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Examining the relationship between the therapeutic bond and the phases of treatment outcome.

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Abstract

Examined the association between the therapeutic bond—an element of the therapeutic alliance—and treatment effectiveness. 114 psychotherapy clients completed self-report questionnaires at intake and throughout open-ended, psychodynamically oriented psychotherapy. Three bond scales, role investment (RI), empathic resonance (ER), and mutual affirmation (MA), were contrasted to session quality and the three phases of outcome (remoralization, remediation, and rehabilitation). Results indicated that different aspects of the bond predicted session quality and treatment outcome. Clients who felt motivated and invested in therapy (relatively high RI) and who reported that the therapeutic environment was friendly and affirmative (relatively high MA) were likely to rate the session as being helpful and productive. Clients who had a relatively high sense of understanding and of being understood (ER) experienced greater remoralization and remediation (but not rehabilitation). The results are placed within the context of recent research into the therapeutic alliance.

Keywords

therapeutic bond, treatment effectiveness, psychodynamically oriented psychotherapy clients

Introduction

The therapeutic relationship can be defined as the affects, cognitions, and behaviors the therapy participants experience and express toward one another in the process of interacting ([Gelso & Carter, 1985](#)). Extensive research has established that the quality of the relationship is an essential ingredient of effective psychotherapy (e.g., [Horvath & Symonds, 1991](#); [Wolfe & Goldfried, 1988](#)). How the relationship influences positive change has yet to be firmly established, however. The present study examined the association between a specific aspect of the therapeutic relationship—the therapeutic bond—and the three phases of treatment outcome, that is, remoralization, remediation, and rehabilitation ([Howard, Lueger, Maling, & Martinovich, 1993](#)).

The parts of the therapeutic relationship and the mechanism by which it influences treatment have been debated since its identification as an important ingredient of psychotherapy. There are two discrete but not mutually exclusive ways that the relationship may influence outcome ([Baron & Kenny, 1986](#); [Gaston, 1990](#); [Horvath & Luborsky, 1993](#)). The relationship may *moderate* or influence the strength of the causal association between other treatment interventions and outcome. From this perspective, the interventions of a particular psychotherapy are effectively implemented only if an adequate relationship exists. In contrast, the relationship may *mediate* the effects of treatment. According to this view, treatment causes the relationship, which in turn causes outcome. From this perspective, the relationship is the treatment intervention.

To both provide justification for the current study and to place it within the context of the literature, the major theoretical perspectives and seminal transtheoretical conceptualizations regarding the ingredients of the relationship are reviewed, and an integration of the conceptualizations is offered. Reviews and meta-analyses examining the association between the relationship and treatment effectiveness are surveyed. Finally, the rationale and hypotheses of the current study are presented.

Major Theoretical Perspectives

Psychoanalytic writers distinguish the alliance and transference aspects of the relationship between analyst and patient. In order to foster positive attachment feelings, for example, [Freud \(1912/1958\)](#) directed analysts to demonstrate “serious interest” and “sympathetic understanding” toward the patient. This collaborative relationship both fosters the transference and allows the difficult work of transference interpretation, the primary curative element of psychoanalysis. Psychoanalysts thus argue that the relationship moderates the association between the active therapeutic intervention—the working through of the transference—and treatment effectiveness (e.g., [Greenson, 1967](#); [Sterba, 1934](#); [Zetzel, 1956](#)).

[Rogers \(1957\)](#) rejected the psychoanalytic position and insisted that the relationship was curative in and of itself. According to the client-centered perspective, if a therapist adopts and expresses certain conditions (accurate empathy, congruence, and unconditional positive regard), these influence and become part of the relationship. A relationship characterized by these conditions inevitably promotes a positive response. In this manner, Rogers argued that a client-centered relationship mediates therapeutic benefit.

Experiential therapy writers have asserted that the relationship both mediates and moderates treatment effectiveness. They draw a distinction between the working alliance and the emotional bonding aspects of the therapeutic relationship. Whereas the emotional aspect of the relationship mediates healing in and of itself, it also promotes the working alliance. The working alliance, in contrast, allows the client to engage in anxiety-provoking but critical therapeutic interventions such as exploration (e.g., [Greenberg, Rice, & Elliot, 1993](#)).

Cognitive and behavioral therapists have tended to emphasize the moderating aspects of the therapeutic relationship. Beck and colleagues ([Beck, Rush, Shaw, & Emery, 1979](#)) view the relationship as a necessary but insufficient aspect of successful treatment. They encourage therapists to adopt attitudes of acceptance, warmth, empathy, and genuineness, but emphasize that this merely fosters trust, rapport, and collaboration which, in turn, facilitates the essential work of collaborative empiricism and cognitive restructuring. Others (e.g., [Raue, Goldfried, & Barkham, 1997](#)) likewise argue that the relationship moderates the client's confidence in the therapist and the therapeutic endeavor, thereby encouraging attempts at new behaviors, cognitive change, and positive outcome.

Seminal Transtheoretical Models

Attempting to explain the consistent findings that different modes of therapy are equally effective, various researchers have proposed that there are common or “generic” factors present in all therapies, including the therapeutic relationship.

[Bordin \(1994\)](#) identified three aspects of the therapeutic relationship: emotional bonding, agreement on tasks, and agreement on goals. Bordin asserted that the emotional bond enables (mediates) the client and therapist to agree on treatment goals and tasks. This consensus, in turn, makes it possible for the client to do the work of treatment (consensus moderates the effectiveness of treatment).

[Gelso and Carter \(1985, 1994\)](#) concluded that the relationship comprises the working alliance, a transference configuration, and a real relationship. The working alliance incorporates the emotional bond and agreement on tasks and goals; the transference configuration is the displacement of past conflicts with significant others onto the therapist; and the real or nontransferential aspect of the relationship is composed of genuineness and realistic perceptions. Gelso and Carter concluded that the real relationship promotes the working alliance, which is the safe haven within which transference occurs. The working alliance enables the client to endure the difficulties of treatment. In this way, the relationship moderates the effectiveness of treatment interventions.

[Orlinsky and Howard \(1986, 1987\)](#) proposed the generic model of **psychotherapy** by organizing therapeutic processes into five categories. “Interventions” are the tasks used during the therapeutic enterprise. “Self-relatedness” refers to the capacity to understand and express oneself. “In-session realizations” are changes that occur during the session, such as insight. The “therapeutic contract” encompasses the practical aspects of implementing therapy, such as payment, format, and agreement on tasks and goals. The “therapeutic bond” includes the behaviors, feelings, and attitudes the participants experience and exhibit during therapy.

Orlinsky and Howard partitioned the therapeutic bond into three aspects. Role investment describes the degree of emotional energy or investment that the client puts into the work of therapy and includes concepts such as motivation and engagement. Empathic resonance refers to the client's sense that the therapist understands his or her thoughts, feelings, and actions. Mutual affirmation reflects the client's sense that therapy is being conducted in an atmosphere of respect, warmth, mutual liking, and acceptance. [Orlinsky and Howard \(1986, 1987\)](#) concluded that there is evidence that the bond both mediates treatment effects and moderates the impact of other interventions.

The Therapeutic Relationship and Treatment Effectiveness: Research Evidence

Reviews and meta-analyses have consistently found a positive association between the therapeutic alliance and treatment outcome (e.g., [Alexander & Luborsky, 1986](#); [Horvath & Luborsky, 1993](#); [Marmar, Horowitz, Weiss, & Marziali, 1986](#)). [Orlinsky, Graw, and Parks \(1994\)](#), for example, reported that “the strongest evidence linking process to outcome concerns the therapeutic bond or alliance, reflecting more than 1,000 process-outcome findings” (p. 360). In a meta-analysis, [Horvath and Symonds \(1991\)](#) evaluated the effect sizes from 24 studies and concluded that there is a moderate and reliable association between the alliance and outcome.

Integration of Relationship Components and Putative Effects

An integration of the various conceptions of the components of the therapeutic relationship is presented in [Figure 1](#). Concurring with most authors (e.g., [Horvath, Gaston, & Luborsky, 1993](#)), the general relationship is first discriminated into transference and alliance aspects. Transference aspects are distortion-laden experiences and behaviors—transferred from important past or other relationships onto the therapist—that occur within the therapeutic relationship. The alliance aspect includes the participants' cognitive, affective, and behavioral attitudes toward one another. These two aspects of the relationship interact: the transference aspects influence both the development and the perception of the alliance, and the strength of the alliance determines how well the transference is managed.

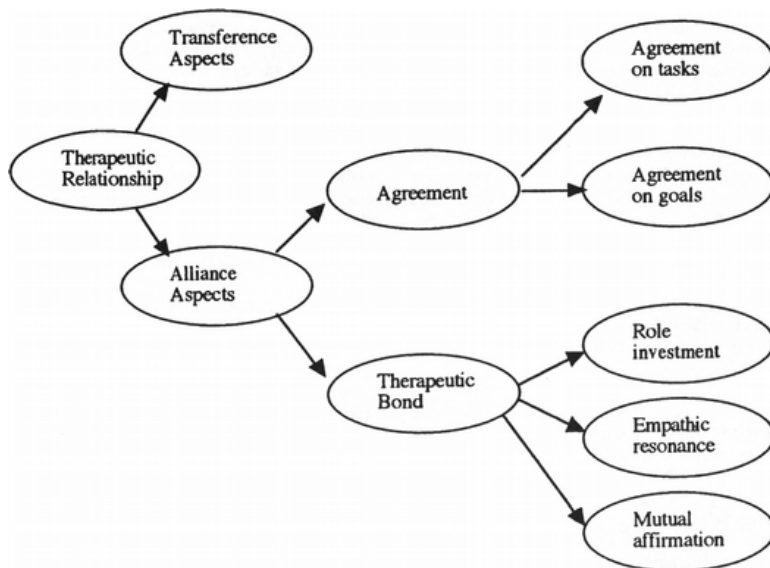


Figure 1. The components of the therapeutic relationship

Since the transference aspects are difficult to operationalize, their effects on the processes and outcome of therapy have been discussed, until recently ([Crits-Christoph, Barber, & Kurcias, 1993](#)), primarily in theoretical writings. Part of unconscious mental activity, transference aspects of the relationship are unmeasurable from a self-report perspective and were not addressed in this study.

Like any relationship, the therapeutic alliance comprises cognitive, behavioral, and affective attitudes. Researchers have divided it into three aspects that generally correspond to particular attitudes. That is, agreement regarding the goals of treatment and consensus about therapeutic tasks reflect cognitive and behavioral aspects of the relationship, whereas the therapeutic or emotional bond encompasses the affective portion of the relationship.

Finally, following the generic model of psychotherapy (and consistent with prior work; [Saunders, Howard, & Orlinsky, 1989](#)), the therapeutic bond is divided into role investment, mutual affirmation, and empathic resonance.

Regarding its effects on outcome, the literature suggests that the therapeutic relationship both moderates the effects of other therapeutic interventions and directly mediates improvement. For this study, it is hypothesized that the cognitive aspects of the alliance (i.e., consensus on goals and tasks) moderate the effectiveness of interventions whereas the affective aspects of the alliance (i.e., the therapeutic bond) mediate treatment outcome (cf. [Gaston & Marmar, 1994](#)).

Critical examination of the research literature suggests two reasons that the association between the relationship and outcome may be underestimated. First, studies have generally operationalized outcome in limited fashion, for example, as change in target complaints, symptoms, social adjustment, or drug usage, as overall session quality or change, as premature termination or as some specific treatment gain (see [Horvath & Symonds, 1991](#)). In contrast, there is growing consensus that health care should not just focus on symptom eradication or disease cure, but should also restore the client's sense of subjective well-being and role functioning (e.g., [Mintz, Mintz, Arruda, & Hwang, 1992](#); [Spitzer et al., 1995](#)). [Howard et al. \(1993\)](#), for example, reported differential rates of response of subjective well-being, symptoms, and functioning, and they proposed a phase model of psychotherapy outcome. They reported that well-being improved initially in the remoralization phase; that symptomatic improvement occurred in the following remediation phase; and that role functioning was restored last, if at all, during the rehabilitation phase of treatment (see also [Mintz et al., 1992](#)).

Second, there has been inadequate attention to whether the association is due to a moderating or a mediating effect (cf. [Shadish & Sweeney, 1991](#)). In a comprehensive review of studies, [Saunders and Close-Goedjen \(1999\)](#) found that most implicitly propose that the relationship both moderates and mediates outcome. With few exceptions (e.g., [Burns & Nolen-Hoeksema, 1992](#)), however, the methodological and statistical procedures ignore this distinction and simply report correlations between the relationship and outcome ([Horvath & Symonds, 1991](#)).

The Present Study

The present study examined the association between the therapeutic bond and treatment effectiveness. The study was guided by the proposition that greater specification of both the bond and outcome measures would yield more meaningful results. Therefore, treatment effectiveness was conceptualized as both session outcome (e.g., quality of the session) and general treatment effectiveness, which was in turn specified from the phase model of psychotherapy outcome into three phases (remoralization, remediation, and rehabilitation) ([Howard et al., 1993](#)). Likewise, the bond was conceptualized as three discrete parts (role investment, empathic resonance, and mutual affirmation), according to the generic model of psychotherapy ([Orlinsky & Howard, 1987](#)).

It was expected that the therapeutic bond would be significantly associated with outcome. Specifically, it was hypothesized that all three bond measures would predict session quality, change in subjective well-being (remoralization), and change in symptoms (remediation). Since change in role functioning (rehabilitation) takes fairly long to occur (cf. [Howard et al., 1993](#); [Mintz et al., 1992](#)), it was also hypothesized that the bond measures would not predict this phase of outcome.

Method

Study Site, Recruitment, and Data Collection Procedures

Data were collected as part of the Long Term Psychotherapy Research Project (LTPRP; [Howard, Davison, O'Mahoney, & Orlinsky, 1988](#)). The project was conducted at the Psychotherapy Program at Northwestern Memorial Hospital's Institute of Psychiatry, which is the teaching facility for Northwestern University's School of Medicine. There are other outpatient programs at the institute, including an eating-disorders program, a chemical-dependency program, a sexual-dysfunction program, and a day hospital for clients with serious or life-threatening psychopathology. All potential clients—including the study participants—were accepted into the Psychotherapy Program only after it was determined, via screening, that they were appropriate for long-term, psychodynamically oriented therapy. The only criteria for being eligible to participate in the research project was acceptance into the Psychotherapy Program.

Participants were recruited during their initial visit to the treatment program. Participation was voluntary, and participants were treated according to the ethical standards of the American Psychological Association.

Participants were not compensated. Participants were informed that the research project was unconnected to the clinical procedures and were assured of the following: that declining to participate would not influence their treatment at the clinic in any way; that research questionnaires were kept separately from clinical files; that their responses to all questionnaires would remain confidential; and that therapists and other clinical staff would not be allowed access to the research data.

It was intended that participants complete a number of questionnaires both prior to entering and throughout therapy. The questionnaire containing bond and session quality information was administered after session 3. The outcome questionnaire was administered prior to the 1st session and then after sessions 4, 10, and every subsequent 10th session until treatment terminated. That is, the outcome questionnaire was typically not administered just prior to actual termination, reflecting the requirements of any such large-scale, community-based study of treatment outcomes.

Therapists and Therapy

At the time of the study, the majority of therapists were in some stage of training, including psychiatry residents, graduate students in clinical psychology, and clinical psychology interns. Therapists were aware of the LTPRP, but they were not informed by research staff whether any particular client was part of the project.

The training orientation of the program is psychodynamic: cases were conceptualized from a psychodynamic perspective and supervisors espoused psychodynamic interventions. Treatment was open-ended.

Participants

The LTPRP collected at least some data from 1,001 persons accepted for treatment at the Psychotherapy Program. Participation in the present study was limited to those who completed the outcome questionnaires at both intake and at a session prior to termination, as well as the bond questionnaire after session 3. This eliminated 831 potential participants who either did not complete the questionnaires at intake ($n = 321$) or at session 3 ($n = 224$) or for whom a second outcome questionnaire was unavailable ($n = 286$). Because the measure used to evaluate treatment effectiveness had a maximum possible score and was thus subject to a ceiling effect, it was determined that any participant who obtained an intake-session (before treatment) score that was within 1/2 standard deviation of the maximum score would not likely show subsequent improvement. These participants ($n = 56$) also were dropped from the current analyses.

There were 114 participants in the present study. Demographic information for these clients is presented in [Table 1](#). Most of the clients were single, white, and female, with at least some college education and an average age of about 32. Over half (55%) received previous individual psychotherapy. Most participants (over 90%) were given a clinical diagnosis of a depressive or anxiety disorder; the remainder were treated for either an adjustment disorder, a personality disorder, or a v-code diagnosis. Over half of the participants (54.4%) attended 10 sessions or fewer, 27.2% attended between 11 and 27 sessions, and the remainder (18.4%) attended at least 28 sessions (the average length of treatment was approximately 17 sessions). Complete diagnostic information was unavailable on the larger data set, and it is thus not determinable whether the smaller group is comparable to the larger with respect to diagnoses. However, the smaller client sample is deemed reasonably representative of the general psychotherapy outpatient population (cf. [Taube, Kessler, & Feuerberg, 1984](#)).

Table 1. Characteristics of Study Participants ($N = 114$) versus Full LTPRP Sample ($N = 1,001$)

Age	Study Sample		Full Sample	
Mean (SD), range	31.8 (8.0), 20-61		32.2 (8.5), 18-68	
	N	%	N	%

Gender				
Female	80	70.1	684	68.3
Male	34	29.9	317	31.7
Race				
White	95	83.3	789	78.8
Nonwhite	19	16.7	212	21.1
Marital status				
Single or never married	69	00.5	611	61.0
Married or remarried	20	17.5	171	17.1
Separated, divorced, or widowed	25	21.9	219	21.9
Level of education				
High school or less	9	7.9	117	11.7
At least some college	69	00.5	595	59.5
Graduate or professional	36	31.6	287	28.7
Employment status				
Not employed	6	5.3	235	23.5
Part or full-time	108	94.7	766	76.5

[Table 1](#) shows how the smaller data set of the current study compares to the complete ($N = 1,001$) LTPRP sample. The two groups were statistically similar with respect to percentage of males and females, $\chi^2(1) < 1$, whites and nonwhites, $\chi^2(1) = 1.27$, the three levels of education, $\chi^2(2) = 1.61$, and the three categories of marital status $\chi^2(2) = 1.07$. The clients in the smaller sample, however, were statistically more likely to be employed, $\chi^2(1) = 20.04$. The clinical characteristics of the samples comprising the two data sets were also compared by examining their responses to a 47-item symptom checklist, adapted from [Derogatis \(1977\)](#). Total scores were calculated by adding the items. The average total score of the full LTPRP data set of 1,001 clients was 49.3 ($SD = 7.0$), which was close to the average total score of 49.2 ($SD = 6.6$) for the smaller sample of the current study (Kruskal-Wallis ANOVA yielded $\chi^2(1) = 2.02$, n.s.).

Measures

Therapeutic Bond Scales-Revised

Bond scores were calculated from clients' responses to the *Therapy Session Report*, or TSR ([Orlinsky & Howard, 1966, 1986](#)). The TSR is a structured questionnaire completed following the psychotherapy session. It assesses a wide range of in-session behaviors and experiences, such as what was talked about, what the client hoped to get out of the session, and the client's sense of progress. The TSR takes about 15 minutes to complete and was administered after the third session.

[Saunders et al. \(1989\)](#) created the Therapeutic Bond Scales (TBS) using items from the TSR. The three scales were psychometrically sound and were shown to be related to treatment effectiveness. [Saunders \(1999\)](#) revised the scales to address two problems. First, the original scales had numerous items with uncertain or poor face validity. Second, the original scales comprised 50 items, which is too lengthy for regular use. To create the Therapeutic Bond Scales-Revised (TBS-R), items were retained from the original scales based on face validity and relatively high item-scale correlations. The "Working Alliance" scale was renamed the "Role Investment" scale.

The TBS-R has 22 items constituting three scales (Role Investment, Empathic Resonance, and Mutual Affirmation). The scales are scored so that higher scores indicate a higher experience or perception of that particular construct. The complete scales are available from the author upon request.

Role Investment (RI)

The RI scale was constructed of seven TSR items assessing the emotional energy and motivational investment that the client puts into the work of therapy. Two items assessed how the respondent felt about coming to the present and subsequent sessions. Three items ascertained how much the participant talked about feelings, was able to focus on concerns, and was attentive to the therapist. Two items asked to what extent the participant felt determined and serious. Using a different data set ($n = 117$), [Saunders \(1999\)](#) calculated coefficient alpha to be .76.

Empathic Resonance (ER)

Empathic resonance refers to the client's sense that he or she and the therapist genuinely understand each other, and it leads to openness, genuineness, and a lack of inhibition. The ER scale was therefore constructed from eight TSR items that assessed these. Seven items evaluated how much the participant felt frustrated, withdrawn, confused, cautious, strange, embarrassed, and inhibited (all indicating poor empathic resonance). The last item assessed to what extent the participant felt that the therapist understood what he or she was thinking and feeling. Coefficient alpha for the ER scale was .75 in the previous study.

Mutual Affirmation (MA)

The MA scale consisted of seven TSR items measuring the client's sense of mutual affection and liking within a warm and friendly relationship. Four items asked how much the participant felt close, affectionate, likable, and accepted. Two asked how much the therapist seemed to feel affectionate and close. One item asked whether the participant was friendly and respectful toward the therapist. Coefficient alpha for the scale was .85 in the prior study.

Global Bond (GB)

The GB was calculated as the average of the three scales.

Session Quality

Session quality (SQ) was operationalized using two items from the TSR (that is, from the same questionnaire from which the bond scales were derived). The items assess the client's evaluation of the quality and helpfulness of the session. The client's responses to the question "How do you feel about your last session?" were rated on a scale ranging from 1 (*very poor*) to 7 (*perfect*). It was combined with the client's response to the question "How helpful do you feel your therapist was to you in your last session?" which was rated on a scale ranging from 1 (*not at all helpful*) to 7 (*completely helpful*). Thus, SQ ranged from 2 to 14, with higher scores indicating better quality. In a sample of 174 outpatients at session 3, the SQ scale attained an alpha coefficient of .81 ([Saunders, 1999](#)).

Treatment Effectiveness

Following the phase model of therapy outcome, treatment effectiveness was operationalized as three distinct phases. Remoralization refers to change in subjective well-being; remediation refers to change in symptomatology (or symptomatic distress); and rehabilitation encompasses change in life functioning. Change was measured by comparing scale scores obtained at intake to scores obtained after a session occurring prior to treatment termination. All were based on self-report measures.

Subjective Well-Being (SWB)

The remoralization phase was measured as change in SWB. SWB was measured using four items ascertaining the client's general upset or distress, energy level, satisfaction with life, and general sense of how well he or she was getting along emotionally and psychologically. In a previous study of a sample of 529 clients at intake, the SWB scale obtained an internal consistency (coefficient alpha) of .79 ([Howard et al., 1993](#)).

Symptomatic Distress (SD)

The remediation phase was measured as change in SD. To measure SD comprehensively, but not burden clients with extensive questionnaires, [Howard and colleagues \(1993\)](#) adapted the Symptom Distress Check List (SCL-90; [Derogatis, 1977](#)). They selected the 47 items that had adequate psychometric properties (based on [Derogatis, 1977](#)) and that were deemed to cover the range of emotional problems typically seen in outpatient samples. These items measured a variety of emotional disorder symptoms, including depression, anxiety, somatic complaints, and mania. Participants rated each item with respect to “How often have you had each experience in the past month?” In a previous study, this scale obtained an alpha of .95 ($n = 442$) and demonstrated validity ([Howard et al., 1993](#)).

Current Life-Functioning (CLF)

Rehabilitation is indicated by changes in life functioning. To create the CLF scale, participants rated to what extent “emotional/psychological problems interfere with” their functioning in specific areas of their lives. The 23 items assessed work functioning, social functioning, family functioning, intimate relationships, health and grooming, and self-management. The CLF score obtained an alpha of .88 ($n = 255$) in the prior study ([Howard et al., 1993](#)).

Mental Health Index

The three measures (SWB, SD, and CLF) were combined to create the Mental Health Index (MHI). As reported by [Howard et al. \(1993\)](#), the intercorrelations of the three (ranging from .54 to .74 at intake) was below the square roots of their reliabilities, indicating that each had substantial unique variance.

Statistical Analyses

Correlational analyses were used to examine the association between the therapeutic bond and session quality, whereas regression analyses were used to examine the mediating effect of the bond on treatment effectiveness ([Cohen & Cohen, 1983](#)). To partial out the influence of initial severity on the final mental health measure (the dependent variable), the initial or intake mental health measure was entered at step 1, followed by the bond measure(s) at a later step. Consistent with the phase model of psychotherapy outcome, when predicting the remediation and rehabilitation phases of outcome (that is, change in symptoms and functioning), the prior phase was taken into account. That is, when predicting remediation, the change in the well-being scale was entered into the equation prior to the bond scores; when predicting rehabilitation, the changes in both the well-being and symptoms scales were entered into the equation prior to the bond scores.

Of particular interest was determining whether greater specification of the bond and outcome constructs would result in clarification of the mediating impact of the therapeutic bond. Regarding the measure of outcome, the first set of analyses examined the prediction of the MHI (the general outcome measure), whereas the second set of analyses evaluated the prediction of the three phases of outcome (using the changes in the specific outcome measures of SWB, SD, and CLF). Regarding the measure of bond, in each set of analyses, the analysis evaluating the association between the general bond measure (global bond or GB) was followed by an evaluation of the predictive power of the more specific bond measures (i.e., RI, ER, and MA).

Results

Initial Analyses

The alpha reliabilities of the three bond scales were calculated and indicated satisfactory internal consistency: RI = .65; ER = .77; MA = .77. The internal consistency of the GB was calculated, using the 22 items constituting the three subscales, to be .82. [Table 2](#) shows the correlations among the GB and the three bond subscales. Two of

the three intercorrelations between the three scales were significant, with RI and MA sharing over 25% of common variance.

Session Quality and the Therapeutic Bond

The correlations between participants' ratings of the quality of the session and both the GB and the three bond scales (RI, ER, and MA) are presented in [Table 2](#). All of the correlations were statistically significant.

Treatment Effectiveness and the Therapeutic Bond

The Global Bond and Change in MHI

In the initial analysis, the GB measure was used to predict the last available MHI score. After accounting for MHI at intake ($\beta_{MHI} = .33, p < .001$), GB contributed significantly to the regression equation ($\beta_{GB} = .24, p < .01$), accounting for an additional 6% of the variance of MHI at the latter session (total $R^2 = .17$).

In the second analysis, shown in [Table 3](#), the three individual bond scales were used in the regression analysis predicting MHI change. ER was the only bond scale that contributed significantly to the regression equation (see [Table 3](#)).

TABLE 3. Summary of Hierarchical Regression Analysis for Predicting MHI Using Bond Scales

Variable	<i>B</i>	<i>SE B</i>	β
Step 1			
MHI at intake	.44	.12	.33***
Step 2			
MHI at intake	.39	.12	.30**
Role Investment (RI)	.21	.36	.06
Empathic Resonance (ER)	.70	.23	.28**
Mutual Affirmation (MA)	.11	.29	.04

Note: $R^2 = .10$ for Step 1. $\Delta R^2 = .09$ for Step 2.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Remoralization

This phase occurs first and entails a change in SWB. The regression equation indicated that, after accounting for SWB at intake ($\beta_{SWB} = .16, n.s.$), the last available SWB rating was not predicted by the GB score ($\beta_{GB} = .13, n.s.$), and in fact the equation itself was not statistically significant (total $R^2 = .04; F = 2.39, n.s.$).

Regression analyses based on the subparts of the bond are shown in [Table 4](#). The regression equation using the scales was also not significantly associated or predictive of SWB at the later session, accounting for just over 6% of its variance.

Table 4. Summary of Hierarchical Regression Analysis for Predicting Subjective Well-Being (SWB) Using Bond Scales

Variable	<i>B</i>	<i>SE B</i>	β
Step 1			
SWB at intake	.17	.11	.15
Step 2			

SWB at intake	.16	.11	.14
Role Investment (RI)	-.12	.38	-.04
Empathic Resonance (ER)	.43	.24	.18
Mutual Affirmation (MA)	.27	.31	.10

Note: $R^2 = .02$ for Step 1. $\Delta R^2 = .04$ for Step 2.

Remediation

To predict change in SD, the following hierarchy of variable entry was used: at step 1, SD at intake was entered; at step 2, change in SWB (i.e., remoralization) was entered; and at step 3, the bond score(s) were entered. In the final equation using the GB score, all three variables made statistically significant contributions. SD at intake ($\beta_{SD} = .17, p < .01$) and change in SWB ($\beta_{SWB} = .68, p < .001$) combined with the GB score ($\beta_{GB} = .21, p < .001$) to account for 61% of the variance in the SD at the later session ($R = .78; p < .001$).

[Table 5](#) shows that substituting the bond scale scores for the GB score likewise generated a regression equation that was significantly associated with SD at the later session, accounting for 64% of the variance. Moreover, [Table 5](#) shows that the ER scale was the only bond scale to make a statistically significant contribution to the final equation.

Table 5. Summary of Hierarchical Regression Analysis for Predicting Symptomatic Distress (SD) Using Bond Scales

Variable	<i>B</i>	<i>SE B</i>	β
Step 1			
SD at intake	.34	.10	.30**
Step 2			
SD at intake	.19	.07	.17**
Change in Subjective Well-Being	.63	.06	.70***
Step 3			
SD at intake	.18	.07	.15*
Change in Subjective Well-Being	.60	.05	.67***
Role Investment (RI)	.38	.21	.12
Empathic Resonance (ER)	.47	.14	.21***
Mutual Affirmation (MA)	-.08	.17	-.03

Note: $R^2 = .09$ for Step 1. $\Delta R^2 = .46$ for Step 2. $\Delta R^2 = .07$ for Step 3.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Rehabilitation

To predict change in CLF, the following hierarchy of variable entry was used: at step 1, CLF at intake was entered; at step 2, change in SWB (i.e., remoralization) and change in SD (i.e., remediation) were entered; and at step 3, the bond score(s) were entered. In the final equation using the GB score, CLF at intake ($\beta_{CLF} = .18, p < .01$), change in SWB ($\beta_{SWB} = .20, p < .001$), and change in SD ($\beta_{SD} = .63, p < .001$) made statistically significant contributions, but the GB score ($\beta_{GB} = .01, n.s.$) did not ($R = .86; p < .001$).

As shown in [Table 6](#), the hierarchical regression analyses using the bond scale scores yielded similar results. Although the final regression equation accounted for 75% of the variance in CLF at the latter session, the bond scales did not make a statistically significant contribution.

Table 6. Summary of Hierarchical Regression Analysis for Predicting Current Life-Functioning (CLF) Using Bond Scales

Variable	<i>B</i>	<i>SE B</i>	β
Step 1			
CLF at intake	.56	.11	.44***
Step 2			
CLF at intake	.22	.07	.17**
Change in Subjective Well-Being	.21	.08	.20**
Change in Symptomatic Distress	.78	.09	.63***
Step 3			
CLF at intake	.21	.007	.16**
Change in Subjective Well-Being	.24	.08	.22**
Change in Symptomatic Distress	.74	.10	.60***
Role Investment (RI)	.06	.22	.02
Empathic Resonance (ER)	.18	.15	.07
Mutual Affirmation (MA)	-.18	.18	-.06

Note: $R^2 = .19$ for Step 1. $\Delta R^2 = .54$ for Step 2. $\Delta R^2 = .01$ for Step 3.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Discussion

The therapeutic relationship between therapist and client has been the focus of a great deal of theoretical and empirical work, but the typical correlation with outcome is found to be modest (cf. [Horvath & Symonds, 1991](#)). The relationship comprises transference and alliance elements, and the alliance comprises agreement regarding tasks and goals and the therapeutic bond.

Based on the prediction that the association between the therapeutic bond aspect of the alliance and outcome is mediating (or directly causative), and that specifying both constructs more precisely would clarify the association, the present study examined the nature of the association between the therapeutic bond and treatment outcome. The bond was divided into three subscales (role investment, or the degree of emotional investment the client puts into the therapy; empathic resonance, or the client's sense that there is mutual understanding; and mutual affirmation, the client's sense that therapy is being conducted in an atmosphere of liking and acceptance). Treatment outcome was divided into two distinct constructs: the quality of the session and treatment effectiveness. Treatment effectiveness was specified using the phases of outcome proposed in the phase model of therapy outcome: remoralization refers to the improvement in general life satisfaction or subjective well-being, and is usually the first phase of outcome; remediation refers to symptom reduction and usually occurs in the next phase; finally, rehabilitation is recovery of life or role functioning, and occurs last if at all ([Howard et al., 1993](#)).

The results indicated that the clients' rating of the quality of the session just completed was correlated more with role investment and mutual affirmation than with empathic resonance. Clients who felt motivated and invested in the work of therapy and who had the sense that the therapeutic environment was friendly and affirmative were likely to rate the session as being helpful and productive. It is noted both the bond and session quality were measured after the session using the same questionnaire, and that the direction of this association is not clear. Indeed, there may not be a causal association at all, as there may be an unmeasured aspect of the session that determines both session quality and the client's sense of role investment and mutual affirmation. Nonetheless, it is intriguing that empathic resonance was much less strongly associated with SQ than the other

two bond variables, especially since the opposite was found with regard to treatment effectiveness. The results indicated that ER, the sense of understanding and of being understood, was a significant predictor of both remoralization and remediation, whereas RI and MA were not.

Thus, the results suggest that immediate results of feeling that the session was helpful and progress was made are associated with feeling liked and being motivated, whereas improving with respect to general emotional distress and symptom patterns relies on feeling that the communication in the session is effective and that one is being understood. These results suggest a distinction between immediate, postsession outcome (i.e., SQ) and ultimate treatment effectiveness. Although [Silbershatz \(1994\)](#) reported significant correlations between a measure of alliance and immediate progress, which he argues contributes to ultimate outcome, the present study suggests that different aspects of the alliance may be responsible for immediate versus long-term treatment effects. More research is needed in this area.

Finally, as hypothesized, the results suggest that the rehabilitation phase of therapy, or recovery of role functioning, was unrelated to any of the therapeutic bond measures. Although not evaluated in the present study, this may be due to the frequent finding that recovery of role functioning occurs last, if at all ([Howard et al., 1993](#); [Mintz et al., 1992](#)). If rehabilitation occurs slowly, or not at all, then it is not surprising that it is unrelated to an early treatment measure of the therapeutic bond.

Although the strength of the therapeutic bond does appear to be directly related to treatment effectiveness, this does not imply that increasing the bond will cause better outcome. The bond is not an ingredient supplied by the therapist and responded to by the client ([Stiles & Shapiro, 1994](#)). Rather, the alliance is an essential part of effective therapy that may have different effects for different clients. The parts of the alliance act as both mediating and moderating variables in the course of therapy ([Shadish & Sweeney, 1991](#)). Whether it primarily facilitates other interventions or is an active ingredient itself likely depends on the needs and predispositions of the client. For example, some clients enter therapy with an established capacity for close relationships, and they will develop such with the therapist quickly. Such a relationship will provide the groundwork for engaging in other interventions. For other clients, such as those with pathological attachment histories, the establishment of a caring, supportive, and active alliance with the therapist may be an active, curative ingredient per se (cf. [Henry & Strupp, 1994](#)). In support of this proposition, [Gaston, Piper, Debbane, Bienvenu, and Garant \(1994\)](#) examined interactions between the alliance and therapist interventions, and they found that clients who were capable of establishing a good alliance could utilize interpretations effectively, whereas clients who were less capable of forming a strong alliance responded better to supportive interventions.

There are limits to the generalizability of the present study. These include the limitations applicable to all naturalistic or effectiveness studies—studies done without subject selection, random assignment to treatment conditions, monitoring of treatment integrity, and set length of treatment duration. That is, not exerting control over experimental (i.e., treatment) conditions precludes elimination of potential sources of error. Likewise, a common limitation of naturalistic studies involves administration of the researchers' process and outcome questionnaires. For example, in the present study, outcome questionnaires were administered on a regular basis (e.g., after every 10th session), which did not necessarily (nor usually) correspond to the termination or final session of therapy. Indeed, if a client in the present study attended 49 sessions, the available outcome questionnaire from the prior 40th session would have been used to evaluate treatment effectiveness. Nonetheless, it is argued that these were generally valid measures of remoralization, remediation, and rehabilitation, as these outcome phases tend to plateau in treatment (cf. [Howard, Kopta, Krause, & Orlinsky, 1986](#)), and it is noted that these results are consistent with other research into the phases of outcome. There is a necessary balance between the information obtained in efficacy versus effectiveness research (cf. [Howard, Moras, Brill, Martinovich, & Lutz, 1996](#); [Seligman, 1995](#)), and the present study adds to the growing literature regarding the mechanisms by which the relationship influences outcome in naturalistic settings.

Another limitation of this study is that it relied entirely on client self-report for both the measurement of the process (bond) and outcome variables, and that the analyses relied on regression or correlational statistics, which was a criticism earlier leveled at other studies of the association between the therapeutic relationship and treatment outcome. This study likewise did not address issues of cognitive dissonance nor self-consistency, and all of these concerns represent potential limitations to the generalizability of the results. It is well established that persons try to be self-consistent. Thus, it can be argued that if these clients rated themselves as being effortfully engaged in the therapeutic process, they may feel compelled to rate the therapy as useful. For these reasons, the present results need to be refined and replicated.

Finally, the representativeness of the study sample limits the generalizability of these results. Any client applying for therapy was either accepted or referred elsewhere using the customary clinical protocol, and any client accepted into psychotherapy was invited to be part of the LTPRP. Moreover, the present study was limited to participants who had fairly complete data. The extent to which this self-selection process limits these results is not known but may be considerable.

The associations between the alliance, other interventions, and outcome is very complex. Moderating and mediating relationships among variables are not mutually exclusive, and their combination can be complex (e.g., moderated mediation and mediated moderation are possible; see [Baron & Kenny, 1986](#)). Recent research into the alliance appears to appreciate the complexity of the associations. For example, [Safran and Muran \(1996\)](#) have developed a task-analytic strategy to examine the resolution of ruptures in the therapeutic alliance, [Sexton, Hembre, and Kvarme \(1996\)](#) used time series analysis to examine the effect of the alliance within different phases of the therapy, and [Blatt, Quinlan, Zuroff, and Pilkonis \(1996\)](#) found that the alliance was related to outcome as a function of clients' pretreatment perfectionism. The results of this study suggest that specifying the proposed effect, in addition to more precise measurement of both the alliance and outcome, will yield a more accurate picture of their association. Clearly, more research into the complexity of the parts and purposes of the alliance in psychotherapy is needed.

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