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EMPIRICAL PAPER

Therapeutic alliance, empathy, and genuineness in individual adult psychotherapy: A meta-analytic review

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Abstract

Objective: Alliance, empathy, and genuineness are each integral parts of the therapeutic relationship. No previous meta-analysis has explored the extent to which therapist empathy and genuineness contribute to the therapeutic alliance. **Method**: In this meta-analysis, a multifaceted search strategy yielded 53 studies. Forty studies reported alliance/empathy relationships, eight studies reported alliance/genuineness relationships, and five studies reported both. **Results**: Random effects meta-analyses revealed that therapeutic alliance was significantly related to perceptions of therapist empathy with a mean $r = 0.50$ (95% CI = 0.42, 0.57). Therapeutic alliance was also significantly related to perceptions of therapist genuineness with a mean $r = 0.59$ (95% CI = 0.45, 0.71). Tests of publication bias indicated a low likelihood of publication bias affecting the strength and direction of the results. Potential moderating variables were explored, including rater perspective, measure of therapeutic relationship variables, and client race/ethnicity. **Conclusions**: Therapeutic alliance has a moderate relationship with perceptions of therapist empathy and genuineness. Of note, there may be reason to believe that when rated by the same person, these constructs have significant overlap and lack discreteness. Future directions for study of the therapeutic relationship are discussed. Implications for practice are provided.

Keywords: alliance; process research; philosophical/theoretical issues in therapy research

Among the potential mechanisms of change in psychotherapy, the therapeutic alliance has its place in the bedrock of the field. Although there are various definitions of the alliance, Bordin's (1979) pantheoretical definition of the working alliance is commonly utilized, which includes three components: (i) bond between client and therapist, (ii) agreement on the tasks directed toward improvement, and (iii) agreement on therapeutic goals. The alliance has been shown to account for approximately 7–15% of the gains made in psychotherapy (Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallup, 2011; Horvath, Del Re, Flückiger, & Symonds, 2011), which is greater than therapists' adherence to a set of techniques or even their competency in delivering psychotherapy (Wampold & Imel, 2015; Webb, DeRubeis, & Barber, 2010). The research base of the therapeutic alliance is strong; and yet, several areas still require additional research, including therapist factors that are associated with high quality alliances.

Indeed, therapists have been shown to vary in their ability to form and maintain high quality alliances (Baldwin & Imel, 2013; Baldwin, Wampold, &

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Imel, 2007; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008; Owen, 2013). Therapists commonly account for approximately 9% of the variance in client ratings of the alliance (see Baldwin & Imel, 2013). However, what accounts for the differences in therapist alliance ability is less well known. The most recent comprehensive review of therapist-based characteristics that contribute to the therapeutic alliance identified client perceptions of therapist characteristics impacting the alliance including empathy, openness, warmth, confidence, respect flexibility, honesty, tension, use of self-disclosure, and rigidity (Hilsenroth, Cromer, & Ackerman, 2012). The present study continued in this tradition by examining the extent to which perceptions of therapists' empathy and genuineness are associated with the therapeutic alliance.

There is no universally agreed-upon definition of empathy or genuineness in psychotherapy (Egan, 2010). For empathy, Batson (2009) identified eight similar-but-different concepts including: (i) knowing another person's emotional state, thoughts, and feelings; (ii) adopting the posture or matching the neural responses of an observed individual; (iii) feeling as another person feels; (iv) projecting oneself into another person's situation; (v) imagining how another is thinking or feeling; (vi) imagining how one would think, feel, or act in the place of another; (vii) experiencing distress when witnessing another suffering; and (viii) feeling for another who is suffering. Comprehensive empathy definitions have often overlaid a handful of these aspects. For genuineness, Rogers (1957) definition included therapists being fully themselves, with experience in therapy being an accurate representation of their self, and therapists communicating their in-therapy experience of the client back to the client. Consistent with Rogers, Gelso and colleagues defined genuineness as being, and being willing to be, "what one truly is in the relationship" (Gelso & Carter, 1994, p. 297).

On theoretical and statistical levels, empathy and genuineness have separate, yet related, functions in the therapeutic relationship. For instance, it is difficult to conceive that a therapist can be empathetic without being genuine. However, a genuine response may not be very empathetic. Factor analyses have shown the distinctions between the constructs (Barrett-Lennard, 1978, 1986; Lin, 1973; Truax & Carkhuff, 1967); yet, there are commonly moderate-to-high ($r = 0.62$; see Gurman, 1977) correlations between the two variables, suggesting that empathy and genuineness are distinct in the minds (and measurement) of clients and therapists, but both tend to be commonly expressed (e.g., Carkhuff, 1969; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010).

Research on empathy and genuineness has supported their role as empirically supported relational components of psychotherapy. For example, Kolden, Klein, Wang, and Austin (2011) conducted the only meta-analysis comparing genuineness with treatment outcome. Using 16 studies, they found a relationship of $r = 0.24$ between the 2 variables, suggesting that genuineness accounted for approximately 6% of the variance in therapy outcomes. Two meta-analyses addressed the relationship between empathy and treatment outcome. Bohart, Elliott, Greenberg, and Watson (2002) used 47 studies to perform the first meta-analysis comparing these 2 variables. They found a relationship of corrected $r = 0.30$, a medium effect size. A more-recent expansion of that previous analysis ($k = 59$) also found the $r = 0.30$ effect size, suggesting that empathy accounts for approximately 9% of the variance in therapy outcomes (Elliott, Bohart, Watson, & Greenberg, 2011).

Collectively, therapist empathy, genuineness, and alliance contribute to several theories of psychotherapy. Some theories of psychotherapy view the therapeutic alliance as one of the strongest mechanisms of change (Barrett-Lennard, 1962; Rogers, 1957; Wampold & Imel, 2015), while other theories believe the alliance is necessary for change, but not a primary mechanism of change (Leichsenring, Hiller, Weissberg, & Leibing, 2006). For instance, Beck and Freeman (1990) stated that a trusting relationship is needed at the beginning of cognitive therapy. They further highlight the importance of openness and honesty (genuineness), mutual work toward goals and means to those goals (alliance), and sensitivity to the client's needs in therapy (empathy). At the core of humanistic psychotherapy, Rogers (1957) theorized that therapist empathy and genuineness acted as primary factors for client change.

It is clear that alliance, empathy, and genuineness have an association with therapy outcomes. Yet to date there has not been a meta-analysis conducted capturing the associations among empathy, genuineness, and alliance. The present study sought to follow moderators tested in previous studies relating therapeutic relationship variables to outcome. We chose to analyze the moderating effects of rater perspective and measurement utilized, as this may provide information for future research on perceptions of the therapeutic relationship. Past research indicates that rater perspectives differ in their ratings of perceptions of therapy process (Ogrodniczuk, Piper, Joyce, & McCallum, 2000). Indeed, rater perspective was a significant moderating variable in each study with a

tendency for client-rated relationship variables to have a stronger association with treatment outcome (Elliott et al., 2011; Horvath et al., 2011; Kolden et al., 2011). Horvath et al. (2011) found that the alliance measure moderated the alliance/outcome relationship, indicating that the measure used may affect the correlation between alliance, empathy, and genuineness.

Further literature presents theories that client race/ethnicity may impact how a clinician approaches the therapeutic relationship. Comas-Díaz (2006) discusses the importance of cultural empathy in addition to cognitive and affective empathy when treating clients from different cultures. Vasquez (2007) discusses how cultural differences may unintentionally inhibit the growth of a strong therapeutic relationship. Therefore, it may be important to explore how client race/ethnicity affects the relationship between perceptions of the therapeutic alliance and perceptions of therapist empathy and genuineness. Overall, we have chosen to focus our testing on the following moderators: alliance measure, empathy/genuineness measure, rater of alliance, rater of empathy/genuineness, and client race/ethnicity.

Method

Inclusion Criteria

Studies included in this review met three criteria: (i) inclusion of a measure of the relationship between alliance and therapist empathy and/or genuineness, (ii) publication in English, French, Spanish, or German, and (iii) study publication after 1969.[1] Two researchers working independently screened abstracts from studies identified through the literature search. Disagreements were resolved in conference.

Literature Search Strategy

The literature search was constructed with intent to limit publication bias. Publication bias occurs when the publication of a report depends on the nature and direction of its results (Dickersin, 1990). This tends to be seen most often in positive effects bias, which is the tendency for researchers to submit manuscripts with positive results and publishers to publish reports that have positive results (Sackett, 1979). This can lead researchers to overestimate positive effects. Unfortunately, there are no strong statistical tests for publication bias, and the best way to limit it is to use a robust, diverse search strategy.

Studies for the systematic review were therefore obtained through different methods and retrieved from a variety of sources. The initial group of studies came from a search of electronic databases. Additional methods, such as Internet search engines and snowballing, were employed in an attempt to draw in the largest number of relevant studies. "Snowballing" entails examining the reference lists of literature reviews for potential missed studies (Rothstein & Hopewell, 2009). The electronic database search required a list of key terms set to draw potential studies examining the alliance related to empathy and genuineness. This list was created through examination of past literature reviews of therapist characteristics (Beutler et al., 2004; Elliott et al., 2011; Kolden et al., 2011) and working alliance (Horvath et al., 2011). In addition, PsycINFO term suggestions were used. Finally, a forward citation search of the seminal review by Ackerman and Hilsenroth (2003) was conducted with attention to terms used in the titles and abstracts to identify any gaps in the term list. The resulting term list was comprised of three categories: (i) alliance terms (i.e., alliance OR rapport OR relationship), (ii) therapist terms (i.e., therapist OR counselor OR analyst OR psychotherapist OR social worker OR practitioner), and (iii) trait terms (i.e., empathy OR congruence OR genuineness OR real relationship).

Electronic databases. Several electronic databases were searched, and the results from these searches were compiled using the citation management program Endnote. We conducted electronic searches of the databases PsycINFO, ProQuest Research Database, ProQuest Digital Dissertations, Social Services Abstracts, Social Sciences Citation Index, Applied Social Science Index & Abstracts, Social Work Abstracts Plus, Medline, PubMed, and ERIC.

Searching the grey literature. With some exceptions (e.g., ProQuest Research Database) electronic databases mainly provide access to published studies, but not all relevant studies are published. To obtain the maximum number of relevant studies and to decrease the possibility of publication bias, we employed additional methods to uncover literature. First, we searched Google Scholar. We also targeted the websites of government agencies that are likely to fund related work. These included The National Institute of Mental Health (NIMH), the National Mental Health Development Unit, and the National Registry of Evidence-based Programs and Practices (NREPP). In addition, we used the snowballing method with any obtained literature reviews. We performed hand searches of *The Journal of Clinical Psychology*, *Counseling and Psychotherapy Research*,

American Journal of Psychotherapy, *Psychotherapy Research*, *Psychotherapy*, *American Psychologist*, *The Journal of Counseling Psychology*, *The Journal of Consulting and Clinical Psychology*, and *Clinical Psychology Review* in the years 1970-present. Finally, we contacted prominent authors in the field about any unpublished material or additional information. Any potentially relevant studies were obtained and screened for study inclusion.

Abstract Screening and Coding Process

Two screeners independently reviewed each of the abstracts obtained through the literature search for study relevance. Studies that could not clearly be ruled out or in were obtained for further evaluation. The screeners worked independently with periodic meetings to discuss individual decisions and reach a consensus on the inclusion/exclusion of studies.

We used a structured coding guide for each study. Similar to the process for the abstract screening, at least two independent coders extracted the data from each study. The coders met intermittently to review their decisions, correct any mistakes, and reach agreement on the extracted data.

Statistical Procedures

Random effects model. Due to important variations between studies, we selected the random effects model to estimate mean effect sizes and their 95% confidence intervals. In a random effects model, researchers do not assume a single population effect size, and study error is assumed to originate from random sampling error, identifiable covariates, and additional random factors that cannot be easily identified (Borenstein, Hedges, Higgins, & Rothstein, 2009).

Effect size computation. We utilized the correlation coefficient as the effect size to represent the magnitude of the relationship between two variables (e.g., the strength of the relationship between the therapeutic alliance and therapist characteristic). The meta-analysis was performed on Fisher's *z*-transformed correlations coefficients. This transformation is used when relevant data are correlational because the variances follow asymmetrical distributions and this metric stabilizes the variance of *r* based on the natural logarithm of the correlation coefficient (Borenstein, 2009). After performing the meta-analysis on Fisher *z* statistics, we transformed the statistics back to Pearson *r* for reporting purposes.

To compute the omnibus effect sizes, we used the program Comprehensive Meta-Analysis (CMA), for the primary analyses and estimates of publication bias as well as R statistical software program (R Development Core Team, 2009) and MAc (Del Re & Hoyt, 2010) and RcmdrPlugin.MAc (Del Re, 2010) to calculate moderator analyses in a manner similar to a multiple regression.

Heterogeneity. Due to sampling error and between-study error we did not expect studies to yield exactly the same effect sizes; heterogeneity is a term that refers to the extent to which study effect sizes differ from one another. One important question is whether differences in study effect sizes are greater than would be expected by chance. To statistically test heterogeneity, we used Cochrane's Q to assess presence of heterogeneity and I^2 to assess its degree.

Cochrane's Q approximately follows a chi-square distribution with the degrees of freedom equal to the number of studies (*k)* minus one. The heterogeneity test is a test of between-studies variance where a significant value of Q indicates that the variation between studies is significantly different from zero, often leading researchers to consider a random effects model.

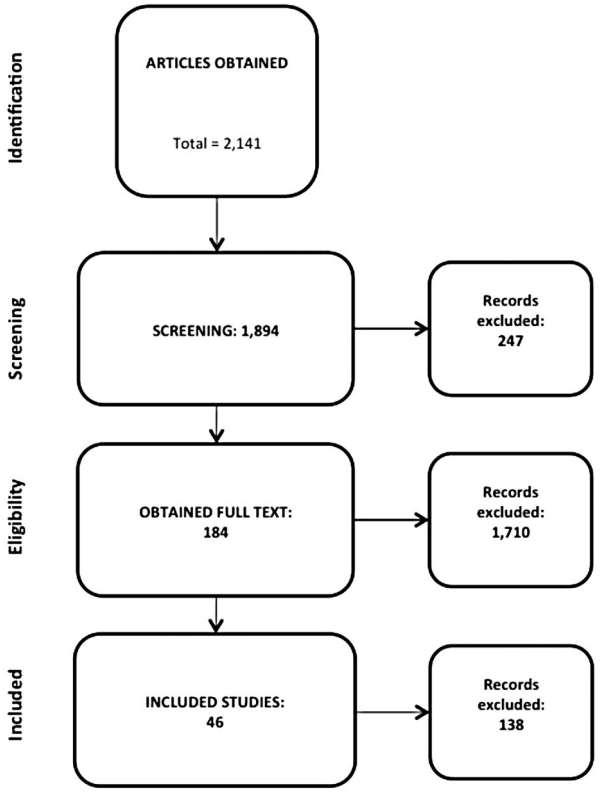
The I^2 statistic provides an estimate of the extent of heterogeneity between the studies. Deeks, Higgins, and Altman (2011) provided approximations for interpreting the I^2 statistic. Under these approximations $I^2 = 0$–40% might not be important, $I^2 =$ 30–60% may represent some moderate heterogeneity, $I^2 = 50$–90% may represent substantial heterogeneity, and $I^2 = 75$–100% indicates considerable heterogeneity.

Moderator analyses. Moderators included rater perspective (i.e., client, therapist, or observer), rater constancy, alliance measure, empathy and/or genuineness measure, and client race/ethnicity.

Results

The search strategy identified 2683 potentially relevant works. Abstract screening reduced the number of potentially relevant works to 192 studies and 33 reviews. Snowballing of the reviews did not produce any new studies. Full text screening revealed 53 studies with sufficient statistics to code. Forty studies reported alliance/empathy relationships, eight studies reported alliance/genuineness relationships, and six studies reported both. Coder agreement was 87.1% and all disagreements were resolved in conference. A flow diagram detailing the inclusion/exclusion of studies is provided in Table I.

Table I. Flow diagram of study inclusion/exclusion.



Therapist Empathy and Alliance

Using a random effects model, the combined effect size for the individual studies examining the relationship between alliance and therapist empathy was $r = 0.50$. This effect size used data collected from 46 studies and a total of 3755 participants. The standard error (SE) was 0.05, giving the overall effect size a 95% confidence interval of 0.42–0.57. This effect size indicates a large relationship between the alliance and therapist empathy, suggesting that one's perception of the alliance may influence their perception of a therapist's empathy. Of course this could work in the opposite direction too, and the relationship could very well be reciprocal. The data for the overall analysis is displayed in a forest plot in Table II. There was a great deal of variability across the studies used in the present analysis. The effect sizes from this group of studies cannot be considered homogenous because $Q(45) = 349.43$, $p < .001$ and $I^2 = 87\%$, indicating that a very large proportion of the observed variance in effect sizes reflects variance in population effect sizes rather than just sampling error.

Due to the large degree of heterogeneity observed in the omnibus effect size results, we limited our exploration of moderating effects as heterogeneity impacts the power of any moderator tests (Valentine, Pigott, & Rothstein, 2010). Still, the results provided from moderator tests should always be considered tentative and suggestive. Table III provides results for each moderator analysis. The type of alliance measure and type of empathy measure were statistically nonsignificant moderators. Statistically significant moderators included: the empathy measure used (the Interpersonal Reactivity Index yielded weaker effects than other measures), the empathy rater's perspective (client and observer ratings yielded stronger effects than therapist ratings), the alliance rater's perspective (again, client and observer ratings yielded stronger effects than therapist ratings), and client race/ethnicity (results of a multiple regression where the overall model was statistically significant, but *post hoc* testing did not reveal certain races or ethnicities to have stronger or weaker alliance/empathy relationships).

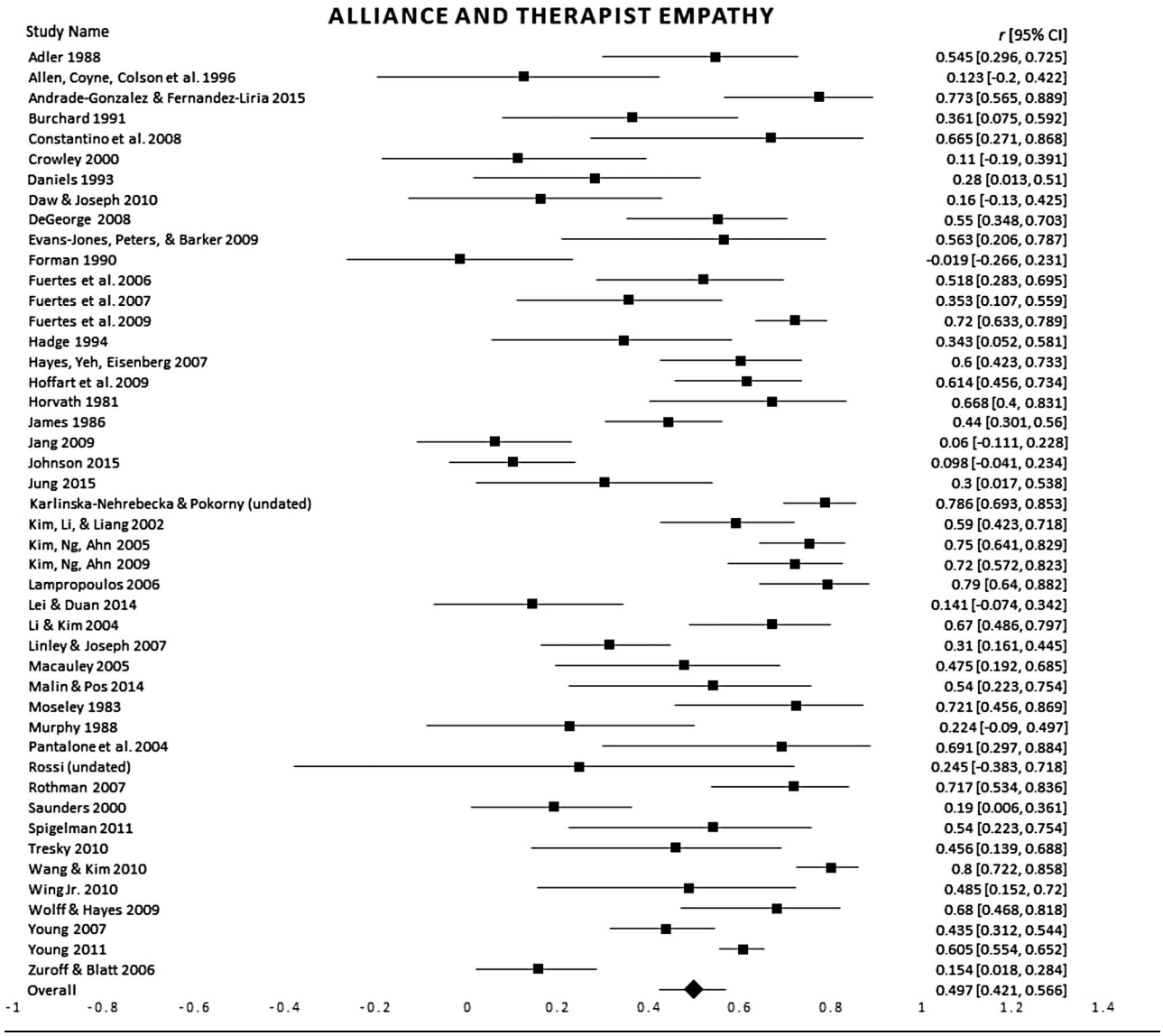
Next, we explored the effect size of keeping the rater consistent for both aspects of the therapeutic relationship, which moderated the influence on the alliance/empathy relationship with $Q_{between}(1) = 27.692$, $p < .001$. Having the same person (client, therapist, or observer) rate both alliance and empathy was associated with a larger effect size ($k = 48$, $r = 0.617$, 95% CI = 0.53, 0.71) than having different raters for each trait ($k = 18$, $r = 0.14$, 95% CI = 0, 0.28). The heterogeneity for same-rater alliance and empathy was still high ($I^2 = 85\%$), but was low for different-rater ratings ($I^2 = 27\%$).

A funnel plot and Trim and Fill analyses helped determine the extent of publication bias. The funnel plot showed a symmetric distribution of studies. There is some scatter in the plot, which can be attributed to heterogeneity. The Trim and Fill analysis did not alter the computed effect size. From these analyses we determined that publication bias likely minimally affected the results.

Therapist Genuineness and Alliance

We found 13 studies examining therapist genuineness related to alliance ($N = 1661$). The combined effect size was $r = 0.59$ with SE = 0.103 using a random effects model. The 95% confidence interval indicated that the true effect size lies between 0.45 and 0.71. This indicates a strong relationship between therapist genuineness and the therapeutic alliance (see Table IV). Similar to empathy, there was significant variability between the studies used in this analysis. In this analysis, $Q(12) = 224.69$, $p < .001$ with $I^2 = 95\%$, again suggesting that a very large proportion of the variance in effect sizes reflects true differences in effect sizes. All but one study

Table II. Alliance and therapist empathy overall analysis.



($k = 12$) used the Working Alliance Inventory (WAI) to estimate the alliance. The Real Relationship Inventory (RRI) was most frequently used to measure genuineness ($k = 9$), followed by the Barrett-Lennard Relationship Inventory (BLRI) ($k = 4$), the Bonner Questionnaire for Therapy and Counseling ($k = 1$), and the Measure of Expressed Empathy ($k = 1$). Some studies used multiple measures. To analyze this variability we coded each study for the therapy used, participant demographics, time of measurement, alliance and genuineness measures, rater perspectives, and time in therapy for each study for subsequent analysis.

We conducted preliminary moderator tests to explore the heterogeneity in the omnibus effect size test of alliance related to genuineness. Due to the high degree of heterogeneity in the omnibus effect size and the low number of studies, the moderator tests lacked statistical power. Therefore, the following moderator results should be interpreted with additional caution. Moderators that were tested and found to have nonsignificant moderating effects included: genuineness measure, alliance rater perspective, and genuineness rater perspective (see Table V).

The most powerful moderating influence on the alliance/genuineness relationship was rater constancy. Having the same person rate alliance and genuineness was associated with a larger effect size ($k = 15$, $r = 0.68$, 95% CI = 0.60, 0.75) than having different raters for each trait ($k = 10$, $r = 0.31$, 95% CI = 0.14, 0.46). The heterogeneity for each group

Table III. Results of moderator tests for therapist empathy and alliance.

Categorical moderators	*k*	Q_b	*p*	*r*
Alliance measure	46	0.808	.667	
WAI	35			0.569
Helping Alliance Questionnaire (HAQ)	5			0.447
Other	6			0.553
Alliance rater*	56	7.949	.019	
Client	33			0.545
Therapist	14			0.308
Observer	9			0.544
Empathy measure**	51	20.457	<.001	
BLRI	22			0.587
Accurate Empathy Scale (AES)	3			0.516
Interpersonal Reactivity Index (IRI)	4			0.08
Burns Empathy Scale (BES)	3			0.627
Other	19			0.398
Empathy rater**	56	16.115	<.01	
Client	28			0.556
Therapist	10			0.273
Observer	14			0.553
Rater constancy**	66	27.692	<.001	
Rater constant	48			0.617
Rater not constant	18			0.14

Continuous moderators	*k*	Coefficient value	Q_{model}	p_{model}
Client race/ethnicity+	26		18.2	0.011
Intercept		1.121		
White		−0.008		
African-American		−0.003		
Latino		1.82×10^{-4}		
Asian-American		-7.41×10^{-4}		
Native American		0.002		
Multiracial		−0.014		
International		−0.098		

Note. *k* = number of studies,
Q_b = heterogeneity between categorical variables, Q_{model} = Model fit Q statistic,
p_{model} = *p*-value (significance level) of model.
*Significant at the $p < .05$ level.
**Significant at the $p < .01$ level.
+Indicates multiple regression.

was smaller than the overall heterogeneity ($I^2 = 89\%$ for same rater; 58% for different raters), but still suggested a moderate-to-large amount of unexplained heterogeneity.

Funnel plot and Trim and Fill analyses were conducted to test publication bias. The funnel plot showed a fairly symmetric distribution of studies. The studies that fall outside the lines of the pyramid can be attributed to heterogeneity. The Trim and Fill analysis added three studies to the right of the mean, increasing the overall effect size to $r = 0.65$. From these analyses we determined that publication bias might have affected the results. It should be noted however that 5 of the 13 observed effect sizes came from unpublished manuscripts.

Discussion

Recent meta-analyses of the therapeutic relationship linked therapy outcome to the therapeutic alliance (Horvath et al., 2011), therapist empathy (Elliott et al., 2011), and therapist genuineness (Kolden et al., 2011). Each of these studies showed a moderate-sized relationship between the chosen relationship variable and outcome. Until the current study, no known systematic review or meta-analysis has explored the therapeutic alliance related to therapist empathy and genuineness.

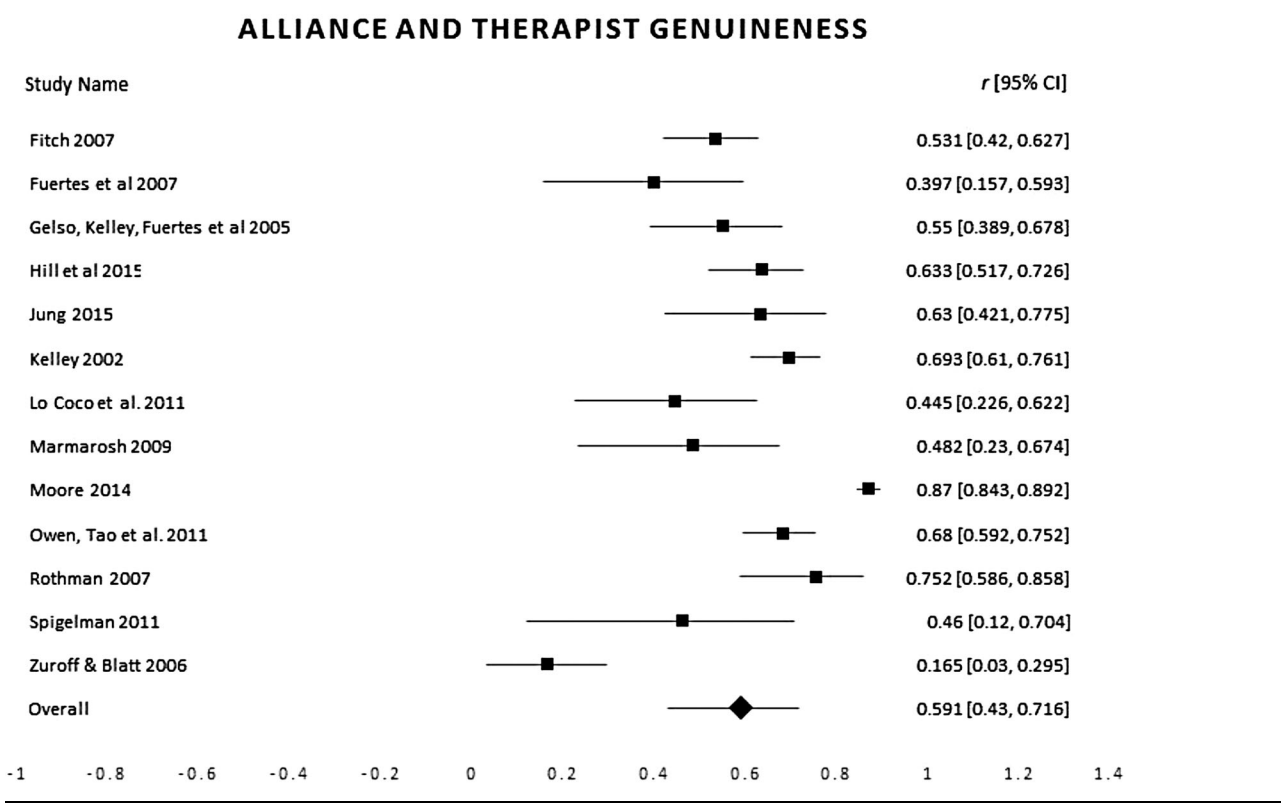
There were strong relationships between the alliance and therapist empathy ($r = 0.50$) and alliance and therapist genuineness ($r = 0.59$). In both cases there was notable variability among the studies, suggesting influence of other variables. Examining the raters indicated one source of this variability. For the relationship between alliance and empathy client and observer ratings of both alliance and therapist empathy were similar, suggesting that client and observer perspectives tend to perceive alliance and therapist empathy similarly.

Clinically, the discrepancies between therapists and client ratings of alliance and empathy may indicate a mismatch in the therapeutic relationship. Following the conclusions of Hannan et al. (2005), therapists' perceptions of the therapeutic process may not be consistent with clients. This may represent opportunities for the therapeutic dyad to engage in conversations about their relationship in the here and now to promote new insights or help bridge gaps in the interpersonal connection. Consistent with past studies (Ogrodniczuk et al., 2000), we suggest the use of multiple perspectives in research and therapist sensitivity to client perspectives in practice. In addition, the use of client feedback could circumvent these discrepancies (Lambert & Shimokawa, 2011).

Another finding to note is the presence of the halo effect. In the Horvath et al. (2011) study of alliance and outcome their tests did not reveal the presence of halo effects. This is noteworthy because in our study the variables under consideration are all related to the therapeutic relationship. This may indicate an individual bias at remaining consistent when rating relationship variables vs. rating relationship to outcome.

Client race/ethnicity significantly modified the alliance/empathy in a positive direction. This moderating effect indicates at least two possibilities. It is

Table IV. Alliance and therapist genuineness overall analysis.



possible that racial/ethnic minorities require their therapist to display higher degrees of alliance and empathy to trust that the relationship will continue to be beneficial. Previous studies of the impact of race/ethnicity in therapy have shown that racial/ethnic minorities generally do not believe a therapist would understand the nuances of their culture and feel less trusting of a therapist (Sanders Thompson, Akbar, & Bazile, 2004). Second, multicultural competency might be a therapeutic relationship skill entwined with other aspects of the therapeutic relationship, such that a more multiculturally competent therapist presents as more empathic and better at alliance building. Vasquez (2007) detailed an evidence-based analysis of how a therapist's cultural competence can affect their ability to build an alliance with a client from a minority background. Comas-Díaz (2006) stressed the importance of cultural empathy as a potentially overlooked variable in cross-cultural therapeutic relationships. Minority clients may feel even more moved, than non-minority clients, when working with a therapist who shows reasonable level of attention to the therapeutic relationship. Future studies may want to assess for any mediating effects.

Table V. Results of moderator tests for therapist empathy and alliance.

Categorical moderator	*k*	Q_b	*p*	*r*
Alliance rater	16	1.979	.195	
Client	10			0.644
Therapist	6			0.51
Genuineness measure	13	0.351	.553	
BLRI	4			0.537
RRI	9			0.618
Genuineness rater	16	1.293	.256	
Client	10			0.628
Therapist	6			0.481
Rater constancy**	25	20.003	.000	
Rater constant	15			0.683
Rater not constant	10			0.307

Note. *k* = number of studies, Q_b = Heterogeneity between categorical variables.
**Significant at the $p < .01$ level.

Limitations

This study is based upon the research available at the time of its writing. Some studies may have been missed by the search strategies of this analysis or may have been disseminated after the writing of this study. As with all correlational studies one cannot infer causation. We cannot say that higher

perceptions of therapist empathy or genuineness lead to a higher alliance rating or vice versa. One can also question the perception-based nature of the therapeutic relationship. Previous studies have demonstrated the ceiling effects seen in ratings of the therapeutic relationship. Thus, it is possible the study only analyzed a restricted range of alliance strength running from good therapeutic relationships to great therapeutic relationships.

There remain a number of factors to consider when combining effects from different studies. These factors include: study quality, similarity between studies, and the perspectives of the relationship raters. Combining these factors can introduce "noise" into the overall findings of a meta-analysis. However, Orlinsky and Howard (1978, pp. 288–289) stated, "If study after flawed study seemed to point in the same general direction, we could not help believing that somewhere in all that variance there must be a reliable effect." The pattern of strong relationships between alliance, empathy, and genuineness is not likely to be dismissed because of study flaws.

Another limitation of the present study is its low power for detecting moderator influences. With the low number of overall genuineness studies and inconsistent reporting across studies it was difficult to perform extensive tests of moderators. We chose to perform some moderator analyses based on past research and theory, but limited our moderator testing in other areas due to the likelihood of Type II error.

Implications

Because this analysis showed such close relationships among alliance, empathy, and genuineness, it might be important to consider how these might appear differently in practice. These constructs may appear very similar to the same raters when presented with statements in a therapy session. Thus, it can be difficult to preserve the distinctness of these constructs in a therapy session. An easy argument could be made that one cannot give an empathic response that does not draw on the therapist's genuine concern. While it is conceivable that a statement like "I would feel very upset if I were in your place" can be said without being genuine this conceptual distinctness is also complicated in situations when the empathic response matches a therapist's genuine feeling. One would see high ratings of both, blurring the conceptual lines between empathy and genuineness, as well as alliance.

At a scale-level, it makes sense that alliance, empathy, and genuineness appear to be very similar constructs. The whole aforementioned analysis can be seen as a study of construct validity. At a level of content validity, some of the scales have very similar items to measure distinct constructs. The WAI has an item "I feel really understood" (Horvath, 1981, p. 227) and the BLRI empathy subscale has a similar item "_____ understands me" (Horvath, 1981, p. 236). Similarly, the WAI contains the item "I feel that _____ is not totally honest with me about his/her feelings toward me" (Horvath, 1981, p. 228) and the Genuineness scale of the RRI has the item "I felt there was a significant holding back in our relationship" (Kelley, 2002, p. 128). From a content validity standpoint, it looks like some overlap between alliance, empathy, and genuineness is to be expected given the similarity in across scale items.

Conceptually, engendering alliance, expressing empathy, and using genuine responses may appear different when used in therapy. Alliance work usually involves discussion of therapy goals and means of achieving those goals. Empathy expression involves the therapist accounting for the client's behaviors, emotions, and words, and then reflecting this understanding back to the client. Use of genuineness occurs when the therapist recognizes a "gut-level" reaction to the client, determines the therapeutic merit of mentioning this reaction, and, if appropriate, divulging this response to the client. The conceptual distinctions between the alliance, empathy, and genuineness are conceptually distinct, that does not prohibit any overlap. There is a high potential for overlap. Examples of overlap can include: (i) use of empathy and genuineness can build the bond aspect of the therapeutic alliance, (ii) empathizing with client frustrations over any perceived barriers to therapeutic goals, (iii) expressing genuine frustration when a client consistently ignores their task work, etc.

Therapists and clients may perceive or define the therapeutic relationship differently. This is a meaningful finding in that disagreement on the therapeutic relationship could have an impact on the progress of therapy. Each perceiver of the relationship appears to have their own consistent viewpoint across relationship variables, but this does not always reflect the viewpoint of a different perceiver. In order to monitor progress in the therapeutic relationship, therapists should solicit and acknowledge their client's perceptions of the therapeutic relationship. Oftentimes, one party will believe that the goals of therapy are clear while the other party will be uncertain about the direction of therapy. Incorrect judgment of the strength of the relationship can impede the progress of therapy. Verbal check-ins (e.g., "Was my understanding of your feelings accurate?")

and/or questionnaires can elicit this feedback. Feedback should be accepted in a non-defensive manner.

In conclusion, the meta-analysis described in this work shows that the therapeutic alliance is very closely related to perceptions of therapist empathy and genuineness. In fact there may be reason to believe that when rated by the same person, these constructs have significant overlap and lack discreteness. A variety of factors affect the strength of this relationship, including rater perspective, client race/ethnicity, and empathy measure. This relationship is especially strong when a client or an observer rate both alliance and perceptions of therapist traits. Future studies can expand upon interrelations within the overall therapeutic relationship.

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