CHAPTER 2

Therapeutic Alliances as Predictors of Psychotherapy Outcomes: Factors Explaining the Predictive Success

LESTER LUBORSKY

For the first 50 years after the beginning of the alliance concept (Freud 1912), clinical methods seemed to be the only ones that could explicate the alliance concept. Yet, bit by bit, for the next 30 years, especially for the last 15 of these, the clinical-quantitative genre has shown progressively more capacity to make significant discoveries on this topic.

By now, there are enough studies to satisfy the aims of this review: (a) to collate the predictive success of all alliance measures that have been correlated with outcomes of psychotherapy; (b) to review the influence of various factors on the predictive success of the alliance measures, for example, the type of alliance measure, and the type of treatment to which they are applied; and (c) to try to understand the basis for the trends in the alliance-outcome correlations (through leaps of interpretive gymnastics), within the mechanisms of action of dynamic psychotherapies.

This review concentrates on the period since 1976, for several good reasons: Up until then, the many studies had used one pioneer instrument, the Relationship Inventory by Barrett-Lennard (1962) for patient and therapist judgments of the relationship; 26 of these studies were summarized by Gurman (1977). Then beginning with Luborsky’s (1976) research, a second type of method came into being: direct assessment of the sessions using operational measures of the alliance concept. It was after 1976 that a variety of methods appeared; both different types of questionnaires and different judgment-of-sessions methods, as part of a renewed generative period of research on the topic.

The preparation for a panel on the therapeutic alliance called together by Bordin (1975) led to the development of an operational measure of the alliance—the Helping Alliance Counting Signs (Luborsky, 1976; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). The alliance measure was based on two types of signs found in sessions: Type 1 represents a helping relationship that depends on the patient’s experiencing the therapist as helpful and supportive, and Type 2 represents a helping relationship based on a sense of working together in a joint struggle against whatever impedes the patient. Six signs were defined for Type 1:

1. The patient feels the therapist is warm and supportive.
2. The patient believes the therapist is helping.
3. The patient feels changed by the treatment.
4. The patient feels a rapport with the therapist.
5. The patient feels the therapist respects and values the patient.
6. The patient conveys a belief in the value of the treatment process.

Type 2 includes four signs:

1. The patient experiences the relationship as working together in a joint effort.
2. The patient shares similar conceptions about the source of the problems.
3. The patient expresses belief about being increasingly able to cooperate with the therapist.
4. The patient demonstrates abilities similar to those of the therapist in terms of being able to use the tools for understanding.

A related method was then developed based on the same signs but allowing the clinician to put together the signs into a global rating; this is the Helping Alliance Global Method (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983). A third method was developed also using the same signs but framing them in a self-report questionnaire format—the Helping Alliance Questionnaire method (Luborsky, Mclellan, Woody, O’Brien, & Auerbach, 1985). The following concept of the alliance was generated by the studies using these three methods: The helping alliance is an expression of a patient’s positive bond with the therapist who is perceived as a helpful and supportive person.

PREDICTIVE SUCCESS OF ALLIANCE MEASURES

All studies were surveyed for their predictive success, regardless of the alliance measuring methods used, and 24 samples were located within 18 studies. Each of these studies was briefly summarized by a categorization of the significance level of the study: “+” if significant and consistent in direction with the main trend; “0” if nonsignificant, and “-” if negatively significant. In this way, we were able to see how well the alliance measures
TABLE 2.1. Alliance Measures as Predictors of Outcome (since 1976)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of Samples</th>
<th>Number of Significant Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Questionnaires</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Observer-rated on session</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>(audio- or videotapes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>19</td>
</tr>
</tbody>
</table>

related to the outcome measures. We found that in 19 of these 24 samples, an alliance measure of some sort achieved significantly positive prediction—an impressive record (see Table 2.1).*

FACTORs INFLUENCING PREDICTIVE SUCCESS OF THE ALLIANCE

After this multi-study predictive record, we can continue to learn more about the alliance by examining each of 11 factors that might influence the level of the prediction in each sample. These factors are described in the following sections.

Type of Measure

The main trend in the comparison of the relative prediction success of the two methods was not a surprise—there is no evidence that one type of alliance measure has a better record of success than the other. And even the two judgment-of-session methods (global ratings and counting signs) have predictive correlations with quite similar levels of success (Alexander & Luborsky, 1986; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988).

We were surprised, however, by the difference in the number of studies with the two methods. Before doing the review, we had thought there were many more of the observer judgment-of-sessions alliance studies, but of the 24 samples, only six are based on the use of judgment of sessions. The preference for the questionnaire may well have to do with its attractive ease of use—reliance on a questionnaire saves the work of transcribing the sessions and the time for assessment of the session. It must be pointed out though that the continued use of the questionnaire method was not based on the ample evidence that the two methods were correlated with each other.

* Only 14 of the 26 studies of the Barrett-Lennard Relationship Inventory assessed the relationship early in treatement, so that these could be examined predictively—twelve of the 14 appeared to have a positive relation with an outcome measure.

A few studies have begun to provide this necessary kind of information. Some of the more specific types of measures overlap in terms of what they measure. Using observer judgments of sessions, Titchner and Hill (1989) showed three measures to be overlapping. California Psychotherapy Alliance Scales (CALPAS; Marmar, Weiss, & Gaston, 1989), the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983) and the Working Alliance Inventory-O (WAI-O; Horvath & Greenberg, 1986), whereas the Penn Helping Alliance Rating measure (Morgan et al., 1982) was related only to the Working Alliance Inventory-O. Further studies of the interrelation of measures are underway by MacKenzie (1989) Bachelor (1990), and Hatcher et al. (1990).

Type of Treatment

One of the most likely factors to investigate is the type of treatment. After all, the alliance concept came from dynamic theory and so it might be especially predictive for dynamic therapy. Also, the majority of the studies are still with dynamic therapies.

But, in fact, the evidence suggests instead that the alliance is significantly predictive in other therapies as well. Marmar, Gaston, Gallagher, and Thompson examined the alliance as a predictor in dynamic, cognitive, and behavioral therapies (1989). A sample of such results, using the Beck Depression Inventory (BDI) as the outcome measure, were as follows: For the therapist version of the alliance questionnaire, cognitive therapy had a mean correlation of .64, whereas behavior therapy had a mean correlation of .21 and dynamic therapy was .37. The results for the patient version of the alliance questionnaire follow: behavior therapy .40, cognitive therapy .36, and dynamic therapy .19. The study's conclusion for the therapist version was that cognitive therapy outcomes are well predicted, dynamic therapy moderately well and behavior therapy less well; for the patient version, the alliance was not as predictive for dynamic therapy. It is noteworthy that the CALPAS used in this study is a questionnaire method in the tradition of the Barrett-Lennard Relationship Inventory. Furthermore, for the results that are presented, its use as a predictor had a limitation—in treatments of 16 to 20 sessions, the CALPAS questionnaire was given at 3 points (Sessions 5, 10, and 15) but then was averaged. For a usual predictive study, these procedures should have been done separately so that the predictive correlations from the early sessions would be known.

The Penn Helping Alliance Questionnaire was first tried in a study with opiate-addicted patients (Luborsky et al., 1985) as rated by the patient and the therapist at the end of the third session for three groups: dynamic (supportive-expressive), cognitive, and drug counseling. The combination of the three groups showed significant prediction (.65), but the individual groups were insignificant.
The Penn Helping Alliance rating scale (Morgan et al. 1982) as applied to sessions of cognitive therapy (DeRubeis & Feely, 1991) was not significantly predictive of outcome (change in BDI). Their study reported the results of assessment of the alliance on only one early session, however.

Patients', Therapists', or Observers' Views

For the questionnaire method, the patient's view of the alliance appeared to predict better than the therapist's view; although not all studies showed this trend, Tichenor and Hill (1989) found a lack of relationship between client, therapist, and observer in judgment of sessions; the observer, however, is really judging the session whereas the client and therapist are responding on a questionnaire.

Positive versus Negative Alliance as a Predictor

The positive alliance was shown to be a better predictor than the negative alliance by Luborsky et al. (1983). The same was shown by Marziali (1984): $P$ positive contribution .43; $P$ negative contribution -.29. The findings were similar for the therapist: $T$ positive contribution .28, $T$ negative contribution -.06.

Overlap between the Alliance and Outcome Measures

The predictive power of the alliance probably benefits from its partial overlap with the outcome measures even with patients with the diagnosis of schizophrenia (Frank & Gunderson, in press). But the overlap is considered to be modest (by Luborsky et al., 1988) between the helping alliance rating items and the outcome measures, because the outcome measures are broadly based composites of patient, observer, and therapist measures. In contrast, the improvements represented by the helping alliance statements within the early sessions were only small improvements compared with the more substantial ones by the end of successful treatment.

Overlap between Alliance and Prior Improvement

If you were making a judgment about your alliance with your therapist, you would almost certainly be influenced by the improvement you had made so far. The only question would be, how much? You might have started to improve and might attribute some of the improvement to the positive alliance. Or, you might not have gained much, but you might feel you have a good alliance and have prospects of future benefits. We would expect therefore that the judgment of the alliance would correlate to some extent with the judgments of the prior improvement.
Facilitation of the Alliance by Mental Health and by Quality of Object Relations

The patient's mental health is correlated with his or her ability in forming an alliance, which suggests that the capacity to form an alliance is partly a quality that the patient brings to the treatment. For example, the Health-Sickness Rating Scale (HSRS) (Luborsky, 1975) correlated with the positive helping alliance counting signs .44 (p < .05), although it was not significantly correlated with the helping alliance rating method.

The quality of interpersonal relationships tends to be highly associated with mental health (Luborsky, 1962) and is therefore included here. An interview measure of it was shown (Piper, Azim, Joyce, & McCallum, 1991) to be the best predictor of outcome but also to be significantly related to patient-rated and therapist-rated therapeutic alliance. All these factors were related to improvement in symptoms and in target complaints.

Facilitation by Basic Similarities between Patient and Therapist

Similarities of patient and therapist in certain basic demographic characteristics may be a factor conducive to forming an alliance. In the Penn study (Luborsky et al., 1983), similarities between patient and therapist (for the extreme groups of 10 more successful and 10 less successful patients) were significantly correlated with both the helping alliance rating method and helping alliance counting signs methods. The similarity score was based on 10 primary demographic basic similarities: age, marital status, children, religion, religious activity, foreign-born parents, shared institutional affiliation (University of Pennsylvania), cognitive style, education, and occupation. One point was given for each similarity or “match.” The sum score correlated .60 (p < .01) with positive helping alliance counting signs, .62 (p < .01) with a difference between positive and negative signs, and .53 (p < .05) with helping alliance rating. The age match and religious activity match contributed the most. These similarity scores and others like them should be further investigated because the presence of certain basic similarities between patient and therapist may facilitate the development of the alliance between them.

Time Course from Early to Late in Psychotherapy

Not enough evidence has been assembled yet on the variations in the time course of the alliance and the relation of such variation to outcome. Most studies have taken the early sessions as a predictor, and a few have averaged across the sessions as a predictor (e.g., Marmar, Gaston, Gallagher, & Thompson, 1989). Hartley and Strupp (1983) sampled the alliance across the sessions and found only one point that was significantly predictive—the 25% point. A similar result appeared in DeRubeis and Feeley (1991)—the early session was predictive but the later one was not.

Size of the Sample of Sessions Needed

It is likely to be difficult to achieve significant prediction with a skimpy sample of the alliance. This limitation was noted even when the scores were inspected for the two sessions used by the Helping Alliance Counting signs method (Luborsky et al., 1983); it seemed likely that a third or fourth session might have produced more alliance scores and probably, in consequence, higher levels of prediction. This factor has not had sufficient research attention.

INTERPRETATION OF THE ALLIANCE-OUTCOME TRENDS

Psychotherapy research has made significant advances in the past 15 years in gaining knowledge about the therapeutic alliance through the mushrooming of operational measures of the concept. The main trend in the studies is that the measures generally predict the outcomes of psychotherapy: In 24 samples of patients (within 18 different studies done since 1976), the level of prediction has mostly been about .20 to .45. The therapeutic alliance is now the most popular in-treatment factor in terms of numbers of studies significantly predictive of the outcomes of psychotherapy. The only predictive factor that has more studies is a pretreatment factor, psychological health-sickness (Luborsky et al., 1988; Luborsky, Diguer, Luborsky, et al., 1993).

In summary, the 11 factors that may influence the level of the correlations of the alliance with outcomes are as follows (see Table 2.2):

1. The type of measure, whether it is a questionnaire or an observer judgment, appears not to make much difference in the level of predictability.
2. The type of treatment does not seem to be a special factor in its predictive capacity. Although most of the studies are with dynamic therapies, the alliance is also predictive in other therapies. More studies are needed, particularly with cognitive therapy and interpersonal therapy.
3. The main points of view are all predictive (patient's, therapist's, observer's) although the patient's point of view is especially predictive.
4. In part, the positive relationship capacity of the patient provides the foundation for the alliance; the positive alliance appears to be more
predictive than the negative alliance. This is not a surprising finding, because a basically positive alliance is therapeutically desirable and therefore, when it is achieved, is associated with a positive outcome; whereas the negative alliance may, after additional therapeutic work, give way to a more positive alliance and the greater likelihood of a positive outcome.

5. The alliance's overlap with outcome measures is only partial.

6. There is more evidence for overlap of the alliance and current improvement. This overlap is no surprise because the more the patient benefits, the more likely it is that an alliance will develop; and the more the alliance develops, the more benefits are likely to accrue.

7. The therapist can facilitate the therapeutic alliance. In addition to clinical armchair evidence, there is a correlation between therapist-facilitating behaviors and the alliance. Further facilitation may also come from the patient's side—those patients who are healthier may be more able to form an alliance. Additional facilitation may come from similarities in basic demographic characteristics between patient and therapist.

8. The association of mental health with the alliance suggests that mental health facilitates the formation of the alliance.

9. The findings of correlations between the alliance and similarities of patient and therapist (Luborsky et al., 1988) suggests that similarities facilitate the formation of the alliance.

10. Variations in the time course of the alliance result in inconsistently significant predictions.

11. Variations in the size of the database used for the alliance measure make prediction difficult. Some studies probably use too-brief samples of the alliance; a larger sample would likely produce higher correlations.

Enlarged Perspectives

It is time now to stand back a bit to try to gain more perspective on the meaning of the general trend of the correlations between the alliance and outcome measures. A primary benefit of the enlarged perspective is the ability to see that the trend of the correlations between the alliance and outcome measures is not strictly confined to measures of the alliance; it is also true for other positive relationship qualities, particularly from the patient's point of view. A grand-scale corroboration of this observation is provided by a review of other positive relationship qualities (Luborsky et al., 1988, pg. 350–351); in 10 such studies, all but one was significantly predictive of outcomes of psychotherapy. The significant positive relationship qualities included "a favorable patient-therapist relationship" (Parloff, 1961), "feeling understood by the therapist" (Feitel, 1968), and "feeling less resistant" (Crowder, 1972). The alliance, therefore, is only one type of instance of the broader category of positive relationship qualities, all of which are positively related to outcomes.

Since the earliest efforts to develop operational measures of the alliance (Luborsky, 1976), it has been viewed as only one component of a broader relationship pattern that eventually was recognized to be the transference. The therapeutic alliance is only that part of the pattern of relationships having to do with the therapist and only that part having to do with the positive bonds with the therapist. Later research on the alliance and the Core Conflictual Relationship Theme (CCRT) has revealed that patients who improve in psychotherapy tend to acquire more positive expectations from others and more positive responses from the self. The therapeutic alliance reflects the positive bonds with the therapist; these bonds tend to fluctuate in tandem with positive expectations from others.

A striking added increment to the enlarged perspective is gained by standing even further back to catch more light from the theory of the curative factors in dynamic psychotherapy. Three broad curative factors have been summarized (Luborsky, 1990):

1. The necessity to establish an at least partly positive relationship with the therapist.
2. The expression by the patient of the patient's conflicts and the working out by the patient and therapist of ways of coping with them.
3. The incorporation of the gains of treatment so that they are maintained after its termination.
Of these three curative factors, the first is consistent with the main trend in the alliance research. This first factor, the establishment of an at least partly positive alliance, has gained considerable support from this review of the predictive strength of the alliance measures. In fact, much more research supports this first factor than the other two factors (Luborsky et al., 1988).

The alliance serves the patient as a "transitional object"—a supportive helpful person who is experienced as having provided and is capable of providing necessary help in achieving the patient's goals. Backing this view are the findings of Olinsky and Geller (Miller, Luborsky, Barber, & Docherty, 1993) on the development of increased representation of the therapist during psychotherapy. This review supports the conclusion that the therapist who can establish an at least partly positive alliance has fulfilled one main condition for the needed growth that typically occurs gradually during and after therapy. The other main therapeutic condition, related to the first, is the growth fostered by the working through of the relationship problems. The positive alliance ultimately is an essential curative factor that partly explains the hot-housed growth that occurs within the treatment environment.

REFERENCES


CHAPTER 3

The Therapeutic Alliance as Interpersonal Process

WILLIAM P. HENRY and HANS H. STRUPP

Our interest in the therapeutic alliance has followed a natural progression from the second author's earliest writings (Strupp, 1958) to some of our most recent research (Henry, Schacht, & Strupp, 1990). Along the way, our conceptualization and empirical study of the alliance has evolved in a manner reflecting current trends in the broader field of psychotherapy research. That is, our research on the therapeutic alliance has moved from establishing that it is important to articulating more precisely how it may be important. Although we continue to operate from a psychodynamic perspective, our thinking has moved in the direction of common factors or processes operating in all therapies. Finally, we have focused increasingly on fine-grained measurements applied to a reduced number of selected dyads as opposed to global measures applied to group designs. In this regard, we have moved from scales designed to tap the general affective and attitudinal climate of the participants to a more highly structured examination of momentary interpersonal process. The result of this progression has been to narrow the conceptualization of the therapeutic alliance or relationship (we use the terms interchangeably) to permit a more operational definition with clear, empirically supported implications for clinical theory and training.

Certain questions are fundamental to any discussion of the therapeutic alliance:

1. What is it? Is it a type of relationship, a set of behaviors, an emotional bond, a consensus on goals and tasks?
2. Is the alliance a unidimensional or multidimensional construct?
3. How does the alliance develop over time?
4. What are the relative contributions of the therapist and patient?
5. Is the alliance directly or indirectly related to therapeutic change?
6. Does the alliance serve different functions in different types of therapy or during different phases of a given therapy?