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Therapist–Patient Alliance, Patient–Therapist Alliance, Mutual Therapeutic Alliance, Therapist–Patient Concordance, and Outcome of CBT in GAD

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The therapeutic alliance is seen as an important dimension in any type of psychotherapy. But patient, therapist, or observers can have different views on the therapeutic alliance. The question is which perspective best represents the therapeutic alliance, and what are the differences between these alternative views. In the present study, the therapist–patient alliance (TPA, the view of the therapist), patient–therapist alliance (PTA, the view of the patient), and mutual therapeutic alliance (MTA, the view of an observer) were measured simultaneously in cognitive behavior therapy of patients suffering from generalized anxiety disorder. Additionally, the concordance between patient and therapist ratings (TPC) was calculated. Cognitive behavior therapists attained high positive scores in all perspectives for all dimensions of the therapeutic alliance, such as empathy, cooperation, transparency, focusing, and assurance of progress. Correlations were consistently higher for ratings between therapist and patient than between observer and patient. A relation with outcome (Hamilton Anxiety Scale) was only found for observer ratings. It was concluded that cognitive behavior therapists can achieve good alliances with their patients. Different perspectives on the therapeutic alliance should be distinguished and taken into account separately in studies on the therapeutic process and outcome.

Keywords: therapeutic alliance; therapist–patient relationship; generalized anxiety disorder; cognitive behavior therapy

The relationship between the therapist and patient is one of the primary areas of psychotherapy research. The therapeutic alliance has been investigated in various psychotherapeutic orientations and settings (Barber, 2000; Castonguay, 1996; Cottraux et al.,

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1995; Frieswyk et al., 1986; Gaston, 1991, 1998; Hartley & Strupp, 1983; Hintikka, Laukkanen, Marttunen, & Lehtonen, 2006; Hogduin, De Haan, & Schaap, 1989; Keijsers, Scraap, Hoogduin, & Lainmors, 1995; Krupnick, 1996; Loeb et al., 2005; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Malik, Bentler, Alimohamed, Gallagher-Thompson, & Thompson, 2003; Newman & Strauss, 2003; Orlinsky, Grawe, & Parks, 1994; Vogel, Hansen, Stiles, & Gotestam, 2006). More recent studies have examined the working alliance even in online psychotherapy (Knaevelsrud & Maercker, 2006).

The scientific literature suggests that the quality of the therapeutic alliance is positively related to treatment outcome and can even lead to therapeutic changes by itself. In a meta-analysis of 25 studies, Horvath and Symonds (1991) found a moderate overall effect size of .26 for the impact of the quality of the therapeutic alliance on treatment efficacy. Similarly, Martin, Garske, and Davis (2000) reported an effect size of .22 on the basis of 79 studies. However, there are also studies that did not find significant correlations between the quality of the therapeutic alliance and treatment outcome (DeRubeis, 1990; Feeley, DeRubeis, & Gelfand, 1999). This may be due to discrepant concepts of the therapeutic alliance (Dill-Standiford, Stiles, & Rorer, 1988; Horvath, 2000; Wolfe & Goldfried, 1988; Zimmer, 1983).

Different psychotherapeutic schools have different concepts of the therapeutic alliance. In psychoanalysis, transference and countertransference are held to be indispensable treatment factors (Freud, 1958), and in client-centered psychotherapy the therapeutic alliance is seen as the primary treatment element (Rogers, 1958; Schmidt-Traub, 2003; Truax & Carkhuff, 1967). Behavior therapy, in contrast, is sometimes suspected to neglect the therapeutic alliance and to be rather mechanical and less personal. There is empirical evidence that cognitive behavior therapists are more active (Greenwald, Kornblith, Hersen, Bellack, & Himmelhoch, 1981; Hardy & Shapiro, 1985; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Stiles, Shapiro, & Firth-Cozens, 1988) and more directive (Brunik & Schroeder, 1979) than other psychotherapists, but they, nevertheless, do also reach high levels of emotional support, empathy, and unconditional positive acceptance towards the patient (Keijsers, Scraap, & Hoogduin, 2000; Sloane et al., 1975; Stiles et al., 1988). From a theoretical and clinical point of view it can even be argued that in behavior therapy an especially good therapeutic alliance is needed as a prerequisite for treatment, which demands a high degree of patient cooperation and trust, as is the case in anxiety disorders treated with exposure therapy, for example. Therefore, treatment concepts and guidelines for cognitive behavior therapy all stress that therapists should be competent in technical as well as in interpersonal aspects such as empathy, warmth, cooperation, transparency, and structure (Beck, 1988; Ghaderi, 2006, Hautzinger, 2000; Hoffmann, 2000; Kanfer, Reinecker, & Schmelzer, 2000; Reinecker, 1986; Sachse, 2000; Schulte, 1998). Correspondingly in cognitive therapy, high correlations could be found between therapist competency and general therapeutic skills (Vallis, Shaw, & Dobson, 1988).

An important question in respect to differences between concepts of the therapeutic alliance has to do with who is evaluating the therapeutic alliance. Tichenor and Hill (1989) found no relationship among the patient, therapist, and observer views of the working alliance. Howard, Kopta, Krause, and Orlinsky (1986) and Marziali (1984) reported that associations with outcome are more consistent when the therapeutic alliance was assessed by the patient.

There are at least four different perspectives on the therapeutic alliance. There is the therapist–patient alliance (TPA), which reflects how the therapist sees his or her encounter with the patient. The patient–therapist alliance (PTA) reflects the same from the perspective of the patient. The mutual therapeutic alliance (MTA) refers to judgments by a third person. Finally, one can ask patient and therapist to make judgments on their relationship and then calculate their concordance (TPC).

It must be assumed that ratings on the therapeutic alliance from different perspectives are not identical and may be differently related to course and outcome of treatment. If this is true,

researchers and therapists cannot take one perspective (e.g., their own) as the sole valid description of the therapeutic alliance. It must be empirically clarified which perspective is relevant in which context (e.g., research or therapeutic process), or how different perspectives can be summarized in one score to describe the overall quality of the therapeutic alliance.

As there is a lack of research on the comparison, interrelations, and effects of these different perspectives of the therapeutic alliance, we investigated TPA, PTA, MTA, and TPC simultaneously. Goals of the study were (a) to assess all four perspectives of therapeutic alliance in routine treatment of patients suffering from generalized anxiety disorder (GAD), (b) to analyze the interrelations among these different measures of therapeutic alliance, and (c) to relate different measures of the therapeutic alliance with outcome.

Method

In a controlled clinical trial, patients with GAD were randomly assigned to either immediate cognitive–behavioral treatment (CBT-A) or to a contact control group (CCG). Patients who completed the control condition then received cognitive behavior therapy (CBT-B). The details of the design can be found in Linden, Zubraegel, Baer, and Schlattmann (2002) and Linden, Zubraegel, Baer, Wendt, and Schlattmann (2004).

Participants

Patients were suffering from GAD according to *DSM-IV* (American Psychiatric Association, 1994). The diagnosis was made by using the M.I.N.I. (Sheehan et al., 1998), a structured diagnostic interview. Patients with comorbid disorders were excluded, as were patients who had a severity score on the Hamilton Anxiety Scale (Hamilton, 1959) less than 18. No psychopharmacological treatment was allowed. Seventy-two patients were enrolled in the study ($n = 36$ per group) and 83% were women. Patients were a mean of 43.3 years old ($SD = 12.0$). During the course of treatment 15 patients dropped out. Their available data were included, where possible, in the analyses.

Treatment

Treatment was guided by a manual developed by Barlow, Rapee, and Brown (1992). Treatment was provided by 12 cognitive behavior therapists who were working full-time in their own private practices. They were a mean of 46.4 ($SD = 5.5$) years of age and had worked as behavior therapists for a mean of 10.8 years ($SD = 6.7$). All therapists were supervised in training workshops. According to the study protocol, a maximum of 25 treatment sessions were planned. This is the number of sessions that is granted as "short-term treatment" by health care insurance in Germany and that can be prolonged up to 80 sessions if necessary. Counting completers and dropouts, the mean number of sessions after the initial intake period was 21.6 ($SD = 7.8$) sessions for CBT-A and 20.8 ($SD = 8.0$) for CBT-B. Each therapy session lasted about 50 minutes and took place in the offices of the participating therapists. Duration of treatment was a mean of 44.8 weeks for CBT-A and 43 weeks for CBT-B. Protocol adherence of each therapist was ensured in several ways and shown to be good (Linden et al., 2002, 2004, 2005). Cognitive behavior therapy turned out to be an effective method in the treatment for GAD. The reduction in the Hamilton Anxiety observer rating scale (Hamilton, 1959) was a mean of 6.4% (1.5 points) in the CCG, 35.4% (9.5 points) in the CBT-A, and 47.3% (10.3 points) in the CBT-B. The differences between treatment and control groups were statistically significant. The clinical improvement remained stable over a follow-up period of 8 months. More details on design and results can be found in Linden et al. (2002, 2004).

Measurement and Analysis of the Therapeutic Alliance

After each session, the patient (PTA) and therapist (TPA) completed visual analogue scales (VAS, range: 0–100). Indicators for the quality of the relation between therapist and patient were empathy, cooperation, transparency, focusing, and assurance of progress, which were rated on VAS by therapist and patient independently of each other during the postsession assessments. All items are listed in Table 1. VAS are well-established, reliable, and economic measures for emotional judgments or ratings of mutual relationship (Fähndrich & Linden, 1982). They were used because postsession assessments had to be short and because we wanted identical ratings from patient and therapist.

TABLE 1. Items of the Session Assessment

Therapist–Patient-Alliance (TPA)		
Empathy		
The patient felt understood in this session.	vs.	The patient did not feel understood in this session.
Cooperation		
The patient and I cooperated with one another.	vs.	The patient and I did not cooperate with one another.
Transparency		
The patient understood the therapeutic procedure.	vs.	The patient did not understand the therapeutic procedure.
Structuring		
The therapeutic session had an excellent structure.	vs.	The therapeutic session was not structured at all.
Focusing		
We talked about something important for the patient.	vs.	We did not talk about something important for the patient.
Session Goal		
We attained our session goal today.	vs.	We did not attain our session goal today.
Progress		
In today's session the patient made progress.	vs.	In today's session the patient did not make any progress at all.
Patient–Therapist-Alliance (PTA)		
Empathy		
I felt understood by the therapist in this session.	vs.	I did not feel understood by the therapist in this session.
Transparency		
I understood the therapeutic procedure today very well.	vs.	I did not understand the therapeutic procedure today at all.
Focusing		
We talked about something important for me.	vs.	We did not talk about something important for me.
Progress		
In today's session I made good progress.	vs.	In today's session I did not make any progress at all.

(*Continued*)

TABLE 1. (*Continued*)

Observer Rating on Mutual Therapeutic Alliance (MTA)		
Empathy		
The patient felt understood in this session.	vs.	The patient did not feel understood in this session.
Cooperation		
The patient and the therapist cooperate with one another.	vs.	The patient and the therapist did not cooperate with one another.
Transparency		
The patient understood the therapeutic procedure.	vs.	The patient did not understand the therapeutic procedure.
Structuring		
The therapeutic session had an excellent structure.	vs.	The therapeutic session was not structured at all.
Focusing		
Patient and therapist talked about somthing important for the patient.	vs.	Patient and therapist did not talk about something important for the patient.
Progress		
In today's session the patient made progress.	vs.	In today's session the patient did not make any progress at all.

The observer ratings on the MTA were done after listening to tape recordings of the therapeutic sessions. The observer rating form was similar to the postsession rating forms for the patient and therapist (Table 1). Ratings were done by seven psychologists who were not involved in treatment. They were in advanced postgraduate training to become behavior therapists and were specially trained to make the ratings in the present study. The audiotapes were all double-rated, resulting in 147 observer ratings. The intraclass correlation coefficient among raters was ICC_{just} = .43 and Cronbach's alpha = .61. These are only moderately high scores, reflecting the difficulty and complexity of such assessments.

Results

Tables 2–4 show the results of patient, therapist, and observer ratings of the therapeutic alliance at three times in the course of therapy (Time 1 = 2nd therapy session, Time 2 = 8th therapy session, Time 3 = 20th therapy session). Scores on the VAS ranged from 34 to 88. Observer ratings of therapeutic alliance, for example, ranged from 34 to 88 (*SD* = 13–28), with progress falling outside range with 34 to 59 (*SD* = 22–25). However, *progress* was the only item showing a significant improvement over the course of time of therapy in the view of the therapist ($p = .002$), of the patient ($p < .001$), and of the observer ($p < .001$).

Pearson correlations among the different items are presented in Tables 5–7, using the data of the third assessment as an example. Most correlations were significant.

Table 8 shows differences and correlations between patient, therapist, and observer in respect to the same aspects of the therapeutic concordance, again using the third assessment as an example. Differences ranged from –2.5 to 17.5. They were smallest between therapist and patient. Minimum and maximum value of differences are additionally presented, which shows the direction and the amount of differences for each variable. Correlations between patient, therapist, and

TABLE 2. Therapist's Perspective on Components of the Therapeutic Alliance

	Mean (*SD*)			ANOVA Time (Time 1–Time 3)	
	Time 1 $N = 51$	Time 2 $N = 55$	Time 3 $N = 55$	F	p
Focusing	76 (15)	80 (13)	81 (11)	2.75	.069
Cooperation	80 (13)	78 (17)	78 (16)	0.52	.599
Empathy	74 (17)	77 (15)	72 (20)	1.51	.225
Transparency	69 (23)	77 (17)	73 (19)	0.41	.666
Structuring	76 (19)	71 (19)	73 (20)	0.18	.833
Session goal	75 (20)	67 (23)	67 (25)	3.87	.024
Progress	52 (16)	62 (19)	64 (20)	6.80	.002

TABLE 3. Patient's Perspective on Components of the Therapeutic Alliance

	Mean (*SD*)			ANOVA Time (Time 1–Time 3)	
	Time 1 $N = 50$	Time 2 $N = 55$	Time 3 $N = 55$	F	p
Focusing	81 (16)	85 (14)	86 (11)	1.95	.149
Empathy	78 (20)	78(19)	85 (13)	2.99	.055
Transparency	78 (20)	80 (20)	85 (15)	0.91	.407
Progress	52 (19)	65 (22)	66 (22)	10.66	$<.001$

TABLE 4. Observer's Perspective on Components of the Therapeutic Alliance

	Mean (*SD*)			ANOVA Time (Time 1–Time 3)	
	Time 1 $N = 49$	Time 2 $N = 50$	Time 3 $N = 48$	F	p
Focusing	86 (16)	88 (10)	85 (13)	0.23	.799
Cooperation	80 (21)	80 (21)	75 (22)	1.04	.358
Empathy	83 (20)	79 (21)	77 (20)	2.42	.096
Transparency	70 (23)	71 (23)	65 (28)	0.23	.792
Structuring	76 (19)	67 (28)	60 (30)	3.20	.047
Progress	59 (25)	34 (22)	47 (24)	9.14	$<.001$

observer ratings were generally nonsignificant. Only the ratings of transparency from therapist and patient were significantly related ($r = .37$).

A regression analysis was conducted to test for relations between therapeutic alliance and outcome, using the initial and the final assessment of the Hamilton Anxiety Scale (Table 9). Predictors were the average scores of the three different perspectives (MTA, PTA, TPA), and the dependent variable was the percentage improvement from the initial to the final score of the Hamilton

TABLE 5. Pearson Correlations Among Items Assessed at Time 3 (20th Therapy Session): Therapist Items

	Empathy	Transparency	Focusing	Progress	Cooperation	Structure	Session Goal
Empathy	—	.64**	.27*	.60**	.65**	.42**	.47**
Transparency		—	.32*	.68**	.70**	.28*	.69**
Focusing			—	**.22**	.29*	.37**	.30*
Progress				—	.58**	.50**	.68**
Cooperation					—	.18	.61**
Structure						—	.53**
Session goal							—

*$p < .01$. **$p < .001$.

TABLE 6. Pearson Correlations Among Items Assessed at Time 3 (20th Therapy Session): Patient Items

	Empathy	Transparency	Focusing	Progress
Empathy	—	.58**	.49*	.30**
Transparency		—	.69*	.23**
Focusing			—	.11
Progress				—

*$p < .01$. **$p < .001$.

TABLE 7. Pearson Correlations Among Items Assessed at Time 3 (20th Therapy Session): Observer Items

	Empathy	Structure	Transparency	Focusing	Progress	Cooperation
Empathy	—	.22	.49**	.63**	–.29*	.69**
Structure		—	.71**	.08	–.52**	.31*
Transparency			—	.31*	–.69**	.56**
Focusing				—	–.18	.54**
Progress					—	–.54**
Cooperation						

*$p < .01$. **$p < .001$.

Anxiety Scale. Results showed that MTA explained a significant portion of variance of outcome. We also tested by regression analysis whether differences between patient and therapist judgments about their relationship (TPC) can explain outcome (Table 10). No significant result emerged.

Discussion

The present study simultaneously assessed TPA, PTA, MTA, and TPC using a controlled clinical trial on cognitive behavior therapy for GAD. Our data and analysis are descriptive rather than experimental. Nevertheless, several important conclusions can be drawn. Results showed that cognitive behavior therapists manage to generate high positive scores in all aspects of the therapeutic alliance, such as empathy, transparency, focusing, structuring, assurance of progress, and cooperation. This was indicated by observer, patient, and therapist ratings. Our results support findings from other

TABLE 8. Concordance of Ratings Between Different Perspectives Rated at Time 3 (20th Therapy Session)

	N	min	max	M_{diff}	*SD*	Pearson *r*
Patient and therapist						
Empathy	57	–26.0	72	13.5	20.5	.23
Transparency	57	–75.0	61	10.1	20.3	.37**
Focusing	57	–69.0	45	2.9	17.0	.07
Progress	57	–68.0	50	1.8	27.1	.15
Observer and therapist						
Empathy	47	–45.0	75.0	–5.8	27.5	.03
Transparency	47	–76.0	77.0	8.9	31.8	.10
Focusing	47	–50.0	33.0	–2.5	17.6	–.15
Progress	47	–63.0	58.0	9.5	29.1	–.12
Observer and patient						
Empathy	47	–60.0	34.0	7.5	23.2	.01
Transparency	47	–89.0	31.0	17.5	30.0	.13
Focusing	47	–43.0	53.0	–0.9	18.6	.17
Progress	47	–76.0	40.0	10.7	32.2	–.01

Note. *N* = number of available and analyzed therapy sessions; M_{diff} = mean of the difference between the ratings **$p < .001$.

TABLE 9. Summary of Linear Regression Analysis for Alliance Variables Predicting Treatment Outcome

Included variable	B	SE B	β	*t*	*p*
MTA	–2.63	1.22	–.201	–2.14	.037*
Excluded variable	β	*t*	*p*	Pr	Collinearity
PTA	–.030	–.292	.771	–.040	.825
TPA	–.157	–1.64	.106	–.218	.938

Note. $R^2 = .52$, $F(1, 55) = 29.38$. Variables included (independent): average score MTA, average score PTA, average score TPA. Criterion variable (dependent): Hamilton Anxiety Scale % improvement.
*$p < .05$.

studies showing that behavior therapists attain high levels of emotional support, empathy, and unconditional positive regard (Keijsers et al., 2000; Sloane et al., 1975; Stiles et al., 1988).

The alliance scores remained high throughout the course of treatment. This suggests that therapeutic alliance is a robust characteristic of the psychotherapeutic relationship and not dependent on single sessions or the course of time. Only for the *progress* item did we find a significant improvement over time, which suggests a growing confidence in the outcome of treatment with the longer duration of treatment.

In addition to subjective ratings on the therapeutic alliance, the concordance between ratings of patient and therapist was calculated, which can be understood as an objective measure of their agreement (Bordin, 1979). The smallest differences were between therapist and patient ratings. The concordant ratings can be understood as a form of external mutual validation, and can also be seen as an indicator for a good therapeutic relationship. The difference for *empathy* was

TABLE 10. Summary of Linear Regression Analysis for Concordance Variables Predicting Treatment Outcome

Included Variable	B	SE B	β	*t*	*p*
Average difference therapist/patient	–6.79	6.15	–.163	–1.11	.274
Average difference therapist/patient	3.94	6.26	.095	.630	.531
Average difference therapist/patient	–1.47	6.71	–.030	–.229	.828

Note. $R^2 = .02$, F (3, 54)= 0.44. Variables included (independent): average difference therapist/patient, average difference observer/patient, average difference observer/therapist. Criterion variable (dependent): Hamilton Anxiety Scale % improvement.

highest, which seems to be the most sensitive item. The observer–patient and observer–therapist differences were greater than the patient–therapist differences. The observer differences ranged between –2.5 and 17.5. Observer and therapist as well as patient agreed most in respect to *focusing*; that is, they agreed on the importance of the content of therapy. They disagreed most in respect to *progress*. Observers saw less progress than therapist or patient, which might have been due to their different involvement in the treatment process. Observers can be neutral. Therapist and patient want treatment to have a positive outcome.

There were few positive correlations over the different assessors, which speaks for the interpretation that patients, therapists, and observers have different points of reference when rating the therapeutic alliance.

There was a significant correlation between observer ratings on the therapeutic alliance and treatment outcome. There were no correlations between ratings of patient or therapist and outcome, including the "objective" measure TPC. This is in contrast to previous research, which found that patient ratings can predict outcome (Howard et al., 1986; Keijsers et al., 2000; Marziali, 1984). An explanation could be that in our study the ratings on the outcome of treatment were done by independent raters also. Although outcome and therapeutic alliance were rated by different persons, they were both neutral raters who were not involved in the treatment process. The assumption is that external raters see similar phenomena, which are different from what therapists and patients see.

The results of this study illustrate the different components of the therapeutic alliance. When one takes into account the different perspectives, the seemingly simple construct of "therapeutic alliance" becomes very complex. The results suggest that it is necessary to differentiate among TPA, PTA, MTA, and TPC. This is true for research and clinical practice. Therapists should be aware that their view on the therapeutic interaction is only one among others.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of disorders* (4th ed.). Washington, DC: Author.

Barber, J. P. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology, 68,* 1027–1032.

Barlow, D. H., Rapee, R. M., & Brown, T. A. (1992). Behavioral treatment of generalized anxiety disorder. *Behavior Therapy, 23,* 551–570.

Beck, A. T. (1988) *Love is never enough.* New York: Harper & Row.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252–260.

Brunik, S. A., & Schroeder, H. E. (1979). Verbal therapeutic behavior of expert psychoanalytically oriented, gestalt, and behavior therapists. *Journal of Consulting and Clinical Psychology, 47,* 567–574.

Castonguay, L. G. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64,* 497–504.

Cottraux, J., Note, I. D., Cungi, C., Légeron, P., Heim, F., Chneiweiss, L., et al. (1995). A controlled study of cognitive-behavior therapy with buspirone or placebo in panic disorder with agoraphobia. A one year follow-up. *British Journal of Psychiatry, 167,* 635–641.

DeRubeis, R. J. (1990). How does cognitive therapy work? Cognitive change and symptom change in cognitive therapy and pharmacotherapy for depression. *Journal of Consulting and Clinical Psychology, 58,* 862–869.

Dill-Standiford, T. J., Stiles, W. B., & Rorer, L. G. (1988). Counselor and client agreement on session impact. *Journal of Counseling Psychology, 35,* 47–55.

Fähndrich, E., & Linden, M. (1982). Zur reliabilität und validität der stimmungsmessung mit der visuellen analog-skala (VAS). *Pharmacopsychiatria, 15,* 90–94.

Feeley, M., DeRubeis, R. J., & Gelfand, L. A. (1999). The temporal relation of adherence and alliance to symptom change in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 67,* 578–582.

Freud, S. (1958). On beginning the treatment: Further recommendations on the technique of psychoanalysis. In J. Stachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12). London: Hogarth Press. (Original work published in 1913.)

Frieswyk, S. H., Allen, J. G., Colson, D. B., Cayne, L., Gibbard, G. O., Horwitz, C. G., et al. (1986). Therapeutic alliance: Its place as a process and outcome variable in dynamic psychotherapy research. *Journal of Consulting and Clinical Psychology, 54,* 32–38.

Gaston, L. (1991). Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy processes. *Psychotherapy Research, 1,* 104–112.

Gaston, L. (1998). Alliance, technique, and their interactions in predicting outcome of behavioral, cognitive and brief therapy. *Psychotherapy Research, 8,* 190–209.

Ghaderi, A. (2006). Does individualization matter? A randomized trial of standardized (focused) versus individualized (broad) cognitive behaviour therapy for bulimia nervosa. *Behaviour Research Therapy, 44,* 273–288.

Greenwald, D. P., Kornblith, S. J., Hersen, M., Bellack, A. S., & Himmelhoch, J. M. (1981). Differences between social skill therapists and psychotherapists in treating depression. *Journal of Consulting and Clinical Psychology, 49,* 757–759.

Hamilton, M. (1959). The assessment of anxiety states by rating. *British Journal of Medical Psychology, 32,* 50–55.

Hardy, G. E., & Shapiro, D. A. (1985). Therapist response modes in prescriptive vs. exploratory psychotherapy. *British Journal of Clinical Psychology, 24,* 235–245.

Hartley, D. E., & Strupp, H. (1983). The therapeutic alliance and its relation to outcome in brief psychotherapy. In J. M. Masling (Ed.), *Empirical studies of psychoanalytic theories* (pp. 1–37). Hillsdale, NJ: Erlbaum.

Hautzinger, M. (2000). *Kognitive verhaltenstherapie bei depressionen. behandlungsleitlinien und materialien.* Weinheim: Beltz Psychologie Verlags Union.

Hintikka, U., Laukkanen, E., Marttunen, M., & Lehtonen, J. (2006). Good working alliance and psychotherapy are associated with positive changes in cognitive performance among adolescent psychiatric inpatients. *Bulletin of the Menninger Clinic, 70,* 316–335.

Hoffmann, N. (2000). Strukturierung des therapieablaufs. In M. Linden & M. Hautzinger (Eds.), *Verhaltenstherapie: Techniken, einzelverfahren und behandlungsanleitungen.* Berlin: Springer.

Hogduin, C. A. L., De Haan, E., & Schaap, C. (1989). The significance of patient-therapist relationship in the treatment of obsessive-compulsive disorder. *British Journal of Clinical Psychology, 28,* 185–186.

Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology, 56,* 163–173.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139–149.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41,* 159–164.

Kanfer, F. H., Reinecker, H., & Schmelzer, D. (2000). *Selbstmanagement-therapie.* Berlin: Springer.

Keijsers, G. P. J., Scraap, C. P. D. R., Hoogduin, C. A. L., & Lainmers, M. W. (1995). Patient-therapist interaction in the behavioral treatment of panic disorder with agoraphobia. *Behavior Modification, 19,* 491–517.

Keijsers, G. P. J., Scraap, C. P. D. R., & Hoogduin, C. A. L. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive-behavior therapy. A review of empirical studies. *Behavior Modification, 24,* 264–297.

Knaevelsrud, C., & Maercker, A. (2006). Does the quality of the working alliance predict treatment outcome in online psychotherapy for traumatized patients? *Journal of Medical Internet Research, 8,* e31.

Krupnick, J. L. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64,* 532–539.

Linden, M., Staats, M., Bär, T. & Zubrägel, D. (2005). The assessment of treatment strategy in cognitive behavior therapy: Using the Pivotal Topic Measure. *Psychotherapy Research, 15,* 382–391.

Linden, M., Zubraegel, D., Baer, T., Wendt, U., & Schlattmann, P. (2004). Efficacy of cognitive behaviour therapy in generalized anxiety disorders. Results of a controlled clinical trial (Berlin CBT-GAD-Study). *Psychotherapy and Psychosomatics, 74,* 36–42.

Linden, M., Zubrägel, D., Bär, T., & Schlattmann, P. (2002). Wirksamkeit der kognitiven verhaltenstherapie bei generalisierten angsterkrankungen—Ergebnisse der Berliner KVT-GAD-Studie. *Verhaltenstherapie, 12,* 173–181.

Loeb, K. L., Wilson, G. T., Labouvie, E., Pratt, E. M., Hayaki, J., Walsh, B. T., et al. (2005). Therapeutic alliance and treatment adherence in two interventions for bulimia nervosa: A study of process and outcome. *Journal of Consulting and Clinical Psychology, 73,* 1097–1107.

Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien C. P., & Auerbach A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42,* 602–611.

Malik, M. L., Bentler, L. E., Alimohamed, S., Gallagher-Tompson, D., & Thompson, L. (2003). Are all cognitive therapies alike? A comparison of cognitive and noncognitive therapy process and implications for application of empirically supported treatments. *Journal of Consulting and Clinical Psychology, 71,* 150–158.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438–450.

Marziali, E. (1984). Three viewpoints on the therapeutic alliance. *Journal of Nervous and Mental Disease, 172,* 417–423.

Newman, C. F., & Strauss, J. L. (2003). When clients are untruthful. Implications for the therapeutic alliance, case conceptualization, and intervention. *Journal of Cognitive Psychotherapy, 17,* 241–252.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy—noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 270–376). New York: Wiley.

Reinecker, F. H. (1986). Grundlagen verhaltenstherapeutischer methoden. In H. Reinecker (Ed.), *Verhaltenstherapie.* Berlin: Springer.

Rogers, C. R. (1958). The characteristics of a helping relationship. *Personnel and Guidance Journal, 37,* 6–16.

Sachse, R. (2000). Empathie. In M. Linden & M. Hautzinger (Eds.), *Verhaltenstherapie: Techniken, einzelverfahren und behandlungsanleitungen* (pp. 25–31). Berlin: Springer.

Schmidt-Traub, S. (2003). Therapeutische beziehung—Ein überblick. *Psychotherapeutische Praxis, 3,* 111–129.

Schulte, D. (1998). *Therapieplanung.* Göttingen: Hogrefe Verlag für Psychologie.

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., et al. (1998). The mini-international neuropsychiatric interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry, 59*(Suppl. 20), 22–33.

Sloane, R. B., Staples, F. R., Cristol, A. H., Yorkston, N. J., & Whipple, K. (1975). Short-term analytically oriented psychotherapy versus behavior therapy. *American Journal of Psychiatry, 132,* 373–377.

Stiles, W. B., Shapiro, D. A., & Firth-Cozens, J. A. (1988). Verbal response mode use in contrasting psychotherapies: A within-subjects comparison. *Journal of Consulting and Clinical Psychology, 56,* 727–733.

Tichenor, V. U., & Hill, C. E. (1989). A comparison of six measures of working alliance. *Psychotherapy, 26,* 195–199.

Truax, C., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy: Training and practice.* Chicago: Aldine.

Vallis, T. M., Shaw, B. F., & Dobson, K. S. (1986). The Cognitive Therapy Scale: Psychometric properties. *Journal of Consulting and Clinical Psychology, 54,* 381–385.

Vogel, P. A., Hansen, B., Stiles T. C., & Gotestam, K. G. (2006). Treatment motivation, treatment expectancy, and helping alliance as predictors of outcome in cognitive behavioral treatment of OCD. *Journal of Behavior Therapy and Experimental Psychiatry, 37,* 247–255.

Wolfe, B. E., & Goldfried, M. R. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology,* 56, 448–451.

Zimmer, D. (1983). *Die therapeutische beziehung: Konzepte, empirische befunde und prinzipien ihrer gestaltung.* Weinheim: Beltz Psychologie Verlags Union.

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