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Are we on the same page? Examining client-therapist alliance congruence and psychological well-being

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Abstract

This study examined client-therapist alliance congruence as a predictor of psychological well-being among 104 Filipino psychotherapy dyads. Descriptive analysis showed that although most dyads had non-identical ratings, 55.8% fell within the conservative broad agreement band; among dyads outside this band, therapist-higher discrepancies were more common. Client- and therapist-rated alliance were analyzed using polynomial regression with response surface analysis (RSA) to model both congruent and incongruent alliance effects on client psychological well-being. Treatment length, treatment interval, therapist professional maturity, and client symptom severity were included as covariates. Results indicated a significant positive linear effect along the line of alliance congruence, such that a mutually perceived alliance was associated with greater psychological well-being. In contrast, significant curvature along the line of incongruence (LOIC) showed that discrepancies between therapist and client alliance ratings were associated with lower well-being, with increasing mismatch predicting progressively poorer outcomes. The findings suggest that therapist and client alliance perceptions should not be treated as interchangeable and that their dyadic alignment provides clinically meaningful information beyond either perspective alone. These results are discussed in relation to alliance monitoring, client feedback, and culturally responsive psychotherapy practice in the Filipino context.

Key words: alliance congruence, therapeutic alliance, Filipino psychotherapy, well-being, polynomial regression, response surface analysis.

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Introduction

The psychotherapy relationship refers to the dynamic interaction between a client and a therapist, shaped by their own histories, expectations, and relational orientations as they engage in the therapeutic process. As treatment progresses, this relationship develops into what is commonly referred to as the “therapeutic alliance”, a collaborative partnership characterized by agreement on treatment goals, or a shared understanding of what the client and therapist are working toward; consensus on therapeutic tasks, or a shared understanding of the activities, methods, and responsibilities involved in therapy; and the development of an affective bond, reflecting the relational quality of trust, acceptance, confidence, and collaborative engagement between therapist and client (Wampold & Flückiger, 2023). Thus, the therapeutic alliance is not simply a general feeling of rapport but a working relational structure through which clients and therapists coordinate the aims, activities, and emotional conditions of psychotherapy.

A robust body of research has consistently demonstrated that the strength of the therapeutic alliance is a reliable predictor of psychotherapy outcomes, including symptom improvement (Saxler *et al.*, 2024), reductions in subjective distress (Prusiński, 2022), lower dropout rates (Høgenhaug *et al.*, 2024), greater treatment satisfaction (Aafjes-van Doorn *et al.*, 2024), and enhanced skills acquisition by the end of therapy (Goldstein *et al.*, 2020).

Despite the well-established importance of the therapeutic alliance, findings regarding whose perspective matters more – the client’s or the therapist’s – have been mixed. Some studies suggest that both perspectives independently predict outcomes (Atzil-Slonim & Tschacher, 2020), while others indicate that client-rated alliance is a stronger predictor (Maku Orleans-Pobee, 2020; Sagui-Henson *et al.*, 2022). Still, other studies report minimal predictive utility for either perspective alone (Prusiński, 2024). This variability highlights the interdependent nature of client and therapist perceptions, as well as the value of examining the alliance at the dyadic level and understanding the phenomenon of *congruence* within therapeutic dyads.

Alliance congruence, defined as the agreement between client and therapist perceptions of the working relationship, predicts outcomes beyond individual alliance ratings (Chen *et al.*, 2022). Research demonstrates that positive outcomes are optimized when alliance perceptions are mutually aligned (Whelen *et al.*, 2023), pointing to the inherently dyadic nature of the alliance. However, traditional alliance-outcome and alliance congruence research has often prioritized symptom reduction and remediation of deficits (Sagui-Henson *et al.*, 2022) as outcome variables. Although symptom change remains a central outcome in psychotherapy research, a narrow focus on symptom reduction may obscure broader forms of client functioning, including autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and

self-acceptance (Kraiss *et al.*, 2022; Prusiński, 2022). Psychological well-being is therefore a clinically meaningful outcome because it captures positive functioning and adaptive life engagement, not merely the absence of psychopathology. Alliance processes may be particularly relevant to psychological well-being because psychotherapy is not only a context for reducing distress but also a relational setting in which clients may clarify goals, develop agency, experience validation, and strengthen capacities for meaningful self-understanding and interpersonal connection. A strong therapeutic alliance may provide the relational conditions through which clients feel sufficiently safe, respected, and supported to explore difficult experiences, revise maladaptive relational expectations, and engage more actively in valued life directions. In this sense, the alliance may contribute to psychological well-being not simply by facilitating symptom reduction, but also by supporting the broader developmental and relational processes through which clients cultivate autonomy, purpose, self-acceptance, and more meaningful connections with others.

The association between alliance and outcome may also be shaped by treatment-, client-, and therapist-related factors. Treatment length may affect outcomes because clients who have completed more sessions may have had more opportunities to benefit from therapy and to develop a stronger alliance. Treatment interval may also matter because more frequent sessions may support continuity, emotional processing, and momentum in therapeutic work (Gergov *et al.*, 2021; Nordmo *et al.*, 2021). Client symptom severity may influence both alliance formation and outcome, as more severe symptoms may complicate engagement, trust, and collaboration (Tetzlaff *et al.*, 2025). Finally, therapist professional maturity, often operationalized through years of clinical practice, may also shape alliance processes because therapist experience may influence relational responsiveness, case formulation, and sensitivity to client feedback (Seewald & Rief, 2024). For these reasons, the present study controlled for treatment length, treatment interval, symptom severity, and therapist professional maturity when examining the association between alliance congruence and psychological well-being.

Although the therapeutic alliance has been extensively studied, much of the dominant alliance literature has been generated within Western psychotherapy contexts and using concepts developed primarily from Western clinical theories. This does not invalidate the broader alliance literature, but it does indicate the need to examine whether and how alliance processes manifest in cultural contexts where relationality, help-seeking, authority, emotional expression, and interpersonal trust may be organized differently. In Filipino psychotherapy, alliance processes may be meaningfully shaped by culturally salient relational concepts, such as *kapwa* (shared identity), *loob* (inner-relational self), *pakikipagkapwa* (sharing of self as part of another), and *pakikipagpalagayang-loob* (mutuality). These concepts foreground the relational self, the movement from being perceived as *ibang tao* (others) toward *hindi ibang tao* (one of us), and the development of trust, mutuality, and interpersonal ease within the helping relationship (Alejo, 2018; Enriquez, 1978; Javier, 2017; Pe-Pua & Protacio-Marcelino, 2000; Reyes, 2015; Yacat *et al.*, 2009).

In this sense, alliance congruence may be especially relevant in Filipino psychotherapy because the therapeutic relationship is not only a technical collaboration but also a culturally embedded relational encounter. Agreement on goals, tasks, and bond may reflect more than cognitive similarity on rating scales; it may also indicate shared relational understanding, mutual recognition, and the client's

felt sense that the therapist is a trustworthy and responsive helper (Rilveria, 2024). At the same time, client and therapist perceptions may diverge because of differences in role expectations, authority gradients, deference, emotional restraint, or differing thresholds for evaluating relational closeness. Examining client-therapist alliance congruence in a Filipino sample therefore offers an opportunity to extend dyadic alliance research beyond predominantly Western settings while also avoiding the assumption that alliance discrepancies have the same meaning across cultural contexts.

Materials and Methods

Research objectives

The present study examined the role of client-therapist alliance congruence and incongruence in predicting psychotherapy outcomes, particularly client psychological well-being. Specifically, this study investigated both the individual alliance effects and dyadic congruence effects of therapist- and client-rated alliance on psychological well-being while statistically controlling for treatment-related factors (treatment length and treatment interval), client-related factors (symptom severity), and therapist-related factors (professional maturity). Specifically, the following hypotheses were tested:

- i) Client-rated therapeutic alliance will be positively associated with psychological well-being after controlling for treatment length, treatment interval, symptom severity, and professional maturity.
- ii) Therapist-rated therapeutic alliance will be positively associated with psychological well-being after controlling for treatment length, treatment interval, symptom severity, and professional maturity.
- iii) Client-therapist alliance congruence will significantly predict psychological well-being above and beyond the individual effects of client- and therapist-rated therapeutic alliance such that greater congruence will be associated with higher psychological well-being and incongruence will be associated with lower psychological well-being.

Methodology

This study employed a quantitative, cross-sectional survey design. The primary variables included dyadic measures of the therapeutic alliance, a client-reported measure of psychological well-being, and therapist-reported indicators of treatment length, treatment interval, symptom severity, and professional maturity.

Research participants

The participants of the study were 104 Filipino client-therapist dyads. Based on G*Power-based calculations, for the focal polynomial/response surface analysis (RSA) block, assuming a medium effect size of Cohen's $f^2 = .15$, $\alpha = .05$, five tested predictors, and nine total predictors in the final model, the required sample size for 80% power is approximately 92 cases. The present sample of 104 client-therapist dyads therefore exceeded this threshold and provided approximately 86% power for detecting a medium-sized incremental RSA block effect.

The participating dyads were required to be in an active, open-ended therapeutic relationship at the time of the study. An active, open-ended psychotherapy was defined as ongoing treatment conducted either on a regular schedule of sessions or on a by-appointment basis (Nordmo *et al.*, 2021). This ensured that the quantitative

data were within the context of a continuing, naturalistic psychotherapy setting. Client participants were eligible to participate if they were at least 18 years old, currently engaged in psychotherapy with a participating therapist, had completed between 5 and 15 sessions with that therapist, and had sufficient English proficiency to complete the survey. The lower bound of five sessions was used because very early therapy may provide insufficient opportunity for the working alliance to develop, whereas the upper bound of 15 sessions was used to reduce heterogeneity in treatment duration and to focus the study on early-to-middle phases of ongoing psychotherapy. Clients were excluded if they were experiencing acute or unstable mental health conditions requiring immediate intervention, had been hospitalized for mental health concerns within the month prior to participation, were currently admitted as psychiatric inpatients, shared the same therapist with another participating client, or were concurrently receiving psychotherapy from more than one therapist. Eligibility screening for clients was conducted by therapists to maintain client anonymity.

Therapist participants were licensed clinical psychologists who were practicing in the Philippines at the time of data collection, and who had a current adult client meeting the study eligibility criteria. The study was limited to licensed clinical psychologists to reduce professional-role heterogeneity and to ensure that the dyads examined involved psychotherapy delivered by professionals with comparable training and scope of practice. Other mental health and allied professionals, including psychiatrists, counselors, social workers, and other helping professionals, were not included. Therapists reported their treatment orientation and treatment modality for the participating client. These variables were used to describe the psychotherapy context of the sample but were not analyzed as comparative treatment groups.

Descriptive information on the participants is presented in Table 1. In terms of therapeutic orientation, the largest proportion of dyads involved therapists who identified as integrative or eclectic in orientation ($n=37$, 35.6%). This was followed by cognitive-behavioral

therapy ($n=21$, 20.2%), humanistic-existential therapy ($n=14$, 13.5%), narrative therapy ($n=14$, 13.5%), psychodynamic therapy ($n=12$, 11.5%), and family systems therapy ($n=6$, 5.8%). Regarding treatment modality, more than half of the dyads received therapy through a hybrid format ($n=55$, 52.9%), while the remaining dyads received therapy through face-to-face ($n=25$, 24.0%) or online modalities ($n=24$, 23.1%). For the numerical therapist- and treatment-related variables, therapists had between 4 and 16 years of clinical practice, with an average of 9.08 years ($SD=3.15$), suggesting that the sample generally consisted of therapists with moderate professional experience. Treatment length ranged from 5 to 15 sessions, with an average of 8.66 sessions ($SD=2.31$). The average treatment interval was 2.21 weeks ($SD=1.06$), with reported intervals ranging from 1 to 4 weeks between sessions. Client symptom severity scores ranged from 18 to 119, with a mean score of 48.51 ($SD=25.40$), indicating variability in current clinical presentation at the time of assessment.

Instruments

Therapists

Therapists completed a background form capturing practice characteristics (e.g., years in practice, therapy orientation, treatment modality) and client-specific treatment variables (treatment length, treatment interval, and symptom severity). Client symptom severity was assessed using the 18-item Brief Psychiatric Rating Scale (BPRS; Dazzi *et al.*, 2016; Overall & Gorham, 1962). The BPRS is a clinician-rated measure of psychiatric symptom severity that assesses different mental health domains. It has demonstrated validity across psychiatric and non-psychiatric samples (Hofmann *et al.*, 2022) and evidence of inter-rater reliability when administered by trained raters (Ligon & Thyer, 2000). Items are rated on an 8-point scale, with 0 indicating that the symptom was not assessed and ratings from 1=*not at all* to 7=*extremely severe* indicating increasing levels of symptom severity. Total scores may range from 18 to 126

Table 1. Descriptive information on client-therapist dyads (N=104).

Categorical variables	n	%				
Orientation						
Cognitive-behavioral	21	20.2				
Psychodynamic	12	11.5				
Humanistic-existential	14	13.5				
Narrative	14	13.5				
Family systems	6	5.8				
Integrative/eclectic	37	35.6				
Treatment modality						
Face-to-face	25	24.0				
Online	24	23.1				
Hybrid	55	52.9				
Numerical variables	Min	Max	Mean	SD	Skewness	Kurtosis
Professional maturity (number of years in practice)	4	16	9.08	3.152	0.279	-0.834
Treatment length (total number of sessions)	5	15	8.66	2.313	0.814	0.437
Treatment interval (number of weeks between sessions)	1	4	2.21	1.058	0.466	-0.976
Symptom severity	10	119	48.51	25.403	0.687	-0.153

SD, standard deviation. Percentages were computed based on the full sample of 104 client-therapist dyads. Orientation refers to the therapist's primary or self-identified theoretical orientation; treatment modality refers to the predominant format through which psychotherapy was delivered. Professional maturity was operationalized as the therapist's number of years in clinical practice. Treatment length refers to the total number of psychotherapy sessions completed by the dyad at the time of assessment, while treatment interval refers to the usual number of weeks between sessions. Symptom severity was indexed using the Brief Psychiatric Rating Scale total score, with higher scores indicating greater client symptom severity.

when all items are validly rated from 1 to 7, with higher scores reflecting greater symptom severity. A sample item is, “*DEPRESSIVE MOOD: Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints*”.

Clients

Clients completed the 18-item Psychological Well-Being Scale (PWBS-18; Ryff & Keyes, 1995). The PWBS-18 assesses six dimensions of eudaimonic well-being: Autonomy, or the capacity to evaluate oneself by internal standards; Environmental mastery, or the perceived ability to manage life demands; Personal growth, or openness to development and continued self-expansion; Positive relations with others, or the capacity for warm and trusting interpersonal relationships; Purpose in life, or the experience of direction and meaning; and Self-acceptance, or a positive and accepting attitude toward the self. Items are rated on a 7-point Likert scale, with higher scores indicating greater psychological well-being after appropriate reverse scoring. A sample item is, “*For me, life has been a continuous process of learning, changing, and growth*”. In the present study, mean scores were used for analysis, with higher scores reflecting greater client-reported psychological well-being. The PWBS-18 has demonstrated adequate construct validity and internal consistency across diverse populations, although some studies have noted overlap among the six dimensions (Clarke *et al.*, 2001; Hsu *et al.*, 2017; Khanjani *et al.*, 2014; Lee *et al.*, 2019).

Client-therapist dyads

The quality of the therapeutic alliance was assessed using the 12-item Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspay, 2006), administered separately to clients and therapists using parallel forms. The WAI-SR assesses three theoretically derived components of the working alliance: Goals, Tasks, and Bond. Goals refer to the extent to which the client and therapist agree on the desired outcomes or direction of therapy. Tasks refer to the extent to which they agree on the therapeutic activities and methods used to pursue those goals. Bond refers to the affective and relational quality of the therapeutic relationship, including trust, respect, acceptance, and confidence in one another. A sample item from the therapist version is, “*We have established a good understanding of the kind of changes that would be good for [name of client]*”. A parallel item from the client version is, “*[name of therapist] and I have established a good understanding of the kind of changes that would be good for me*”. Items are rated on a 5-point Likert scale ranging from 1 to 5, with higher scores indicating stronger perceived alliance. Because empirical overlap between the Goals and Tasks subscales has been documented, and because the present study focused on overall dyadic alliance congruence, mean total alliance scores were used in the analyses (Falkenström *et al.*, 2015; Paap & Dijkstra, 2017). The WAI-SR has demonstrated adequate internal consistency, convergent validity, and predictive validity for psychotherapy outcomes (Munder *et al.*, 2010; Paap & Dijkstra, 2017).

Study procedures

Therapists were recruited using purposive and convenience sampling through professional networks, direct invitations, and a publicly advertised research link. Interested therapists accessed the therapist survey via Google Forms, reviewed the participant infor-

mation sheet, and provided informed consent before completing the survey. The therapist survey included eligibility confirmation, therapist background information, client-specific treatment information, therapist-rated symptom severity, and therapist-rated alliance.

After completing the therapist survey, each therapist received a unique 13-character tracking code and a separate client survey link. Therapists were instructed to forward the client information sheet, survey link, and tracking code to one eligible client. Clients accessed the survey independently, reviewed the participant information sheet, and provided informed consent before answering any study questions. The client information sheet explained the purpose of the study, the voluntary nature of participation, the topics covered by the survey, the use of the tracking code for dyadic matching, and the absence of identifying information in the client survey. Clients who did not provide consent were redirected to an exit page and did not complete the survey.

The tracking code was used only to match therapist and client responses from the same dyad. No client names, contact details, or other direct identifiers were collected from clients. Therapists were not given access to their clients' survey responses, and clients were informed that their participation or non-participation would not affect their ongoing psychotherapy.

Data analysis

All quantitative analyses were conducted using R (Version 4.6.0). Data were screened for missing values, outliers, coding errors, and distributional characteristics. Descriptive statistics were computed for therapist characteristics, treatment characteristics, symptom severity, psychological well-being, and therapist- and client-rated alliance. Continuous variables were summarized using means, standard deviations, ranges, skewness, and kurtosis. Categorical variables were summarized using frequencies and percentages.

To address the absence of a formal clinical cut-off for the WAI-SR, one-sample *t*-tests were conducted to compare therapist- and client-rated alliance means with the scale midpoint of 3.00. Because therapist and client alliance ratings came from members of the same dyads, a paired-samples *t*-test was used to compare therapist- and client-rated alliance. This paired-samples test was selected instead of an independent-samples *t*-test because the two ratings were not statistically independent.

Alliance agreement and discrepancy were examined descriptively in two complementary ways. First, a broad agreement band classification was computed to distinguish substantively meaningful discrepancies from small rating differences. A signed difference score was calculated by subtracting the client-rated alliance from the therapist-rated alliance. Dyads were classified as being in agreement when the absolute therapist-client difference fell within 0.50 standard deviations of the signed difference score. Dyads were classified as showing a therapist-higher discrepancy when therapist-rated alliance exceeded client-rated alliance beyond this agreement band, and as showing a client-higher discrepancy when client-rated alliance exceeded therapist-rated alliance beyond this agreement band. The 0.50 *SD* threshold was used as a pragmatic descriptive criterion for identifying discrepancies that were large enough to be meaningfully distinguished from minor rating variation. Conceptually, a half-standard-deviation difference corresponds to a moderate standardized difference and is commonly used as a practical benchmark for distinguishing trivial from potentially meaningful differences in psychosocial and clinical

measurement contexts. In the present study, this threshold was not treated as a validated clinical cut-off. Rather, it served as a conservative descriptive band to avoid classifying very small differences between therapist and client alliance ratings as substantive disagreement. This was particularly important because therapist and client ratings were obtained using parallel versions of the same alliance measure, where minor numerical differences may reflect ordinary response variation rather than clinically meaningful incongruence. Second, an exact directional comparison was computed to describe the direction of any non-identical therapist-client alliance rating, regardless of magnitude. Using the same signed difference score, dyads were classified as therapist higher than client when therapist-rated alliance was greater than client-rated alliance, client higher than therapist when client-rated alliance was greater than therapist-rated alliance, and equal rating when the two alliance scores were identical. Unlike the broad agreement band classification, this exact directional comparison did not impose a minimum discrepancy threshold and was therefore used only to describe the raw direction of rating differences. Finally, an absolute discrepancy score was computed by taking the absolute value of the therapist-client alliance difference. This score represented the magnitude of perceptual distance between the therapist and the client, regardless of whether the discrepancy favored the therapist or the client. These categorical and discrepancy indices were used for descriptive purposes and to contextualize the sample. The primary inferential test of alliance congruence and incongruence was conducted using polynomial regression and RSA, which preserves the separate contributions of therapist- and client-rated alliance and avoids the limitations of relying solely on difference scores.

Hierarchical multiple regression was then conducted to examine the unique contributions of therapist- and client-rated alliance to psychological well-being. Treatment length, treatment interval, client symptom severity, and therapist professional maturity were entered in the first block. Therapist- and client-rated alliance were entered in the second block to determine whether alliance ratings explained additional variance in psychological well-being beyond the covariates.

Finally, polynomial regression with RSA was used to exam-

ine dyadic congruence and discrepancy effects. Therapist-rated alliance and client-rated alliance were pooled-mean-centered and entered as linear terms, squared terms, and an interaction term. Treatment length, treatment interval, symptom severity, and therapist professional maturity were retained as covariates. Response surface parameters were used to interpret effects along the line of congruence (LOC), where therapist and client ratings are equal, and the line of incongruence (LOIC), where therapist and client ratings diverge. This approach allowed the analysis to model whether psychological well-being was associated with the level of shared alliance, the degree of discrepancy, and the direction of discrepancy.

Statistical power and sensitivity were examined for the major inferential analyses. These analyses were conducted as *post hoc* sensitivity checks and were not treated as substitutes for an *a priori* power analysis. For the hierarchical regression, sensitivity was evaluated for the incremental contribution of client- and therapist-rated alliance above the covariate-only model. For the polynomial regression with RSA, sensitivity was evaluated for the incremental contribution of the five polynomial alliance terms above the covariate-only model.

Results

Descriptive profile and alliance ratings

Client psychological well-being had a mean of 3.98 ($SD=0.50$) on the PWBS-18 mean-score scale. On the WAI-SR, therapist-rated alliance had a scale mean of 3.74 ($SD=1.01$), whereas client-rated alliance had a scale mean of 2.90 ($SD=1.37$).

Because the WAI-SR does not have a formal clinical cut-off, one-sample *t*-tests were conducted using the midpoint score of 3.00. Therapist-rated alliance was significantly higher than the WAI-SR midpoint, $t(103)=7.49$, $p<.001$, 95% CI [3.55, 3.94], Cohen's $d=0.73$. In contrast, client-rated alliance did not significantly differ from the midpoint, $t(103)=-0.78$, $p=.438$, 95% CI [2.63, 3.16], Cohen's $d=-0.08$. A paired-samples *t*-test indicated that therapist-rated alliance was significantly higher than client-rated alliance, mean difference = 0.85, 95% CI [0.55, 1.14], $t(103)=5.73$, $p<.001$, Cohen's $d=0.56$. Taken together, these findings indicate that therapists, on average, rated the alliance more positively than clients in the present sample.

Skewness and kurtosis values indicated no substantial departures from normality for the main analytic variables (West *et al.*, 1995), although therapist-rated alliance showed some negative skew and client-rated alliance showed a relatively flat distribution. These distributional patterns were retained in the analysis because the regression-based models were robust and because alliance ratings were central to the hypotheses.

Client-therapist alliance agreement and discrepancy

Client-therapist agreement and discrepancy classifications are presented in Table 2. Using the conservative agreement-band criterion, 58 dyads (55.8%) were classified as broadly in agreement. Among dyads outside this agreement band, 42 dyads (40.4%) were classified as therapist-higher discrepancy dyads, whereas 4 dyads (3.8%) were classified as client-higher discrepancy dyads.

Exact directional comparisons were also examined to describe any non-identical rating, regardless of magnitude. These comparisons showed that 64 dyads (61.5%) had higher therapist-rated than client-rated alliance, 34 dyads (32.7%) had higher client-rated than

Table 2. Client-therapist alliance agreement and discrepancy classifications.

Classification	n	%
Broad agreement band classification		
In agreement	58	55.8
Therapist-higher discrepancy	42	40.4
Client-higher discrepancy	4	3.8
Total	104	100.0
Exact directional comparison		
Therapist higher than client	64	61.5
Client higher than therapist	34	32.7
Equal rating	6	5.8
Total	104	100.0

Broad agreement was defined as an absolute therapist-client alliance difference within 0.50 standard deviations of the signed difference score. Therapist-higher discrepancy refers to dyads in which therapist-rated alliance exceeded client-rated alliance beyond the broad agreement band. Client-higher discrepancy refers to dyads in which client-rated alliance exceeded therapist-rated alliance beyond the broad agreement band. Exact directional comparison refers to the direction of any non-identical therapist-client alliance rating, regardless of magnitude.

therapist-rated alliance, and 6 dyads (5.8%) had identical therapist and client ratings. This exact comparison indicates that non-identical alliance ratings were common, although many of these differences were small enough to fall within the broad agreement band. This distinction is important because exact directional differences and conservative agreement-band classifications answer different descriptive questions: the former describes whether ratings are identical, whereas the latter describes whether ratings differ by a practically meaningful amount. To address whether the magnitude of client-therapist alliance discrepancy was associated with client psychological well-being, the absolute difference between therapist- and client-rated alliance was examined. Absolute alliance discrepancy was significantly and negatively correlated with psychological well-being, $r(102)=-.60$, $p<.001$, 95% CI $[-.71, -.46]$. Thus, larger differences between therapist and client alliance ratings were associated with lower client psychological well-being. A bivariate regression model showed the same pattern, with absolute alliance discrepancy significantly predicting lower psychological well-being, $B=-0.25$, $SE=0.03$, $t(102)=-7.54$, $p<.001$. This model explained 35.8% of the variance in psychological well-being, $R^2=.358$, adjusted $R^2=.352$, $F(1, 102)=56.86$, $p<.001$. The association remained significant after controlling for treatment length, treatment interval, symptom severity, and therapist professional maturity. In the covariate-adjusted model, absolute alliance discrepancy remained a significant negative predictor of psychological well-being, $B=-0.26$, $SE=0.03$, $\beta=-.62$, $t(98)=-7.61$, $p<.001$. The full model explained 42.3% of the variance in psychological well-being, $R^2=.423$, adjusted $R^2=.393$, $F(5, 98)=14.35$, $p<.001$.

Unique effects of client- and therapist-rated alliance

To examine the unique contributions of client- and therapist-rated alliance to psychological well-being, a hierarchical multiple regression analysis was conducted, controlling for treatment length, treatment interval, client symptom severity, and therapist professional maturity (see Table 3).

In the model including only covariates, the overall model was not statistically significant, $F(4, 99)=2.21$, $p=0.074$, and explained a modest 8.2% of the variance in psychological well-being (adjusted $R^2=0.045$). When therapist and client ratings were added to the

model, the overall fit improved substantially, explaining 74.1% of the variance in well-being (adjusted $R^2=0.725$), $\Delta F(2, 97)=123.45$, $p<.001$. Both therapist- and client-rated alliance were significant positive predictors, but when looking at the unique variance explained by each, client-rated alliance contributed more to the model ($B=0.268$, $p<.001$) than therapist-rated alliance ($B=0.140$, $p<.001$). The addition of therapist- and client-rated alliance to the covariate-only model produced a large incremental effect, $\Delta R^2=.659$. With 104 dyads, two numerator degrees of freedom, and 97 residual degrees of freedom, the analysis had sensitivity to detect an incremental effect of $f^2=0.099$ at 80% power and $\alpha=.05$.

Client-therapist congruence effect

To examine whether congruence and discrepancy between therapist- and client-rated therapeutic alliance were associated with client psychological well-being, a second-order polynomial regression with RSA was conducted.

Overall model fit

The full second-order polynomial model was statistically significant, $R^2=.802$, $p<.001$ (adjusted $R^2=.783$), indicating that therapist-client alliance ratings and their higher-order terms explained approximately 80% of the variance in psychological well-being. The addition of the five polynomial alliance terms to the covariate-only model produced a large incremental effect, $\Delta R^2=.720$. With five numerator degrees of freedom and 94 residual degrees of freedom, the analysis had sensitivity to detect an incremental effect as small as $f^2=0.131$ at 80% power and $\alpha=.05$.

Regression coefficients: main and higher-order effects

Examination of the polynomial regression coefficients revealed several notable patterns (see Table 4). Client-rated alliance showed a strong positive linear association with psychological well-being, $B=0.268$, $p<.01$, indicating that higher client perceptions of alliance were robustly associated with greater well-being. Likewise, the therapist-rated alliance exhibited a significant linear effect, $B=0.140$, $p<.01$, indicating that therapists' global alliance perceptions are also sufficient predictors of client well-being when client perceptions were taken into account.

Table 3. Hierarchical linear regression predicting psychological well-being (N=104).

Predictor	B	SE	95% CI		β	R^2	Adj. R^2	ΔR^2
			LL	UL				
Model 1						.082	.045	-
Intercept	3.981*	0.048	3.89	4.08	-			
Treatment length	-0.064**	0.024	-0.111	-0.017	-.299			
Treatment interval	0.043	0.048	-0.052	0.138	.091			
Symptom severity	-0.003	0.035	-0.073	0.067	-.009			
Professional maturity	-0.001	0.017	-0.034	0.033	-.006			
Model 2						.741*	.725	.659*
Intercept	4.04*	0.030	3.98	4.09	-			
Treatment length	-0.019	0.013	-0.045	0.007	-.087			
Treatment interval	0.027	0.026	-0.025	0.079	.058			
Symptom severity	0.036	0.019	-0.002	0.074	.103			
Professional maturity	0.002	0.009	-0.016	0.020	.011			
Client-rated alliance	0.268*	0.020	0.228	0.308	.737			
Therapist-rated alliance	0.140*	0.027	0.086	0.193	.285			

CI, confidence interval; B, unstandardized regression coefficient; SE, standard error; LL, lower limit; UL, upper limit; β , standardized regression coefficient; R^2 , proportion of variance explained by the model; ΔR^2 , change in explained variance from the previous model; * $p<.01$; ** $p<.001$. All predictors were mean-centered prior to analysis.

Table 4. Polynomial regression predicting psychological well-being (N=104).

Predictor	<i>B</i>	<i>SE</i>	95% CI		β
			LL	UL	
Intercept	4.23*	0.095	4.04	4.41	-
Client-rated alliance (X)	0.199*	0.031	0.138	0.260	.510
Therapist-rated alliance (Y)	0.125**	0.050	0.027	0.224	.321
X ²	-0.046	0.043	-0.131	0.040	-.148
XY	0.082*	0.013	0.057	0.107	.268
Y ²	-0.110**	0.053	-0.217	-0.004	-.360

CI, confidence interval; B, unstandardized regression coefficient; SE, standard error; LL, lower limit; UL, upper limit; β , standardized regression coefficient; * $p < .01$; ** $p < .001$. X refers to client-rated alliance, and Y refers to therapist-rated alliance. X², XY, and Y² represent the quadratic and interaction terms used in the polynomial regression model. Therapist-rated alliance and client-rated alliance were mean-centered prior to computing the squared and interaction terms. Treatment length, treatment interval, professional maturity, and symptom severity were included as covariates but are not displayed in the table. The 95% CIs are reported for the unstandardized coefficients.

The quadratic effect of client-rated alliance was negative but nonsignificant, $B = -0.046$, $p = .214$, indicating no evidence that the association between client-rated alliance and psychological well-being was curvilinear after accounting for therapist-rated alliance, the interaction term, and the covariates. On the other hand, the quadratic term for therapist-rated alliance was significant and negative, $B = -0.110$, $p = .01$, indicating that the association between therapist-rated alliance and psychological well-being was concave downward. Thus, the effect of therapist-rated alliance became progressively less positive – or more negative – at higher levels of therapist-rated alliance.

Most critically, the interaction between therapist- and client-rated alliance was positive and statistically significant, $B = 0.082$, $p < .001$, indicating that the association between either member's alliance rating and psychological well-being varied as a function of the other member's rating. Specifically, the positive association between client-rated alliance and well-being became stronger at higher levels of therapist-rated alliance, and the association between therapist-rated alliance and well-being similarly became stronger as client-rated alliance increased. This complementary pattern suggests that psychological well-being was greatest when both clients and therapists perceived the alliance positively, rather than when a strong alliance was reported by only one member of the dyad. None of the covariates reached statistical significance in the full model, whereas the polynomial alliance terms remained strongly associated with well-being.

Response surface tests: congruence and incongruence effects

Response surface tests further clarified the nature of these effects (see Table 5). The corresponding response surface depicting the association between client-therapist alliance congruence and psychological well-being is presented in Figure 1. Along the LOC, where therapist and client alliance ratings are equal, there was a significant positive linear effect, $a_1 = 0.324$, $SE = 0.038$, 95% CI [0.251, 0.398], indicating that increases in psychological well-being were linked with increases in congruent client-therapist alliance ratings. High-high alliance congruence was associated with greater psychological well-being than low-low alliance congruence. The absence of significant curvature along the LOC, $a_2 = -0.074$, $SE = 0.048$, 95% CI [-0.167, 0.019], suggests a linear, rather than curvilinear, benefit of increasing congruent alliance.

Along the LOIC, there was no significant linear slope, $a_3 = 0.073$, $SE = 0.064$, 95% CI [-0.053, 0.200], indicating that predicted psychological well-being did not differ significantly according to whether client-rated alliance exceeded therapist-rated alliance or therapist-rated alliance exceeded client-rated alliance. In contrast, the curvature along the LOIC was significant and negative, $a_4 = -0.238$, $SE = 0.046$, 95% CI [-0.329, -0.147], indicating that larger discrepancies between client and therapist alliance ratings were associated with lower psychological well-being, regardless of the direction of discrepancy.

The difference between the client- and therapist-specific quad-

Table 5. Response surface test statistics for client-therapist alliance congruence.

Surface parameter	Description	Estimate	<i>SE</i>	95% CI	
				LL	UL
a_1	Linear effect along LOC	0.324**	0.038	0.251	0.398
a_2	Curvature along LOC	-0.074	0.048	-0.167	0.019
a_3	Linear effect along LOIC	0.073	0.064	-0.053	0.200
a_4	Curvature along LOIC	-0.238**	0.046	-0.329	-0.147
a_5	Difference in curvature between client-rated and therapist-rated alliance	0.065	0.075	-0.082	0.212

CI, confidence interval; estimate, unstandardized surface parameter estimate; SE, standard error; LL, lower limit; UL, upper limit; LOC, line of congruence, representing combinations in which therapist- and client-rated alliance are equal; LOIC, line of incongruence, representing combinations in which therapist- and client-rated alliance differ; ** $p < .001$. The a_1 parameter represents the linear slope along the LOC, indicating whether psychological well-being changes as both therapist- and client-rated alliance increase together; the a_2 parameter represents curvature along the LOC, indicating whether the association between congruent alliance ratings and psychological well-being is nonlinear; the a_3 parameter represents the linear slope along the LOIC, indicating whether psychological well-being differs depending on the direction of the discrepancy between therapist- and client-rated alliance; the a_4 parameter represents curvature along the LOIC, indicating whether larger discrepancies between therapist- and client-rated alliance are associated with psychological well-being; the a_5 parameter reflects the degree of curvature difference across the client-rated and therapist-rated alliance dimensions, indicating whether curvature in the client-rated alliance dimension is more positive, or less negative, than curvature in the therapist-rated alliance dimension.

ratic effects was not significant, $a_5=0.065$, $SE=0.075$, 95% CI $[-0.082, 0.212]$, suggesting that there was no statistically reliable evidence that the curvature associated with client-rated alliance differed from the curvature associated with therapist-rated alliance. Overall, psychological well-being was highest when alliance ratings were highly congruent, whereas larger discrepancies in either direction were associated with poorer well-being.

Surface geometry, stationary point, and principal axes

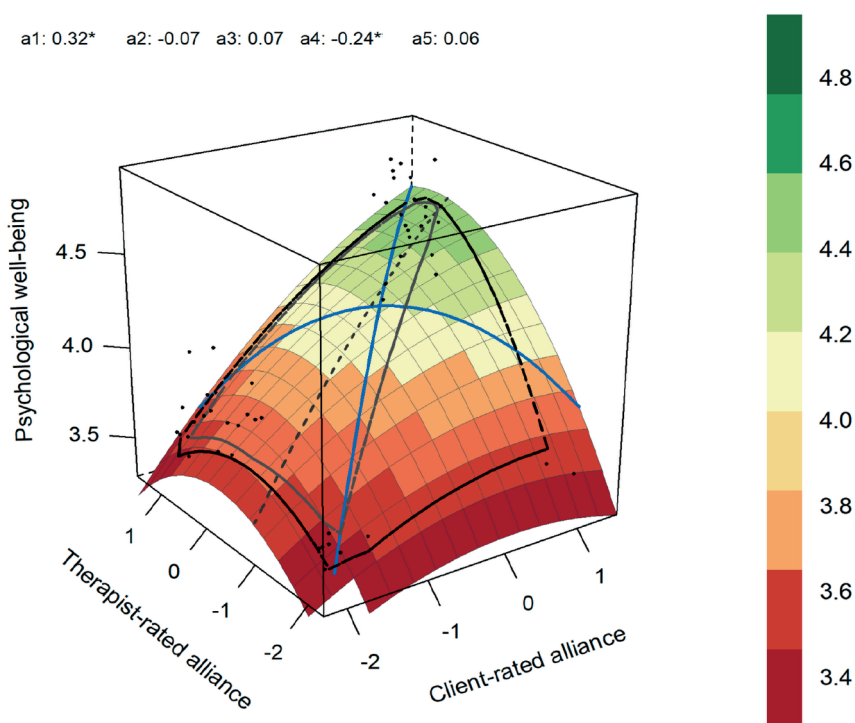
The response surface had a concave, dome-shaped form, indicating that predicted psychological well-being was highest near the upper region of the fitted surface and declined as alliance ratings moved away from that region. Both eigenvalues were negative, $\lambda_1=-0.0256$ and $\lambda_2=-0.1303$, confirming that the stationary point was at a maximum rather than a minimum or saddle point. The surface was relatively broad and gradual in one direction but more sharply curved in the other. In practical terms, well-being changed more slowly when moving along the surface's ridge but declined more rapidly when moving away from it. This sharper decline was broadly consistent with the significant negative curvature along the LOIC, $a_4=-0.238$, showing that larger differences between client and therapist alliance ratings were associated with lower predicted well-being.

Table 6 presents the estimated stationary point and principal-axis parameters of the response surface. The stationary point was located at $X_0=4.060$ for client-rated alliance and $Y_0=2.079$ for therapist-rated

alliance on the centered scale. On the original scale, these values corresponded to 7.380 and 5.399, respectively, with a predicted well-being score of $Z_0=4.761$. However, the stationary point fell outside the observed range of the data. Client-rated alliance scores ranged from 1.250 to 4.750, while therapist-rated alliance scores ranged from 1.333 to 4.667. The stationary point should therefore be viewed as a model-based extrapolation rather than an observed optimal combination of alliance ratings. Within the actual range observed, well-being tended to be higher when both clients and therapists reported stronger alliance and lower when their perceptions were more discrepant.

The first principal axis had an intercept of $p_{10}=0.112$, $SE=0.113$, 95% CI $[-0.110, 0.333]$, and a slope of $p_{11}=0.485$, $SE=0.359$, 95% CI $[-0.219, 1.188]$. Neither the intercept ($p=.323$) nor the slope from the line of congruence ($p=.151$) differed significantly from its reference value. Thus, there was no statistically reliable evidence that the first principal axis deviated from the LOC. Likewise, the second principal axis had an intercept of $p_{20}=10.459$, $SE=16.315$, 95% CI $[-21.52, 42.44]$, and a slope of $p_{21}=-2.064$, $SE=1.528$, 95% CI $[-5.059, 0.932]$. Neither the intercept ($p=.521$) nor the slope from the line of incongruence ($p=.486$) differed significantly from its reference value.

The results provide no significant evidence that the fitted ridge was displaced or rotated away from the LOC, or that the second principal axis departed from the LOIC. In substantive terms, the geometry does not support the conclusion that psychological well-being was systematically higher when clients rated the alliance



X, client-rated alliance; Y, therapist-rated alliance; * $p<.001$. The response surface depicts covariate-adjusted predicted psychological well-being across pooled-mean-centered client- and therapist-rated alliance scores. Green regions indicate higher predicted psychological well-being, whereas red regions indicate lower predicted psychological well-being. Black points represent observed cases. The blue lines represent the line of congruence (LOC; $X=Y$) and the line of incongruence (LOIC; $X=-Y$). The black lines represent the principal axes of the fitted response surface. a_1 is the linear slope along the LOC; a_2 is the curvature along the LOC; a_3 is the linear slope along the LOIC; a_4 is the curvature along the LOIC; and a_5 is the difference between the client- and therapist-specific quadratic effects.

Figure 1. Response surface plot of psychological well-being as a function of client- and therapist-rated alliance.

Table 6. Stationary point and principal axes of the response surface.

Parameter	95% CI			
	Estimate	SE	LL	UL
Stationary point				
Therapist-rated alliance	2.079	-	-	-
Client-rated alliance	4.060	-	-	-
Predicted well-being	4.760	-	-	-
Principal axes				
Intercept of 1 st principal axis	0.112	0.113	−0.110	0.333
Slope of 1 st principal axis	0.485	0.359	−0.219	1.19
Intercept of 2 nd principal axis	10.5	16.3	−21.5	42.4
Slope of 2 nd principal axis	−2.06	1.53	−5.06	0.932

CI, confidence interval; SE, standard error; LL, lower limit; UL, upper limit. The stationary point represents the mathematically estimated point on the fitted response surface at which predicted psychological well-being reaches its maximum. Because the polynomial regression model was estimated using pooled-mean-centered therapist- and client-rated alliance scores, the stationary point should be interpreted in relation to the centered metric and the observed range of the data. If the stationary point falls outside the observed data range, it should be treated as an extrapolated mathematical estimate rather than as a substantively observed alliance profile. The principal axes describe the orientation of the response surface. The first principal axis indicates the direction of least curvature and approximates the ridge of the surface, whereas the second principal axis is orthogonal to the first. Deviation of the first principal axis from the line of congruence indicates that the surface's highest predicted values do not fall exactly along perfect client-therapist agreement.

above therapists, or vice versa. Rather, these findings reinforce the interpretation from the primary surface parameters: well-being was higher when both parties reported stronger alliance, and larger discrepancies were associated with lower well-being, but the direction of the discrepancy was not reliably important.

Discussion

The present study examined the cross-sectional associations between client-therapist alliance perceptions and client psychological well-being among 104 Filipino psychotherapy dyads using a dyadic RSA framework. The findings corresponded closely with the study hypotheses. First, therapists rated the therapeutic alliance significantly more positively than did their clients, indicating a systematic difference in how the two members of the dyad perceived the working relationship. Consistent with Hypothesis 1, client-rated alliance was independently associated with greater psychological well-being after controlling for treatment length, treatment interval, symptom severity, and therapist professional maturity. Hypothesis 2 was likewise supported, as therapist-rated alliance also demonstrated a significant positive association with client well-being beyond the effects of the covariates and client-rated alliance. Although both perspectives were independently informative, the association was stronger for client-rated alliance, underscoring the particular relevance of the client's subjective experience of collaboration, relational safety, and therapeutic fit. Furthermore, the RSA findings provided qualified support for Hypothesis 3. Along the LOC, psychological well-being increased as client and therapist alliance ratings increased together, indicating that high-high congruence was associated with greater well-being than low-low congruence. Thus, agreement alone was not uniformly beneficial; rather, the level at which agreement occurred was clinically important. In addition, the significant negative curvature along the LOIC indicated that larger discrepancies between client- and therapist-rated alliance were associated with lower psychological well-being. However, the nonsignificant linear effect along the LOIC showed that the direction of discrepancy was not reliably associated with well-being. Client-higher and therapist-higher discrepancies therefore did not differ significantly in their implications; the magnitude of the mismatch, rather than which party rated the alliance more positively, was the more

salient feature. Taken together, these findings support the value of conceptualizing therapeutic alliance as a dyadic configuration rather than treating client and therapist ratings as interchangeable indicators. They are consistent with contemporary alliance research identifying the therapeutic relationship as a robust correlate of psychotherapy outcomes across treatment modalities and client presentations (Di Malta *et al.*, 2025; Saxler *et al.*, 2024; Wampold & Flückiger, 2023), as well as dyadic research showing that patterns of agreement and discrepancy provide clinically meaningful information beyond either informant's rating considered in isolation (Prusiński, 2024; Whelen *et al.*, 2023).

Clinical implications

Centering client feedback without disregarding therapist judgment

From a clinical standpoint, the findings reinforce the ethical and therapeutic imperative to prioritize the client's experience of the alliance. Alliance monitoring, particularly through client feedback, may therefore serve as an early warning system for misattunement that is not readily apparent to therapists. It is crucial to monitor possibilities of discrepancies or disagreements in how clients and therapists perceive the goals, tasks, and bond of therapy, as these dimensions can shape psychological well-being and treatment benefit.

Moreover, the stronger association between client-rated alliance and psychological well-being suggests that therapists should not assume that their own sense of a positive working relationship is sufficient evidence that the client experiences the alliance similarly. This is particularly relevant because therapist-higher discrepancies were common in the present sample. Recent work on routine outcome monitoring and clinical feedback supports the use of ongoing client-reported information to guide therapeutic decision-making, identify clients who are not progressing as expected, facilitate rupture-repair processes, and support timely treatment adjustments (Barkham *et al.*, 2023; McAleavey *et al.*, 2024; Muran *et al.*, 2022; Zilcha-Mano & Muran, 2024).

The significance of the client's perspective may be particularly salient within Filipino psychotherapy, where the helping relationship is experienced not only as a technical, professional collaboration but also as a relational encounter involving trust, respect, recognition, and shared inner experience. From a Filipino psychology perspective, clients may evaluate whether the therapist has moved from

being experienced as *ibang tao* (others), or a relatively distant professional other, toward *hindi ibang tao* (one of us), someone with whom they can gradually share their *loob* (inner-relational self). In this context, therapy becomes a form of *pakikipagkapwa* (sharing of self as part of another) in which the client feels encountered as a whole person rather than merely as a case, diagnosis, or recipient of intervention (Rilveria, 2024). A strong client-perceived alliance may therefore reflect more than procedural agreement on treatment goals and tasks; it may also represent a deeper sense of *pakikipagpalagayang-loob* (mutuality), relational ease, and mutual trust. Thus, this cultural perspective raises questions about whether standardized alliance measures fully represent the relational qualities Filipino clients consider therapeutically meaningful. Although the WAI assesses goals, tasks, and bond, Filipino clients may evaluate the relationship through additional experiential markers, such as *gaan ng loob* (sense of ease), *pakikipagkapwa* (sharing of self as part of another), *pakikipagpalagayang-loob* (mutuality), and the felt movement from *ibang tao* (others) toward *hindi ibang tao* (one of us). Therapists, by virtue of their clinical training, may be more likely to interpret alliance items according to formal indicators of goal agreement, task collaboration, and observable relational engagement. Clients, by contrast, may evaluate the alliance according to a broader and more embodied standard – whether they feel genuinely accepted, accompanied, understood, and safe enough to share their *loob* (inner-relational self). This perspective might offer an explanation for why therapist alliance ratings were higher than client alliance ratings in this sample. However, this interpretation should remain tentative because the present study did not directly examine the cultural adequacy, measurement invariance, or construct coverage of the WAI among Filipino psychotherapy dyads. Nevertheless, alliance assessment in Filipino settings may benefit from supplementing standardized measures with culturally grounded questions about relational safety, mutual recognition, shared understanding, and *ginhawa* (holistic well-being). Lower client ratings should therefore not automatically be interpreted as indicating a globally weak alliance, as they may also point to unmet culturally meaningful relational needs or limitations in how existing instruments operationalize the therapeutic relationship. Therefore, in practice, therapists may invite clients to provide qualitative feedback on whether therapy addresses what matters to them, whether the therapeutic activities feel meaningful and useful, and whether they feel understood, respected, and emotionally safe. These recommendations represent clinical extensions of the findings rather than interventions directly evaluated in the present study.

Understanding alliance incongruence

Traditionally, discrepancies in therapeutic alliance ratings have been interpreted as indicators of relational breakdown or therapeutic rupture (Prusiński, 2024). However, the present findings invite a more nuanced reconceptualization of alliance discrepancies as clinically informative relational signals rather than deficits to be eliminated. Alliance discrepancies may emerge because clients and therapists evaluate the therapeutic relationship from different role positions and sources of information. Clients have privileged access to their internal sense of safety, trust, hope, engagement, and fit with the therapist's approach, whereas therapists may evaluate the alliance through observable participation, perceived collaboration, clinical formulation, and assumptions about treatment progress. Thus, the two informants may both be responding to real aspects of the therapeutic process, but from different vantage points (Høgenhaug *et al.*, 2024; Muran *et al.*, 2022; Tschuschke *et al.*, 2022; Zilcha-Mano & Muran, 2024).

Clinically, therapist-higher discrepancies may occur when clients appear compliant, agreeable, emotionally contained, or behaviorally engaged despite unspoken dissatisfaction, uncertainty, or relational discomfort. In such cases, client-higher ratings may warrant attention to possible missed rupture markers, unrecognized disagreement about goals or tasks, or premature assumptions of relational security. Conversely, therapist-lower ratings may sometimes reflect appropriate caution, humility, and responsiveness to possible alliance strain rather than a weak alliance. This interpretation is consistent with rupture-repair literature, which conceptualizes ruptures as disagreements about goals or tasks, strains in the emotional bond, or disruptions in the negotiation of client and therapist needs (Høgenhaug *et al.*, 2024; Muran *et al.*, 2022; Zilcha-Mano & Muran, 2024). Furthermore, client-higher and therapist-higher discrepancies may likewise carry different clinical meanings. When clients rate the alliance lower than therapists, a pattern that was more common in the present sample, this may indicate felt distance, dissatisfaction, mistrust, or unmet relational and therapeutic needs that have not been sufficiently articulated. Conversely, in some dyads where clients rate the alliance more positively than therapists, the discrepancy may reflect a client's experience of safety, trust, or relational benefit that is not equally recognized by the therapist. Large client-higher discrepancies should nevertheless be interpreted cautiously, as they may also reflect idealization, dependency, gratitude, or reluctance to evaluate the therapist critically. Importantly, the present findings did not indicate that either direction of discrepancy was more strongly associated with psychological well-being. Thus, the clinical meaning of alliance discrepancy is likely to depend on its magnitude, persistence, developmental course, and relational context rather than solely on which member of the dyad provides the higher rating. Recent dyadic studies similarly suggest that alliance discrepancy and convergence may vary across treatment phases and may not predict outcomes in a simple linear manner (Prusiński, 2024; Tschuschke *et al.*, 2022; Whelen *et al.*, 2023). These findings support treating discrepancy as a process marker that invites clinical inquiry rather than as automatic evidence of therapeutic failure.

From a cultural lens, the phenomenon of incongruence may not always be observed in explicitly articulated alliance ratings. This is instead felt as distance between clients and therapists, especially in the Filipino cultural context, where *hiya* (sense of propriety), deference to professional authority, gratitude, and concern for preserving relational harmony may only reinforce superficial compliance and discourage clients from openly expressing disagreement, dissatisfaction, or discomfort. At the same time, therapists may also hesitate to directly address perceived tensions, confront the apparent compliance, or invite potentially uncomfortable feedback out of concern that doing so might threaten trust, evoke shame, or disrupt the therapeutic relationship. Thus, cultural pressures toward harmony may operate on both sides of the dyad, allowing implicit discrepancies in alliance perceptions to persist despite an outwardly cooperative relationship. Culturally responsive alliance monitoring should therefore aim not simply to obtain high ratings from either party, but to create opportunities for clients and therapists to clarify how each experiences the goals, tasks, and relational bond of therapy. Therapists should invite clients to express appreciation as well as hesitation without fear of appearing disrespectful, ungrateful, or disruptive to relational harmony. Such dialogue may help transform numerical agreement into genuine mutual attunement and support the development of a therapeutic relationship characterized by *pakikipagkapwa* (sharing of self as part of another), trust, agency, and *ginhawa* (holistic well-being).

Implications for supervision and therapist development

Supervisory practices may benefit from encouraging therapists to adopt a stance of “informed uncertainty”, continually checking assumptions about the relationship and remaining open to client feedback. This is particularly relevant for experienced therapists, for whom confidence may inadvertently obscure subtle alliance strains. Effective supervision should aim to develop therapists’ capacity for mentalization, the ability to understand and reflect on both their own and their clients’ mental states, and critical self-reflection (Bateman & Fonagy, 2016; Fonagy & Luyten, 2018). However, recent alliance and rupture-repair literature further emphasizes that therapists require training not only in technique but also in recognizing, negotiating, and repairing relational disruptions (Høgenhaug *et al.*, 2024; Muran *et al.*, 2022; Zilcha-Mano & Muran, 2024). Supervisors can facilitate this through structured reflective exercises, process notes, live or video review of sessions, and guided discussion of alliance ruptures and discrepancies (Barkham *et al.*, 2023; McAleavey *et al.*, 2024).

Moreover, culturally responsive therapist development should include training in reflexivity regarding client meaning-making, particularly when therapist and client differ in cultural background, authority position, or expectations about emotional expression and help-seeking. Furthermore, culturally responsive supervision should additionally attend to how Filipino relational norms may shape both parties’ willingness to acknowledge tension. Therapists are encouraged to remain alert to the possibility that their perception of the alliance may not mirror the client’s experience. The goal is not to eliminate all discrepancy, but to develop the therapist’s capacity to notice, inquire into, and work productively with differences in relational perception.

Limitations

Several limitations should be acknowledged. First, the study used a cross-sectional design, which precludes causal inference. Although alliance congruence and discrepancy were associated with psychological well-being, the study cannot determine whether alliance patterns shaped well-being, whether clients with higher well-being perceived the alliance differently, or whether both were influenced by other unmeasured factors. Longitudinal and session-by-session designs are needed to examine how alliance congruence changes over time and how such changes relate to subsequent outcomes. Second, the sample was restricted to dyads involving licensed clinical psychologists and adult psychotherapy clients in the Philippines. This strengthened professional-role consistency but limited generalizability to other mental health professionals, group therapy, family therapy, psychiatric care, school counseling, or multidisciplinary treatment contexts. The study also focused on dyads who had completed between 5 and 15 sessions, leaving very early alliance formation and longer-term therapy processes unexplored. Third, although therapists reported treatment orientation and modality, the study was not designed or powered to compare alliance congruence across therapeutic modalities. Different orientations may place different emphasis on explicit discussion of the therapeutic relationship, rupture repair, transference, collaboration, or structured goal-setting. These modality differences may influence alliance congruence and should be examined in future research. Fourth, the study relied on self-report measures of alliance and client-reported psychological well-being. Although this is appropriate for examining perceived alliance, it does not capture in-session interactional processes, therapist behaviors, rupture markers, or moment-to-moment shifts in collaboration. The study also did not directly measure possible mechanisms of alliance discrep-

ancy, such as client deference, therapist responsiveness, emotional expression, relational safety, or culturally specific experiences of trust and healing. Finally, although the sample size was adequate for detecting medium-sized effects in regression analyses, the polynomial regression and RSA model included multiple higher-order terms. The response surface findings should therefore be interpreted as an important but preliminary contribution that requires replication in larger samples.

Future directions and recommendations

Future research should examine alliance congruence using longitudinal and session-by-session designs. Such designs would allow researchers to test whether changes in client-therapist agreement predict later changes in well-being, symptom severity, dropout, or treatment satisfaction. Incorporating alliance rupture-repair processes within RSA frameworks may provide particularly rich insights into the mechanisms of therapeutic change. Future studies should also examine whether alliance discrepancies differ across therapeutic modalities, treatment phases, clinical presentations, and delivery formats.

In the current study, alliance predictors were obtained from both members of the dyad, whereas psychological well-being was reported only by clients. Future research should collect outcomes from both members of the dyad to deepen understanding of shared and divergent perceptions and their impact on therapy outcomes.

The use of indigenous measures of alliance and psychological well-being may yield more nuanced, culturally resonant data. Reconceptualizing these constructs within Filipino cultural frameworks can enhance ecological validity and provide insights into culturally specific expressions of relationality and shared realities.

Qualitative approaches are also recommended to contextualize alliance congruence and discrepancies. Exploring client and therapist narratives can identify the relational and contextual factors that contribute to alignment or divergence. Additionally, methods such as interpersonal process recall, where dyads review session recordings to describe in-the-moment alliance experiences, can address biases associated with retrospective reporting.

Clinically, future work should investigate the utility of integrating routine outcome monitoring systems with dyadic feedback tools to support real-time alliance calibration. Training programs can incorporate explicit instruction on identifying and working with alliance discrepancies as therapeutic opportunities rather than dangers, fostering therapist reflexivity, attunement, and adaptive responsiveness.

Conclusions

The present study provides novel insights into therapeutic alliance congruence and incongruence, highlighting that psychological well-being is shaped by a complex, asymmetric interplay between client and therapist views of the therapeutic relationship. Dyadic analyses showed that higher shared alliance ratings were associated with greater well-being, whereas larger discrepancies were associated with poorer well-being. The direction of the discrepancy was not reliably associated with well-being.

Taken together, this study calls attention to the clinical, supervisory, and training implications of dyadic alliance assessment, emphasizing the particular importance of clients’ experiences while retaining therapist perspectives as independently informative, and the potential of alliance discrepancies as therapeutic opportunities rather than threats. Future research should continue to explore these processes longitudinally, across diverse clinical

populations, and within culturally grounded frameworks, ultimately contributing to more responsive, effective, and culturally sensitive psychotherapy.

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