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A PATTERN-SETTING THERAPEUTIC ALLIANCE STUDY REVISITED

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The editors of Psychotherapy Research had invited me to review my now-classic 1976 paper on the alliance and to include these topics: what that paper was about and the impact it has had on my own and other peoples' research. This paper has provided that. A brief summary follows of what the 1976 paper was about: it contained the first report of the two new session-based alliance measures, the HAcs and the HAr. It also contained the first report of the central relationship pattern measure, the Core Conflictual Relationship Theme (CCRT). A brief summary also follows of what the 1976 paper led to: (a) a similarly composed trio of alliance measures, including the HAcs, the HAr, and the HAq-I (this has since been expanded to become the HAq-II); (b) the discovery of moderately high to high intercorrelations among the Penn alliance measures and other main alliance measures in the field (Tichenor & Hill, 1989; Tang & DeRubeis, in press; and Hatcher & Barends, 1996); and (c) considerable expansion of information about the positive predictive capacities of these and other alliance measures for the outcomes of psychotherapy.

A generative context of events led to my 1976 theoretical-empirical paper on the therapeutic alliance. At the start of these events in 1974, Edward Bordin, a father of theory-making about the therapeutic alliance, asked me to be on a then-innovative panel on the topic of the alliance at the 1975 Society for Psychotherapy Research meeting. Most of his own research on the alliance was theoretical, like most or all the psychotherapy research on this topic at the time. Yet his invitation struck a responsive chord in me—being me, I knew my paper for the panel had to be both theoretical and empirical; my paper had to be based on a combination of a theoretical review and a scoring system for defining the alliance in psychotherapy sessions.

It became such a combination. To accomplish these twin goals, I did what I typically did in trying to understand a clinical concept: I examined a sample of psychotherapy sessions that reflected different degrees of improvement in psychotherapy. As I read and reread the sessions, I began to get hunches about alliance signs that were associated with improvement in psychotherapy. I put these signs together into

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a manual and tried them, and others tried them also. That is the brief story of my tried, and often true, method of making new measures out of old clinical concepts (as more fully exemplified in Luborsky, 1998).

THE MAIN POINTS IN MY 1976 ALLIANCE PAPER

The main points made in the original article of 1976 that are surveyed here are: a review of the theories of the therapeutic alliance; a description of the new alliance scoring manual for psychotherapy sessions; a description of a new personality measure called the Core Conflictual Relationship Theme (CCRT); and the main findings about the alliance and the CCRT from that first sample of 20 psychotherapy cases.

A REVIEW OF THEORIES OF THE ALLIANCE

My paper began with a review of theories of the therapeutic alliance in psychotherapy, drawing on Freud's concept of the essential quality of a "proper rapport" with the therapist (1913/1958, p. 139) and on Bordin's concept of the goals, techniques, and bonds related to the alliance with the therapist (1975). It also contained the first presentation of my partially theory-based yet operational measure of the therapeutic alliance and its interaction with my also then-new operational measure of the CCRT method (Luborsky, 1977; Luborsky & Crits-Christoph, 1998).

Specifically, the paper went on to illustrate how "the strength of the working alliance may be judged by: (a) its capacity to withstand stress under pressure from regressive developments (usually based on increased transference) versus its readiness to break down under pressures from external frustrations and (b) its degree of dedication to, and persistence in, the work of the treatment for overcoming obstacles in one's self" (pp. 94–95). My discussion then specified the interaction of the alliance with the transference: "the strength of the helping alliance varies from time to time, especially in relation to surges in transference, which may then be diminished or controlled through the therapist's interventions" (p. 95). The expectation in the 1976 paper, behind the development of the alliance measures, the Helping Alliance Counting signs and the Helping Alliance Rating (HAr) measures, was that some kinds of evidence of the alliance would show themselves more or less directly in the treatment sessions. Up until this time no alliance measure had been based on a clinical observer's scoring of the content of a session. The selection of the seven signs in the alliance manual to be scored in the session was not primarily derived from theory, but rather was based on attending to the differences between the sessions of the most versus the least improved patients in the Penn Psychotherapy Project sample.

A NEW SCORING MANUAL FOR TWO ALLIANCE MEASURES THAT WERE DESIGNED AS MEASURES BASED ON PSYCHOTHERAPY SESSIONS

One of the paper's main contributions was the manual for the Helping Alliance Counting Signs (HAcs) which helped clinicians and researchers to reliably identify the signs of the therapeutic alliance in a psychotherapy session. This manual delineated concretely how in a psychotherapy session these signs could be reliably recognized and scored by clinical judges (as specified in Appendix A of that paper).

Another related manual for the HAr was also described in the 1976 paper. In it the judge rates the same session—either a segment of a session or the entire ses-

sion—to form a clinically based judgment combining all impressions of the alliance, not just those listed in the signs. Our plan was to score both the HAcs and HAr measures in each session and then to compare the assets and liabilities of each.

A NEW PERSONALITY MEASURE, THE "CORE CONFLICTUAL RELATIONSHIP THEME" (CCRT) METHOD

Another main contribution of the 1976 paper was its description of the basics of a relationship pattern measure that was broader than the alliance measure: the CCRT measure (Luborsky, 1977; Luborsky & Crits-Christoph, 1998). The method, as used in this study, relied on 20-minute segments of the sessions and identified the relationship episodes (REs) within them. The use of REs as a unit within sessions was also novel in psychotherapy research. These REs were narratives about specific episodes of interactions between the patient and another person who was important to the patient; in a few of these interactions, the other person was the therapist. All relationship episodes were inspected in sequence in order to find the thematic consistencies across them. A high frequency of thematic consistencies across a set of narratives was considered to be a likely mark of a central relationship conflict; that principle gave the name to the method as the "core *conflictual* relationship theme."

THE MAIN FINDINGS FROM THE ALLIANCE AND THE CCRT MEASURES, BOTH BASED ON EXTREME GROUPS OF TREATMENT OUTCOMES

The Penn Psychotherapy Project (Luborsky, Crits-Christoph, Mintz & Auerbach, 1988) provided two measures of treatment outcome: (1) *residual gain,* a composite of measures provided by the patient and by a clinical observer both initially and at termination and (2) *rated change,* a combination of ratings of change made by the patient and by the therapist independently, each weighted equally. From among the 73 patients in the Penn Psychotherapy Project, extreme outcome groups were selected of the 10 most improved and 10 least improved patients on each of the two kinds of outcome measures; the original paper's contributions relied primarily on the residual gain measure. The segment of the sessions scored were the first 20 minutes of two early sessions, 3 and 5, and of two late sessions adjacent to the 90% point of completion of treatment. The most concrete definition of the alliance concept is provided by the seven signs in the original HAcs manual, as they were scored on the 10 most improved and the 10 least improved patients. The first four of the seven signs are classified as "Type 1," which means the patient experiences the therapist as providing the help: (1) the patient believes that the therapy is helping; (2) the patient feels changed since the beginning of treatment, or he is considered to be better; (3) the patient feels a rapport with the therapist, and feels understood and accepted; and (4) the patient feels optimism and confidence that the therapist and treatment can help. The next three signs are labeled as "Type 2," which means the patient has a sense of working together with the therapist in a joint struggle against what is impeding the patient; (5) the patient experiences the treatment as working together with the therapist in a joint effort, as part of the same team; (6) the patient shares with the therapist similar conceptions of the etiology of the problems; and (7) the patient demonstrates qualities that are similar to those of the therapist, especially in having the tools for understanding. As summarized in the 1976 paper, the most and least improved patients showed large differences in these seven signs as scored by me. In the sample of cases that were most appropriately scorable (because they

contained 25 or more sessions), six of the seven improvers and none of the eight nonimprovers showed positive signs; instead they showed negative helping relationship signs.

The results of the two Helping Alliance manuals applied to narratives in the 20-minute segments of psychotherapy sessions of the most improved versus the least improved patients were then generalized into several propositions about helping relationships that were mainly supported by the data:

Proposition 1: The early sessions confirmed the beginnings of Type 1 helping relationships in the most improved, as compared with the least improved patients. As noted above, this proposition was confirmed.

Proposition 2: A sample of the late psychotherapy sessions showed that a few of the most improved patients developed Type 2 helping relationships, while the nonimprovers did not. Some evidence for this was present but it was not strong.

Proposition 3: A CCRT that was pervasive across REs and sessions was abstracted from them for each patient. That theme was formulated for each patient and was found to resemble the clinically derived transference pattern. The main difference between the most and least improved patients was not in the theme's pervasiveness across the REs and the sessions but in the capacity that was evident for the improvers to cope with and master the theme when it was experienced in the relationship.

Proposition 4: The most improved patients came to treatment with slightly more positive expectations from others, which may have facilitated their formation of helping relationships. These results were evident in the sample of REs and sessions, as noted above.

Proposition 5: The therapists of the more improved patients tried harder to develop helping relationships with their patients. This result needs further examination.

THE IMPACTS OF THE 1976 ALLIANCE PAPER ON MY WORK AND ON THE WORK OF OTHERS

The 1976 paper preceded, and may have directly or indirectly set off, some of the subsequent swelling cascade of alliance findings from a cornucopia of such studies. A representative sample of the impacts that were most relevant to our findings follows:

THE OPERATIONAL MEASURES OF THE HELPING ALLIANCE WERE FURTHER DEVELOPED FOR USE WITH PSYCHOTHERAPY SESSIONS

The central contribution of helping alliance measures is in their operational transformation of the clinical concept of the therapeutic alliance for patients in psychotherapy whose treatment outcomes were known. I therefore used the term "alliance" as the name of the measure; and then realized that it happened to be the first use of the term alliance in a controlled empirical study of psychotherapy. Since then, the term alliance has become a common one in many of such studies. A re-reading of the titles of the numerous alliance references in Orlinsky, Grawe, & Parks (1994, page 365–370) revealed the absence of the term before 1976 in psychotherapy research studies. But in the clinical literature, in contrast, the term had been used by

Zetzel (1956) and by Greenson (1965), who are examples of clinicians who have stressed the importance of collaboration between patient and therapist.

A TRIO OF TYPES OF PENN HELPING ALLIANCE MEASURES HAVE BEEN FASHIONED AND USED

This trio of measures of the helping alliance shared many of the same items with each other (Alexander & Luborsky, 1986; Luborsky, Crits-Christoph, Alexander, Margolis, and Cohen, 1988). 1) The ratings of sessions by a clinician with the HAcs measure (Luborsky, 1976); 2) a similar measure in the form of a broad clinical judgment of the whole segment of the session by the Helping Alliance Rating measure (HAr, Luborsky, 1976; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983) and; 3) a self-report measure by the Helping Alliance Questionnaire (HAq-I; Luborsky, Woody, O'Brien, & Auerbach, 1985), that was then revised and expanded into HAq-II (Luborsky et al., 1996; Luborsky et al., 1999).

MANY ALLIANCE MEASURES HAVE BEEN DEVELOPED AND THEN FOUND TO BE ASSOCIATED WITH EACH OTHER

A variety of other types of alliance measure have also become commonly used. The most frequently used among them are the Vanderbilt Therapeutic Alliance Scale (VTAS; Strupp, 1993), the Working Alliance Inventory (WAI; Horvath, 1994; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Horvath, Gaston, & Luborsky, 1993) and the California Psychotherapy Alliance Scale (CALPAS; Marmar, Weiss, & Gaston 1989). All of these contain self-rating questionnaire formats; only the CALPAS also has an observer-rating version.

The main measures tended to be correlated with each other, as shown by the three studies reviewed below: Tichenor & Hill (1989), Tang & DeRubeis (in press), and Hatcher & Barends (1996):

Observer ratings of these main alliance measures (rather than self-report on questionnaires), including the Penn HAq-I measure, were intercorrelated by Tichenor & Hill (1989). Session ratings were made by six raters of eight cases of brief psychotherapy. The ratings of these measures tended to overlap, implying that they were mostly similar measures. Only the Penn Helping Alliance Scale (HAq-I) used as an observer rating, showed partial overlap with the other rated measures—its correlation with the WAI was (.71*), but correlations were lower with the other scales: VTAS (.51) and the CALPAS (.34).[1] However, another finding was also informative: the self-report version of the WAI, by the client and by the therapist, did not correlate significantly with the observer rated versions of any of the three other measures: the Penn Helping Alliance, the Vanderbilt Working Alliance, or the CALPAS. The important general implication from this is that the self-report versions of the three alliance scales did not, and perhaps generally do not correlate significantly with the observer rated versions (as suggested also by a study by Luborsky et al., 1999).

More information showing the moderately high agreement of different alliance measures with each other is offered by Tang and DeRubeis (in press, p. 15). They only used observer rated versions of the VTAS (Hartley & Strupp, 1983), the WAI;

[1]One asterisk means that the correction was significant at the .05 level; two asterisks, at the .01 level; and three asterisks, at the .001 level.

(Horvath & Greenberg, 1994) and the Penn Helping Alliance Rating Scale (HA-I; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). The interrater correlations of the three observer-rated scales were .70, .76, and .60, for each in order. The average score composite reliability of the two raters (Allen & Yen, 1979) was estimated as .82, .86, and .75 for each in order.

Self-rated questionnaires in joint factor analysis by Hatcher & Barends (1996) using all of these measures, showed: CALPAS and WAI (r = .85) CALPAS and HAq-I (r = .74) and WAI and HAq-I (r =. 74) ($p < .001$, n = 231) with a strong general factor across the three measures. Two of the six factors correlated with the patients' estimate of improvement. They were *confident collaboration* and *idealized relationship* which showed predictive correlations of .37 and –.23 respectively, at $p < .001$. Hatcher & Barends (1996) also removed the items in the HAq-I that might be associated with outcome. The factor analysis with such items removed, yielded five factors with item loadings almost the same as in the full analysis. In summary, the corrected factor analysis and the corrected factor scores had five factors, with the help items and the general factor removed from each. The five factors from Hatcher & Barends (1996) correlated with improvement .37* (confident collaboration), –.05, –.07, –.23* (the idealized relationship), and .02. (The asterisk refers to $p < .001$ for a sample of 231.) In essence, from the patient's point of view, by self-report and across the three measures, confident collaboration is the largest factor with a significant relationship to outcome of the treatment. (Perhaps it will turn out in subsequent research—because of the emphasis on collaboration—that this factor will be associated with the Type 2 category. Several other measures have also been shown to be associated with the self-report measures (Piper, Azim, McCallum, and Joyce, 1991; Piper, Joyce, McCallum, and Azim, 1998).

THE TYPE 1 VERSUS TYPE 2 DISTINCTION HAS BEEN FURTHER EXAMINED

In the 1976 paper Type 1 was reported to be relatively frequent and Type 2 was relatively infrequent (Greenspan and Cullander, 1975). Morgan et al. (1982) and Luborsky et al. (1988) using a version of the Helping Alliance Global Rating measure (HAr) with two new independent judges, reconfirmed the finding in the same sample. They also found that the correlation of Type 1 with Type 2 was .91 both at the early and late points (Luborsky et al., 1988, p. 170). The correlation was so high in this sample that separate Type 1 and Type 2 results can be considered to represent essentially the same finding.

THE SESSION-BASED HAR MEASURE SHOWED MODERATE TO GOOD AGREEMENT WITH THE ALSO SESSION-BASED HACS MEASURE

It was expected that the two measures would agree with each other, because they are both observer-judged alliance measures based on the same sessions. In fact, they did agree even though each had been scored by two different pairs of independent judges. The high level of agreement implies some validity for the method (Luborsky et al., 1983; Luborsky et al., 1988, Table 12-3). They agreed more highly for the late sessions (.83***) than for the early sessions (.57**), perhaps because in the late sessions, the outcome of the treatment might have been more evident in what the patient and therapist said in the session.

Because the sample so far described was based on only 20 extreme-group cases—10 most improved and 10 least improved patients—we reexamined the reliability

and the agreement of the HAr and the HAcs using a new complete sample of 19 depressed patients and a manual enlarged from 7 to 13 categories to increase the range of the measure (Luborsky et al., 1999). In this new sample, the agreement of the two judges with each other was good, with a kappa of .80* for the HAcs and moderately good for the HAr, with a kappa of .73. However, in this new sample the correlation of the HAcs with the HAr was only low moderate, that is, .51 (significant at the .05 level, two-tailed).

THE POSITIVE SIGNS RATHER THAN THE NEGATIVE SIGNS IN THE HAc MEASURE HAVE SPECIAL PREDICTIVE PROPERTIES

The positive signs were more frequent and more predictive by far than the negative ones (Luborsky et al., 1988). The positive signs therefore were more reliable harbingers of eventual beneficial outcomes of the treatments.

A NEW MEASURE, THE THERAPIST FACILITATIVE BEHAVIORS (TFB) FOR THE HELPING ALLIANCE, WAS TESTED

This new measure was designed to estimate the therapist's role in facilitating or inhibiting the helping alliance. Two versions of the TFB measure were developed: the Therapist Facilitative Behaviors Rating scale (TFBr) of 10 items that paralleled the ones on the HAr scale, and the Therapist Facilitative Behaviors Counting Signs (TFBcs) measure that paralleled the items on the HAcs. The agreements were for the positive ratings of the two types of measures of facilitative behavior, the TFBcs with the TFBr (Luborsky et al., 1988, Table 13-2). For the early sessions for the positive ratings it was low (.25), but for the late sessions for the positive ratings it was moderately adequate (.66**). Evidence was also found that high levels of TFB were associated with high levels of helping alliance. Therefore, it might be correct to infer that the TFB influenced the formation of a positive alliance, even though the TFB itself did not predict the outcome of treatment to the same extent as the alliance.

ACCURACY OF INTERPRETATION APPEARS TO STIMULATE IMPROVEMENT IN THE POSITIVE ALLIANCE

Crits-Christoph, Cooper, & Luborsky (1998), and Crits-Christoph, Barber, & Kurcias (1993) showed that accurate interpretations, based on convergence of the interpretation with the independently established CCRT's Wish and Response from Other, were associated with improvement in the alliance during treatment. The likelihood is that such greater accuracy of interpretation helps with improving the alliance with the therapist.

IMPROVEMENTS IN THE FORM OF "SUDDEN GAINS" ARE FOLLOWED BY AN INCREASE IN THE ALLIANCE

A partly similar set of relationships was found to that of the accuracy of interpretations in association with the alliance by Crits-Christoph, Barber, & Kurcias (1993), in comparision with the novel findings of Tang and DeRubeis (in press). They found reliable evidence that (a) some patients show sudden gains on the Beck Depression Inventory from one session to the next and (b) the therapeutic alliance tends to improve after such therapeutic gains. They examined independent judges' ratings of

the therapeutic alliance in the session *after* the sudden gain and discovered that the alliance was then better than in the pre-gain session. This improvement in the alliance was significant for the Penn (HA-I, Morgan et al., 1982) ($p = .03$), and was a trend for both the VTAS ($p = .06$) and the WAI ($p = .07$).

THE CCRT METHOD HAS BECOME VERY WIDELY USED

The CCRT method as described in the 1976 paper was the first reliable clinical-quantitative method of measuring a central relationship pattern or schema within psychotherapy. It also appeared to be a reasonable operational stand-in for the clinical concept of the transference pattern (Luborsky, 1997; Luborsky & Crits-Christoph, 1998). Perhaps in part because of this, the CCRT method has become much used—as one example, the *CCRT Newsletter* lists 181 ongoing CCRT studies world-wide (Luborsky, Kaechele, Dahlbender, and Diguer, 1999).

Through further applications of the method it was found (Luborsky, 1977) that (a) a central conflictual relationship theme recurrently appeared that was similar from the early to the late sessions of treatment; (b) the more improved patients showed increased signs of mastering their CCRT in the later sessions, as confirmed by a subsequent operational measure of mastery by Grenyer & Luborsky, (1998) and Grenyer (in press); and (c) so far 19 discoveries about personality structure and change have been reported through the use of the CCRT measure (Luborsky et al., 1999).

THE PREDICTIVE SUCCESS OF ALLIANCE MEASURES HAS BEEN GENERALLY CONFIRMED

A much referred to meta-analytic compendium of the predictive validity of alliance measures is Horvath & Symonds (1991). For 24 studies with 20 distinct sets of data, which met the meta-analysis' criteria for studies with an adequate design, the mean level of correlation of alliance scores with outcome measures was .26. It is currently being updated and enlarged into sets of data from about 40 alliance predictive studies (Horvath, Luborsky, Diguer, & Descoteaux, 1999). Some of the data sets being added in the enlarged meta-analysis include: studies of patients who are substance abusers (Luborsky, Barber, Siqueland, Woody, McLellan, 1997); (Barber, Luborsky, & Gallop, 1999); (Luborsky, 1994); (Gerstley et al., 1989); studies of patients diagnosed as borderline (Gunderson, Najavits, Leonhard, Sullivan, & Sabo, 1997), and of patients diagnosed as depressed (Weiss, Gaston, Propst, Weisebord, & Zicherman, 1997).

By far the largest review of predictive factors of the outcomes of psychotherapy is Orlinsky et al. (1994). Under the broad heading of "therapeutic bond" for example, they note that "there are more than a thousand process-outcome findings . . . with a high rate of significant positive associations for these across multiple process perspectives." For the more limited concept of the therapeutic bond/cohesion, the Orlinsky et al. review (1994) lists 132 findings (p. 354) with 66% showing significant correlations with outcomes of the treatment.

A SET OF RECOMMENDATIONS FOR RESEARCH AND FOR PRACTICE

I remember becoming increasingly enthusiastic as I worked on the 1976 paper and achieved a saltatory succession of discoveries with it. Now I see its place in psycho-

therapy research and practice even more clearly than I did then. Yet, even at the time of the study, it was already clear that the application of an observer-judged alliance measure to psychotherapy sessions was a useful clinical innovation (Luborsky & Crits-Christoph, 1988, 1998). Although Barrett-Lennard's (1962) "relationship questionnaire" had been in earlier use, alliances as scored directly from transcripts of sessions were new. However it came about, after the 1976 paper appeared, both the self-report questionnaire measures and the session-based observer-rated alliance measures were increasingly used. In effect, the 1976 paper may have served for some researchers as a stimulus to empirical research on the therapeutic alliance as well as for use in the practice of psychotherapy (Luborsky, 1984; Luborsky, 1990; Luborsky, 1996), Luborsky, Barber, & Crits-Christoph 1990, 1992). Here, I have listed six ideas for specific sequalae of the 1976 paper that need to be followed up further:

- The HAcs has been used much less than the HAr in later research. It may be that the expected labor of using the HAcs discourages some researchers from trying it. However, although the HAr seems simpler, the evidence so far is that the HAcs is not difficult to use and the psychometric properties of the HAcs appear to be somewhat better than those of the HAr.
- More research is needed on the Type 1 and Type 2 groupings of scoring categories in the HAcs manual. As explained, Type 1 refers to the patient's experience of receiving help from the therapist and Type 2 refers to the patient's experience of working together with the therapist in a joint effort to achieve the goals of the treatment. Both the original study and its replications by others have shown only modest evidence for this distinction, but the evidence so far may have been restricted because the studies tend to be based on short-term treatment where the brevity of the treatment may stunt the growth of the Type 2 alliance.
- Further studies are needed of the capacity of a therapeutic alliance to withstand the stresses from internal and external sources without rupturing. A suitable research method to measure this capacity would rely on an expansion of analyses of the context for alliance ruptures, as in Safran, Muran, & Samstag (1994) so that a range of assessments would be made, such as (a) the frequency of ruptures within sessions and over the course of treatment; (b) the degree of the impairment in the alliance in each rupture; (c) the degree and nature of the internal and external stressors at the time of each rupture; and (d) the capacity for mastery of the conflicts pushing toward a rupture.
- A combination of the two main types of procedures should be used for assessment of the alliance: a self-rating questionnaire method (e.g., the HAq-II, the revised and expanded alliance measure) and a clinical observer rating method (e.g., the HAcs or HAr). The combination of these two main assessment procedures is recommended because of the low intercorrelations between these procedures and the limitations of each method, such as: (a) the psychotherapy session may not reveal sufficient recognizable-to-the-clinical-observer evidence of the therapeutic alliance and therefore a self-report questionnaire may be a useful supplement; and (b) the patient in filling out the self-report questionnaire may not answer it truthfully with regard to the quality of the alliance, at times because of withholding and at times because of a difficulty in being aware of the state of the therapeutic alliance.
- Research is still needed on a prominent hypothesis in the theory advanced in the 1976 paper: there will be an interrelationship of measures of the thera-

peutic alliance concept and measures of the transference concept. When such interrelationships are examined empirically they will probably reveal basic similarities in the two concepts. After all, the therapeutic alliance deals with a relationship pattern of the patient with the therapist; similarly, the transference pattern deals with that same relationship but also with the patient's relationship patterns with others. Such interconcept evaluation is a promising task that should have a high priority on the research agenda (Connolly, Crits-Christoph, Shappell, Barber, & Luborsky, 1999). In fact, studies by Hentschel, Kiessling, & Rudolph (1997) are supportive of our expectations about the parallels of transference pattern measures and alliance measures—they found that introjected images of fathers and mothers, especially mothers, played a part in the interaction with the therapist. Their data was 126 patients from the Berlin Psychotherapy Project (Rudolph, 1991).

- At the start of the research on session-based alliance measures in the 1976 paper with the HAcs and the HAr, the relationship of these was examined with improvement in psychotherapy. Since then there has been an increasing production of predictive studies that confirm the relationship, for example in Horvath and Symonds (1991). What has never been examined and is now recommended as a productive topic is an examination of studies of the alliance in terms of which approaches offer statistically significant predictions of outcomes and which ones do not. The first steps on this topic have already been taken in the enlarged Horvath and Symonds (1991) meta-analysis. One factor especially seems likely to help to explain nonsignificant studies: the lack of range in the predictor and in the outcome measures.

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Zusammenfassung

Die Herausgeber der Zeitschrift haben mich dazu eingeladen, unsere mittlerweile klassische Arbeit über die therapeutische Allianz aus dem Jahr 1976 zu kommentieren und folgende Themen zu behandeln: Worum ging es in dieser damaligen Arbeit und welche Auswirkungen hatte der Inhalt auf meine eigene

Forschung und die anderer. In diesem Beitrag wird dies zusammengefaßt. Die damalige Arbeit war der erste Bericht über zwei neue Maße der therapeutischen Allianz, die sich auf einzelne Therapiesitzungen bezogen, die HAcs und die HAr. In dem Artikel wurde auch erstmalig über das Maß zentraler Beziehungsmuster, das zentrale Beziehungskonfliktthema (ZBKT) berichtet. Im folgenden wird zusammengefaßt, was aus der Veröffentlichung resultierte: a) ein ähnlich komponiertes Trio von Allianzmaßen, bestehend aus der HAcs, der HAr und dem HAq-I (jetzt ausgeweitet als HAq-II), b) die Entdeckung mittelhoher Korrelationen zwischen den Allianzmaßen und anderen wichtigen Allianzmaßen in diesem Feld (z. B. jene von Tichenor und Hill, 1989, Tang und DeRubeis in Druck, Hatcher und Barends, 1996); c) eine beträchtliche Ausweitung des Wissens über die positiv prädiktiven Möglichkeiten dieser und anderer Allianzmaße für das Ergebnis von Psychotherapien.

Résumé

Les éditeurs de Psychotherapy Research m'avaient invité à reprendre l'article de 1976, entretemps devenu un classique, sur l'alliance, et d'y inclure les sujets suivants: l'essence de cet article, et l'impact qu'il a eu sur ma propre recherche et celle d'autres chercheurs. C'est ce que cet article offre effectivement; il résume brièvement le sujet, à savoir, la première communication sur les deux nouvelles mesures de l'alliance d'une séance, la HAcs et le HAr. En outre, il contient la première mention de la mesure du pattern relationnel central, le Thème Relationnel Conflictuel Central (CCRT). Un bref résumé décrit les conséquences que cet article de 1976 a eues: a) un trio de mesures de l'alliance, composé de façon semblable, et incluant le HAcs, le HAr, et le HAq-I (qui a depuis évolué vers le HAq-II); b) le constat d'intercorrélations moyennement hautes entre les mesures de l'alliance de Penn et d'autre mesures de l'alliance dans ce domaine (Tichenor and Hill, 1989; Tang and De Rubeis, in press; and Hatcher and Barends, 1996); et c) une expansion considérable en information au sujet des capacités prédictives des résultats de psychothérapies de ces mesures de l'alliance et d'autres.

Resumen

Una investigación clásica. Los editores de Psychotherapy Research me invitaron a revisar mi ya clásico trabajo de 1976 sobre la alianza terapéutica, en el que debía incluir: el tópico de aquel trabajo y su influencia sobre mis investigaciones y las de otros investigadores. El trabajo proporciona: un breve resumen del tema y el primer informe de dos nuevas medidas de la alianza terapéutica basadas en la sesión, el HAcs y el Har. También contenía el primer informe de la medida de la pauta central relacional, el Tema Nuclear Relacional Conflictivo (Core Conflictual Relationship Theme, CCRT). Este artículo contiene, además, un breve resumen de lo logrado por el trabajo de 1976: a) un trio de medidas de alianza compuesto en forma similar, el HAcs, el Hr, y el Haq-I (este se ha ampliado desde entonces para llegar a ser el Haq-II; b) el hallazgo de intercorrelaciones moderadamente altas entre las medidas de alianza Penn y otras medidas principales en nuestro campo (Tichenor y Hill, 1989), Tang y DeRubeis (en prensa), y Hatcher y Barends (1996); y c.) considerable ampliación de la información acerca de la capacidad de predicción positiva de estas y otras mediciones de la alianza sobre los resultados de la psicoterapia.

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