12-1-1989

The Therapeutic Bond Scales: Psychometric Characteristics and Relationship to Treatment Effectiveness

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Acknowledgement

Abstract

The Therapeutic Bond Scales assess the quality of the therapeutic relationship from the patient's perspective. The therapeutic bond is composed of 3 aspects: working alliance, empathic resonance, and mutual affirmation. Scales were developed to measure these aspects and the therapeutic bond as a whole. The correlations between these scales and 2 measures of outcome (session quality assessed by the patient and termination outcome evaluated by nonparticipant raters) were examined. All scales were significantly correlated with session quality. Therapeutic bond was significantly correlated with termination outcome in both a linear and a curvilinear fashion, suggesting that, at least in the initial phase of therapy, the therapeutic bond can be too high as well as too low.

Introduction

A substantial accumulation of empirical findings exists relating psychotherapy process variables to treatment outcome (cf. Orlinsky & Howard, 1986a). One of the most consistent findings in the psychotherapy research literature is that the quality of the relationship between the patient and the therapist is a major determinant of psychotherapeutic effectiveness (e.g., the therapeutic alliance literature: Alexander & Luborsky, 1986; Marmar, Horowitz, Weiss, & Marziali, 1986). Reviews (Gurman, 1977; Lambert, Shapiro, & Bergin, 1986; Orlinsky & Howard, 1986a; Patterson, 1984) consistently demonstrate that (a) a good therapeutic relationship is at least a major contributing factor, if not a necessary and sufficient condition (Rogers, 1957), for successful treatment, and (b) that the *patient's* perception of the quality of the relationship is most consistently positively related to outcome. Yet most systems for measuring this aspect of the therapeutic relationship are based on the non-participant observer perspective.

The primary goal of the present study was to develop a reliable measure of the quality of the therapeutic relationship, from the patient's perspective, based on a theoretical model of the therapeutic bond. We also investigated the relationship between the quality of the bond, measured in this way in the early stage of therapy, and two measures of therapeutic effectiveness: an assessment, by the patient, of the overall quality of the session and a measure of outcome at termination, rated by nonparticipant judges.

Conceptualization of the Therapeutic Bond

Orlinsky and Howard's (1978, 1986a, 1987) definition of the therapeutic bond goes beyond previous conceptions of the "therapeutic alliance":

> The therapeutic alliance is a compact between the patient and the rapist to cooperate in performing their respective roles. The therapeutic bond, on the other hand, extends beyond patient and therapist roles to include certain personal qualities of the relationship that forms—or fails to form—between the participants. (Orlinsky & Howard, 1987, p. 10)

In this conceptualization, the therapeutic bond is composed of three dimensions.

The first dimension is the energy that each participant invests in the process of psychotherapy or, more precisely, in his or her respective role in the process. Initially it was called "reciprocal role-investment" and was contrasted with "role-distancing" in which the individual desires to convey the impression that the therapy behaviors are "not really me." The concept was expanded to include other investment dimensions, such as motivation, and was relabeled the *working alliance.* It reflects, above all, an investment of the self into the appropriate role by each participant. For example, it is necessary that the patient be willing to assume the role

of the one who is seeking help from psychotherapy and that he or she be the one who will bring concerns into the session. The working alliance is determined by how genuine or self-congruent the patient and the therapist perceive their respective role behavior to be. Therapist genuineness and credibility are examples of this dimension, as are the activity level and motivation of the patient (for further discussion of this and the other two bond dimensions, see Orlinsky & Howard. 1978. 1986a. 1987).

Empathic resonance, the second dimension, is the participants' sense of being "on the same wavelength." It is the patient's and the therapist's sense of understanding and being understood. When empathic resonance is present in the relationship, it is reflected in communications that are characterized by mutual trust and comfortableness. Therapist empathic receptivity and patient expressiveness have been researched extensively, but the present definition focuses on the quality of the relationship rather than on attributes of individuals. Hence, patient empathic receptivity and therapist expressiveness are equally important.

The third dimension is called *mutual affirmation.* It is conceptually close to the Rogerian concept of unconditional positive regard because of its emphasis on the reciprocity of caring and on the recognition that caring, although normally experienced as warmth and acceptance, can on occasion lead to confrontation and challenge. Mutual affirmation is "an interest and endorsement of (the other's) well-being, motivating behavior that is essentially caring in quality" (Orlinsky & Howard, 1986a, p. 348). This dimension encompasses the patient's sense of a friendly, accepting attitude on the part of the therapist. But, it is worth repeating, this definition emphasizes mutuality, and the therapist will also experience such an attitude on the part of the patient within a good therapeutic bond (e.g., Tovian, 1977).

Working alliance, empathic resonance, and mutual affirmation are the dimensions comprising the therapeutic bond. As may be evident from the above conceptualizations, the three dimensions are closely related. Indeed, by definition, they are mutually dependent. It is hard to imagine, for example, that either of the latter two dimensions could develop in a relationship that was not also characterized by a high level of energy investment on the part of both participants (i.e., a good working alliance). It should be recognized that the bond is not a reflection of the individuals but of their interaction—it emerges in the patient's and therapist's interaction during therapy, and its quality is a reflection of this interaction and not of the participants themselves.

Method

The consideration of observational perspective is a crucial methodological issue. One might choose to operationalize working alliance, for example, either from the patient's perspective, from the therapist's perspective, or from the perspective of a nonparticipant observer. Although each of these alternatives is valid in its own right and yields information not duplicated by the others, we focused on the patient's observational perspective, utilizing ratings made by patients of themselves and of their therapists. The quality of the therapeutic bond, perhaps above and beyond any other process variable, is phenomenological in nature, and we assumed that it would be best captured from this perspective. This assumption is supported by other studies. Gurman (1977) concluded that ratings of the therapist-offered relationship made by nonparticipant judges and by the therapists themselves have not been powerful predictors of outcome, whereas ratings from the patients' perspective have consistently yielded positive findings. Similarly, Orlinsky and Howard's (1986a) exhaustive review of process-outcome studies noted that the perspectives of participant observers have most consistently been found to be related to outcome.

Instrument

The material for constructing measures of working alliance, empathic resonance, and mutual affirmation was drawn from the Patient version of the Therapy Session Report (TSR) questionnaire (Orlinsky & Howard, 1966). The TSR, which requires 10 to 15 minutes to complete after a session, is a 145-item structured-response

instrument designed as a general survey of the experiences that patients have in individual psychotherapy (see Orlinsky & Howard, 1986b, for a detailed presentation of the TSR).

The TSR presents the patient with items organized under the following broad questions: What did you talk about during this session? What did you hope or want to get out of this session? What problems or issues were you concerned with in this session? How did you act towards your therapist during this session? How did you react to yourself during this session? What were your feelings during this session? What did you get out of this session? Patients are also asked to indicate their motivation for coming to the session and for returning the next time, to rate the overall quality of the session, and to assess their current level of functioning.

The TSR also includes items concerning the patient's perception of the therapist during the session: How well did your therapist seem to understand you? How helpful was your therapist to you? How did your therapist act towards you? What did your therapist seem to be feeling?

Patients

TSRs were completed by 113 psychotherapy outpatients who underwent individual treatment at Northwestern Memorial Hospital's Institute of Psychiatry. This study utilized TSRs obtained from each patient after the third or fourth session of psychotherapy (the third session was preferred). The number of sessions attended by these patients ranged from 3 to 242, and the median number of sessions was 26. Table 1 shows the demographic characteristics of the patients. The typical patient was a single, white female between the ages of 25 and 35 with at least some college education. Patients were self-referred and were treated for a variety of mild to moderate psychological disorders. The patient sample is reasonably representative of the psychotherapy patient population (cf. Taube, Kessler, & Feuerberg, 1984).

Table 1. Individual and Social Characteristics of the Patient Sample

Characteristics	N	%
Age		
18-24 years	23	20.4
25-28 years	29	25.6
29-34 years	30	26.5
35-59 years	31	27.4
Sex		
Female	69	61.1
Male	44	38.9
Race		
White	101	89.4
Nonwhite	12	10.6
Marital status	66	58.4
Single		
Married	25	22.1
Divorced	15	13.3
Other	7	6.2
Level of education		
Some high school or less	4	3.5
High school degree	13	11.5
Some college	30	26.5
College degree	40	35.4
Some graduate school or more	26	23.0

Employment status		
Employed	81	71.7
Unemployed	32	28.3
Termination Outcome Ratings		
Considerably worse through *no change*	42	37.2
Slightly through *considerably improved*	71	62.8

Note. N= 113.

Via screening interview, all patients were determined to be appropriate for psychodynamically oriented, intensive, individual therapy. Participation in the research project was voluntary, informed consent was obtained, and confidentiality of responses was ensured.

Therapists

There were about 80 therapists in the Institute's Psychotherapy Program. The majority of these were in some stage of training—psychology practicum students, psychology interns, and psychiatry residents—although most had had considerable additional experience. Sixty percent of the therapists were psychologists, 29% were psychiatrists, and 11% were social workers. Ninety-four percent were 20–39 years of age, 54% were male, and 54% were married. Eighty-three percent of the therapists had had personal therapy. The orientation of the Institute is psychodynamic; supervisors espouse this therapeutic approach, case presentations follow this model, and attempts are made to conceptualize each case from this perspective.

The Therapeutic Bond Scales

The Therapeutic Bond Scales were extracted from the TSR, which, as noted above, was designed as a general survey of the patients' intrasession experiences. The development of the bond scales involved three steps. First, all TSR items were evaluated for appropriateness of inclusion on one of the scales. Upon consensus of the three authors that an item reflected an aspect of the bond, it was retained for that particular scale. Second, correlations between each item of the three scales and each scale were computed. Any item that correlated less with its assigned scale than with the other two scales was dropped. Finally, an alpha reliability coefficient was calculated for each scale. Any TSR item that lowered a scale's internal consistency was dropped from the scale. Thus, the bond scales were developed on a conceptual basis and then subjected to psychometric revision in order to achieve maximum reliability.

Therapeutic Effectiveness

Two measures of therapeutic effectiveness were used in the present study. Session quality was assessed using the patient's overall assessment of the session just completed. The first item on the TSR asks the patient to rate this on a 7-point scale ranging from *perfect* to *very poor*. With respect to these scores, 79.7% of the patients indicated that their session was *pretty good* or better (*very good, excellent, or perfect*); 20.3% rated their sessions as *fair* or poorer (*pretty poor* or *very poor*).

Termination outcome scores were calculated from ratings of the closed clinic files using the evaluation method developed by Tovian (1977). To be usable, clinic files had to contain, at the minimum, information about the intake interview and disposition at the end of treatment (or treatment summary). Most files also contained therapist notes concerning individual sessions. Each file was examined independently by two judges, graduate students in clinical psychology. Each judge made two ratings: the patient's overall condition at closing, and symptom change, that is, the extent of change in the presenting problem(s). Each of these ratings was scored on a 7-point scale ranging from *considerably worse* (1) through *no change* (4) to *considerably improved* (7). Raters received no special training with the exception of being told to emphasize that each presenting problem be rated separately. When there was more than one presenting problem, each was rated separately and they were

then averaged to yield a single rating of symptom change. These scores were combined to yield a single outcome index, which ranged from 2 to 14.

Ratings were completed for all of the 113 patients. The two component parts of the outcome index were highly correlated across all raters (average r = .90). Interrater reliability of the index was also high (r =.91). With a cutoff of 10 (indicating that both outcome dimensions were rated 5 [*slightly improved*] by both raters) as a conservative lower limit of treatment success, 71 (62.8%) of the patients were rated as successful (see Table 1).

Procedure

We were interested in two general research questions: (a) What are the patients' perceptions of the quality of the therapeutic bond early in treatment and are these perceptions related to their judgment of the quality of the session? and (b) Is the perception of the quality of the bond early in treatment predictive of eventual success or failure? Because some researchers have reported that third-session data are particularly useful in predicting variables such as duration of treatment and outcome (e.g., O'Malley, Suh, & Strupp, 1983; Saltzman, Leutgart, Roth, Creaser, & Howard, 1976), only TSRs obtained in either the third (preferably) or the fourth session were utilized.

In an attempt to make the scale scores directly analogous to the TSR items (which the patient rates on a 0-1-2 scale), we transformed each bond scale score so that it ranged from 0 to 20. Thus, a score of 0 would correspond to *no* experience of that dimension, a score of 10 would indicate *some* experience of that aspect of the bond, and a score of 20 would be equivalent to "*a lot of*" experience of that bond dimension. The Global Bond scale was an average of the three subscales.

Analyses and Results

The Therapeutic Bond Scales

The Working Alliance scale

The patient's experience of the working alliance (WA) was reflected in the endorsement of the items shown in Table 2. Patient motivation for coming to the session and patient motivation for returning to the next session were viewed as relevant items for the WA scale. Two patient feelings ("determined" and "serious") and three patient behaviors (talking, focusing on important concerns, and taking initiative) were also included in this scale. Five items on this scale were endorsed under the question stem, "This session I hoped or wanted to." The five can be categorized into three identifiable therapeutic realizations that the patient hoped to attain: insight ("understand the reasons behind my feelings and behavior" and "find out what my feelings really are and what I really want"); catharsis ("get a chance to let go and get things off my chest" and "get relief from tensions or unpleasant feelings"); and working on a particular problem ("work out a particular problem that's been bothering me"). Only three items in the Patient version of the TSR reflected the therapist's state of role-investment. All of these were therapist affects perceived by the patient.

Table 2. The 15 Items Comprising the Working Alliance (WA) Scale

	Corrected item-total correlations	
Item	WA scale	Global bond
1. How did you feel about coming to therapy this session?	.46	.43
2. To what extent are you looking forward to your next session?	.39	.39
This session I hoped or wanted to:		
3. Get a chance to let go and get things off my chest.	.38	.31

4. Get relief from tensions or unpleasant feelings.	.38	.29
5. Understand the reasons behind my feelings and behavior.	.33	.16
6. Find out what my feelings really are, and what I really want.	.38	.28
7. Work out a particular problem that's been bothering me.	.37	.22
During this session how much did you feel:		
8. Determined	.39	.48
9. Serious	.32	.17
During this session, how much:	.39	.44
10. Were you able to focus on what was of real concern to you?		
11. Did you take initiative in bringing up the subjects that were talked about?	.32	.38
12. Did you talk?	.24	.25
During this session my therapist seemed to feel:		
13. Thoughtful	.24	.38
14. Involved	.16	.40
15. Confident	.20	.44

Note. Readers interested in the conversion of these items into corresponding Therapy Session Report items should contact Stephen M. Saunders.

The 15 items reflecting the patient's experience of the working alliance are shown in Table 2, which also shows the item–total correlations between the individual items and the WA. scale. The scale had a reliability (alpha coefficient) of .72 and an average score (endorsement) of 13.3 (SD = 2.8), equivalent to between some and a lot of experience of it. The range of scores was 5 to 19.

The Empathic Resonance scale

Empathic resonance (ER) refers to a quality of communication between patient and therapist that depends on their compatibility in range and style of expressiveness and understanding. The 17 items defining this scale are listed in Table 3. One TSR item reflecting the patient's receptivity during the session was the question "Were you attentive to what your therapist was trying to get across to you?" Six other items focused on aspects of the patient's expressiveness, most directly the question "How much did you talk about what you were feeling?" but also responses to questions about the patient's feelings such as not feeling "inhibited" and "withdrawn." Indirectly, patients were judged as likely to have been more expressive in their sessions when they reported feeling "confident" and *not* feeling "embarrassed," "frustrated," and other similar affects.

Table 3. The 17 Items Comprising the Empathic Resonance (ER) Scale

Item	Corrected item-total correlations	
	ER scale	Global bond
1. How well did your therapist seem to understand what you were feeling and thinking?	.36	.54
During this session I felt:		
2. Frustrated(-)[a]	.55	.32
3. Impatient (-)	.52	.34
4. Withdrawn (-)	.44	.29
5. Confused(-)	.41	.20
6. Cautious (-)	.41	.24
7. Strange(-)	.40	.28

8. Embarrassed(-)	.34	.23
9. Confident	.33	.37
10. Inhibited(-)	.32	.18
11. Helpless (-)	.28	.16
During this session, how much:		
12. Was your therapist attentive to what you were trying to get across?	.35	.44
13. Were you attentive to what your therapist was trying to get across to you?	.26	.40
14. Did you talk about what you were feeling?	.22	.42
During this session my therapist seemed to feel:		
15. Bored(-)	.33	.34
16. Interested	.28	.44
17. Alert	.21	.49

[a] These items were reversed so that low endorsement corresponded to a better bond score.

The patient's view of the therapist's empathy was reflected in six TSR items. Two of these were responses to the questions "Was your therapist attentive to what you were trying to get across?" and "How well did your therapist seem to understand what you were feeling and thinking?" The remaining three items were patient perceptions of the therapist's affect during the session.

Item-total correlations between these items and the ER scale are listed in Table 3. This bond subscale's reliability was .77. Average endorsement of the ER scale was 14.5 (SD = 2.8), which is also between "*some*" and "*a lot of*" experience of the dimension, and the range was 6 to 19.

The Mutual Affirmation scale

The third constituent facet in our conception of the therapeutic bond is mutual affirmation (MA), reflecting the care, respect, and commitment to the other person's welfare that the patient and the therapist may evoke in and feel for one another. The 18 items defining MA were drawn from the patient's perceptions of interpersonal behaviors and affective states and are presented in Table 4. Both patient and therapist affirmation were represented. MA was reflected in responses to three questions concerning, generally, the patient's friendly, negative, and critical behavior toward the therapist. Seven patient feelings also reflected affirmation toward the therapist.

Table 4. The 18 Items Comprising the Mutual Affirmation (MA) Scale

Item	Corrected item-total correlations MA scale	Global bond
This session I felt:		
1. Grateful	.61	.61
2. Accepted	.59	.59
3. Hopeful	.56	.58
4. Close	.55	.52
5. Pleased	.51	.56
6. Likeable	.46	.49
7. Affectionate	.46	.37
I feel that I got:		

8. More of a person-to-person relationship with my therapist.	.62	.57
During this session, how much:		
9. Was your therapist friendly and warm towards you?	.54	.52
10. Did you tend to accept or agree with what your therapist said?	.42	.57
11. Did your therapist tend to accept or agree with your ideas and point of view?	.37	.34
12. Friendliness or respect did you show your therapist?	.31	.41
During this session, my therapist seemed to feel:		
13. Pleased	.61	.60
14. Close	.57	.53
15. Cheerful	.52	.49
16. Affectionate	.49	.35
17. Optimistic	.32	.35
18. Attracted	.30	.31

The therapist's affirmation toward the patient was reflected in the following items: "Was your therapist warm and friendly towards you?" and "Did your therapist tend to accept or agree with your ideas and point of view?" The patient's perceptions of various therapist "affirming" feelings were also included in this scale. Indirectly, therapist affirmation was reflected by the patient's feeling "accepted," "likeable" and "pleased." Finally, one item—the patient's satisfaction with having "more of a person-to-person relationship" with the therapist—was taken as an indicator of affirmation on the part of both participants.

The items comprising the MA scale and the item–total correlations between them and the MA scale are shown in Table 4. This scale had the highest reliability of the three (α = .87). Endorsement of the MA scale was considerably lower than that of the other two scales: The average score was 8.0 (SD = 3.4), equivalent to *some* experience of the dimension, and the range of scores was 0 to 17.

The Global Bond scale

The Global Bond scale is a composite of the three subscales. Calculating its internal reliability as a function of the relationship between the three subscales (i.e., N= 3 in the formula), we obtained an alpha of .62. The item–total correlations of each item with the Global Bond scale are shown in Table 2, Table 3, and 4. Endorsement of the Global Bond scale indicated that the average score was 11.9 (SD = 2.3), and the range of scores was 6 to 18.

Correlations Among Bond Scores and Therapeutic Effectiveness

Table 5 shows the correlations among the three scales and the Global Bond scale. The highest correlation was between the WA and MA scales, and they shared about 26% of their variance. The MA and ER scales were also significantly correlated, sharing 17% of their variance. The WA and ER scales shared less than 1% of their variance.

Table 5 Pearson Product-Moment Correlations Among the Bond Dimensions and Between the Bond Dimensions and Outcome Measures

	WA	ER	MA	Global bond
Bond dimensions				
Working Alliance (WA)	(.72)			
Empathic Resonance (ER)	.09	(.77)		
Mutual Affirmation (MA)	.51**	.42**	(.87)	
Global Bond	.70**	.65**	.88**	(.62)

Outcome measures				
Session quality	.34**	.51**	50**	.60**
Termination outcome [a]	.11	.16	.16	.19*

Note. N= 113. The diagonal entries are the alphas of the scales.
[a] Bonferroni correction to control for experiment-wise error rate would requires = .0125.
*p<.05.
**p<.001.

We next investigated the relationship between the patients' bond scale scores and two measures of effectiveness. First, we wanted to determine if the patient's perception of the quality of the therapeutic bond was related to a measure of session quality operationalized as the patient's rating of the overall quality of the session. Table 5 shows the correlations between each of the four scales (WA, ER, MA, and Global Bond) and session quality. All of the correlations between session quality and the bond measures were significant at beyond the .001 level. The ER scale had the highest correlation of the three subscales, but the Global Bond scale's correlation was highest of all.

As stated, the two parts (i.e., patient's overall condition at closing and symptom change) comprising the termination outcome ratings were highly correlated across all raters, and interrater reliability was high. Table 5 shows the correlations between termination outcome ratings and the bond scales. The correlations between termination outcome and the various bond subscales did not achieve significance. The correlation between termination outcome and the Global Bond score was significant, however ($r = .19$, $p < .05$).

We conducted an additional analysis to investigate the possibility of a curvilinear aspect to the relationship between the therapeutic bond and treatment effectiveness. Post hoc, we theorized that there might be an optimal quality level of the therapeutic bond and that perceiving its quality as either too low or too high would predict poorer outcome. In a hierarchical multiple regression analysis, the Global Bond score was entered first, and then the square of the Global Bond score was entered. The resulting multiple correlation was .27 ($p < .05$), and both the linear and curvilinear components were statistically significant. The beta for the square of the Global Bond score was negative, indicating that the lower and the upper ranges of the bond scores were associated with poorer outcome.

Discussion

The results indicate that the TSR provides a psychometrically sound basis for assessing the theoretical qualities of the therapeutic bond. The relative ease with which this instrument is administered, completed, and analyzed underscores its potential usefulness.

The patients in this study seemed to experience mutual affirmation as being related to both of the other scales, whereas working alliance and empathic resonance were experienced as separate entities. We assumed that the three dimensions would be related, because they assess the same construct, but we hoped that they would not be so highly correlated as to preclude the establishment of separate subscales. The ER and WS scales shared little variance (less than 1%), which suggests that they are distinct, but both were highly correlated with the MA scale. Together, they accounted for over 40% of the latter scale's variance, which might indicate that the MA scale is somewhat redundant. It might be argued that the MA scale should be collapsed into these two and that WA and ER are truly distinct parts of the bond. This argument fits well with various other conceptualizations and research results. Bordin's (1979) conceptualization of the therapeutic alliance states that a good relational bond is necessary for, and combines with agreement on and implementation of particular tasks and goals of therapy to become, the therapeutic alliance. (Bordin's conceptualization also recognizes the importance of both patient and therapist influences on the bond.) Translated into the terminology of the generic model, a good therapeutic bond is partly personal investment of energy (i.e., the working alliance = tasks and goals) and partly relationship variables (i.e., empathic resonance = relational bond). Horvath and Greenberg (1986) developed the Working

Alliance Inventory to test Bordin's assertions and have shown that it is predictive of patient ratings of treatment effectiveness.

Patients generally reported experiencing the bond scales at high levels (the lowest endorsement being for MA at around *some* experience of it). This could indicate a genuine experience of the offered relationship, or it could mean a reluctance to be critical at such an early stage of treatment. It is likely that expectation and an early form of transference play a role in the patient's experience of the early-therapy bond because there is little actual information with which the patient can realistically evaluate it. Practitioners try to remain aware of transference and expectation issues and the problems that they sometimes pose for therapy. The bond scales might prove useful as an indicator of these phenomena and may help to identify patients who have excessive or unreasonable needs for and expectations from the therapeutic relationship. For example, Daskovsky (1988) used these scales to investigate the relationship between pretherapy assets of patients (specifically, a measure of object relatedness) and patients' capacity to enter into the therapeutic relationship (early-session Global Bond scores). Patients' level of object relatedness was inversely correlated with the therapeutic bond. These results were interpreted to mean that patients with better object relatedness were more able to be critical or, perhaps, realistic about the quality of the bond in this early stage of therapy.

All of the scales (including the Global Bond scale) were highly correlated with session quality. The strength of these correlations with session quality was probably somewhat inflated because both the session bond and session quality measures were derived from the same instrument. Even so, the result is consistent with other research reporting a significant correlation between the quality of the patient–therapist relationship and the rated quality of the session as a whole (e.g., Marziali, Marmar, & Krupnick, 1981; O'Malley et al., 1983; Sachs, 1983). In general, patients who perceived a better quality bond rated the quality of the session to be better.

We based the present analyses on data drawn from the third or fourth session in order to see whether early manifestations of the bond were predictive of treatment effectiveness. Although the therapeutic bond subscales were not predictive of treatment outcome, the composite of these subscales, the Global Bond scale, was significantly correlated with treatment outcome. In addition, the hierarchical multiple regression analysis suggested that there is a curvilinear component to the bond: Both the lower and upper bounds of the Global Bond scale were associated with poorer outcome. This is an important finding for both researchers and practitioners. It suggests that patients can overestimate the quality of the bond early in treatment and, presumably, be disappointed with its development and consequently have poorer outcomes. Again, the Daskovsky (1988) finding that patients' level of object relatedness was inversely correlated with the therapeutic bond is relevant. It is reasonable to suggest, based on clinical experience and these findings, that some patients enter therapy with excessive "need" of the therapeutic bond and that this need may be detrimental to the progress of therapy.

The results of our study are consistent with those of other studies that have shown a positive correlation between the quality of the bond and treatment effectiveness. The size of the association was not as large as that reported in other studies, however (e.g., Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Suh, Strupp, & O'Malley, 1986). It is possible that the relatively low correlation reported in this study was the result of analyzing the correlation between a process instrument rated from the patients' perspective and an outcome instrument rated by nonparticipant judges. Orlinsky and Howard (1986a) reported that congruent process–outcome perspectives consistently yielded the greatest proportion of positive findings. The highest percentage of significant findings occurred in the subcategory that used therapists' process reports and therapists' outcome evaluations, followed by studies based on the patients' perspective of both process and outcome (Orlinsky & Howard, 1986a, p. 371). The relationship between the various perspectives that are utilizing the same instrument has yet to be delineated adequately, and this seems an important area on which to concentrate future research effort (cf. Alexander & Luborsky, 1986). For example, the Therapist version of the TSR might be

used to investigate the congruence or association between the patient's and the therapist's perception of the therapeutic bond.

Another important distinction of the present study concerns the length of therapy and, consequently, the unusually long period of time between the assessment of process and outcome. For example, the Penn Helping Alliance Scales studies (which reported a correlation of .58 between process and outcome measures) were conducted on therapy that lasted between 3 and 24 sessions, with a mean of about 12 sessions (Luborsky et al., 1985). In comparison, the range of sessions for patients in our sample was between 3 and 242, and over half of the patients attended more than 26. Other studies that have reported high correlations between the quality of the relationship and outcome also had relatively short therapy durations; for example, Marziali et al. (1981) studied brief (12-session) dynamic therapy, and the Vanderbilt Psychotherapy Research Project patients attended at most 25 sessions (Suh et al., 1986).

It seems possible and perhaps likely that the various components of the therapeutic bond develop at different rates during therapy. Both the WA and the ER scales were endorsed at fairly high levels: The average patient experience of these dimensions at this early stage was about halfway between *some* and *a lot*. It appears that patients generally felt that they and their therapists were genuinely invested in the treatment process and that they expressed themselves well and were well understood by their therapists. Relative to the other subscales, MA was endorsed at the lowest level, slightly less than *some*. Theoretically, it is reasonable that mutual affirmation would develop gradually in the dyad only after association between patient and therapist had begun to prove fruitful. Similar to what Frieswyk et al. (1986) suggested, the change in mutual affirmation across therapy might be a useful indicator of its effectiveness.

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