

RESEARCH ARTICLE

How recent psychological distress relates to session quality in psychotherapy: The mediating roles of the real relationship and working alliance

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Abstract

Objective: To examine how clients' recent psychological distress (PD) relates to perceived psychotherapy session quality (SQ), and to test whether this association is statistically accounted for by clients' ratings of the real relationship (RR) and the working alliance (WA).

Methods: Secondary analyses combined data from two studies of adults ($N=1175$) receiving individual psychotherapy. Following a session, clients completed measures of anxiety and depressive symptoms (7-day recall), RR, WA (task, goal and bond), and SQ. A covariate-adjusted path model was performed.

Results: PD was associated with weaker RR and poorer task agreement, but not with goal or bond. RR was positively associated with all WA dimensions. When predicting SQ simultaneously, task showed the largest unique association, with smaller unique contributions from goal, bond, and RR; PD also retained a small direct association. Bootstrap decomposition indicated that indirect associations through task accounted for most of the distress–SQ link, with additional indirect associations through bond and an RR-only pathway. Task effects reflected both a direct distress-to-task pathway and a serial distress-to-RR-to-task pathway.

Discussion: This study suggested task agreement as a central correlate of SQ when clients are distressed but cannot establish temporal ordering or causality.

KEYWORDS

psychological distress, real relationship, session quality, structural equation modelling, working alliance

[Correction added on 25 March, 2026, after first online publication: The title of the article is corrected from “How recent psychological distress session quality in psychotherapy: The mediating roles of the real relationship and working alliance” to “How recent psychological distress session relates to quality in psychotherapy: The mediating roles of the real relationship and working alliance” in this version.]

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Relational processes are consistently associated with psychotherapy outcomes, extending beyond the effects of specific techniques (Prusiński, 2022; Wampold & Flückiger, 2023). Contemporary accounts conceptualize the therapeutic relationship as multifaceted, comprising three core, interrelated components (Gelso, 2014, 2018; Hill, An, Kivlighan Jr., & Gelso, 2024): the real relationship (RR), the working alliance (WA), and the transference–countertransference dynamics.

The RR refers to the genuine and realistic (i.e., transference-free) personal connection between therapist and client, marked by the extent to which each is authentic with the other and perceives/experiences the other as they truly are (genuineness; realism) (Gelso, 2014, 2018; Stefana, Fusar-Poli, et al. 2025). Following Bordin's transtheoretical model, the WA consists of agreement on goals, agreement on tasks, and the bond (the felt trust/connection that supports the work) (Gelso, 2018; Wampold & Flückiger, 2023). The bond is often discussed in relation to the RR (warmth, caring, genuineness) and to trust in the therapist's competence; both facets can facilitate adherence and outcome (Flückiger et al., 2018; Gelso et al., 2018; Wampold & Flückiger, 2023). The third important component is the transference–countertransference dynamic. Transference denotes the patient's displacement of perceptions, attitudes, and feelings rooted in prior personal relationships onto the therapist; while countertransference refers to the therapist's emotional, cognitive, and behavioural reactions to the patient, shaped by the therapist's personal history and current emotional vulnerabilities (Gelso, 2014, 2018; Stefana, 2017a; Stefana & Youngstrom, 2024; Stefana et al., 2020, 2022, 2025).

Importantly, RR and WA are closely intertwined (Gelso, 2014; Vaz et al., 2024) and frequently described as “sister concepts” (Gelso & Kline, 2019; Vaz et al., 2024). RR is often conceptualized as a foundation for the WA; a basic sense of safety and authenticity may support collaborative work (Lavik et al., 2022; Vaz et al., 2024), especially on goals and tasks (Gelso, 2010; Wampold & Flückiger, 2023). RR and WA can be understood as the relational context in which transference–countertransference dynamic unfold. Empirically, elements of RR and WA covary, and RR has been associated with symptom change above and beyond WA in some studies (Gelso, 2010). More broadly, evidence indicates that the WA shows robust associations with outcomes, with tasks and goals dimensions often especially salient early in treatment (Wampold & Flückiger, 2023). In sum, the RR and WA provide the relational context within which transference–countertransference unfolds.

The task dimension of WA is especially critical because it reflects the client–therapist's shared engagement in therapeutic work and, in this respect, distinguishes the WA from the more personal qualities captured by the RR (Stefana et al., 2024; Hill, An, Kivlighan Jr., & Gelso, 2024). Empirical work indicates that, particularly early in psychological treatment, tasks and goals tend to show stronger associations with depressive symptom change than the bond (Webb et al., 2011). Moreover, aspects of the bond have been interpreted as overlapping with elements of the “real relationship” (genuineness/warmth) versus trust in the therapist's competence, which further clarifies how the task component uniquely demarcates the WA's collaborative work from RR's personal qualities (Wampold & Flückiger, 2023).

Regarding the task dimension, it must be noted that many widely used evidence-based therapies explicitly emphasize collaboration and shared agreement on therapeutic tasks. In cognitive-behavioural therapy (CBT), this collaborative stance is often articulated as collaborative empiricism (Tee & Kazantzis, 2011), in which therapist and client jointly determine treatment goals, specify criteria for evaluating whether goals are being met, and work within a hypothesis-testing approach that applies to session objectives, homework assignments, and techniques (Dobson & Kazantzis, 2024). This emphasis makes the task component of the working alliance especially concrete in CBT, insofar as the “work” of therapy is repeatedly clarified and evaluated in relation to agreed-upon aims and between-session application. Likewise, in dialectical behaviour therapy (DBT), task clarity is structurally supported by a multimodal format and by a balance between acceptance-oriented and change-oriented work, with explicit skills practice and generalization to clients' daily contexts (Linehan, 2025). In contrast, psychodynamic approaches have traditionally emphasized the unfolding relational field and unconscious processes, often within a “contained” therapeutic space designed to facilitate exploration and meaning-making (Gelso & Kline, 2024; Stefana, 2017b). Importantly, this does not mean an absence of “tasks,” but rather

that tasks can be framed differently (e.g. sustaining free association, tracking relational patterns in the here-and-now, or exploring in-session affects).

Beyond the above-mentioned structural components, client psychological distress powerfully shapes the relational field (Lavik et al., 2022; Trusty et al., 2025). Clients commonly enter therapy with fear, shame, or self-doubt; a strong RR is particularly salient in the outset because it is linked to authenticity and a sense of safety and trust (Gelso, 2018; Lavik et al., 2022). While the RR is often described as a foundation, task agreement shows the strongest association with clients' evaluations of session quality (Stefana et al., 2024), consistent with broader evidence that goal–task agreement is a key early driver of improvement (Wampold & Flückiger, 2023).

Psychological distress is also associated with session evaluations, with negative affect consistently correlating with lower session ratings (Stefana et al., 2024), and it is conceptually embedded in the characterizations of low-quality sessions (Sukhorukov et al., 2024). Taken together, these findings suggest that distress both covaries with the therapeutic relationship and shows independent associations with session outcomes, making it a plausible focal variable in a theoretically ordered path model.

The interplay between the RR and the WA is often described theoretically as sequential, with the RR conceptualized as foundational to the WA (Lavik et al., 2022). Theory and evidence suggest that therapy typically involves establishing the RR, which may be associated with lower distress and with stronger WA appraisals (Lavik et al., 2022; Wampold & Flückiger, 2023). In the present study, because all focal constructs were assessed simultaneously in a single post-session assessment, we treated the RR → WA ordering as theoretically motivated rather than empirically established. We examined whether the pattern of cross-sectional associations is consistent with a model in which recent distress varies with RR and WA dimensions and, in turn, with session quality.

METHOD

Data set

This study is a secondary analysis of two sources: a longitudinal study (reference masked) and a randomized controlled trial (RCT; reference masked). For the RCT, analyses included only baseline assessments (collected prior to randomization) and follow-up assessments from participants in the control arm. Pooling the datasets was motivated by (i) the shared eligibility criteria, which were the same except that participants in the RCT were asked to attend therapy at least twice per month, while no restriction was applied for the longitudinal study; (ii) the shared measurement approach, as there was no difference in the baseline assessment for both studies (importantly, the baseline assessment for the RCT was before randomization); and (iii) the goal of estimating the association pattern among distress, RR, WA dimensions, and session quality with greater precision. [Tables S1](#) and [S2](#) detail the sample characteristics separately for each study. Both studies received approval from the Institutional Review Board (IRB) at the University of North Carolina at Chapel Hill [masked].

Participants

The analytic sample included 1175 adults engaged in individual psychotherapy for a range of psychological concerns. Women comprised 74% of the sample. Ages were distributed as follows: 18–29 years (30%), 30–39 years (28%), 40–49 years (16%), and 50 years or older (26%). Most participants identified as White (80%). A total of 85% reported at least one psychiatric diagnosis, most commonly anxiety disorders (70%) and major depressive disorder (59%). Nearly half (47%) had been in treatment for more than 2 years, while the rest were evenly distributed among the time period groups: 0–3 months (16%), 4–6 months (13%), 7–12 months (12%), and 13–24 months (13%). Most attended therapy once a week (39%) or 2–3 times per month (45%). Additional demographic, clinical, and treatment characteristics

appear in [Table S1](#). Symptom severity at assessment was as follows: GAD-7, $M=8.2$, $SD=5.3$ (Spitzer et al., 2006); PHQ-9, $M=9.9$, $SD=6.2$ (Kroenke et al., 2001).

Measures and covariates

A broad set of self-report instruments assessed patient characteristics and facets of the therapeutic relationship.

Sociodemographic, clinical, and treatment data

Participants completed an 11-item survey capturing sociodemographic, clinical, and treatment-related factors.

Anxiety symptoms

Generalized anxiety was assessed with the Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006), a 7-item self-report measure rated on a 4-point scale from 0 (not at all) to 3 (nearly every day). Prior work has shown high internal consistency and convergent validity with related constructs (e.g., anxiety, stress, depression, and worry; Kertz et al., 2013). In the present sample, reliability was excellent (McDonald's $\omega_i = .92$).

Depressive symptoms

Depression severity was measured with the Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001), consisting of 9 items rated from 0 (not at all) to 3 (nearly every day). Evidence indicates stronger criterion validity than the Hospital Anxiety and Depression Scale and the WHO Well-Being Index (Löwe et al., 2004). In the current sample, internal consistency was high (McDonald's $\omega_i = .90$).

Working alliance

Therapeutic alliance was measured with the Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillasp, 2006), a 12-item self-report scale with three 4-item subscales—Task, Goal, and Bond. Items are rated on a 6-point scale from 0 (not at all) to 5 (completely) (Falkenström et al., 2015; Stefana, 2025). Prior evidence supports construct validity, including strong associations with other alliance measures (e.g. the Helping Alliance Questionnaire; Munder et al., 2010). Reliability in this dataset was excellent ($\omega_i = .97$ total; subscales: Task $\omega_i = .93$, Goal $\omega_i = .93$, Bond $\omega_i = .92$).

Real relationship

The Real Relationship Inventory-Client Short Form (RRI-C-SF; Stefana et al., 2024) assessed patients' perceptions of the "real relationship" with their therapist. The instrument includes two 4-item dimensions: Genuineness (authenticity and openness in self-expression) and Realism (accuracy of perceiving and experiencing the other; Gelso et al., 2012). Responses are given on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). Convergent validity is supported by its association with the WAI-SR ($r = .59$; Stefana et al., 2024). Internal consistency in the current sample was high ($\omega_i = .93$ overall; Genuineness $\omega_i = .88$; Realism $\omega_i = .87$).

Session quality

Session quality was assessed using the five-item version of the Session Evaluation Scale (SES; Hill & Kellems, 2002; Lent et al., 2006). The first four items are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), while the fifth item is rated on a 5-point scale ranging from 1 (not effective) to 5 (highly effective). The SES demonstrated strong psychometric properties (Stefana & Hill, 2025). In our sample, the SES exhibited McDonald's ω_1 of .89.

Procedures

Eligibility for both projects required participants to be 18 years or older, fluent in English, and currently engaged in individual psychotherapy. For the RCT subsample, participants were additionally required to attend therapy at least twice per month. Recruitment for the longitudinal study occurred March–April 2023, and RCT enrollment occurred September–November 2023. Both studies recruited through two national online registries, Research for Me and ResearchMatch (Harris et al., 2009). ResearchMatch—a nationwide database developed by a consortium of academic institutions under the NIH Clinical and Translational Science Awards (CTSA) Programme—included more than 158,000 volunteers. Prior work indicates that participants recruited through this registry provide reliable self-report data without financial incentives (Chandler & Shapiro, 2016) and exhibit higher completion rates than individuals recruited through peer networks (Faro et al., 2021).

All participants provided electronic informed consent via Qualtrics, which also served as the data-collection platform for both studies. Assessments were completed following a therapy session within participants' ongoing treatment.

All focal constructs were assessed in a single survey completed after a therapy session. The GAD-7 and PHQ-9 were administered with a 7-day recall window (modified from the standard 14-day period); thus, the distress composite reflects recent symptom distress that likely includes pre-session experience but may also be influenced by the session and by retrospective reporting.

Statistical analysis

All analyses were performed in R (version 4.5.1; The R Foundation for Statistical Computing Platform, 2024) using *lavaan* (v0.6–19). Real relationship, the three alliance dimensions (task, goal and bond), session quality, and distress were ζ -standardized. Recent psychological distress (PD) was computed as the ζ -score of the row-wise mean of depressive (PHQ-9) and anxiety (GAD-7) totals. This composite score for psychological distress was intended to index broad internalizing symptom burden (i.e. general psychological distress/negative affectivity) rather than disorder-specific severity, by capturing shared variance across depressive and anxiety symptoms assessed in the same reporting window.

We adjusted for seven covariates: age, gender, ethnicity, self-reported mental disorder, treatment length, treatment frequency, and treatment setting. All dummy covariates were included as predictors in every endogenous regression (real relationship, the three alliance dimensions, and session quality). Because age was collected as categorical age groups, it was modelled using a set of dummy-coded indicators for each age group, with the youngest group serving as the reference category.

We specified a covariate-adjusted path model consistent with theory in which PD was associated with the real relationship (RR) and each alliance dimension; RR was also associated with each alliance dimension; and session quality (SQ) was simultaneously regressed on task, goal, bond, RR and PD (all with covariates). Residual correlations among the alliance dimensions (task–goal, task–bond and goal–bond) were freely estimated. Because all focal constructs were assessed concurrently in a single post-session survey, defined “indirect effects” are interpreted as statistically modelled indirect associations (i.e. a decomposition of covariance implied by the specified paths) rather than evidence of temporal precedence or causal mediation.

We defined indirect effects for: (a) the “RR-only” path (PD → RR → SQ); (b) each mediator's direct component (PD → mediator → SQ); (c) each mediator's theoretically ordered serial component via real relationship (PD → RR → mediator → SQ); (d) mediator-specific totals (direct + serial); (e) the grand total indirect; (f) the total effect (direct + all indirects); and (g) planned contrasts among mediator-specific totals (task vs. goal, task vs. bond, goal vs. bond). For effect estimation and bootstrap confidence intervals, the covariate-adjusted parallel-mediation model was fit with maximum likelihood and nonparametric bootstrap standard errors (percentile 95% CIs; 5000 draws).

Because the primary covariate-adjusted model is saturated ($df=0$), confirmatory evaluation relied on two theory-driven, non-saturated variants estimated with MLR (robust SEs and scaled test statistics) and covariates treated as fixed: a Task-only model (goal → SQ and bond → SQ fixed to zero) and an Equal-alliance model (task, goal and bond paths to SQ constrained to be equal). Each constrained model was compared with the full covariate model using robust ΔCFI , $\Delta RMSEA$ and $\Delta SRMR$ (scaled where available), along with Satorra–Bentler robust likelihood-ratio tests.

For robustness, we additionally refit the full covariate model with ML + bootstrap (5000 draws) and refit the Task-only model with ML + bootstrap (5000 draws) to obtain percentile CIs for all defined indirects. From the Task-only bootstrap table, we computed (i) the proportion of the total PD–SQ association represented by defined indirect associations and (ii) the shares of the total indirect association attributable to task (total, direct component and serial component) and to the RR-only path. There were no missing data.

RESULTS

Primary path model (covariate-adjusted)

Analyses were based on $N=1175$ observations. As shown in Table 1 and Figure 1, in the covariate-adjusted model, PD was associated with a lower RR ($\beta = -0.195, p < .001$). RR, in turn, was positively associated with all three WA dimensions: task ($\beta = 0.478, p < .001$), goal ($\beta = 0.507, p < .001$) and bond ($\beta = 0.533, p < .001$). When entered simultaneously, task ($\beta = 0.465, p < .001$), goal ($\beta = 0.082, p = .026$) and bond ($\beta = 0.132, p < .001$) each uniquely were associated with SQ, alongside a direct RR → SQ association ($\beta = 0.156, p < .001$) and a direct PD → SQ association ($\beta = -0.046, p = .020$). PD was also associated with lower alliance task ($\beta = -0.126, p < .001$), but its paths to goal ($\beta = -0.014, p = .613$) and bond ($\beta = -0.033, p = .206$) were not significant. The model explained 58.8% of SQ variance ($R^2 = .588$), with $R^2 = .115$ for RR, .330 for task, .305 for goal and .356 for bond.

TABLE 1 Key direct paths in the full covariate model.

From	To	β	SE	p
Distress	RRI	-0.195	0.031	< .001
RRI	Task	0.478	0.041	< .001
RRI	Goal	0.507	0.040	< .001
RRI	Bond	0.533	0.043	< .001
Distress	Task	-0.126	0.028	< .001
Distress	Goal	-0.014	0.029	.629
Distress	Bond	-0.033	0.028	.229
Task	SES	0.465	0.039	< .001
Goal	SES	0.082	0.038	.034
Bond	SES	0.132	0.035	< .001
RRI	SES	0.156	0.030	< .001
Distress	SES	-0.046	0.023	.041

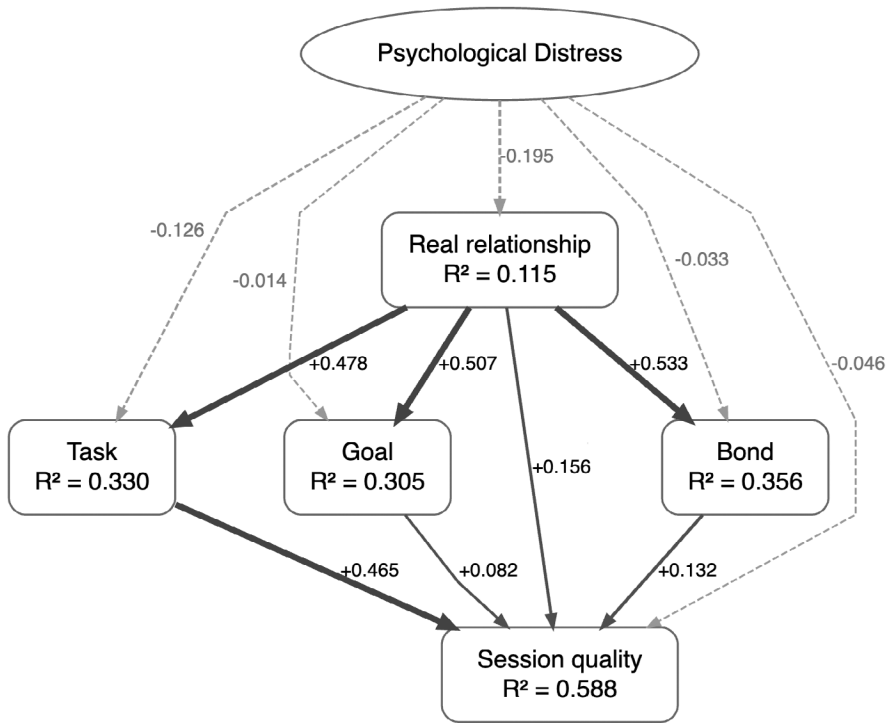


FIGURE 1 Path diagram of the full covariate model with key standardized coefficients.

Indirect and total effects (bootstrap)

As shown in Table 2, percentile-bootstrap estimates indicated a negative total indirect association of PD on session quality ($\beta = -0.160, p < .001$) and a negative total effect (direct + indirect; $\beta = -0.206, p < .001$). The task route represented the largest component of the defined indirect association (total via task $\beta = -0.102, p < .001$), comprising a direct PD \rightarrow task \rightarrow SQ component ($\beta = -0.059, p < .001$) and a theoretically ordered PD \rightarrow RR \rightarrow task \rightarrow SQ component ($\beta = -0.043, p < .001$). Smaller but reliable

TABLE 2 Indirect and total effects of psychological distress on session quality.

Effect	β	SE	95% CI	<i>p</i>
Distress \rightarrow RRI \rightarrow SES (ind_rr)	-0.030	0.008	[-0.047, -0.017]	< .001
Distress \rightarrow Task \rightarrow SES (ind_task_direct)	-0.059	0.014	[-0.089, -0.033]	< .001
Distress \rightarrow RRI \rightarrow Task \rightarrow SES (ind_task_serial)	-0.043	0.009	[-0.062, -0.029]	< .001
Total via Task (ind_task_total)	-0.102	0.018	[-0.140, -0.070]	< .001
Distress \rightarrow Goal \rightarrow SES (ind_goal_direct)	-0.001	0.003	[-0.008, 0.004]	.675
Distress \rightarrow RRI \rightarrow Goal \rightarrow SES (ind_goal_serial)	-0.008	0.004	[-0.017, -0.001]	.047
Total via Goal (ind_goal_total)	-0.009	0.005	[-0.021, -0.001]	.086
Distress \rightarrow Bond \rightarrow SES (ind_bond_direct)	-0.004	0.004	[-0.013, 0.003]	.269
Distress \rightarrow RRI \rightarrow Bond \rightarrow SES (ind_bond_serial)	-0.014	0.004	[-0.023, -0.006]	.001
Total via Bond (ind_bond_total)	-0.018	0.006	[-0.033, -0.007]	.005
Total indirect (ind_total)	-0.160	0.024	[-0.209, -0.114]	< .001
Total effect (total)	-0.206	0.030	[-0.265, -0.146]	< .001

indirect associations emerged via bond (total via bond $\beta = -0.018$, $p = .005$), driven by the theoretically ordered component ($\beta = -0.014$, $SE = 0.004$, $p = .001$). For goal, the theoretically ordered component was significant ($\beta = -0.008$, $p = .047$), while the goal total was small and borderline by z -test ($\beta = -0.009$, $p = .086$). A distinct “RR-only” path ($PD \rightarrow RR \rightarrow SQ$) was also significant ($\beta = -0.030$, $p < .001$). Planned contrasts among total indirect associations confirmed that task exceeded goal (difference = -0.093 , $p < .001$) and task exceeded bond (difference = -0.084 , $p < .001$), whereas goal and bond did not differ (0.009 , $p = .268$).

Complementary confirmatory summary (task-only model)

As a compact summary of association decomposition, the Task-only covariate model yielded a proportion mediated of the total $PD \rightarrow SQ$ association represented by defined indirect associations of 0.832, indicating that $\sim 83.2\%$ of the total $PD \rightarrow SQ$ association was represented by the set of defined indirect paths (see Table 3). Of the total indirect association, 76.8% was attributable to the task route, partitioned into 44.2% via the direct $PD \rightarrow \text{task} \rightarrow SQ$ path and 32.6% via the theoretically ordered $PD \rightarrow RR \rightarrow \text{task} \rightarrow SQ$ path. The remaining 23.2% reflected other mechanisms (RR-only, goal, bond), aligning with the full-model decomposition (Tables 2 and 3). For completeness, key paths from the Task-only MLR fit are reported in Table 4.

Model comparisons

Because the full covariate model is saturated ($df = 0$), confirmatory checks relied on nested constrained models. Both constraints degraded fit relative to the full model:

Task-only (fixing goal and bond $\rightarrow SQ$ to zero) produced $\Delta CFI = 0.008$, $\Delta RMSEA = 0.110$, $\Delta SRMR = 0.004$, with robust $\Delta \chi^2_{(2)} = 30.513$, $p < .001$. Equal-alliance (task = goal = bond) produced $\Delta CFI = 0.008$, $\Delta RMSEA = 0.112$, $\Delta SRMR = 0.003$, with robust $\Delta \chi^2_{(2)} = 31.582$, $p < .001$. These comparisons are consistent with differentiating the three alliance components and retaining the direct $RR \rightarrow SQ$ path (Table 5).

DISCUSSION

Recent psychological distress (PD) was associated with a weaker real relationship (RR). In turn, a stronger RR was associated with higher scores on all working alliance (WA) dimensions—task, goal and bond. When considered simultaneously, the task dimension showed the strongest unique association with session quality (SQ), while goal and bond added smaller but still unique contributions. RR and PD each also showed direct associations with SQ beyond the alliance. In addition, PD was inversely related to the task dimension but showed no reliable association with goal or bond. Indirect-effect analyses (interpreted here as statistically modelled indirect associations given concurrent measurement) indicated that the pathway through task accounted for the largest share of the $PD \rightarrow SQ$ association, with smaller yet reliable indirect pathways via bond and, to a lesser extent, goal. A pathway from PD to SQ operating solely through RR was also supported. Planned contrasts

TABLE 3 Planned contrasts among total indirect effects.

Contrast	Estimate	SE	<i>p</i>
Task – Goal	–0.093	0.018	< .001
Task – Bond	–0.084	0.016	< .001
Goal – Bond	0.009	0.008	.268

TABLE 4 Proportion mediated and component shares (Task-only confirmatory model).

Metric	Value
Proportion mediated (PM)	0.832
Share of indirect via Task	0.768
Task share — direct component	0.442
Task share — serial via RRI	0.326
Share of indirect via RR-only	0.232

TABLE 5 Model comparisons (constrained vs. full).

Model	Δ CFI	Δ RMSEA	Δ SRMR	Robust χ^2 diff (df)	<i>p</i>
Task-only	0.008	0.110	0.004	30.513 (2)	< .001
Equal-WAI	0.008	0.112	0.003	31.582 (2)	< .001

favoured the task pathway over goal and bond, with no reliable difference between goal and bond. Finally, model comparisons showed that constraining the alliance to a single (task-only) route or forcing equal contributions among task, goal and bond degraded fit, supporting a differentiated alliance structure and the retention of a direct RR \rightarrow SQ path.

Taken together, the findings are consistent with a theory-consistent pattern of associations: higher distress co-occurs with lower ratings of genuineness and realistic mutual perception (RR), and stronger RR aligns with more favourable views of alliance tasks, goals, and bond. Clients' evaluations of session quality appear to be shaped most by agreement on tasks (i.e. the concrete activities that define what the therapist and client will do), while goal clarity and bond contribute additional, smaller portions of unique variance. The direct links from RR and PD to session quality suggest that safety/credibility and current affective load each colour session experience in ways that are not fully captured by alliance appraisals. However, because all focal constructs were assessed concurrently in a single post-session assessment, these findings should be interpreted as associations rather than evidence of temporal precedence or causal processes.

This pattern coheres with relational theories like Gelso's tripartite model (Gelso, 2014; Hill, An, Kivlighan Jr., & Gelso, 2024) in which the RR is theorized to provide the secure base that scaffolds the alliance: authenticity and accurate mutual perception enable the move from safety to collaboration on goals and, especially, tasks. Our results are consistent with this theoretical framing at the level of cross-sectional associations. This pattern also aligns with Greenson's (1965); Gelso (2011) view that the working alliance develops out of the real relationship. Furthermore, the predominance of the task dimension resonates with Bordin's (1979, 1994); Horvath (2018) conceptualization of the alliance as comprising goals, tasks, and bond, in which tasks represent the concrete activities required for therapeutic work. Conceptually, our findings also clarify why task stands out. Elements of the bond can overlap with the personal qualities emphasized by the RR (e.g. warmth, caring and genuineness), whereas task crystallizes the collaborative work that distinguishes the WA from the RR. The observed direct association of RR with session quality fits the view that feeling met as a real person in therapy enhances the immediate experience of sessions over and above collaborative planning.

This task-centred pattern invites consideration of how different clinical traditions negotiate therapeutic work. Across orientations, the findings suggest that when clients report higher distress, what most differentiates better versus worse sessions is not only feeling connected but being aligned on what therapist and client are doing together in the session—the “work” of the hour. In CBT and DBT, that alignment is often made explicit through collaborative structuring (e.g. shared rationales, agreed targets, and concrete in-session and between-session plans). By contrast, in psychodynamic/psychoanalytic work, the “task” may be less procedural and more embedded in a shared commitment to the therapeutic frame and moment-to-moment aims (e.g. staying with affect, tracking relational patterns and working with transference), such that

task agreement may be present but more implicit. This cross-orientation framing also helps clarify why RR and WA can remain conceptually distinct yet empirically correlated in clients' reports.

The close yet distinct nature of the RR and WA has been supported in recent meta-analyses. Vaz et al. (2024) reported a strong correlation (i.e., $r \geq .60$; Stefana et al., 2025) but not complete overlap between the two constructs. Gelso and Kline (2019) described them as “sister concepts,” overlapping on the bond component but serving different theoretical and clinical functions. Our results extend this view by showing that the RR contributes to session quality through both direct and indirect pathways. Furthermore, meta-analytic findings indicate that the RR is more strongly associated with outcomes than the WA ($r = .66$ [Gelso et al., 2018] vs. $r = .38$ [Flückiger et al., 2018], respectively), underscoring the unique contribution of the RR.

Our results also suggest that patients' subjective experiences of the therapeutic relationship are central to their evaluations of session quality. This is consistent with a recent study that found that client characteristics shape early alliance development, suggesting that psychological distress can heighten the fragility of the alliance (Trusty et al., 2025).

Clinical implications

PD functions both as context and driver of session experience. As context, heightened negative affect is associated with a weaker RR, whereas a stronger RR aligns with more favourable WA appraisals (task, goal and bond). As a driver, PD is directly linked to lower SQ and undermines task agreement in particular, without a comparable pattern for goal or bond. This dual role fits the idea that clients' recent psychological distress (assessed post-session via 7-day recall) can simultaneously coincide with lower in-session safety and reduced engagement with the concrete work (although the present data cannot determine directionality).

From a clinical lens, how the work is organized and enacted together appears to offer the most leverage. Among predictors of session quality, being “on the same page” about tasks shows the strongest unique association, while goal and bond add smaller, yet distinct contributions. The RR also relates to session quality independently of the WA and is associated with higher ratings across all three WA dimensions. When distress is elevated, therapists may help protect session quality by briefly making the session's task focus explicit and mutually verified—whether the task is skills practice/targets (CBT/DBT) or an agreed focus on in-the-moment relational and affective processes (psychodynamic/psychoanalytic).

A practical sequence (offered here as hypothesis-generating rather than prescriptive) emerges: establish a basic RR stance to absorb PD and create safety; translate safety into structure by reaching explicit agreement on tasks (and then goals); and maintain brief bond/goal “touch points” throughout ongoing care, especially when distress is high.

Clinical takeaways

- Lead with safety, then structure. Begin by cultivating genuineness and realistic mutual perception; follow with clear, collaborative agreement on what will be done in session and between sessions.
- Make tasks unmistakable. Keep the work concrete (agenda, brief steps, specific rationales and practice plans) and verify mutual understanding.
- Plan for distress. Expect pre-session and in-session distress to pull task alignment down; build in scaffolding (written agendas and bite-sized tasks) and brief relational check-ins to sustain collaboration.
- Keep the whole alliance in view. Continue aligning goals and nurturing the bond, and treat the RR as an independent contributor to how sessions feel—particularly when distress remains elevated.

These clinical implications are best viewed as exploratory and should be tested in designs that assess pre-session distress prospectively and track within-person change across sessions.

Limitations and future directions

Several limitations temper these conclusions. Although the analytic model was specified in a theory-consistent ordering, the evidence is observational and cross-sectional, with all focal constructs assessed concurrently in a single post-session assessment. Associations among distress, the real relationship, alliance components, and session quality cannot establish temporal precedence or causality without designs that capture change over time or experimentally manipulate relationship behaviours and task clarity. Moreover, because distress was assessed post-session using a 7-day recall window, it reflects recent distress and may have been influenced by the session itself and retrospective reporting. Measurement is another constraint: all focal constructs were assessed via self-report in the same assessment window, which raises concerns about shared method and mood-state effects; incorporating observer ratings, behavioural indicators of engagement, and multi-informant perspectives would strengthen construct validity. Moreover, the use of a 7-day assessment window for the GAD-7 and PHQ-9, rather than the standard 14 days, may limit comparability with other studies. Finally, generalizability may be bounded by treatment modality, stage of therapy, and client characteristics. For example, the sample was predominantly white and female, which restricts the generalizability of the findings to more diverse populations. Cultural norms regarding authenticity, emotional expression, and collaboration may shape both the RR and WA differently (Prusiński, 2022). The relative salience of task, goal and bond likely shifts across phases of work, and therapist interpersonal skills and responsiveness may moderate the links observed here. Additionally, we did not gather information on the therapeutic approach used in participants' treatment, which limits our ability to assess whether the observed pattern of associations differs across approaches.

Future research should adopt temporally sensitive and mechanism-focused approaches. Intensive longitudinal and cross-lagged designs can test whether changes in the RR precede changes in task agreement and subsequent shifts in SQ. Experimental work that manipulates task clarity, structure, and specific relationship behaviours would further probe causal pathways. Future research should also examine moderators that may amplify or attenuate the task route, including client preferences, reactance, attachment patterns, and cultural identity, as well as therapist responsiveness and interpersonal skills. On the measurement side, parsing distinct aspects of the real relationship, such as genuineness versus realism, and mapping their differential links to goal, task and bond could refine theory. Finally, models that allow interactions among alliance components and that integrate behavioural indices of engagement (e.g. between-session practice) may more fully capture how collaboration translates into session experience.

CONCLUSION

The findings support a task-centred yet differentiated view of the alliance situated within a broader relational matrix. In this cross-sectional, post-session assessment, PD was associated with a weaker RR and a stronger RR was associated with more favourable alliance appraisals (especially tasks). These relationship processes, together with direct associations of RR and distress, help explain how clients evaluate their sessions. Early therapeutic work may be optimized by coordinating RR-based safety with task-focused collaboration.

AUTHOR CONTRIBUTIONS

Alberto Stefana: Conceptualization; investigation; funding acquisition; writing – original draft; formal analysis; data curation; project administration.

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CONFLICT OF INTEREST STATEMENT

The author declares no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

AI USE DECLARATION

During the preparation of this work, the author used ChatGPT 5 to edit the language (grammar, syntax, clarity, and readability) of the original draft. After using this tool, the author reviewed and edited the content as needed and took full responsibility for the content of the publication.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Table S1. Demographics, clinical, and treatment characteristics of participating patients.

Table S2. Measurement scores.

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