs regarding the therapeutic relationship and the therapist. This study was published under the following reference: Ribeiro, P. R., & Neto, D. D. (2025). Therapeutic Relationship Through the Lenses of the Real Relationship, Therapeutic Alliance, and Attachment to the Therapist: In Search of a Synthesis. *Counselling and Psychotherapy Research*, *25*(1), e12894. https://doi.org/10.1002/capr.12894. The second study is an additional study linked to the first, in which we adapted the Real Relationship Inventory – Client Version into a Portuguese version. This study was carried out with a Portuguese sample of adults with experience in individual therapy. The results showed good internal consistency and acceptable adjustment, presenting the same factorial structure as the original version. This study was published with the following reference: Rodrigues Ribeiro, P., & Dias Neto, D. (2023). The real relationship: The Portuguese version of the *Real Relationship Inventory-Client* form. *Research in Psychotherapy: Psychopathology, Process and Outcome, 26*(2). https://doi.org/10.4081/ripppo.2023.678. In the third study, we intended to understand the role of techniques in the therapeutic alliance and their weight in the alliance

and therapy outcome. To answer these questions, a systematic review was conducted, analyzing quantitative studies of therapy that included descriptions of the techniques used and measurements of the therapeutic alliance. A protocol was developed, placed in the Open Science Framework, and registered in PROSPERO. The results of the final analysis of 53 studies indicated that techniques could have either a positive effect on the alliance or no significant effect at all. No adverse effects of the techniques on the therapeutic alliance or outcome were found. This study was submitted with the following reference: Ribeiro, P. R., Sebastião, R., Almeida, M., Castro, C., Sardinha, E., & Neto, D. N. (2025). The Influence of Psychotherapy Tasks on the Therapeutic Alliance: A Systematic Review and Realistic Synthesis [manuscript submitted for publication].

The third chapter investigates how this theoretical perspective of the relationship, techniques, and rupture-repair interacts in clinical settings. In the fourth study, we conducted a case study of a brief therapeutic intervention with an adult patient. Nineteen sessions were audio-recorded and transcribed. A reflexive thematic analysis was conducted to understand which relational needs emerged from patients towards the therapist and the relationship, and which techniques the therapist used and their influence on the relationship. The Rupture Resolution Rating System was used to identify which ruptures would emerge, from whom they would emerge, and whether the therapist could identify and repair them. Results show the emergence of three main themes and four subthemes. Results also showed more confrontation-type ruptures, equally distributed between patient and therapist. However, the therapist did not proceed with the expected intervention to repair ruptures, which did not appear to affect the course of the therapeutic alliance or the therapeutic relationship, suggesting that the therapist's presence and responsiveness were essential to the development of a strong and secure relationship. This study was submitted with the following reference: Ribeiro, P. R., & Neto, D. D. (2025). The Interplay of a Integrated Therapeutic Relationship Framework and Intervention: Insights from a Reflexive Thematic Analysis Case Study [manuscript submitted for publication].

Figure 3 shows the schematic representation of the present dissertation and the positioning of the chapters.

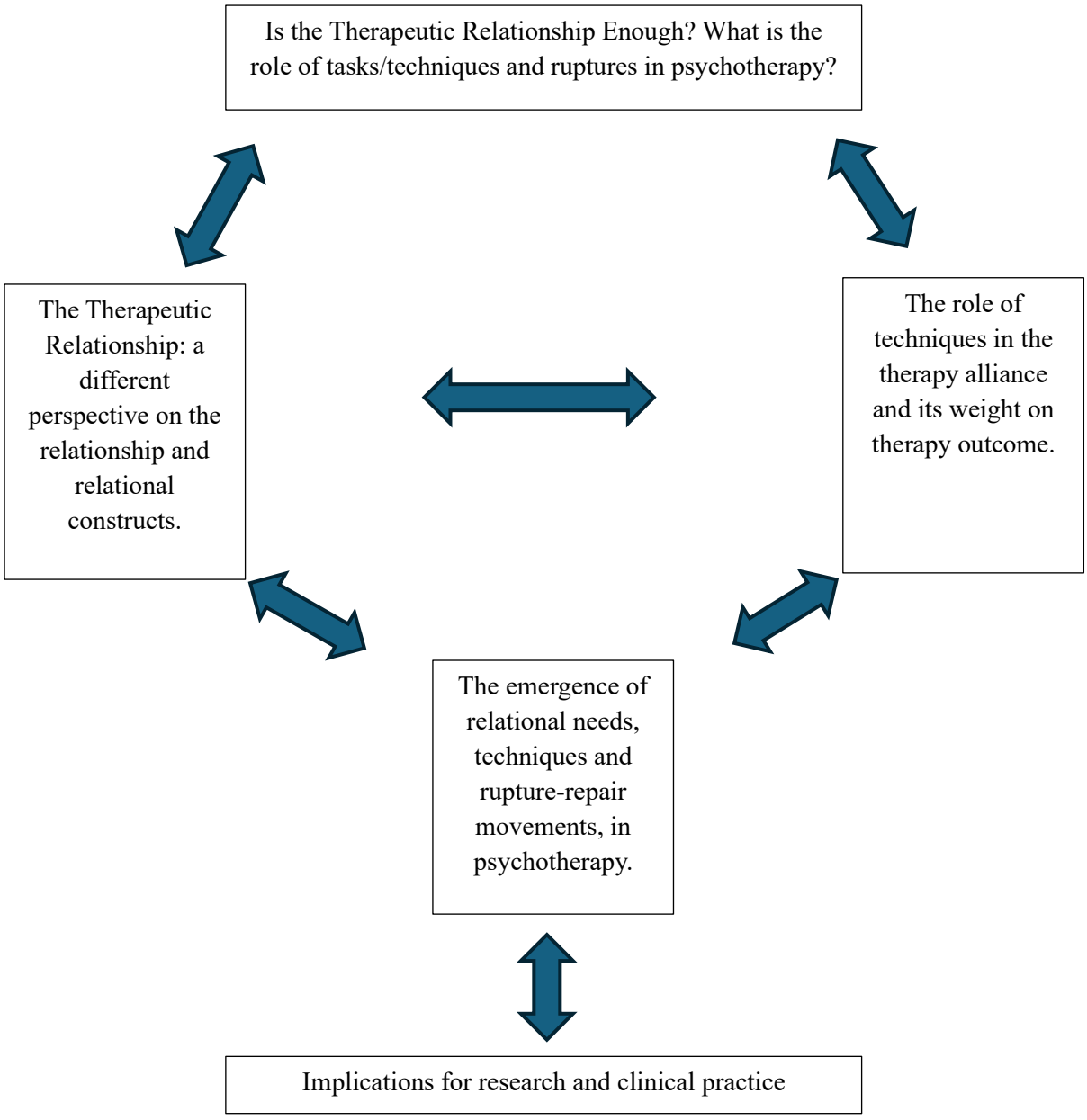

Figure 3 – Schematic representation of the present dissertation and positioning of the research chapters/studies

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Chapter 2

Therapeutic Relationship: The Relation with Techniques

This chapter is based on the papers:

Rodrigues Ribeiro, P., & Dias Neto, D. (2023). The real relationship: The Portuguese version of the *Real Relationship Inventory-Client* form. *Research in Psychotherapy: Psychopathology, Process and Outcome, 26*(2). https://doi.org/10.4081/ripppo.2023.678

Ribeiro, P. R., & Neto, D. D. (2025). Therapeutic Relationship Through the Lenses of the Real Relationship, Therapeutic Alliance, and Attachment to the Therapist: In Search of a Synthesis. *Counselling and Psychotherapy Research*, *25*(1), e12894. https://doi.org/10.1002/capr.12894

Ribeiro, P. R., Sebastião, R., Almeida, M., Castro, C., Sardinha, E., & Neto, D. N. (2025). The Influence of Psychotherapy Tasks on the Therapeutic Alliance: A Systematic Review and Realistic Synthesis [manuscript submitted for publication].

The real relationship: the Portuguese version of the *Real Relationship Inventory-Client* form

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ABSTRACT

The Real Relationship is a relational construct that has influenced other constructs, like the working alliance, although empirically neglected. The development of the Real Relationship Inventory provides a reliable and valid way of measuring the Real Relationship in research and clinical applications. This study aimed to validate and explore the psychometric properties of the Real Relationship Inventory Client Form with a Portuguese adult sample in the context of psychotherapy. The sample includes 373 clients currently in psychotherapy or concluded recently. All clients completed the Real Relationship Inventory (RRI-C) and the Working Alliance Inventory. The confirmatory analysis revealed the same two factors in the RRI-C for the Portuguese adult population, Genuineness and Realism. The observation of the same factor structure suggests the cross-cultural value of the Real Relationship. The measure demonstrated good internal consistency and acceptable adjustment. A significant correlation was found between the RRI-C and the Working Alliance Inventory and significant correlations between the Bond and Genuineness and Realism subscales. The present study reflects on the RRI-C while also contributing to the importance of the Real Relationship in different cultures and clinical contexts.

Key words: real relationship; therapy relationship; real relationship inventory; alliance.

Introduction

Psychotherapy is a multidimensional and complex process in which the relationship between therapist and client plays an important role (Barkham & Lambert, 2021; Norcross, 2019). The therapeutic relationship has consistently accounted for as much, and probably more, of the outcome variance as particular treatment methods (Norcross, 2019). The therapeutic relationship can be defined by the feelings and attitudes the therapist and client have toward one another and how these are expressed (Gelso & Carter, 1985, 1994). Research has been focusing on other relational constructs and the dichotomy transference/countertransference. As noted by Gelso (2011), the real relationship, among all the relational constructs, has been the most empirically neglected possibly because of the lack of reliable and valid ways to measure it.

Real relationship: a brief review

As emphasized by Gelso & Carter (1985, 1994) and by Gelso & Hayes (1998), the modern transtheoretical definition of the real relationship has been *the personal relationship between therapist and patient marked by the extent to which each is genuine with other and perceives/experiences the other in ways that befit the other* (Gelso, 2009, p. 119). The basis for the real relationship can be traced to the beginning of psychoanalysis when *not every relation between an analyst and his subject during and after analysis was to be regarded as transference; there were also friendly relations which were based on reality and proved to be viable* (Freud, 1937). From Anna Freud's perspective, the real relationship was seen as the counterpoint to transference, meaning a realistic involvement of each participant in perceiving and experiencing the other in ways that befit the other, rather than through transference (Freud, 1954).

Another aspect of the real relationship was referred to by Ralph Greenson (1967), and it concerns the genuineness of the analytic dyad, where the analyst and patient can be themselves in the relationship rather than holding back or being artificial. With a focus on realism and genuineness, Greenson's views seem to be connected by humanistic/experiential therapies that placed congruence or genuineness as the central treatment point (Gelso et al., 2019; Pearls, 1969; Rogers, 1957). Current thoughts and research consider this conception of realism and genuineness crucial for understanding the real relationship (Gelso, 2014; Wampold & Budge, 2012). Gelso sustained that the strength of the real relationship should not vary

according to the therapist's theoretical orientation, supporting the current focus of the real relationship as being transtheoretical, applying to all theoretical orientations in psychotherapy (Gelso, 2009, 2011; Gelso & Carter, 1985, 1994; Gelso & Silberberg, 2016; Wampold & Budge, 2012).

Both therapist and patient contribute to the real relationship. From the therapist's perspective, direct self-disclosure of thoughts, feelings, and information, but also the therapist's sense of humor, attire, office decoration, facial expressions, body posture, and the like, enables the patient to build an image of the therapist as a person. Also, the therapist contributes to the strength of the real relationship by being genuine and real and perceiving/experiencing the patient as they are instead of a projection based on the therapist's past and present unresolved conflicts (Gelso et al., 2019).

From the patient's perspective, the enacting role contributes to forming and developing the real relationship, which is built and strengthened by the patient getting in touch with inner experiences and through both verbal and non-verbal exploration and communication that shows who they genuinely are (Gelso et al., 2019).

The real relationship is then presented from the first contact between therapist and patient, perceived as immediate, probably to varying degrees (Couch, 1999; Gelso, 2009, 2011, 2014; Greenson, 1967). It is suggested that as the therapeutic relationship deepens, the strength of the real relationship increases throughout the work (Gelso, 2014).

Since the real relationship is a relational construct, it seems related to others such as the working alliance. Gelso (2014) has theorized that the real relationship and the working alliance are highly interrelated concepts. Initially, the most significant difference established by Greenson (1967) and Gelso (2014) between the real relationship and the working alliance is that, while the real relationship is more foundational, the working alliance is seen as an artifact of treatment, with the sole purpose of getting the work accomplished.

Bordin's pantheoretical view of the working alliance (1975,1989, 1994) based on Greenson's (1965) and Rosenzweig's (1936) ideas, was a collaborative stance in therapy supported by 3 components: agreement on the therapeutic goals, consensus on the tasks that make up therapy, and a bond between the client and the therapist (Flückiger *et al*., 2019). The bond established in the working alliance is a working bond, a connection between therapist and client that reflects directly on their therapeutic work (Gelso, 2014, 2011). Whenever either the therapist or the client feels a connection to the other on a person-to-person basis or feels liking

or caring for the other as a person, the bond resides in the real relationship, thus there is an overlapping between the working alliance and the real relationship (Gelso *et al*., 2019).

Research supports that when therapists rate the working alliance and the real relationship, they are found to be moderately correlated, but each adds unique aspects to the session prediction and treatment outcome (Bathia & Gelso, 2013; Fuertes *et al*., 2007; Gelso *et al*., 2005; Lo Coco *et al*., 2011; Marmarosh *et al*., 2009). When clients do the rating, the real relationship and working alliance are highly related (Fuertes *et al*., 2007; Kelley *et al*., 2010; Lo Coco *et al*., 2011; Marmarosh *et al*., 2009; Owen *et al*., 2011).

Although the correlation value may suggest that these constructs might be the same, from a client's perspective, Kelley *et al*. (2010) found that the relationship was substantially stronger for the bond subscale than for the agreement on goals and tasks sub-scales (Gelso, 2014).

Measuring the real relationship

The measurement of the real relationship has only been conducted in recent years since no reliable instrument had been created before 1990 (Gelso *et al*., 2019). Eugster and Wampold (1996) developed the first measure of the real relationship. It consisted of a patient-rated, 8-item scale of the therapist' and patient's real relationship. It assesses patients' feelings and reactions toward their therapists, and their therapist's perceptions, feelings and reactions toward them (Gelso *et al*., 2019).

At the same time, Eugster and Wampold (1996) developed a therapist-rated scale with the same 8-item for the therapist and patient's real relationship. These items focused more on the genuineness and liking elements, with little attention to the realism element (Gelso *et al*., 2019). Eugster and Wampold (1996) and Kelley *et al*. (2010) found modest internal reliability, with Cronbach's a coefficients ranging from the .60s to mid .70s., and significant correlations with several other measures expected to be associated, providing support for the constructs and convergent validity.

Since then, quantitative research on the real relationship has been done using 2 measures specifically developed: the real relationship inventory-therapist version (RRI-T; Gelso *et al*., 2005) and the real relationship inventory-client version (RRI-C; Kelley *et al*., 2010). While the RRI-T measures the therapist's perception of the real relationship, the RRI-C measures the client's perceptions (Gelso *et al*., 2019).

The RRI-C is a 24-item self-report questionnaire with a 5-point Likert scale (strongly agree-strongly disagree). According to the psychometric study by Kelley *et al*. (2010), this inventory consists of 2 dimensions of 12 items each, representing genuineness and realism. This inventory can be used to assess the client's perception of the real relationship, regardless of the theoretical model of psychotherapy. In this study, the responses of 187 adult clients were accessed and correlated with the working alliance inventory (WAI). As expected, the bond scale of the WAI was found to be significantly more highly correlated with the RRI than the task and goals scales.

After the initial study of the RRI, Hill *et al*. (2014) presented an abbreviated version of 12 items, with 6 items in each scale, realism, and genuineness. Because of high internal consistency and inventory completion time, the items that better represented the 2 measures were chosen. The short-version is correlated with the RRI-C (.91) and further studies demonstrated its reliability and validity (Kivlighan *et al*., 2017).

Present study

Research shows that the therapeutic relationship generally accounts for at least as much as the treatment method in terms of successful psychotherapy (Norcross, 2019). Measures that can access different theoretical dimensions of the therapeutic relationship are essential for psychotherapy research and informed clinical applications. Although Portuguese adaptions for measuring the working alliance are available (Machado & Horvath, 1999; Paixão & Nunes, 2008; Ramos, 2008), measurements for the real relationship are still lacking. This study aims to provide a Portuguese version of the RRI-C (Kelley *et al*., 2010) and contribute to further the understanding of relational concepts, such as the real relationship. We will explore the psychometric properties of the Portuguese version by confirming his factorial structure. Also, we intend to demonstrate convergent validity with the working alliance.

Methods

Participants

This study was conducted in Portugal, with a convenience sample of 373 participants. Recruitment was done online and from societies and associations of psychotherapy. Inclusion criteria were: 18 years or older, participating or having completed individual psychotherapy. Participants were primarily female (*n*=326). The mean age was 36.7 (SD=9.2), aged range between 20 and 70. 93% of the participants were undergraduates and graduates from university, 6.2% concluded high school and 0.8% finished middle school. 64.6% were on psychotherapy.

The main reasons for seeking psychotherapy were family difficulties, professional difficulties and personal development. 26% were diagnosed with a mental diagnosis. The most frequent mental diagnoses were anxiety disorders and depression. Regarding the main models of psychotherapy, 96 (25.8%) indicated Psychodynamic/Psychoanalytic Therapy, 79 (21.2%) indicated Cognitive-Behavioral Therapy, and 33 (8.9%) indicated Psychoanalysis. Sample characteristics are described in Table 1.

Table 1. Sample characteristics of the participants (N=373).

Variable	Frequency	Percentage
Gender		
Female	326	87.4
Male	47	12.6
Age		
20	1	0.3
>20-30	110	29.5
>30-40	144	38.6
>40-50	82	22
>50-60	28	7.5
>60-70	4	1.1
Education		
University Undergraduates	16	4.3
University Graduates	331	88.7
High School	23	6.2
Middle School	3	0.8
Psychotherapy		
Where in process	241	64.6
Family difficulties	73	19.6
Relational difficulties	111	29.7
Personal difficulties	160	42.9
Mental diagnosis	63	26
Anxiety disorders	38	10.2
Depression	30	8
Psychotherapy models		
Psychodynamic/psychoanalytic	96	25.8
Cognitive behavioral	79	21.2
Psychoanalysis	33	8.9

Instruments

Real relationship inventory-client version

RRI-C (Kelley *et al*., 2010) comprises 24 items consisting of statements on how the client perceives the relationship with the therapist, with a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Along with the global score of the relationship, RRI-C has two subscales: realism and genuineness. Items nº 3, 6, 8, 12, 14, 21, 22, and 24 are reversedscore. Internal consistency analysis indicates the RRI-C α=.88, realism α=.84, and genuineness α=.88. In the present study, the total score (α=.91) showed high internal consistency and all the subscales showed good internal consistency: realism (α=.82); genuineness (α=.86). Additional psychometric properties of the RRI-C will be presented in the *Results* section.

Working alliance inventory-short form

The working alliance inventory-short form [(WAI-S), Tracey & Kokotovic, 1989; Machado & Horvath, 1999 (Portuguese version)] consists of a short version of 12 items of the original 36 items version statements on how the client perceives the therapeutic alliance with the therapist, with a 7-point Likert scale from 1 (never) to 7 (always). Along with the global score of the alliance, the WAI-S also has three subscales: bond, tasks, and goals. Items nº 3, 5,

6, 7, 9, and 12 were reversed-scored. In the present study, the total score (α=.91) showed high internal consistency and all the subscales showed acceptable to good internal consistency: bond (α=.78); tasks (α=.84); goals (α=.86).

Procedure

Ispa – Instituto Universitário's Ethical Committee approved the present study (Nº D-052-06-22). Permission was sought and obtained from Charles Gelso for the Portuguese adaptation of the RRI-C. The RRI-C (Kelley et al., 2010) was translated by one of the authors and retro-translated back to English by an experienced psychotherapist proficient in English. Despite language differences, the item's meaning is maintained because of the in universal qualities of relational constructs and cultural similarities in Western countries. Semantic, idiomatic, experiential and conceptual equivalence was achieved as best as possible. Following Beaton et al. (2000), a pretest was made with 10 participants who had previously experienced a psychotherapy process. Each participant's remarks were taken into consideration for further enhancements. A group of expert psychologists were consulted so cross-cultural equivalence could be achieved.

Data was collected online through the Qualtrics platform. All participants signalled their informed consent, which was anonymous and voluntary. The order of application of the instruments was as follows: socio-demographic variables, RRIC and WAIS-S. The study was disseminated *via* social networks and Portuguese associations of psychotherapy.

Data analysis

We verify the factorial structure of the RRI-C, following a similar strategy to the one adopted by Kelley *et al*. (2010) using confirmatory factorial analysis. The adjustment quality of the factorial model was evaluated according to indexes with empirical statistical support (Marôco, 2014), specifically: Chisquare of adjustment ($\chi 2/df$); Tucker-Lewis index (TLI>.90); comparative fit index (CFI>.90); root mean square error of approximation (RMSEA). Finally, we performed convergent validity analysis, referring to the analysis of scales constituting the same or an identical construct, and so it is expected that these measures present positive and high correlations between them (Marôco, 2014). For this study, we explore the correlation between the RRI-C and WAI-S, using Pearson correlation. All of these analyses were performed on Jamovi version 2.3 (Sydney, Australia).

Results

Confirmatory analysis

Confirmatory factor analysis was performed with the current sample to evaluate the theoretical model's adjustment quality to the observed correlated structure between latent items (Marôco, 2014). The results of the confirmatory factor analysis indicate an acceptable adjustment model {$\chi 2$ (251)=679, p<.001; CFI=.810; TLI=.791; RMSEA=.084; P[rmsea≤.05]<.001}. This model confirmed the 2 factors: the realism factor, constituted by 12 items and the genuineness one, which includes 12 items (Figure 1).

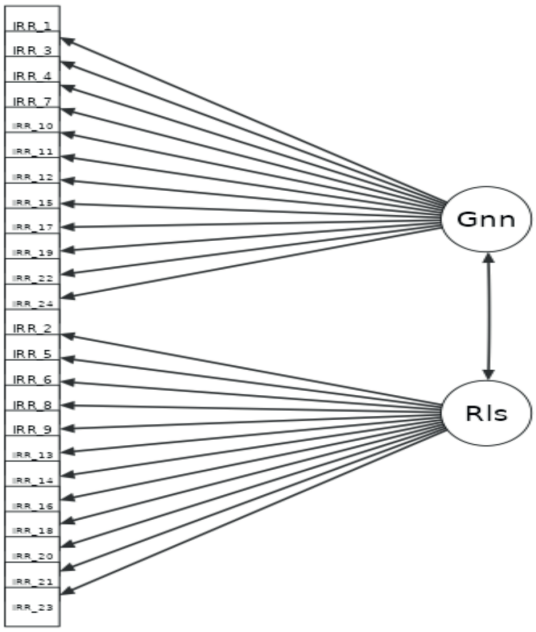

Figure 1.Path diagram of a confirmatory model of real relationship inventory - client version with two-factor model with acceptable adjustment indices {$\chi 2$ (251)=679, p<.001; comparative fit index=.810; Tucker-Lewis index=.791; root mean square error of approximation (RMSEA)=.084; P[rmsea≤.05]<.001.

Convergent validity

Convergent validity analysis was performed between the RRI-C and the WAI-S. We found different correlations between global scores and respective subscales from the RRI-C and WAIS. Associations where r<.25 are considered weak, associations with .25≤|r|<.5 are considered moderate, associations of.5≤|r|<0.75 are considered strong, and associations of |r|≥.75 are considered very strong (Marôco, 2018).

We found a statistically significant and strong association between the global scores of the RRI-C and WAI-S (r=.75, p<.001), the RRI-C and the goals subscale (r=.62, p<.001), the RRI-C and the tasks subscale (r=.63, p<.001), the genuineness subscale and the WAI-S (r=.71, p<.001), the genuineness subscale and the goals subscales (r=.57, p<.001), the genuineness subscale and the tasks subscales (r=.63, p<.001), the realism subscale and the WAI-S (r=.72, p<.001), the realism subscale and the goals subscale (r=.62, p<.001), the realism subscale and the tasks subscale (r=.62, p<.001), the bond subscale and the RRI-C (r=.73, p<.001), the bond subscale and the genuineness subscale (r=.72, p<.001) and finally the bond subscale and the realism subscale (r=.67, p<.001).

Discussion and Conclusions

In this study, we intend to adapt the RRI into the Portuguese context, so that therapists and researchers can have a reliable way to measure the real relationship. Measurements for relational constructs had been previously adapted, such as the WAI (Machado & Horvath, 1999), the California psychotherapy alliance scale (Paixão & Nunes, 2008), and the alliance negotiation scale (Galvão *et al*., 2019). However, until now, an instrument measuring the real relationship had not been adapted. Moreover, we aim to explore and investigate the psychometric properties of the RRI-C for the adult Portuguese population in clinical practice. Finally, we intend to explore the convergent validity between the RRI-C and the WAI-S.

Our results suggest the RRI-C for two factors, one for genuineness and one for realism, similar to what was found in the original validation study (Kelley *et al*., 2010), including the same items for each factor. While our adjustment model value was lower than the original study, it is still acceptable and confirms the factorial structure of the RRI-C. Although there is insufficient information to extrapolate the cause of the difference, one theory is that some of the items may have lost some of their meaning during translation

As for the convergent validity, the results align with the research and the original study. We found strong associations between the bond subscale of the WAI-S and the global score of the RRI-C, and also between the bond subscale and the genuineness and realism subscales. As previously noted by Kelly *et al*. (2010), the bond aspect of the working alliance seems to emerge from the real relationship not only from a theoretical perspective but also from a research one. Not only does the real relationship seem to be a common factor in psychotherapy,

but it can also transcend different cultures. Genuineness, reflecting one's authenticity and honesty (Bohart, 2005), is considered to be an essential part of the real relationship (Gelso, 2011) and a necessary condition for change in the psychotherapy context (Rogers, 1957). It is an essential element of psychotherapy relationships, and it seems that in the cultures where studies of efficacy outcomes have been done, mainly Western ones, outcome improvement increased the more therapists were seen as genuine by their clients (Kolden *et al*., 2018). Despite some cultural and language differences, our results show that this Portuguese version can measure the client's perspective of the real relationship, considering that psychotherapy is supported by a therapeutic human encounter in which the client can be in a state of incongruence, vulnerability, or anxiety, and the therapist is in a state of congruence and integrated into the relationship (Rogers, 1957). Through a personal and genuine relationship, the therapist and client can work on what they perceive in reality that benefits the client (Gelso, 2009).

The main focus of this study is to develop a Portuguese version of the RRI-C and compare our psychometric properties with the original version (Kelley *et al*., 2010). Since this is the first study involving the Portuguese population, further studies are suggested. All the instruments that were used in this study had a self-report format, reflecting only the client's subjective experience, which may not show all aspects of the relational experience if the client does not recognize them or decides not to share them with the therapist. Participants also completed the questionnaire at their time, which could have been across more than one therapy session. Because of this, it was difficult to standardize the researchers' control of the data collection.

The study has several limitations. Firstly, the adaptation was based on a convenience sample. The sample size limited our analysis. Further research is suggested using the item response theory to improve the measure. The item-response theory (Bond & Fox, 2001) is a method that analyzes the properties of items and scales and their relationship to the underlying dimension the scale is intended to assess. This method has several advantages over the classical psychometric theory and has been successfully used in WAI (Hatcher & Gillaspy, 2006).

Following Ronkko and Cho (2022), we suggest more cross-cultural adaptations of the RRI-C to access the strength of the factorial structure to ensure better discriminant validity. Consistent factorial structures, in different languages and cultures, may offer a validation for the Real Relationship.

Despite these limitations, our findings support that this Portuguese adaptation of the RRI-C is suitable for further research concerning relational constructs in psychotherapy and especially for exploring the real relationship. In clinical settings, the RRI-C can be used to measure the real relationship in the adult population and provide feedback for the therapist on the development and quality of the real relationship.

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Therapeutic Relationship Through the Lenses of the Real Relationship, Therapeutic Alliance and Attachment to the Therapist: In Search of a Synthesis

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ABSTRACT

Aim: There is an overlap in psychotherapy research and clinical applications between these three views of the therapeutic relationship: the real relationship, the therapeutic alliance and attachment theory.

Objective: This study aimed to provide a synthesis by exploring this overlap in the client's perspective on the therapeutic relationship.

Method: The sample included 373 adult clients of individual therapy. An exploratory principal components analysis was conducted.

Results: Parallel analysis revealed a five-component structure generating a final solution explaining 47% of the variance. These components seem to illustrate different clients' needs and views about the relationship and how the therapist might perceive the Relationship and their interactions. It presents dimensions such as the need for security in the therapist, the need to be cared for by the therapist, the fear of being genuine to the therapist, working on the goals of therapy and the need for more contact and expanding the therapeutic relationship beyond the boundaries that can be relevant for assessment, clinical decision-making and responding to a client's core needs.

Conclusion: This theoretical perspective may be useful beyond a specific relational construct, stressing the transtheoretical potential of clients' core needs towards the relationship and better preparing therapists to be more responsive to them.

Keywords: attachment; real relationship; therapeutic alliance; therapeutic relationship

Introduction

Within process research, the literature supports the therapeutic relationship as one of the most consistent processes that accounts for as much, and probably more, of the outcome variance as particular treatment methods (Norcross 2019). According to Gelso and Carter (1985, 1994), the therapeutic relationship is the feelings and attitudes the therapist and client have towards one another and the manner in which these are expressed. Although this definition opens the relationship to include everything therapeutic, for Gelso and Hayes (1998), any sound definition must incorporate the expression of feelings and attitudes as central elements to the relationship.

In the last decades, a diversity of theoretical constructs associated with the therapeutic relationship have been researched, predominantly the therapeutic alliance (Ribeiro 2019). In a recent meta-analysis, Vaz et al. (2023) reported a significant omnibus effect on the association between the real relationship and working alliance. Other relational constructs, such as attachment, are also significantly associated with the real relationship (Gelso, Kivlighan, and Markin 2019) and the working alliance (Mallinckrodt and Jeong 2015).

The Real Relationship

As defined by Gelso (Gelso and Carter 1985, 1994; Gelso and Hayes 1998), the real relationship is ‘the personal relationship between therapist and patient marked by the extent to which each is genuine with other and perceives/experiences the other in ways that benefit the other’ (Gelso 2009, p. 119). The initial formulations of real relationship can be traced to the beginning of psychoanalysis, where Freud (1919, 1937) stated that ‘Not every good relation between an analyst and his subject during and after analysis was to be regarded as transference; there were also the friendly relations which were based on reality and which proved to be viable’ (p. 222). Ana Freud viewed the real relationship as a counterpoint to transference, the more ‘realistic’ involvement of each participant in perceiving and experiencing the other in ways that befit the other, rather than through transference (Freud 1954; Rodrigues Ribeiro and Dias Neto, 2023). The roots of the real relationship can be traced to the beginning of psychoanalysis, in which a poor relationship between analyst and patient must be regarded as transference and can be based on the reality perceived and experienced by both.

A significant step to the Real Relationship was taken by Ralph Greenson (1967) regarding the genuineness of the analytic dyad, where analysts and patients can be themselves in the relationship, instead of holding back or being artificial (Rodrigues Ribeiro and Dias Neto, 2023). This is viewed as a connection with humanistic/experiential therapies where congruence and genuineness are central (Rogers 1957; Pearls 1969; Gelso, Kivlighan, and Markin 2019). Realism and genuineness became fundamental for the current understanding of the real relationship (Wampold and Budge 2012; Gelso 2014). The strength of the real relationship should not vary regarding the therapist's theoretical orientation, which supports the real relationship as being transtheoretical, applying to all orientations in psychotherapy (Gelso and Carter 1985, 1994; Gelso 2009, 2011; Wampold and Budge 2012; Gelso and Silberberg 2016).

Both therapist and patient contribute to the real relationship, from different perspectives. From the therapist, elements such as direct self-disclosure of thoughts, feelings, information, sense of humour, attire, office decoration, facial expressions and body postures enable the patient to view the therapist as a person. Another contribution is being genuine and real and experiencing the patient as they are instead of a projection based on the therapist's past and present unresolved conflicts (Gelso, Kivlighan, and Markin 2019; Rodrigues Ribeiro and Dias Neto 2023).

From the patient's view, the enactment contributes to the formation and development of the real relationship, built and strengthened by the patient getting in touch with inner experiences and through verbal and non-verbal exploration and communication that shows who they genuinely are (Gelso, Kivlighan, and Markin 2019; Rodrigues Ribeiro and Dias Neto 2023).

The real relationship seems to be present from the first contact between therapist and patient, perceived as immediate, probably to varying degrees (Greenson 1967; Couch 1999; Gelso 2009, 2011, 2014). It is also suggested that as the therapeutic relationship deepens, the strength of the real relationship increases throughout the work (Gelso 2014).

The Therapeutic Alliance

The therapeutic alliance is one of the most researched relational constructs, with exponential growth in the literature since 2000 (Flückiger et al. 2019). The main reasons for this growth can be attributed to the fact that research consistently finds a moderate relation between the alliance and outcome (Horvath and Bedi 2022; Horvath and Symonds 1991; Martin, Garske, and Davis 2000; Horvath et al. 2011) and also the alliance can be assessed practically and directly (Flückiger et al. 2019).

Considering the collaborative aspects of the therapist–client relationship, the term *alliance* has been preceded by different terms, such as therapeutic, working or helping, showing the range and differences among authors regarding the concept's precise meaning (Flückiger et al. 2019).

The concept of the alliance can be traced to the work of Freud (1913), with the premise that all relationships were based on transference (Freud 1913, 1958). Initially, Freud suggested the existence of an 'analyst' with the client supporting the healing journey, to justify why the patient continued in the analysis in the face of the unconscious fear and rejection of exploring repressed material. Later, Freud theorised about the reality-based collaboration between therapist and patient, a conjoint effort to conquer the client's pain, which he referred to as unobjectionable or positive transference (Freud 1913).

Sterba (1934) proposed the term ego alliance, conceptualizing the alliance as part of the client's ego-observing process that alternated with the transferential process. For Zetzel (1956), the term therapeutic alliance refers to the patient's ability to use the healthy part of their ego to accomplish therapeutic tasks jointly with the therapist. In the following decade, Greenson distinguished between the working alliance and the therapeutic alliance. The working alliance relates to the patient's ability to align with the tasks of analysis (Greenson 1965, 1967) and the therapeutic alliance to the therapist's and client's capacity to form a personal bond (Horvath and Luborsky 1993).

Luborsky and Bordin's work on the alliance was crucial to the development of the alliance and in going beyond its psychodynamic roots. From Zetzel's conceptualisation, Luborsky (1976) suggested that the alliance develops in two phases, 'Type I' and 'Type II'. Type I alliance involves the patient's belief in the therapist as a strong source of help provided through a warm, supporting and caring relationship, representing a secure holding for the beginning of the work in therapy. Type II alliance involves the patient's investment and faith in the therapeutic process and the client's personal investment to share ownership of the therapeutic process. Luborsky's description of the alliance as a therapeutic process made the application to all forms of treatment possible (Flückiger et al. 2019).

Bordin's (1975, 1979, 1989, 1994) theoretical version of the alliance, called the working alliance, was based on Greenson (1965), departing from the psychodynamic perspective and Rosenzweig's (1936) identification of common factors across particular orientations. The core of the alliance was a collaborative stance in therapy centered on three

components: agreement on the therapeutic goals, consensus on the tasks that make up therapy and a bond between the client and the therapist. Due to the transtheoretical nature of this definition, the 'ideal' working alliance would differ based on the specific demands on the relationship from diverse therapeutic approaches. Contemporary reconceptualisation of the alliance emphasizes collaboration and consensus, highlighting the collaborative parts of therapists and clients (Hatcher and Barends 2006).

Attachment Theory

Attachment theory was developed to explain the behavioural and emotional responses that bind young children and their caregivers in close proximity (Bowlby 1969), explaining responses to separation and loss (Bowlby 1973) and the development of emotional attachment after infancy (Bowlby 1977; Ainsworth 1989; Mallinckrodt, Gantt, and Coble 1995). In an optimal attachment bond, the caregiver provides a comforting presence for the child that reduces anxiety and promotes feelings of security, allowing the exploration of the physical and social environment (Bowlby 1969, 1988; Mallinckrodt, Gantt, and Coble 1995).

From Ainsworth's pioneering attachment studies (Ainsworth et al. 2014), three attachment patterns were identified: secure, anxious-ambivalent and anxious-avoidant. In a secure pattern, the infant freely explores in the mother's presence, showing some anxiety upon separation but easily comforted upon reunion. In an anxious-ambivalent pattern, the infant is excessively anxious, angry and clinging to the extent that it interferes with exploration, shows distress during separation and has difficulty being comforted upon reunion. In an anxious avoidant pattern, infants show little interest in their mother and little strong affect throughout the observation. These patterns have been confirmed in subsequent studies (Egeland and Farber 1984; Egeland and Sroufe 1981).

According to Bowlby (1977) and Bretherton (1985), early attachment experiences are thought to become internalised, affecting the development of the child's concept of self and expectations about others. Young children's working model involves beliefs about whether they are generally worthy of care and help from others versus being unworthy of help and comfort. These working models of others involve generalised expectations that caregivers will be responsive, helpful and nurturing versus unresponsive, aloof and possibly harmful. Using the term working model means that in early childhood, internal representations can be revised as new attachments are encountered (Mallinckrodt, Gantt, and Coble 1995). As development proceeds, these models become increasingly resistant to change, since new information that does not fit into existing structures is difficult to process and tends to be defensively excluded (Bowlby 1969, 1973; Bretherton 1985).

Research suggests that the attachment system established in childhood continues to have a major influence on adult social relationships (Hazan and Shaver 1994; Coble, Gantt, and Mallinckrodt 1996) and can be activated by any close, intimate relationship that evokes potential for love, security and comfort, including friendship, kinship, romantic partnership and the therapeutic alliance (Ainsworth 1989).

According to Bowlby (1988), the psychotherapy relationship contains many features that can activate an adult client's ingrained attachment expectations and behaviours (Mallinckrodt, Gantt, and Coble 1995). The therapist offers emotional availability, a comforting presence, affect regulation and a secure base to explore the inner and outer worlds (Pistole 1989).

For Jones (1983), the client re-experiences a primary attachment, reproducing parts of an old and unsatisfactory relationship with the therapist. When the attachment patterns are re enacted in the therapeutic relationship, the therapist gains access to the client's working models, which become conscious and subject to challenge and change (Sperling and Lyons 1994).

Present Study

Research in the common factors approach shows that the therapeutic relationship is one of the variables that most strongly predicts the outcome of the therapeutic process. The therapeutic relationship can be composed of several constructs, since no single construct can describe all of it. The real relationship, the working alliance and attachment theory all illustrate different facets of the relationship.

Just as the therapeutic relationship is intended to be transtheoretical, all of these relational constructs are intended to be present in all forms of therapy. Several instruments have been developed to measure their impact on the relationship, such as the Real Relationship Inventory, the Working Alliance Inventory and the Client's Attachment to Therapist Scale.

Each of these instruments only measures a specific facet of the relationship, not the therapeutic relationship as a whole. Also, parts of these constructs overlap, from a theoretical standpoint and a measuring perspective, like the Bond aspect of the Working Alliance Inventory and the Real Relationship Inventory.

The client's perspective was considered in this research for two reasons. First, clients largely make therapy work. If clients do not participate and invest in the therapeutic process, they will have a poor outcome. Bohart and Tallman (2022) propose that the client's role goes beyond only participating and that the client's creativity, agency, initiative and inventiveness make therapy effective. Second, in measuring relational constructs, such as the therapeutic alliance, results show that the therapist and client do not have the same perspective on the alliance. Therapists must anticipate and acknowledge the importance of client feedback on the relationship (Bachelor 2011).

The significant overlap between the previously mentioned relational constructs and the lack of a conceptual model that structures them into a cohesive model suggests the need for more clarifications and distinctions. Concerning the real relationship and therapeutic alliance, there has been discussion around which one appears first, or which one depends on the other. While the bond aspect of the alliance greatly overlaps with the entire concept of the real relationship, it could be argued that the term ‘real’ represents an implication that other relational aspects can be different in this respect, considering that clients tend to re-experience and re-enact primary attachment styles with the therapist.

This study aims to contribute with a different theoretical perspective from the client's view of the real relationship, the working alliance and the client's attachment to the therapist. Using an exploration data reduction technique, we aim to group the same factoring measures in a new structure. This structure is intended to contribute to the continuous study of the therapeutic relationship.

Method

Participants

The present study was conducted in Portugal, with a convenience sample of 373 participants. Recruitment was done online, in associations of psychotherapy and general dissemination among therapists. Inclusion criteria were as follows: 18 years or older, and participating in or having completed individual psychotherapy. In Table 1, we presented the descriptive statistics. Participants were primarily female (n = 326). The mean age was 36.7 years (SD = 9.2), ranging between 20 and 70. Ninety-three per cent of the participants were undergraduates and graduates from university, 6.2% concluded high school and 0.8% finished middle school. Of the participants, 64.6% were currently receiving psychotherapy.

The main reasons for seeking psychotherapy were family difficulties, professional difficulties and personal development. Twenty-six per cent had received a mental health diagnosis. The most frequent diagnoses were anxiety disorders and depression. Participants were asked to openly indicate the time that they were in therapy and the regularity of the sessions. The shortest time period indicated by the participants was 1 month, and the longest was 11 years. At most, participants were seen once or twice per week most, and at least once or twice every two weeks. Regarding the main models of psychotherapy, 25.8% reported receiving psychodynamic/psychoanalytic therapy, 21.2% cognitive behavioural therapy (CBT) and 8.9% psychoanalysis.

TABLE 1 | Sample characteristics of the participants ($N = 373$).

Variable	Frequency	Percentage
Gender		
Female	326	87.4
Male	47	12.6
Age		
20	1	0.3
> 20–30	110	29.5
> 30–40	144	38.6
> 40–50	82	22
> 50–60	28	7.5
> 60–70	4	1.1
Education		
University Undergraduate	16	4.3
University Graduate	331	88.7
High School	23	6.2
Middle School	3	0.8
Psychotherapy		
Were currently in process	241	64.6
Family difficulties	73	19.6
Relational difficulties	111	29.7
Personal difficulties	160	42.9
Mental diagnosis	63	26
Anxiety disorders	38	10.2
Depression	30	8
Psychotherapy Models		
Psychodynamic/ psychoanalytic	96	25.8
Cognitive behavioural	79	21.2
Psychoanalysis	33	8.9

Instruments

Real Relationship Inventory—Client Version

In the present study, we used the Portuguese version of the Real Relationship Inventory—Client Version (RRI-C; Kelley et al. 2010). It consists of 24 statements on how the client perceives the relationship with the therapist, rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Along with the global score of the relationship, the RRI-C has two subscales: realism and genuineness. Items 3, 6, 8, 12, 14, 21, 22 and 24 were reverse scored. The Portuguese adaptation of the measure (Rodrigues Ribeiro and Dias Neto 2023) showed good psychometric properties.

Working Alliance Inventory—Short Form

In the present study, we used the Portuguese version of the Working Alliance Inventory—Short Form (WAIS-S; Tracey and Kokotovic 1989). It consists of 12 (compared to the original 36 item version) statements on how the clients perceive the therapeutic alliance with the therapist, rated on a 7-point Likert scale from 1 (never) to 7 (always). Along with the global score of the alliance, the WAIS-S also has three subscales: bond, tasks and goals. Items 3, 5, 6, 7, 9 and 12 were reverse scored. The Portuguese adaptation of the measure (Machado and Horvath 1999) showed good psychometric properties.

Client Attachment to Therapist Scale

In the present study, we used the Portuguese version of the Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, and Coble 1995). It consists of 36 statements on how the client perceives the attachment to the therapist, rated on a 6-point Likert scale from 1 (totally disagree) to 6 (totally agree). Along with the global score, the CATS has three subscales: secure, avoidant/ fearful and preoccupied/merger. The Portuguese adaptation of the study (Brandão, Carvalho, and Matos 2012) showed good psychometric properties.

Procedure and Data Analysis

The present study was approved by Ispa—Instituto Universitário's Ethical Committe (N° D 052-06- 22). Data were collected online through the Qualtrics platform. All participants signalled their informed consent. The order of the application of the instruments was as follows: socio-demographic variables, RRI-C, WAIS-S and CATS. The study was disseminated through social networks and Portuguese associations of psychotherapy from different theoretical orientations.

We started by verifying the internal consistency of the RRI-C, WAI-S, CATS and respective subscales. Second, we performed a convergent analysis, referring to scales constituting identical constructs. These measures are expected to present positive and high correlations between one another (Marôco 2014). For this analysis, we used Pearson correlation to explore the correlation between RRI-C, WAI-S and CATS. Third, a principal component analysis was used as a multivariate exploratory way to transform correlated variables into linear combinations called principal components, reducing the amount of information (Marôco 2018). Horn's parallel analysis (Horn 1965) was used to determine the number of components to be extracted. Items were excluded using item communalities considering the cut-off above 0.20 (Child 2006).

These analyses were performed on Jamovi version 2.3 (Sydney, Australia).

Results

Internal Consistency Analysis

Internal consistency analysis was performed to measure the reliability of the RRI-C, WAI-S and CATS.

For the RRI-C, the total score ($\alpha = 0.91$) showed high internal consistency, and all the subscales showed good internal consistency: realism ($\alpha = 0.82$) and genuineness ($\alpha = 0.86$).

For the WAI-S, the total score ($\alpha = 0.91$) showed high internal consistency, and all the subscales showed acceptable to good internal consistency: bond ($\alpha = 0.78$); tasks ($\alpha = 0.84$); and goals ($\alpha = 0.86$).

For the CATS, the total score ($\alpha = 0.68$) showed questionable internal consistency, and all subscales showed good internal consistency: secure ($\alpha = 0.88$); avoidant/fearful ($\alpha = 0.86$); and preoccupied/merger ($\alpha = 0.81$).

Convergent Validity

Convergent validity analysis was performed between the RRI-C, WAI-S and CATS. We found different correlations between global scores and respective subscales. Associations where $r < 0.25$ are considered weak, associations of $0.25 \leq |r| < 0.5$ are considered moderate, associations of $0.5 \leq |r| < 0.75$ are considered strong and associations of $|r| \geq 0.75$ are considered very strong (Marôco 2018). In Table 2, we present the Pearson correlations between the global scores and subscales of the RRI-C, WAIS-S and CATS.

We found a statistically significant and strong association between the global scores of the RRI-C and WAI-S ($r = 0.75$, $p < 0.001$), the RRI-C and the Goals subscale ($r = 0.62$, $p < 0.001$), the RRI-C and the Tasks subscale ($r = 0.63$, $p < 0.001$), the Genuineness subscale and the WAI-S ($r = 0.71$, $p < 0.001$), the Genuineness subscale and the Goals subscales ($r = 0.57$, $p < 0.001$), the Genuineness subscale and the Tasks subscales ($r = 0.63$, $p < 0.001$), the Realism subscale and the WAI-S ($r = 0.72$, $p < 0.001$), the Realism subscale and the Goals subscale ($r = 0.62$, $p < 0.001$), the Realism subscale and the Tasks subscale ($r = 0.62$, $p < 0.001$), the Bond subscale and the RRI-C ($r = 0.73$, $p < 0.001$), the Bond subscale and the Genuineness subscale ($r = 0.72$, $p < 0.001$), the Bond subscale and the Realism subscale ($r = 0.67$, $p < 0.001$) and, finally, the Secure subscale and RRI-C ($r = 0.52$, $p < 0.001$).

TABLE 2 | Pearson correlation matrix.

Variables	1	2	3	4	5	6	7	8	9	10	11
1. RRI_Total	—										
2. RRI_Genuineness	0.87***	—									
3. RRI_Realism	0.88***	0.53***	—								
4. WAI_Total	−0.08	−0.13*	−0.01	—							
5. WAI_Bond_	−0.43***	−0.40***	−0.36***	0.41***	—						
6. WAI_Goals	0.35***	0.26***	0.34***	0.39***	−0.54***	—					
7. WAI_Tasks	0.21***	0.16***	0.20***	0.47***	−0.41***	0.43***	—				
8. CATS_Total	0.33***	0.30***	0.28***	−0.06	−0.06	0.05	−0.05	—			
9. CATS_Secure	0.51***	0.47***	0.43***	−0.06	−0.47***	0.41***	0.24***	0.61***	—		
10. CATS_Avoidant	−0.04	−0.03	−0.04	−0.01	0.43***	−0.36***	−0.34***	0.60***	−0.04	—	
11. CATS_Preocuppied	0.17***	0.15**	0.15**	−0.05	0.03	−0.09	−0.08	0.84***	0.27***	0.42***	—

***$p < 0.001$.
**$p < 0.01$.
*$p < 0.05$.

We found a statistically significant and moderate association between the global scores of the CATS and RRI-C ($r = 0.33$, $p < 0.001$), the CATS and the Genuineness subscale ($r = 0.30$, $p < 0.001$), the CATS and the Realism subscale ($r = 0.28$, $p < 0.001$), the Secure subscale and the Genuineness subscale ($r = 0.47$, $p < 0.001$), the Secure Subscale and the Realism subscale ($r = 0.44$, $p < 0.001$), the Secure subscale and the Bond subscale ($r = -0.48$, $p < 0.001$), the Secure subscale and the Goals subscale ($r = 0.41$, $p < 0.001$), the Avoidant/Fearful subscale and the Bond subscale ($r = 0.43$, $p < 0.001$), the Avoidant/Fearful subscale and the Goals subscale ($r = -0.36$, $p < 0.001$) and, finally, the Avoidant/Fearful and Tasks subscale ($r = -0.35$, $p < 0.001$).

We found a statistically significant and weak association between the Secure subscale and the Tasks subscale ($r = 0.24$, $p < 0.001$), the Preoccupied/Merger subscale and the RRI-C ($r = 0.18$, $p < 0.001$), the Preoccupied/Merger subscale and the Genuineness subscale ($r = 0.16$, $p < 0.001$) and, finally, the Preoccupied/Merger subscale and the Realism subscale ($r = 0.15$, $p < 0.001$).

Principal Components Analysis

According to Horn's parallel analysis, five components should be extracted. A principal components analysis was run on five components, with an adequate solution (KMO = 0.94; Bartlett's $\chi 2$ (2556) = 15,072, $p < 0.001$). This solution explained 47% of the total variance. Every item from the different scales was above the 0.20 cut-off.

Every component includes items from all instruments. Component one was identified as Security in the Therapist. Component two was identified as Care from the Therapist towards the Client. Component three was identified as Afraid of Being Genuine to the Therapist. Component four was identified as Working on Goals for Therapy. Component five was identified as the Need for More Contact Beyond the Therapeutic Relationship. As shown in Table 3, we also organised the components in two dimensions: Needs from the Relationship and Beliefs about the Therapist. Components 1 and 4 are in the first dimension and Components 2, 3 and 5 are in the second dimension.

TABLE 3 | Description of the dimensions of the five components model.

Needs from the relationship	Beliefs about the therapist
Need for security in the therapist	Client's need to be cared for by the therapist
Working on the goals of therapy	Client's fear of being genuine to the therapist
	Client's need for more contact and expanding the therapeutic relationship beyond therapy boundaries

Discussion

In this study, we intended to provide a new way to view the therapeutic relationship from the client's perspective. Also, we intended to demonstrate the existing associations between these relational constructs. Regarding the relational constructs and measures presented in this study, there seems to be some empirical support for the relevant association between the real relationship, the therapeutic alliance and attachment (Gelso, Kivlighan, and Markin 2019).

Associations Between WAI-S, RRI-C and CATS

We found strong associations between the Bond subscale of the WAI-S and the global score of RRI-C and between the Bond subscale and the Genuineness and Realism subscales (Kelley et al. 2010; Rodrigues Ribeiro and Dias Neto 2023; Vaz et al. 2023). The overlapping of the bond part of the therapeutic alliance with the real relationship can explain this association. Gelso (2014) noted that three of the four items of the Bond subscale in the 12-item measure tap into personal feelings between therapist and client. Attachment and the real relationship are also present, differing from Gelso and Hayes's theoretical assumption that insecure attachment would be related to a stronger real relationship (1998). Our results show a stronger association between the global measure of attachment and the real relationship, and secure-based patterns have a stronger real relationship. The CATS Preoccupied subscale results show an association with the real relationship, differing from Fuentes (Fuertes et al. 2007) and Moore and Gelso (2011). A high score might establish a relational bond with the therapist, but also a desire that the relationship could transpose the boundaries of therapy and a therapeutic relationship. Finally, regarding attachment and the therapeutic alliance, our data shows relations with all the WAI-S subscales. These clients present the ability to establish a bond with the therapist, but this alliance starts to deteriorate with the negotiation of Goals and Tasks.

Description of the Components' Model

Our hypothesis for a different theoretical perspective is intended to be supported by a transtheoretical perspective, meaning that all therapies share specific change processes, independent of their theoretical orientation (Stricker and Gold 2006), by analysing data from different psychotherapeutic orientations, regarding the real relationship, therapeutic alliance and client attachment to the therapist.

The first component expresses the need for security in the therapist and explains the most variance in the model. Regarding this need, previous attachment to caregiving figures has important functions, such as proximity seeking, a safe haven when children feel threatened, and a secure base that permits children to explore the environment and develop growing mastery (Mallinckrodt 2022). As the therapeutic relationship activates previous attachment patterns, the goal of attachment behaviour by the client is the perception of felt security. In the initial stages of the therapeutic process, the client is trying to assess if the therapist can manage their needs, emotions or even the sensitive narratives that can be exposed.

The therapist's role is to deliver a sense of security, through a genuine and empathic posture, being responsive to the client's needs and worries. This is an important part of creating the therapeutic relationship bond. It is also the foundation of the development of trust in the relationship and the therapist's ability to restructure cognitive distortions and regulate emotional distress.

The second component expresses the client's need to be cared for by the therapist and explains the second most variance in the model. Caring is an intrinsic and fundamental human motivation that involves a universal need to give care (Mayseless 2016). It is important in psychotherapy to build a secure base for healthy attachments. When clients feel cared for, not only does their sense of security grow, but they also realise their thoughts, emotions and behaviours are met with importance. Therapists must develop a deep interest and curiosity for the client, believing in their capacity and resources to change and showing this belief in an empathic and genuine way. Being focused on the moment, the therapist can maintain a presence in the relationship and adequately respond in a caring way.

The third component expresses the client's fear of being genuine to the therapist and explains the third most variance in the model. In the context of the therapeutic relationship, being genuine is to be freely and deeply in contact with the experience accurately represented by their awareness of themselves (Rogers 1957). The client's perception might be that the therapist adopts a judgmental position about the reasons to seek therapy or that those issues might be too embarrassing to share in the therapeutic relationship. Also, the client could consider that the therapist cannot understand or relate to what they are revealing. As the therapeutic relationship develops, this fear might occur if the client and therapist do not resolve potential ruptures. It is important that the therapist, through an empathic, present and accepting posture, can transmit a felt sense of caring and that the client and being in the relationship are the priority at that moment.

The fourth component expresses working on the goals of therapy and explains the fourth most variance in the model. Establishing goals and goal consensus between patient and therapist is a key part of treatment success (Bordin 1979). This component directly relates to Bordin's formulation of establishing goals for therapy and negotiating the necessary tasks to accomplish those goals. While establishing goals for therapy is important, it seems

that, from the client's perspective, it is more important to first develop a secure and trusting relationship with the therapist. Having established that secure, genuine, caring and trusting relational base, both client and therapist may start to negotiate a consensus and work collaboratively towards goals. The therapist needs to be responsive to the client's needs and be flexible to resolve potential disagreements on the goals.

The fifth component expresses the client's need for more contact and expanding the therapeutic relationship beyond therapy boundaries and explains the least amount of the model's variance. Clients can engage in personal dialogue and dynamics with the therapist, in an attempt to discover the therapist's life, personal story, significant relationships, etc. For some clients, this is a way of building trust in the therapist by identifying with them on a personal level. For others, there is a belief that the therapist might abandon them and the relationship. In such a situation, clients can increase behaviours such as texting, emailing or trying to call the therapist at a superior rate agreed upon in therapy. The client's fear of process termination or changes in the therapeutic relationship can also activate the client's desire to establish a personal relationship with the therapist.

This five-component theoretical perspective embraces concepts from Gelso's tripartite model and Bordin's formulation while expanding on the client's perspective on the relationship. The inclusion of the client's attachment to the therapist greatly contributes to further realizing core needs that clients perceive as important in the therapeutic relationship. The importance of early and significant interactions potentially re-emerges in the therapeutic relationship and can define the way therapists might engage and offer more relational corrective experiences. This perspective is also sequential, meaning that, from the client's perspective, there is a roadmap for establishing a healthy therapeutic relationship. A sequential approach can be very useful for guiding therapists in the therapeutic relationship, across the therapeutic process. Another important contribution from this theoretical perspective is an internal dynamic view of the relationship, as we see the client having a perspective of the relationship but also an expectation of the therapist's view of the relationship and the client themself.

The Application Across the Therapy Process

This theoretical perspective might be useful to identify, understand and be responsive to the client's core needs, across the therapeutic process and different therapeutic orientations. Rather than trying to redefine or establish another definition of the therapeutic relationship, our approach intends to expand the discussion around the complexity of the relationship. The multidimensional aspect of the relationship becomes more evident when considering that the

real relationship and the working alliance alone cannot measure and structure all aspects of all relationships in a single cohesive perspective. We can expand on Bordin's key crucial elements by showing that clients identify special needs inside the relational bond with the therapist, like the need for security in the therapist and the need to be cared for by the therapist. Most importantly, this need for security and caring makes the client fearful of rejection by the therapist, afraid of being genuine to the therapist, but also produce to expand their connection beyond the limitations of the therapeutic relationship. Working on goals seems important to clients, not so much on the specific tasks to accomplish those goals. The expression of these needs can inform us what relational aspects of clients are most favourable in establishing the therapeutic relationship, offering a more in-depth complexity for Bordin's perspective of the working alliance and even Gelso's real relationship.

A Perspective on Ruptures and Repair

Having such a perspective might also improve the identification and resolution of potential ruptures in the alliance and relationship. Contemporary research attributes great relevance to rupture repair as one of the most robust predictors of outcome efficacy in a therapeutic process. Ruptures naturally appear in the relationship and require the therapist and client to work on their resolution collaboratively. If the therapist acknowledges the importance of previous relational patterns, the possibility that those patterns might appear in the therapeutic relationship, and the core needs presented by the client, therapists might be better prepared to identify relational ruptures and be more responsive to negotiate the repair of such ruptures.

Limitations of the Current Study

The main focus of this study was to present a different theoretical construction of the therapeutic relationship from the client's perspective. Since this is an initial proposal, further studies are suggested. All instruments used use a self-report format, reflecting only the client's subjective experience, whether the client does not recognise them or decides not to share them with the therapist. Standardising the control of the data collection was difficult since the participants completed the questionnaires in their own time, which could have been across multiple therapy sessions. The client's perspective, while very important, is the only one measure in this study. The therapeutic relationship is a dyad; both therapist and client are

responsible for the quality of the relationship and for repairing ruptures in the alliance (Eubanks et al. 2019). One of the consistent findings in the alliance literature is the low association between clients' and therapists' perceptions (Tichenor and Hill 1989; Hatcher et al. 1995; Bachelor and Horvath 1999), suggesting that the therapy participants have different views of the alliance and its dimensions (Bachelor 2011). Contemplating the therapists' and the dyads' perspectives can give us a more felt sense of the therapeutic relationship and how it evolves across therapy.

Future Research Directions

Despite these limitations, our findings add a more in-depth discussion to developing the therapeutic relationship. In clinical settings, this perspective can prepare therapists to be more aware of a good initial establishment of the relationship, offering a secure base to foster the therapeutic process and being ready to repair movements or ruptures based on the needs expressed by our components. In research, our contribution can present a view of different components that can be attached to the same dimension, creating a more unified view of the therapeutic relationship.

Future research can be directed to increase the value of this theoretical perspective. Research should focus on determining the pathways to integrate the real relationship, the therapeutic alliance and the client's attachment. Multivariate analysis may test specific models of interrelation of these variables. Qualitatively, this theoretical perspective should be used and explored in analysing therapy sessions, measuring the quality of the real relationship and therapeutic alliance, the client's attachment to the therapist and the client's core needs identified by these components. Finally, these insights could be developed into specific interventions, which could then be tested in their contribution to repairing ruptures or fostering the therapeutic relationship.

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The Influence of Psychotherapy Tasks on the Therapeutic Alliance: A Systematic Review with Critical Interpretive Synthesis

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ABSTRACT

Aim: There is a growing interest in psychotherapy research and clinical applications, further exploring the value of tasks and techniques in the therapeutic process.

Objective: This study aimed to gain a deeper understanding of the impact of psychotherapy tasks on the therapeutic alliance.

Method: A systematic literature review with a real synthesis analysis was conducted across five databases using search terms related to the variables of interest (tasks, techniques, and therapeutic alliance).

Results: Fifty-three studies were identified. Thirty-seven techniques were found and organized into three categories: exploratory, supportive, and work-enhancing. From this, fourteen techniques were shown to have a positive effect on the therapeutic alliance's effect size, and twenty-three were shown to have no significant impact on its effect size. Among techniques with a positive weight on the alliance, 42.8% are exploratory strategies, 42.8% are work-enhancing strategies, and 14.3% are supportive strategies. Among techniques with no significant weight in the alliance, 58.3% are work-enhancing strategies, 20.8% are exploratory strategies, and 20.8% are supportive strategies.

Conclusion: Tasks and techniques strengthen the therapeutic alliance primarily through goals and tasks. Exploratory and work-enhancing strategies further advance therapeutic outcomes, including providing the patient with skills and forms of self-regulation that he/she can use after the end of the therapeutic intervention.

Keywords: Systematic Review, Realistic Synthesis, Techniques, Therapeutic Alliance, Therapy

Introduction

In the psychotherapy literature, the therapeutic relationship is one of the most consistent processes, accounting for as much, and probably more, of the outcome variance as treatment methods (Norcross & Lambert, 2019). Regarding the relationship, the therapeutic alliance has been one of the most widely researched relational constructs (Fluckiger et al., 2018; Ribeiro, 2019).

Initially, the therapeutic alliance was believed to be a positive transference from the patient toward the therapist (Ackerman, 2003; Freud, 1913; Frieswyk et al., 1986). The therapeutic alliance evolved into an active and conscious collaboration between the patient and therapist, supported by agreement on therapeutic goals, consensus on tasks, and a bond between the patient and the therapist (Bordin, 1979).

For the last two decades, research has been focused on the technical and relational aspects of the alliance, such as patients' characteristics and therapist activity (Ackerman, 2003; Barber et al., 1999; Blatt et al, 1996; Frieswyk et al., 1986; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Hillard, Henry, & Strupp, 2000; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998). Despite this advance in the research, most therapists' contributions have been less focused on the development of the alliance, as reviewed by Orlinsky and colleagues (1994), especially the clarification of the relationship between the therapist's specific in-session contributions, such as technical interventions, and the development of a strong alliance (Ackerman, 2003).

The therapy tasks consist of the specific activities (either overt or covert) that the patient must engage in to benefit from the treatment (Safran & Murran, 2003). These tasks can be related to specific interventions (free association to psychoanalysis, behavioral assignment between sessions to cognitive therapy, engaging in a dialogue between parts of self to Gestalt therapy) or used in a format of technical eclecticism (Stricker & Gold, 2006). Additionally, relating authentically and groundedly to the therapist can be considered another therapeutic task (Safran & Murran, 2003).

It is essential to consider that any intervention may have a positive or negative impact on the quality of the bond between patient and therapist, depending on the idiosyncratic meaning it holds for the patient and may be experienced as more or less facilitative, depending on the preexisting bond (Safran & Murran, 2003).

Crits-Christoph and Connolly (1999), in a review of the literature on alliance and technique in short-term dynamic therapy, identified four studies that directly examined the relationship between technique and alliance. The authors concluded that there is insufficient evidence to establish a link between the technique and alliance, despite the reviewed studies using only short-term psychodynamic techniques. A review of the theoretical and empirical literature on the session environment in cognitive therapy for depression (Whisman, 1993) highlights the therapeutic alliance, the therapist's adherence, competence, and other key factors, including cognitive interventions. Whisman suggested that future research investigations need to focus on the interaction between patient and therapist in the therapeutic relationship (Ackerman, 2003; Whisman, 1993).

Chen and colleagues (2020) investigated the relationship between therapists' flexibility in using therapeutic techniques from different theoretical orientations and the quality of the therapeutic alliance. One of their conclusions is that there is a moderate effect on the therapeutic alliance when therapists implement the right amount of therapeutic techniques flexibly.

The Present Review

As Ackerman (2003) stated, psychotherapy research benefits from a close examination of the relationship between therapists' variables, including techniques and alliance, revising existing empirical findings from a variety of therapeutic orientations (i.e., psychodynamic, cognitive, cognitive-behavioral, integrative, etc.). Therefore, this review aims to provide a comprehensive examination of the influence and weight of techniques in the therapeutic alliance. This review is not intended to criticize methodological issues or measures of the alliance; the goal of this review is to increase the understanding of the contributions of techniques to the development of a positive treatment alliance, also guiding future research to the discovery of more efficacious techniques. To organize these techniques for a better analysis of their contribution, we rely on the organization of the Inventory of Therapeutic Strategies (Gaston & Ring, 1992). The Inventory of Therapeutic Strategies (ITS) is an instrument designed to assess the major intentions underlying therapists' interventions, organized into three categories: exploratory, supportive, and work-enhancing (Gaston & Ring, 1992). Exploratory strategies are all tasks that challenge the patient's sense of self. These strategies are employed in moments when addressing a patient's problematic reaction and implicitly invite the patient to reflect (Gaston & Ring, 1992). Supportive strategies are all tasks that structure or contain the patient's sense of self, providing empathic support or structure (Gaston

& Ring, 1992). Work-enhancing strategies are all tasks that enhance the patient's contribution to the therapy process, inviting the patient to reflect upon those tasks (Gaston & Ring, 1992). The ITS and these categories have been shown to reliably rate different tasks, regardless of theoretical and therapeutic orientation (Gaston & Ring, 1992).

Method

In order to conduct this review, the guidelines of the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Thomas, 2019) and the Preferred Reporting Items for Systematic Reviews and Meta-Analysis Protocols (PRISMA) (Moher et al., 2015) were followed. The review was also registered in PROSPERO (CRD42024548356) and Open Science Framework (https:// https://osf.io/4tu59).

Search Strategy

We searched the EBSCO, PsycINFO, PubMed, Web of Science, and Scopus electronic databases in March 2024 to retrieve studies addressing the influence of specific tasks or techniques on the therapeutic alliance in therapy. To include as many relevant studies as possible, a comprehensive search strategy was utilized, combining the terms *tasks*, *techniques, therapeutic alliance,* and *therapy*, as follows: [AB (tasks* OR techniques*) AND AB (therapeutic alliance*) AND AB (therapy*)]

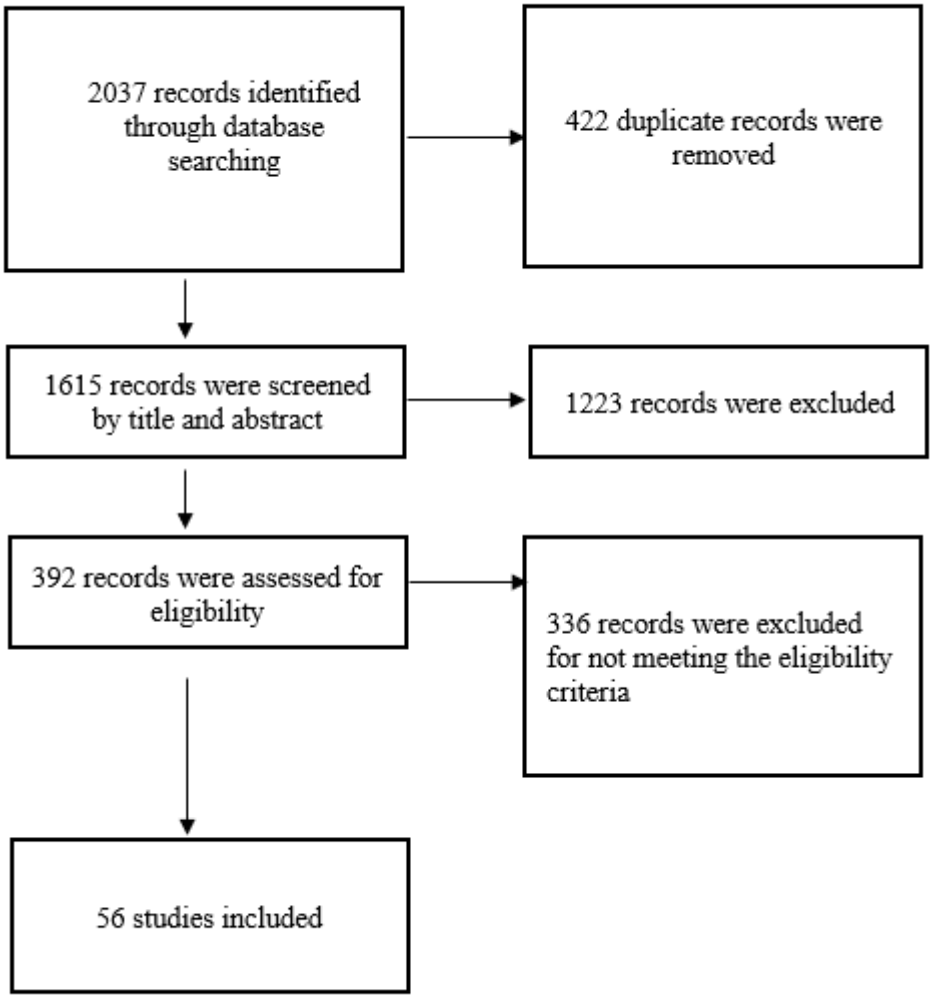
Inclusion and Exclusion Criteria

The review included (i) empirical studies intended to address the association between specific tasks or techniques and therapeutic alliance in individual psychotherapy with adults, and (ii) studies written in English, Portuguese, or Spanish, languages chosen by convenience, given the authors' understanding of them. Methodologies such as quantitative, qualitative, mixed-design studies, randomized controlled trials, and meta-analysis were considered for inclusion, as they are recognized for adding value in comprehending specific tasks, techniques, and therapeutic alliance in the context of therapy. Given Bordin's pantheoretical definition of the alliance, no restrictions were placed on the therapeutic approach model in the included studies. We excluded studies that associated specific tasks/techniques and therapeutic alliance (i) in domains unrelated to psychotherapy (e.g., medical studies or other forms of non-empirical validated therapeutic interventions), (ii) with populations other than adults (e.g., children, adolescents), (iii) and in psychotherapies involving multiple participants (e.g., group therapy), due to distinct dynamics of the alliance present in such therapies.

Study Eligibility

The process of identifying and selecting studies was conducted in four stages. Zotero and RAYYAN software were used to aggregate all identified records, and duplicates were first removed. A total of 2037 studies published without publication date restrictions were identified in the database searches. Initially, 422 duplicate studies were excluded. In the second stage, studies were screened based on titles and abstracts, resulting in the exclusion of 1223 studies, namely (insert all reasons for exclusion). In the third stage, a full-text analysis was conducted on the remaining 392 studies. A total of 336 studies were excluded because they did not meet the eligibility criteria. Ultimately, 53 studies met criteria and were included in this review (see Figure 1).

Figure 1 – Flow Diagram



Data Extraction

Data extraction was performed on the remaining 56 studies. A standardized data extraction form was constructed in Microsoft Excel, covering information regarding study details (authors, year of publication, country), sample characteristics (population), intervention characteristics (study design, name of the intervention), specific tasks characterization (in accordance with the ITS), alliance measurement, and results.

Data Synthesis

Considering the heterogeneity of the population, outcomes, the nature of the techniques, and the primary purpose of this review, a critical interpretive synthesis approach was employed to better integrate the results. The synthesis focused on identifying the methodological treatments used, the specific techniques across all studies, and integrating the weight of such techniques with the therapeutic alliance.

Results

Study Characteristics

Most studies were conducted in the United States of America (n = 22), followed by Canada (n = 9), Germany (n = 5), England (n = 3), and a smaller representation in Australia (n = 2), Sweden (n = 2), Switzerland (n = 2), Israel (n = 1), Norway (n = 1), France (n = 1), Denmark (n = 1), and Iran (n = 1). Therapeutic approaches were diverse, with 39 interventions based on cognitive-behavioral therapy, 12 interventions based on psychodynamic psychotherapy, three interventions based on cognitive processing therapy, three interventions based on motivational interviewing, two interventions based on exposure therapy, one intervention based on hope therapy, one intervention based on dialectical-behavior therapy, one intervention based on client-centered therapy, and one intervention based on integrative therapy. We identified 35 randomized controlled trials, six secondary analyses of randomized controlled trials, five clinical trials, two randomized implementation trials, one repeated-measures analysis, one secondary analysis of clinical trials, one pilot study, one controlled trial, one experiential single-case study, and one quantitative study. A description of the studies' characteristics is presented in Appendix, Table 1.

Therapeutic Techniques

From the data extraction process, thirty-eight techniques were identified. These techniques were then separated and organized into the categories of the ITS, according to their therapeutic purpose, exploring, supporting, or enhancing the respective intervention. Regarding therapeutic models, the different types of interventions used include pharmacological approaches, cognitive-behavioral therapy, psychodynamic psychotherapy, humanistic and person-centered approaches, twelve-step programs, exposure therapies, motivational interviewing, schema therapy, mindfulness-based cognitive therapy, cognitive-analytic therapy, cognitive processing therapy, rational emotional behavior therapy, dialectical behavior therapy, transference-focused therapy, and treatment as usual interventions.

The following tasks were identified: acceptance (3 studies), assertive strategies (2 studies), avoidance coping (2 studies), behavioral activation (11 studies), breathing techniques (5 studies), case conceptualization (9 studies), chair work (1 study), cognitive dispute (6 studies), cognitive restructuring (13 studies), dream exploration/interpretation (4 studies), emotional expression (5 studies), emotional regulation (1 study), empathic responses (3 studies), establishing the therapeutic alliance (11 studies), exposure (23 studies), feedback (10 studies), focus on past experiences (4 studies), focus on interpersonal experiences (4 studies), focusing (3 studies), functional analysis (3 studies), goal setting (2 studies), identifying problematic cognitions (6 studies), identifying recurring themes (5 studies), imagetic exposure (5 studies), journalling (8 studies), mindfulness (7 studies), motivational interviewing (3 studies), problem solving (19 studies), psychoeducation (49 studies), rapport (3 studies), relapse prevention (31 studies), relaxation techniques (12 studies), rupture repair (2 studies), self-care (1 study), shared experiences (3 studies), socratic questioning (4 studies), thoughts monitorization (11 studies), transference/countertransference (2 study). Table 3 illustrates the organization of tasks across therapeutic models, interventions, and their corresponding weight distribution within the therapeutic alliance. The information is summarized in Table 2.

Table 2 – Techniques and their relative frequency on the therapeutic alliance

Tasks (n studies)	Interventions	Frequencies	Tasks (n studies)	Interventions	Frequencies
Acceptance (n=3)	Deprexis; DBT, TSF	0.66 + 0.33 =	Functional Analysis (n=2)	CBT, Return to Work	1.50
Assertive Strategies (n=2)	IIDEA, Deprexis	1 +	Goal Setting (n=2)	GFERT, SET	1 +
Avoidance Coping (n=2)	RP	0.50 + 0.50 =	Identifying Problematic Cognitions (n=5)	CPT, DBT, CBT, PT	0.20 + 1 =
Behavioral Activation (n=7)	CBT, Return to Work, Deprexis, MI, RI-CBT	0.71 + 0.86 =	Identifying Recurring Themes (n=4)	CBT, IT, CT, PT,	0.25 + 1 =
Breathing Techniques (n=4)	PE, Deprexis, TAU, PMR, CBT	0.50 + 0.75 =	Imagetic Exposure (n=4)	CBT, COPE, REBT, MI, CBT	0.25 + 1 =
Case Conceptualization (n=5)	VP, CBT, Return to Work, RO-PP	1 + 0.60 = 0.20 -	Journalling (n=7)	VP, CPT, CAT, NR, SFT, PT	0.42 + 0.71=
Chair Work (n=1)	SFT	1+	Mindfulness	MBCT, IIDEA, Deprexis, MBSR, TAU, PMR	0.40 + 1= (n=5)
Cognitive Dispute (n=5)	CBT, RP, RI-CBT	0.20 + 1=	Motivational Interviewing (n=3)	IIDEA, MI, CBT	0.33 + 0.66 =
Cognitive Restructuring (n=9)	VP, CBT, IIDEA, MI, SFT	0.66 + 0.44 = 0.33 -	Problem Solving (n=13)	CBT, VP, Deprexis, Feedback, MI-CBT, NDI, CBT-CBT, IBCBSM, TAU	0.61 + 0.76 = 0.07 -
Dream Exploration/Interpretation (n=4)	Deprexis, SPPT, PT	1+	Psychoeducation (n=33)	VP, CBT NDI, PE, COPE, MBCT, VRET, ET, IIDEA, Deprexis, MBSR, Feedback, SS, MI-CBT, Return to Work, DBT, CBASP, BST, TSF, IT, CAT, GFERT, BDI, TARGET, SFT, IBCBSM, SET	0.57 + 0.66 = 0.24 -
Emotional Expression (n=5)	SCM, STPT, IT	0.80 + 0.20 -	Rapport	VP, CBT	1 + 0.5 - (n=2)
Emotional Regulation (n=1)	TARGET	1=	Relapase Prevention (n=21)	VP, CBT, IIDEA, Feedback, MI-CBT, NDI, RP, STPT, RI-CBT	0.47 + 0.71 = 0.28 -
Empathic Responses (n=2)	ISL, CBASP, BST	1 = 0.50 -	Relaxation Techniques (n=8)	CBT, Deprexis, MI-CBT, NDI, Return to Work, TAU, PMR, IBCBSM	0.62 + 0.62 = 0.25 -
Establishing the Therapeutic Alliance (n=9)	CBT, VP, ROPT, STPT, SET,	0.66 + 0.55 =	Rupture Repair (n=2)	STPT	1+
Exposure (n=16)	VP, PE, COPE, CBT, VRET, MI, Return to Work, DBT	0.43 + 0.81 = 0.18 -	Self Care (n=1)	GFERT	1+
Feedback (n=8)	NDI, TAU, TMA, MBCT, Feedback, MIT, BDI	0.12 + 0.62 = 0.50 -	Shared Experiences (n=2)	MBCT, MI-CBT	1= 0.50 -
Focus on Past Experiences (n=4)	IT, STPT PT,	1+	Socratic Questioning (n=4)	CPT, PT	1=

Focus on Interpersonal Experiences (n=4)	PFPT, STPT, PT	0.75 + 0.25 =	Thoughts Monitorization (n=8)	CBT, Deprexis, FCBT-CBT, MI-CBT, RI-CBT	0.37 + 0.87 = 0.12 -
Focusing (n=3)	RP, TARGET	0.66 = 0.33 -	Transference/ Countertranference (n=2)[i]	TFT, PFPT	0.5 = 0.5 -

[1] Note: CBT - Cognitive-Behavioral Therapy; DBT – Dialectical Behavior Therapy; MI – Motivational Interviewing; PE – Prolongue Exposure; RP – Relapse Prevention; RI-CBT – Religious Integrated CBT; TAU – Treatment as Usual; TSF – Twelve Step Facilitation; VP – Videoconferencing Psychotherapy; PMR – Progressive Muscle Relaxation; RO-PP – Relational-Oriented Psychodynamic Psychotherapy; SFT – Schema-Focused Therapy; SPPT – Short-Term Psychodynamic Psychotherapy; PT – Psychodynamic Psychotherapy; SCM – Supportive Clinical Management; IT – Interpersonal Psychotherapy; TARGET – Trauma Affect Regulation: Guide for Education and Therapy; ISL – Individual Supportive Listening; CBASP – Cognitive-Behavioral Analysis System of Psychotherapy; BST – Brief Supportive Therapy; SET – Supportive Expressive Therapy; VRET – Virtual Reality Exposure Therapy; NDI – Non-Directive Intervention; TMA – Therapeutic Model of Assessment; MBCT – Mindfulness-Based Cognitive Therapy; MIT – Motivational Enhancement Therapy; BDI – Brief Directive Intervention; PFPT – Panic-Focused Psychodynamic Psychotherapy; GFERT – Goal-Focused Emotional Regulation Therapy; CPT – Cognitive Processing Therapy; REBT – Rational Emotional Behavioral Therapy; MI-CBT – Motivational Interviewing CBT; CAT – Cognitive-Analytic Therapy; NR – Narrative Reformulation; MBSR – Mindfulness-Stress Based Reduction; CBT-CBT – Computer Based Training for CBT; IBCBSM – Internet-Based Cognitive Based Stress Management; SS – Seeking Safety; TFT – Transference-Focused Therapy;

The weight distribution of the techniques was considered based on the number of studies showing a greater impact on the therapeutic alliance compared to other interventions or the waiting list. This impact is evident in various alliance metrics and other indicators, including follow-up evaluations. Results indicate that some techniques may positively influence the size effect of the therapeutic alliance, while others appear to have no significant impact. For those who have a positive weight, we have: Acceptance, Assertive Strategies, Case Conceptualization, Chair Work, Cognitive Restructuring, Dream Exploration and Interpretation, Emotional Expression, Establishing the Therapeutic Alliance, Focus on Past Experiences, Focus on Interpersonal Experiences, Goal Setting, Rapport, Rupture Repair, and Self-Care. For those who have no significant impact on the size effect of the therapeutic alliance, we have: Avoidance Coping, Behavioral Activation, Breathing Techniques, Cognitive Dispute, Emotional Regulation, Empathic Responses, Exposure, Feedback, Focusing, Functional Analysis, Identifying Problematic Cognitions, Identifying Recurring Themes, Imagetic Exposure, Journalling, Mindfulness, Motivational Interviewing, Problem Solving,

Psychoeducation, Relapse Prevention, Relaxation Techniques, Shared Experiences, Socratic Questioning, Thoughts Monitorization, and Transference/Countertransference.

Therapeutic Strategies

Using the ITS, we can categorize the techniques and further understand their function in the different therapeutic interventions and in their role in the therapeutic alliance. As exploratory strategies, we employ a range of approaches, including rapport building, case conceptualization, identifying problematic cognitions, Socratic questioning, identifying recurring themes, focusing on past experiences, focusing on interpersonal experiences, establishing the therapeutic alliance, dream exploration and interpretation, and functional analysis. As supportive strategies, we have psychoeducation, shared experiences, feedback, relapse prevention, thought monitoring, acceptance, and self-care. As work-enhancing strategies, we have exposure, imagetic exposure, focusing, cognitive dispute, avoidance coping, mindfulness, cognitive restructuring, problem solving, journaling, affect regulation, emotional expression, relaxation techniques, assertive techniques, behavioral activation, breathing techniques, goal setting, empathic responses, emotion regulation, chair work, and rupture repair. It is important to note that some techniques may have aspects that allow them to be inserted into more than one category. Table 3 summarises the information.

Table 3 – Tecniques organized according to the Inventory of Therapeutic Strategies

Exploratory Strategies	Supportive Strategies	Work-Enhancing Strategies
Rapport Building	Psychoeducation	Exposure
Case Conceptualization	Shared Experiences	Imagetic Exposure
Identifying Problematic Cognitions	Feedback	Focusing
Socratic Questioning	Relapse Prevention	Cognitive Dispute
Identifying Recurring Themes	Thought Monitoring	Avoidance Coping
Focusing on Past Experiences	Acceptance	Mindfulness
Focusing on Interpersonal Experiences	Self-Care	Cognitive Restructuring
Establishing the Therapeutic Alliance		Problem Solving
Dream Exploration and Interpretation		Journaling
Functional Analysis		Affect Regulation
		Emotional Expression
		Relaxation Techniques
		Assertive Techniques
		Behavioral Activation
		Breathing Techniques
		Goal Setting
		Empathic Responses
		Emotion Regulation
		Chair Work
		Rupture Repair

From the results, the distribution of the therapeutic strategies that seem to have a positive effect on the size effect of the therapeutic alliance is 42.8% of Exploratory Strategies, 42.8% of Work-Enhancing Strategies, and 14.3% of Supportive Strategies. Regarding the distribution of therapeutic strategies that appear to have no significant effect on the size of the therapeutic alliance, we have 58.3% of Work-Enhancing Strategies, 20.8% of Supportive Strategies, and 20.8% of Exploratory Strategies.

Discussion

This systematic review aimed to provide a comprehensive view of the roles and tasks in the therapeutic alliance in the context of psychotherapy. Specifically, we focused on identifying tasks that indicate potential weight to the therapeutic alliance and outcomes. Regarding the therapeutic alliance, we follow Bordin's pantheoretical perspective for two reasons: it is the most researched and widely used perspective in the field. It is suited for every therapeutic intervention, regardless of their theoretical orientation. Through database searches, we identified 53 studies with a predominant emphasis on quantitative approaches, with special emphasis on different types of trials.

The studies presented a range of interventions directed at the adult population, comparing two or more approaches. The approaches varied in their theoretical orientation and in the derivation of primary interventions, such as cognitive-behavioral therapy and third-wave CBT. All studies presented a definition of therapeutic alliance, mostly Bordin's perspective. The instruments for measuring the alliance rated the global score and the bond, goals, and tasks dimensions. All studies presented clear intervention guidelines, divided into modules with specific tasks. To analyze the role of these tasks, they were organized into the categories of the Inventory of Therapeutic Strategies (Gaston & Ring, 1992). The results of this review indicate that all the techniques fall into one of two categories: those that have a positive effect on the therapeutic alliance and those that appear to have no significant impact on the therapeutic alliance. No technique has been shown to affect the therapeutic alliance negatively. One possible conclusion is that not all techniques seem to contribute to the therapeutic alliance or that the impact of the technique can be influenced by the context of the intervention and the way the therapist presents it. Considering Bordin's perspective on the alliance, one of the key elements of the alliance stands on the agreement to on the tasks of therapy. This agreement is important, no only to the progress of the therapeutic intervention, but also for the strength of the alliance, to prevent ruptures.

Considering a number of techniques that do have a positive impact, this result suggest that certain techniques can contribute to built the therapeutic alliance and the relationship, due to nature of the technique, the relational contribution or by having an effect on parts of the relational process. This suggests that the establishment of the therapeutic alliance and relationship can be both relational as technical, where a good alliance is the result of a relational encounter, delivered in a relational/technical way.

A cautionary consideration about techniques that didn't show any effect. This doesn't mean that they're not effective, as relation builders, but rather if we need more rigorous forms of measuring the relationship, especially the interaction between relation and techniques. This require precision, not over or underestimating the value of techniques. It's important to study the mechanisms that make techniques work and how can we be effective, consistently, in their application and even increase their impact on relational processes.

Finally, it's also important that we invest in our interventions. This means the opportunity to test a greater diversity of therapeutic models, not only to prove effectiveness, but also to allow therapist to be more technical capable to be more responsive to particular

populations, characteristics, needs or contexts. In a sense, be more able to delivery the intervention the intervention that the patient needs.

This systematic review examined the role of tasks and techniques in the therapeutic alliance within single adult therapy; therefore, it is essential to acknowledge the limitations of generalizing beyond this specific context. The impact of tasks and techniques in the alliance may vary across different therapeutic settings, such as group therapy, systemic therapy, or therapy with children and adolescents. Differences in task weight and technique can arise when considering alternative perspectives on the alliance and different instruments for measuring. Since this is a review, these results may change across time, which suggests new updates in the future. Despite these limitations, this review contributes to the discussion on exploring the interplay between techniques, the alliance, and the therapeutic relationship.

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Chapter 3

Interplay Between Relationship, Techniques, and Ruptures in Practice

This chapter is based on the papers:

Ribeiro, P. R., & Neto, D. D. (2025). The Interplay of a Integrated Therapeutic Relationship Framework and Intervention: Insights from a Reflexive Thematic Analysis Case Study [manuscript submitted for publication].

The Interplay of the Integrated Therapeutic Relational Framework and Intervention: Insights from a Reflexive Thematic Analysis Case Study

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ABSTRACT

Introduction: The patient's perspective on the therapeutic relationship highlighted the importance of core needs in shaping the relationship and the therapist's perception. At the same time, by attending to the patient's needs, the therapist can better establish the relationship responsively.

Objective: This study aimed to explore the five-component transtheoretical perspective on the therapeutic relationship in a brief therapeutic intervention, the therapeutic techniques, and ruptures in the alliance.

Method: This research employs a qualitative approach, guided by Reflexive Thematic Analysis to inform data collection and analysis. A therapeutic dyad composed of an adult male patient and a male therapist was recorded across nineteen sessions of brief individual therapy. Alliance ruptures were also analyzed with the Rupture Repair Rating System.

Results: Two themes were identified: "patient's relational needs" and "techniques of therapy". Being able to be genuine and feel secure with the therapist is linked to the five-component model, which addresses constant thoughts and emotions, which seemed to be a specific case need. Techniques of therapy were found to be intervention-specific and more technically eclectic. The primary type of ruptures observed, confrontation markers, did not seem to affect the quality of the alliance or relationship.

Conclusion: This study advances the patient's theoretical perspective on the therapeutic relationship, stressing the role of the patient's core needs and the ability of the therapist to be more centered in responding to patient's needs, integrating relational stances and techniques.

Keywords: therapeutic relationship, patient's core needs, therapeutic intervention, integration

Introduction

The therapeutic relationship has been considered one of the most consistent factors in accounting for outcome variance in treatment methods (Norcross, 2019). The therapeutic relationship can be viewed as the feelings and attitudes that the therapist and client have towards one another, and how these are expressed (Gelso & Carter, 1985, 1994). Although accepted as a working definition by various working groups, Gelso and Carter's definition of the relationship has been criticized, especially regarding its expression. Hill (1994) stated that this inclusion "muddies the water and opens up the relationship to include everything" (p. 90). Regarding this criticism, Gelso and Carter (1998) further suggested that psychotherapy consists of both a relational and a technical component, which constantly interact and influence one another in a profound synergy.

Another significant challenge in defining and operationalizing the therapeutic relationship is determining what elements to include and exclude. Norcoss (2019) presented the relationship like a diamond – a diamond composed of multiple, interconnected facets – a complex and multidimensional entity. Following this analogy, Ribeiro and Neto (2025) proposed a synthesis of the therapeutic relationship, through the real relationship, the therapeutic alliance, and the client's attachment to the therapist, the Integrated Therapeutic Relationship Framework.

In this study, Ribeiro and Neto (2025) assess the perceptions of 373 adult clients of individual therapy, regardless of theoretical model, regarding the real relationship, the therapeutic alliance, and the client's attachment to the therapist. The focus on the patient's perspective was given, considering their activeness and their sense of initiative and agency for investing in the therapeutic process (Bohart & Tallman, 2022; Ribeiro & Neto, 2025), as well as their more accurate and precise view of the alliance (Bachelor, 2011; Ribeiro & Neto, 2025). A five-component structure model emerged, illustrating what appear to be the patient's needs in the relationship and beliefs about the therapist. Regarding the relationship, they were identified as "Need for security in the therapist"; the development of a secure base, from which the patience might feel that the relationship and the therapist can support his/her needs and worries, establish a base in which emotions can be express and regulated; and a "Working on the goals of therapy"; an important part of success of therapy, where patience and therapist meet in negotiation of what the most important for the patient to change and the tasks that are require to do so. Regarding beliefs about the therapist, they were identified as

the “Clients’ need to be cared for by the therapist”; this represents an intrinsic and fundamental need to give and receive caring, a need that allows the growth of the sense of security and that their thoughts, emotions, and behaviors are important for the relationship and the therapist; “Client’s fear of being genuine to the therapist”; from the patient’s perspective, there are intense moments where the therapist can adopt a judgmental posture on the motives and reasons to seek therapy, or that the therapist cannot understand or relate to what the patient is saying or feeling; and the “Client’s need for more contact and expanding the therapeutic relationship beyond therapy boundaries”; wanting to have some knowledge of the therapist’s personal life can be a way of building trust by identifying with him/her or to regulate the fear of a belief of abandonment. The authors emphasized the transtheoretical potential of the Integrated Therapeutic Relationship Framework in addressing the patient’s core needs with the therapeutic relationship and in preparing therapists to be more responsive to them (Ribeiro & Neto, 2025). One such process might be identifying and repairing ruptures.

Identifying Ruptures

Over the last few decades, research on ruptures and rupture repair has shown the increasing importance of alliance quality and the overall effectiveness of therapy outcomes (Eubanks et al., 2018). Ruptures have been defined as disagreements on how the patient and therapist work together (e.g., on tasks), to what end (e.g., goals), and a deterioration in the bond (the extent to which there is distrust and disrespect between patient and therapist) (Safran & Muran, 2000, 2006). This definition was based on Bordin’s (1979) transtheoretical reformulation of the alliance construct, which comprises the interdependent dimensions of *purposeful collaboration*—agreement on the goals and tasks of treatment—and *affective bond* -mutual trust and respect (Muran et al., 2023). This laid the foundation for considering ruptures as an integrative variable or common factor (Wampold & Imel, 2015; Wolfe & Goldfried, 1988).

Regarding the type of ruptures that can occur and therapy, a distinction between withdrawal and confrontation markers was made. Withdrawal markers include movements away from another person, such as going silent or pivoting away to discuss another topic or engage in abstract talk. These can include movements away from certain aspects of oneself to appease the other, such as begrudgingly going along with someone to avoid conflict.

Confrontation markers include movements against the other, involving aggression or control, such as criticisms or manipulations (Muran & Eubanks, 2020; Safran & Muran, 2000; Samstag et al., 2004).

Although ruptures are defined as markers, making them easier to identify, it is essential to recognize that they emerge within the context of a co-constructed therapeutic relationship. Additionally, they can be defined in terms of intrapersonal markers, emotional states indicating empathic failures, interpersonal pulls, enactments, and power plays (Muran et al., 2023). Recognizing these markers is not enough to ensure the quality of the relationship and the outcome of therapy. The therapist and patient must work collaboratively to negotiate these disagreements, creating moments that allow the dyad and the relationship to move forward.

The recently revised typology of rupture-repair strategies, derived from empirical and practical clinical literature, includes three possible pathways for engaging the repairing process. Each path begins with an acknowledgement of the rupture, whether by the therapist, the patient, or both, and ends with a provision of a new relational experience. The first two pathways are categorized as *immediate* strategies, focusing directly on responding to the rupture and taking corrective steps to get the treatment back on track. The third pathway is categorized as *an expressive strategy, involving the exploration of the rupture and the respective contributions of both the therapist and the* patient. The goal is to achieve clearer expression and recognition of implicit needs (Muran et al., 2023). The most emphasized principle in rupture repair is *metacommunication* (Kiesler, 1996; Safran & Muran, 2000), which involves communicating about the communication process as it unfolds. It is viewed as a form of *mindfulness-in-interaction*, bringing bare attention to both the patient's and the therapist's states and actions in the present moment. It is also a means to an end, realizing mutual recognition of both patients' and therapists' subjectivities and bridging the path to resolving the dialectical tension they each experience as they negotiate their respective needs (Muran, 2019; Muran & Eubanks, 2020).

Advancements in the therapeutic relationship and rupture repair can also be provided through tasks, techniques, tools, or methods used by the therapist to facilitate effective therapy and positive behavior change in clients (Harper & Bruce-Sandford, 1981).

Techniques can also be associated with Bordin's task component of the alliance, which refers to specific, overt, or covert activities the patient must engage in to benefit from the treatment (Safran & Muran, 2003). Safran and Muran also described: "the process of relating to the therapist in an authentic and organismically grounded fashion (common to both existential and relational psychoanalytic approaches) can be thought of as yet another therapeutic task" (p.13). Some of the research seems to support this by concluding that techniques can have an impact on the alliance (Ackerman & Hilsenroth, 2003), where exploratory strategies can enhance the bond between therapist and patient (Bachelor, 1991), such as accurate interpretation (Crits-Christoph, Barber, & Kurcias, 1993) and reflection, listening, and advising (Sexton, Hembre, & Kvarme, 1996).

Present Study

On theoretical debate about the relationship, some authors have emphasized the need to analyze the procedural interaction within the relational dyad (Ribeiro, 2019; Horvath, 2005; Muntgil & Horvath, 2014). In this regard, qualitative approaches, such as this case study, have been more readily accepted for understanding moment-to-moment process quality. Case study approaches allows for the researcher to create an detailed narrative of the patients therapeutic experience along the intervention period, being able to understand the processes of change and capture their depth and complexity (Salgado & Cunha, 2025)

Building on the work of Ribeiro and Neto (2025), this study aims to contribute to the transtheoretical perspective by examining the development of relational core needs within the therapeutic relationship during a brief therapeutic intervention. Using a qualitative approach to a case study, we intend to answer the following questions:

1) How can we understand the patient's needs in the Integrated Therapeutic Relationship Framework throughout the therapeutic process?
2) What quality of specific tasks is used by the therapist throughout the therapeutic process?
3) What specific ruptures are identified throughout the therapeutic process? What impact do they have in this therapeutic relationship?

Method

Participants

Client. Filipe (fictional name) was a Portuguese man in his early twenties with compulsory education and a low socioeconomic status. He was single and resided with his parents. Filipe seeks treatment for an increase in anxiety and prolonged suffering due to not being able to leave his home. At the time of the intervention, Filipe had had a previous therapeutic intervention, where, at the beginning, it helped with some of the anxiety symptoms and was later terminated by Filipe for what he considered a decline in the quality of the relationship. No previous diagnosis of any Anxiety Disorder was attributed; only a current diagnosis of agoraphobia was made in accordance with the DSM-5 (APA, 2013).

Beyond the diagnosis, Filipe's core issues were related to difficulties in emotional regulation, having feelings of anger towards people, in general, and some former classmates. He believes that people are not to be trusted and that they will hurt you at the first chance they have. Early experiences might explain this difficulty in emotion regulation and core beliefs; at 6 years old, Filipe contracted a severe infection in his stomach that could have endangered his life. Consequently, Filipe had difficulty controlling his sphincters and sometimes would involuntarily defecate, and was the object of ridicule by the other children. At 15 years old, Filipe was the target of bullying and was constantly beaten. According to Filipe, he felt ashamed by what was happening, by not being able to defend himself, and by what others might think of him, and that is why he hid it from his parents. When he was able to speak out, apparently, the school director took no measures, which led Filipe and his parents to feel even more frustrated and to distrust the school. At 18 years old, Filipe decided to enroll in a professional computer science course, not only because of his personal interest in computer science and gaming, but also because the course's description motivated him. According to Filipe, the course did not match its description, and he eventually blamed the teachers and the school for deceiving him. This last situation was the catalyst for Filipe's decision to drop out of school and lock himself in his home. As time went by and his feelings of anger and mistrust toward people increased, Filipe started to experience more difficulty in leaving his home, until the mere thought of doing so triggered anxiety and some panic. The current treatment was performed at Filipe's house, during 19

therapeutic sessions. Filipe's case was within the established inclusion criteria for this study: (1) an individual therapeutic intervention with (2) an adult, performed by (3) a qualified psychologist with post-graduate training in psychotherapy, (4) regardless of the theoretical approach. Both Filipe and the therapist consented to have the sessions audiotaped after they were informed about the aims of this study, the procedures for handling the audiotaped sessions by the research team and the publication of the results for research purposes.

Therapist. Filipe's therapist was a male clinical psychologist with a master's degree, a member of the Order of Portuguese Psychologists, in his early forties. He had 12 years of experience as a psychologist and had been trained in CBT, n psychotherapy model that draws on concepts and techniques from cognitive and behavioral therapies. CBT is usually synonymous with cognitive therapy, a structured, short-term, present-oriented psychotherapy for depression, later adapted to a diverse set of problems or disorders, populations, settings, and formats (Beck, 2020)..Additionally, he received further training in relaxation, breathing, mindfulness meditation, and EMDR.

Process Measures

Working Alliance Inventory – Short Form. In the present study, we used the Portuguese version of the Working Alliance Inventory – Short Form (WAI-S; Tracey & Kokotovic, 1989). The short version consists of twelve statements assessing the patient's perception of the therapeutic alliance with the therapist, rated on a 7-point Likert scale ranging from 1 (never) to 7 (always). Along with the alliance's global score, the WAI-S also includes three subscales: Bond, Task, and Goals. Items 3, 5, 6, 7, 9, and 12 were reverse-scored. The Portuguese adaptation (Machado & Horvath, 1999) showed good psychometric properties.

Rupture Resolution Rating System. The Rupture Resolution Rating System (3RS; Eubanks et al., 2015) is an observer-based measure designed to identify ruptures and their subsequent resolutions. The 3RS differentiates withdrawal ruptures and confrontation ruptures based on patient-based rupture markers identified by Harper (1989a, 1989b). Withdrawal rupture occurs when a patient's behavior appears to indicate disengagement from an emotional state (e.g., defensiveness), from the therapist (e.g., minimal response), or from some other aspect of the treatment (e.g., avoidant storytelling). Confrontation ruptures occur

when the patient directly expresses dissatisfaction with the therapist (e.g., by complaining to the therapist) or with an aspect of the intervention (e.g., by rejecting it). The 3RS also identifies therapist-based resolution markers based on rupture-resolution strategies (Safran & Muran, 2000). Additionally, the 3RS enables coders to assess the clinical impact of each type of rupture, the extent to which ruptures were resolved during the session, and the degree to which the therapist contributed to and/or exacerbated ruptures. The 3RS has demonstrated high interrater reliability (intraclass correlation coefficient, ICC = 0.73-0.96) with previously trained coders (Coutinho et al., 2014; Eubanks et al., 2019).

Procedure and data analysis

The Ispa-Instituto Universitario's Ethical Committee approved this study (Nº D-052-06-22). The study was disseminated through social networks, with a focus on practicing psychologists. The study's informed consent was structured in accordance with the General Data Protection Regulation's guidelines for the processing of personal data of the participants. A master's degree psychology student was added to the research team to provide further assistance with data treatment and analysis.

Therapist selection was conducted according to the study's inclusion criteria, case availability, and patient acceptance. Inclusion criteria for the patient include (1) being 18 or more, (2) being in individual therapy, and (3) authorized that the sessions could be recorded. For the therapist, the inclusion criteria included (1) being a psychologist, (2), a official member of the Order of Portuguese Psychologists, and (3) have pos-graduated training in psychotherapy. Instructions for the study and special attention was given to recording sessions to ensure optimal recording conditions. Instructions for completing the Working Alliance Inventory were given in the first, sixth, and eighteenth sessions. After each session, the first author arranged a personal meeting with the therapist to obtain a recording of that session. The first author placed each session on an encrypted drive to ensure the confidentiality and proper treatment of the material. Each session was organized and transcribed by the student using Microsoft Word. Data analysis was conducted as follows: the first author analyzed all sessions in MAXQDA and conducted a Reflexive Thematic Analysis to answer research questions 1 and 2. To answer question 3, both the first author and the student independently analyzed each session using the Rupture Resolution Rating System, and then conducted a third analysis together to resolve any disagreements and achieve inter-rater reliability.

Reflexive thematic analysis

Reflexive thematic analysis is a varied approach to conducting thematic analysis, popularized by Braun and Clarke (2022), characterized as an easily accessible and theoretically flexible interpretive approach to qualitative data analysis that facilitates the identification and analysis of patterns or themes within a dataset.

This approach highlights the researcher's active role in producing knowledge. Codes are viewed as the researcher's interpretations of patterns of meaning across the dataset, and are considered a reflection of the researcher's interpretative analysis conducted between: (1) the dataset; (2) the theoretical assumptions of the analysis; and (3) the analytical skills/resources of the researcher (Braun & Clarke, 2022). It is expected that no two researchers will analyze these three criteria in the same way, and therefore, the codes and themes may not be fully reproducible. Instead, the goal of the reflexive thematic analysis is to achieve a richer interpretation of meaning, remaining cognisant that qualitative analysis does not claim to provide a single or "correct" answer (Braun & Clarke, 2022). The following data analysis follows the six distinct phases of Reflexive Thematic Analysis (Braun & Clarke, 2022): data familiarization, generating initial codes, generating themes, reviewing potential themes, and defining and naming themes.

Data Familiarization

Initially, all 19 sessions were transcribed verbatim, totalling 17 hours, 27 minutes, and 41 seconds. It is important to note that not all sessions had the exact time limit. An interview was transcribed per day, in a process that took 19 days. The transcription includes all nuances, words, and punctuation, with accuracy ensured by listening back to each recording at least twice. No transcription software was used in this process to fully immerse in the material of each session. In this stage, a general tone for the sessions and interactions was observed, with significant emotional activation. This tone could be important to explore in future stages and to discuss among the research team. The notation from the first author, at this stage, took the form of bullet points, each representing a perception of the session worth discussing.

Generating Initial Codes

Initial code generation was started as soon as each session was transcribed. This decision was made due to time constraints and management. Also, during this, the first author felt that the session's immersion and its material remained very present, facilitating the coding process. Each session was transcribed in Microsoft Word, and initial code ideas were handwritten. Moreover, because this was done after the transcription and listening back to the recording, the initial notation included the degree to which the author felt the patient was activated. For context, both authors are experienced psychologists and CBT-trained psychotherapists with clinical practice. Hence, the discussions revolved around the codes considering their clinical sensibility and the five-component relational model. The first author needed to be mindful of any projections from the data set and to the data set.

After each initial code idea was written, the transcribed session was imported into MAXQDA, qualitative data analysis software, to better organize the data and use computer-assisted coding. Each transcription line was numbered, and the central ideas or events were noted for future coding. At this point, the first author felt that his ideas and first codes might be more influenced by his experience in psychotherapy and his relational component model, especially with the first research question in mind. His greatest challenge was to understand relational needs that were not explicitly requested by the patient but could be implicitly conveyed in the dialogue. For the second question, the first author felt that recognizing specific techniques used by the therapist came more easily for him. There was a sense of surprise at the significant time devoted to emotional dysregulation and the need to establish a better relationship with emotions, given the standard CBT training and therapeutic goal. On the other hand, focusing on dysfunctional beliefs and thoughts restructuring is more aligned with CBT interventions. Both seemed like something the patient needed and sometimes requested. From the therapist, while some strategies or techniques were more easily identified as CBT-specific, the first author found it interesting that the therapist seemed responsive to the patient and to relational shifts. This allowed the first author to refine a more raw set of ideas into valuable code sets.

Generating Initial Themes

After the third pass through the code, the first author read the transcripts meticulously to ensure accuracy and the proper fit of the codes to the patient-therapist interactions. When in doubt, the first author would return to the audio recordings and listen to the specific section where he had doubts about the coding. Using MAXQDA's theme-generation capabilities, the first author grouped every code he deemed to have a similar core meaning. At this point, difficulties arise with theming and a disconnection between the author's perception and the material. This disconnection seemed to stem from the author's conceptions of the therapeutic relationship and his previous work. The recognition of similarities between certain parts of the material and codes, using the five-component relationship model, led the first author to question his objectivity in the coding analysis, prompting him to discuss his doubts with the second author. It was agreed that some codes could generate themes related to components of the relationship model. In contrast, other themes emerged from the therapeutic work for the first research question. Regarding the second question theme, there was a consensus on the coding process. By this point, the first author had fully adopted the critical perspective; the challenge was balancing this perspective with remaining faithful to the first research question and the study's general aim.

Defining and naming themes

This phase of the analysis was straightforward and clearly defined by theoretical and clinical concepts. Each theme was supported by a distinct concept that made sense to us and felt consistent with the data set and the therapeutic intervention's tone. The first research question was based on the five-component perspective on the therapeutic relationship. Something that became clear was to assume a position of confirmation if the dataset showed any material related to the theoretical perspective, while at the same time exploring any new material or codes related to this process. For the second research question, we acknowledge the importance of choosing themes that could give a level of organization for better analysis of the results. From the first author's perspective and experience with this coding analysis, this decision illustrates the difficulty of conducting a Reflexive Thematic Analysis while following all the steps and phases outlined by Braun and Clarke (2022).

Results

Findings on the Reflexive Thematic Analysis

To answer the two research questions, "how do the five-structure components of the relationship interact throughout the therapeutic process?" and "what quality of specific tasks is used by the therapist throughout the therapeutic process?", all 19 sessions were analyzed according to the reflexive thematic analysis guidelines (Braun & Clarke, 2020). For the first research question, one theme and four subthemes were constructed; for the second research question, one overall theme, two themes, and three subthemes were constructed (Table 1)

Table 1 – Themes and Subthemes

Themes	Subthemes
Patient's relational needs	Able to be genuine
	To feel secure with him
Techniques of therapy	Dealing with constant thoughts
	Handling emotions
	Therapist's specific techniques
	Beyond traditional CBT

Theme 1 – Patient's relational needs

Across the sessions and the intervention, several moments were identified as patient needs. These needs naturally emerge from the interaction between the patient and the therapist. The needs seemed to emerge at different moments when therapy reached depth or activation, influenced by the quality of the relationship, the therapist's posture, and the therapeutic strategies employed. Most of the needs could be identified across several points in the dialogue between the patient and therapist, even though the patient did not explicitly ask for them.

Subtheme 1 - Able to be genuine

Despite the patient's view that most people are untrustworthy and have harmful intentions, throughout the sessions, he seemed willing to discuss several delicate episodes from his life, especially those linked to traumatic events. For the patient to be genuine about parts of himself and particular difficult moments, we can expect a relationship based on trust and a nonjudgmental attitude from the therapist. The following is an example from the sixth session, between the patient (P) and the therapist (T):

P – And those things were happening to you?

T – Yes, it is just that… for him, it was safe to be inside the car, next to the school gate. It did not talk with the teachers, did not talk with the principal, did not mention the fact that I was

suffering from bullying in school, did not mention to any teacher or the school council that other kids were calling me names and hitting me, or did this and that.

Subtheme 2 – To feel secure with him

As the relationship develops, the patient seems to perceive a sense of safety and security, built on interactions with the therapist. Because the patient feels that he can be genuine, not be judged, and that the therapist respects him, he feels safe in the relationship. This safety might be new, depending on the establishment of previous relationships, and it builds confidence that the therapist will not abandon the patient or the relationship. The following is an example from the tenth session:

P – I can only speak for myself… If I notice that one day… If you do not have the mind… Or simply without… If you feel down… Or something like that… I do not blame you for it… Because we all have days like that…

T – No… If that day were to happen… And… It might happen… Even despite my best efforts… Please… We can talk about it… Because obviously this is something important about our relationship…

P – Sure… However, if it happens… I won't blame… Won't judge…

T – On the other hand…

P – We all have bad days…

Subtheme 3 - Dealing with constant thoughts

Initially, the patient presented dysfunctional beliefs about himself and others. These beliefs took form in automatic thoughts triggered by specific events. Those thoughts seemed difficult to deal with, generating physical and emotional discomfort. Despite that discomfort, the patient chose to elaborate on them in therapy, most often when the therapist invited him to do so. The following is an example from the ninth session:

P – Yes. That is why I said there is a 70-30 percent split. 30%. Because… Sure, I will not deny it: if I am walking down the street, the discomfort becomes apparent. It is not quite uncomfortable. The head starts to go to places it is not supposed to, and the discomfort adds to it. And then, of course, it comes to that small thought of "fuck it", I would rather be at home gaming on my PC, where I am much more comfortable.

T – Because here I am comfortable.

P – Yes. No, I am… I am comfortable in the street; it is just a different kind of comfort. I am comfortable being on the street. I feel good about being on the street and not staring at my PC. I feel good seeing something different from the PC screen. I feel comfortable with the idea of being in the street. What fucks it all, pardon the expression, is the distance. It is the distance, and when it comes, when the limit comes, is when things start to get worse.

Subtheme 4 – Handling emotions

One characteristic of the intervention is a focus on the patient's emotions and emotional activation. The patient expresses a need to deal with emotions; at the same time, he recognizes that this is particularly difficult for him, especially those that can cause discomfort, tension, and suffering. The therapist seems to acknowledge this need, focusing a large part of the therapeutic work on working with emotions and their regulation. The following is an example from the fourth session:

P – There is something that happened yesterday that I cannot understand. We are going to move the conversation along a little.

T – We never move away.

P – Because after that feeling of relief, my legs failed, I sat on the couch, but there is something else. I do not know what happened. Moreover, do not ask me to describe the emotions, because I cannot. I have been thinking about it since yesterday, and I cannot decipher them. Moreover, it was an accumulation of emotions, a great mixture, that I practically… Not practically, I am basically just crying.

T – That seems relief to me.

P – Relief with despair, with God knows what.

Theme 2 – Techniques of therapy

In analyzing this intervention, we observed that the therapist was highly technically active. Those techniques seem to achieve four goals: establishing the therapeutic relationship, restructuring automatic thoughts and dysfunctional beliefs, working with emotions, and problem-solving. Overall, the patient appears to collaborate with the therapist and to integrate some of these therapeutic strategies for day-to-day use.

Subtheme 1 – The specific techniques

Further analysis of the therapist's techniques could identify CBT-specific methods, which is expected given the therapist's training. Cognitive-behavioral strategies focus on identifying distortions in automatic thoughts, underlying assumptions, and core schemas or beliefs. Specific techniques used by the therapist, along with the intervention, included: psychoeducation, the A-B-C Technique, cognitive restructuring, cognitive dispute, examining the evidence, and the downward arrow technique. The following is an example from the fifth session:

P – That is right, but if it is pending on the good side, eventually something bad will happen.

T – And why can't it simply balance? Stay this way for some time? Why does it have to be…

P – Right. Again, based on my own life experience, my balance is always falling to the wrong side. It is always heavier on the opposing side.

T – Hum. Always?

P – Almost always. (P – Hum) Almost all the time. What I have noticed in the last 5, 6 years is that, if needed, I go through months simply dealing with negative things that come and no positive ones. If something positive comes, I am so distracted that I do not notice it.

T – Because you have 6 years right now…

Subtheme 2 – Beyond traditional CBT

The therapist seems to rely on other techniques and therapeutic strategies beyond the scope of CBT-specific training. Some of these techniques were further assimilated into other generations of cognitive interventions and other psychotherapeutic interventions beyond CBT. The identified techniques were metacommunication, self-disclosure, therapeutic metaphors, hypnosis, empathic affirmation, miracle scale, and grounding. The following is an example from the fifth session:

T - …Your life scheme, or your current life scheme, is this. Moreover, what do you do? You try to confirm it. Even if some things are not related, in your mind, they help justify your scheme because there is an existential question. If you do not have this scheme, what do you have? Or even better, if you do not have this scheme, who are you? (Silence)

P – Good question. Good question. Something that I cannot answer right now.

T – It is hard for people to have. Because it considers their own identity, it is just like the metaphor: If I take off all my clothes and get myself naked, what is left of me? (Silence)

P – I do not know how to answer it right now. I would like to… If you take this justification, this plan, what does it bring me? Fuck!

Working Alliance

The working alliance was measured using the Working Alliance Inventory, which assesses the perceived quality of the alliance established between the therapist and the patient, from the patient's perspective. To account for natural fluctuations in the alliance throughout the therapeutic process, data were collected at three distinct points: the first, sixth, and eighteenth sessions. Global and subscale scores were calculated. The following results are presented in Table 2.

Table 2 – Working Alliance Inventory (WAI) scores

	WAI-S Dimensions			
Sessions	**Bond**	**Goals**	**Tasks**	**Global Score**
1	4.00	3.50	3.50	48
6	3.50	3.50	3.00	44
18	4.00	5.00	4.75	59

Looking at the global score results, we see a slight decrease between the first and sixth sessions. However, between the sixth and the eighteenth sessions, we see a significant increase in the quality of the alliance. While fluctuations in the alliance are expected, throughout the therapeutic intervention, overall, we see the establishment of a good alliance.

Rupture Resolution Rating System

Audio-recorded sessions were used for this analysis. The transcripts served as verification when specific interactions were unclear due to sound issues. Both the author and the student conducted individual coding analyses of all sessions, and a third analysis was conducted collectively to ensure coding agreement. 5-minute segments were established according to the manual, with each segment coded for rupture markers. Attention was given to rupture markers initiated by the patient, by the therapist, and by both simultaneously. Attention was also given to resolution strategies for each rupture and their efficacy. Coding was done in two 5-point Likert scales provided in the manual.

For the individual coding procedure, both the author and the student coded two sessions per day over ten days. For the joint coding procedure, the same process was used, coding two sessions per day over ten days. For the most part, both agree with the same rupture markers in the same time segments. A total of five segments were analyzed due to individual disagreements; all decisions reverted to the author's coding analysis, based on his clinical experience and extensive training in psychotherapy.

Regarding rupture analysis, the quality of the rupture coding was assessed by calculating inter-coder reliability in IBM SPSS Version 29. Inter-coder reliability was considered moderate (k = .696). Only 8 of the 19 sessions were identified with ruptures. A total of fourteen ruptures were coded, of which ten were coded as confrontation markers and four as withdrawal markers. In the relational dyad, both the patient and the therapist exhibited similar patterns in initiating rupture markers. The patient initiated 7 ruptures, the therapist initiated 5, and only 2 were initiated by both. Table 3 will present a summary of these results.

Table 3 – Rupture analysis with the 3RS

Session	Segment	Type of Rupture	Patient or Therapist	Rupture Repair	Rupture's Alliance Impact
2	40-45	Confrontation	Patient	No	2
(1:05:55)	45-50	Confrontation	Both	No	2
	55-60	Confrontation	Patient	No	2
3	45-50	Confrontation	Therapist	No	2
(56:11)	50-55	Confrontation	Therapist	No	2
4	5-10	Confrontation	Therapist	No	2
(42:48)					
7	10-15	Confrontation	Patient	No	2
(47:58)					
12	30-35	Withdrawal	Patient	No	2
(57:06)	40-45	Withdrawal	Therapist	No	2
13	20-25	Confrontation	Therapist	No	2
(58:30)					
14	35-40	Withdrawal	Patient	No	2
(1:08:41)	40-45	Confrontation	Both	No	2
18	5-10	Withdrawal	Patient	No	2
(55:13)	45-50	Confrontation	Patient	No	2

Regarding the rupture repair, none of the ruptures were considered repaired per the 3RS Manual (Eubanks & Muran, 2023). Nevertheless, those ruptures did not appear to affect the quality of the therapeutic alliance or the overall state of the therapeutic relationship. However, when considering the three pathways of rupture resolution and the core rupture repair strategies, such as metacommunication, the therapist did not identify rupture markers or initiate rupture-specific repair interventions.

Discussion

In this study, we intend to explore further the Integrated Therapeutic Relationship Framework in a brief therapeutic intervention. A qualitative case study methodology was chosen to provide a contextual comprehension of the relationship, with a realistic illustration of therapy. We see an increase in case studies to inform the fine-tuning of the quality of the therapeutic relationship, a more process-focused type of research. We then tried to understand which components of Ribeiro and Neto's (2025) framework emerged during the therapeutic intervention, which specific techniques the therapist used, and, finally, which ruptures emerged during the intervention and how and where they were repaired.

Through a reflexive thematic analysis, we found patients' relational needs. The first needs can be identified in Ribeiro and Neto's (2025) framework model, "able to be genuine" and "to feel secure with him". As explored by Ribeiro and Neto (2025), the need for safety in the therapist is highly influenced by attachment theory and the patient's conscious or unconscious goal to establish a perception of felt security. This felt security is not only psychological but also physical and is supported not only by Bowlby's definition of attachment (1969; 1988) but also by Maslow's motivation theory, which proposes that human beings possess two sets of needs: deficiency needs and growth needs (Maslow, 1997). From the patient's point of view, there is an encounter with a therapist who is available to meet him at the lowest point of his situation, accepting his reality without judgment, offering trust and a collaborative posture. There is an understanding of psychological needs and a genuine capacity for relating, establishing a presence in the here and now. This presence allows the therapist to explore the patient's intention to implement change in their life, developing a sense of self-efficacy and motivation. While comprehending the need for security, caring, and unconditional positive regard is important for the initial establishment of the therapeutic relationship, in some situations, these qualities are not expressed. Patients might feel that it is difficult to put into words what they are feeling, or to have a conscious understanding of what they need. These difficulties can be expressed nonverbally (tense body posture, lack of eye contact, long periods of silence) or verbally (avoiding specific themes, opposing the therapist's solicitations). The therapist needs to be present and responsive, asking the patient directly about his needs and what he is feeling, or to try to verbalize the patient's needs through empathetic conjectures. Regarding "dealing with constant thoughts", this need seems to be specific to the patient and this case. The five-component therapeutic relationship

perspective identifies pantheoretical needs, needs that seem to be present regardless of the therapeutic approach, and for most people. The model appears to be sequential, with the first 3 components serving as the base levels for building a strong relationship, and the last 2 components help the working development of the relationship and the therapeutic process. Beyond these core needs, we can hypothesize the emergence of specific needs associated with the patient's unique characteristics, diagnosis, or the therapist's particular therapeutic approach. In this case, the presence of automatic dysfunctional thoughts and beliefs is typical of anxiety symptoms or anxiety disorders. It is also a key point in CBT models, both in their conceptualization and in their interventions. As with core needs, the therapist needs to assume a responsive posture and develop a therapeutic presence to be flexible in responding to the most important needs. For the final need, "handling emotions", we can categorize it as an intermediate core need. Emotions are complex states that result in physical and psychological changes that influence thought and behavior. They are universal and fulfill three central aspects: action tendencies, information, and need satisfaction (Greenberg, 2025). It is possible to include emotional processing or emotional regulation as a core need. On the other hand, we can also consider it a characteristic-specific need, since not all patients need help with emotion expression or regulation. We can also consider it a diagnosis-specific need, where depressive disorders, anxiety disorders, phobias, or PTSD present difficulties in emotion regulation, or even in borderline personality disorder, some authors consider the fulcrum point of the disorder to be the intense fear of abandonment. Finally, it can also be a specific intervention need, where emotion plays a more main role, like in Accelerated Experiential Dynamic Psychotherapy or Emotion-Focused Therapy, in contrast with Cognitive Behavioral Therapy or Psychodynamic Psychotherapy.

Regarding the therapist and the techniques that were used, we can infer a certain level of responsiveness, were is uses techniques from other therapeutic models alongside specific CBT techniques. They are seemed to be used in a more genuine way, more empathic and accepting than in more traditional CBT models. Being more emphatic and present can effectively help to develop a strong therapeutic relationship. Despite not doing a formal case conceptualization, the therapist used several techniques from CBT, especially psychoeducation, when dealing with automatic dysfunctional thoughts, and tried to restructure several cognitions. Other strategies beyond CBT included grounding (most closely related to anxiety), miracle scaling in problem-solving, metacommunication from

Metacognitive Therapy, several therapeutic metaphors, and self-disclosure, a particular technique that, when done correctly, can enhance the therapeutic relationship. Despite using several techniques, the therapist looked pretty responsive to the patient, to the point that the patient did not refuse.

Regarding ruptures and the results from the 3RS, we found that ruptures did not occur in all sessions and that both the patient and the therapist were equally responsible for initiating rupture markers. From the patient's perspective, most rupture markers are confrontational, suggesting disagreement with the goals and tasks of therapy. In some instances, the therapist adopted a more challenging stance when the patient might have needed more validation or support in regulating their emotions. Regarding the therapist, most of the rupture markers were also confrontation markers, validating the patient's reaction to being more challenged and suggesting that the therapist was very technically active and that some techniques could not meet the patient's specific needs. Although we see various rupture markers, the quality of the alliance and relationship did not suffer significant alterations. From the patient's perspective, the alliance had a solid quality across the intervention. One can argue that by responding to the patient's core needs of security and genuineness, both the patient and the therapist constructed a solid relationship based on a felt sense of security, honesty, genuineness, empathy, and positive regard, some of Rogers' necessary and sufficient conditions for change (1957). At the same time, having a felt sense of being in the moment and responsive to changes, especially when a disagreement might appear, can facilitate a form of "naturalistic rupture resolution", where both patient and therapist can meet and avoid ruptures outside the pathways defined by Muran and colleagues (2023).

The main goal of this study was to explore patients' core needs, as defined by the five-component transtheoretical perspective on the therapeutic relationship, in a brief therapeutic intervention. Since this is the first case study, further research is suggested. This is only a brief intervention; it is essential to understand how the relationship evolves and how the patient progresses in further stages of the therapeutic process. Since this is a transtheoretical perspective, more case studies should be conducted that present other therapeutic interventions, including evidence-based and integrative approaches, for comparison and to provide more substantial support for the five-component model. Whenever possible, video

recording should be preferred over audio recording to enrich our understanding of the subtleties of the therapeutic relationship, including the ability to analyze nonverbal behavior.

Despite these limitations, our findings contribute to a more in-depth discussion of developing a comprehensive relational system based on core needs, where we can establish a hierarchy of central needs, regardless of the theoretical model, that facilitates relational depth through the use of tailored tasks, a person-centered and relational-centered approach, enhancing the therapist's ability to be more present and responsive.

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Chapter 4

General Discussion

Discussion

The field of Psychotherapy is one of the divisions in the quest for the most efficacious means of psychological change. This division persists to this day, supported by mixed results in psychotherapy research; some favor the efficacy of specific interventions for specific conditions or pathologies, while others favor the efficacy of all therapeutic interventions, regardless of theory, condition, or pathology. While psychotherapy integration is not a central theme to this work, a comment should be made about the "Dodo Bird" verdict (Rosenzweig, 1936). In the current view of psychotherapy, it is essential to achieve a balance and not fall to either extreme, either being totally evidence-based or totally based on common factors. Both paths have strengths and weaknesses, and they can complement each other, bringing out the best of each side, while also highlighting the importance of standard processes, such as the therapeutic relationship.

The therapeutic relationship is one of the most relevant processes in psychotherapy research. As seen in the work of previous APA Task Forces, the therapeutic relationship remains a constant, moderate common factor in psychotherapeutic change (Fluckiger et al., 2019). Research on the efficacy of the relationship supports the development of integrative approaches to psychological interventions, such as the Contextual Model (Wampold & Imel, 2015). The difficulties with the therapeutic relationship begin with its basic definition, which is interpreted differently across perspectives. Gelso and Carter (1985, 1994) sought to offer a more global, aggregable definition, which served as the basis for APA's Task Force to define the relationship and select all studies that aligned with such a relational perspective. As much as this was a good attempt, it was not without its criticism, namely in the way that the therapist would operationalize and address how feelings were expressed in the relationship (Hill, 1994).

Nevertheless, Gelso's work led to the development of a therapeutic relationship model, supported by the Real Relationship, the Working Alliance, and the Transference/Countertransference configuration. Rooted in psychoanalytic concepts and tradition, Gelso argued for their transtheoretical use across different therapeutic interventions and models (Gelso, 2014). However, the Tripartite Model encounters two significant issues: first, non-psychoanalytic interventions have their own interpretations and uses of some of this model's relational constructs. For example, cognitive-behavioral therapy recognizes transference and countertransference as processes. However, the CBT therapist does not

focus on their emergence, which eventually becomes a weaker relational process than in more psychoanalytic-oriented interventions. Second, the Working Alliance, particularly Bordin's pantheoretical perspective (Bordin, 1975, 1979, 1989, 1994), became a more acceptable transtheoretical relational construct, with a vast body of research supporting its efficacy (Horvath, Del Re, Fluckiger, & Symonds, 2011). These issues, along with other criticisms, have diminished the Tripartite Model's overall importance, while research seems to be increasingly focused on the Working Alliance and Real Relationship. Recently, Amy Wenzel (2025) proposed Therapeutic Relationship-Focused Cognitive Behavioral Therapy, a CBT intervention grounded in Gelso's Tripartite Model of the Therapeutic Relationship. According to Wenzel, high-quality CBT is delivered when the therapist simultaneously attends to the cultivation, nurturance, and enhancement of the therapeutic relationship, as well as to the strategic and responsive delivery of cognitive-behavioral therapeutic interventions (Kholenberg & Tsai, 1991; Safran & Segal, 1990).

The delivery of psychotherapy was secured not only by the therapeutic relationship but also with specific strategies designed to explore or enhance therapeutic change work. Techniques became part of the therapeutic intervention, a unique aspect since several are explicitly designed with therapeutic models in mind. Research has shown that techniques can impact the therapeutic process and the relationship and alliance.

Considering the formation of the relationship as a relational task, it is important to recognize techniques that serve that purpose, such as identifying and repairing ruptures in the alliance. Centered on the working alliance, rupture research expanded on Bordin's (1979) intersubjective view of the alliance, which regards the negotiation of needs between therapist and patient. When this negotiation fails to meet the dyad's needs, disagreements can arise in either component of the alliance: Bond and Agreement on Goals and Tasks. These disagreements constitute ruptures in the alliance. They can be categorized as withdrawal, confrontation, or mixed ruptures, each with specific markers that can be behaviorally observed in the therapist and the patient. When these markers are identified and resolved, research suggests that the quality of the alliance increases and the outcome of therapy is enhanced (Alldredge et al., 2021; Bengardi et al., 2025; Eubanks et al., 2018; Eubanks, 2022; Hongenhaug et al., 2024; Mahon, 2023; Muran et al., 2023).

The main question this work poses is whether the therapeutic relationship is sufficient, and it explores the roles of techniques, therapeutic tasks, and rupture repair in psychotherapy.

It is intended to contribute to the continuous discussion between those who defend evidence-based practices and caution the validity of the "Dodo Bird Verdict, and those who support their interventions with such a verdict, bringing the emphasis on standard processes and claiming that every intervention has the same efficacy. The three primary studies presented contribute to the understanding and research base of these processes. We also suggest implications for future psychotherapy research and clinical applications.

In our first study, we adopted a different perspective on the therapeutic relationship, one that intersects with the concepts of the real relationship, the therapeutic alliance, and the patient's attachment to the therapist, regardless of the therapeutic model. The client's perspective on the therapeutic relationship was chosen in line with Bohart and Tallman's proposal that the patient's role extends beyond mere participation in the process and that the patient's creativity, agency, initiative, and inventiveness make therapy effective (Ribeiro & Neto, 2025). A convenience sample of 373 adults who participated in or had completed individual therapy, regardless of therapeutic intervention. The real relationship, therapeutic alliance, and client's attachment to the therapist were measured. For measuring the real relationship, the Real Relationship Inventory-Client Version was adapted. This adaptation proved to be more robust at measuring the genuine relationship than the original instrument (Ribeiro & Neto, 2023). Data was analyzed with an exploratory principal components analysis. Results show that the therapeutic relationship can be organized into a five-component framework, each representing the patient's specific needs regarding the relationship or his/her beliefs about the therapist: need for security in the therapist; client's need to be cared for by the therapist; client's fear of being genuine to the therapist; working on the goals of therapy; client's need for more contact and expanding the therapeutic relationship beyond therapy boundaries. These beliefs also seem to persist regardless of the therapeutic model or intervention the therapist uses, which is consistent with the therapeutic relationship being a common factor and a process of change. From this framework, the relationship stems from preexisting needs that have been assimilated across the patient's development and previous attachment situations. These needs are activated within the therapeutic relationship and the relational dyad. As the therapeutic relationship evolves, so do the patient's psychological needs, giving this framework the potential to be a progressive one, with developing a secure base as the starting point from the patient's perspective. The therapeutic relationship's secure base can be provided by the therapist's non-judgmental

posture, in which the patient realizes that the therapist can contain his narrative and emotional expression without criticism, fostering a sense of caring and genuineness. The direction of the relationship and the therapeutic process can then be structured around the patient's goals, with the therapist and patient negotiating a consensus on what the therapeutic work should focus on, for the patient's benefit. Finally, throughout the therapeutic process, patients can develop a special interest in extending the relationship beyond the boundaries of therapy, a way of building trust by identifying with the therapist at a personal level, or of soothing a possible fear of abandonment from them and the relationship (Ribeiro & Neto, 2025). The conclusions of this study suggest that this framework can be helpful for the therapist in identifying and understanding patients' needs and how those needs can evolve, along with the therapeutic relationship and therapeutic process. When the therapist meets the patient's needs, the relationship can be better aligned and may increase the patient's expectations of the intervention, his motivation for change, and his belief that we can succeed. When needs are not met, the quality of the relationship can drop, and ruptures can begin to appear to the point that the patient might not believe that the intervention will help and drop out. If the therapist acknowledges the importance of matching the patient's needs and being present in the relationship, he can better prevent ruptures or engage in more effective rupture resolution. To do that, the therapist needs to assume a responsive posture, able to match each patient's unique characteristics and tailor the intervention to those needs. An emphatic and accepting posture has been shown to improve relationship quality and establish a therapeutic presence. To establish these types of postures and responsiveness, active collaboration is necessary to achieve the goals of therapy and the process of change, which could be achieved through technical implementation.

To understand the technical implementation in the relationship, we conducted a systematic review on the role of techniques in the therapeutic alliance in psychotherapy. With this review, our goals were to understand the perceived weight of techniques in the therapeutic alliance, in psychotherapy outcomes, and in change. A systematic review protocol was developed and registered in Prospero and the Open Science Framework, in accordance with the guidelines of the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Thomas, 2019) and the Preferred Reporting Items for Systematic Reviews and Meta-Analysis Protocols (PRISMA) (Moher et al., 2015). This review included empirical studies intended to address the association between specific tasks or techniques and

therapeutic alliance in psychotherapy with adults, written in English, Portuguese, or Spanish (languages chosen by convenience), and quantitative, qualitative, mixed-design studies, randomized controlled trials, and meta-analyses. No restrictions were placed on the therapeutic approach model in the included studies, due to Bordin's (1979) pantheoretical definition of the alliance. Studies that associate specific techniques and therapeutic alliance in domains unrelated to psychotherapy, with populations other than adults, and in psychotherapies involving forms of group therapy were excluded from this review (Ribeiro & Neto, 2026). Following all steps, data from 53 studies were fully extracted and analyzed. To facilitate that analysis, the techniques were organized into the categories of the Inventory of Therapeutic Strategies (Gaston & Ring, 1992): Exploratory, Supportive, and Work-enhancing. A total of 37 techniques were analyzed and categorized. 14 techniques were shown to positively affect the therapeutic alliance's effect size, with 42.8% exploratory, 42.8% work-enhancing, and 14.3% supportive strategies. 23 techniques were shown to have no significant impact on the effect size of the therapeutic alliance, with 58.3% work-enhancing, 20.8% exploratory, and 20.8% supportive strategies (Ribeiro & Neto, 2026). These results support the argument that techniques play a role in therapeutic process outcomes and can affect the quality of the therapeutic relationship and alliance. Techniques are, at the same time, vehicles for delivering therapeutic communication and for operating such communication experientially. They are an important resource for achieving therapy goals and are intrinsic to many therapeutic postures and stances. As with conceptual models, techniques were also part of psychotherapy integration, with technical eclecticism and advances across generations of therapeutic models. In Mindfulness-Based Cognitive Therapy, for example, the principles of Mindfulness and Mindfulness meditations and exercises were integrated into cognitive and cognitive-behavioral approaches. Emotion-Focused Therapy integrates experiential tasks from Gestalt Therapy to enhance emotional activation and further integrate needs and parts of Self (ex., two-chair work). Finally, there is evidence supporting the importance of viewing techniques in establishing the therapeutic relationship and ensuring the quality of the therapeutic alliance (Matos & Dimaggio, 2023). These conclusions lend greater support to the technical implementation of the five-component framework and to the therapist's role. If, in fact, some techniques are mainly associated with exploratory and work-enhancing strategies, they can play an effective role in meeting patients' needs.

However, we cannot ignore the fact that some techniques did not affect the therapeutic alliance. The question then is: is it the nature of the techniques that explains the lack of impact on the relationship, or is it the way the therapist implements them?

To better understand the five-component framework of the therapeutic relationship and the therapist's technical implementation, a brief therapeutic intervention was analyzed in a case study using a qualitative methodology. For this exploration, we sought to understand the dynamic between the five-component framework and techniques, notably which components are identifiable from the patient's experience, the quality of the therapist's technical implementation, and whether and, if so, what ruptures appear in the therapeutic relationship. 19 sessions of an individual therapeutic process between a young adult and a CBT-trained psychotherapist were audio record. Each session was audio-recorded in accordance with the procedure approved by the Ispa-Instituto Universitario's Ethical Committee and later translated. Reflexive thematic analysis was used to analyze and code each session's content. The Rupture Resolution Rating System (Eubanks & Muran, 2023) was used to code each session for analyzing ruptures, and the Portuguese version of the Working Alliance Inventory – Short Form (Machado & Horvath, 1999; Tracey & Kokotovic, 1989) was used to measure the quality of the therapeutic alliance, along with the therapeutic intervention. Following Braun and Clarke's (2022) thematic analysis six-phase process, a total of two themes and seven subthemes were coded. The first theme, "patient's relational needs", emerged from the relational interaction between the patient and therapist throughout the therapeutic intervention. Four subthemes were included, of which "able to be genuine" and "to feel secure with him" have a more direct connection to the five-component framework. "Dealing with constant thoughts" and "handling emotions" were patients' needs outside the five-model framework. The second theme, "techniques of therapy", emerged from the therapist's technical interventions throughout the therapeutic intervention. Two subthemes were included: "the specific techniques," which are directly related to the therapist's main psychotherapy training, and "beyond traditional CBT," which is directly related to techniques used by the therapist that come from other therapeutic interventions. From the results, it seems that some relational needs from the five-component framework, namely those focused on establishing a secure base and a genuine relationship, may appear to be fundamental needs, supported by previous attachment relations, regardless of the therapeutic intervention.

The other components, working on goals and going beyond the therapeutic relationship, might also appear in later moments of the relationship, as the five-component framework appears to be sequential. Emotional needs, while they are presented as one of the fundamental processes of change, are also specific and contextual: contextual, since therapy and the therapeutic relationship imply emotional activation; specific, since not all patients need emotional regulation strategies, and not all therapeutic interventions address emotion with the same focus or consideration. “Dealing with constant thoughts” can be perceived as a specific need. Greater awareness of thoughts, monitoring, or restructuring are characteristics of a more CBT-based intervention (Leahy, 2017), suggesting that other needs can emerge depending on specific interventions, patients’ characteristics, and the reasons for seeking therapy. Regarding the quality of the therapeutic alliance, no significant differences were found, indicating that a good alliance was established between the therapist and patient. Despite this, 14 ruptures were identified in 8 of the 19 sessions. Ten were identified as confrontation ruptures and four as withdrawal ruptures. The patient initiated seven ruptures, the therapist initiated five, and both initiated two. This symmetry might be explained by the quality of the alliance and the consistent alignment with the patient’s needs. At the same time, confrontation ruptures initiated by the therapist can occur with an excessive use of techniques, rather than following the patient’s own needs. That therapist did not identify and repair ruptures in accordance with Safran and Muran’s pathways of rupture resolution (Muran et al., 2023; Safran & Muran, 2000), although we cannot say whether this was due to a lack of knowledge or training in rupture repair. For future studies, qualitative interviews with patients and therapists could help deepen understanding of the moment-to-moment interactions within the therapeutic relationship. Finally, it is important to note that ruptures were not persistent and seem to have been resolved, in part by the therapist's responsiveness to the patient and his needs, empathetically following the patient rather than implementing additional techniques. This posture can be explained by the therapist’s training, clinical experience, or personal characteristics. Since we did not conduct a follow-up interview, we can only consider possibilities regarding the therapist’s posture.

In line with the sequence of studies, this work supports the idea that the therapeutic relationship alone is insufficient for therapeutic outcomes and change. The therapeutic relationship is an important part of therapy, as years of psychotherapy research have systematically demonstrated. The five-component framework is intended to be a different framework for understanding the therapeutic relationship. The patient's perception of the

quality of the relationship with the therapist is important for creating the conditions for change. As much as the patient is an important and active part of the therapeutic process, the therapist's communication complements the patient's active work. Creating a framework in which core needs are “ingredients” for establishing the therapeutic relationship suggests that they pre-exist the context of therapy and the therapeutic relationship, being a product of previous attachments and relationships that molded the patient's perspective on the self and others, as attachment theory shows. When these core needs are not met, we can expect an increase in the number of ruptures in the relationship, which can lead to a poor therapeutic outcome or even a dropout. On the other hand, when the therapist meets these needs, the therapeutic relationship becomes solid and can even enhance its quality, leading to positive therapeutic outcomes and therapeutic change.

A relational stance implies a technical stance as well. When establishing the relationship, the therapist adopts stances based on empathy, compassion, acceptance, and non-judgment. These processes are also used as techniques, such as empathic conjectures, therapeutic presence, attending to transference/countertransference, and motivating change. By using active listening and considering nonverbal behavior, the therapist can meet the patient's core needs. The advantage of organizing techniques into categories is that it provides the therapist with tools to explore the patient’s core needs and internal world, to support continued nurturing of those needs, and to enhance the patient's ability to work on the goals of therapy. In this regard, techniques can affect the quality of the therapeutic relationship and the working alliance between patient and therapist. Another relational and technical role of the therapist is to promote a working collaboration with the patient, to promote the negotiation of therapeutic goals, to suggest and educate the patient on techniques that can be used to reach those goals in therapy, as well as in other contexts where those skills are needed (e.g.).: teaching breathing techniques for managing anxiety or panic attacks.

Beyond core needs, there also seem to be contextual needs specific to a patient’s characteristics and psychological conditions. While they are not core needs, they can have a positive or a negative impact on the relationship and process outcome. It is also important to recognize that some of these secondary or specific-order needs might not be resolved with only relational stances. For emotional core needs, the therapist can have a greater impact with emotion-specific techniques or approaches, or with techniques that, though not emotion-specific, can be integrated to address such needs. Again, it is an appeal for the therapist to be

active in the relationship and the process. Regarding specific psychological conditions, techniques that address them can improve the quality of the therapeutic relationship, allowing the therapeutic work to resolve those issues and increasing the chances of a better therapeutic outcome. In this work, we encounter such an example: a patient whose particular condition and personal characteristics required specific techniques to advance the intervention.

Despite the important and well-researched role that identifying and repairing ruptures plays in the therapeutic alliance and relationship, the therapist's role is almost decisive in engaging in the repair process. If the rupture comes from the therapist, it is important that he can self-regulate, bring it to his awareness by focusing his attention on the present moment (mindfulness), and express what he is thinking or feeling, or assume responsibility for the rupture (metacommunication). He might even negotiate better tasks or techniques by clarifying or explaining the rationale for the technique (psychoeducation). All of these are important technical movements and decisions that the therapist chooses based on the pathways for rupture repair. If the rupture comes from the patient, it is important for the therapist manage his internal reactions to the moment and the patient’s behavior (countertransference), and again express what he is feeling or thinking in that moment (metacommunication). There are situations in which ruptures may occur and, at first glance, no formal repair process is used, yet the therapeutic relationship and alliance remain positive. This could be explained by a strong foundation of safety and trust, initially built by attending to the patient’s core needs, the therapist's therapeutic responsiveness, and the balance between an active technical stance and a more relational stance.

It is important to address limitations so that psychotherapy research can continue to grow in the right direction. Each represents a difficulty in conducting psychotherapy research. Using self-report measures, as in the first study, provides only the participant's subjective perspective. In contrast, observer-based measures can be more objective in measuring variables and the processes in which they are involved. While conducting study two’s systematic review, it was acknowledged that the lack of diversity in therapeutic interventions, most being from cognitive-behavioral interventions or cognitive-behavioral-based interventions, makes it difficult to understand how therapeutic processes compare across theoretical interventions. Researchers from different therapeutic orientations should conduct studies not only to validate the efficacy of the intervention for specific conditions, but also to demonstrate how specific or common processes work and interact with the intervention.

Finally, building a stronger bridge between researchers and clinicians can facilitate access to more realistic clinical conditions and patients, allowing us to analyze therapeutic interventions using qualitative methodologies, such as case studies and thematic analysis, or even task analysis studies, allowing us to understand the mechanisms and processes by which factors like the relationship or techniques work.

It is hoped that this work can contribute to a path toward balance between the two sides of the psychotherapy research spectrum. It is important to recognize the value of developing specific interventions for conditions or pathologies that are exceptions to the common factors approach, such as personality disorders and culturally or religiously specific contexts. By the same token, it is important to focus research on the comprehension of different therapeutic processes and mechanisms of change, sensitizing therapists to be more relational in their approach, with a capacity to be more humane in their encounter with the patient, more technically capable to be responsive to patients' needs and challenges from the therapeutic process and tailor the intervention to the patient's unique characteristics.

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Chapter 5

Appendixes

Appendix A

Institutional Review Bord Statement

Comissão de Ética de Investigação
ISPA - Instituto Universitário de Ciências Psicológicas, Sociais e da Vida
Rua Jardim do Tabaco, 34,
1149-041 Lisboa
Telefone: (351) 218 811 700
Fax: (351) 218 860 954

COMISSÃO DE ÉTICA

PARECER

Título do projeto: Será a Relação Terapêutica suficiente? O papel de Tarefas e Resolução de Ruturas em Psicoterapia.

Investigador responsável: Pedro Rodrigues Ribeiro / Orientador: David Neto

Instituição/Curso: ISPA – Instituto Universitário

O protocolo do estudo apresenta objetivos relevantes. Foram descritos adequadamente os métodos e procedimentos a adotar e estes respeitam os direitos humanos e as recomendações constantes nos documentos nacionais e internacionais relativos à ética em investigação.

Assim, o parecer da Comissão de Ética do ISPA-Instituto Universitário é favorável à realização do estudo em epígrafe.

Qualquer alteração futura aos procedimentos descritos do estudo que possam colidir com os critérios éticos de investigação com seres humanos ou animais não humanos constantes nos referidos regulamentos, exigem uma reapresentação do pedido de apreciação a esta Comissão.

Comissão Ética do ISPA – Instituto Universitário

(Assinatura do Presidente da CE)

Lisboa, 28 de Junho de 2022.

Appendix B

Letter from the Society for Psychotherapy Research granting permission to use the WAI

SOCIETY FOR PSYCHOTHERAPY RESEARCH

March 31, 2022

Pedro Rodrigues Ribeiro
ISPA-Instituto Universitário
Lisbon, Portugal

Dear Pedro Rodrigues Ribeiro:

You have our permission to use the Working Alliance Inventory in your PhD research on Therapeutic Relationship and the Therapeutic Alliance and how they impact on psychotherapy processes. Please be aware that we require publishing the following note at the end of the measure:

Reprinted by permission of the Society for Psychotherapy Research © 2016.

We wish you the best in your work. Please consider joining the Society for Psychotherapy Research, an international, multidisciplinary scientific association devoted to research on psychotherapy. SPR also plays an important role in providing opportunities for interaction and dialogue between researchers and clinicians interested in psychotherapy. You may read more about us at www.psychotherapyresearch.org.

Sincerely,

Bernadette Walter, Ph.D.
Interim Executive Director
Society for Psychotherapy Research
sprexecutive@gmail.com

www.psychotherapyresearch.org phone: (502) 905-3926

Appendix C

Informed Consents

Consentimento Informado (Estudos quantitativos)

Caro(a) Participante,

Este estudo ao qual pedimos a sua colaboração decorre no âmbito do projeto de investigação de Doutoramento de Pedro Rodrigues Ribeiro, em Psicologia Clínica, sob a orientação do Professor Doutor David Dias Neto, pelo Ispa-Instituto Universitário de Ciências Psicológicas, Sociais e da Vida, tem como finalidade estudar a qualidade e impacto dos processos de Relação Terapêutica e Aliança Terapêutica no processo psicoterapêutico.

Para poder participar neste estudo deverá ter mais de 18 anos, estar a realizar ou ter realizado um processo de Psicoterapia.

A sua participação é carácter voluntário, sendo a decisão de participar livre e pessoal. Assim, pode recusar e/ou retirar este consentimento a qualquer momento se o desejar. A sua participação é extremamente importante, sendo determinante para a realização deste estudo e o avanço de conhecimento científico.

A sua participação terá um único momento, com duração aproximada de 20 minutos e consiste em responder a um conjunto de questões online na plataforma Qualtrics. A equipa de investigação irá garantir a confidencialidade e o anonimato dos dados recolhidos na plataforma e apenas os mesmos terão acesso à informação recolhida.

Ao participar garante que tem mais de 18 anos, está a realizar ou realizou um processo de Psicoterapia, leu e concordou com as indicações acima e que aceita colaborar livre e voluntariamente neste estudo.

Caso seja do seu interesse, numa fase posterior, receber informações adicionais sobre este estudo poderá entrar em contacto através do email pedro.r.ribeiro07@gmail.com.

Agradecemos a sua participação!

A equipa de investigação:
Pedro Rodrigues Ribeiro
David Dias Neto
Ispa-Instituto Universitário de Ciências Psicológicas, Sociais e da Vida

Consentimento Informado (Estudo de Caso)

Consentimento Livre e Informado

Convidamo-lo/a a participar do estudo "Resolução de Ruturas como uma Tarefa Relacional, em Psicoterapia: Um Estudo de Caso", conduzido pelo aluno de doutoramento Pedro Rodrigues Ribeiro e sob a coordenação do Prof. Dr. David Neto, do Ispa-Instituto Universitário. Este estudo tem como objetivo compreender processos e de psicoterapia, dando especial atenção à relação terapêutica estabelecida com o/a seu/sua terapeuta e como esta se desenvolve ao longo do tempo. Procuramos identificar possíveis ruturas e como estas podem ser lidadas, de modo a podermos personalizar a intervenção terapêutica para melhor atender as necessidades de cada paciente.

Caso concorde em participar, solicitamos a sua colaboração para o preenchimento inicial de questionários. Estes questionários abordarão a sua a forma como perceciona a relação como o seu/sua terapeuta.

Iremos solicitar a gravação, em formato de áudio, de um conjunto de 16 sessões do seu processo. Estas gravações estão protegidas pelo Regulamento Geral de Proteção de Dados em vigor, salvaguardando os seus dados pessoais, a proteção das gravações pela equipa de investigação e a sua respetiva destruição, após a análise das mesmas. Se a qualquer momento decidir interromper a sua participação e/ou terapia, pode entrar em contacto (por email) solicitando a destruição das gravações.

A sua participação irá contribuir para o avanço do conhecimento científico sobre psicoterapia, permitindo que pacientes possam beneficiar de intervenção mais eficazes e personalizadas no futuro.

Todos as informações recolhidas serão tratadas com a total de confidencialidade, garantindo a anonimidade das suas informações pessoais, apenas acedidas pela equipa de investigação. Os resultados deste estudo serão divulgados de forma agregada, sem a sua identificação pessoal.

A sua participação é totalmente voluntária, podendo recusar-se a participar ou retirar o sei consentimento a qualquer momento. Não haverá qualquer prejuízo pela sua recusa.

Em caso de dúvidas sobre este estudo, pode entrar em contacto com Pedro Rodrigues Ribeiro (pribeiro@ispa.pt).

Ao assinar este consentimento, declara que leu e compreendeu as informações que lhe foram apresentadas, tendo a oportunidade de esclarecer as suas dúvidas, concordando em participar voluntariamente no estudo ""Resolução de Ruturas como uma Tarefa Relacional, em Psicoterapia: Um Estudo de Caso".

Assinatura do Participante:
Data:

Appendix D

Sociodemographic questionnaire

Sexo (assinale com um x a opção que lhe corresponde):

Masculino	
Feminino	
Outro/Não Binário	

Idade: ____anos

Nacionalidade (assinale com um x a opção que lhe corresponde):

Portuguesa	
Outra	

Ser respondeu outra. Qual? _____

Distrito de residência (assinale com um x a opção que lhe corresponde):

Aveiro	
Beja	
Braga	
Bragança	
Castelo Branco	
Coimbra	
Évora	
Faro	
Guarda	
Leiria	
Lisboa	
Portalegre	
Porto	
Santarém	
Setúbal	
Viana do Castelo	
Vila Real	
Viseu	
Açores	
Madeira	

Estado Civil (assinale com um x a opção que lhe corresponde):

Solteiro(a)	
Casado(a)	
União de Facto	
Separado(a)	
Divorciado(a)	
Viuvo(a)	

Escolaridade (assinale com um x a opção que lhe corresponde):

4º Ano	
9º Ano	
12º Ano	
Bacharelato	
Licenciatura	
Mestrado	
Doutoramento	

Neste momento encontra-se num processo psicoterapêutico? (assinale com um x a opção que lhe corresponde):

Sim	
Não	

Se sim, quais? _____

Tem algum diagnóstico atribuído? (assinale com um x a opção que lhe corresponde):

Sim	
Não	

Se sim, qual/quais? _____

Se está em Psicoterapia, qual a duração temporal? (Ano(s)/Meses) _____

Qual a periodicidade média das consultas? (assinale com um x a opção que lhe corresponde):

2 vezes por semana ou mais	
Semanal	
Menos de quinzenal	
Quinzenal	

Se esteve em Psicoterapia, qual a duração temporal? (Ano(s)/Meses) _____

Qual a orientação teórica do seu/sua Psicoterapeuta? (assinale com um x a opção que lhe corresponde):

Psicanálise	
Psicoterapia Psicanalítica/Dinâmica	
Terapia Cognitivo-Comportamental	
Terapia Existencial ou Fenomenológica	
Psicoterapia Centrada no Cliente	
Psicoterapia Humanista	
Psicoterapia Integrativa ou Eclética	
Psicoterapia EMDR	
Não Sei	
Outra	

Se outra, qual? _____

Sexo do terapeuta (assinale com um x a opção que lhe corresponde):

Masculino	
Feminino	
Outro/Não Binário	

Idade estimada do(a) Psicoterapeuta (Anos) _____

Qual o contexto em que tem/teve as sessões de Psicoterapia? (assinale com um x a opção que lhe corresponde):

Hospital Público	
Centro de Saúde	
Hospital Privado	
Prática Privada	

Qual o formato de Psicoterapia que realiza/realizou? (selecione todas as opções adequadas):

Presencial	
Videochamada	
Chamada	
Ambas	

Durante o acompanhamento, tomava medicação para questões de Saúde Mental? (assinale com um x a opção que lhe corresponde):

Sim	
Não	

Appendix E

Systematic review protocol published on Prospero and https:// https://osf.io/4tu59

NIHR | National Institute for Health and Care Research

PROSPERO
International prospective register of systematic reviews

The influence of psychotherapy tasks on the Therapeutic Alliance: A Systematic Review

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Review methods were amended after registration. Please see the revision notes and previous versions for detail.

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Citation
Pedro Ribeiro, Rita Sebastiao, Margarida Almeida, Catia Castro, Eduardo Sardinha, David Neto. The influence of psychotherapy tasks on the Therapeutic Alliance: A Systematic Review. PROSPERO 2024 Available from https://www.crd.york.ac.uk/PROSPERO/view/CRD42024548356

REVIEW TITLE AND BASIC DETAILS

Review title
The influence of psychotherapy tasks on the Therapeutic Alliance: A Systematic Review

Original language title
A influência de tarefas terapêuticas na Aliança Terapêutica: Uma Revisão Sistemática

Review objectives
What is the association of therapeutic tasks/techniques with the Therapeutic Alliance, regardless of their orientation?

Keywords
Specific tasks, Techniques, Therapeutic Alliance, Therapy

SEARCHING AND SCREENING

Searches

A systematic literature search will be conducted in 5 electronic databases (PsycINFO, PubMed, Web of Science, Scopus, and EBSCO) in order to identify multiple tasks/techniques associatied with the Therapeutic Alliance in diferent psychotherapeutic interventions.
The search terms will be represented: i) tasks, and techniques, ii) therapeutic alliance, and iii) therapy. These terms will be searched in the Title, Keywords, and Abstract sections.
In addition, the reference section of the included studies will be checked to complement this search, as well as any grey literature, like book chapters, and unpublished master and doctoral thesis.

Study design
We will include empirical studies, quantitative studies, mixed method studies, randomized controlled trials, and meta-analyses.

ELIGIBILITY CRITERIA

Condition or domain being studied
This review focuses on the association of therapeutic tasks and techniques with the Therapeutic Alliance, in different models of individual therapy.

Population
The population was set as adult patients with or without mental disease diagnosis.

Intervention(s) or exposure(s)
Studies that evaluate interventions were specific tasks or techniques that could be associated with the Therapeutic Alliance and outcome.

Comparator(s) or control(s)
Any type of control will be included.

Context
Interventions can be set anywhere, including being delivered via digital or blended modalities, as long as they are in individual therapeutic modalities and measure the association of therapeutic tasks or techniques with the Therapeutic Alliance.

OUTCOMES TO BE ANALYSED

Main outcomes
The outcome we expect to see is the influence that psychotherapeutic tasks have in the Therapeutic Alliance in therapy, by analysing clients' and therapists' ratings in the same instrument such as Working Alliance Inventory, Helping Alliance Inventory, Helping Relationship Questionnaire, or California Psychotherapy Alliance Scales.

Additional outcomes
None.

DATA COLLECTION PROCESS

Data extraction (selection and coding)

All identified articles will be combined using Zotero and RAYYAN software and duplicated records will be first removed. After, the screening of the studies' titles and abstracts will be conducted in full by two authors for eligibility. In case of disagreements, the lead author will decide which ones will be included or excluded. The lead author and another author will review the resulting full-text articles and assess them for eligibility. Key reasons for exclusion will be recorded at the full-text stage, which will include: I) reports not written in English, Portuguese, and Spanish; II) studies with no quantitative analyses; III) studies with no information on the effect of the relationship between tasks/techniques and the Therapeutic Alliance; IV) individuals that weren't adults in individual therapy; V) instruments that don't rate tasks/techniques in the Therapeutic Alliance; VI) not able to obtain the full text.
For data extraction, the included studies will be conducted in full by two authors using a standardized data extraction form covering:
I) Study details: authors, year of publication, study design;
II) Sample details: type of samples, gender, mean age of sample;
III) Intervention components: mode of delivery, name of the intervention, theoretical perspective of the intervention, tasks/techniques used; name of the measure for the Therapeutic Alliance;
IV) Statistical data for the variables of interest: outcome variable, sample size of intervention and control groups, effect size.
Uncertainties and disagreements related to data extraction will be double-checked by another author.

Risk of bias (quality) assessment

The methodological quality of studies will be critically appraised using the validated tool Cochrane Risk of Bias (RoB) 2. Two authors will independently assess the risk of bias, with disagreements being discussed with a third author.

PLANNED DATA SYNTHESIS

Strategy for data synthesis

Studies will be synthesized according to the following criteria: general characteristics of the studies (e.g., theoretical background; type of data; study design); general characteristics of the sample (e.g., age, gender, profession); type of therapy; reasons for going to therapy; assessment of the task/techniques; assessment of the quality of the Therapeutic Alliance.

Analysis of subgroups or subsets

Not appliable.

REVIEW AFFILIATION, FUNDING AND PEER REVIEW

Review team members

- Mr Pedro Ribeiro, APPsyCI, Ispa-Instituto Universitario, School of Psychology
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Review affiliation
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Funding source
No funding or sponsoring was used for the review

TIMELINE OF THE REVIEW

Review timeline
Start date: 14 March 2024. End date: 10 September 2024

Date of first submission to PROSPERO
18 May 2024

Date of registration in PROSPERO
29 May 2024

CURRENT REVIEW STAGE

Publication of review results
The intention is to publish the review once completed.The review will be publcished in English

Stage of the review at this submission 1 change

Review stage	Started	Completed
Pilot work	✓	✓
Formal searching/study identification	✓	✓
Screening search results against inclusion criteria	✓	✓
Data extraction or receipt of IP	✓	✓
Risk of bias/quality assessment	✓	✓
Data synthesis	✓	✓

Review status
The review is currently planned or ongoing.

ADDITIONAL INFORMATION

PROSPERO version history

- Version 1.3 published on 18 Nov 2024
- Version 1.2 published on 01 Jun 2024
- Version 1.1 published on 29 May 2024
- Version 1.0 published on 29 May 2024

Review conflict of interest
None known

Country

Portugal

Medical Subject Headings
Humans; Professional-Patient Relations; Psychotherapy; Therapeutic Alliance

Revision note 1 change
At this moment, all of the steps for this systematic review are completed.

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