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ORIGINAL ARTICLE

Spanish adaptation of the Revised Helping Alliance Questionnaire (HAq-II)

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Abstract

Background: The working or helping alliance is one of the most widely studied constructs in psychotherapy process research.
Aim: The aim of this study was to adapt the patient and therapist forms of the Revised Helping Alliance Questionnaire II (HAq-II-P and HAq-II-T, respectively) into Spanish.
Method: The two measurement instruments were adapted through a systematic translation process, a pilot study and a clinical study. The psychometric properties were examined following the third psychotherapy session.
Results: Mean scores on the Spanish-language HAq-II-P and HAq-II-T were high. The corrected item-total correlations for >94% of the items were >0.30. Cronbach's α values for internal consistency were 0.88 and 0.93, respectively. Correlations for convergent validity with the respective versions of the Spanish-language Working Alliance Inventory were 0.80 and 0.87, respectively. In terms of predictive validity, there was a significant correlation between HAq-II-T and the patients' residual gain scores on the Spanish-language Beck Depression Inventory after the tenth psychotherapy session.
Conclusions: These results are consistent with studies using the original English versions of the HAq-II.

Keywords

HAq-II, Revised Helping Alliance Questionnaire, Spanish adaptation, working alliance

History

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Introduction

One of Luborsky's best-known conceptual contributions is the helping alliance (Luborsky, 1976), which is ''broadly defined as the patient's experience of the treatment or relationship with the therapist as helpful or potentially helpful'' (Alexander & Luborsky, 1986, p. 326). According to Luborsky (1994), there are two types of helping alliance. A type 1 alliance is characterized by the patient's perception of the therapist as a person who is able to help and support them. A type 2 alliance is characterized by teamwork between the patient and therapist, which is conducive to resolving the patient's problems.

One well-known measurement is The Helping Alliance Questionnaire (HAq; Alexander & Luborsky, 1986). It consists of 11 items, with eight and three measuring the type 1 and type 2 alliances, respectively. The patient responds to these 11 items using a Likert scale to assign a score between −3 and +3. The HAq also includes two open questions for the patient to evaluate the changes they have undergone and one item to estimate the degree of improvement. The HAq was revised by Luborsky et al. (1996), who eliminated six items relating to patient improvement and added 14 new items that capture different aspects of the alliance outlined by Bordin (1979) and Luborsky (1976). The revised versions for patients (HAq-II-P) and therapists (HAq-II-T) contain 19 items each (14 and 5 written in a positive and negative sense, respectively) that patients and therapists respond to using a Likert scale from 1 to 6 (Luborsky et al., 1996).

The HAq-II-P and the HAq-II-T have favorable psychometric properties. In a sample of 246 patients with cocaine dependence, Luborsky et al. (1996) found that internal consistency reliability for both questionnaires was excellent: after psychotherapy sessions 2, 5 and 24, Cronbach's α coefficients were 0.90, 0.90, and 0.93, respectively for the HAq-II-P, and 0.93, 0.90, and 0.91, respectively for the HAq-II-T. These findings were confirmed by later studies (e.g. Crits-Christoph et al., 2009; Petry et al., 2010; Ruglass et al., 2012). In addition, Luborsky et al. (1996) showed that test-retest coefficients for the HAq-II-P and HAq-II-T between sessions 2 and 5 were 0.78 ($p < 0.001$) and 0.56 ($p < 0.001$), respectively.

With regard to convergent validity, at sessions 2, 5 and 24 the total scores of the HAq-II-P correlated with those of the patient version of the California Psychotherapy Alliance Scale (CALPAS-P; Gaston, 1991; Gaston & Marmar, 1994) (0.59, 0.68, and 0.69, respectively; $p < 0.001$), and total scores of the HAq-II-T correlated with those of the therapist version of the

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same scale (CALPAS-T) (0.79, 0.79, and 0.75, respectively; $p < 0.001$) (Luborsky et al., 1996). In terms of discriminant validity, the HAq-II-P did neither correlate with five demographic variables nor with different pre-treatment measures of psychiatric dysfunction and drug use. Regarding factorial validity, principal component analysis of the HAq-II-P showed that positive therapeutic alliance (items 1, 2, 3, 5, 6, 7, 9, 10, 12, 13, 15, 17 and 18) and negative therapeutic alliance (items 4, 8, 16 and 19) accounted for most of the variance (Luborsky et al., 1996). However, they presented results for the entire HAq-II-P (19 items) because of the high correlation between these two factors and the high internal consistency of the entire questionnaire.

Turning to criterion validity, and specifically concurrent validity, Luborsky et al. (1996) found that after the fifth session, alliance as measured by the HAq-II-P negatively correlated with the number of times the patients had used cocaine (-0.18, $p < 0.05$). Subsequent research reviewed in a meta-analysis by Horvath et al. (2011) revealed that the HAq-II-P and HAq-II-T correlated reasonably well with the outcome of different psychotherapeutic interventions.

The aim of the present study was to adapt the HAq-II-P and the HAq-II-T into Spanish because both measures proven useful in research carried out in English. As with the original versions, it is expected that the Spanish-language HAq-II-P and HAq-II-T will show satisfactory degrees of reliability and validity.

Methods

To adapt the HAq-II, we used data from samples of patients and therapists who participated in the pilot and clinical studies carried out to adapt the Working Alliance Inventory (WAI) into Spanish (Andrade-González & Fernández-Liria, 2015). Thus, the information presented below regarding the demographic characteristics of patients and therapists, the treatment received by patients in both studies, most of the measures applied, and the procedure used in this adaptation of the HAq-II all correspond to the aforementioned Spanish adaptation of the WAI.

Legal requirements

Professor Jacques P. Barber of Adelphi University, New York, authorized us to adapt the HAq-II into Spanish.

Translation of the HAq-II-P and HAq-II-T into Spanish

The original English versions of the HAq-II-P and HAq-II-T were translated into Spanish using a forward-back translation process by two bilingual professional Spanish translators who were taught the basic concepts of psychotherapy and the helping alliance. Both questionnaires were translated into Spanish by one translator, and then they were back translated into English by the other translator. Both translators compared the syntax and semantics of the back translations with the original questionnaires and concluded that they were quite similar. Five Spanish experts in psychotherapy then evaluated the preliminary Spanish versions of these questionnaires. Two criteria were agreed upon for the translated instructions and questionnaire items to be acceptable: (1) they were understood with a rating of 10 (on a scale of 0–10) by all five experts and (2) no corrections were submitted by those experts. The measures' instructions, as well as 11 HAq-II-P items (58%) and 14 HAq-II-T items (74%), met these two conditions. The rest of the items were reformulated according to the experts' corrections and re-reviewed. Four items from the HAq-II-P and one from the HAq-II-T passed the second review. The remaining items were judged to be doubtful (items 1, 14, 15 and 16 of the HAq-II-P and HAq-II-T). An improved translation was agreed upon by the translators and the main author of this research. Lastly, two linguists from the University of Alcalá reviewed both measures and confirmed that both translations would be understood by most Spaniards.

Pilot study

Ten outpatients suffering from depressive disorders received individual psychotherapy from 10 integrative therapists at three Spanish public healthcare clinics. After the third session, the patients and clinicians completed the Spanish-language HAq-II-P and HAq-II-T, respectively. The patients and therapists were not aware of each other's responses.

Seventeen items (89.5%) from the Spanish-language HAq-II-P and 17 (89.5%) from the Spanish-language HAq-II-T obtained corrected item-total correlations >0.30. The respective Cronbach's α values for the Spanish-language HAq-II-P and HAq-II-T were 0.86 and 0.91. The therapists did not express difficulty understanding these measures. Based on these results, it was decided that the instructions and items would not need to be rewritten. In addition, the translators, main author of this paper, and linguists from the University of Alcalá reported that the four items (two from each version) with corrected item-total correlations <0.30 could be understood by most Spaniards (Andrade-González, 2009).

Clinical study

Participants

Thirty-six outpatients participated in the study before treatment and after their third psychotherapy session. Of these, 30 completed the assessments after the tenth session. All of the patients received treatment in Spanish public healthcare clinics; they did not receive any remuneration for taking part in this research. The average age of the 36 initial patients was 42.4 years ($SD = 10.56$; range = 19–62 years), and 30 (83.3%) were female. According to their therapists, 31 (86.1%) met the Diagnostic and Statistical Manual of Mental Disorders IV Text Revision (DSM-IV-TR; American Psychiatric Association, 2002) diagnostic criteria for a major depressive disorder (single or recurrent episode with no psychotic or catatonic symptoms), and five (13.9%) met the criteria for a dysthymic disorder. Of the 36 initial patients, 20 (55.5%) lived with a partner and 16 (44.5%) did not. Regarding education level, 16 (44.5%) had university qualifications, 13 (36.1%) completed high school and 7 (19.4%) finished primary school.

Twenty-one therapists took part in the study before treatment and after the third psychotherapy session. Sixteen of them participated after the tenth session. All were clinicians employed by the Spanish Public Healthcare

System. The average age of the initial 21 therapists was 35 years ($SD = 10.00$; range = 24–54 years). Eleven (52.4%) were male. Thirteen of the therapists (62%) were initially trained in medicine and eight (38%) in psychology. In terms of theoretical orientation, 15 therapists (71.4%) defined themselves as integrative, 3 (14.3%) as interpersonal (interpersonal psychotherapy for depression), 2 (9.5%) as cognitive behavioral and 1 (4.8%) as humanistic. The average clinical experience of the 21 clinicians as psychotherapists was 8.33 years ($SD = 9.23$; range = 1–29 years). Six of the 21 clinicians were residents enrolled in a postgraduate program in psychiatry, and four were residents enrolled in a postgraduate program in clinical psychology. The 21 therapists who participated before treatment and after the third session treated 2.25 patients on average, and the 16 therapists participating after the tenth session treated an average of 1.88 patients.

Treatment

The outpatients received individual hour-long psychotherapy sessions as their main treatment. For the first three sessions, 30 patients were treated with integrative psychotherapy, 3 with interpersonal psychotherapy for depression, 2 with cognitive behavioral psychotherapy and 1 with humanistic psychotherapy. Three patients treated with integrative psychotherapy and one who received humanistic psychotherapy subsequently dropped out of treatment. In addition, two patients receiving integrative psychotherapy were excluded from the data analysis as their therapist was transferred to another clinic. The patients were not randomly assigned to these treatment conditions. This research only considered patient and therapist ratings carried out until the end of the tenth psychotherapy session.

Measures

The following instruments were used to adapt the HAq-II into Spanish:

Spanish-language Revised Helping Alliance Questionnaire, Patient form (HAq-II-P): The HAq-II-P (Luborsky et al., 1996) measures the alliance as perceived by the patient. It includes 19 items with six possible responses ranging from 1 (strongly disagree) to 6 (strongly agree). Items 4, 8, 11, 16 and 19 are written in negative form. Prior to calculating the HAq-II-P total score (the score sum of the 19 items), the five negative item scores must be inverted. The range of overall HAq-II-P scores is between 19 and 114 points. The Spanish-language HAq-II-P items are found in Appendix A.

Spanish-language Revised Helping Alliance Questionnaire, Therapist form (HAq-II-T): The HAq-II-T (Luborsky et al., 1996) measures the alliance as perceived by the therapist. The HAq-II-T has 19 items with six possible responses ranging from 1 (strongly disagree) to 6 (strongly agree). Items 4, 8, 11, 16 and 19 are written in negative form. The total HAq-II-T score is calculated in the same manner as the HAq-II-P. The range of overall HAq-II-T scores is between 19 and 114 points. The Spanish-language HAq-II-T items are listed in Appendix B.

Spanish-language Working Alliance Inventory, Patient form (WAI-P; Andrade-González & Fernández-Liria, 2015*)*: The Working Alliance Inventory (WAI; Horvath, 1981; Horvath & Greenberg, 1986, 1989) measures the working alliance according to Bordin's model (1979) by assessing: (1) the bond between patient and therapist (which includes mutual trust and respect for each other), (2) agreement between the patient and therapist about the goals of psychotherapy, and (3) agreement between them regarding psychotherapy tasks. The WAI-P measures the alliance as perceived by the patient using 36 items spread across three subscales (Bond, Goal and Task) with 12 items each. The patient responds to each item using a Likert scale with seven possible responses ranging from 1 (never) to 7 (always). The range of overall scores is between 36 and 252 points. The psychometric properties of the Spanish adaptation of the WAI-P are similar to those of the English version (Andrade-González & Fernández-Liria, 2015).

Spanish-language Working Alliance Inventory, Therapist form (WAI-T; Andrade-González & Fernández-Liria, 2015*)*: The WAI-T (Horvath, 1981; Horvath & Greenberg, 1986, 1989) measures the alliance as perceived by the therapist using 36 items spread across three subscales (Bond, Goal and Task) with 12 items each. The therapist responds to each item using a Likert scale with seven possible responses ranging from 1 (never) to 7 (always). Overall scores on the WAI-T range from 36 to 252 points. The psychometric properties of the Spanish adaptation of the WAI-T are similar to those of the English version (Andrade-González & Fernández-Liria, 2015).

Beck Depression Inventory (BDI), revised version (Beck et al., 1979*; Beck & Steer,* 1993*), Spanish adaptation (Sanz & Vázquez,* 1998*; Vázquez & Sanz,* 1997, 1999: The revised BDI measures depression intensity using 21 items with four possible responses ranging from 0 to 3. The range of overall scores on the BDI is between 0 and 63 points. The Spanish adaptation of the revised BDI has shown satisfactory reliability and validity (Sanz & Vázquez, 1998; Vázquez & Sanz, 1997, 1999). In the present study, Cronbach's α values obtained for the BDI before treatment and after the third and tenth psychotherapy sessions were 0.82, 0.90 and 0.91, respectively.

Procedure

The database resulting from the clinical study to adapt the WAI into Spanish (Andrade-González & Fernández-Liria, 2015) was used. Before treatment, patient BDI scores (used as a screening instrument) were used along with the data provided by patients and therapists on their respective demographic data sheets. After the third psychotherapy session, patient data from the BDI, HAq-II-P and WAI-P, and therapist data from the HAq-II-T and WAI-T were used. Finally, after the tenth session, patient data from the BDI was used.

Data analysis

Statistical analyses were carried out using the Statistical Package for the Social Sciences (IBM SPSS Statistics 20, Armonk, NY, USA: IBM Corp.) and R (R 2.15.1, Vienna, Austria: R Foundation) software. The scores of negative items from the HAq-II-P, HAq-II-T, WAI-P and WAI-T were inverted. One therapist who did not respond to any of the HAq-II-T items was excluded from the data analysis.

The small amount of data lost for various measures was replaced with the participant's average score on the corresponding subscale or scale. Two variables were dichotomized: marital status of patients (coded as married/cohabiting or otherwise) and therapists' initial training (medicine or psychology). The patients' residual gain scores on the BDI ($n = 30$) was examined using the Shapiro-Wilk test and showed a normal distribution. The homoscedasticity of all variables was inspected using Levene's test. The null hypothesis of homogeneity of variance was not rejected for any variable. The corrected item-total correlations for HAq-II-P and HAq-II-T items were obtained by correlating the scores on each item with the total score on the corresponding measure minus that item. Cronbach's α was used to determine the reliability (internal consistency) of these measures. The convergent validity of the HAq-II-P and HAq-II-T was determined by correlating both measures with the WAI-P and WAI-T, respectively, after the third psychotherapy session. Their discriminant validity was estimated by correlating the two versions of the HAq-II with some patient and therapist variables. The correlations between the HAq-II-P and three patient demographic variables were calculated, as were correlations between the HAq-II-P and patient BDI scores before treatment. Likewise, the correlations between the HAq-II-T and two therapist demographic variables were calculated, as well as those between the HAq-II-T and the therapists' initial training. A linear regression analysis was carried out to measure patients' change on the BDI after the tenth psychotherapy session; the dependent and independent variables were their BDI scores at the end of the tenth session and before treatment, respectively. This generated a new variable: an unstandardized residual BDI score ($M = 0.00$; $SD = 0.46$) that reflected patients' BDI scores after the tenth session of psychotherapy regardless of their pre-treatment scores. In relation to the criterion validity of the HAq-II-P and HAq-II-T, their predictive validity was determined by correlating the scores on the two measures after the third session with patient residual gain scores on the BDI after the tenth session. Pearson's coefficient was used to calculate the correlations for the convergent, discriminant and predictive validities of the HAq-II-P and HAq-II-T.

Results

Mean scores, corrected item-total correlations and reliability

The mean scores on the Spanish-language HAq-II-P and HAq-II-T were 5.24 ($SD = 0.57$) and 4.96 ($SD = 0.59$), respectively. Eighteen items (94.7%) from the Spanish-language HAq-II-P and HAq-II-T obtained corrected item-total correlations >0.30. Only item 17 of the HAq-II-P obtained a correlation of 0.22, and only item 11 of the HAq-II-T obtained a correlation of 0.30 (Table 1). In terms of reliability (internal consistency), Cronbach's α values for the HAq-II-P and HAq-II-T were 0.88 and 0.93, respectively.

Construct validity and criterion validity

Regarding the convergent validity of the Spanish-language HAq-II-P and HAq-II-T, the correlations between HAq-II-P and WAI-P (total and subscales) were ≥0.73 ($p < 0.01$), while the correlations between the HAq-II-T and WAI-T (total and subscales) were ≥0.78 ($p < 0.01$) (Table 2). As for discriminant validity, the HAq-II-P did not significantly correlate with either the three patient demographic variables or the pre-treatment BDI score. The HAq-II-T did not significantly correlate with the sex or initial training of therapists, although there was a significant correlation with therapist age (Table 2). In terms of predictive validity, correlations between the Spanish-language HAq-II-P and HAq-II-T and patient residual gain scores on the BDI after the tenth session were in the expected direction. However, only the correlation between the HAq-II-T and these scores was statistically significant (Table 2).

Table 1. Mean scores, standard deviations and corrected item-total correlations corresponding to the items of the Spanish-language HAq-II-P and HAq-II-T after the third psychotherapy session.

HAq-II-P[a]				HAq-II-T[b]			
Item No.	*M*	SD	$r_{i(T-i)}$	Item No.	*M*	SD	$r_{i(T-i)}$
1	5.58	1.03	0.49	1	5.26	0.82	0.64
2	5.44	0.77	0.78	2	5.11	0.76	0.80
3	5.53	0.88	0.38	3	5.34	0.77	0.68
4	5.06	1.49	0.39	4	4.63	1.03	0.77
5	5.36	0.80	0.82	5	4.91	0.85	0.81
6	5.31	0.75	0.57	6	4.49	0.95	0.67
7	5.47	0.70	0.64	7	5.14	0.60	0.62
8	4.81	1.53	0.38	8	4.83	0.89	0.48
9	5.31	0.82	0.59	9	4.89	0.68	0.76
10	5.14	0.80	0.78	10	4.83	0.82	0.75
11	4.83	1.56	0.40	11	5.14	0.98	0.30
12	5.22	0.68	0.64	12	5.14	0.77	0.84
13	5.47	0.74	0.77	13	4.94	1.14	0.51
14	5.86	0.43	0.47	14	5.57	0.70	0.35
15	5.28	0.78	0.72	15	5.00	0.77	0.61
16	5.33	0.83	0.68	16	4.23	1.35	0.48
17	4.94	1.04	0.22	17	4.94	0.80	0.54
18	4.64	1.15	0.36	18	4.80	0.90	0.60
19	4.94	1.37	0.59	19	4.97	1.10	0.76

[a]36 patient ratings of the HAq-II-P; [b]35 therapist ratings of the HAq-II-T; HAq-II-P = Spanish-language Revised Helping Alliance Questionnaire-II, Patient version; HAq-II-T = Spanish-language Revised Helping Alliance Questionnaire-II, Therapist version.

Discussion

The psychometric properties of the Spanish-language HAq-II-P and HAq-II-T were acceptable. Mean scores on both measures were high. These scores match those reported for the original versions of the HAq-II. Tryon et al.'s (2008) meta-analysis revealed that the mean scores on the English HAq-II-P and HAq-II-T represented 84.64 and 74.57%, respectively, of the total alliance scores from these two measures. The corrected item-total correlations >0.30 for >94% of the items on the Spanish-language HAq-II-P and HAq-II-T demonstrate that these items satisfactorily correlate with the corresponding HAq-II version. In addition, the reliability (internal consistency) of these two Spanish versions of the HAq-II was excellent according to Muñiz's scales (2005); that is, there was a strong covariance between items from the two versions of the HAq-II. These reliability results coincide with the findings of the development study for the HAq-II-P and HAq-II-T (Luborsky et al., 1996) and

Table 2. Pearson's correlation coefficients for convergent validity, discriminant validity and predictive validity of the Spanish-language HAq-II-P and HAq-II-T.

Variable	HAq-II-P[a]
Working alliance	
WAI-P Bond	0.84**
WAI-P Goal	0.73**
WAI-P Task	0.73**
WAI-P Total	0.80**
Demographic characteristics and BDI before treatment	
Sex	−0.02
Age	0.16
Marital status	0.25
BDI before treatment	−0.22
Patient change	
BDI residual gain scores[b]	−0.24
	HAq-II-T[c]
Working alliance	
WAI-T Bond	0.82**
WAI-T Goal	0.87**
WAI-T Task	0.78**
WAI-T Total	0.87**
Demographic characteristics and initial training	
Sex	−0.02
Age	0.40*
Initial training	0.30
Patient change	
BDI residual gain scores[b]	−0.39*

[a]36 patient ratings of the HAq-II-P; [b]after the tenth psychotherapy session; [c]35 therapist ratings of the HAq-II-T; HAq-II-P = Spanish-language (SL) Revised Helping Alliance Questionnaire-II, Patient version; HAq-II-T = SL Revised Helping Alliance Questionnaire-II, Therapist version; WAI-P = SL Working Alliance Inventory, Patient version; WAI-T = SL Working Alliance Inventory, Therapist version; BDI = SL Beck Depression Inventory.
*$p < 0.05$ (two-tailed); **$p < 0.01$ (two-tailed).

subsequent research using one or both versions of the English HAq-II (e.g. Crits-Christoph et al., 2009; Petry et al., 2010; Ruglass et al., 2012).

In terms of construct validity, the convergent validity of the Spanish-language HAq-II-P and HAq-II-T were excellent. According to Luborsky et al. (1996), the high correlations found between the HAq-II and the WAI occurred because the HAq-II contains 14 items that assess different aspects of the alliance proposed by Bordin (1979) and Luborsky (1976). These results are in line with those obtained by the creators of the HAq-II (Luborsky et al., 1996) when they correlated the HAq-II-P and HAq-II-T with corresponding versions of the CALPAS. The discriminant validities of both Spanish versions of the HAq-II were also satisfactory. However, the number of demographic variables and pre-treatment outcome measures used by Luborsky et al. (1996) to evaluate the discriminant validity of the HAq-II-P was greater than those used in the present study. In addition, the Spanish-language HAq-II-T correlated significantly with therapist age, and though we are not aware of any existing research that has examined the relationship between the HAq-II-T and therapist age, Hersoug et al. (2009) found that greater therapist age was significantly associated with greater therapist alliance scores on the WAI-T.

In terms of predictive validity, mixed results were obtained for the Spanish-language HAq-II-P and HAq-II-T. While the HAq-II-T significantly correlated with patient change on the BDI after 10 psychotherapy sessions, we did not observe a significant correlation between the HAq-II-P and this change. This is probably due to the small patient sample size in the present study. Although Luborsky et al. (1996) did not provide data on the predictive validity of this measure in the study that developed the HAq-II, Horvath et al. (2011) performed a meta-analysis and found that both versions of the HAq-II correlated with psychotherapy outcomes. It is therefore recommended that future studies investigating the relationship between the alliance (measured using the HAq-II) and psychotherapy outcomes use larger patient samples.

The present study has several shortcomings. Firstly, the small patient and therapist sample sizes limit the statistical power of this research, making it difficult to generalize the results and preventing a factorial analysis that might have allowed us to examine the factorial structure of the two Spanish versions of the HAq-II. Secondly, all the patients were suffering from depressive disorders, and most were female, again making it difficult to generalize the results to other types of patients. Thirdly, it is not clear that the change that patients registered on the BDI after 10 sessions can be wholly attributed to the psychotherapeutic treatment they underwent. Fourthly, the study design did not include analysis of patient medication; therefore, these data were not collected. Fifthly, the correlation between the alliance and the change could not be calculated for six patients who did not continue the treatment beyond the third session for a variety of reasons. Finally, it is possible that the correlation between the Spanish-language HAq-II-P and the change in the BDI was somewhat inflated because it was the patients themselves who provided data on the alliance and the psychotherapy outcomes.

The Spanish adaptation of the HAq-II-P and the HAq-II-T adds to previous interest shown in this measure of alliance by other researchers, such as Conn et al. (2013), who adapted the HAq-II-P for use in Argentina. These authors found that the factorial structure of the HAq-II-P was made up of two alliance dimensions (bond between patient and therapist, and goal/task agreement), thus differing from the factorial structure of the original HAq-II-P that comprised two factors (positive and negative therapeutic alliance) (Luborsky et al., 1996).

In conclusion, results obtained using the Spanish-language HAq-II-P and HAq-II-T were consistent with results obtained using the English versions of these questionnaires. Both versions can therefore be used by Spanish-speaking researchers to measure alliance from the patients' and therapists' viewpoints. It is recommended that future studies be performed to provide more data on the psychometric properties of the Spanish-language HAq-II-P and HAq-II-T, and in particular on their factorial and predictive validities.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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Appendix A: Spanish-language HAq-II-P items

No.	Statement
1	Siento que puedo confiar en el terapeuta.
2	Siento que el terapeuta me comprende.
3	Siento que el terapeuta quiere que consiga mis objetivos.
4	A veces desconfío de los criterios del terapeuta.
5	Siento que el terapeuta y yo trabajamos juntos y hacemos un esfuerzo conjunto.
6	Creo que el terapeuta y yo tenemos ideas similares acerca de la naturaleza de mis problemas.
7	Por lo general, respeto las opiniones que el terapeuta tiene sobre mí.
8	Los métodos empleados en mi terapia no se adaptan a mis necesidades.
9	Me gusta el terapeuta como persona.
10	En la mayoría de las sesiones, el terapeuta y yo encontramos la manera de trabajar juntos en mis problemas.
11	La manera que tiene el terapeuta de relacionarse conmigo hace más lento el progreso de la terapia.
12	Se ha creado una buena relación entre el terapeuta y yo.
13	Parece que el terapeuta tiene experiencia en ayudar a la gente.
14	Deseo intensamente solucionar mis problemas.
15	El terapeuta y yo tenemos conversaciones significativas.
16	A veces el terapeuta y yo tenemos conversaciones inútiles.
17	De vez en cuando, el terapeuta y yo hablamos sobre los mismos acontecimientos importantes de mi pasado.
18	Creo que le gusto al terapeuta como persona.
19	A veces el terapeuta parece distante.

Appendix B: Spanish-language HAq-II-T items

No.	Statement
1	El paciente siente que puede confiar en mí.
2	El paciente siente que yo le comprendo.
3	El paciente siente que yo quiero que consiga sus objetivos.
4	A veces el paciente desconfía de mis criterios.
5	El paciente siente que trabajamos juntos y hacemos un esfuerzo conjunto.
6	Creo que el paciente y yo tenemos ideas similares acerca de la naturaleza de sus problemas.
7	Por lo general, el paciente respeta mis opiniones sobre él.
8	El paciente cree que los métodos empleados en su terapia no se adaptan a sus necesidades.
9	Le gusto al paciente como persona.
10	En la mayoría de las sesiones, el paciente y yo encontramos la manera de trabajar juntos en sus problemas.
11	El paciente cree que la manera de relacionarme con él ralentiza el progreso de la terapia.
12	El paciente cree que se ha creado una buena relación entre nosotros.
13	El paciente cree que tengo experiencia en ayudar a la gente.
14	Deseo intensamente que el paciente solucione sus problemas.
15	El paciente y yo tenemos conversaciones significativas.
16	A veces el paciente y yo tenemos conversaciones inútiles.
17	De vez en cuando, el paciente y yo hablamos sobre los mismos acontecimientos importantes de su pasado.
18	El paciente cree que me gusta como persona.
19	A veces el paciente percibe en mí una actitud distante.