Connecting couple negativity, the active therapist, and the therapeutic alliance

by

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A thesis submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

Major: Human Development and Family Studies (Marriage and Family Therapy)

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Iowa State University
Ames, Iowa
2003
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Signatures have been redacted for privacy
I dedicate this thesis to my loving husband,

Derek James Thomas, who has always inspired me to
be the best that I am capable, and who has unconditionally supported
my efforts, grieved my failures and celebrated my victories
as if they were his own.
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ABSTRACT

Prior research in the psychotherapy field has yielded answers to the question: what makes therapy effective? Researchers have attempted to unearth which couple behaviors are destructive to couples' relational well-being, as well as the ways in which therapists hinder or help the floundering couple. This endeavor strives to review the literature that has examined themes that have emerged regarding effective couple therapy, and connect several concepts, including couple negativity, the active therapist, and the therapeutic alliance. A total of 112 couple and family cases were coded and evaluated by trained observers for specific client and therapist behaviors, as well as assessed the therapeutic alliance. As is the human condition, it is clear that a multitude of variables are at play when examining a construct as complicated as couple therapy. Stepwise regression analyses suggest that spousal and therapist behaviors integrate to form a synthesis that predicts an effective therapeutic alliance, therefore influencing couple therapy outcome.
CHAPTER 1. INTRODUCTION

To make the connections between what predicts good therapy outcome and what occurs within the therapeutic session, researchers must examine a number of phenomena. What is destructive to couples may also be destructive to therapy, so this thesis begins with an investigation of couple negativity. From there, we can investigate what predicts better therapy: namely, the therapeutic alliance. Therefore, there is a focus on the components of the alliance, as well as the connection between the alliance and outcome. Then, looking into what therapist or couple behaviors influence the therapeutic alliance is an important part of understanding what contributes to an effective alliance. Finally, the purpose and associated hypotheses for this research study are included.

Couple Negativity

The literature in the family studies and mental health field demonstrates overwhelming evidence that negative affect and remarks between romantic partners are detrimental to couples. John M. Gottman has received considerable professional and popular attention regarding his research surrounding these negative behaviors. Gottman (1999) identifies the Four Horsemen of the Apocalypse, his figurative behavioral precursors and predictors of divorce.

The four horsemen of the apocalypse. The first Horseman is Criticism. He states: “Criticism is any statement that implies that there is something globally wrong with one’s partner, something that is probably a lasting aspect of the partner’s character.” (Gottman 1999, p. 42) This is distinctly different from a complaint, which is a specific statement regarding an act or event, not the character of one’s partner. Gottman (1999) gives the following example:
**Complaint:** “I’m upset that you talked about yourself all through dinner and you didn’t ask me anything about my day. That hurts my feelings.”

**Criticism:** “You talked about yourself all through dinner and didn’t ask me anything about my day. How can you treat me this way? What kind of a self-centered person are you?” (p. 44)

Complaints transcend into criticism when they attack the other person. One way this happens is by adding the words “always”, or “never” to the statement. Then, “I’m upset that you didn’t help me with the dinner” turns into “You never help me with anything”, taking the specific occurrence into a global character flaw, and the complaint into a critical remark (Gortman, 1999).

The second Horseman, Defensiveness, is any attempt to defend oneself from an attack. He states that in marital interaction, defensiveness takes the common structure of the “innocent victim” position, with negative affect thrown in. A defensive person might say: “Why are you picking on me? What about all the good things I do? I never get any credit for those things” (Gottman 1998, p. 45). Often a person who is acting defensive will respond to a critical statement by counterattacking, deflecting the statement back onto the other, and using melodramatic language to exaggerate and divert attention away from the complaint. “What about you? You’re the one who crashed the car into the parking meter last month!”

The third Horseman, Contempt, is any statement or nonverbal behavior that puts oneself on a higher plane than one’s partner. This often takes the form of mocking and degrading one’s partner. For instance, a husband imitates his wife: “I forgot to get milk again, I’m sooooooo stupid that I can’t even read the grocery list…” Gottman states that mockery can be a very powerful form of contempt, as well as other forms of contempt that
can be equally potent. For example, researchers have identified several facial expressions that express contempt as clearly as verbalizing such emotions. It is apparent that unspoken communications can give a clear message to the partner (Gottman, 1999).

The fourth and final Horseman, Stonewalling, occurs when the listener withdraws from the interaction. Generally, this occurs by one person leaving the room or the location. If the stonewaller stays in the room with their partner, such as in the situation of therapy or a research lab, the stonewaller ceases all verbal and nonverbal communication. They tend to look away and down, maintain a stiff neck, and abstain from comment, even when urgently implored by their partner to respond (Gottman, 1999).

Negative start-up. Gottman also identifies negative “start-up”, the way a conflictual discussion begins, as highly indicative of how couples function. He states that harsh or negatively-based start-up, particularly by the woman, is predictive of failed conflict resolution. Also, since women demonstrate negative start-up more frequently than men, Gottman (1999) maintains that the poor interaction is facilitated by an equally frequent incidence of stonewalling by men (Gottman, 1999). This harsh start-up is another example of negative behaviors that couples may demonstrate in therapy. An example of harsh start-up is: “I think that you are very inconsiderate because you leave me with an empty gas tank every time you use my car.” Softened startup might be more like this: “I would really appreciate your conscientiousness by making sure that I’m not low on gas when you return your car—it really stresses me out if the car is almost empty. Thank you, dear. It feels good to know that you will try to be so considerate.”

Empirical evidence of the consequences of couple negativity. Although negative affect occurs in all marriages, most scientific literature describes negativity as destructive
when it consistently escalates and partners are poorly skilled at decreasing the intensity of the negativity (Flora & Segrin, 2000). Hooley and Hahlweg (1986) demonstrated that there exists a strong, significant correlation between negative verbal behaviors and self-reported marital quality, indicating that heightened negativity and depleted marital satisfaction go hand-in-hand. A total sample of 30 dyads were taped and coded for specific couple interactions, to connect negativity and marital quality (Hooley & Hahlweg, 1986). This same research team used a similar methodology to examine different populations in a 1989 cross-cultural study that examined criticism in couples from different European nationalities. Marital satisfaction was assessed using either the General Happiness Rating Scale or the Dyadic Assessment Scale, and interaction observers coded couple communication behaviors. For both the 41 German couples, and the 30 British couples, it appeared that marital satisfaction was strongly and significantly tied to negative verbal behaviors between couples (Hooley & Hahlweg, 1989).

Similarly, Gavazzi, McHenry & Jacobson (2003) examined the effects of expressed emotion, marital quality, and psychiatric symptomology on displays of verbal aggression by both relationship partners. The sample included 152 married couples residing in a large metropolitan area in the Midwest, ages 20-77. Most were European American (89.5%), and the remainder (8.6%) were African American. The couples had been married an average of 10.56 years, and generally had one or two children. They were largely lower middle class. The research team assessed their communication behaviors using the Family Emotional Involvement and Criticism Scale (FEICS), to assess negative comments from family members, as well as to measure emotional over-involvement of family members from the client’s perspectives. Other measures included the Brief Symptom Inventory (BSI), The
Autonomy and Relatedness Inventory (ARI), the Marital Comparison Level Index (MCLI), and the Conflict Tactics Scale (CTS). Couples were surveyed to look for a connection between marital satisfaction and negative remarks. Both female and male ratings of marital satisfaction were significant predictors of negative verbal aggression. That is, higher marital quality scores were significantly associated with lower scores regarding partner verbal aggression. In other words, those partners who reported high levels of marital satisfaction also report lower levels of between-couple verbal aggression (Gavazzi, McHenry, & Jacobson, 2000).

When examining the timing of divorce, Gottman (2000) discovered that negative affect predicted early divorce in newlywed couples. He investigated the effect that certain marriage behaviors have on the timing of divorce, based on the statistics that most divorces occur within two “problem” times: the first seven years of a marriage and the period in which the first child reaches 14 years of age (Gottman, 2000). His sample included approximately 200 couples who responded to a newspaper advertisement. The measures included a demographic questionnaire, two measures of marital satisfaction, and coded interactions. The presence of high incidence of negative behaviors like verbal aggression, negative start-up, and the Four Horsemen of the Apocalypse (Gottman, 1999), was able to predict, with high accuracy, divorce in the first seven years of marriage (Gottman 2000).

*Origins of couple negativity.* Negativity between partners may stem from various sources. Depressed spouses seem to be more critical of their partners than non-depressed spouses (Heins, 1978). Some studies suggest that depressed women show an increased amount of hostile behavior towards their husbands. This study demonstrated clear evidence of increased negative affective expression toward the partner in the depressed marriages
(Heins, 1978). Also, sensitivity to criticism and other negative behaviors is highly correlated with depression. The literature indicates a significant relationship between receiving criticism and a lower sense of self-worth, particularly in women (Prince, 2000). In a qualitative research study, utilizing a sample that included 40 heterosexual couples, 40 gay male couples, and 40 lesbian couples, yielded results that indicated that the use of criticism also seems to be highly associated with attempts to gain power in the relationship. Prince’s (2000) research revealed that being in the demander role in an intimate relationship was highly associated with fears of criticism and rejection, regardless of the gender of the demander. Contrasting to this, other research in the field indicates that negative couple behaviors vary by frequency for men and women, and has a different effect on the recipient based on their gender.

Thus it becomes increasingly clear that couple negativity is destructive to couples’ relationships. The Four Horsemen of the Apocalypse (Gottman, 1999), as well as negative start-up (Gottman, 1999) and aggressive verbal behaviors are examples of couple negativity. Various empirical studies have established a link between negative behaviors and the deterioration of couple relationships. Next, an examination of how individuals’ gender and such negative behaviors are connected.

**Gender and Criticism**

Gender has been a means of societal organization for millennia. Historically, dress, duty, and privilege have been assigned according to gender. Today, gender seems to influence how much some people are paid, their appropriateness for certain lines of work, and life expectations. As persons are organized in this manner, power differentials are assigned. In our society, women tend to have less power than men in relationships
(Haddock, Zimmerman, & Lyness, 2003). It is possible that this lack of power might be connected to some behaviors, such as using negativity to equalize the score between partners.

Research has shown that women criticize their romantic partners more than men (Gottman, 1999). Additionally, the more that women seem to show negative behaviors while in conflict, such as criticism, the more the relationship seems to flounder. Flora & Segrin (2000) found, when examining criticizing versus complimenting behaviors, strong support for the detrimental effect of negative behaviors on relationship well being. In order to discover how affect and behavioral involvement in partner complaints and compliments relate to current and longitudinal well being, the researchers examined 65 married couples, who were at least 20 years old and were native English speakers. The majority were European-American students, and most were either enrolled or had completed a four-year degree. The average length of the marriage was 52.19 months. Measurements they used included administering the Positive and Negative Affect Scale (PANAS) every 7 minutes during interaction, and using Hendrick’s (1988) 7-item relational assessment scale as well as Stafford and Canary’s (1991) Commitment Scale. Additionally, observational coders recorded frequency of specific communication behaviors, establishing that the more wives express negative affect, the more their own and their husbands’ concurrent satisfaction and commitment suffered. In other words, when wives experienced a great deal of negative affect and arousal while the couple was attempting to discuss problems and complaints, both partners seem less happy to be in and less driven to stay in a marriage (Flora & Segrin, 2000). So, the more the wife expresses negativity during conflict resolution, the more the relationship satisfaction of both partners suffer.
The damaging effects of inequity. Gender has a profound effect on the well being of partners in a marriage. In a review of several studies, McGoldrick (1989) reported that numerous studies have stated that married women’s sense of well-being is lower than that of married men’s. Although inequity is undoubtedly damaging to women, it also negatively influences men by threatening the worth of their family relationships, which are central to the happiness and well being of both men and women. Inequity in marital or intimate partnerships has been shown to have negative effects on relationship satisfaction, despite whether partners are under- or over-benefiting, although under-benefiting is most injurious (Haddock, Zimmerman, & Lyness, 2003). Therefore, it is essential that therapists recognize that marital relationships experience inherent, societal-driven power inequities, and that partners use various tactics as means for gaining power in their relationships. Criticism and other negative behaviors may be easily used as such a tactic, and admonishing these from a couple’s relationship, without understanding the power differentials or replacing the negative behaviors with other means to maintain equitable power, may be destructive to the marriage and detrimental to the well-being of the partners.

It is also important for professionals to note that there is evidence that negative behaviors, as a signal for marital discord, are highly influential on the mental health of women. Women seem to be more susceptible to depression in the face of marital discord. In fact, medical correlation data indicates that the risk for developing depression is 25 times higher among women who are maritaly distressed than among those who are satisfied with their relationship (Epstein, 2002). Although the research regarding whether a linear relationship exists between relational negativity and depression, as well as controversy
regarding the direction of such a relationship, it is essential researchers and practitioners alike recognize that such a relationship is significant.

It is clear that negative behaviors have a profound and specified effect on relationships, and affect partners differently based on their gender, as evidenced by Gottman’s (1999) conclusions, as well as others who had established that a clear crevice has emerged between how the genders perpetuate and handle negativity (Flora & Segrin, 2000). Finally, the origins of such negativity, an example of which is depression, were discussed.

Although the connection between these behaviors and the deterioration of romantic relationships is evident, other types of relationships may also be vulnerable to negativity. Another relationship that may be influenced by couple negativity, the therapeutic alliance, is a special and delicate relationship that is also closely studied in the professional literature.

*The Relationship between Alliance and Outcome*

To begin to discuss the relationship between alliance and outcome, it is important to explore the origin of the concept. The therapeutic alliance was first described by Freud (1912, 1913, as in Asay & Lambert, 1999). He emphasized the essential nature of both the client’s attachment to the psychoanalyst and the psychoanalyst’s interest in and “asymptomatic understanding” of the client in the early treatment relationship. Following Freud, many additional classical authors in the field discussed the alliance, including Bowlby (1988), Fennichel (1941), Sterba (1929), and Zetzel (1956) (Asay & Lambert 1999).

*The diverse theoretical nature of the alliance.* It is relatively uncomplicated to conclude that the therapeutic alliance is essential to the therapy process. The importance of the alliance transcends nearly every therapeutic theoretical model. Minuchin and Fishman (1981) viewed the family and therapist as forming a partnership for a specified purpose and
for a certain period of time. They stated that the therapist must be skilled at developing and maintaining a functional therapeutic milieu that continually balances the therapist relationship with each family member, as well as various coalitions within the family.

The alliance has emerged in the literature as a promising construct for studying and better understanding the change process. It is defined as the extent to which a client and therapist work collaboratively and purposefully and connect emotionally, is conceptualized as a common, or generic, factor in that it is believed to cut across various treatment approaches. It has been found to be correlated positively with a broad range of psychotherapy outcomes and, overall, appears to be a relatively strong predictor of client change (Hanson, Curry, & Bandalos, 2002, p. 654).

Diverging from more classical schools of therapeutic thought, the social-constructivist’s approach disclaims the therapist’s “expert role” and favors a less restricted relationship between therapist and client (Rait, 2000). Since therapy is, in essence, conversations about problems in order to develop new meaning and behaviors, clients are viewed as equal participants in the co-construction of meaning. The therapeutic alliance therefore becomes a vehicle for the deconstruction of confining narratives and consideration of new ones. J. Bird (1993), a practicing therapist influenced by Michael White’s work on therapeutic alliance, suggested that although there has been a focus on specific therapeutic behaviors, research has ignored the therapeutic relationship that “is critical in determining the client’s experience” (Bird, 1993).

The conversation between the therapist and client exists because of the relationship – that has no other parallels in life . . . It is time to bring the therapeutic relationship out of the closet. It is time to experiment with new descriptions that are respectful,
engage in conversations of discovery with colleagues and clients and lastly, but most importantly, honor and celebrate relationships (p. 48).

Bird (1993) suggests that the therapeutic relationship is special because the client trusts the therapist with his or her vulnerability. Therefore, the therapist must use his or her skills to thoroughly understand the thoughts and feelings of the client to develop the therapeutic relationship. Highlighting the critical importance of the human aspects of the therapeutic alliance provides grounds for departure from the imagined therapist bearing of objectiveness and neutrality. One might even dare to say that the processes of tackling and resolving problems within the context of the alliance are not simply prerequisites to change, but rather the core of the true change process, particularly with clients who experience relational difficulty (Muran & Safran, 1998).

Empirical evidence supporting the therapeutic alliance. The literature to date supports the importance of the therapeutic alliance by demonstrating marked evidence that high therapeutic alliance precedes effective therapeutic outcome. A positive correlation has been identified between the development of a working alliance between therapist and client and a successful therapeutic outcome (Barnard & Kuehl, 1995). The therapeutic alliance provides a context for interpersonal relatedness between therapist and client family members, offers the opportunity for corrective experience, and alternately can be viewed as either a necessary or sufficient condition for therapeutic change (Rait, 2000). Kivighan (1990) conducted a meta-analysis on 24 studies based on 20 distinct data sets to evaluate various measures of the working alliance to treatment outcome. This revealed that better quality working alliance predicted positive therapy outcome. Also the type of treatment, the length
of treatment, and the number of participants have minimal influence on the relationship of the working alliance to therapy outcomes.

In the National Institute of Mental Health Treatment of Depression Collaborative Research Program, Krupnick (1996) using a modified version of the Vanderbilt Therapeutic Alliance Scale, examined the function of the therapeutic alliance in the psychotherapy and pharmacological treatment of depressed individuals. Results showed that the therapeutic alliance had a noteworthy bearing on outcome for both psychotherapy and for active and placebo pharmacotherapy. Client ratings of alliance were significantly associated with treatment effect (NIMH in Asay & Lambert, 1999).

**Why the alliance is significant.** Gaston (1990) has proposed three major roles of the alliance: (a) therapeutic in and of itself; (b) a prerequisite for therapeutic interventions to be effective; and (c) interacting with various types of therapist interventions, exploratory versus supportive, for determining success in psychotherapy (Gaston, 1990, p. 148). Also interesting is Gaston’s view that the alliance is a necessary, but not sufficient ingredient of fruitful psychotherapy. Bohart (2002) has written extensively on the relationship as a means of facilitating productive client thinking. He states:

Bohart et al (in press) described three general ways empathy could facilitate change. These can be expanded to the relationship in general. First, the relationship can facilitate change by promoting client involvement and participation. Second, the relationship can help through its capacity to promote new learning through “corrective emotional experiences”. Third, the relationship can promote and support productive client information-processing. (p. 65)
The Dodo Verdict, the conclusion that all therapies work approximately equally well for different disorders, continues to receive support; the alliance continues to stand out as a crucial vehicle for client change. What is particularly effective is specific to each therapist and client, but the literature clearly states that its essential nature should not be underestimated (Bohart, 2002).

The Components of the Alliance

What contributes to the formation of a solid working alliance? Bordin (1979, 1994) has developed considerable theory surrounding the concept of the therapeutic alliance, which is described as a “pan-theoretical” approach.

Goal, task & bond. Therapeutic alliance, according to Bordin (1979, 1994) consists of three main dimensions: goal, task and bond. These aspects make up the therapeutic alliance; the extent to which the therapist and client(s) collaborate to determine where therapy is going and how they will get there, as well as the sense of warmth and understanding they share. Bordin (1979, 1994) defines the goals aspect of the therapeutic alliance as the therapist and client negotiated outcomes for therapy. Tasks are the behaviors and cognitions that occur within the context of the therapeutic process. Lastly, bond is described as the portion of the therapeutic alliance that refers to the degree to which the therapist and client share a sense of connection and a relationship that has the capacity for warmth.

Bordin’s (1994) pan-theoretical approach is particularly interesting because it transcends the boundaries of therapy models. In other words, the use of these ideas to build the alliance may, without drastic changes, be integrated into the use of other treatment models, and therefore is compatible with most therapy approaches. In accordance with the
Dodo Bird Verdict, therapists who are able to facilitate a positive therapeutic alliance are proportionally likely to have successful therapy outcomes, and those therapists that neglect to develop a good therapeutic alliance may see their clients reflect this both in unfulfilled potential and attrition rates. Attending closely to goal, task and bond in the therapy process is purported to yield positive therapy results.

*Modern applications.* Many modern marriage and family therapists value the alliance, and are somewhat successful in establishing a productive therapeutic alliance. Gurman (2001) commented that at least in ideal practice circumstances, family therapists with empirically supported theoretical orientations are quite likely to be high on all three dimensions of the therapeutic alliance, as elaborated by Pinsof (1994), and based on Bordin’s (1979, 1994) tripartite model of bonds, tasks and goals. They appear to be, as a whole, particularly skilled at enhancing the task and bond dimension, even in early treatment (Pinsof, 1999)

Bordin’s (1979, 1994) conceptualization of the therapeutic alliance is useful for several reasons. It highlights the fact that at a fundamental level, the client’s ability to trust, hope and have faith in the therapist’s ability to help can play a central role in the change process. Some parts of alliance involve conscientious and thoughtful decisions, but other aspects are less obvious and more emotionally based (Muran & Safran, 1998). For example, a therapist clearly has the ability to monitor his or her overt behaviors, such as how he or she dresses, or how he or she responds to a mid-session phone call. However, the same therapist has minimal control over some of the emotional reactions that the client might have to the therapy process, as these emotional reactions are rooted in the client’s history and personality. Thus, different clients will react uniquely to certain session circumstances, and
therapists must make their own judgments regarding the degree to which they will moderate conversation in the therapy session, including negativity. The alliance provides a context for a therapist to tailor therapy to the individual needs of each unique client.

In addition to sculpting therapy to serve each client, the alliance provides a rational framework for guiding the therapist’s interventions in a flexible fashion. Rather than designing a therapeutic approach centered around false expectations of objectivity, one can be directed by an understanding of what kind of meaning a specific therapeutic task has to a particular client, because of the deep understanding that a therapist may develop of his or her client (Muran & Safran, 1998). Understanding clients as diverse in capability and variable in experience highlights the importance of the negotiation between client and therapist about the tasks and goals of therapy. The conceptualization of the alliance as both dynamic and mutual is consistent with a view that the essence of therapy is an ongoing negotiation between two subjective beings: between the client(s) and the therapist (Muran & Safran, 1998).

The Importance of the Therapeutic Alliance

As defined in the literature, the alliance is the overall relationship that the client shares with the therapist. It is rational and permits the client to work purposefully with the therapist (Bordin, 1979; Horvath & Symonds, 1991; Horvath, 1994). Given that no one therapeutic model has been shown to be, without fail, more effective than any other in precipitating therapeutic change, one might attribute research interest in this concept to the search for understanding the process of therapeutic change. Bordin (1979) suggested that an effective alliance is a predictor of change in all forms of psychotherapy, and has concisely defined the concept. The concept of the alliance is essential, because research in the field indicates that if the alliance is strong, the client is better able to deepen the significance of the
therapeutic matter presented by recognizing and overcoming struggles and striving for therapeutic progress (Patton, Kivligian, & Multon, 1997).

**Proportional predictors of therapeutic change.** Michael Lambert (in Asay & Lambert, 1999) has proposed that four therapeutic factors are the principal elements that account for change in clients. The four factors are:

1) Client/extratherapeutic factors. According to this hypothesis, these are the client's life circumstances that aid in the client's recovery, regardless of the client's participation in therapy. They include the client's strengths, supportive elements, and even chance events. Therefore, what Lambert proposes to account for 40% of the variance in client change and recovery, is truly out of the scope of therapy (Asay & Lambert, 1999). For example, a supportive family member, religious faith, a string of luck, or an inherent optimistic attitude greatly influences the client's change—more than any of the factors that occur within therapy.

2) Relationship factors. Accounting for the most variance of any of the therapy factors, the strength of the client-therapist relationship accounts for about 30% of the outcome variance. This includes relationship-mediated variables such as empathy, warmth, acceptance, mutual affirmation, and encouragement. There is consensus in the field that the therapeutic relationship is critical (Asay & Lambert, 1999).

3) Placebo, hope and expectancy factors. About 15% of the variance is noted here (Asay & Lambert, 1999). This is the portion of improvement that can be credited to the client's knowledge of his or her own treatment, assessment of credibility of the therapist's rationale, and belief that therapy will be effective. This strand of influence is closely related
to the therapeutic alliance, as its successful implementation is dependent on open
communication, shared focus, and therapist credibility.

4) Model/technique factors. A mere 15% of therapy improvement can be accredited
to the correct use of therapeutic interventions. Seemingly disproportionate to the amount of
effort and consideration the field spends on the topic, model/technique factors have minimal
influence on client improvement. This may be, at least in part, because the clients' ability to
utilize whatever is offered exceeds any differences that might subsist in techniques or
approaches (Tallman & Bohart, 1999).

Figure 1.1: Influential Factors on the Therapeutic Alliance
According to this model, much of what happens in therapy is out of the hands of the therapist—about 40% of the outcome variance is attributed to circumstances that have nothing to do with therapy. Also, the techniques and models that the therapist uses accounts for very little of the successful outcome variance, so hours and days spent agonizing over such things may be with minimal significance. Third, most of what makes a true therapeutic difference with clients has to do with the therapeutic alliance, because clients who trust and respect their therapists do better in therapy. Therefore, every therapist has the opportunity to improve their client’s chances at being successful in therapy by paying specific attention to the therapeutic alliance, as well as communicating rationale and hope to the client (Asay & Lambert, 1999).

So, if the therapist is truly given this unique opportunity to use the therapeutic alliance for the purpose of providing excellent care, it would serve the therapist well to understand what client and therapist characteristics are associated with positive alliance. Therefore, it seems salient to investigate the influence of both client and therapist characteristics on the therapy process.

*Participant characteristics that predict change.*

Client characteristics, and particularly client gender differences, play into how therapy is conducted. In one study (Werner-Wilson, Zimmerman, & Price, 1999) that strove to discover how gender influences the ability to successfully introduce therapeutic topics in marital and family therapy, it surfaced that such gender differences do exist in the therapy session. The study utilized two samples, both collected at a large southern American Association of Marriage and Family Therapy (AAMFT) accredited university. The first included 103 couples that were adult men and women who had attended a first therapy
session. The second sample consisted of 31 couples and 10 families who had also attended a first session of therapy. Coders established a global topic for each of three segments within therapy session, and this was analyzed for interaction. It was found that in couple therapy, women's goals were honored more often than men’s goals, and that in family therapy men’s goals were honored more often than women’s goals (Werner-Wilson, Zimmerman, & Price, 1999). Although this study design did not directly investigate the therapeutic alliance, one might infer that the goal aspect of the therapeutic alliance could be affected by how therapists relate client gender, goal introductions, and therapy modality.

Additionally, in a similar study, researchers found that men and women experienced therapy in a different way, depending on the modality of the sessions. The study design included 46 couples and 19 families that consisted of both an adult woman and man, who attended at least the first three sessions at an AAMFT-accredited MFT clinic, as well as completed the WAI after the third session. All therapists were doctoral students in the program. They concluded that the women experienced a stronger therapeutic alliance when in the context of marital therapy, and men experienced a stronger alliance when in family therapy. This lends itself to conclusive results regarding the experiences of therapy, particular the goals and tasks of therapy, depending the interaction between gender and modality experience.

Existing research that scrutinizes how therapist characteristics impact the therapy process is even more abundant. In one study, researchers strived to identify therapist behaviors that are associated with more effective and less effective therapists. The participants included 16 therapists, all with at least two years experience post-degree. Ten were men and six were women. The client participants included 80 clients, aged 24-64, who
were not identified as having substance use disorders, severe medical problems, or needed psychotropic medication or inpatient treatment. The results yielded that a subgroup of "most effective" therapists could be identified. More effective therapists showed more positive behaviors and fewer negative behaviors than less effective therapists. When examining effective therapy characteristics, the "most effective" therapists seemed to be the ones that were perceived by clients to be more warm, affirming, understanding and helpful (Najavits & Strupp, 1994). In other words, it seems that those therapists who were seen by their clients as more effective were also those who possessed characteristics that made them approachable and appealing with whom to develop a therapeutic relationship.

A study performed by Reif (1998) found that the clients' perception of the alliance accounted for the majority of the variance, indicating that the perceived therapist characteristics were more influential in determining the therapeutic alliance than the client's characteristics. The sample included 28 couples selected from a university Marriage and Family Therapy (MFT) clinic, an employee assistance program, and three private practices. Their age ranged from 19-50, and 40% of the couples saw a female therapist, and 60% saw a male therapist. The participants were predominantly European American (76.8%) with the remaining Hispanic (17.9%) and African-American (5.4%). Their length of marriage ranged from 1-21 years. Measurements for this research study included the Couple Therapy Alliance Scale (CTAS), Miller Social Intimacy Scale (MSIS), Dyadic Adjustment Scale (DAS), and the Perception of Therapist Behaviors Inventory (PTBI). When tested, the results yielded a significant finding: the perception of the therapist accounted for 67.9% of the variance in total alliance. In other words, it seems that from this sample, one concludes that
client characteristics are far less important than therapist characteristics when forming the therapeutic alliance. Reif states:

These results show the importance of perceived therapist characteristics in the development of the therapeutic alliance in couple therapy. Both members of the couple must feel accepted and that the therapist is not critical or hostile to enable the development of a strong alliance. The couple must feel accepted and that the therapist is neither critical nor hostile toward the couple. (p. 50)

Reif (1998) indicated that her findings concur with the results of previous studies showing that predictive factors of a good alliance include the client perceiving the therapist as demonstrating warmth, caring and emotional involvement.

Of particular interest to this research endeavor, Estrada & Holmes (1999) identified 12 effective, client-defined therapy ingredients in couple therapy in order to better understand couple’s perceptions of the change process regarding helpful and hindering aspects of therapy. Participants included 8 “highly experienced” staff therapists, 5 advanced student therapists as well as 15 married, heterosexual couples who contacted the clinic for services. Criteria included: 1) married no less than 3 years, 2) had a child younger than 12 years, 3) reported marital satisfaction and the possibility of divorce by at least one member of the couple during intake, 4) both partners consented to and were available for study, 5) both partners expressed a desire to improve the relationship and avoid divorce if possible, and 6) neither partner met the criteria for a DSM-IV diagnosis of Major Affective or Psychotic Disorder. Couples met with a therapist both at the beginning of therapy and after the eight session to complete a DAS and participate in a Brief Therapy Interview (BTI). The BTI’s were coded to generate a list of helpful and hindering aspects of treatment reported by each
couple. When coded, several specific themes emerged regarding the therapist’s characteristics and behaviors such as: the therapist moderates and controls discussion, the therapist provides a safe environment, the therapist encourages participation, and the therapist helps in resolving problems (Estrada & Holmes, 1999). It distinctly emerged that when the therapist behaves in a way that is active in the session, demonstrating behaviors such as moderating conversation or reducing negativity, the client identifies therapy as more effective. Clearly, it is important to determine how these behaviors affect the therapeutic alliance.

How the Therapeutic Alliance is Developed and Maintained

Safran & Muran (1998) outline a means of establishing a solid therapeutic alliance:

1. Facilitate the development of the bond aspect of the therapeutic alliance by conveying warmth, respect, and genuine interest; a therapist may do this by making a practice of connecting with each client on a personal level—asking about interests, acting in a manner that the client may consider to be friendly, making efforts to be respectful of each person’s opinion, ideas, and story.

2. Outline the therapeutic rationale (including tasks and goals) throughout treatment; this can be accomplished easily if a therapist takes the time during each session to explain to the client what approaches the therapist is using and why—and how that will help the client to reach his or her own goals.

3. Establish realistic goals; each client is given the opportunity to state what he or she would like to see occurring as a result of work in therapy, and the therapist is able to hear those ideas and collaborate with the clients to form a measurable, obtainable goal to work toward.
4. As therapy proceeds, be prepared to educate or remind patients about the purpose or function of therapeutic tasks that do not make sense to them; nearly always maintaining transparent motives in order to help clients to trust the tasks to be useful and purposeful. Many clients need to be reminded of the purpose of the task, and have them re-explained to them throughout the duration of therapy.

5. Establish and maintain a therapeutic focus; maintain conversation regarding the goals to help both the client and therapist develop a therapeutic vision and stay motivated to work toward that goal together.

6. Maintain a balance between activity and receptivity; every therapist must pay attention to his or her senses of when clients need direction and when they need to be heard. Finding this balance nourishes the therapeutic alliance.

7. When possible, minimize the enactment of vicious cycles; if such cycles that occur with in couples are allowed to continue in therapy, the couple may become frustrated with the therapist and the therapy situation, and the thus alliance is weakened. For example, a couple who comes to therapy for a vicious argument cycle might feel as if nothing is changing if they fight in therapy in a way that is practically identical to the way they argue at home.

8. Alliance ruptures must be detected early and addressed. If a client is upset with the therapist or the therapy process, it is essential that the therapist approach that client and process what has happened. If the rupture is left to its own devices, under most circumstances the alliance will continue to deteriorate.

9. Be aware of the types of alliance ruptures characteristic of particular approaches; each theoretical model has a unique set of difficulties that may interfere with the alliance
between the therapist and family members. For example, those therapists who practice from the structural model of therapy may be more at risk to be perceived as judgmental or “on a pedestal” by their clients because of the model’s inherent “therapist as expert” stance. It is essential that all therapists be aware of the types of ruptures that may accompany each model of therapy, and then maintain vigilance regarding them.

10. Be aware of multiple alliances within a system; in a family or couple therapy session it is essential that the therapist be cognizant of the possibility of one or more persons feeling estranged in a session, and becoming resentful of an imbalance in the alliance.

11. Prepare clients for termination and explore its meaning for them. Many therapists may experience a rupture in the alliance when nearing termination, particularly when the termination is not being processed. Clients may experience termination as highly stressful, particularly if they have experienced difficult separations in the past. Addressing these concerns may help the final sessions to be more successful.

Duncan & Miller’s (1999) work, The Heroic Client, echoes Bordin’s (1979, 1994) tripartite explanation of the therapeutic alliance. First, they recommend that therapists facilitate the bond dimension of the alliance by making efforts to discover what the client’s experience of a good relationship has been, and attempt to fit into that as well as possible, by being likeable, friendly, and responsive. Also, being certain that the client is thoroughly understood and being flexible by being “many things to many people” will help to develop the bond aspect of the therapeutic alliance. Next, the authors identify accepting the client’s goals as an essential aspect of the alliance. Therapists should identify them by asking questions such as: What is your goal for treatment? What did you hope would be different because of coming for treatment? What would be the first sign to you that you have taken a
solid step on the road to improvement, even though you might not yet be out of the woods? (Duncan & Miller, 1999). It is important that therapists respect and value the clients’ goals regardless of their own opinion regarding what is best for the family. Finally, the authors suggest that the third aspect of the alliance is based on the tasks of therapy. This includes coordinating with the client specific techniques or points of view, topics of conversation, interview procedures, and frequency of meeting. Open collaboration and agreement regarding such therapy procedures has a strong impact on the therapeutic alliance, as it allows the client insight, power, and motivation regarding therapy (Duncan & Miller, 1999).

Other than this brief, and somewhat vague subjective conceptualization of how to build a positive alliance, we know very little regarding what leads to an effective therapeutic alliance; empirical research regarding the subject is virtually non-existent.

*The Active Therapist*

To begin looking at a single facet of the idea of moderating the therapeutic process, one must examine the relationship between couple negativity within the session and the therapeutic alliance. It is probable, from all of the literature surrounding between-couple criticism, that the free exchange of criticism (which is linked to feelings of depression and detrimental communication patterns) and the lack of therapeutic intervention on the part of the therapist may consequently lead to decreased alliance between the therapist and the client(s). Thus, one concludes that a more active therapist might better control the exchange of criticism in the therapy session. Gurman (2001) states very clearly:

This acceptance of the role of therapist-as-expert leads rather predictable to certain patterns of therapists’ behavior. These patterns emphasize a high level of therapist activity, a characteristic common to most brief individual therapies. Such active
family therapists strive to develop individual caring alliances with each family member from the outset of treatment, structure the therapeutic encounter for patients, and are highly collaborative. (p. 61)

In this segment, Gurman (2001) is proposing that this pattern of heightened therapist activity in family/couple therapy has a particular and profound impact on the therapist-client relationship. The alliance can, especially in long-term work, become a pivotal focus for promoting change. By actively structuring the sessions, the therapist is given a unique opportunity to use this special relationship to help a couple reshape their behaviors and work together to make changes that are deep-rooted and significant (Gurman, 2001).

The unique therapeutic relationship. Tallman & Bohart (1999) state that the therapeutic relationship and the therapy environment is a unique stage for change, in part because it provides a “corrective emotional experience”. The therapist’s skills may be healing because they may help to eradicate toxic relationship behavior, and reinforce more appropriate behaviors. The therapeutic endeavor provides a new learning opportunity in which the couple might learn how to be in a relationship more effectively (Tallman & Bohart, 1999).

Gottman (1999) provides an example of therapist intervention when working with a couple that is critical of each other:

Client: ...Two years in which she is being a goddamned selfish bitch and I won’t put up with it. She can just take a hike. She will never get custody of her kids. I will see to it that she just loses her precious kids.
**Therapist:** Let me just stop you here, Mike. Research has shown that there are some patterns of interaction in marriage that are very destructive of love. These are being contemptuous and [critical], and being threatening. I cannot let you interact like that here. I suggest that you don’t do it at home either. [Negativity] and threats are part of a pattern of psychological abuse. Nothing is more destructive to love. So, please rephrase your complaints and try not to use these ways of expressing yourself. (p. 193)

Such intervention that is firm and non-threatening to clients is an example of how an active therapist might help to restructure the interaction of a couple that uses negativity when in distress. Being able to use such active strategies to provide a corrective experience in therapy not only gives clients hope for continued change and deepens their commitment to the process, but it also increases the likelihood of their investment in the tasks of therapy. This increases their ability to use the tools that are offered to them in therapy, and improves their opportunities to fulfill their therapy goals.

**The Importance of the First Session**

It has been suggested in the research literature that the first session significantly influences the therapy process, including the alliance as well as the outcome. Alexander (1988) has commented considerably on the importance of the first session. He states that the initial stage of intervention, termed the introduction phase, includes some crucial aspects of the therapeutic process.

*First session stages of therapy.* The first sessions are focused around the goal and task segments of the therapeutic relationship. Alexander (1988) states that the therapist
should focus on maximizing the family's initial expectation of positive change by setting realistic and useful goals. Also, the therapist should appear appropriate and credible to each family member. He gives the example of looking competent and professional to adults, while appearing relaxed and approachable to adolescents. By wearing specific clothing and jewelry that appeals to both parties, he can display superficial qualities that reflect expertise and openness, and therefore helping all family members to feel comfortable and hopeful. The abstract qualities of competence and credibility are represented by superficial qualities in the initial phase of intervention. This stage generally occurs within the first few seconds of the first session. Just as a therapist attempts to gain credibility with her or his audience by dressing properly and having an appropriate setting, he or she also attempts to do so with other actions (Alexander 1988).

The Assessment/Understanding phase also begins in the first session. During this stage the therapist is attempting not only to become familiar with the parameters of the family and their potential for change, but also to elicit and structure information and develop a plan. During this phase, the therapist is collecting information and the manner in which he or she elicits and receives such information may be essential to the development of a trust and a positive rapport with the clients. The accuracy and complete nature of the information the client feels comfortable with disclosing will directly impact the types of interventions that the therapist provides for the couple, and is therefore directly linked to therapy's success.

The Assessment/Understanding Phase develops very quickly into the Induction/Motivation phase, as the information that was gathered and processed in the preceding phases, as well as any credibility that the therapist has gained, form a synthesis that influences the degree to which the clients are engaged and thus motivated to make
changes. Generally this phase begins in the first session—sometimes when the therapist gives the family their first homework assignment. The therapist implements certain tasks that help the couple to move toward their goals, and uses relational skills to change negativity, such as that which is evident in couples who are highly critical of each other. Often therapists will use reframing and relabeling to structure the session and set the tone for therapy, as well as decrease the amount of negativity exchanged during the session. This may help the clients to feel as if change is possible and motivate them to change more behaviors. Considering these ideas, if a therapist were to allow the free exchange of negativity within a session, according to Alexander’s (1988) concepts, the credibility of the therapist may be undermined and the induction/motivation phase inhibited.

Opportunities unique to the first session. A number of studies scrutinizing the effect of outcome of the therapeutic alliance early in therapy have plainly ascertained that the early alliance is a significant predictor of final treatment outcome. Though the relation between the alliance measured at later stages and client change is also noteworthy, it appears to be more modest in magnitude. These ideas describe a positive therapist-client relationship that is critical from the onset of therapy. There appears to be a “window of opportunity” in the early sessions to develop a good therapeutic alliance, or the client may withdraw (Mohl, Martinez, Ticknor, Huang & Cardell, 1991; Plotnicov, 1990; Tracey, 1986; in Bachelor & Horvath 1999). Therefore, it is believed that therapists should be attentive to the early relationship climate, and work out any visible complications in the client-therapist relationship in the initial sessions.
Purpose

Gottman (1999) and other researchers have explored and established the predictive power of negative behaviors for divorce. The Four Horsemen of the Apocalypse: Criticism, Defensiveness, Contempt, and Stonewalling, are among those negative behaviors that destroy relationships and precede divorce. Continued couple negativity in the therapy room could erode hope for positive change and undermine the credibility of the therapist (Alexander, 1988). There exists an obvious gap in the research when investigating the effect of certain couple and therapist behaviors on the alliance. It is clear that certain negative couple behaviors occur in communication patterns and, enduring as they may be, can be destructive to the satisfaction and quality of the couple relationship. Negative behaviors are among those patterns that may be destructive within the couple relationship, which prompts a query—are they additionally destructive within the therapeutic setting? Negativity is touted in both the research and the popular culture as both detrimental to the couple relationship, and a symptom of a problematic interaction (such as in the female-demand/male-withdraw relationship pattern). Considering that couple communication patterns seem to be enduring over time (Vogel, Wester, & Heesacker, 1999), it could easily be expected that these types of communication might carry into the conversation that takes place within the therapy session.

Although the field acknowledges that task, goal and bond are essential to the development of the therapeutic alliance, it is unclear how other therapeutic circumstances influence the development and maintenance of the relationship. In most areas of social science and psychology, phenomena such as the therapeutic alliance have multiple determinants. Therefore the most realistic goal is to seek mediators that significantly affect the effect of the independent variable on the dependent variable (Baron & Kenny, 1986).
Investigation of the effect of some therapists and couple characteristics on therapy outcome yields that therapist behaviors seem to be more influential mediators than client characteristics, and clients perceive that active therapists more positively. Therefore, since therapist activity seems to be positively linked to outcome, and given that couple negativity is destructive to relationships, is it safe to say that both the therapist’s moderating behaviors such as challenging clients and giving advice, as well as couple negativity behaviors, influence the alliance?

It is essential that this gap in the research be filled. If it is indeed true that such therapeutic interference in the use of negativity between partners in the therapy session does increase the quality of therapeutic alliance, it can be consequently inferred that such action may improve the therapeutic outcome. Therapist activities such as challenging clients and advice-giving are examples of moderating behaviors. Such findings may help therapists who are in doubt determine whether or not to moderate conversations that precipitate partner-negativity, and understand best the effect their actions have on the alliance, and thus the outcome (since better alliance seems to predict more positive therapeutic outcome).

As L.C. Wynne stated, in his 1986 address on the state and future of marriage and family therapy:

What can no longer be accepted in family therapy research, in my opinion, is a concept of the therapist as an outsider, separable from the family. Instead, the therapeutic alliance of therapist and family interacting with one another is crucial for the study of process. The therapist is not an external observer, but, rather, is participant in the observing system. The extensive work on the therapeutic alliance in
individual psychotherapy research is beginning to receive comparable attention in family therapy research, led by process researchers (p. 261).

Research Question

To what extent do partner negativity and therapist activity influence client therapeutic alliance?

Hypotheses

In this research study, the author predicts that therapists who moderate couple negativity by being active in the session will cultivate a stronger therapeutic alliance, and it’s respective components (goal, task bond). The more negativity that a partner directs toward his or her partner within the context of therapy, the less strong one may expect the therapeutic alliance to be between the therapist and the partners.

1. There will be a negative relationship between the number of negative comments made by a partner and the score on the goal subscale of the WAI for both men and women.
2. Both men and women will demonstrate a positive correlation between the amount of active therapist behaviors and the goal subscale of the WAI.
3. There will be a negative relationship between the number of negative comments made by a partner and the score on the task subscale of the WAI for both men and women.
4. Both men and women will demonstrate a positive correlation between the amount of active therapist behaviors and the task subscale of the WAI.
5. There will be a negative relationship between the number of negative comments made by a partner and the score on the bond subscale of the WAI for both men and women.
6. Both men and women will demonstrate a positive correlation between the amount of active therapist behaviors and the bond subscale of the WAI.
CHAPTER 2. METHOD

Participants

The sample included therapists and clients from two sources: (a) doctoral student therapists and clients at an AAMFT accredited southern state university’s not-for-profit marriage and family therapy clinic (n=80), and (b) “master” therapists from the Master Series video collection produced and distributed by the AAMFT (n=32). “The Master Series presents the world’s most respected marriage and family therapists conducting live, unedited therapy sessions at AAMFT annual conferences” (AAMFT Catalog, 1993, p. 4). The Master’s tapes are a rare source of live therapy demonstration by the field’s “standard of excellence” therapists (Haddock, MacPhee, & Zimmerman, 2001). Every videotaped session, regardless of the therapist, was the initial consultation with the clients, and featured both an adult man and an adult woman who identified themselves as romantic partners. The taped sessions consisted of both family and couple sessions. Those clients who were selected from the university marriage and family clinic identified themselves entirely as European Americans. Descriptive information is available in Table 2.1.

<table>
<thead>
<tr>
<th>Therapist Gender</th>
<th>Student Therapists</th>
<th>Master Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>58</td>
<td>16</td>
</tr>
<tr>
<td>Women</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>Co-therapy</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 2.1 (continued)

<table>
<thead>
<tr>
<th></th>
<th>Student Therapists</th>
<th>Master Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Modality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couple</td>
<td>62</td>
<td>18</td>
</tr>
<tr>
<td>Family</td>
<td>18</td>
<td>14</td>
</tr>
</tbody>
</table>

T-tests were completed to investigate the degree to which student therapists and master therapists used similar behaviors (see Table 2.2) Also, t-tests were performed to look for mean differences between Master and Student Therapists, as well as men and women therapists, yielding little. Results are displaying in Tables 2.3 and 2.4, respectively.

Table 2.2 Independent Samples T-Test, Couple and Family Cases

<table>
<thead>
<tr>
<th>Behavior</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner makes positive statement about client</td>
<td>1.611</td>
</tr>
<tr>
<td>Partner makes negative statement about client</td>
<td>0.243</td>
</tr>
<tr>
<td>Partner challenges client</td>
<td>1.142</td>
</tr>
<tr>
<td>Partner self-discloses</td>
<td>0.375</td>
</tr>
<tr>
<td>Therapist challenges the client</td>
<td>0.241</td>
</tr>
<tr>
<td>Therapist gives advice to the client</td>
<td>1.216</td>
</tr>
<tr>
<td>Therapist self-discloses</td>
<td>-0.1998</td>
</tr>
</tbody>
</table>

*p < .05
## Table 2.3 Independent Samples T-Test, Master and Student Therapists

<table>
<thead>
<tr>
<th>Behavior</th>
<th>$t$-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner makes positive statement about client</td>
<td>1.175</td>
</tr>
<tr>
<td>Partner makes negative statement about client</td>
<td>2.177*</td>
</tr>
<tr>
<td>Partner challenges client</td>
<td>1.234</td>
</tr>
<tr>
<td>Partner self-discloses</td>
<td>-1.245</td>
</tr>
<tr>
<td>Therapist challenges the client</td>
<td>-1.759</td>
</tr>
<tr>
<td>Therapist gives advice to the client</td>
<td>-0.901</td>
</tr>
<tr>
<td>Therapist self-discloses</td>
<td>-0.068</td>
</tr>
</tbody>
</table>

*p < .05

## Table 2.4 Independent Samples T-Test, Men and Women Therapists

<table>
<thead>
<tr>
<th>Behavior</th>
<th>$t$-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner makes positive statement about client</td>
<td>0.47</td>
</tr>
<tr>
<td>Partner makes negative statement about client</td>
<td>1.403</td>
</tr>
<tr>
<td>Partner challenges client</td>
<td>0.420</td>
</tr>
<tr>
<td>Partner self-discloses</td>
<td>1.908</td>
</tr>
<tr>
<td>Therapist challenges the client</td>
<td>-2.087*</td>
</tr>
<tr>
<td>Therapist gives advice to the client</td>
<td>0.478</td>
</tr>
<tr>
<td>Therapist self-discloses</td>
<td>1.289</td>
</tr>
</tbody>
</table>

*p < .05
**Measures**

In this research study, the Working Alliance Inventory, Observer Version (WAI-O), developed by A.O. Horvath (1994), was used to measure the degree to which the therapist and individuals within the session seem to have developed a sense of therapeutic alliance. The WAI is a popular measure of working alliance, although the WAI-O is somewhat less widely used than the self-report version. It is an instrument that can be administered easily and completed rapidly, either by a client, a therapist, or a non-participant observer. It is theoretically rooted in Bordin’s (1979, 1994) conceptualizations of the therapeutic alliance. Finally, its scores have been shown to share a significant amount of common variance with other measures of working alliance and it is familiar to psychotherapy process researchers, as well as to clinicians (Hanson, Curry, & Bandalos, 2002). The WAI has been demonstrated to be both reliable and valid for measuring therapeutic alliance, with reliability score estimates that are uniformly high, ranging from .79 to .97. These estimates easily meet professional standards of acceptability (Hanson, Curry, & Bandalos, 2002). The scale shows a .98 Cronbach’s alpha, demonstrating high internal consistency, and an inter-rater reliability estimate of the total scores (Hanson, Curry, & Bandalos, 2002). When compared with other means of measuring alliance, such as the California Psychotherapy Alliance Scales (CALPAS), The Penn Helping Alliance Rating Scale, and The Vanderbilt Therapeutic Alliance Scale, the WAI-O seems to demonstrate internal consistency (.98) and high inter-rater reliability (.92) for measuring alliance by observation (Tichenor & Hill 1989). The WAI-O is included in Appendix D.
Procedures

By examining the first therapy session to control for treatment duration, we were able to look carefully at the incidence of between-partner criticism. As therapy sessions have predictable stages (e.g. social, engagement, information collection, intervention, closure), (Wilson 1997) this study was designed to examine multiple time segments within the session. Three five-minute segments were coded for each tape in order to analyze information from early, middle and later stages in the session: (a) the 10:00 to 15:00 minute segment; (b) the 25:00 to 30:00 minute segment; and (c) the 40:00 to 45:00 minutes segment. Three senior-level undergraduate students, who were unaware of the purpose of this research, coded the tapes. A graduate student, also unaware of the study’s purpose, served as the criterion coder, and coded every sixth session to calculate inter-rater reliability. The coders maintained an acceptable level of inter-rater reliability through the coding process: intraclass correlations were .68.

Coder Training. Coders were trained in the coding scheme by practicing tapes not included in the actual sample until they were able to achieve .80 agreement with the criterion coder. Coders were instructed to watch the tapes free of interruptions, and to use the VCR’s time function to navigate the tapes to the proper segment when viewing those tapes that were not previously edited to the three five-minute segments.

Coding Scheme. The coders observed the videotaped interaction and looked for specific therapist and client behaviors, such as negative statements. Each coder was provided a transcript of the tape, which were arranged to include the statements of the videotaped trio, as well as the codes for each spoken line. This was to promote reliability by eliminating the need for coders to memorize codes: the coders were able to view the video with the transcript
and circle the appropriate codes as they occurred. Each statement included identical sets of possible codes. An excerpt of a transcript is available in Appendix C. This not only enhanced reliability, but disguised the nature of the research as coders identified a variety of therapist/couple behaviors and thus avoided concentrating heavily on one behavioral occurrence (such as negativity). The behaviors observed included six client behaviors and six therapist behaviors. The client behaviors included: 1) interruptions of either their partner or the therapist, 2) making positive statements about the partner or the therapist, 3) making negative statements about the partner or the therapist, 4) making challenging statements toward the partner or the therapist, 5) giving advice, or 6) self-disclosing. The therapist behaviors included: 1) interrupting clients, 2) making positive or 3) negative statements about the clients, 4) challenging the clients, 5) giving advice, or 7) self-disclosing. In addition, the coders identified a global topic as well as the topic’s introducer for each segment, and completed the WAI-O for both the male and female client, to measure therapeutic alliance. The coders were blind to the purpose of the WAI-O, and simply completed the questions based on their responses to such queries. The purpose was not revealed to them prior to the completion of the coding.

Variables

Negativity. Couple negativity was labeled “negative statements”. Negative statements were defined as the following: “These are statements that are directed toward a target that have a direct or implied disapproval. Implied evaluations suggest that something bad has been done, such as “I can’t believe you did that”.” It was emphasized that these are not statement that describe a situation, such as “That’s fine”. The coder also were to avoid coding an emotion, such as, “I’m angry with him”, although they were to mark the code if the
emotion is connected to the action of partner, such as in “I’m angry with him because he continues to avoid helping me around the house”, and it is an implied evaluation. Other examples of negative statements (i.e. criticism, implied evaluation) given to the coders included: “You make me nervous”, and “You terrify me when you act like that”, because these are implied negative evaluations. This conceptualization of negativity is congruent with Gottman’s conceptualization of Criticism, one of his Four Horsemen of the Apocalypse. Another Horseman, Contempt, would also be coded as negativity under these instructions. The reliability (adjusted alpha) score for negative statements between partners is .8026.

Positive Statements. Positive statements were defined as statements that have a direct or implied approval. They are indicators that something good has been done. They might be evaluative comments, such as “Good for you.” The coder was cautioned against coding for personal feelings, although they might be a part of the statement. For example “I’m thrilled!” is not a positive statement, but “I’m thrilled that he cleaned the kitchen without even having to say anything” qualifies as a coded positive statement. The reliability (adjusted alpha) score for positive statements between partners is .6595.

Challenging statements. Both the therapist and the clients were evaluated for challenging statements. The coding directions specify that there are many subtle and direct ways to challenge a person. Disagreements are an example of the most obvious challenges, and example of which might be “that’s not what happened”. Also, providing alternatives is an example of a challenging statement. Any statement that offers another point of view might be a challenging statement: “Another way to think about that would be …”, or “Would you be willing to consider another explanation?” Finally, requesting an explanation is a challenging statement, such as “what do you mean by that?” In other words, challenging a
person to provide more detail or clarify a point. The reliability (adjusted alpha) score for challenging statements between partners is .4800. The reliability (adjusted alpha) score for challenging statement from the therapists is .4368.

**Advice-giving.** The coding instructions specify that advice giving may come from a client to partner or therapist, or from the therapist to a client. These types of statements generally come in the form of “I think you should...”, “He needs to...”, or “Many couples benefit from making ‘I’ statements. Would you be willing to try that?” The reliability (adjusted alpha) score for advise-giving from the therapist is .6358.

**Self-Disclosure.** Self-disclosing statement occur when someone shares something from their personal experience. This may be a client or the therapist. An example: “It’s difficult for me to trust him because I’ve been hurt by so many other men in my life.” Coders were additionally instructed to pay close attention to the meaning that a client is attempting to convey (a criticism vs. a need to trust), as well as tone of voice and body language to determine if a self-disclosing statement is being conveyed. The reliability (adjusted alpha) score for self-disclosing statements between partners is .7532.

**Therapeutic alliance.** The alliance was measured using the Working Alliance Inventory, Observer (WAI-O), which was completed by coders immediately after viewing the video segments for each case. Two forms, one to measure each the alliance between the male client and the therapist and the alliance between the female client and the therapist, measured the strength of the dimensions of the therapeutic alliance. Reliability (standardized alpha) for the subscales of the WAI-O are as follows: goal is .3416, task is .2318, and bond is .5795.
CHAPTER 3. RESULTS

Stepwise regression analyses were conducted to examine the relationship between the tripartite alliance model and partner negative behaviors. This type of statistical analysis was selected because of the exploratory nature of our research. As the integration of these conceptualization (couple negativity, the active therapist and the therapeutic alliance) has not has not had any predecessors in the literature, it was a natural decision. Also, due to the design of the study, individually analyzing the variables proved inconclusive because on a low level of variance. The analyses were performed separately for men and women, as well as for the goal, task, and bond segments of the alliance. Results are aligned with the hypotheses that couple characteristics and behaviors influence the therapeutic alliance, as do therapist behaviors.

Goal Hypotheses

1. There will be a negative relationship between the number of negative comments made by a partner and the score on the goal subscale of the WAI for both men and women.

2. Both men and women will demonstrate a positive correlation between the amount of active therapist behaviors and the goal subscale of the WAI.

Goal subscale and women clients. There were no significant predictor variables for this subscale of the WAI-O. The hypotheses were not satisfied for this portion of the study.
**Goal subscale and men clients.** Only one variable emerged as a significant predictor of the goal subscale of the WAI for men. This was the partner makes negative statements about the client (adjusted $R^2 = .194; F = 12.573; p < .001$). The variable significantly negatively predicted the outcome variable on the goal subscale ($\beta = -.459; p < .005$). See Figure 3.1 for a visual presentation of these results.

![Figure 3.1 Goal Subscale for Men Clients](image)

$\beta = -.459**$

* $p < .05$; ** $p < .01$; *** $p < .001$

**Task Hypotheses**

3. There will be a negative relationship between the number of negative comments made by a partner and the score on the task subscale of the WAI for both men and women.

4. Both men and women will demonstrate a positive correlation between the amount of active therapist behaviors and the task subscale of the WAI.

**Task subscale and women clients.** The results for the task subscale were identical to those for the goal subscale of the WAI for women. Variables that were significant predictors of the task subscale of the working alliance inventory (WAI) for women were the therapist challenges the client (adjusted $R^2 = .128; F = 8.015; p < .05$), and the partner challenges the
client (adjusted $R^2 = .215; F = 7.564, p < .005$). The therapist challenges the client positively predicted the goal subscale of the WAI outcome variable ($\beta = .382, p < .05$). Partner challenges client significantly, but negatively, predicted the goal dimensions of the WAI outcome ($\beta = -.322; p < .05$). See Figure 3.2 for a visual presentation of these results.

Task subscale and men clients. Also identical to the goal subscale for men, significant predictors of the task subscale of the WAI for men included the partner makes negative statements about the client (adjusted $R^2 = .154; F = 9.758; p < .005$), the therapist challenges the client (adjusted $R^2 = .277; F = 10.197; p < .001$), and the therapist gives advice (adjusted $R^2 = .325; F = 8.713; p < .001$). The variable, the partner makes negative statement about the client, significantly negatively predicted the outcome variable on the goal subscale ($\beta = -.415; p < .005$). The therapist challenges the client positively predicted the WAI goal subscale for men ($\beta = .368; p < .005$). The variable, the therapist gives advice to the client positively predicted the goal dimension of the outcome variable, the working alliance ($\beta = .250; p < .05$). See Figure 3.3 for a visual presentation of these results.

FIGURE 3.2. Task Subscale for Women

* $p < .05$; ** $p < .01$; *** $p < .001$
FIGURE 3.3. Task Subscale for Men

Partner makes negative statement about the client

Therapist challenges the client

Therapist gives advice

\[ \beta = .415 \text{ ***} \]

\[ \beta = .368 \text{ **} \]

\[ \beta = .250 \text{ *} \]

*\( p < .05 \); **\( p < .01 \); ***\( p < .001 \)

Bond Hypotheses

5. There will be a negative relationship between the number of negative comments made by a partner and the score on the bond subscale of the WAI for both men and women.

6. Both men and women will demonstrate a positive correlation between the amount of active therapist behaviors and the bond subscale of the WAI.

Bond subscale for women clients. The significant predictor variables for the bond subscale of the WAI for women included the therapist challenges the client (adjusted \( R^2 = .143; F = 9.014; p < .005 \)), the partner self discloses (adjusted \( R^2 = .233; F = 7.001; p < .005 \)), and the partner challenges the client (adjusted \( R^2 = .259; F = 6.598; p < .005 \)). The therapist challenges the client positively predicted the bond dimension (\( \beta = .401; p < .001 \)). The partner self discloses also positively predicted the bond subscale of the working alliance inventory (\( \beta = .270; p < .05 \)). Negatively, the partner challenges the client predicted the bond
aspect of the WAI ($\beta = -0.271; \ p < .05$). See Figure 3.4 for a visual presentation of these results.

**Bond subscale for men clients.** Significant predictors of the outcome variable, the bond subscale of the WAI, include the partner challenges the client (adjusted $R^2 = 0.279; \ F = 19.582; \ p < .001$), the partner makes negative statements about the client (adjusted $R^2 = 0.511; \ F = 26.070; \ p < .001$), and the partner self discloses (adjusted $R^2 = 0.566; \ F = 21.889; \ p < .001$). The partner challenges the client positively predicts the bond dimension of the working alliance ($\beta = 0.542; \ p < .001$). The partner makes negative statements about the client negatively predicts the outcome variable, the bond dimension ($\beta = -0.487; \ p < .001$). Finally, the partner self discloses is a positive predictor of the bond dimension of the WAI ($\beta = 0.258; \ p < .05$). See Figure 3.5 for a visual presentation of these results.

**FIGURE 3.4 Bond Subscale for Women**

![Diagram](https://via.placeholder.com/150)

*\(p < .05\); **\(p < .01\); ***\(p < .001\)
FIGURE 3.4 Bond Subscale for Men

Partner challenges client

Partner makes negative statement about client

Partner self discloses

β = .542 ***

β = -.487 ***

β = .258, *

Bond Subscale of the WAI

*p < .05; **p < .01; ***p < .001
CHAPTER 4. DISCUSSION AND CONCLUSION

The present research integrates two streams of literature because prior process research has examined how couple behaviors influence relationship qualities, or how therapist behaviors influence the therapeutic process, and specifically the alliance. John Gottman has contributed significantly to the field with his research regarding how negative couple behaviors influence their relationship. To be noted, Gottman's (1999) findings regarding the importance of a 5:1 ratio of positive to negative statements did not surface in this study. In fact, positive statements seemed to have insignificant influence on the therapeutic alliance. Other researchers have concentrated decades of research to uncover how therapist behaviors contribute to therapy outcome, including the couple's well being. Therapeutic alliance seems to be influenced by both couple and therapist behaviors. The success of therapy seems to be a result of delicately managed behaviors, which are, in some cases, mediated by gender.

Goal for Women Clients

Unexpectedly, there were not significant predictor variables for the goal subscale of the WAI-O, for women. This refuted our hypothesis, and implies that neither couple negativity, nor active therapist behaviors are essential to women concerning goal formation for the alliance. Therefore, more research is necessary to investigate which behaviors, other than those utilized in this research design, are important for the goal subscale.

Goal for Men Clients

For men, it became clear that partner negativity was highly predictive of the goal subscale of the therapeutic alliance. Perhaps this is because men believe that it is very difficult to make progress or establish an end goal if there is an excess of complaining and
criticizing happening in therapy. Although this did not emerge for women as a significant predictor, it would benefit the therapist to perhaps monitor the amount of negativity that is being exchanged between partners, so to successfully establish goals for both partners, and begin to work towards them.

_task for women clients_

For both of Bordin’s goal and task dimensions of the therapeutic alliance, two of the predictor variables were significant for women: therapist challenges the client, and the partner challenges the client. Female clients seem to benefit from being challenged by their therapists, perhaps they are asked questions to contest their viewpoint, or the validity of concerns might be examined more closely, and they find direction in this. This seems to be a positive therapist behavior for female clients. However, women clients do not appreciate being challenged by their partner in therapy, as evidenced by this behavior’s negative association with the therapeutic alliance. It is also possible that the alliance of the therapist and the female client is damaged if the therapist fails to intervene when her partner is criticizing her. In either case, it is fair then to infer that the therapist would be well served to maintain sensitivity and vigilance regarding this couple behavior to best maintain the task and goal segments of the therapeutic alliance.

_task for men clients_

For both the goal and task dimensions of the therapeutic alliance, a few predictors were significant: the partner makes a negative statement about the client negatively predicted alliance, and the therapist challenges the client as well as the therapist gives advice were positive predictors. The first predictor, the partner makes a negative statement about the client, is congruent with Gottman’s Four Horsemen of the Apocalypse. The first horseman,
Criticism, is the same as the coder’s definition of a negative statement—a disparaging complaint that targets the partner’s character or personality. It is clear that if the partner is given the opportunity to openly make such negative statements about the client, that the therapeutic alliance will suffer, consequently harming therapy outcome. A negative statement would also encompass a statement that would qualify as a Contempt statement, also congruent with Gottman’s Four Horsemen of the Apocalypse, although this research design does not distinguish between the two. An example of the coding instructions for coding negativity is available in Appendix B.

The therapist challenges the client, and the therapist gives advice are both therapist behaviors that are representative of an active therapist. This is consistent with Alexander’s (1988) research and Gurman’s (2001) commentary on the benefit of the active therapist. Gurman clearly states that the therapist as expert stance is unavoidable and even essential to the therapeutic process; therapy provides a setting for corrective experience and change. Gottman even gives examples of a therapist sensitively but firmly insisting upon decreased negativity. Active therapists also are vigorous in their effort to challenge couples to see their circumstances in different lights and try out new behaviors, so it makes intuitive sense that these therapist behaviors, as well as client behaviors, are statistically predictive of the goal and task dimensions of the therapeutic alliance.

Bond for Women Clients

The therapist challenges the client, the partner self-discloses, and the partner challenges the client are all predictive of the bond dimension of the therapeutic alliance for women clients. As with bond and task, women may respond well to being challenged by the therapist. Such challenging, representative of an active therapist, seems to help them to see
their circumstances in a new way, or come to new conclusions. Again, the partner challenging the client again emerges as a negative predictor of the alliance for women, again emphasizing the importance of the active therapist, who maintains vigilance regarding such behaviors. This behavior has the potential to deteriorate the therapeutic alliance with clients, and thus therapy outcome.

Self-disclosure of the partner influences the bond dimension of the therapeutic alliance, but not for goal and task. Self-disclosure of the partner in therapy is reliant on trusting not only one’s partner, but also the environment. A client must feel emotionally safe, probably free from criticism or contempt from one’s partner or the therapist. Therefore, it seems probable that a therapist who provides a context for self-disclosure is managing negative behaviors, to allow for such positive behaviors such as self-disclosure of a partner to emerge. If self-disclosure is permitted and nurtured in a safe environment, the therapeutic alliance also seems to be cultivated.

**Bond for Men Clients**

The partner makes a negative statement about the client, the partner self-discloses, and the partner challenges the client were significant predictors of bond. So, allowing the partner to be critical or express negativity in the session seemed to negatively predict the cultivation of an atmosphere of warmth and genuine regard between clients and therapists. Perhaps such partner behaviors create sufficient tension and chill in the session to suppress warmth between the clients and therapists. Regardless of how it happens, it is clear that such couple behaviors degrade the therapeutic relationship, and thus pose a serious threat to therapy outcome. However, the partner challenging the client is a positive predictor of the alliance. Male clients seem to respond positively to challenging by their partner—perhaps
they feel that such discussion is productive and therefore reflects positively on the therapist. Interestingly, the fact that male clients respond well to such challenging is in contrast to female clients responding in such a manner. Challenging statement from a partner degrades the therapeutic alliance for female clients, but fortifies the alliance for and male clients. Therefore, therapists must take care to avoid a tendency toward striving for symmetric behaviors in a session, as men and women clients react differently to challenging behaviors.

Similarly to female clients, male clients respond positively to the self-disclosure of their partners. Again, self-disclosure requires an assurance of emotional security, and so knowing that one’s partner feels safe enough to share with them gives the impression of such security, and perhaps a sense of gratitude and warmth for the therapist.

Clinical Implications

This research yields compelling implications for clinical practice. Not only does it confirm and affirm Gottman’s and other’s results regarding couple negativity, but it shows the destructiveness of such behaviors in the therapy process. Couple negativity is harmful to the couple, regardless of the context, but couple negativity also deteriorates the therapeutic process when it is allowed to continue within the therapy session. Gottman gives a gentle but firm example of a therapist insisting upon reduced negativity, and suggests that therapists do not allow for that to occur because it is dangerous to the couple. Our research results concur with such findings and take those cautions a step further: not only are such behaviors dangerous to the couple, they are dangerous to therapy success. Therefore, the active therapist who moderates, perhaps by challenging clients or moderating negativity, increases their likelihood of developing a positive alliance with the couple partners.
Additionally, this research provides insight regarding how therapists should respond to men and women differently in therapy. For example, the partner challenging the client does not seem to significantly predict alliance measures for men, it negatively predicts good alliance for women—women respond poorly to being challenged by their partners. Therefore, setting up “ground rules” for both partners in therapy may not always be entirely appropriate—as some behaviors are more significant for men than women. Thus, therapists should be cautioned to maintain the view that each individual and couple is unique, and that trends indicate gender differences.

Limitations and Directions for Future Research

Although these results proved both exhilarating and profound in meaning, it is clear that certain limitations for their generalizability exist. Cultural homogeneity stunts the sample, as the overwhelming majority of participants were predominately white, middle-class Americans. Racial and ethnic variety may greatly vary the results of the study, and it would be beneficial to examine the effect of such variables.

Another limitation of this study is seen in the reliability coefficients of some of the variables. As is the inherent risk of a research design that simultaneously studies a multitude of variables, the reliability of several variables is lower than ideal. It would be beneficial to investigate the impact of this circumstance, as well as ways to conduct research that would maintain the integrity of the reliability of all variables in question.

Additionally, there were a few mean differences noted in the independent sample t-tests that focused on Master and Student Therapist expertise differences. In particular, these two groups differed in only one behavior: negative statements between partners. For some reason, the number of negative statement exchanged between patterns is more in one group
than another. Examination of this may yield fascinating results regarding therapist expertise and behaviors, and aid in training of new therapists. As in the expertise level t-tests, there was also a single significant difference in a second test, examining the differences between men and women therapists. The two groups differ on the number of challenging statements that the therapist issues. Perhaps this difference might be linked to societal power issues. As intriguing as it is, it should be further investigated.

Although the first session provides an adequate biopsy of the therapy process, it is limited in its scope. Research examining change in the predictor variables over time for alliance outcome, focusing on the change in significant variables over the course of therapy, would yield even more conclusive results. Future researchers have the opportunity to more closely examine the therapeutic “dance” between therapist and couple behaviors, to investigate and determine how specific behaviors change in their influence on the therapeutic alliance over the course of therapy—not just in the beginning stages, but also in the mid and late stages of therapy. Also, Gottman’s (1999) 5:1 ratio of positive to negative statements was not noted to be significant in this research study. It would be interesting for future researchers to examine this occurrence more thoroughly, and investigate the significance of seemingly conflictual findings.

Finally, it is imperative that further research better define what other client and therapist predictor variables, besides those utilized in this thesis, accurately foretell therapeutic alliance and success. Gender seems to be a mediating variable that has a great deal of influence throughout the therapy process. It is an important that future researchers to examine, for both the gender of the clients, as well as the gender of the therapist. It would be interesting to see how these variables change depending on the sex of the therapist,
particularly regarding the therapist's activity. Perhaps clients receive advice and challenging from a male therapist better than a female therapist? Examinations might reveal compelling new information that changes the way therapists provide services for their clients.

Also, qualitative research may lend fascinating results to uncover why certain variables are so essential to the therapeutic process, particularly depending upon gender. A research study design that asked couples to watch the tape after the session and comment on specific portions of the interaction may lead to new and exciting insight, particularly regarding the issue of power in the session. Men and women reacted differently to a number of variables, and some of these differences may be attributed to power differentials in the couple, as well as the therapeutic relationship. Qualitative research that strives to understand the meaning of such behaviors may lend some insight into such differentials and how the various behaviors interact. Also, coding that examines power in the relationships may yield results that address this query.

This thesis has succeeded in integrating three streams of literature that have been, until now, viewed as separate and perhaps unrelated. Through statistical analyses and discussion, it has emerged that couple negativity, the active therapist, and the therapeutic alliance are indeed closed linked constructs. Further research that examines the synthesis of various constructs and scrutinizes emerging gaps in the knowledge of the field will help professionals to improve its training of new and seasoned therapists.
APPENDIX A
ANNOTATED BIBLIOGRAPHY


**Topics: Alliance, Process Research**
1. Discusses Lamberts “Big Four” factors that attribute change in clients: 1) Extratherapeutic change-40%, 2) Therapeutic relationship-30%, 3) Expectancy (placebo)-15%, 4) Techniques-15%. Emphasizes the importance of the therapeutic relationship highly influential for the recovery of the client, as well as the disproportionate nature of a field obsessed with models.

2. Additionally emphasizes how limited therapists and their models are in assisting clients to recovery, especially when they concentrate their efforts on interventions and technique, and ignore the more human parts of the relationship—the relationship and the client’s belief that they will get better.


**Topics: Alliance, Early Sessions**
1. Summarizes research that has investigated the impact on outcome of the therapeutic alliance early in therapy, to establish that early alliance is a significant predictor of final treatment outcome. These findings indicate that the development of a positive therapist–client relationship may be critical from the onset of therapy. There appears to be a “window of opportunity” in the early session to establish a viable therapeutic relationship, or else the client may withdraw. (p. 139)


**Topics: Alliance, Process Research**
1. Examines the developmental course of the alliance over therapy. Views the helping alliance as a dynamic, rather than static phenomenon that is responsive to the changing demands of different phases of therapy.

2. Cites several research projects which identified a quadratic, or high-low-high pattern of alliance over the course of therapy, however, outcome seems to be most highly predictive and working alliance was largely determined by the first therapy session.

3. Participants: 27 Caucasian therapist-client dyads, drawn from a sample of 47 dyads. Clients were seen weekly for a range of 15 to 37 weeks, and included 20 women and 7 men.

4. Results: Findings support the view that individual characteristics of the therapeutic relationship evolve differently over time. The variability of perceptions over the time course appears greater when individual clients’ or therapists’ alliance perceptions are
monitored, as compared with a focus on pooled ratings. This adds to the understanding of the time course of a broad range of relationship characteristics as seen by the therapy participants. It also appears worthwhile to pursue investigation of individual differences in perceptions of relationship qualities across the course of therapy.


Topics: Alliance, therapy effectiveness.
1. Luborsky and colleagues (1993) reviewed relevant research on the concept of the therapeutic or working alliance and concluded that a positive correlation exists between the development of a working alliance between therapy and clients and a successful therapeutic outcome. They suggest that for there to be a successful joining of the therapist and client in the "therapeutic journey," the therapist must foster with the client the development of a sense of collaboration and trust, agreed upon goals, and faith in the procedures of therapy. They also advocated the importance of attending to the therapeutic relationship.

2. The authors offer a series of assumptions related to the application of the outcome evaluation of family therapists. 1) The client’s experience of therapy is what matters the most. 2) Clients are assessing therapists at the same time therapists are assessing clients. 3) Clients possess information and expertise that, if elicited and incorporated, can advance the development of the working alliance and therapeutic outcome. 4) The client’s experience of therapy has been underutilized as a direct source of improving therapist time with client than they do with other mental health professional. 6) Idea generated in training settings should be considered tentative until substantiated in the therapeutic setting. (p. 168)


Topics: Process research
1. Purpose: Clarify for experimental researchers the importance of respecting the distinctions between the moderator and the mediator.

2. Stresses that because most areas of social science and psychology, treat phenomena that have multiple causes, a more realistic goal may be to seek mediators that significantly decrease the effect of the independent variable on the outcome variable, rather than eliminating the relation between the independent and dependent variables all together. (p. 176)


Topics: Alliance, Gender
1. Bird, a practicing therapist from Australia and influenced by White’s work on therapeutic conversation, expressed that there has been clinical research interest in
collaboration between client and therapist. Focused primarily on therapeutic behavior, research has ignored the therapeutic relationship which "is critical in determining the client's experience. The conversation between the therapist and client exists because of the relationship — that has no other parallels in life. . . . It is time to bring the therapeutic relationship out of the closet. It is time to experiment with new descriptions that are respectful, engage in conversations of discovery with colleagues and clients and lastly, but most importantly, honour and celebrate relationship." (Bird, 1993, p. 48)

2. Bird (1993) suggests that the therapeutic relationship is special because the client trusts the therapist with their vulnerability. Therefore, the therapist must understand the thoughts and feelings of their client to develop the therapeutic relationship.


**Topics: Alliance, Role of Therapist**

1. "The Dodo bird conclusion that all therapies work approximately equally well for different disorders continues to receive support".

2. describes three general ways empathy and the relationship can facilitate change: one, the relationship can facilitate change by promoting client involvement and participation. Two, the relationship can help through its capacity to promote new learning through "corrective emotional experiences". Three, the relationship can promote and support productive client information-processing.

3. Therefore, the relationship provides an "empathic workspace" in which the client can drop defensiveness and adopt a more task-oriented approach.


**Topics: Alliance**

1. Four propositions provide a conceptual framework for understanding the difference among different theories and approaches to psychotherapy, and point the way for converging investigations: 1) all genres of psychotherapy have embedded working alliances and can be differentiated most meaningfully in terms of the kind of working alliance each requires; 2) the effectiveness of a therapy is a function in part, if not entirely, of the strength of the working alliance; 3) different approaches to psychotherapy are marked by the difference in the demands they make on patient and therapist; 4) the strength of the working alliance and the personal characteristics of patient and therapist.

2. Goals: are commonly laid in the client's commerce with other helpers prior to the first meeting with the therapist. Therapists vary in their emphasis on the enduring and central qualities of the goals that the therapist defines, either explicitly or implicitly.

3. Task: collaboration between patient and therapist involves an agreed-upon contract, which takes into account some very concrete exchanges.

4. Bonds: the goals set and collaboration specified appear intimately linked to the nature of the human relationship between therapist and client. Generally, at first they are more concerned about liking or not liking the therapist than anything else.
5. The idea that the bonds between patient and therapist have a significant positive role in psychotherapy is sufficiently new to leave us with a relatively undeveloped set of specifying regarding it. In his analysis of the role of the therapeutic alliance in the outcome of psychotherapy in the Menneinger project, Horwitz (1979) discusses the patient’s capacities to see the therapist as a good object as an influence toward establishing a strong working alliance. Presumably such capacities are intimately related to hopeful and trustful states and dispositions. It is extremely likely that we are not just dealing with static conditions, as it is likely that these conditions are responsive to the adaptive responses of the therapist. Horwitz deal with such alternative when he speaks of the possibility that, in particular instances, a more effective and stronger working alliance could have been achieved through inpatient as compared to outpatient treatment (p. 258).


**Topics: Alliance**

1. Theory: Goal is “a careful search with the patient for the change goal that most fully captures the person’s struggle with pains and frustration relative to the story of his or her life is a key part of the building of a strong therapeutic alliance” (Bordin, 1994, p. 15). A strong therapeutic alliance refers to a collaborative relationship in which the therapist helps the client to see new possibilities. Goals often change over the course of therapy. “…reaching an understood and mutual agreed-on change goal is the key process in building an initial, viable alliance” (Bordin, 1994, p. 16)

2. Task is “specific activities that the partnership [of therapist and client] will engage in to instigate or facilitate change”. (Bordin, 1994, p. 16)

3. Bond is what extends in a therapeutic alliance from the shared activity and is expressed as liking, trust, mutual respect, sense of commitment, and shared understanding.

4. Variables that influence change include: the strength of the alliance, the power of the therapeutic tasks, and strain on the alliance. This includes temporary breaks or ruptures that momentarily affect the client’s commitment to the working alliance.


**Topics: Alliance**

1. Discusses the idea of the how to create a relationship with a client, by examining Bordin (1994, 1979) ideas of goal, task and bond.

2. Goal: Although there are exceptions, many therapists believe that they know what is best for the clients. Therefore, sometimes when therapists ask about client goals, they are encouraging participation—not self-defined direction. Therefore, the authors recommend that therapists listen and amplify stories and experiences that the client offers about his or her problems, to find out their ideas about “where they want to go and the best way to get there”.
3. Tasks: in a working alliance, the client perceives tasks as germane and effective. It is best for the alliance if the therapist and clients explore material that the client’s perceive to be important and “compulsively address” what the client indicates as significant.

4. Bond: this is important for setting the scene for other therapeutic interests. The authors suggest that therapists take care to be likeable, friendly and responsive, make sure that the client feels understood by using empathy skills liberally, and being flexible by allowing oneself to be many things to many people.


**Topics: Criticism in therapy, process research.**

1. Purpose: To better understand couple’s perceptions of the change process regarding helpful and hindering aspects of therapy.

2. Participants: 8 “highly experienced” staff therapist, 5 advanced student therapists; 15 married, heterosexual couples who contacted the clinic for clinical services. Criteria included: 1) married no less than 3 years, 2) had a child younger than 12 years, 3) reported couple satisfaction and the possibility of divorce by at least one member of the couple during intake, 4) both partners consented to and were available for study, 5) both partners expressed a desire to improve the relationship and avoid divorce if possible, and 6) neither partner met the criteria for a DSM-IV diagnosis of Major Affective or Psychotic Disorder. They were given a 15% reduction in clinical fees per session for participation.

3. Method: Couples met with a therapist at the beginning of therapy and after the eight session to complete a DAS, and participate in a Brief Therapy Interview. The BTI’s were coded to generate a list of helpful and hinder aspects of treatment reported by each couple.

4. Results: Coders compiled a list of 12 effective ingredients for couple therapy including: therapist moderates and control discussion, therapist provides a safe environment, therapist encourages participation, and therapist helps in resolving problems. (All consistent with the limitation of critical statement exchange within therapy.)

5. Generally, couples identified almost three times as many effective ingredients as ineffective ingredients. Also, compared to poor-outcome couples, good-outcome couples identified twice as many effective and ineffective change process categories. These data suggest that while good- and poor-outcome couples perceive similar change processes in therapy, the good-outcome couples make many more observations relative to these categories.


**Topics: Gender and criticism**

1. Negative affect occurs in all marriages, and a large body of research names negative affects as a serious problem when it consistently escalates and partners are poorly skilled at decreasing the intensity of the negativity.
2. Purpose: Discover how affect and behavioral involvement in partner complaints and compliments relate to current and longitudinal well being.

3. Sample: 65 married couples, at least 20 years old and native English speakers. The majority were European-American students, and most were either enrolled or had completed a four-year degree. The average length of the marriage was 52.19 months.


5. Results: Most relevant to these endeavors included those that supported the notion that negative affect has a strong negative impact on relational well being. Also, the more wives' experienced negative affect, the more their and their husbands' concurrent satisfaction and commitment suffered. In other words, both partners seem less happy to be in and less driven to stay in a marriage when wives experienced a great deal of negative affective arousal as the couple attempted to discuss problems and complaints.


**Topics: Alliance**

1. Zetzel (1956) introduced the term “therapeutic alliance”. She considered the therapeutic alliance as stemming from the patient's attachment to and identification from the analyst. She viewed the therapeutic alliance as a repetition of the good aspects of the mother-child relationship. Rather than specifically defining the concept of therapeutic alliance, Zetzel primarily discussed its technical implications for success in psychoanalysis.

2. Brenner (1979) argued that there is no such phenomena as the alliance, and that the entire relationship of the patient to the therapist is an expression of transference and should be dealt with as a resistance.

3. Psychotherapy definition: The therapeutic alliance encompasses the more sentimental aspects of the patient's cooperation in therapy, which are oriented toward the person of the therapist. The working alliance reflects the more skillful aspects of the patient's collaboration, which are directed toward the tasks of treatment.

4. "Three major roles played by the alliance in psychotherapy have been postulated: (a) the alliance as being therapeutic in and of itself; (b) the alliance as being a prerequisite for therapeutic interventions to be effective; and (c) the alliance as interacting with various types of therapist interventions, exploratory versus supportive, for determining success in psychotherapy. Many psychoanalytic authors conceptualize the alliance as a necessary BUT NOT sufficient ingredient of successful psychotherapy." (p. 148) This remains to be empirically demonstrated. However, the empirical evidence shows that the alliance is both theoretically sound, as well as clinically useful, as well as predictive of therapy outcome.

### Topics: Between-couple criticism

1. **Purpose:** examined the effects of expressed emotion, marital quality, and psychiatric symptomology on displays of verbal aggression by both relationship partners.
2. **Sample:** 152 married couples residing in a large metropolitan area in the Midwest. Ages 20-77 years of age. Most were European American (89.5%), and the remainder (8.6%) were African American. The couples had been married an average of 10.56 years, and generally had one or two children. They were largely lower middle class.
3. **Measures:** The Family Emotional Involvement and Criticism Scale (FEICS), used to assess critical comments from and emotional over involvement of family members from the client's perspectives. Other measures include the BSI (Breif Symptom Inventory), The Autonomy and Relatedness Inventory (ARI), the Marital Comparison Level Index (MCLI), and the Conflict Tactics Scale (CTS).
4. **Results:** For both males and females, the subjects' ratings of marital quality were a significant negative predictor of verbal aggression. This is, higher marital quality scores were significant associated with lower scores regarding partner verbal aggression.


### Topics: Criticism

1. **Discuss the difference between a criticism and a complaint.** Gottman (1999) identifies criticism as the first of his Four Horsemen of the Apocalypse, his figurative precursors and predictors of divorce. He states: “Criticism is any statement that implies that there is something globally wrong with one's partner, something that is probably a lasting aspect of the partner’s character.” (Gottman 1999, p. 42) This is distinctly different from a complaint, which is a specific statement regarding an act or event, not the character of one's partner.
2. **States that women criticize more than men.**
3. **Gives an anecdote for a therapist who is intervening in a conversation in which a couple is using strong and disconcerting criticism.**
   "Mike: ... Two years in which she is being a goddamned selfish bitch and I won't put up with it. She can just take a hike. She will never get custody of her kids. I will see to it that she just loses her precious kids.
   Therapist: Let me just stop you here, Mike. Research has shown that there are some patterns of interaction in marriage that are very destructive of love. These are being contemptuous and [critical], and being threatening. I cannot let you interact like that here. I suggest that you don't do it at home either. [Critical remarks] and threats are part of a pattern of psychological abuse. Nothing is more destructive to love. So, please rephrase your complaints and try not to use these ways of expressing yourself" (Gottman 1999, p. 193).

**Topics: Criticism and divorce**

1. **Purpose:** Investigate the effect that certain marriage behavior have on the timing of divorce—most divorces occur within two “problem” times, the first seven years of a marriage and the period in which the first child reaches 14 years of age.

2. **Sample:** Approximately 200 couples who responded to an advertisement.

3. **Measures:** a demographic questionnaire, two measures of marital satisfaction, and coded interactions.

4. **Salient Results:** The presence of negative behaviors, including criticism, was able to predict with high accuracy which couples would divorce in the first seven years of marriage.


**Topics: Role of therapist, family therapy, alliance**

1. A work that references many other sources to provide a contrast between brief and long-term family/couple therapy, as well as provide an idea of what brief therapy provides.

2. “This acceptance of the role of therapist-as-expert leads rather predictable to certain patterns of therapists’ behavior. These patterns emphasize a high level of therapist activity, a characteristic common to most brief individual therapies (Bloom 1992). Such active family therapist strive to develop individual caring alliances with each family member from the outset of treatment, structure the therapeutic encounter for patients, and are highly collaborative in jointly setting the goals for treatment.” (p. 61)

3. Rait’s (1998) survey of family therapists found that 81% of the respondents “always” or “often” explicitly negotiated treatment goals with families and couples. At least in ideal practice circumstances, family therapists with empirically supported orientations are quite likely to be high on all three dimensions of the therapeutic alliance, as elaborated by Pinsof (1995), based on Bordin (1979) oft-cited tripartite model of bonds, tasks, and goals, and they appear especially skilled at enhancing the second and third of these dimensions, even very early in treatment (Pinsof, 1999).

4. This pattern of heightened therapy activity in family/couple therapy has particular impact on an aspect of therapist-patient relationship, which in long-term treatment often becomes the pivotal focus for promoting change. The transference relationship, as it is traditionally called, is mitigated by the usual short length of family/couple treatment, the therapist’s participation as a relatively real object, and the inconstancy of the therapist’s behavior. (p. 61)

**Topics: AAMFT Master Series, Gender in MFT**

1. The Master's Series sessions are widely regarded as a kind of "standard of excellence" in practice. They are used as demonstration tapes for clinical training. They are also a rare example of a live session that is available to the public.
2. Purpose: examine integration of feminist principles in AAMFT tapes, by "leaders" in the field.
3. Sample: 23 randomly selected tapes form the series.
4. Results: Feminist principles were grossly under-represented in the Master's Series sessions.


**Topics: Gender, Couple Dynamics**

1. The authors discuss in depth how our society is organized by gender, and women are valued as a level lower than that of men, as evidenced by the amount of money that women are paid in relation to men for the same job.
2. Cited a review of a number of studies that found that married women's sense of well being is lower than that of married men's. Although inequality is clearly detrimental to women, it also negatively influences men by compromising the quality of their family relationships, which are generally as central to men's happiness and well being as they are women's. Inequity in marital or intimate partnerships has been consistently shown to have negative effects on relationship satisfaction, regardless of whether partners are under- or overbenefiting, although underbenefiting is more harmful.


**Topics: WAI reliability, alliance**

1. States that the working alliance has emerged in the literature as a promising construct for studying and better understanding the change process. It is defined as the extent to which a client and therapist work collaboratively and purposefully and connect emotionally, is conceptualized as a common, or generic, factor in that it is believed to cut across various treatment approaches. It has been found to be correlated positively with a broad range of psychotherapy outcomes and, overall, appears to be a relatively strong predictor of client change.
2. WAI: the most popular measure of WA available, and is a self-report instrument that can be administered easily and completed rapidly, either by a client, a therapist, or a not participant observer. It is theoretically based. Finally, its scores have been shown to share a significant amount of common variance with other measure of WA and it is familiar to psychotherapy process researchers, as well as to clinicians.
3. Goals subscale measures the extent to which a client and therapist agree on the "goals (outcomes) that are the target of the interventions" (Horvath and Greenberg, 1989, p. 224). The Tasks subscale measures the extent to which a client and therapist agree on the "in-counseling behaviors and cognitions that form the substance of the counseling process". (p. 224). The Bond subscale measures the extent to which a client and therapist possess "mutual trust, acceptance, and confidence" (p. 224)

4. Internal consistency: .98 and .92, respectively for the internal consistency and interrater reliability estimates of the total scores.

5. To what extent are WAI and WAI-S scale scores reliable? "To a great extent". Reliability score estimates were uniformly high, means ranging from .79 to .97. These estimates easily meet professional standards of acceptability.


**Topics: Alliance, Gender, Empirical Validation**

1. Influenced by Pinsof and Catherall's (1986) suggestions that (1) therapeutic alliance has been overlooked and (2) therapeutic relationship in family therapy has three dimensions: individual, subsystem and whole system alliances.

2. Purpose: Evaluate statistical soundness of several couple and family therapy alliance scales.

3. Participants: 66 clients, 32 men and 34 women; 16 therapists, 12 men, 4 women at an outpatient clinic in a large northeastern hospital which specialized in family therapy.

4. Results: (1) rating were normally distributed; (2) good internal consistency suggested reliability; (3) scores were similar for men and women as well as for couples and families; and (4) there was evidence to support split alliance, a theoretical construct suggested by Pinsof and Catherall (1986).


**Topics: Criticism between couples, depression.**

1. Authors state that increased expression of negative affects is easily seen in the marriages of distressed persons. In fact the evidence is quite consistent that there is increased criticism by depressed patients and by partners toward depressed patients.

2. Some studies suggest that depressed women show an increased amount of hostile behavior towards their husbands. This study demonstrated clear evidence of increased negative affective expression toward the partner in the depressed marriages. (Weissman, Klerman et al, 1971)


**Topics: Negativity, depression**

1. Purpose: increase knowledge of the emotional responses of families and enhance understanding of how they cope with a psychiatrically ill individual.
2. Sample: 30 dyads that agreed to be videotaped. They were recruited while one partner was in an Oxford, England psychiatric hospital suffering from an episode of depression.

3. Measures: coded using the KPI coding scheme, depression established by the Beck Depression Inventory, and self-report of marital satisfaction (DAS).

4. Results: Critical remarks from one’s partner had a direct and significant relationship with the reported marital satisfaction.


**Topic: Between-couple criticism**

1. Purpose: Examine the consistency of marital communication across two cultural samples, looking at correlations between self-reported marital satisfaction and observed communication behavior.

2. Sample: Two samples were taken, each from either Munich (n= 29 distress couples, and n=12 non-distressed couples), or Oxford (n=30 couples), recruited either by radio advertising, or by recruitment in psychiatric facilities.

3. Measures: marital satisfaction was assessed using either the General Happiness Rating Scale or the Dyadic Assessment Scale, and communication behaviors were coded by interaction observers.

4. Results: A strong, significant correlation was established between negative verbal behaviors and self-reported marital quality. Thus, inferring that heightened criticism and poor marital quality seem to appear hand in hand.


**Topics: Alliance**

1. Purpose of WAI: to “investigate therapeutically active factor(s) shared by all forms of therapies” (Horvath, 1994, p. 110); develop a measure which was clearly linked to a theoretical construct; and develop a measure which was linked to a general theory of therapy and change. Based on Bordin’s (1975, 1976, 1980, 1989, 1994) model of alliance. It emphasizes content validity.

2. Content validity was established by evaluation of items by experts on alliance and a random selected of licensed psychologists. The WAI correlates positively with other established inventories of alliance, such as the CALPAS, the Helping Alliance, and the Vanderbilt scales. The WAI seems statistically sound: research on item homegeneity-based on Cronbach’s alpha- is high for the entire instrument, although lower for the subscales (.84-.93, and .68-.92 respectively reported). Test-retest reliability ranges from .66-.74 and the subscales are “strongly correlated”, ranging from low .60’s to the high .80’s.

3. Relationship of WAI to Outcome: There seems to be a positive relationship between alliance and outcome; alliance measures obtained early in therapy are better predictors of outcome that measure taken in the middle or at the end. The WAI
seems to measure something distinct from therapeutic progress, so it does not simply reflect change.

4. Alliance is determined by client characteristics, therapist characteristics, and an interaction between the two, which is shown in Fig 5.1 (p. 121). Client characteristics which contribute to a good working alliance include submission, isolation, friendliness, positive response to confrontation, and ability to deal with the here-and-now relationship positively influence therapeutic alliance while hostility, aggression, and dominance negatively influence it (note: “pretherapy client factors had an effect size of .32 as a determinant of subsequent measure of the alliance” (Horvath, 1994, p.110)). Gender differences did not seem to precipitate alliance difference, nor did cross-gender combinations of client and therapist (man-woman, woman-man), and was not statistically significant.

5. Therapist characteristics which seems to predict higher working alliances include a focus on the here-and-now relationship, and thematically focused, challenging, distant rather than intimate therapists are most likely to improve the working alliance”. Additionally, “therapist empathy and trustworthiness are prerequisites for alliance development”. Finally, individual therapist factors seem to be more predictive of therapeutic alliance than theoretical orientation. (Horvath 1994, p. 121)


**Topics: Therapeutic alliance scales**

1. Purpose: to conduct a meta-analysis of twenty-four studies, based on twenty distinct data sets, to evaluate various measure of working alliance to treatment outcome.

2. Results: (1) Quality of the working alliance predicted positive therapy outcome; (2) client assessments of working alliance were better predictors of therapy outcome than therapist assessments of working alliance; (3) observer’s rating of working alliance were the least predictive of therapy outcome; and (4) relationship of working alliance to therapy outcome does not seem to be influenced by type of treatment, length of treatment, or number of participants who are a part of the research.


**Topics: Therapeutic alliance scales**

1. Purpose: explore the relationship between counselor intention and clients’ perception of the working alliance.

2. Sample: 42 volunteer clients paired with 42 student counselors.

3. Measures: Intentions List to measure nonmutually-exclusive therapist intentions (e.g. set limits, get information, give information, support, focus, etc...); WAI, and Interpersonal Checklist (ICL), a measure of interpersonal attitudes to be used a control variable.

4. Results: three counselor intentions (assessment, exploration, support) negatively predicted working alliance. None of the other dimensions were statistically significant.

**Topics: Therapeutic alliance scales**

1. **Purpose:** Examine working alliance as it develops during the early phase of counseling.
2. **Sample:** 144 (95% of prospective participants) counseling dyads at a large Midwestern university counseling center; 15 out of 16 staff psychologists. Selection: all student clients at the beginning of the fall 1998 semester who (a) completed an intake interview, (b) scheduled additional counseling, and (c) were assigned to one of the participating therapists.
3. **Measures:** (a) WAI; (b) the Interpersonal Relationship Scale (IRS) (used by counselors to rate client's hostility level, quality of interpersonal relationship, and family relationship quality); (c) the Problem Severity Rating Scale (PSRS), adopted from the CRF, (used by counselors to rate client's overall psychological health (e.g. severity of problem, subjective distress, quality of interpersonal functioning and academic performance)); (d) Therapist Satisfaction Scale (TSS), a 7-item measure of counselor satisfaction with the process of individual counseling; (e) Client Satisfaction Scale, a 5-item measure of client satisfaction with overall process of counseling sessions; (f) Self-Report Checklist (CRC), a measure developed for this research, (asks clients to rate the type and severity of 24 common presenting problems); and (g) measurement of premature termination status (operationalized as (a) the counselor and client met fewer than four times and (b) client did not appear for scheduled sessions).
4. **Procedure:** (a) prior to intake, clients completed the SRC; (b) after their first session, clients completed the Client WAI and the CSS; (c) following the first session counselors completed the Counselor WAI, TSS, and PSRS.
5. **Results:** (a) canonical analysis revealed at least one statistically significant underlying canonical root between client and counselor WAI scores in one dimension, and IRS, PSRS, and SRC in the other; (b) partial support for relationship between client characteristics and quality of working alliance (e.g. client hostility [-], quality of current relationships [+], and past family relationships [+], predicting working alliance); and (c) client characteristics did not predict premature termination.


**Topics: Marital Conflict, Criticism**

1. Criticism was defined as a statement in which one spouse attempted to influence the other by blame or disparagement.


**Topics: Alliance**

1. **Purpose:** Examine the impact of training level on working alliance.
2. **Sample:** 50 counselor-client dyads from three counseling agencies.
3. Procedure: Counselors grouped into three training levels: (a) novice (student therapists in their first practicum); (b) advanced trainees (students in second practicum through predoctoral internship) (c) experienced counselors (postdoctoral staff). Both counselors and clients complete the WAI after the 3rd session of therapy.

4. Results: (a) two-way (Training Level X Source of WAI) multivariate analysis of variance revealed significant main effects for training level and source (counselor vs. client), but the interaction of Training Level X Source was not found to be significant; and (b) follow-up one-way ANOVAs separately for client and therapist for each dimension of the subscale (bond, goals, tasks) revealed statistically significant differences for level of training on tasks and goal subscales for both clients and therapists.

5. Discussion: Mallinckrodt & Nelos (1991) predicted the lack of statistical difference for the bond scale because they suggest that the sequence of counselor training emphasizes building rapport in the early stages of training so there would be less difference on this dimension, but more difference on tasks and goals as those are skills that are later attained and sophisticated by experience.


Topics: Alliance
1. Interest in this concept among researchers can be partly attributed to the search for understanding change across treatments, given that no particular treatment has been shown to be consistently better than any other in effecting change. Bordin suggested that a good alliance is a prerequisite for change in all forms of psychotherapy and defined the concept. (p. 6)

2. By highlighting the critical importance of the real, human aspects of the therapeutic alliance, it provided grounds for departing from the idealized therapist stance of abstinence and neutrality. In fact, one might say that the processes of developing and resolving problems in alliance are not simply prerequisite to change but rather the essence of the change process.

3. Bordin’s conceptualization of the therapeutic alliance may be useful for several reasons. It highlights the fact that at a fundamental level, the patient’s ability to trust, hope and have faith in the therapist’s ability to help always plays a central role in the change process. Some aspects of this type of alliance many involve conscious, rational deliberation, but other aspects are unconscious and affectively based. (p. 7) Also, it provides a rational framework for guiding the therapist’s interventions in a flexible fashion. Rather than designing a therapeutic approach centered around false expectations of neutrality, one can be guided by an understanding of what a particular therapeutic task means to a particular patient in a given moment. (p. 8) Understanding patients as diverse in capacity and variable in experiencing highlights the importance of the negotiation between patient and therapist about the tasks and goal of therapy. The conceptualizing of the alliance as both dynamic and mutual is
consistent with a view of the essence of therapy as entailing an ongoing negotiation between two subjectivities, between the patient and the therapist. (p. 9)


**Topics: Therapists effectiveness, alliance.**
1. Purpose: Identify therapist behaviors that are associated with more effective and less effective therapists.
2. Participants: 16 therapists, all with at least two years experience post-degree, 10 males and 6 females, 8 psychologists and 8 psychiatrists. 80 patients, aged 24-64, excluded if they had substance use disorders, severe medical problems, or needed psychotropic medication or inpatient treatment.
3. Results: A subgroup of “most effective” therapists was identified. More effective therapists showed more positive behaviors and fewer negative behaviors than less effective therapists. Examples of positive variables were warmth, affirmation and understanding, and helping and protecting. Examples of negative variable were belittling and blaming, ignoring and neglecting, attacking and rejecting.
4. More effective therapists were more self-critical than were less effective therapists. More effective therapists actually rated their session as having gone less well than did the less effective therapists. Even the best therapists were not entirely free of negative behaviors—all therapists displayed them to some extent.
5. “Therapists were differentiated almost entirely by relationship variable than technical ones. Thus, basic capacities of human relating—warmth, affirmation, and a minimum of attack and blame—may be at the center of effective psychotherapeutic intervention. (p. 121)


**Topics: Alliance**
1. Research on Scales: Two preliminary studies focused on two aspects of the scale (a) distribution of scores on the scales (e.g. is there sufficient spread/distribution to the scale); and (b) rate-rerate reliability. The alliance is conceptualized as an evolving state rather than a static trait. Subjects: therapists from a variety of backgrounds who spent a one year minimum on a part-time basis at the Family and Child Clinic at the Center for Family Studies/The Family Institute of Chicago; all completed the alliance measures after each of two consecutive sessions. Clients were assured confidentiality.
2. Study One: 25 clients (n=9 individual clients, 12 couples, and 4 families) seen by 21 therapists; they used a 5-item likert version of the scale. All rate-rerate correlations were statistically significant at the .005 level of significance. The distribution of each scale was highly skewed (e.g. from 80% to 91% of the responses were positive attributions).
3. Study Two: The scale was expanded from 5 to 7 points in order to reduce skew, and increased outcome. Results: (a) confirmed rate-rerate reliability figures form first study; (b) the distribution of scores did increase in the 7-item measure; and (c) the
amount of skew diminished, although many of the scores were still in the favorable rating range.

4. Conclusions: (a) the scales have adequate rate-rerate reliability; and (b) clients seemed to be disinclined to report negative alliance.


**Topics: Counseling Process, Working Alliance**

1. Purpose: Asks four questions: (1) What are the important dimensions of the psychoanalytic counseling process? (2) What is the nature of changes in these dimensions over time? (3) What are the ways in which these dimensions are related to each other over time? (4) How are changes in these dimension related to client outcomes?

2. Working alliance is defined as the part of the overall relationship the client has with the counselor that is rational and permits the client to work purposefully with the counselor. The counselor’s task is to offer a working alliance to the client, and the client’s responsibility is to accept the alliance. Patton et al. states that if the working alliance is firm, the client is able to deepen the relevance of the material presented by recognizing and overcoming resistances and surfacing and examining the present relevance of transferenceal patterns of interpersonal relationships (p. 190).

3. Methods: Participants were 16 clients, all European American and included university factual, staff and students. Two were HIV-positive gay men. Education ranged from 2 years of college to a doctoral degree. Counselors were five doctoral student and 1 advanced master’s level-student in counseling psychology. Four were men and two were women ranging in age from 24 to 62 years. Raters were twelve master’s level graduate students in counseling psychology (10 women and 2 men, 1 African American and 11 European American). Sessions were measured for alliance using the WAI: bond, agreement on goals, and agreement on tasks.

4. Results: the sample as a whole showed a significant increase in working alliance across the counseling sessions (p<.001), as well as demonstrating a quadratic growth pattern of change (high-low-high effect), with the middle sector significantly related to client outcome.


**Topics: Process research**

1. Conceptual framework determined to be: (a) clear, (b) inclusive, and (c) epistemologically sufficient.

2. Basic definitions: (a) family therapy is “any psychotherapeutic endeavor that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family” (from Gurman et al, 1986, p. 565); (b) process research is “the study of the interaction between the patient and therapist system. Its objective is to identify change processes in the interaction
between systems. It attempts to embrace all the behaviors and experience of these systems, both within and outside the treatment sessions, thus valid to the process of change. (from Greenberg & Pinsof, 1986, p. 18); and (c) family therapy process research (akin to the definition of process research) includes “all of the behaviors and experience of these systems and subsystems, that pertain to changed in the interaction between family members and their individual and collective levels of functioning” Pinsof, 1989, p. 54.

3. Key framework components: (a) system/subsystem focus, (b) emphasis on circular interaction over time; (c) interest with change processes connecting out-of-session process with in-session process; (d) abolishes the distinction between process and outcome research; and (e) demonstrates a sensible use of behavioral and experiential data and suitable method (e.g. self-report or observation). Attends to the criticism that self-report measures do to measures interaction by noting that data from this source “yield interesting and useful intersubjective data” (Pinsof 1989, p. 56).

4. Methodological criteria: (a) descriptiveness; (b) specificity/reconstructivity; and (c) universality.


Topics: Process Research

1. Three core components of a scientific paradigm for family psychology (a) underlying systems model, influenced by interactive constructivism, which includes two macrosystems (e.g. client system, and therapist system) that are both direct (e.g. person or persons in therapy) and indirect (e.g. person or persons who influence therapeutic process and are influenced by therapy), and implies that the only distinction between individual and family therapy is the boundary between the direct and indirect client subsystems; (b) an emphasis on family and therapeutic process; and (c) commitment to theoretical and technical integration.


Topics: Process Research

5. Conceptual structure of the scales: Three categories of the content dimension, (based on Bordin 1979) and identical to the WAI, are (a) tasks; (b) bonds; and (c) goals. Three categories of the system dimension: (a) self-therapist; (b) other therapist; and (c) group-therapist. This forms a 3 X 3 matrix.

6. Common Methodological Features of the Scales: (a) access strategy is rooted in the point of view of the individual client, therefore a self-report approach is most appropriate; (b) application of the scale takes about five minutes and must be completed immediately following a session; (c) scale and item format require the participant to evaluate the degree to which they agree or disagree; (d) individual patient scores are used to appraise dimensions of the alliance; (e) conjoint scores estimate whole family and couple system scores.
7. Alliance Dimensions: (a) content dimensions (based on Bordin 1979) include Tasks, Goals, and Bonds; (b) interpersonal system dimension, a unique property of this scale, measures relationships between the therapist and other relevant members of the client’s interpersonal system (e.g. Self-Therapist, Other-Therapist, and Group-Therapist).


**Topics: Criticism**

1. Purpose: to define dependency as it may be associated with power rather than gender.
2. Sample: 40 heterosexual married, 40 gay and 40 lesbian that completed self-report measure of dependency, dyadic power, and depression.
3. Results: Sensitivity to criticism was significantly correlated with depression, and negatively correlated with several measure of dyadic power. Several indices of low dyadic power was correlated with depression. Sensitivity to criticism was also highly correlated with fear of aloneness, which seems to be related to low amounts of power and dependency.
4. Criticism did not differ by sex. However, being in the demander role contributed significantly to the prediction of scores on sensitivity to criticism. Since heterosexual women reported higher frequency of being in the demander role than other groups including lesbian women, these results again suggested that factors distinct from being female may have contributed to previously observed sex differences in dependency. (p. 114)
5. Sensitivity to criticism appeared especially related to power processes: being in the demander role in relationships characterized by demand-withdraw interaction was highly associated with fears of criticism and rejection, regardless of sex or couple type. Aspects of dependency tapped by the sensitivity to criticism and fear of aloneness facets are related to dyadic power, specifically having fewer structural resources, being in the demander role, and wanting more closeness than one’s partner. (p. 116)


**Topics: Alliance, Couple Relations**

1. “It is held widely that the success of any therapeutic endeavor depends on the participants establishing and maintain an open, trusting and collaborative relationship or alliance.” (p. 211) The therapeutic alliance provides a context for interpersonal relatedness between therapist and family members, offers the opportunity for corrective experience, and alternately can be viewed as either a necessary or sufficient condition for therapeutic change.
2. “…virtually every prominent clinical theorist has discussed the importance of establishing and maintain a positive therapeutic relationship with the family. This includes the patient’s affective bond with the therapist, the patient’s capacity to work effectively in therapy, the therapist’s empathic understanding and involvement and
the agreement of patient and therapist on the tasks and goals of therapy. Pinsof & Catherall (1986) refer to the alliance as "that aspect of the relationship between therapeutic system and the patient system that pertains to their capacity to mutually invest, and collaborate on, therapy. (p. 139).

3. The therapeutic alliance must be considered from a systemic viewpoint, because it "depends not merely on the relationship between the therapist and the family members, but also on the interrelationships among the family member themselves." (Falloon, 1991 p. 84)

4. Minuchin and Fishman (1981) viewed the family and therapist as forming a partnership for a specified purpose and for a certain period of time. Thus, the therapist must be skilled at developing and maintain a functional therapeutic milieu that continually balances the therapist relationship with each family member, as well as various coalitions within the family.

5. Since therapy is about conversations about problems to develop new meanings and behaviors, clients are viewed as equal participant in the co-construction of meaning. The therapeutic alliance therefore become the vehicle for the deconstruction of confining narratives and the consideration of new ones. The social-constructivist approaches repudiate the therapist's "expert role" and favor a more egalitarian relationship between therapist and client.

6. Resistance: Ruptures in the therapeutic alliance can be defined as a negative shift in the quality of the therapeutic alliance or an ongoing problem in establishing one. (Breaches, miscommunication, misunderstanding, impasses, or indirect communication of hostility, disagreement about the goals or tasks of therapy, noncompliance etc) Therapeutic "impasse" include insufficient joining, lack of therapeutic intensity, lack of pacing, inability to challenge the system, diffusing conflict, being ahead of the family, lack of leadership, being overly directive or siding or neglect individuals or subsystems. According to Whitaker (1968), the responsibility to prevent or terminate an impasse lies with the therapist. However, resistance can be viewed as information that can be used to form a better alliance. DeShazer (1980) proposed that there are no resistant families, only "misunderstood" ones.

7. One must assume that problems in the alliance will occur, and the therapist must transform these ruptures into learning experiences by offering a corrective experience, modeling new behaviors, etc. By doing so, the therapist remains engaged with the family to ensure continuity as the system begins to reorganize in response to therapeutic interventions until they can continue on their own. (p. 223)


Topics: Process Research

1. Sample: Four brief therapy cases; two identified as having high alliance and two as having low alliance. Therapists were predoctoral interns "with considerable previous experience" (Reanadeau & Wampold, 1991, p. 108). Researchers collected data from
14 dyads and chose the two highest and two lowest, as reflected on combined therapist and client WAI scores.

2. Measures: WAI was used to evaluate level of alliance. Perman Classification Scheme, a measurement of verbal communication dyads, was coded verbal communication along two dimensions: power (operationalized as interpersonal influence and involvement, ranged from positive to negative and includes interpersonal factors such as affiliation, solidarity, sociability, and acceptance)** This developed a two dimensional matrix (e.g., power increased from top to bottom and interpersonal involvement increasing from left to right). They were coded at both manifest and latent levels. Manifest level was coded as a 3 X 3 matrix which included nine codes: aggressiveness, advise, support, disagree, exchange, agree, avoid, request, and concede. The latent level, a 4 X 4 matrix, included 16 codes: reject control initiate, share, counter, resister offer, collaborate, evade, abstain, seek, oblige, remove, relinquish, submit, and cling (Reandeau & Wampold, 1991, p. 109)

3. Procedure/Data Analysis: Message units were coded along two dimensions: (a) power; and (b) involvement. Three sessions were audio taped following intake. Coding units were operationalized as a “single unitary event” (Reandeau & Wampold, 1991, p. 109). Three graduate students, blind to the research purpose, coded the transcripts using the Penman Classification Scheme, attained a mean interrate reliability of Cohen’s kappa at .72.

4. Results: Base rate of behavior at the manifest level revealed that the most frequently used code for (a) clients was exchange (P=.67), a neutral score for the dimensions of power and involvement; and (b) therapists was advise (P=.53), a high-power/neutral involvement code.


Topics: Therapeutic alliance, therapist and client characteristics

1. Tested four hypothesis regarding therapeutic alliance, the second of which was most relevant to the interest of this thesis. The hypothesis stated that perceived therapist characteristics accounted for a significant portion of variance in the therapeutic alliance in couple therapy.

2. Sample: 28 couples selected from a university MFT clinic, an employee assistance program, and three private practices. Their age ranged from 19-50, and 40% of the couples saw a female therapist, and 60% saw a male therapist. The participants were predominantly European American (76.8%) with the remaining Hispanic (17.9%) and African-American (5.4%) Their length of marriage ranged from 1-21 years.

3. Measurements: Couple Therapy Alliance Scale (CTAS), Miller Social Intimacy Scale (MSIS), Dyadic Adjustment Scale (DAS), The Perception of Therapist Behaviors Inventory (PTBI).

4. Results: When tested it was significant for the perception of the therapist as Critical-Hostile, which accounted for 67.9% of the variance in total alliance. In other words, it seems that from this sample, one might conclude that client characteristics are less important than therapist characteristics when forming the therapeutic alliance!
5. Reif states: “These results show the importance of perceived therapist characteristics in the development of the therapeutic alliance in couple therapy. Both members of the couple must feel accepted and that the therapist is not critical or hostile to enable the development of a strong alliance. There result concur with the result of Bachelor (1991) who found that predictive factors of a good alliance included the client seeing the therapist as demonstrating warmth, caring and emotional involvement.” (p. 50)

6. Conclusion: “Couple relationship characteristics were found to be related to therapeutic alliance in martial therapy; however client perception of therapist characteristics accounts for a larger portion of the variance in therapeutic alliance than couple relationship characteristics.” (p. 56)


Topics: Alliance
1. States that clients who are seriously impaired in their fundamental capacity to trust other people are more likely to benefit from a longer term treatment, in which the establishment of a therapeutic alliance can become the work of the therapy, rather than a recondition for treatment.

2. Also outlines a means of establishing a solid therapeutic alliance: 1) Facilitate the development of the bond aspect of the therapeutic alliance by conveying warmth, respect, and genuine interest, 2) Outline the therapeutic rationale (including tasks and goals) at the beginning of treatment, 3) Establish realistic goals, 4) As therapy proceeds, be prepared to educate or remind patients about the purpose or function of therapeutic tasks that do not make sense to them, 5) Establish and maintain a therapeutic focus, 6) Maintain a balance between activity and receptivity, 6) Where possible, minimize the enactment of vicious cycles, 7) Alliance ruptures must be detected early on and addressed, 8) Be aware of the types of alliance ruptures characteristic of particular approaches, 9) Be aware of multiple alliances within a system, 10) Prepare patients for termination and explore its meaning for them.

3. There is an important therapeutic paradox: change is more likely to occur within the context of acceptance. (p. 229)


Topics: Alliance, Model Differentials
1. “Teaching MFT models as though they are primarily responsible for client change verges on professional scandal” (p. 353). Because most evidence we have center on the quality of the therapeutic alliance, we think that the heart of training should be on how we develop mutually satisfying and empowering bonds, goals, and tasks with clients. The relationship variables are not always sufficient for therapeutic change in most cases (although in some cases they are), but there is little evidence for the
differential effect of what MFT's do beyond establishing strong bonds and credible goals and tasks with their clients.


**Topics: Alliance, Process**
1. The *Dodo Bird Verdict* is what the field refers to as the result that researchers have ended up with—no theory or model has been empirically shown to be much more effective than any other. Therefore, the authors suggest that this may be because the client’s abilities to use whatever is offered surpass any differences that might exist in techniques or approaches.

2. The authors propose that the therapeutic relationship provides a context for healing, because it provides a “corrective emotional experience.” Also, it heals be it provides an environment in which more appropriate behaviors receive reinforcement. The relationship provides new learning opportunities: clients learn to be in a relationship more effectively.


**Topics: Alliance, Instrument accuracy**
1. Purpose: (1) Establish the reliability of each measure, using indices of internal consistency; (2) Determine whether interrater reliability could be obtained on the observer-rated measures; (3) Determine the correlations between the measures of working alliance.

2. Participants: Four male and four female therapists (aged 34-78 years), and eight female clients (aged 32-60 years), for a total of eight brief therapy cases. Six (2 male, 4 female) doctoral students in counseling or clinical psychology served as raters for the observer-rated working alliance measures.

3. Methodology: Clients and therapists were not aware of the specific purposes of the study, but therapy were fully informed about all research procedures and signed consent forms before and after treatment. Clients, therapists and raters completed the following alliance inventories that applied to their position in the system: The California Psychotherapy Alliance Scales (CALPAS), The Penn Helping Alliance Rating Scale, The Vanderbilt Therapeutic Alliance Scale, and the Working Alliance Inventory (WAI).

4. Results: No significant differences were found between the scales. All but two (CALPAS and VTAS) were highly correlated. These exceptions may be a result of a small sample size (n=8). All measures were internally consistent (>0.90) and high interrater reliability was demonstrated (>0.71).

5. Discussion: All six measures of alliance seem to be sound for evaluating alliance from the perspective of therapist, client and observer. (Including the WAI.)

**Alliance: Criticism**

1. Contrasting definition: “In giving criticism, we want to tell another person that we don’t like something he or she is doing”. (p. 197)


**Topic: Criticism**

1. The demand-withdraw pattern is more consistently found in distressed marriages (where criticism is expected to be present), and is detrimental to long-term relationship satisfaction.
2. Couple communication patterns seem to be enduring over time, and generally present well before marriage. (p. 299)
4. Results: Biggest point: “women and men communicate and behave very differently in relationships, despite the overwhelming evidence that women and men are more similar than different”. (p. 304) While the female-demand/male-withdraw pattern seems to have a negative effect on the relationship satisfaction, the reverse seems to contradict the results. Male-demand/female-withdraw seems to result in increased wife satisfaction, however it may only be useful if the couple is able to later employ a more effective communication pattern.


**Topic: Alliance**

1. Purpose: “We expect that, based on different socialization and treatment of women and men, women and men clients will report different conceptions on the goals and task dimensions of the therapeutic alliance as well as the total alliance.” (p. 7)
2. Sample: 46 couple and 19 families that consisted of both an adult woman and man who attended at least the first three session at the MFT clinic, as well as completed the third session assessments. All therapists were doctoral students in the program.
4. Results: Women and men clients report different experience in therapy based on treatment modality. Also, women and men report different experiences of the process of marriage and family therapy on two important dimensions—goals of therapy and tasks of therapy—as well as their perception of the overall alliance. Therefore, we might infer that gender does not directly affect the therapeutic relationship, but men and women have different experiences in therapy based on modality (marriage vs. family). (pp. 13-14)

**Topics: Gender, Modality**

1. **Purpose:** Discover how gender influences the ability to successfully introduce therapeutic topics in couple and family therapy.
2. **Two samples:** Both were collected at a large southern AAMFT accredited university. The first included 103 couples that were adult men and women who had attended a first therapy session. The second sample consisted of 31 couples and 10 families who has also attended a first session of therapy.
3. **Measurement:** Coders who established a global topic for each of three segments within therapy session.
4. **Results:** This was analyzed for interaction, and it was found that in couple therapy, women’s goals were honored more often than men’s goals, and that in family therapy; men’s goals were honored more often than women’s goals. Various proposed ideas of why this may be were listed.


**Topics: gender, therapeutic alliance**

1. **Article** specifies that the field’s gender diversity topics generally focus on the oppression of women, but that our society seems to additionally oppress men by socialized them to restrict their own emotion and avoid expression of those emotions. “Big boys don’t cry” becomes a mantra. (p.371)
2. **This phenomena** sets up a difficult precedence for men in therapy, either as a client or as a therapist. Today men are “expected to contribute to the relationship, as well as be warm, caring and supportive to their children and partners—behavior they were not necessarily taught during their development.” (p. 371)
3. The article pinpoints several emotional patterns that result for men. Male gender role conflict (GRC) predominates, and is induced when men: “a) deviate from, or otherwise violate, masculine gender role norms; b) try, but fail to meet masculine gender role norms; c) experience a discrepancy between their real self-concept and their ideal self-concept based on masculine gender role stereotypes” (p. 371). The author states that subsequent patterns emerge after GRC is experience. Counseling is a highly intimate and self-disclosing experience which the author states is likely to stimulate GRC, both in clients and in male therapists.
4. The authors additionally urge that the therapist recognize the “men’s behavior as adaptations to their socialization rather than as evidence of inherent flaws” (p. 374).

**Topics: gender, therapeutic alliance**

1. Authors state that emotion is considered to be a significant, although not primary, element of the counseling process, and “counseling psychologists' increased understanding of affective phenomena may increase their ability to facilitate certain therapeutic change processes”. (p.631)

2. Men and women are generally considered by the public to be one of two relations: totally different creatures (i.e. Gray’s *Mars and Venus*...) with all sex differences exaggerated and emphasized; or one and the same, with these sex differences minimized or ignored.

3. The authors, from the literature in the field seemed inconsistent. Most emotion-based sex differences seemed to be evident when “individuals experience increased motivation to present themselves in a certain way as a response to normative pressure. The reviews of subjective report research also support La France and Banaji’s (1992) assertion that sex differences in emotion are present only under four conditions: (a) when the measure of emotion employed is indirect, (b) when the self-reported emotion is potentially perceptible by others, (c) when the context under scrutiny is interpersonal, and (d) when general rather than discrete emotion is examined.” (p. 637) Thus, it is important to consider this, as much of what is a part of therapy may fall under one or more of these circumstances. Counseling “typically explores relationship development, expression of feelings, and discussion of emotional problems in a manner that some suggest is more congruent with women’s affective characteristics than men’s”. Thus, men may be forced into a set of gender role-prescribed behaviors, rather than being granted the freedom to explore and expand their abilities. Conversely, women may have their affective behaviors dismissed as being the result of female hyperemotionality. (p. 643)


**Topic: Alliance**

1. “What can no longer be accepted in family therapy research, in my opinion, is a concept of the therapist as an outsider, separable from the family. Instead, the therapeutic alliance of therapist and family interacting with one another is crucial for the study of process. The therapist is not an external observer, but, rather, is participant in the observing system. The extensive work on the therapeutic alliance in individual psychotherapy research is beginning to receive comparable attention in family therapy research, led by process researchers.” (p. 261)
Videotape Information

The videotapes we are coding come from several sources. Some are tapes of initial therapy sessions with clients at marriage and family therapy clinics. Others are demonstration tapes of therapists providing consultations with couples or families in order to demonstrate a particular technique or approach to working with a particular problem.

We are not coding the entire tape. We are only coding three segments: (a) 10:00 to 15:00 minute segment; (b) 25:00 to 30:00 minute segment; and (c) 40:00 to 45:00 minute segment. Almost all of the transcripts for initial sessions of therapy at MFT clinics have been edited for these three segments, so it will be easy to code them. For tapes that have not been edited, use the time function on the VCR to forward to these three segments and code only them.

Codes

**Man**
MIT MIW MPT MPW MNT MNW MCT MCW MGA MSD

**Wife**
WIT WIM WPT WPM WNT WNM WCT WCM WGA WSD

**Therapist**
TIM TIW TPM TPW TNM TNW TCM TCW TGA TSD

Other Duties For Each Transcript
1. Identify a global topic for each segment on the Therapy Rating Form.
2. Identify the source of the global topic for each segment. Who introduced the theme that became the global topic? Circle one of the five choices located at the end of each segment.
3. **WAI -- OBSERVER.** Complete this 36-item questionnaire for the man and woman client after you have finished all other coding for the case; this coding sheet is attached to the Therapy Rating Form. Answer items based on your perception of each client's experience in this therapy session.
Details for Codes

1. Man (husband):
   MIT = Man interrupts therapist.
   MIW = Man interrupts woman (partner).
   MPT = Man makes a positive statement about therapist.
   MPW = Man makes a positive statement about woman (partner).
   MNT = Man makes a negative statement about therapist.
   MNW = Man makes a negative statement about woman (partner).
   
   MCT = Man makes a challenging statement that is directed at the therapist.
   MCW = Man makes a challenging statement that is directed at woman (partner).
   MGA = Man gives advice.
   MSD = Man self-discloses.

2. Woman (wife):
   WIT = Woman interrupts therapist.
   WIM = Woman interrupts man (partner).
   WPT = Woman makes a positive statement about therapist.
   WPM = Woman makes a positive statement about man (partner).
   WNT = Woman makes a negative statement about therapist.
   WNM = Woman makes a negative statement about man (partner).
   
   WCT = Woman makes a challenging statement that is directed at the therapist.
   WCM = Woman makes a challenging statement that is directed at man (partner).
   WGA = Woman gives advice.
   WSD = Woman self-discloses.

3. Therapist (of either gender):
   TIM = Therapist interrupts man client.
   TIW = Therapist interrupts woman client.
   
   TPH = Therapist makes a positive statement about man client.
   TPW = Therapist makes a positive statement about woman client.
   TNM = Therapist makes a negative statement about man client.
   TNW = Therapist makes a negative statement about woman client.
   TCM = Therapist makes a challenging statement that is directed at the man client.
   MCW = Therapist makes a challenging statement that is directed at woman client.
   TGA = Therapist gives advice.
   TSD = Therapist self-discloses.

Parts of Each Code

1. First letter is the person talking:
M = Man client (husband).
W = Woman client (wife).
T = Therapist.

2. Second letter describes action or is part of a compound code:
a. Action codes:
   I = interruption. In addition to circling this code, identify it’s purpose
   (see Coding Details instructions).
   P = positive statement.
   N = negative statement.
   C = challenging statement.
b. Compound codes:
   GA = gives advice In addition to circling this code, identify the person
   who the advice is directed to (i.e., “M,” “W,” or “T); if the advice is
   directed to the couple, use the code “C”.
   SD = self-discloses.

3. Third letter describes the object of the action or is the second part of the compound
code:
a. Object:
   M = Man client.
   W = Woman client.
   T = Therapist.
b. Compound codes: see section 2.b.

Coding Details

It is very important that you consider more than punctuation when you code. Don’t
code something as a question just because a question mark is at the end of the sentence; don’t
code an interruption because the last sentence of a thought doesn’t contain a period. It is also
necessary for us to be clear about each code. It is particularly important for you to consider
the context of the situation, tone of voice and other features of the conversation when coding.
Consider the following when you code.

Interruption

There is a subtle difference between an interruption and overlapped dialogue that occurs in a
normal conversation. Consider the following before coding an interruption:

1. Some sentences tail off in tone or volume, although the person didn't complete a formal
   sentence or thought. The tailing off suggests that the person was through and is using this
tactic to invite a reply. This would an be an interruption. It is difficult to code an
interruption from the text because context is important, so circle interruptions as they occur.
2. If you code an interruption, identify the purpose of it:
   a) Does the interruption support the person who was previously speaking? Examples:
      “I’ve had a similar experience.” or “I hadn’t thought about that. That’s exciting.” If this occurs, write a “+” next to the code.
   b) Does the interruption challenge the previous speaker? Examples: “That’s not true.” or “I disagree.” If this occurs, write a “-” next to the code.
   c) Does the interruption change the topic of conversation? Example: “I don’t want to talk about that. We should be discussing __________.” If this occurs, write a “-“ next to the code.

Positive and Negative Statements:

These are statements that are directed toward a target that have a direct or implied approval or disapproval.

1. Implied evaluations (positive or negative) suggest that something good or bad has been accomplished by someone. Examples:
   a) "Good for you."
   b) "Congratulations."
   c) "I can't believe you did that."

2. These are not statements that describe a situation. Example: "That's fine."

3. Positive and negative statements are not personal feelings, but personal feelings may be a part of the sentence. This can be kind of tricky, and we may need to clarify this more. Examples:
   a) Do not code: "I'm angry at him."
   b) Do code: "I'm angry at him because he continues to avoid helping me around the house."
   c) Do code: "You make me nervous" or "You terrify me when you act like that" because these are implied negative evaluations.

Challenging Statements

There are many subtle and direst ways to challenge someone.

1. Disagreements: these statements are probably the most obvious challenges. Example: “That's not what happened.”
2. Providing Alternatives: in response to a comment, someone might provide an alternative point of view. This is more subtle. Example: “Another way to think about that would be ...” or “Have you thought about __________ in this way ...” or “Would you be willing to consider another explanation?”
3. Request an explanation: by asking someone to clarify a point or provide more detail, someone could be offering a challenge. Example: “What do you mean by that?”
Advice

Advice statements are common in marriage and family therapy. Partners may offer advice to each other and the therapist may offer advice to a particular person or to the couple. As with other codes, some advice is direct and others are indirect. Examples:
1. “I think you should ...”
2. “He needs to ...”
3. “Many couples benefit from making ‘I’ statements. Would you be willing to try to do that?”

Self-Disclosure

Self-disclosure statements occur when someone share something from their personal experience. Examples:
1. “It’s difficult for me to trust him because I’ve been hurt by so many other men in my life.”
2. Some statements are more difficult to code because the statement depends on the context. For example, the following statement could be coded as either self-disclosure or as a negative statement: “It’s difficult for me to trust him because he has hurt me so often in the past.”
   a) The distinction would between codes is based on context of the statement (e.g., responding to a criticism versus tearfully responding to a need to trust).
   b) Tone of voice and body language also provides information about the context of the statement.
APPENDIX C
TRANSCRIPT EXPCERPT

This is a sample of the transcripts that each coder followed while observing the videotapes.

T: How long did you know one another before you married? TIM TIW TPM TPW TNM
    TNW TCM TCW TGA TSD

M: Oh, Uh, I think about, be like...(wife laughs). Uh this would be approximately, maybe uh, ten years. MIW MIT MPW MPT MNW
    MNT MCW MCT MGA MSD

T: Uh huh, before you got married? TIM TIW TPM TPW TNM
    TNW TCM TCW TGA TSD

M: Yes, before we got married. MIW MIT MPW MPT MNW
    MNT MCW MCT MGA MSD

T: So you knew each other a long time? TIM TIW TPM TPW TNM
    TNW TCM TCW TGA TSD

W: Umhmm. WIM WIT WPM WPT WNM
    WNT WCM WCT WGA WSD

T: What attracted you to him? TIM TIW TPM TPW TNM
    TNW TCM TCW TGA TSD

W: Umm, the real honesty being, I was just looking at him funny because the story he’s telling is a little off base. WIM WIT WPM WPT WNM
    WNT WCM WCT WGA WSD
    Umm...

M: No it’s not. MIW MIT MPW MPT MNW
    MNT MCW MCT MGA MSD

W: I, I... WIM WIT WPM WPT WNM
    WNT WCM WCT WGA WSD

T: Well that’s why here to uh... TIM TIW TPM TPW TNM
    TNW TCM TCW TGA TSD

W: I met ____ I was married, I was dating his brother, and I married his brother. WIM WIT WPM WPT WNM
    WNT WCM WCT WGA WSD
APPENDIX D
WAI-OBSERVER VERSION
Therapeutic Relationship (WAI-O): Man

Below are statements that describe some of the different ways a therapist/client may interact in therapy. Answer these questions as they relate to the therapist and the man in therapy. If the statement describes the way you always (consistently) perceive the dyad, circle the number 7; if it never applies to the dyad, circle the number 1. Use the numbers in between to describe the variations between these extremes.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is a sense of discomfort in the relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. There is agreement about the steps taken to help improve the client’s situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. There is concern about the outcome of the sessions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. There is agreement about the usefulness of the current activity in therapy (i.e., the client is seeing new ways to look at his/her problem).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. There is good understanding between the client and therapist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. There is a shared perception of the client’s goals in therapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. There is a sense of confusion between the client and therapist about what they are doing in therapy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. There is a mutual liking between the client and therapist.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>9. There is a need to clarify the purpose of the sessions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. There is disagreement about the goals of the session.</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. There is a perception that the time spent in therapy is not spent efficiently.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>12. There are doubts or a lack of understanding about what participants are</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Question</td>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
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<tr>
<td>trying to accomplish in therapy.</td>
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</tr>
<tr>
<td>13. There is agreement about what client's responsibilities are in therapy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>14. There is mutual perception that the goals of the sessions are important for the client.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>15. There is the perception that what the therapist and client are doing in therapy is unrelated to the client's current concerns.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>16. There is agreement that what the client and therapist are doing in therapy will help the client to accomplish the changes he/she wants.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>17. The client is aware that the therapist is genuinely concerned for his/her welfare.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>18. There is clarity about what the therapist wants the client to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>19. The client and the therapist respect each other.</td>
<td>1</td>
<td>2</td>
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Therapeutic Relationship (WAI-O): Woman

Below are statements that describe some of the different ways a therapist/client may interact in therapy. Answer these questions as they relate to the therapist and the woman in therapy. If the statement describes the way you always (consistently) perceive the dyad, circle the number 7; if it never applies to the dyad, circle the number 1. Use the numbers in between to describe the variations between these extremes.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
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<tr>
<td>1. There is a sense of discomfort in the relationship</td>
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<td>2. There is agreement about the steps taken to help improve the client's situation</td>
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<td>3. There is concern about the outcome of the sessions</td>
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<td>4. There is agreement about the usefulness of the current activity in therapy (i.e., the client is seeing new ways to look at his/her problem)</td>
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<td>5. There is good understanding between the client and therapist</td>
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<td>6. There is a shared perception of the client's goals in therapy</td>
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<td>7. There is a sense of confusion between the client and therapist about what they are doing in therapy</td>
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<td>8. There is a mutual liking between the client and therapist</td>
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<td>9. There is a need to clarify the purpose of the sessions</td>
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<td>10. There is disagreement about the goals of the session</td>
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<td>11. There is a perception that the time spent in therapy is not spent efficiently</td>
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<td>12. There are doubts or a lack of understanding about what participants are</td>
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<td>13. There is agreement about what client's responsibilities are in therapy.</td>
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<td>14. There is mutual perception that the goals of the sessions are important for the client.</td>
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<td>15. There is the perception that what the therapist and client are doing in therapy is unrelated to the client's current concerns.</td>
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<td>16. There is agreement that what the client and therapist are doing in therapy will help the client to accomplish the changes he/she wants.</td>
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<td>17. The client is aware that the therapist is genuinely concerned for his/her welfare.</td>
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<td>18. There is clarity about what the therapist wants the client to do.</td>
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ACKNOWLEDGEMENTS

The author would like to extend her gratitude to her graduate committee: Dr. Ronald Werner-Wilson, Dr. Megan Murphy, and Dr. David Vogel, for their guidance, as well as their attentiveness during the project. In particular, Dr. Werner-Wilson has served not only as an inspiring professor, but also as a professional resource on many occasions and a compassionate and dutiful therapist and colleague. Additionally, he is to be thanked for his generosity in allowing the use of his data set for this project.

Appreciated also are the other faculty in the Graduate College of Human Development and Family Studies for the curricula that demanded greatness, and challenged the mind. Thank you to Andrea Dickerson, a fellow graduate student who offered support, critique and wisdom throughout the graduate school and thesis process.

Finally, thank you to the husband and parents of the author. To her husband, who offered continual support and ideas, and showed her a standard of excellence and dedication. To her parents, thanks for raising a child in an atmosphere that expected success and encouraged her to excel, regardless of gender or other constraints.