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# THERAPEUTIC RELATIONSHIP – WHAT INFLUENCES IT AND HOW DOES IT INFLUENCE ON THE PSYCHOTHERAPY PROCESS?[1]

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**Summary**

This article presents the review of results of psychotherapy researches presented in the Psychotherapy Research in years 2004–2012. The main point of interest was a common factor of many psychotherapeutic schools – the therapeutic relationship. Collected information were divided into three categories. The first one consist of variables which can be used to describe the relationship, specified with use of tools created for their measurement. Most of them were easy to measure, however, some concerned abstract concepts. The second category consists of factors which affect the relationship. Those were classified within 4 categories: influence of a patient, his features and experience, also characteristics of a therapist and his actions. The last category was on the association between the relationship variables and variables of a therapeutic process. Those within the second category described in this article, were studied the most. Least information was provided about the third category. It clearly shows that the matter of the psychotherapeutic relationship is commonly examined by many researchers, nevertheless it still leaves place for future studies.

**Key words:** therapeutic relationship, psychotherapy process, alliance

## Introduction

Psychotherapy is an effective way of treating many of mental illnesses. Results of empirical researches show, that effectiveness of psychotherapy is connected with many variables. Lately there are some ideas that therapies should be based on the empirical averments. During the last three decades many researches on the effectiveness of psychotherapy have been made. Their results show that psychotherapy is successful independently of the theoretical background [1]. Afterwards, in the search for variables important for effects of the psychotherapy, researches on the psychotherapeutic process have been started. Many of them show that one of these variables is therapeutic relationship. Norcross and Lambert [2], summarizing results of researches on the effectiveness of psychotherapy, present factors important for its effects: variables of a patient explain 30% of psychotherapy effects variation, therapeutic relationship – 12%, modality of psychotherapy – 8%, variables of a therapist – 7%, 40% of factors influencing the effectiveness of psychotherapy are unknown.

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In last few years many researches on the issue of what therapeutic relationship is and how it is connected with changes observed during psychotherapy, have been made. In the search for researches on variables describing therapeutic relationship and their meaning to psychotherapy process and effects, together with a group of students from seminary classes, we made a review of last annuals of the "Psychotherapy Research." The found publications from years 2004–2010 were analyzed in the search for answers to three questions:

1. What variables are mostly used to describe therapeutic relationship?
2. What influence therapeutic relationship?
3. What connections can be found between variables of therapeutic relationship and variables of psychotherapeutic process?

**Ways of describing the variables of therapeutic relationship**

Gelso and Hayes [3] in their description of therapeutic relationship components referred to definition by Geslo and Carter [4], which says that those are "mutual feelings and attitudes in the relation between therapist and client, and also way of expressing them". [3, p. 16]. On the basis of this definition they constructed 3 elements which, in their opinion, come into part of so called therapeutic relationship. They consist of: working alliance, which is being said to be the base of relationship in which both sides are cooperating to achieve their shared therapeutic goals. In the opinion of the authors: "it is a basic factor in the healing process" [3, p. 16]. The second component is called configuration of assignment, understood both as relation between assignment and counter assignment in therapy which, by assisting in the process from the beginning, influences the formation of the relationship [3]. The last of listed components is real relationship which means one that is based on genuine and real behaviours of the therapist and the patient [3]. Better relationship brings better results of the therapy [3]. The importance of genuine and real relationship was stressed by the authors of RRI (Real Relationship Inventory, Geslo et al., Kelley et al.) [after 5].

Cooperation between the therapist and the patient is an important matter in the studies on therapeutic relationship. Common goals and means to achieve them are two of the three aspects of working alliance that can be measured with WAI-S (shortened version of Working Alliance Inventory, Horvath and Greenberg) [6, 7]. The partnership understood as that is also important for the authors of ARM (Agnew Relationship Measure, Agnew-Davis et al.) [8] and HAQ-I (Helping Alliance Questionnaire, Alexander and Luborsky) [9]. The authors of tools listed above have paid a special attention on the matter of common goals in the therapy, which is used for building relationship based on shared work and effort. Widely understood cooperation between the two sides also found its reflection in researches made with the use of CIS (Collaborative Interaction Scale,

Colli and Lingiardi) [10]. For the author of CALPAS (California Psychotherapy Alliance Scale, Marmar et al.) [11] alliance is one of the most important variables.

Alongside the cooperation, the important variables are those which each side brings individually into the therapy, and also the feelings about the process. An important variable for the therapeutic relationship are not only engagement and contribution of the therapist (CALPAS) [11] or the kind of intervention (CIS) [10], but also a way of perceiving him/her as warm, helpful and supporting (HAQ-I) [9]. In case of the patient his contribution (CIS) [10] and engagement in the therapeutic process (CALPAS) [11] is a very important variable.

Tools which are commonly used for measuring the therapeutic relationship also include more abstract variables. Those variables include bond between the patient and the therapist (WAI-S, ARM, HAQ-I) [6–9], relational depth (RDI, Relational Depth Inventory, Wiggins et al.) [12] perceived as an engagement between sides, assessed on the basis of such aspects of the relationship as respect, intimacy or love.

## Variables which influence the therapeutic relationship

### A. Influence of the patient

Bedi [after 13] noticed that patients will not confirm their participation in creating the therapeutic alliance. Researches made by Fitzpatrick et al. [13] had a purpose to check this observation and the results tend to confirm it. In a perception of the ordinary patient it is the therapist who is mostly responsible for a therapy course and creating the relationship. Patients who seek alliance create new ways of making an agreement themselves. Moreover, by endeavouring to experience their positive emotions and owing to the attitude of openness patients who seek alternative methods to solve their problems, become a driving force of change in their lives. Fitzpatrick et al. [13] also point that understanding the matter of self influence on the therapeutic process has a great therapeutic meaning. They point at researches [Zwick and Attkinsson; after 13], the results of which indicate a positive influence of self awareness of self influence on the outcomes of the therapeutic process. This awareness is believed to help in reducing patients' clinical symptoms [after 13], showing positive attitude towards the therapeutic process [after 13], but also to reduce the risk of quitting a therapy [after 13].

### B. Features and experiences of the patient

Results of researches reveal that elements which influence the therapeutic relationship are most often clinical variables. It was observed that patients with more clinical symptoms have more problems with establishing and developing the relationship, than those with less symptoms [14]. By analyzing, with CALPAS, therapeutic cooperation of patients with various types of disorders, it was emphasized that for paranoid, schizoid and schizotypal patients developing relationship is much

harder, while for therapists the most challenging for establishing a relation are patient with personality disorders [15]. By assessing symptoms with the SCL-90 scale, it was pointed that the best results with establishing the alliance, both from therapists' and patients' perspective, were achieved with dependable patients and those with obsessive compulsive disorder [15].

Depressive symptoms are also being considered as problematic in establishing therapeutic relationship [13]. On the basis of results of their researches Fitzpatrick et al. [13] raise the statement that patient's depression can lead to magnifying the influence of the therapist on the relationship, at the same time minimizing the possibility of noticing influence of the patient on the relationship. To confirm this assumption the authors of this thesis refer to researches by Fresco et al. [16] and Peterson et al. [17], who state that depressive patients tend to see good things in their lives as the results of external reasons.

In their researches Hersoug et al. [18] obtained results which show, that not only symptoms of illness have an influence on the alliance, but also their whole performing. Results obtained with the use of the GAS (Global Assessment Scale) and WAI show, that those two variables correlates with themselves, which indicates that the better the performing before the beginning of the therapy, the better chances to establish a relationship. What is important, differences in the working therapeutic alliance between patients were not constant, because after 20 sessions all of them obtained approximate results. Patients were examined during $3^{rd}$, $12^{th}$, $20^{th}$, $40^{th}$, $60^{th}$, $80^{th}$, $100^{th}$ and $120^{th}$ session.

Besides the good general performance of the patients, establishment of strong relationship was also affected by other features of psychotherapy participants. Patients with rewarding interpersonal relations and those, who declared good mother care till the adolescence, obtained better results in the first WAI surveys. Hersoug et al. [18] explained it with their better preparation to establishing bonds and setting common goals from the very beginning of a therapeutic work. People with many interpersonal problems, described as cold and out spaced, obtained lower results at the beginning, but it has been changing with time, becoming equal with the results of the patients with better relations, after $20^{th}$ session.

Similar results were obtained by Constantino and Smith-Hansen [19] in their research on therapeutic alliance with patients with bulimia. Their results indicated connection between painful interpersonal relations and therapeutic alliance, measured during therapy with the use of the HAQ. The more painful and hard those experienced were, the lower were opinions about therapeutic alliance at the beginning and in the middle of therapy, but in contrast to results obtained by Hersoug et al. [18], those were constant. The opposite results were obtained in relation to the need of affiliation. Those who tended to establish and develop relations with others were more likely to

agree to perform planned tasks and to achieve goals of the therapy, to give greater value of an alliance, and their results were not only higher, but also growing with time. Those patients were examined during 19 sessions which lasted for 20 weeks [19].

In opposition to above stands results obtained by Sexton et al. [20], where the authors did not reveal any connections with therapeutic alliance ($p > 0.005$), assessed with WAI, neither for patients' symptoms, nor his performance before a therapy or even confirmed personality disorders. Divergence between results obtained by Hersoug et al. [18] and Sexton et al. [20] is even more interesting, because of the fact of using WAI for measuring alliance and GAS for performance in both of the researches. Perhaps the results obtained by Sexton et al., unlike Hersoug et al., did not indicate relation between relationship and previous performance of a patient because of fact, that WAI researches were only made during first two sessions, with instruction to estimate each of them separately (independently), when Hersoug et al. [18] included results up to $120^{th}$ session.

Sexton et al. [20] indicate that such patients' behaviour as talking about themselves and engagement in the therapy has a positive influence on development of the relation with a therapist – as such this variable was about 20% of patient alliance and 25% of therapist alliance variance measured during 2 sessions. The authors suggest that connection between a patient and a therapist can be a sort of highlighter of therapeutic relationship in the micro therapeutic process during a session.

Patient's features which influence the therapeutic relationship are connected with a style of attachment typical for him/her. It includes aspects such as: comfort and self assurance in close relations, fear of being rejected, longing for intimacy or preference of self-efficiency and interpersonal distance. Diener et al. [21] proofed on the statistically significant level, that those with secure attachment style declare more positive alliance, than those with other styles. Moreover, Fuertes et al. [5] observed that secure style of attachment to the therapist is connected with perceiving the relation with a therapist as more realistic ($r = 0.33$, $p < 0.05$), than if a patient would mark him-/herself with anxiety-avoiding style of attachment to the therapist ($r = -0.64$, $p < 0.001$).

As features which hinder the therapist showing sympathy for the patient, which is understood by authors as greater and wider than empathy, Vivino et al. [22] list coldness of the patient, distance, not being engaged into therapeutic process and avoidance of taking responsibility for actions, and disturbances, which bring on negative feelings in the therapist (such as paedophilia). It is very important because patients perceive sympathy as soothing kindliness, candidness, openness, acceptance without judgement [22]. It helps them to become more open-minded, face their suffering and deepen their experience, which leads to the feeling of relief, healing thanks to simply being understood, heard out and taken care of by sympathetic therapist.

Moreover, interesting results were obtained in reference to patients' age – older patients obtained better results with therapeutic alliance [18], which tends to confirm the theory by Di Giuseppe et al. [after 23]. The authors suggested that different components of the alliance should be connected with different age groups. They observed that for younger patients bounds were of more importance than agreement for goals and actions of therapy.

The authors also examined patients' features which are not in favour of creating therapeutic alliance. Hersoug et al. [18] pointed coldness, Sexton et al. [20] suggest that vindictiveness and remembrance of the patient could explain 11% of alliance variation. Unyielding and unfriendly clients can see alliance in negative way. Work with such a person can demand from a therapist greater awareness in reference to alliance from the very beginning of a therapy [19].

An obstacle in establishing alliance can be patient's unspoken need of receiving more than a therapist can give him/her. Fitzpatrick et al. [13] give examples such as anticipation of dedicating more spare time by a therapist, which unachieved can lead to belief that therapist, just like others from surroundings, has no time for a patient or is simply overworked. As a result, a client became frustrated and uncertain about the therapist's sympathy for him. Also unaccomplished expectations for a therapist to speak more and more during sessions, led to avoidance of subjects important for the client. In the end the client felt misunderstood, perceived the therapist as cold and not engaged in the therapy process, and thought that he must deal with his problems himself. The occurrence of such "unspoken needs" can lead to quitting a therapy, that is considered ineffective by the patient [13].

### C. Therapist interventions

An important meaning for therapeutic relationship are therapist interventions during early time of a therapy. Results of researches [13] show that therapists use many methods, which lead to improvement of therapeutic alliance. Those include: making creation of new thoughts and acts easier, supporting, not judging, communication of understanding, as well as therapist's sensitivity, participation in patient's experiences and devoting attention. Fitzpatrick et al. [13] agree with researches by Ackerman and Hilsenroth [after 13], on the basis of which it was observed that supporting, understanding, helping in search of new solutions and therapist's candidness help in developing an alliance.

If, by the means of therapist interventions, a patient was able to feel, that his/her therapist is trustworthy and he/she is being accepted, that would lead to greater candidness from his/her side. Opposite effect was achieved by interventions, which suggested lack of therapist knowledge or experience or his/her being edginess [24]. Client–therapist connection, which was already defined in this work as easy to observe aspect of therapeutic alliance also plays an important role. It can

even lower itself, if a therapist is not fully engaged into a therapy, what can be manifested by his/her emotionless voice and overall advices to his/her client [20]. Nevertheless, it does not have to be connected with therapist's competences [25].

Results of Crits-Christoph et al. [26] can be a solution of negative influence of some therapist interventions. Based on three examinations of patients led by therapists trained in cognitive-behavioural psychotherapy, the authors observed that an appraisal of therapeutic alliance was more and more positive with time. The researchers used tools for measuring alliance, such as CALPAS and HAq-II. The authors emphasise an exploratory character of their research and suggest that it would be worth considering to make similar studies with different types of therapist trainings and different cases of patients.

Interesting results were obtained by Oddli and Rønnestad [27], who have been examining a technical aspects of therapeutic alliance. They have identified eight types of actions of therapists and after that classified them into 2 categories. The first category was supporting patient's actions. It included interventions such as: exploring ways of dealing with problems, emphasising patient's choices/authority, concentration on here and now and naming them as a method of showing openness (e.g.: You are right, your facial expression has changed), showing cooperation by the use of characteristic speech tone, which includes: use of hypothetical forms, not finishing sentences and giving a patient a chance to do that (as a way of inviting client to cooperate). The second category included therapist actions that lead to immediate use of special techniques – therapists during preparation for a task were giving elements of it in instructions given to patients (revisiting already discussed materials with a help of role playing or imagining as a way of working with a problem, not just talking about it), educating them (giving new information to patients, e.g. about techniques of dealing with stress, etc.), provoking changes in perceiving themselves, a problem and mechanisms of change (e.g. showing alternate ways of dealing with problem), placing himself as an expert (appealing to knowledge, experiences or opinions of a patients). The authors indicated that technical aspects of the early relation cannot be fully understood in reference to an agreement between a client and a therapist which emphasises open negotiations between two independent persons. They think it is acquired for therapists to take greater responsibility, as a one who makes decisions about techniques of achieving changes and bringing on new ways of troubleshooting.

In researches more often appear attempts to understand the influence of dealing with crisis in therapeutic relationship on a quality of relation. The matter of breakthroughs was researched by Fitzpatrick et al. [24]. To check how patients understand an importance of turning points during therapy process, data from interviews were analyzed with the use of Consensual Qualitative Research (CQR) [28, 29]. This method allows for making compact and trustworthy comparisons.

On the basis of this analysis the researchers were able to specify 5 categories that described critical points in therapy process, which should be understood as those events that patients perceived as such thanks to therapist interventions, not by interventions themselves.

First of the specified categories was a description of a critical point. This consisted in pointing, by patients, which of a therapist interventions initiated breakthroughs in the therapy process. Those included actions such as: help in changing patients' ways of thinking, coaxing patients to engage in a therapy process, corresponding to patients' needs, providing tools needed to achieve therapy goals, as well as giving a significant information or positive feedback. The second category was assigning a meaning to critical points, third – patient contribution, e.g. his/her candidness during helping process, which was a basis for development of therapeutic relationship. Influence of events on the relationship by freeing, thanks to them, positive feelings such as trust for a therapist and overall result of critical points, which was increasing candidness and productiveness of a patient, as well as deliverance of his/her positive emotions and expectations were fourth and fifth category. The authors proved that moments important for patients in an early stage of therapy allow for revealing positive emotions and a will of exploration, which helps with developing bonds and setting goals of therapy. Those events can be foundations for exploration process, which will help a therapist in his/her task.

Influence of many factors intruding a process of psychotherapy – from both a therapist and a patient – on developing an alliance was examined by Aspland et al. [30]. With Agnew Relationship Measure (ARM), used for measuring alliance level, and basing on researches by Bordin [after 30] they determined 24 moments in the therapy, in which disruptions can occur. Lack of security, antipathy for emotional explorations, questioning goals and values of therapy and different expectations toward therapists were recognized as the most important disruptions from the patient side. The disruptions from the therapist side were: overrating of his/her capabilities in regard to developing alliance and not considering previous experiences of a patient. Disruptions which engage both sides, in authors opinion, are communication problems and breaking off emotional agreement.

As a cure for problems mentioned above Aspland et al. [23] propose affirming positive character of alliance, positive ways of solving communication crises, and engaging a patient into therapy planning process, however, they do not explain how those actions could be fulfilled. The authors coax a therapist to consider his/her contribution in difficulties in a relation. The results of those researches complete results of previous researches in an interesting way, pointing out a matter of overrating own possibilities by a therapist and not considering patient's exceptional experiences, which was previously not included. It is an interesting matter because both sense of insufficient

expertise and overrating them by therapist can have a negative influence on a process of creating therapeutic relationship. It is recommended to attend awareness of self abilities and constant reflection on them and on patient as a person.

D. Therapist properties

Therapist with avoiding attachment style less often estimate relation as authentic [5], those with anxiety attachment style had a worse opinion about their patients' progress and because of that they had a lower appraisal of established therapeutic alliance. What is interesting, empathy also had a negative correlation with opinion about patient's proceed, however, the authors did not find an explanation for this result.

Interesting results were obtained in researches on compassion. Vivino et al. [22] define that construct as a relation of a therapist and a suffering patient and aspiration to change this by actions. This relation is to be easily observable aspect of alliance because it is a measure of intimacy and commitment between a patient and a therapist. Sympathy helps a patient to feel understood and free himself from symptoms. A therapist cannot learn it, it can only be awaken inside of him/her. The authors in their work present a number of ways, owing to which therapists can draw out sympathy for patient. One of them is an attempt of understanding by therapist what exactly has happened to a patient, that made him/her undertaking such decisions. Sympathy is not a constant attribute of a therapist, but it depends of a context of a therapeutic situation. Revealing of sympathy depends on a number of factors: great suffering of a patient, possibility of understanding a patient by a therapist, coming to like him/her, identification with him/her and commitment to a therapy. Moreover, a factor that impacts revealing sympathy is a compromise of good therapeutic relationship – therapists who appraise a relation as good usually feel sympathy for client easier.

## What are the dependencies between variables of the therapeutic relationship and variables of the psychotherapy process?

Some data show that there is a connection between the effects and completion of the psychotherapy, and a type of therapeutic relationship. In a study of Botell et al. [31], the authors point to the link between the strength of the alliance, measured by using a shortened version of the Working Alliance Inventory (WAI-S), and a reduction in syndromes expressed by the patient both during and at the end of the therapy. Statistically significant correlations between the alliance and the level of symptoms for each session, for which the data were collected – third, fourth and every fourth session up to 32, were found in that study. Data obtained after 32 therapeutic session could not be interpreted by researchers due to low number of respondents in the test group. The number of respondents decreased with each session, which was interpreted by researchers as a premature ending of the therapy by increasing number of its participants. From 3 to 24 sessions they found

negative correlations, increasing in subsequent measurements, between patients' symptoms and the strength of the therapeutic alliance, ranging between $r = -0.302$ ($p < 0.001$, $N = 168$) for the session 4 and $r = -0.444$ ($p < 0.01$, $N = 42$) for session 20. For the last two sessions, the results of which have been the subject of analysis, has been found the average negative correlations – for session 28 $r = -0.610$ ($p < 0.01$, $N = 20$) and $r = -0.615$ ($p < 0.01$, $N = 19$) for session 32. The strongest, but not being further interpreted due to the group of only 14 people in, was the correlation obtained for the session 36 ($r = -0.822$, $p < 0.001$). The data presented above may indicate that patients with lower levels of correlation between the alliance and reducing the severity of symptoms ended the therapy earlier. Lingiardi et al. [15] in their work, pay attention to the relationship between the two aspects of the alliance from the perspective of the therapist and continuing, or falling out of the therapy by the patients. On the basis of the analysis of variance, the authors showed that at the beginning of the therapy (session 5) therapists demonstrate a greater commitment to and understanding of the patient ($F(1.45) = 6.92$, $p < 0.05$) and readiness for consensus in deciding about activities taken during the therapy ($F(1.45) = 6.88$, $p < 0.05$) in relation to patients who continued the therapy in the future, than those who opted out of it. Work by Barber et al. [32] shows that the results of the therapy can be predicted on the basis of the measurement of the strength of the alliance. In their research, they proved that the measurement of the alliance made during 2 therapeutic sessions shows no possibility to predict the results of the therapy. Only the measurement of about 5 therapeutic sessions gives such a possibility. Both of the previously mentioned studies meet the "5$^{th}$ session" postulate. Studies of Zuroff and Blatt [after 13] confirmed that for patients with a stronger alliance, compared to others, a faster decrease in depressive symptoms is observed. Researches by Staasi et al. [after 13] showed moderating influence of the therapeutic alliance on the relation a result of a therapy and other than the secure attachment style, making that the effect of this attachment style became irrelevant for patients diagnosed with depression. Barber et al. [32] write about the results obtained in a therapy depending on the strength of therapeutic alliance. On the basis of the results of research on linear correlation and, therefore, of line integrals between a compliance with the principles of the therapy, the therapist's competence, and a quality of the alliance, the authors have found that the best results in the treatment were achieved by patients in a therapeutic relationship of moderate strength of the alliance and the compliance with the principles of therapy at a similar level. They pointed out the need to take into account the complexity of the moderate therapeutic effect of the alliance.

## Recapitulation

It is possible to summarise this results with a statement that Kazdin's [33] conclusions are a bit off the mark. In his opinion people still do not know why psychotherapy leads to changes and

that there are only few information about that in the researches. Previous researches show only basics for thinking that good therapeutic relationship has positive influence on the psychotherapy process and outcome. Nowadays there are more accurate methods to measure therapeutic relationship. It means that there is a possibility to describe this, almost indefinable, therapeutic relationship with solid, measurable variables. This days it can be said that therapeutic relationship is a bond – increasingly perceived not only as mutual, emotional involvement but also mutual intellectual effort. Results of the empirical researches show, that nowadays it is more possible than ever before to delineate which features and behaviour of patients and a therapist correlate with quality of therapeutic relationship.

Till now there are only few variables used to describe therapeutic relationship. There can be fund such variables as relation depth or bond between a patient and a therapist, which are hard to define. There are also such variables as collaboration, partnership or agreement – easier to measure by such points as setting goals and tasks together, by which this goals are going to be reached. What is more, not only configuration of transference, but also realism and authenticity of relationship are variables used to its description. It is accepted that an important variable connected with a therapist is type of undertaken interventions [10, 24, 26], and with patient – way of preceiving the therapist [Bedi; after 13]. Commitment and input are important for both sides of the relationship [6–8, 10–2, 15, 20, 22, 24, 30].

On the side of the patient an important positive factor in the therapeutic relationship is not only a commitment to a therapy [20] or openness to the process [24], but also the perception of their own participation in the creation of the alliance [Bedi; Zwick and Attkinsson; Acosta et al.; Reis and Brown: after 13]. Age has became an important demographic variable for development of therapeutic relationship. Older people establish a stronger alliance than the younger, but they also account for other aspects [18, Di Giuseppe; after 23]. The older the person, the more attention he/she gives to the goals and methods used in a therapy, and less to the bond with a therapist. Clinical factors [13–17] and global functioning of patients [18, 20] are also important for the relation, although the data obtained in this area are contradictory. In addition to all these features huge importance has attachment style [5, 21] of a person which is participating in a therapy – people with secure attachment style easier set up a therapeutic alliance. Similar results can be obtained by people with a great need for affiliation [19].

Patients perceived as cold, keeping distance, vengeful, detached in treatment and avoiding accepting responsibility for their own actions impede therapists by these characteristics and behaviours to establish a strong therapeutic alliance [20, 22]. While people who do not express their

needs and expectations related to a treatment, unfriendly and tough have difficulties in making a satisfactory relationship with the therapist [13, 19].

The most important disturbance resulting from the patient side are: insecurity, unwillingness to the exploration of emotional experience, questioning the values and goals of therapy as well as different expectations from a therapist [30].

To make it easier to forge a strong therapeutic relationship therapist intervention include activities such as communicating understanding, showing compassion, sensitivity and participating in patients' experience, mindfulness, openness and lack of judging, supporting the patient and helping him/her to create new thoughts and actions [13, Ackerman and Hilsenroth: after 14, 22, 27]. These actions of the therapist, which initiate the breakthroughs in therapy, which are critical moments for patients, are also important [24]. These types of interventions are carried out by therapists who encourage patients to engage in the therapeutic process, respond to their needs, help in changing ways of thinking and provide them with tools to help them achieving their goals. Those therapists who share with their patients positive reflections about them or personal information take interventions conducive to establish the alliance [24]. An important feature of the therapists is their attachment style [5] – as in the case of patients – secure style helps to better estimate established relationship.

Interventions obstructing establishing strong therapeutic alliance include actions which suggest lack of knowledge or experience of the therapist, show his/her nervousness and lack of commitment [20, 24]. Also overrating of his/her own capabilities and not taking into account past experiences of a patient is not conducive to building an alliance [30].

One of the relationships between therapeutic relationship variables and psychotherapy process variables is link between strength of the alliance and reduction of symptoms and its moderating influence on the relationship between the result of therapy and patient's attachment style [Staasi et al. after 14, 31]. Strong alliance modifies the negative impact that, different from the secure, attachment styles have on the process of psychotherapy. Worth to remember is the fact that the most effectively functioning alliance is one that is at a moderate level.

Of course, despite the undeniable progress in the research on the therapeutic relationship still it is an inexhaustible source of inspiration for a number of researchers. Year-on-year the number of publications on this aspect of psychotherapy increases, which bodes well for increasing the level of knowledge about it.

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