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Characteristics of the Therapeutic Alliance in Couple Therapy: Perspectives from the Field

Nathan Daniel Tomcik
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To the Graduate Council:

I am submitting herewith a dissertation written by Nathan Daniel Tomcik entitled "Characteristics of the Therapeutic Alliance in Couple Therapy: Perspectives from the Field." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Kristina Coop Gordon, Major Professor

We have read this dissertation and recommend its acceptance:

Deborah P. Wells, Robert Gillespie

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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CHARACTERISTICS OF THE THERAPEUTIC ALLIANCE IN COUPLE THERAPY: PERSPECTIVES FROM THE FIELD

A Dissertation
Presented for the
Doctor of Philosophy Degree
The University of Tennessee, Knoxville

Nathan Daniel Tomcik
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DEDICATION

This dissertation is dedicated to my wife, Dana, for her unwavering support and perennial patience throughout the course of my graduate school career. Thank you for inspiring me and believing in me.

With love,

-N

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I would also like to thank the couples I have seen at the University of Tennessee Psychological clinic who have continually touched me with their trust and routinely amazed me with their courage.

Finally, most of all, I would like to thank Kristina Coop Gordon whose guidance and mentorship has taught me both the science and the art of couple therapy.

ABSTRACT

The purpose of this study was to investigate practicing mental health care professionals' perceptions of the most important components of the therapeutic alliance in couple therapy. 151 therapists responded to requests posted to professional listservs and completed an online survey asking them to rate 18 aspects of the alliance on relative importance for couple therapy and individual therapy. Therapists also were given space to write narratives asking them to provide their definition of the therapeutic alliance in couple therapy as well as to describe unique ruptures in the alliance that may occur in the course of couple therapy.

Therapists who responded to the survey rated Balance and Resisting Triangulation to be significantly more important aspects of the alliance in couple therapy than in individual therapy. Moreover, these items were rated to be more important than broader aspects of the alliance such as Task agreement, Goal agreement, and Therapeutic Bond. No differences were found between theoretical orientations or degree of clinical experience among the components thought to be important to the alliance in couple therapy.

Clinical and research implications of therapists' perceptions of important aspects of the alliance in couple therapy were discussed.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

Introduction

It is widely accepted that a psychotherapist's primary duty is to help patients resolve their presenting complaints and come to a better understanding of themselves. Exactly how therapists and patients work together to construct the therapeutic process has been a source of considerable debate and empirical scrutiny. Over the last few decades researchers have unlocked a treasure trove of knowledge that has begun to clarify how psychotherapy may be helpful to patients. This has been a formidable undertaking considering the seemingly endless number of interactions that may take place between therapists and their patients. An additional layer of complexity is added to the process by the vast array of theoretical models that govern the manner in which therapy is ultimately conducted. One important component of the therapeutic process that has received considerable attention, and possibly transcends the various psychotherapy treatment modalities, has been the quality of the therapeutic alliance between therapist and patient (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

Depending upon the theoretical orientation of the therapist, the strength of the therapeutic alliance has been thought to influence the process of therapy in several ways. The relationship between the therapist and the patient may in itself be therapeutic, presumably by allowing the patient to experience a relationship that is fundamentally different than their usual social and family relationships (F. Alexander, 1950). It also is possible that the therapeutic alliance acts as a prerequisite for the effective use of therapeutic interventions or even interacts with specific types of intervention. For

example, supportive interventions may be most effective if the quality of the therapeutic alliance is poor while more exploratory or active interventions may be most effective only after a good therapeutic alliance has been established (Gaston, 1990). This finding makes sense if one believes that most clients come to therapy not knowing exactly what to expect and need to develop some measure of confidence that their therapist understands their emotional experience before making use of the interventions presented. Whereas it remains unclear exactly how the therapeutic alliance influences the process of psychotherapy, the alliance has been solidly linked to treatment outcome across theoretical orientations and treatment modalities (L. B. Alexander & Luborsky, 1986; Gomes Schwartz, 1978; Horvath & Symonds, 1991; Luborsky & et al., 1971; Marmar, Gaston, Gallagher, & Thompson, 1989; Marmar, Horowitz, Weiss, & Marziali, 1986).

Although research on psychotherapy with individual clients has had time to mature and be refined, therapeutic process research of couple therapy, has not yet reached the same breadth and depth. It is estimated that 20% of married couples in community samples are currently experiencing significant distress (Baucom, Epstein, Rankin, & Burnett, 1996). Considering that marital distress and dissolution is significantly related to an increased risk of psychopathology, suicide, violence (Bloom, Asher, & White, 1978) and physical illness (Burman & Margolin, 1992) preserving healthy marital relationships carries with it enormous social benefit. It is difficult to imagine that the therapeutic alliance in couple therapy does not have a role to play in the process of effective treatment. However, little attention has been devoted to understanding how the relationship between those involved in couple therapy impacts the

treatment process as a whole. In fact very little is known about the therapeutic alliance in couple therapy in general.

To date researchers are beginning to devote more attention to the therapeutic alliance in couple therapy but many questions still remain. Whereas the general topography of the alliance in couple therapy may be similar to that of individual therapy, there also may be important differences that warrant special attention. Process research in couple therapy is a burgeoning area of exploration that has yet to reach the richness that is found in the individual psychotherapy literature and this area of research will benefit greatly when more is known about the therapeutic alliance in work with couples. One way of exploring the general characteristics and nuances of the alliance in couple therapy, in contrast to that of individual therapy, is to ask practicing couple therapists to report their ideas about the alliance in their work with couples.

Valuable information can be gleaned from professional therapists thoughts about their craft, and this methodology has been used in previous studies to gain a better understanding of intractable couple problems (Whisman, Dixon, & Johnson, 1997) as well as to help develop better measures of therapeutic alliance in individual therapy (Horvath & Greenberg, 1989). Asking those who work with couples to discuss their ideas about the therapeutic alliance can similarly yield information that could potentially lead to more accurate methods of studying the alliance. A better understanding of the characteristics of the alliance in couple therapy from clinicians' perspectives could help researchers more effectively attend to aspects of the alliance that may be somewhat unique to couple therapy. The purpose of this study is to explore practicing therapists'

ideas about the important aspects of the alliance in couple therapy in order to enrich our understanding of the alliance in this modality and direct future psychotherapy process research with couples.

Therapeutic Alliance Defined

Although the concept of the therapeutic alliance as we know it today was not officially discussed in research circles until the 1940's, the idea that transactions take place between therapist and patient that are either conducive or destructive to therapy began with Freud's writings on transference. Freud (1912/1966) aptly noted that patients typically related to him in a manner that was similar to the way they related to other important figures in their lives. If the therapist maintained an adequate amount of neutrality, the transference between the patient and therapist was enhanced. As any relationship between the patient and the therapist existed only so far as the patient transferred patterns of relating from their past, it was assumed that any and all emotional reactions to the therapist were purely constructed by the patient. The primary importance of transference reactions in early psychoanalytic therapy was for the therapist to interpret for the patient how their reactions to the therapist were not based in reality but instead a function of previous relationship experiences. The idea that transference is the defining characteristic of the patient/therapist relationship later evolved to include the "real" interactions that take place during the course of therapy (Gelso & Carter, 1994). This line of thinking represented a paradigm shift from the unidirectional transference focused therapist-patient relationship to the two-person psychology approach that is found in most therapeutic styles today.

The idea that the relationship between the patient and the therapist may be based at least as much in reality as in transference was introduced in the 1950's and was hotly debated (Greenson, 1965). This perspective led to the notion of the therapeutic alliance as a joining of forces between the therapist and the patient in the process of alleviating the patient's distress. Interpersonal therapies and Carl Roger's client-centered approach viewed the therapist as an active participant in the development of this alliance (Rogers, 1951). By the late 1960's and early 1970's the concept of the therapeutic alliance in individual psychotherapy came to be seen as distinctly different from transference, and as having a unique role to play in the process of psychotherapy. Thus, the concept of the therapeutic alliance spread to other forms of psychotherapy that have not traditionally accorded the therapeutic alliance central status, such as cognitive-behavioral therapy. Different treatment modalities naturally emphasized different aspects of the therapeutic alliance as more important to effective therapy. For the interpersonal and client-centered approaches, the relationship between the patient and therapist was the most important aspect of the alliance (Kramer, 1995) but for cognitive-behavioral psychotherapists it was more important for the patient and therapist to agree and collaborate on the actual "work" of therapy (Waddington, 2002).

The therapeutic alliance seemed to consist of many interwoven facets of therapy that involved everything from the relationship itself to whether or not the patient and therapist agree on what the focus of the therapy should be. As many writers suggested that the therapeutic alliance comprised many different aspects of therapy, consequently it was very difficult to operationalize. It became necessary to develop a framework for

understanding the therapeutic alliance by organizing its components. This organizational effort was essentially accomplished by Bordin's (1979) work, which divided the therapeutic alliance into three separate but related components of task agreement, goal agreement, and therapeutic bond. A strong therapeutic alliance consisted of solid agreement between the patient and therapist on what the goals of therapy should be as well as the therapeutic tasks necessary to achieve those goals. During the course of negotiating this agreement the therapist and patient develop a bond that includes a positive attachment that inspires trust and confidence. The articulation of these components of the therapeutic alliance was a major step in operationalizing a very complex dynamic and led the way for scientific exploration of the process of psychotherapy. In sum, Bordin took a major step toward defining the alliance in a way that could be applied to all treatment approaches. He defined the alliance as the strength of consensus between the therapist and patient on the goals of therapy, how best to meet those goals (Task) and the human bond that develops between them. The main idea was that the alliance consists of a mutual collaboration between the therapist and patient toward resolving their presenting complaint as well as the attachment component of the relationship. Bordin's pantheoretical definition of the alliance has been widely accepted by clinicians and researchers alike and is the definition that will be used in the context of the present study.

Alliance Research: Individual Therapy

It has been a consistent finding over the last thirty years of psychotherapy research that different therapeutic orientations produce similar therapeutic gains

(Luborsky et al., 2002; Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977; Stiles, Shapiro, & Elliott, 1986). While this finding has been criticized by some as resulting from methodological shortcomings, suggesting that differences among therapies may be more apparent when matching groups of clients based on their type of distress (Beutler, 2002), most psychotherapy researchers have interpreted these results as an indication that there may be common characteristics across psychotherapies that account for patients' improvement. These findings sparked a renewed interest in examining the therapeutic alliance as a non-specific factor of psychotherapy that is essential for effective treatment.

In order to examine the ways in which the patient-therapist relationship may impact treatment, researchers were first faced with the daunting task of quantifying a concept that presumably has many subtle facets. The decision regarding what to measure in the patient-therapist relationship to indicate the presence of a strong therapeutic alliance was naturally influenced by the theoretical orientation of the researcher and their ensuing definition of what the therapeutic alliance entails. Staying true to the psychodynamic roots of the concept, pioneer researchers of the therapeutic alliance emphasized the relational nature of the alliance as well as patient-therapist transactions (Greenson, 1965; Langs, 1975; Luborsky & et al., 1971).

Generally speaking, the more widely used measures of the therapeutic alliance attempted to quantify three major domains; patient contributions, therapist contributions and patient-therapist interactions (Henry & Strupp, 1994). Although many of the predominant instruments used to gauge the alliance in individual psychotherapy

emphasize slightly different aspects based on the theoretical understanding of the researcher, they have been shown to be highly correlated (Cecero, Fenton, Frankforter, Nich, & Carroll, 2001; Hatcher, Barends, Hansell, & Gutfreund, 1995; Safran & Wallner, 1991). Despite variations in the types of patient-therapist interactions to which these measures are sensitive, they are likely highly correlated because the authors have organized the data collected according to Bordin's task, bond, and goal model.

Many of the early alliance measures were naturally focused on adult individual psychotherapy and were rated by trained observers. As many researchers began to notice that third party observational coding was exceptionally time consuming and ignored the perspective of the individuals involved in the relationship, most of the measures were eventually adapted so that patients and therapists could also rate the alliance. Four such measures that have been extensively studied are the Helping Alliance Rating Method (Har) (Luborsky, Barber, Siqueland, Johnson, & et al., 1996), the Vanderbilt Therapeutic Alliance Scale (VTAS) (O'Malley, Suh, & Strupp, 1983); the Working Alliance Inventory (WAI)(Horvath & Greenberg, 1989); and the California Psychotherapy Alliance Scale (CALPAS) (Marmar et al., 1986).

Building on the promising empirical research of Hartley & Strupp (1983) as well as Gomez-Schwartz (1978) and Luborsky (1983), Horvath and Greenberg took aim at developing a self-report measure of therapeutic alliance in individual psychotherapy that was based directly on Bordin's (1979) trans-theoretical view of the alliance. This presented a significant addition to psychotherapy process research in that their measure would directly assess the strength of the alliance from the vantage point of the individuals

involved in the therapy and would target factors of the alliance presumably present in all treatment approaches. To this end, Horvath and Greenberg were interested in using Bordin's conceptualization of the Task, Bond, and Goal elements of the therapeutic alliance to ask therapists and clients about specific feelings and attitudes they had about the therapy that could be used to assess the overall strength of the therapeutic alliance. Horvath and Greenberg developed the items for the scale in an interesting manner by directly enlisting the input of practicing therapists.

Initially 91 items were generated (35 bond, 33 goal, and 23 task items) and evaluated by three psychologists of differing theoretical orientation to reduce conceptual bias. Next, seven researchers who had personal expertise in the area of therapeutic alliance research also rated the items in regard to it's relevance to the alliance and to which of the three dimensions (Task, Goal, Bond) it measured. As a result twenty-one items were removed and the remaining items were sent to twenty-one local psychologists who were asked to rate the items in the same manner. Those items that were left after this round were piloted in three validation studies with adequate reliability and convergent validity (Horvath & Greenberg, 1989). The Working Alliance Inventory became the first therapeutic alliance inventory to directly measure Bordin's task, bond, and goal domains. This gave the measure some range and versatility that was heretofore absent from previous measures. As the Working Alliance Inventory was added to a growing list of valid measures of the therapeutic alliance one of the first utilizations of these measures was the exploration of the link between alliance and outcome

Measures of the therapeutic alliance were put almost immediately to the test of predicting treatment outcome with exceptionally strong results. Using meta-analytic methods to synthesize the findings of studies exploring the link between alliance and outcome, Horvath and Symonds (1991) and more recently Martin, Garske, and Davis (2000) found moderate effect sizes of $r = .23$ and $r = .22$. The authors note that these are likely conservative estimates in that non-significant effect sizes were coded as $r = 0$. By coding non-significant effect sizes as 0, non-significant trends in the relationship between outcome and alliance are not added to the overall effect size. Despite the conservative estimates, the clear relationship between therapeutic alliance and outcome was striking. The question of the causal relationship between alliance and outcome was investigated and the alliance was consistently found to impact outcome and not vice-versa (Barber, Connolly, Crits Christoph, Gladis, & Siqueland, 2000).

With many studies indicating that therapeutic alliance is a significant predictor of treatment outcome, researchers began to move toward exploring the multitude of factors that could possibly influence the relationship between therapeutic alliance and outcome. One of the possible factors that were thought to possibly influence this relationship was the theoretical orientation of the therapist. Not only was the therapeutic alliance shown to be an important predictor of outcome for each orientation (i.e. psychodynamic, gestalt, behavioral and cognitive), no significant differences were found when comparing the strength of the alliance-outcome relationship between treatment approaches (Horvath & Symonds, 1991; Martin et al., 2000). These meta-analyses also found that the alliance-outcome relationship was unaffected by the type of outcome measured or treatment

length. In fact no linear relationship was found between treatment length and the strength of the therapeutic alliance. Subsequent studies suggest that fluctuations in the strength of the alliance occur naturally overtime through ruptures and repairs and in fact the resolution of these ruptures seem to be an important ingredient to the overall therapeutic outcome (Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996).

Clearly, psychotherapy process research, and particularly research on the therapeutic alliance, has been well developed over the course of the last thirty years. Findings that the theoretical orientation of the therapist did not impact overall therapeutic gains led to a renewed effort to explore many psychotherapy process variables, such as the therapeutic alliance, in the hopes of isolating trans-theoretical commonalities among therapies. Building on theoretical writings of psychodynamic therapists, researchers began to ask important questions about which aspects of the alliance are the most critical to therapeutic outcome as well as the best way to measure it. Once therapeutic alliance was shown to be a factor contributing to treatment outcome, the focus naturally shifted to exploring aspects of therapy that influence the alliance-outcome relationship. A great deal of research has been conducted on many aspects of the therapy process that influence the development of the therapeutic alliance, such as patient characteristics/behaviors, therapist characteristics/behaviors, and patient-therapist interactions.

Understanding the evolution of therapeutic alliance research in individual therapy is useful in considering how therapeutic alliance research may develop in other

therapeutic modalities such as couple therapy. It is notable that the body of therapeutic alliance research conducted in couple therapy is relatively anemic when compared to the breadth and depth that similar research has reached in individual therapy. There are many distinct and fundamental differences between individual therapy and couple therapy that will certainly play a role in how therapeutic alliance is explored. These differences must be fully considered before one may attempt to apply similar tactics in quantifying the alliance gleaned from individual psychotherapy literature.

Therapeutic Alliance: Couple Therapy

Prior to the introduction of general systems theory in the 1950's it was not very practical for psychotherapists to see more than one patient at a time. The general consensus among therapists was that individuals generate assumptions about their interpersonal relationships based on previous relationship experiences, which in turn directly contribute to their current psychological troubles. Therefore, helping patients gain an understanding of these assumptions and develop flexibility in their application was considered to be the best way to alleviate their distress.

Building on the work of Ludwig von Bertalanffy (1968), Gregory Bateson developed an approach to understanding human behavior that was quite innovative. Bateson was an anthropologist by training and noted that human behavior occurs in the context of social interaction and behavior of an individual usually serves some adaptive function for the social system as a whole. Bateson stressed the complex and interdependent patterns that develop between people and proposed what he termed a cybernetic approach to understanding human behavior (1972). Cybernetic theory stresses

not just the social context in which behavior occurs, but also the notion that all human behavior results from patterns of reciprocal interaction between individuals and their social system (e.g. family, community, work group).

Moreover, interpersonal behavior becomes quite stable over time through self-regulating mechanisms of the system. Thus one's internal experience (and psychopathology) is developed and maintained by the system of reciprocal relationships surrounding that individual. As such, the system's functioning as a whole is directly impacted by each individual's behavior, good or bad. When an individual's behavior begins to deviate from the norm, the system's homeostatic balance is upset and pressure is exerted by the system to draw that person back to their usual idiosyncratic methods of interacting as defined by that particular system. The pressure by the system to maintain homeostasis and regulate interpersonal behavior was termed negative feedback.

This idea seemed to resonate with some psychotherapists who began to notice that the circular causality between their patients and the systems in which they were embedded maintained their patient's disorders, making them quite resistant to treatment. Many systemic approaches to therapy developed that emphasized the site of psychopathology as not simply residing in the individual's developmental or learning history, as the linear reductionistic approaches of the time suggested. Utilizing the concept of general systems theory, some psychotherapists began to develop a new therapeutic modality that emphasized the complex interplay between the individual and their social context shifting the focus away from the past to present ongoing interactions *between* people (Haley, 1976; Minuchin, 1974; Satir, 1967; Whitaker, 1973).

As systemic therapists shifted the focus from the individual to the interpersonal system, the therapist's role in treatment changed. This shift in turn altered therapists' conception of therapeutic alliance. One such therapeutic approach, predicated on cybernetic theory, was proposed by Salvadore Minuchin (1974). Minuchin's structural family therapy approach to treating families rested on three assumptions. The first assumption was that the mental life of individuals, and thus their unique personality characteristics, are not entirely the result of internal dynamics, but instead are dependent upon feedback from the system in which they are rooted. The second assumption is that changes in the structure of the persons immediate system would *necessarily* result in change in the individual. Finally, in order for change to occur the therapist must join the family system and create a new therapeutic system.

While not referring to the therapeutic alliance per se, Minuchin thought it was critical for therapists to engage the family therapeutically in order to alter the structure of the system as a whole. From Minuchin's perspective, it is necessary for the therapist to simultaneously operate as both participant and observer by being initiated into the system by the family members (a.k.a. joining) as well as maintaining enough distance to operate outside of the system in order to have the perspective necessary to effectively restructure it. The task of the therapist was to periodically structure movements within the family and maintain the ability to disembed himself or herself from the system, a task which highlights one major difference between the therapeutic alliance in individual and family therapy.

However, even among couple and family therapists, differences seem to exist as to how the therapeutic alliance is utilized by the therapist in treatment. The more behavioral and social learning approaches, as well as Emotion Focused Couple Therapy, seem to emphasize the importance of the alliance as a pre-condition to effective treatment (Holtzworth Munroe, Jacobson, DeKlyen, & Whisman, 1989; Johnson & Greenberg, 1989). The alliance considered in these approaches exists in order to increase client collaboration and engagement in the actual tasks of therapy. Other couple and family therapists, especially the systems theorists, emphasize the alliance as an actual unfolding process between the therapist and the system in which the formation of and maintenance of the alliance is of itself one of the tasks of therapy (Haley, 1976; Minuchin, 1974; Whitaker & Bumberry, 1988). From this perspective the therapist is an active participant in the patient system and as such the therapists' relationship with the system and subsystems within the family is an ongoing aspect of the therapy itself. Additionally, there are couple and family therapists whose work is informed by the object relations tradition and thus view the alliance in terms of transference relationships, emphasizing the importance of interpreting transferential themes both between the members of the system as well as the therapist (Rutan & Smith, 1985). However, despite variations between couple and family therapy orientations, there are several common and unique aspects of the therapeutic alliance that require attention.

One commonality across differing couple and family therapy approaches may be that the therapist must be attentive to the formation and maintenance of several alliances. Therapists treating more than one person at a time must be aware not just of the role they

play in the system as a whole but must attend to the development of multiple alliances with each member of the system throughout the course of therapy. This higher attentional demand presents an onerous task for therapists, as most couple and family members come to treatment with differing levels of motivation, expectations, and goals for therapy. It is up to the therapist to engage each member of the system and validate each person's unique perspective. It is important to consider the idea that therapists must continually balance the development of multiple alliances with family members. The successful management of multiple alliances must be an integral part of couple therapy, which is often laden with intense conflict, resentment, and vulnerability. The role of multiple alliances as part of the nature of couple therapy continues to be unclear. Several researchers have attempted to close the gap between what is known about the alliance in individual therapy compared to that of couple therapy, and some crucial work has been conducted along these lines.

Alliance Research: Couple Therapy

In their development of the most widely used measure of couple and family therapeutic alliance, Pinsof and Catherall propose the utility of assessing the alliance on Bordin's content dimension of Task, Goal, and Bond at various levels of the therapist/patient system (Pinsof & Catherall, 1986). Pinsof and Catherall's integrated systems perspective of conceptualizing the therapeutic alliance consists of two dimensions: the interpersonal system dimension and content dimension. The interpersonal system dimension refers to the alliance at various levels of patient/therapist system interaction, basically the "who" of the alliance, and the content dimension refers

to agreement on task, goals, and the strength of the bond, basically the "what" of the alliance. The most molecular alliances are the individual alliances that exist between all individuals involved in the patient and therapist systems. Thus individual alliances exist between the therapist and each patient involved in the patient system. For example, in couple therapy with a heterosexual couple individual alliances exist between the therapist and the wife as well as the therapist and the husband.

The next level of alliance to be assessed on agreement of goals, tasks, and bond exists *between* interpersonal subsystems. Interpersonal subsystem alliances must include a group of two or more people from either the therapist or patient system. For example, in family therapy an alliance may exist between the therapist and parents (or children). The next widest level of alliance exists between whole systems. An alliance may exist between the therapist and the entire family system, or in individual therapy between the patient and the entire therapist system. Utilizing their integrative system perspective, Pinsof and Catherall (1986) developed a self-report measure to assess various levels of the alliance administered to each member of the direct patient systems. The authors intentionally did not include a therapist-report measure because they felt that the patients' reports of the alliance would be a more important predictor of outcome than the therapists report.

Thus, Pinsof and Catherall provide a useful measure of the therapeutic alliance because it takes into account various levels at which alliances can occur in therapy. The strength of this conceptualization is that it is the first to take into account the bi-directional impact of both the therapist and patient systems. However, whereas the

authors integrated system model states rather strongly that mutual causality exists between patient and therapist system, they have yet to include a measure of the therapist's perspective of the alliance. This is unfortunate because although therapist reports of the alliance may not be as strongly related to outcome, their theory provides the groundwork necessary for exploring the interplay between therapist and patient reports of the alliance. Another drawback of this measure is that the therapist-group subscale may not be accurately capturing the unique aspects of the overarching couple and family alliance since the viewpoint of individuals involved in the system may be a bit myopic. Relying on patients involved in a dysfunctional system to possess the ability to observe the therapist's fit in the meta-alliance may be a bit optimistic. If the therapist is unwittingly being drawn into the system during conflict it may even be difficult for the therapist to report on the quality of the meta-alliance. Overall, the integrative systems measures seem to capture an aspect of the therapeutic alliance that has been missing in previous measures of the alliance. However, there are several unique aspects of the therapeutic alliance in couple and family therapy that the integrative systems measures are not equipped to detect, such as triangulation, the balance of multiple alliance, and perhaps feelings of physical safety.

Despite its limitations, couple therapy process research was greatly enhanced by the addition of the integrated systems measure of the therapeutic alliance. However, other than this measure, to date not much attention has been given to the role of the therapeutic alliance in couple therapy outcome. One of the most notable attempts to examine the relationship between behavioral marital therapy (BMT) outcome and process

variables found that BMT outcome was predicted by the therapist's ability to induce a collaborative set, as well as clients reports of collaboration, active participation, and homework compliance (Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989). Although, the authors did not assess therapeutic alliance directly, client and therapist reports of collaboration and clients' participation are certainly aspects of the alliance that may be easily measured.

Other studies have also provided some preliminary evidence of the impact of the therapeutic alliance on couple therapy outcome (Bourgeois, Sabourin, & Wright, 1990; Coupland & Serovich, 1999; Raytek, McCrady, Epstein, & Hirshch, 1999) and have even suggested that wives' reports of therapeutic alliance may be more predictive of outcome than husbands' reports (Quinn, Dotson, & Jordan, 1997). While this body of research represents a good start in exploring the link between therapeutic alliance and outcome in couple therapy, much more needs to be done in regards to firmly establishing this link. The scarcity of research in this area may be explained by the relative dearth of measures capable of assessing the alliance in couple therapy. It has been suggested that a useful strategy in couple therapy alliance research may be in the utilization of both self-report and observational methods (Pinsof, 1994). However, a viable observational coding system that takes into account other unique aspects of couple therapy alliances has yet to be developed.

Thus, it is clear that couple therapy process research has significantly lagged behind the leaps and bounds that have been made in the individual psychotherapy process research. The course of development of the therapeutic alliance in couple therapy as well

as therapist actions that impact this development has yet to be determined. It is the author's belief that if the purpose of couple therapy process research is to improve the quality of the manner in which therapy is actually delivered, researchers must focus on how therapy is conducted in the field (e.g. effectiveness) as well as on therapists' perspectives of their experience of actually providing therapy (Pinsof & Wynne, 2000). It is important for researchers to gain a better understanding of therapists' views of couple therapy alliance in the way it is actually practiced. Once it is understood what therapists view as important markers of strong couple therapy alliances, steps may be taken to develop measures that capture the work therapists actually do in the field. For example, therapists working from different orientations may view different aspects of the alliances as more important for their work. It is crucial to understand these differences in order to explore the ways in which therapists may handle unique ruptures in the alliance. This may help researchers create and fine tune alliance measures to capture the natural dynamic ebb and flow of therapeutic alliance over the course of therapy.

Elements of the Alliance

A rich body of literature has clarified many facets of the alliance in individual therapy as well as delineated a host of influential factors. This is in stark contrast to what little is known about the alliance in couple therapy. It is reasonable to think of the alliance in couple therapy as a complex and elaborate set of interactions between the therapist and couple that form an overarching sense of collaboration and respect for the process of therapy. If the alliance is strong, the couple will be more likely to weather through the rough periods of therapy by attributing emotionally arousing sessions or

interactions to a process that will ultimately make their relationship more satisfying. While this overarching sense of trust in the process and unity toward the goals of therapy may be the essence of the alliance in couple therapy, at this time it is unknown what the precise building blocks are. We have some sense of what they are in individual therapy as well as some ideas about how they might be different in couple therapy. What remains unclear is not just what are the building blocks of the alliance in couple therapy but also whether they fit together in the same way they do in individual therapy. For example, are the sub-groups of task, goal, and bond sufficient to capture the greater complexity of the alliance in couple therapy or is it necessary to also attend to the unique elements of couple therapy, such as balance and triangulation. The following sections will review the elements that comprise the larger sub-groups of the alliance as well as factors that are important to its development.

Goal

The degree to which the client and therapist agree about the goals of therapy is widely thought to be a major component of the therapeutic alliance as a whole. Agreement about what the focus of therapy should be is a necessary precursor toward collaborating with the therapist toward ameliorating presenting symptoms. It seems that alliance ruptures may occur when the therapist thinks that they are in agreement about the focus of therapy when in fact the client has secondary goals or hidden agendas that may not be directly expressed. Goal agreement is likely just as important in couple therapy and perhaps more difficult to manage considering the wildly different ideas each member of a couple may have about what a good therapeutic outcome will be. Another aspect of

goal agreement that may be important is the therapist's and clients' perceptions that they are progressing toward these agreed upon goals. It seems likely that perceptions that work is being done toward set goals may be extremely important to maintaining strong goal agreement. This aspect of goal agreement has yet to be examined in the literature but may be a previously overlooked aspect of goal agreement.

Task

The general definition of the task component of the therapeutic alliance is the degree to which the therapist and client agree upon the means necessary to accomplish the goals of therapy. It is necessary for clients to agree with the therapist that the interventions being offered will lead to the amelioration of their presenting complaints. Negotiating this agreement likely takes some skill on the part of the therapist to present a rationale for the upcoming treatment interventions and to instill a sense of trust that they will work. It seems that part of the therapist's job is to deliver to the clients a message that the therapeutic goals they have set are achievable and that the therapist can help the client achieve these goals by engaging in the interventions they present to the client. Therefore, it is necessary for the client to have a sense that the therapist possesses the skills necessary to help them or overall task agreement may be despoiled. Additionally, I think that therapist's perceptions of their own ability to help the client will affect their capacity to communicate to the client a coherent rationale for treatment. Therapists who are intimidated by a client's presenting complaints or, as is often the case with inexperienced therapists, do not feel they are capable of treating the client might ultimately have difficulty developing strong task agreement.

Bond

The Bond component of the therapeutic alliance represents the emotional connection between the client and therapist. The Bond is the relational aspect of the alliance that likely includes positive transference reactions as well as the "real relationship that develops between client and therapist. An aspect of the Bond component that may be the most important is the client's feeling "emotionally safe". This emotional safety can be thought of as the therapist's ability to provide an environment that is conducive to disclosing vulnerability, which may have been absent from the client's previous life experience. If clients have had relationships in the past that include trust and vulnerability it is reasonable to suspect that it will be easier for the therapist to foster emotional safety during the therapeutic encounter. Another aspect of the Bond component is the client's sense that they are supported by the therapist through the process of therapy. This is the general sense that they can rely on the therapist when things get rough during the therapy hour. This is separate from emotional safety in that a client may have a sense that their therapist understands them and will support them in therapy but may not be comfortable disclosing vulnerability. It also seems that strong bonds in the therapeutic alliance will be characterized by a pervasive sense of genuineness in the relationship. This will be expressed by both the client and therapist feeling comfortable being honest with each other in the therapeutic milieu. This may be more important when the therapy focuses on the exploration of transference and countertransference themes, but also may be important in other types of therapy if the client has misgivings about certain treatment approaches.

A related aspect of a solid Bond component is the therapist's freedom to challenge the client without the client feeling attacked or even worse, shamed. A therapist's ability to effectively challenge the client in a way that stimulates discussion but mains a sense of safety is likely to be an integral aspect of solid therapeutic bond. These aspects of the Bond component of the therapeutic alliance are likely to be similarly important in couple therapy. Creating an atmosphere of safety is extremely important in couple therapy when partners may be highly reluctant to express vulnerable feelings in front of a spouse whom they fear may exploit their vulnerability. Similarly, a strong bond component may be necessary for a therapist to effectively challenge one spouse without fearing that the partner will feel "ganged up on". As with the Task and Goal elements it is likely that these components will similarly be important to the alliance in couple therapy, however as mentioned previously there may be aspects of the alliance in couple therapy that may not be found in individual therapy that could be equally important.

Balance

Pinsof's conceptualization of the therapeutic alliance as a *process* of interaction between therapist and patient systems is a useful one. It takes into account more than what is directly taking place between the therapist and patients in the consulting room and acknowledges the impact of indirect systemic influences. According to this model the only difference between individual and couple therapy is the number of individuals involved in the direct patient and therapist systems. In couple therapy for example it is often the case that both members of the couple have drastically differing views on the nature of their difficulties and have developed the false notion that one of their views

must be the "right" one. Therefore the expectation exists that the therapist should side with one of the members of the couple in convincing the partner that his or her view is correct.

This sensitivity sets the stage for couples to be hypervigilant about whom the therapist is "siding with." Not only does the therapist have the task of validating each member's viewpoint by offering legitimacy to it; the therapist usually must reframe both partners' often competing goals as being compatible and interrelated. If this task is not addressed well by the therapist there exists a possibility that a unique rupture in the therapeutic alliance may occur, in which the therapist has developed a strong alliance with one member of the couple at the expense of the alliance with another. Pinsof has termed this type of rupture in the therapeutic alliance as a "split alliance" and suggests that therapy may be prematurely terminated if this rupture is not successfully attended to and repaired. This highlights the importance of the therapist's ability to balance and maintain multiple alliances and the critical role it plays in successful couple therapy.

If adding individuals into the direct patient system creates a new task for the therapist in managing multiple alliances, it's likely that it creates other unique dimensions as well, which are considered below.

Safety

As any couple therapist can attest, treating multiple clients involved in the same direct patient system opens the possibility for intense interpersonal conflict to arise during sessions. It is not uncommon for family members to enter therapy with deep feelings of hostility and resentment towards each other. Many negative patterns of

interaction have become so deeply entrenched that family members are reluctant to let down their guard and expose vulnerable feelings in the presence of others who may use those feelings as weapons against them. In this respect couple therapists are confronted with another unique challenge, in that the therapeutic alliance may be dependent on the therapists ability to provide a safe environment for the couple to explore intense conflicts and underlying vulnerable emotions, which includes elements of physical safety as well as emotional safety.

It seems that various theoretical orientations of couple therapists place a different premium on the importance of establishing this safe environment in therapy. Whereas all seem to agree that providing some element of safety, especially physical safety, is important to the therapeutic process (Connell, Mitten, & Bumberry, 1999; Epstein & Baucom, 2002; Johnson, 1998; Minuchin, 1974); safety becomes essential if the therapist's primary interventions involve exploring underlying feelings of vulnerability.

Emotion focused marital therapy (EFT) provides a good example of the importance of establishing a safe environment. In fact, the therapist's ability to provide a safe environment is considered an integral part of the therapeutic process. EFT rests on the notion that intense emotions drive and maintain reciprocal patterns of interaction between the couple. From this perspective, successful therapy must lay the groundwork for uncovering and understanding not just the overt emotions evident in couples interactions, but identifying and expressing more subtle vulnerable emotions (Johnson & Greenberg, 1989). Therefore it is critical for partners involved in EFT to have the

freedom to explore their underlying vulnerable feelings without feeling attacked, belittled or humiliated by their partner.

Conversely, family therapists such as Carl Whittaker and Jay Haley feel that it is important to allow families to enact their "family dance" and allow family interactions to become quite volatile during sessions. According to Whittaker it is necessary for these enactments to take place in order to point out and restructure dynamic family movements that foster and maintain the presenting problem (Whitaker & Bumberry,1988). However, whereas Whittaker's interventions may seem a bit unorthodox, even he seems to advocate therapist direct intervention or laying ground rules if conflict becomes too intense or potentially dangerous. It seems that if therapists are unable to provide at least minimal feelings of safety that it is unlikely that they will ally with the therapist in confronting the predominant issues at hand. Whereas familial conflict presents couple and family therapists with the unique task of providing at least some measure of safety for couple and family members to enact and explore conflict, it also presents the therapist with the challenge of resisting the family's pull to participate in that conflict.

Triangulation

Another aspect of couple therapy that is likely to influence the therapeutic alliance, but is largely absent from individual psychotherapy, is the ever-present notion of triangular interactions. It has been proposed that a central and sometimes overlooked phenomenon in couple therapy is the tendency for individuals involved in dyadic conflict to draw in a third member as an ally and/or to diffuse the tension created by the conflict (Bowen, 1976; Minuchin, 1974). Systems oriented therapists have long understood that

that any event that occurs during therapy sessions naturally involves the therapist and underscores the importance of the therapist to keep in mind that any interaction between the couple also involves the therapist as well (Haley, 1976).

Triangulation of the therapist into dyadic disputes can take many forms depending on the couple or family's style of conflict resolution. In volatile couples and families, in which conflict has become a competition of sorts to assert power, triangulation can take the form of actively soliciting the therapist's opinion to enlist her as an ally or by suggesting that the therapist likely agrees with them because of their shared understanding of the traits of the opposite sex. For couples who naturally avoid conflict, triangulation may take on a completely different form. For example, it may be easier to voice a grievance with their spouse to the therapist instead of directing their comment to their spouse. It is commonly thought by couple and family therapists that if the therapist is not actively attentive to the natural pull of the couple they will ultimately end up implicitly colluding with and maintaining the family's maladaptive patterns.

It is likely that triangulation has implications for the development of the therapeutic alliance in one of two ways. Therapists who are unaware of being triangulated into couple and family disputes will be handicapped in their ability to detect and intervene upon problematic family interactions. Additionally it is possible that while forming an emotional bond with family members may facilitate the development of the therapeutic alliance, emotional bonds that are overly developed may make it difficult for the therapist to disembed herself from the system and thus resist triangulation. Awareness of triangular processes help cue therapists to sidestep the maladaptive engagement of a

couple that may thwart therapeutic progress. Although it is probably impossible for therapists to remain completely unaffected by the emotional connection with family members, being attentive to triangular interactions allow therapists sufficient emotional contact with the family while simultaneously maintaining enough distance to produce therapeutic change. In fact, the couple and family therapist's strategic use of emotional connection with family members as a therapeutic tool may be another aspect of the alliance that is somewhat different than individual therapy.

Ruptures

If adding individuals to the direct patient-therapist system changes the structure and nature of the therapeutic alliance, it also may open the possibility for unique ruptures in the alliance to occur. The possibility of unique ruptures of the therapeutic alliance in couple therapy is a topic that has yet to be explored in the empirical literature. Some authors have proposed the concept of a "split-alliance" as a rupture in the therapeutic relationship in which the therapist has a strong relationship with one member or subsystem and a weak relationship with another (Pinsof, 1994). As most members of a couple entering treatment have differing levels of motivation and perspectives about what the presenting problem is, a split in the therapeutic alliance is likely to be a common occurrence in couple therapy. While the effect of a split-alliance rupture on the course of treatment has yet to be explored, it may be assumed that members with weak alliances with the therapist will be less likely to engage in the tasks of therapy or motivated to continue. The therapists' ability to reframe the presenting problem and balance the

alliance by joining with marginalized members of the system should minimize the likelihood that a split-alliance will be detrimental to the treatment.

While the split alliance is a potentially important rupture to be explored in couple and family therapy, there may be others as well. If therapists have not adequately fostered an environment of safety for members of the couple to explore vulnerable feelings they may be disinclined to do so, which may signal the occurrence of a safety rupture. Other ruptures in the alliance may include the diffusion of boundaries between the therapist and couple system in a way that is detrimental to treatment or perhaps when the therapist is unwittingly triangulated by a particular dyadic interaction. All of the above possibilities may impact effective treatment and therefore should be further explored.

Orientation and Experience

Psychotherapists practicing from different orientations naturally conduct therapy in a manner consistent with their theoretical leanings. Thus, it is reasonable to suspect that therapists from different orientations would emphasize different aspects of the therapeutic alliance to be more important based on their preferred style of interaction with the client. For example, it might be expected that therapists who describe themselves as practicing from a cognitive-behavioral orientation will assign more homework between sessions and provide more structured session time when compared to psychodynamic therapists. There are a great deal of theoretical writings from which one may infer that certain aspects of the alliance are seen as differentially important to the work of therapy. However, to date no empirical research has been conducted to test this

assumption. For example, interpersonal, client centered, and psychodynamic approaches theoretically emphasize the emotional relationship between the therapist and patient as the most important aspect of the alliance (F. Alexander, 1950; Kramer, 1995), while cognitive-behavioral approaches emphasize the agreement between therapist and patient on the actual "work" of therapy (Waddington, 2002). Additionally, theoretical writings by authors of various orientations suggest that the same may be true in couple therapy. Cognitive and behavioral marital therapists emphasize mutual collaboration between the couple and therapist toward clearly defined goals (Holtzworth Munroe et al., 1989). Work that centers on the expression of underlying vulnerable feeling, such as Emotion Focused and psychodynamic marital therapy (Johnson & Greenberg, 1989; Rutan & Smith, 1985), require a fair degree of trust and emotional support. It would be reasonable to assume that therapists who use these approaches would emphasize the importance of the therapeutic bond in their work. Finally, systemically-oriented therapists may emphasize more systemic constructs in their work with couples, such as triangulation, primarily because systems therapists are trained to use their role in the couple's system as an agent of change.

Whereas the orientation of the therapist may influence which aspects of the alliance are emphasized, it is less clear how therapists' experience levels might shape their views of the alliance. It is possible that as therapists grow in experience they become more dogmatic in their approach and their views regarding which aspects of the alliance are more important to treatment might become more firmly entrenched. However, clinical lore passed through discussions with practicing therapists suggests that

as therapists become more experienced, the manner in which they work becomes more similar. This view makes sense if one believes that practicing therapists become more flexible in their theoretical ideas as they encounter more patients that challenge their assumptions about therapeutic process. Additionally, inexperienced therapists may cling rigidly to their theoretical ideas in order to garner some confidence and assure themselves that they are treating their patients in a manner best suited to alleviate their presenting problems. The influence of theoretical orientation and experience on therapist's views of the alliance has yet to be fully explored and therefore will be addressed in the current study.

The Present Study

What little is known about the alliance in couple therapy has by and large been extrapolated from what is known about the alliance in individual therapy. There is reason to believe that there are some aspects of the alliance in couple therapy that are fundamentally different than the alliance in individual therapy. However, it is still unclear whether or not these aspects are important to the alliance as a whole, or if the larger components of Task, Bond, and Goal are sufficient. It is important to gain a better understanding of how these factors fit together in couple therapy as opposed to individual therapy. One way to accomplish this task is to enlist the help of practicing therapists to express their views of the relative importance of these elements to the alliance in couple therapy as compared to individual therapy. The purpose of the present investigation is to utilize the collective knowledge of couple therapists in the field to gain a better

understanding of how the therapeutic alliance is experienced and developed in couple therapy practice.

Study Hypotheses

Hypothesis 1

As this study is essentially exploratory in nature, the first purpose is to find out what aspects of the alliance therapists feel are the most important to the development of the alliance in couple therapy overall. It is hypothesized that Balance, Triangulation, and Physical Safety will be seen as significantly more important to the therapeutic alliance for couple therapy than individual therapy.

Hypothesis 2

It is hypothesized that the unique aspects of the therapeutic alliance in couple therapy such as balance, physical safety, and resisting triangulation will be rated by practicing therapists to be as important to the couple therapy alliance as the traditional components of task agreement, goal agreement, and therapeutic bond.

Hypothesis 3

Therapists' theoretical orientations are expected to influence which factors they feel are the most important to the development of the therapeutic alliance in the following ways:

A. Behavioral and Cognitive perspectives will be more likely to rank Task and Goal agreement higher.

B. Systemic approaches will rank highest the therapist's ability to resist triangulation as well as balance.

C. Psychodynamic approaches will likely rank highest the Bond elements.

Hypothesis 4

The fourth objective is to explore the impact of therapist experience on which aspects of the alliance are emphasized. Therapist experience will be measured in two ways:

A. chronologically (how long the therapist has been practicing) and

B. numerically (how many couples the therapist has treated).

It is hypothesized that at higher levels of experience therapist views of what factors contribute most to the therapeutic alliance will converge and no differences will be found between theoretical orientations. This analysis will be conducted using a moderator regression model, with therapist experience as the moderator variable. At low levels of therapist experience differences will be found between theoretical orientations but at high levels of experience no differences will be found.

Hypothesis 5

Finally, the survey will explore therapist's ideas about the alliance by gathering qualitative data. Therapists will be asked to describe unique alliance ruptures that may occur in the course of couple therapy. It is hypothesized that these narratives will include descriptions that highlight the importance of balance, resisting triangulation, and physical safety.

CHAPTER 2

Method

Participants

Participants are 151 practicing psychotherapists who responded to requests posted to professional email listservs. The therapists who responded had an average of 12 years of clinical experience (*SD* = 10.65). The median for career total of individuals seen in therapy was 200 (*M* = 931, *SD* = 2,342) and 25 (*M* = 529, *SD* = 3,266) for the number of couples seen. 87 of the therapists were female (57.6%) and 64 were male (42.4 %). One therapist reported their degree as a B.A. or B.S. (.7%), 4 were M.S.W's (2.6%), 10 reported their degrees as M.A or M.S. (6.6%), 101 were Ph.D's or Psy.D's (66.9%), 3 were MD's (2%), 24 were current graduate students (15.9%), and 8 listed their degree as "other" (5.3%). When asked to identify the license under which they practice 74 identified themselves as Psychologists (49%), 7 listed themselves as Social Workers (4.6%), there were also 3 Psychiatrists (2%), 22 Marriage and Family Therapists (14.6%), 8 identified themselves as unlicensed counselors (5.3%), 33 were unlicensed graduate students in supervision or unlicensed post-doctorates (21.9%) and 4 identified their license as "other" (2.6%). When asked to identify their *predominant* theoretical orientation 26 labeled themselves as Cognitive-Behavioral (17.2%), 27 as Psychodynamic (17.9%), 12 as Family Systems-Structural or Strategic (7.9%), 7 as Family Systems-Bowenian (4.6%), 12 as Family Systems-Narrative or Post-modern (7.9%), 8 as Family Systems-other (5.3%), 5 as Emotion Focused (3.3%), 7 as

Humanistic/Existential (4.6%), 1 as Behavioral (.7%), 13 as Interpersonal (8.6%), and 33 as Integrative (21.9%).

Measure

Items for the first version of the survey were generated by six graduate students and one experienced couple therapist involved in a graduate research lab with a focus on couple therapy and marital research. Those involved in generating items for the survey were all members of a couple therapy practicum and were currently seeing couples as part of their clinical training as well as reading a broad array of the research literature on couple therapy.

This process yielded thirty items that were assembled into three broad categories of general characteristics of the alliance, therapist characteristics, and couple/client characteristics. Under each item two 7-point Likert scales asked the therapists to rate the item on level of importance to the alliance first for individual therapy and then for couple therapy. The therapists were given the option to select "not applicable" (n/a) if they felt that the item did not apply. The Likert scale for each item ranged from 1= "not at all important" to 7= "absolutely essential". For each category the therapists were also asked to select the four items they feel are the most important to the alliance for individual therapy and then select the four they feel are the most important for couple therapy. Additionally, text box fields were made available for the therapists to write their own items if they felt that there was an important factor that was not listed. The last section of the survey asked therapists to write text responses for four questions. The first asked for their definition of the therapeutic alliance in couple therapy. The second asked them

to discuss their ideas about what creates it. The third asked them to discuss aspects of the alliance they feel affect treatment outcome. And the fourth asked them to describe any ruptures in the alliance they feel may be unique to couple therapy.

This initial version of the survey was sent to five experienced couple therapists in the Knoxville area for professional verification of the items that were generated. The therapists were specifically asked to take the survey and provide feedback about the items as well as to list any additional items that may have been left out. The therapists appeared to be in agreement that the items were important items and none of them listed additional items.

With the help of University of Tennessee Web Services professionals, the survey was converted to HTML and posted to the authors University of Tennessee web space. The survey was piloted on a listserv belonging to the Association for the Advancement of Behavior Therapy (AABT), Couple Research Special Interest Group. This listserv was chosen because it is likely to reach experienced couple therapists and the number of subscribers was known so a response rate could be estimated. From the initial posting only 8 of the 110 subscribers responded. After a reminder was sent two weeks later the total respondents rose to 22 of 110, which is approximately a 20% response rate. Some feedback from the pilot sample suggested that the survey was too long and that busy therapists may have been disinclined to complete the survey because of its length.

With this feedback in mind the final version of the survey was constructed. See Appendix A for a copy of the final version of the survey. The text responses were moved from the end of the survey to the beginning in order to ensure that the respondents'

answers to the open-ended questions would not be primed by the survey items themselves and these qualitative items were made optional in order to decrease attrition. The text response items were cut from the original four to two. The items retained were "What is your definition of the therapeutic alliance in couple therapy?" and " A rupture occurs when the therapeutic alliance has been damaged in some way. Please describe any ruptures in the therapeutic alliance that may be unique to COUPLE therapy." The Therapist Characteristics and Client Characteristic sections were deleted in the final version because they were not seen as central to the general hypotheses; however, some items from the therapist and client characteristics section that were discussed the most in alliance research and theoretical articles were retained. These items were; Therapist's Empathic Connection, Therapist's Self-Monitoring, Client's Motivation for Therapy, and Client's Attachment Style. It was felt that therapists working from a more psychodynamic perspective might value self-monitoring and client attachment style in their views of the alliance, while Therapist's Empathic Connection might well be seen as an integral aspect of the general "Bond" component of the alliance. Client Motivation for Therapy was retained due to the research identifying it as a possible common factor that may closely impact the development of the alliance.

The final version of the survey consisted of 18 variables that were ranked on a five point Likert scale ranging from 1=important to 5 =absolutely essential. Feedback from the pilot data suggested that practicing therapists felt that all items were thought to be important, therefore, in an attempt to reduce clustering at the higher end of the scale the label for 1 was changed from "not at all important" to "important". The therapists

still had the option of choosing not applicable (n/a) if they thought it was not at all important or not applicable. After completing the Likert items, the therapists were also asked to choose the four items that they thought were the most important to the alliance for individual therapy and then the four they thought were the most important for couple therapy. Therapists continued to have the option of writing their own items if they felt important factors were left out of the list provided. The new version of the survey retained the items essential to the present study and managed to cut the estimated time to complete the survey in half.

Procedure

Therapists were recruited via electronic postings to professional listservs. As the target population for this study was a group of practicing therapists from different disciplines, and of varying levels of experience and theoretical orientations, listservs were chosen with these characteristics in mind. The original postings to the listservs described the study as an exploration of practitioners' ideas about the therapeutic relationship with couples and asked them to click on a link that would direct them to the online survey. For an example of the message posted to the listservs, see Appendix B. Listservs contacted included state chapters of the National Association of Social Workers, as well as the American Association of Marriage and Family Therapy, and selected American Psychological Association Division Listservs. For a complete list of the listservs to which the contact letter was posted see Appendix C.

Therapists who were interested in participating in the study followed the link to the survey website and submitted their responses electronically. The data was posted to

the author's web space provided by the University of Tennessee. Participants read an informed consent page prior to completing the survey that informed them of their rights as participants and that their participation was completely voluntary. They also were informed that they would not be compensated for their participation in the study. E-mail addresses were collected only from those participants who indicated that they would like to receive the results of the study. The completion time of the survey itself was estimated to be 10-15 minutes depending on how much the participants chose to write in the optional text boxes. The participants then completed a short demographics questionnaire that asked them to identify their theoretical orientation from a list of drop-down options, clinical experience (measured by years practicing and the number of individuals/couples seen), as well as degree and license under which they practice. The first section of the survey asked the therapists to rate the relative importance of 18 variables to the therapeutic alliance in couple therapy compared to individual therapy. These ratings ranged from 1= important to 5= absolutely essential. Therapists were also given the option of indicating that they thought the item was not applicable. The therapists were then asked to choose the four items they feel are the most important to the alliance in individual therapy and the four the feel are the most important to the alliance in couple therapy. Additionally, therapists were given the option of including their own items in text box fields if they felt an important factor did not appear on the list provided. The second section of the survey was optional and asked the therapists to first describe their definition of the therapeutic alliance in couple therapy and then asked them to describe ruptures in the alliance that may be unique to couple therapy. Following completion of

the study short summaries of the results were emailed to those therapists that indicated interest via the E-mail addresses they provided.

CHAPTER 3

Results

Considering that the items presented to the therapists have all been linked either theoretically or empirically to the development of the therapeutic alliance, the first step in the analyses was to determine if the items could be grouped into larger domains of Task, Goal, and Bond. Composite scores were compiled from groups of variables expected to be Task, Bond, or Goal elements of the alliance in couple therapy. The Bond composite score included the following items: Support ($M = 4.37$, $SD = .79$), Therapist's Empathic Connection ($M = 4.02$, $SD = 1.07$), Effective Challenge ($M = 4.14$, $SD = .91$), Genuineness ($M = 4.09$, $SD = .91$), and Emotional Safety ($M = 4.42$, $SD = .84$). Chronbach's Alpha was computed to test the internal consistency of these items which yielded an alpha coefficient of .62. Similarly, the Goal composite score included the following items: Goal Agreement ($M = 4.10$, $SD = .99$), Client's Perception of Working Toward Goals ($M = 4.10$, $SD = .88$), and Therapist's Perception of Working Toward Goals ($M = 3.37$, $SD = 1.14$). The test of internal consistency for these three items yielded an alpha coefficient of .67. Finally, the Task composite score included the following items: Task Agreement ($M = 3.59$, $SD = 1.09$), Client's Perception of Competence ($M = 4.34$, $SD = .83$), and Therapist's Perception of Competence ($M = 3.95$, $SD = .96$). The test of internal consistency for these items yielded an alpha coefficient of .62.

As all of the alpha coefficients for the composite scores were less than .70 it became necessary to make a decision about what would be the best way to test the global

constructs of Task, Goal, and Bond. It was decided that the items Task Agreement and Goal Agreement would be used to represent the global Task and Goal domains, because they are the most face valid items and remained true to the purest definition of the constructs. It was somewhat less clear which items to use to capture the essence of the Bond domain. Bond as defined by Bordin (1979) refers to the emotional connection between the therapist and the client and Pinsof (1988) refers to Bond in a similar fashion. Measures of therapeutic bond have included items that query about the therapist's support, trust in the therapist, and candor about therapeutically relevant issues (Horvath & Greenberg, 1989; Pinsof & Catherall, 1986). It became clear that not one or even two of the items from the survey would completely capture the construct of therapeutic Bond. It was decided that the moderate level of internal consistency (.62) for this composite score was acceptable given that it is comprised of only five items and a composite score was necessary to measure this multifaceted global construct. Other studies that have measured constructs such as attribution bias have deemed acceptable alpha coefficients between .42-.70 for sub-scales comprised of 4-5 items (Dodge & Price, 1994; Dodge, Price, Bachorowski, & Newman, 1990; Price & Glad, 2003). Therefore, it was decided to use the single items of Task Agreement and Goal Agreement to measure the global constructs of Task and Goal while the Bond composite score was retained.

Hypothesis 1

The first hypothesis of this study is that therapists will rate Balance, Resisting Triangulation, and Physical Safety to be significantly more important to the therapeutic alliance for couple therapy than individual therapy. This hypothesis was tested in three

sets of analyses. The first set involves an analysis of the drop down selection data to determine if Balance, Resisting Triangulation, and Physical Safety were more likely to be selected for couple therapy than for individual therapy. The second set of analyses investigates whether or not Balance, Resisting Triangulation, and Physical Safety were more likely to be selected as not applicable to the alliance in individual therapy. Finally a series of paired t-tests was conducted to test for differences in the Likert scale ratings of the importance of Balance, Resisting Triangulation and Physical Safety for the therapeutic alliance in couple and individual therapy. Paired t-tests were also conducted between ratings of Task Agreement, Goal Agreement, and a composite score reflecting therapeutic bond for individual and couple therapy in order to test for differences between therapist's ratings on these items as well.

Analyses of Drop-Down Selection Data

Therapists were asked to first select the four components they believe to be the most important to the therapeutic alliance in individual therapy and then select the four they believe to be the most important to the therapeutic alliance in couple therapy. Table 1 and Table 2 display the top five most frequently selected items. The complete list of items arranged by frequency selected, may be found in Appendix D. Table 3 displays the top five items selected separated by theoretical orientation.

Collaborative Relationship, Therapist's Empathic Connection, and Emotional Safety were all among the top five items selected for both individual and couple therapy. However, Resisting Triangulation and Balance were among the top five items selected for

Table 1

Top Five Selected as Most Important to the Therapeutic Alliance For Couple Therapy

Characteristic	Sum*	Percentage
Collaborative Relationship	82	54.6
Resisting Triangulation	78	52.0
Balance	62	41.3
Emotional Safety	54	36.0
Therapist's Empathic Connection	51	34.0

*The sum of therapists who selected this item, $n = 150$

Table 2

Top Five Selected as Most Important to the Therapeutic Alliance For Individual Therapy

Characteristic	Sum*	Percentage
Collaborative Relationship	106	77.7
Therapist's Empathic Connection	90	60.0
Emotional Safety	63	42.0
Client Motivation for Therapy	60	40.0
Genuineness	46	30.7

*The sum of therapists who selected this item, $n = 150$

Table 3

Top Five Selected as Most Important to the Therapeutic Alliance For Couple Therapy: By Orientation

	Sum	Percentage
Cognitive-Behavioral (n = 27) :		
Resisting Triangulation	16	59.3
Collaborative Relationship	16	59.3
Balance	13	48.2
Goal Agreement	11	40.7
Emotional Safety	8	29.6
Client's Motivation for Therapy	8	29.6
Client's Perception of Competence	7	25.9
Psychodynamic (n = 52):		
Collaborative Relationship	25	48.0
Resisting Triangulation	24	46.2
Therapist's Empathic Connection	22	42.3
Balance	20	38.5
Emotional Safety	19	36.5
Family Systems (n = 39):		
Collaborative Relationship	22	56.4
Resisting Triangulation	20	51.3
Emotional Safety	16	41.0
Balance	15	38.5
Therapist's Empathic Connection	12	30.7
Integrative (n = 33):		
Collaborative Relationship	19	59.4
Resisting Triangulation	18	56.3
Balance	14	43.8
Therapist's Empathic Connection	13	40.6
Client's Perception of Working Toward Goals	12	37.5

couple therapy alone. McNemar's test of marginal homogeneity was used to determine that Balance, χ^2 (1) = 57.01, $p < .001$, Resisting Triangulation, χ^2 (1) = 66.32, $p < .001$, and Physical Safety, χ^2 (1) = 4.08, $p < .05$ were significantly more likely to be selected for couple therapy than individual therapy.

Analyses of "N/A" Data

For the Likert scale items therapists were given the option to select "N/A" if they felt an item was not applicable to the alliance in individual or couple therapy. 97% of the therapists felt that Resisting Triangulation could be applicable to the alliance in individual therapy as opposed to 100% for couple therapy. 81% of the therapists felt that Balance could be applicable to the alliance in individual therapy as opposed to 99% for couple therapy. Similarly, 91% of the therapists felt that Physical Safety could be applicable to the alliance in individual therapy as opposed to 97% for couple therapy. McNemar's test of homogeneity was used to determine if differences exist between whether or not therapists felt the item was applicable for individual or couple therapy. For the items Balance, χ^2 (1) = 25.03, $p < .001$, and Physical Safety, χ^2 (1) = 10.80, $p < .01$, therapists were significantly more likely to select "N/A" to the therapeutic alliance for individual therapy than for couple therapy. No significant differences were found between reports of "N/A" for Resisting Triangulation.

Paired t-tests

Next, paired t-tests were conducted to test for differences between ratings on the Likert scale items for Balance, Resisting Triangulation, and Physical Safety as well as for differences between the Task Agreement and Goal Agreement scores for the importance

of the item to the therapeutic alliance in couple and individual therapy. Differences between the composite Bond ratings for individual therapy and couple therapy were tested as well. Due to the number of t-tests conducted, significant *p* values were set at < .008 (.05/6) to control for the possibility of Type 1 errors. Table 4 displays the t-tests for each pair. Only therapists who believed Balance, Resisting Triangulation, and Physical Safety were applicable to the alliance for both individual and couple therapy were included in the analyses. As displayed in Table 4, therapists rated Balance, Resisting Triangulation, and Physical safety to be significantly more important to the alliance for couple therapy than individual therapy. Somewhat unexpectedly, Task agreement was rated significantly more important for couple therapy than individual therapy while no differences were found for the Goal Agreement or Bond items.

Hypothesis 2

Next, it was hypothesized that Balance, Resisting Triangulation, and Physical Safety will be rated to be as important to the alliance in couple therapy as the traditional components of Task Agreement, Goal Agreement, and therapeutic Bond. In order to determine how Balance, Resisting Triangulation, and Physical Safety were rated in comparison to the Task Agreement, Goal Agreement and Bond for couple therapy a series of paired t-tests was conducted and is displayed in Table 5. Due to the number of t-tests conducted, significant *p* values were set at <.006 (.05/9) to control for the possibility of Type 1 errors. For couple therapy, therapists rated both Balance and Resisting Triangulation as significantly more important to the therapeutic alliance in couple therapy than the Task Agreement, Goal Agreement, or Bond scores.

Table 4

Paired t-tests Comparing Therapeutic Alliance Characteristics for Couple Therapy and Individual Therapy

Characteristics	Mean Difference	SD	t value	df	sig*
Balance CT – Balance IT	.74	1.02	8.02	122	<.001*
Triangulation CT – Triangulation IT	.59	.83	8.50	146	<.001*
Physical Safety CT – Physical Safety IT	.72	1.03	8.18	136	<.001*
Task CT – Task IT	.21	.65	3.80	150	<.001*
Goal CT – Goal IT	.13	.81	2.02	150	.05
Bond CT – Bond IT	-.06	.32	-.2.45	150	.02

* significant p-value set at < .008 to control for Type 1 error.

Table 5

Paired t-tests Comparing Task, Goal, and Bond Elements with Balance, Triangulation, and Physical Safety in Couple Therapy.

Characteristics	Mean Difference	SD	t value	df	sig*
Balance – Task	.90	1.25	8.74	145	<.001*
Balance – Goal	.38	1.12	4.17	149	<.001*
Balance – Bond	.29	.73	4.83	149	<.001*
Triangulation – Task	1.18	1.12	12.73	146	<.001*
Triangulation – Goal	.62	1.08	7.07	150	<.001*
Triangulation – Bond	.53	.65	9.88	150	<.001*
Physical Safety - Task	.77	1.20	7.67	144	<.001*
Physical Safety -Goal	.23	1.15	2.50	148	.014
Physical Safety - Bond	.15	.71	2.54	148	.012

* significant p-value set at < .006 to control for Type 1 error.

Physical Safety was rated significantly more important than Task Agreement but not the Goal Agreement or Bond items.

Hypothesis 3

The third hypothesis in this study is that the theoretical orientation of the therapist will influence the ratings of certain domains in their importance to the therapeutic alliance. Specifically, it was thought that therapists who utilize cognitive and behavioral approaches would rate Task and Goal agreement higher than therapists of other orientations, while psychodynamic and interpersonally oriented therapists would rate Bond higher in its importance to the alliance and family systems oriented therapists would rate balance, resisting triangulation, and physical safety higher than therapists of other orientations.

In order to determine if the theoretical orientation of the therapist impacted the components they thought to be important to the development of the therapeutic alliance, six separate one-way ANOVA's were conducted with 4 levels of orientation (cognitive behavioral, psychodynamic, family systems, and integrative). Results are displayed in Table 6. No significant effects were found between therapists' theoretical orientation and their ratings of the items of interest. Means and standard deviations for each item by theoretical orientation are displayed in Table 3 of Appendix D.

Hypothesis 4

Next, it is hypothesized that therapist experience will moderate the influence of theoretical orientation on the therapists ratings of importance of the items. Although, no

Table 6

One-way Analyses of Variance of Items by Theoretical Orientation.

Characteristics	df	F	sig*
Task Agreement	3	.61	.61
Goal Agreement	3	.97	.41
Bond	3	.62	.60
Balance	3	.62	.60
Resisting Triangulation	3	.60	.61
Physical Safety	3	.43	.73

* Note that each row represents separate one-way ANOVAs with significant p-value set at < .008 to control for Type 1 error.

differences were found between theoretical orientations on the items therapists believed to be most important to the alliance in Hypothesis 3, it still remained possible that differences might exist at different levels of experience. Six separate analyses of covariance were conducted for each item by theoretical orientation controlling for the therapist's experience (number of years practicing) and including an interaction term between years practicing and orientation. No significant main effects, including the experience by orientation interaction, were found for each of the six ANCOVA's . For reference, Table 4 in Appendix D displays a tripartite split of the therapists by experience in years practicing and the corresponding means and standard deviations of the items of interest.

Hypothesis 5

Finally, the last hypothesis examined whether the therapists spontaneously discussed themes of balance, triangulation, and physical safety when asked to describe potential ruptures in the alliance in couple therapy. It was also of interest if therapists discussed other aspects of the alliance in couple therapy that were not presented in the survey. At various points in the questionnaire, respondents also were given the option to write in a text box other factors they believe to be important to the development of the therapeutic alliance if it was not included in the list presented to them. Of the 151 therapists who responded only one wrote in these text boxes. This therapist wrote "transference interpretations" as an important factor not included for the individual therapy and "Reflections on childhood patterns of upbringing (insight)" for the couple therapy field.

Rupture Narratives

Therapists were also asked to describe potential ruptures in the therapeutic alliance that may be unique to couple therapy. 106 therapists responded to this item. Some therapists wrote more than one potential rupture and these were separated into a total of 145 rupture responses. The rupture narratives were distributed to 4 undergraduate research assistants and 4 advanced graduate students in clinical psychology to read through and place into one of five categories. The first category was reserved for ruptures that mention a split alliance or balance rupture. The second category was reserved for ruptures that mention triangulation or the therapist unwittingly maintaining the couple's problematic interactions. The third category was for ruptures that mention the therapist's failure to provide an atmosphere of physical safety. The fourth category was for other types of ruptures that would be considered unique to couple therapy and the fifth category was for ruptures that could also occur in individual therapy. The coders received no training on how to code the responses other than brief descriptions of each category drawn directly from the definitions located on the survey itself.

The overall level of agreement among the coders was acceptable, yielding a Kappa coefficient of .49, $p < .001$. The mean number of Balance type ruptures found to be present by the coders was 80.4 (54%). Below are three examples of Balance ruptures that were agreed upon by all of the coders:

Balance Rupture 1:

> "When one partner perceives that the therapist is too strongly aligned with the other partner."

Balance Rupture 2:

> "In couple therapy it is possible to have a positive alliance with one person, while having a negative relationship with the other."

Balance Rupture 3:

> "Therapist not being able to remain neutral, or therapist being perceived by either or both members of the couple as not neutral."

The mean number of Triangulation type ruptures was 24.4 (17%). Below are three examples of Triangulation ruptures that were agreed upon by the coders:

Triangulation Rupture 1:

> "Triangulation is a constant threat to the alliance in couples therapy."

Triangulation Rupture 2:

> "Secret communication with one partner."

Triangulation Rupture 3:

> "The therapist colluding in keeping secrets"

The mean number of Physical Safety ruptures was 3.3 (2%). Due to the low occurrence of this code there were very few items on which most of the coders agreed on this classification. Below are two examples of rupture narratives were most of the coders agreed that it may involve physical safety:

Physical Safety Rupture 1:

> "If either partner feels unsafe in the therapist's office in that s/he cannot control the process as well as s/he could if alone in individual. i.e., the therapist."

Physical Safety Rupture 2:

> "One member of the couple threatens suicide, not only to communicate to therapist, but also to communicate to partner. One or both members of the couple refuse to accept referral for concurrent individual work to deal with individual problems."

The mean number of other couple therapy unique ruptures was 24.0 (16%). Below are three examples of ruptures described by the therapists that the coders agreed were unique to couple therapy but do not involved balance, resisting triangulation or physical safety.

Couple Therapy Unique Rupture 1:

> "When either member of the couple decides to go against the working goal of the couple and sabotages the relationship."

Couple Therapy Unique Rupture 2:

> "When you find out that one of the partners has been lying to you and to their spouse about something important to the marriage."

Couple Therapy Unique Rupture 3:

> "If one member of the couple no longer wants the relationship to continue but does not express this in or out of therapy.

Finally, the mean number of couple therapy non-unique ruptures was 12.5 (8%). Below are three examples of ruptures that the majority of the coders agreed should be classified as non-unique to couple therapy.

Couple Therapy Non-Unique Rupture 1:

> "Therapist is culturally insensitive, or in any way disrespectful or judgmental."

Couple Therapy Non-Unique Rupture 2:

> "When the therapist does not understand what that person says/feels/experiences."

Couple Therapy Non-Unique Rupture 3:

> "Therapist of one sex inadequately able to understand dynamics of opposite sex."

CHAPTER 4

Discussion

The therapeutic alliance in couple therapy is undeniably an important component for the effective treatment of marital distress, but at this time it is not as well understood as its counterpart in individual psychotherapy. One of the main objectives of this study was to shed some light on the important aspects of the alliance in couple therapy by accessing the collective wisdom of practicing therapists. The primary endeavor was to determine what aspects of the therapeutic alliance practicing therapists felt to be the most vital in couple therapy and to explore possible components that may be uniquely important to this modality. It was thought that therapists will recognize that the formation and maintenance of multiple alliances, as well as resisting triangulation and providing an element of physical safety, are aspects of the alliance that are more important in couple therapy than individual therapy. By and large this expectation was supported by the therapists' responses.

Alliance Components in Couple Therapy

Surprisingly, Balance and Resisting Triangulation were rated to be significantly more important to the alliance by practicing therapists than Task Agreement, Goal Agreement and Bond. Physical Safety was only thought to be more important than Task Agreement. The fact that therapists rated Balance and Resisting Triangulation to be more important than Task, Goal, and Bond dimensions in couple therapy illustrates how important therapists think these items are to the alliance in couple therapy as a whole. At the very minimum it appears that therapists think Balance and Resisting Triangulation are

integral aspects of the alliance in couple therapy. At maximum, the greater emphasis on these issues suggest that these qualities may be unique components to the therapeutic relationship in couple therapy that are potentially separate from the task, goal, and bond components. Regardless, it is clear that therapists see these components to be important aspects of the alliance. Unfortunately, current measures of the alliance are not equipped to verify whether or not these components truly are important qualities of the alliance as it unfolds in couple therapy.

What is interesting is not simply that therapists thought that the elements of Balance, Resisting Triangulation, and to a lesser degree Physical Safety are important to the therapeutic alliance, but the degree to which the therapists selected them as their top four in the drop down boxes. While all three of these items were more likely to be selected for couple therapy as opposed to individual therapy; Balance was selected by 41% of the therapists and Resisting Triangulation was selected by 52%, while only 9% chose Physical Safety as one of their top four. Clearly, therapists feel that Balance and Resisting Triangulation are essential components of the therapeutic alliance in couple therapy, but Physical Safety was not as often selected. While this lends more support to the idea that Balance and Resisting Triangulation may be critical components of the alliance in couple therapy, it is possible that Physical Safety is either not truly an aspect of the alliance or is of lesser importance than the broader components.

This points to the question of whether or not Physical Safety is indeed an aspect of the alliance or if it is in some other way important to couple therapy. One possibility is that while physical safety may be an important aspect of the therapeutic alliance in

couple therapy, there are several other aspects that simply are considered more important. Moreover, perhaps providing an atmosphere that ensures physical safety may only be important for certain types of couples and therefore may not be conducive to the alliance as a whole across all couples seen in therapy. If a highly volatile couple seeks treatment and it become evident that they usually escalate conflict rapidly, for example with a tendency to pick up nearby objects and throw them, it is highly unlikely that the therapist will be able to establish a viable therapeutic alliance unless the couple can feel safe exploring heated topics. However, for other couples who do not have a history of violence or rapid escalation of conflict, the element of physical safety may be a non-issue and consequently irrelevant to the development of the alliance. Therefore the importance of ensuring physical safety to the therapeutic alliance may vary depending on the volatility of the couple.

Of course another possibility is that Physical Safety actually does not have much to do with the therapeutic alliance at all. The issue of physical safety may not be an aspect of the therapeutic alliance per se but instead simply a part of the therapeutic frame in couple therapy. Therapists may see physical safety to be a boundary of their sessions that is simply part of their work and therefore not exactly an issue of very much relevance to the alliance as a whole. It should be noted that while most therapists did not select physical safety as one of their top four items most important to the alliance in couple therapy, the mean rating on the 5-point Likert scale item, ranging from 1= important to 5= absolutely essential, was approximately 4.3. Therapists are reporting that this item is important, but whether or not physical safety is directly an aspect of the

therapeutic alliance or just a practical piece of the frame of couple therapy is a topic worthy of theoretical conjecture and empirical investigation.

The special importance of Balance, Resisting Triangulation, and Physical Safety to the alliance in couple therapy was further examined by analyzing the degree to which therapists selected "not applicable" for these items in individual therapy. For the most part, therapists felt that these items were certainly applicable to the therapeutic alliance in individual therapy. One could easily imagine balancing and validating the competing views of an adolescent seen in individual therapy with that of their parents. Individual therapy clients may also be quite adept at subtly enlisting the help of their therapist in managing conflict in their personal relationships, which would require the therapists' vigilance toward resisting triangulation. It is a bit more of a stretch to imagine how physical safety may be applicable in individual safety, unless therapists interpreted this to include protecting a patient from self-inflicted personal harm or placing themselves in harmful situations outside of the therapy session. Although the majority of therapists felt that these items could be applicable to the therapeutic alliance in individual therapy, they were more likely to select "n/a" for Balance and Physical Safety than they were for couple therapy. However, 97% of the therapists felt that Resisting Triangulation is a concept applicable to the alliance in individual therapy compared to 100% who thought it was applicable to couple therapy. Therapists were no more likely to select "N/A" for individual therapy than they were for couple therapy, when rating Resisting Triangulation. It is important to note that the descriptions of the items were written in such a way that would not rule out its applicability to the therapeutic alliance in

individual therapy, yet it appears that therapists had more difficulty thinking about how Balance and Physical Safety would contribute to the alliance when working with a single patient.

In order to directly compare the relative importance of Balance, Resisting Triangulation, and Physical Safety to the alliance in couple therapy as compared to individual therapy, only the therapists who felt that these items were applicable to the alliance for *both* individual and couple therapy were included in the analyses. The therapists that thought Balance, Resisting Triangulation, and Physical Safety were applicable to the therapeutic alliance for both treatment modalities rated these items to be significantly more important to the alliance in couple therapy. Thus, it appears that the therapists overall believed that the items of Balance, Resisting Triangulation, and Physical Safety were more central components to the alliance in couple therapy than individual therapy, which supported the first hypothesis of this study.

If one considers the systemic nature of the items Balance, Resisting Triangulation, and Physical Safety it may not come as much of a surprise that these items are rated by therapists to be more important to the alliance when working with couples. The simple fact of having more than one person involved in the therapy may make these components more salient than when working with just one person. Furthermore, whereas these items were written in such a way as to be conceivable applicable to the alliance in individual therapy, the therapists who responded to this survey overall see these items to be key components to the alliance in couple therapy, more so than they are to individual therapy. Unfortunately, researchers to date have yet to explore the role that Balance,

Triangulation, and Physical Safety play in the therapeutic alliance in couple therapy. Considering that the current measures used to assess the strength of the therapeutic alliance have been more or less extensions of alliance measures in individual therapy, and do not measure concepts such as Balance, there exists the possibility that important aspects of the alliance in couple therapy are not being accounted for in contemporary psychotherapy research. Current measures that assess the strength of the alliance on Task, Goal, and Bond dimensions may be missing essential components of the alliance in couple therapy.

In the current study, it was thought that therapists would rate the broad aspects of the alliance (Task, Goal, Bond) to be similarly important to the alliance for both individual and couple therapy. Contrary to expectations, Task Agreement was rated to be more important to the alliance in couple therapy than individual therapy, while no differences were found between individual and couple therapy for Goal Agreement and Bond. At first it seems to be puzzling why Task Agreement would be seen to be more important to the alliance as a whole for couple therapy than individual therapy. One could say that simply having more people in the room with competing ideas about the nature of their difficulty would complicate the process of agreement on what to do about the problem, but the same also might be said for Goal Agreement. Therapists might have assumed that the vast majority of couples who present for treatment likely have very different ideas about what a good therapeutic outcome would look like. Forging Goal Agreement involves a fair degree of therapeutic skill in reframing the problem in such a way as to appeal to the competing individual goals of each member of the couple.

However, in couple therapy the Tasks required to meet those goals usually requires each member of the couple to go beyond simple agreement and actually engage in activities that seem less congruent with their individual aims than might have initially been expected. In individual therapy, Task Agreement only involves one patient agreeing with the therapist on how to best proceed in treatment, in couple therapy both partners have to agree on engaging in behaviors that might be inconsistent with their original ideas about the nature of the problem.

A case example might better illustrate this point. One couple seen in therapy by the author eventually agreed upon the overarching goal of achieving more emotional intimacy in their relationship. The wife of this couple felt that her husband was not interested in discussing topics of emotional significance and felt shut out by him because he did not pursue discussions with her when she felt depressed. Her initial belief about the problem (that her husband was uninterested in her) led her to expect that the tasks of therapy would be to direct her husband to approach her more when she felt depressed and show more interest in her. The husband of this couple on the other hand was confused by this because he rarely knew when to approach his wife and expected her to let him know when she was feeling badly. Consequently, he initially expected that the tasks of therapy would be for his wife to make her needs explicitly known when she is depressed and how he can help meet them. Their mutually held beliefs that the nature of their problem was the passivity of their partner made it very difficult for them to agree to the aspects of the intervention that required them to activate and approach the other. In other words, they had to change their beliefs about the nature of the problem in order to agree on what

needed to be done to reach their goal of increased intimacy. This alteration in belief structure is inherently more difficult when the tasks deviate from the individuals' initial ideas about the nature of the problem, which in this case was change in their partner's behavior. Had this couple not ultimately agreed on what needed to be done to reach their mutual goal of increased intimacy, the therapeutic alliance would have floundered (and at times did). It is possible that since couple therapy usually requires both partners to engage in tasks that appear to be at times diametrically opposed to their initial assumptions of the problem, Task Agreement may be more important to the alliance, which seems to reflect the opinion of the therapists who responded to this survey.

One puzzling finding of this study worth noting is that although therapists' ratings for Task Agreement was higher for couple therapy than for individual therapy, overall Task Agreement rankings were rather low. Task Agreement was only selected as one of the four most important characteristics of the alliance by 9% of the therapists for couple therapy and 11% for individual therapy. Goal Agreement and all of the Bond items were higher on the likert scale items and ranked more often in the top four. It is clear that the therapists thought that Task Agreement was an important aspect of the alliance, however it does not appear that they thought it was as important as the other items. Given the primacy of the therapeutic relationship in many approaches, the therapists may have been more likely to emphasize the Bond items when ranking. Furthermore, the therapists were given more Bond items to choose from and consequently Task Agreement was less likely to be selected in the top four drop down items. It is likely that the lower incidence of

ranking Task Agreement are at least partially due to the fact that the list is comprised of more Bond and Goal items from which to choose.

Task, Goal, Bond: Interaction with or Separation from?

If therapists believe that Balance and Resisting Triangulation are essential ingredients to the therapeutic alliance in couple therapy, it is important to consider whether or not these items are separate from, interact with, or may be subsumed under the broader concepts of Task Agreement, Goal Agreement and therapeutic Bond. It is not likely that Resisting Triangulation and Balance are completely separate and independent from Task, Goal, and Bond dimensions, considering that Task, Goal, and Bond components themselves tend to interact with each other. For example, in individual therapy early work on developing goals and agreeing on how to reach those goals eventually leads to the formation of the therapeutic bond. The same could be true when thinking about how Balance and Resisting Triangulation are related to Task, Bond, Goal elements of couple therapy. One possibility is that the therapists' action of managing Task, Bond, and Goal dimensions of the therapeutic alliance with two individuals while being mindful of the ultimate therapeutic goal, captures the essence of Balance. In this regard Balance is the process by which the therapist juggles multiple therapeutic alliances. Skillful managing of multiple alliances may interact with these components by enhancing the therapeutic bond (or even goal or task agreement for that matter). Furthermore, Balance may be uniquely important to the therapeutic bond in couple therapy in a way that is more or less absent from individual therapy. Balance may be

more than the therapist being an impartial or neutral arbiter of therapy, but instead is reflected by a perception by both partners that the therapist is partial toward them.

Another case example might illustrate this point a bit better. One couple seen by the author for over one year in the process of terminating therapy discussed why and how the therapy was useful for them. During this discussion the husband mentioned that the therapist always knew where he was coming from and always felt like he was on his side. In response to this the wife of the couple laughed and said "No dear, he was always on *my* side." Here it is clear that the couple did not see the therapist as impartial or a neutral judge who presided over their therapy. They both very much thought that the therapist was working with them by understanding and advocating for their individual goals in the context of improving the quality of their relationship. Balance as a component of the therapeutic bond is the continual providing of support and understanding by the therapist in a manner that does not jeopardize the other partner's perception of the therapist's support for their view. While this may occasionally occur in individual therapy as peripheral family members move into the direct patient-therapist system, Balancing and supporting multiple viewpoints is an omnipresent aspect of couple therapy.

It is an additional possibility that Balance may be the therapist attending to the Bond component of the couple on the individual level and Resisting Triangulation may be the therapist attending to the Bond component at the systemic level. In other words Resisting Triangulation involves the therapist attending to their "fit" with a particular system in the process of moving the couple toward change. It is important to note again what exactly is meant by resisting triangulation; after all, couple therapy itself can be

seen as a type of triangulation in which one of the parties (the therapist) uses their expertise to rebuild the bond of another relationship. The therapist attending to how they "fit" into the system of the couple is partially what is meant by resisting triangulation. Triangulation may be overtly obvious, such as when one member of a couple asks the therapist to acknowledge how hopeless their partner is or it may be much more subtle. Another couple seen by the author was entrenched in a standoff period about halfway through their therapy with no real progress being made. The husband had difficulty naming and expressing the feelings he experienced to his wife, who assumed that he was emotionally unaffected by events in their lives, which in turn left them with a subsequent deficit of intimacy in their relationship. As they worked session after session the therapist began to wonder why none of the richness of emotion he had witnessed him express during the therapy hour made its way home to their conversations during the intervening weeks. It became clear in the coming sessions that the therapist had assumed a vital role in their relationship that was hindering progress. Through his impatience with the apparent lack of progress, he was inadvertently becoming this man's mouthpiece by helping him find the words in session he was searching for to convey his feelings to his wife without giving him the space he needed to continue to do this on his own. In essence he did not need to practice the skills he used in session at home because the therapist had, without knowing it, provided him (them) with what he (they) needed in session, thus continuing their lack of intimacy. Ultimately, this couple began to do much better after the therapist noticed how he was fitting into their system and maintaining their problem.

Whereas resisting triangulation with this couple removed a substantial roadblock to the viability of the therapeutic alliance in reaching their relationship goals, it is unclear if this resistance of triangulation had any impact on the Task, Goal or Bond domains of the alliance. In this case it is likely that Resisting Triangulation enhanced the degree to which the therapist "fit" with the system in the process of moving them toward change. In other words the therapeutic Bond between the system as a whole and the individual alliances with the therapist was enhanced. It is not clear exactly whether or not Balance and Resisting Triangulation are separate aspects of the alliance in couple therapy or if they are unique sub-components of Task, Goal, and Bond domains. The answer to this question may be impossible to ascertain from the data collected from this study, but what is clear is that therapists believe that Balance and Resisting Triangulation may be significantly more important to the alliance in couples therapy than Task Agreement, Goal Agreement or the Bond items.

From a measurement perspective the question of whether or not Balance and Resisting Triangulation are systemic constructs of the alliance that exist outside of the Task, Goal and Bond domains or are themselves an aspect of the therapeutic Bond is an important one. The fact that therapists rated Balance and Resisting Triangulation to be more important to the alliance than many other very important aspects of the alliance suggests that larger systemic constructs take precedence in the minds of therapists when thinking about the alliance in couple therapy. This can be found very clearly in many of the therapist's narrative definitions of the therapeutic alliance in couple therapy:

> "An alliance in couple's therapy should be with both members of the couple-as equally as possible. The therapist should attempt to connect with both members of the couple as individuals, as well as via their relationship as a couple. An alliance with the couple should work to help them achieve the goals specified in therapy."

The therapist's narrative definitions of the alliance inform and help make sense out of the data that was recorded in their rankings. As in the example above many of the therapists described the alliance in terms of individual alliances and a systemic alliance. The perspectives of the therapists seem to fit well with Pinsof's (1994) multi-systemic conceptualization of the alliance. Therapists seem to agree that there is an aspect of the alliance that exists between the couple as a unit and the therapist. However, the only instrument that attempts to capture this level of the alliance is Pinsof and Catherall's (1986) Integrative Psychotherapy Alliance Scale. The alliance measure at the systemic level assesses Task, Goal, and Bond domains between the couple as a unit and the therapist by having both members of the couple rate items such as "The therapist understands my relationship" (Bond). However, the systemic constructs of Balance and Resisting Triangulation are not directly assessed. It appears that therapists agree that the alliance in couple therapy exists at both the individual and systemic levels, however there is little room in existing measures to account for the constructs of Balance and Triangulation.

Orientation Effect

Surprisingly, the components the therapists believed to be most important to the alliance in couple therapy did not vary by their theoretical orientation. Therapists tended to rate the importance of the items in a similar fashion regardless of their theoretical

leanings. One possible explanation for this finding is that whereas their views on the important aspects of the therapeutic alliance in individual therapy may be quite different, couple therapists view the therapeutic alliance similarly when they work with couples despite their theoretical orientation. This idea was tested with post-hoc analyses of the therapist's ratings of the six items (Balance, Resisting Triangulation, Physical Safety, Task, Goal, and Bond) for individual therapy by their theoretical orientation. These analyses also revealed no significant differences in ratings by orientation. The question remained as to why the therapists' ratings of the items did not vary by their theoretical orientation. Considering that Bordin developed his ideas about Task, Goal, and Bond dimensions of the therapeutic alliance with the intent that they be transtheoretical concepts, perhaps it is not so surprising that no differences were found between orientations in the degree to which they felt the items were important. This finding suggests that previous conjecture that theoretical orientations may emphasize different aspects of the alliance may not be correct (Gaston, Goldfried, Greenberg, Horvath, & et al., 1995). It also may be important to note that the last fifteen years of psychotherapy process research has emphasized the importance of common factors such as the alliance to therapeutic outcome, so perhaps more therapists attend to the alliance in treatment than once was the case. Perhaps cognitive and behavioral therapists have come to emphasize the more relational aspects of their work while psychodynamic therapists have become more pragmatic in emphasizing mutual collaboration toward identifiable goals in light of pressure by managed care providers to practice short-term therapy.

Alliance Ruptures

The fact that therapists discussed themes of Balance and Resisting Triangulation in their narratives *before* they completed the survey lends further strength to the idea that these are integral aspects of the alliance in couple therapy. However, the therapists spontaneously in their narratives rarely, if ever, mentioned Physical Safety. Once again it is possible that Physical Safety is not generally a vital aspect of the alliance in couple therapy , although it may be more important for some couples. Or perhaps Physical Safety may more accurately be described as part of the frame of couple therapy and is not exactly an aspect of the alliance itself. The narratives described by the therapists rarely mentioned the importance of establishing an environment that ensures physical safety. However, therapists discussed themes of Balance and Resisting Triangulation with some regularity.

The ruptures coded as Triangulation seemed to include two types, those that mention Triangulation directly such as:

"Triangulation is a constant threat to the alliance in couple therapy".

As well as those that mention the therapist engaging in behaviors that suggest Triangulation has occurred such as:

"The therapist colluding in keeping secrets."

Or

"Secret communication between the therapist and one member of the couple"

After the coded narratives had been collected and the data had been entered, many of the coders discussed some of the difficulty in determining whether or not a rupture should be coded as a Balance Rupture or a Triangulation Rupture. The coders mentioned that their

guiding rule of thumb was that ruptures that explicitly mentioned a stronger alliance with one member of the couple than the other or the perception of bias was coded as a Balance Rupture while other therapist behaviors that covertly stall treatment was coded as Triangulation ruptures. Balance ruptures accounted for approximately 54% of the total ruptures coded. The vast majority of these ruptures described what has been called a "split alliance". Mainly that the therapist has failed to cultivate equally strong alliances with both partners. Such as:

> "When one partner perceives that the therapist is too strongly aligned with the other partner."

Or

> "In couple therapy it is possible to have a positive alliance with one person, while having a negative relationship with the other."

Some very interesting ruptures were described by the therapists that did not neatly fit into any of the categories above but appeared to the coders to be unique to couple therapy. These couple therapy unique ruptures accounted for approximately 16% of the total ruptures reported and generally fell into three categories. There were those that dealt with hidden agendas that confound therapy, such as:

> "If one member of the couple no longer wants the relationship to continue but does not express this in or out of therapy."

Others mentioned the destructiveness of deliberate deception by one member of the couple:

> "When you find out that one of the partners has been lying to you and to their spouse about something important to the marriage."

And others discussed collusions and alliances by the couple against the therapist:

"When both partners gang together against you "

Additionally, the coders also found about 8% of the ruptures to be non-unique to couple therapy in that they could very well occur in individual therapy. These were usually described as empathic failures or misunderstanding by the therapists, such as:

"When the therapist does not understand what that person says/feels/experiences."

Overall, the coders found many of the ruptures described by the therapists to include Balance ruptures, mostly described as split-alliance ruptures as well as Triangulation ruptures which seemed to be identified as the therapist unknowingly being drawn into the couples dynamic in a counter-therapeutic way. As with the definition narratives Physical Safety ruptures were very few and none of them explicitly mentioned the failure of the therapist to protect one member of the partner from violence by the other. Again, Physical Safety does not appear to be an important enough aspect of the alliance to be mentioned spontaneously by the therapists in their narratives. The general theme of the narrative data suggests that therapists mentioned Balance frequently in their definitions of the alliance and also described Balance and Triangulation often in describing potential ruptures in the alliance.

A fascinating aspect of the rupture narrative data was the descriptions of therapeutic alliance ruptures that do not involve Balance, Resisting Triangulation or Physical Safety. The couple aligning against the therapist is mentioned as a potential rupture in the alliance. It certainly makes sense that if the couple's boundary with the therapist is so impermeable that that they see themselves as working together against the therapist that a major problem with the alliance has occurred. One therapist in the couple therapy practicum attended by the author discussed a couple in which their collective

belief about people in general is that they are not to be trusted and will generally not understand the quirky idiosyncrasies of their relationship. In other areas of their life they developed a strong "us vs. everyone else" boundary that governed their interactions with people. The therapist working with this couple felt shut out by them and at times felt as if he was the butt of a private joke they shared. The therapist skillfully resolved this rupture and was eventually accepted into their somewhat eccentric world. The resolution of this rupture had the end result of moving the therapy forward and strengthening the therapeutic bond. It appears at least from this clinical example that indeed alliances against the therapist can stifle the therapeutic alliance and could signify a potential rupture. Other ruptures described were those that described one member of the couple keeping an important secret that hinders therapy as well as intentionally sabotaging the therapy with hidden agendas. It is important to note that there were only 24 of these other "couple therapy unique" ruptures, which comprised 16% of the total ruptures reported.

While Balance and Triangulation ruptures are mentioned frequently by therapists there appear to be several other types of ruptures to the alliance that may be unique to couple therapy. It is difficult to say how common these types of ruptures actually occur in couple therapy, but the reports given by the therapists who responded to this survey certainly open the door to further discussion and exploration. It is clear that therapists when describing the flow of the alliance in couple therapy commonly think of the concepts of Balance and Resisting Triangulation, which again suggests that there is

something about these concepts that the therapists see to be an integral aspect of their work.

Limitations

There are several limitations of this study that are worth noting. There is likely a selection bias for this study found in the fact that only 150 therapists completed the survey. While the exact number of practitioners that were reached by the email postings is not available, a rough estimate of the total listserv membership is 1-2 thousand. This suggests that the response rate was 10-20%, which is a common response rate for cold call surveys that do not provide an incentive (e.g., Gordon & Baucom, 2003). Even though completing the survey did not take very much time, approximately 15-25 minutes, this survey likely required some thought and consideration, which may have dissuaded respondents from fully taking part in the survey. In this regard it is possible that only therapists who are interested in the alliance responded to the survey. This could account for the lack of differences found between orientations on their ratings of importance. It may be that the behavioral and cognitive-behavioral therapists were more interested in the therapeutic relationship than other therapists of their orientation. It is important to keep this in mind when making interpretations about the lack of findings of difference between orientations.

In addition to the selection bias it is important to point out other limitations of the sample. The overall sample size was relatively small, which limited the number of therapists when divided by orientation. There were roughly 25-35 therapists to represent each orientation group. Furthermore, 60% of the sample was comprised of psychologists,

which points to the fact that therapists from disciplines other than psychology were underrepresented in this study. Another important sample consideration is that the therapists who were included in this study were reached by email postings to professional listservs, therefore therapists who do not subscribe to listservs obviously could not be included. There may be substantial differences between the therapists who completed this survey and other practicing couple therapists that should be taken into consideration when thinking about the generalizability of these findings.

It is also important to note that the data gathered for this study is survey data and not observational, which is to say that because therapists think these items are important to the alliance in couple therapy in no way is proof that they actually are. At this point there is no way of discerning whether or not Balance and Resisting Triangulation actually predict the strength of the therapeutic alliance from the couples' perspective or if they are related to successful therapeutic outcome. This study provides an avenue to explore the possible aspects of the alliance in couple therapy that are important and different from the alliance in individual therapy. However, further research, preferably using observational data and couple reports, involving couple therapy is needed to lend validity to the claim that these characteristics are central to the development of the alliance in work with couples.

Implications and Conclusion

It is clear that Balance, Resisting Triangulation, and Physical Safety are seen by practicing therapists to be more important to the alliance in couple therapy than individual therapy. Not only were these items more likely to be picked by therapists to

be one of their top four most important characteristics to the alliance, they were also rated more important to the alliance in couple therapy on the Likert scale items. This makes intuitive sense in that these concepts are generally systemic in nature and are more easily applied to working with relationships between people rather than individual. The main purpose of this project was to determine how important these concepts are in comparison to the broad, pantheoretical components of Task, Goal, and Bond in couple therapy. The therapists in this study felt that Balance and Resisting Triangulation were significantly more important to the alliance than Task, Goal, and Bond dimensions in couple therapy. Physical Safety was not seen to be more important to the alliance than the Goal, and Bond elements. Taken with the lack of mention in the therapists narratives as well as the low number of times it was selected as one of the most important components to the alliance, Physical Safety may not be such an integral aspect to the alliance as Balance and Resisting Triangulation.

This is not to say that Balance and Resisting Triangulation are separate and autonomous aspects of the alliance from Task, Goal and Bond elements, in that these aspects of the alliance may interact with each other. Balance may be seen as the larger ebb and flow surrounding the management of several Task, Goal, and Bond relationships. Or Balance may be a more specific and unique aspect of cultivating the therapeutic bond between the therapist and each member of the couple. That is being seen as supportive to an individual in couple therapy without jeopardizing the support felt by the other. Triangulation on the other hand is likely not visible on the individual level but instead

reflects the therapist's place in the couple's system and whether or not that place is facilitating treatment or maintaining their distress.

If Balance and Resisting Triangulation are integral aspects of the alliance in couple therapy it is important to account for these aspects of the alliance in couple therapy process research. To date there is only one measure of the therapeutic alliance in couple therapy, developed by Pinsof & Catheral (1986) which requires the therapist and both members of the couple to fill out a self-report measure that captures Task, Goal, and Bond elements of the alliance at three systemic levels.

This measure of the alliance is very useful because it accounts for the systemic nature of couple therapy and assesses the alliance at the individual, group, and systemic level. However, this measure does not directly assess Balance or Triangulation, mainly because it is likely impossible to do with a self-report measure. One of the utilities of the CTA measure is that one can see if there are discrepancies between the strength of the relationship between the therapist and each member of the couple. In this regard one can find "split alliances" where the report of Task, Goal, and Bond is stronger with one member of the couple than the other. This, however, is not a direct measure of Balance in that the presence of a split alliance may not necessarily indicate a Balance problem. It may indicate poor motivation or lack of investment in therapy. Similarly, Triangulation is not measured by the current couple therapy alliance instruments. The point here is that whereas the couple therapy alliance measure currently in use is valuable, Balance and Resisting Triangulation are process elements of the alliance that are likely difficult to tap with self-report measures alone. Unfortunately, it is much easier and efficient to use self-

report measures of the alliance but it may be essential to use other options as well when studying the alliance in a larger system.

One possibility may be to use qualitative data in conjunction with self-report data to enrich the information gleaned from the quantitative instruments. This may help identify causes and consequences of ruptures such as split alliances. Another option that may be useful to explore could involve groups of trained therapists observing couple sessions as they occur and comment or ask questions about the process observed after the session. This would occur much in the same way as some "fishbowl" groups or in the same way that reflecting teams have been used in Milan family systems approaches. Of course the drawback to this approach is that simply involving a reflecting team and discussing process at the end of a session changes the way the therapy is conducted which may make generalization more difficult. However, a great deal useful information could be gleaned from these sessions that could direct the field toward process research in couple therapy that takes into consideration the fundamentally unique aspects of the alliance in this modality. For example, valuable data could be collected from the couple's perspective about the development and flow of the alliance during the course of therapy. Ultimately, this information could be used to develop more effective observational coding systems for videotaped sessions to help identify issues of balance and triangulation in couple therapy without intruding on the process itself. If Balance and Triangulation are essential ingredients to alliance in couple therapy the field is in need of more robust measures of the alliance to enhance what is known about the development of the therapeutic relationship in couples work.

Furthering what is known about the alliance in couple therapy also carries with it tremendous clinical implications. There is no better way to train future couple therapists than to direct their attention to the formation and maintenance of the therapeutic alliance. Research of the important characteristics of the alliance in couple therapy can be infinitely useful in helping new therapists side step many of the pitfalls that can potentially thwart the therapeutic process. Therapists who are aware of the importance of Balance can be taught ways in which they can phrase supportive and empathic comments to a member of a couple without alienating the spouse. Even among training programs that are geared toward couple therapy, most therapists begin their work with individuals. Attending to the maintenance of the alliance by noticing the aspects that are fundamentally different than in individual therapy may help couple therapists be more effective in their work. Deterioration of the therapeutic alliance has been found to be directly related to drop out in conjoint treatment of alcoholism (Raytek et al., 1999). Helping therapists recognize and work through ruptures in the alliance in couple therapy would likely increase the retention rate of couples who seek treatment. It is clear from this study that there are likely many types of ruptures that occur in couple therapy. The field can only benefit from further research that explores potential ruptures in the alliance as well as the process by which they are repaired.

Couple therapy process research, specifically in regard to the therapeutic alliance, is a burgeoning field with many unanswered questions. The therapeutic alliance in couple therapy has much in common with the alliance in individual therapy but there are many aspects that are unique and should not be ignored. It is imperative that future

couple therapy process research continues to investigate the richness of the alliance in couple therapy and the manner in which it unfolds to shape treatment. As more robust measures of the alliance are developed a deeper understanding of the importance of maintaining multiple alliances and the therapist's systemic involvement in the overall therapeutic alliance may be fully explored. This will allow therapists the ability to keenly attend to their role in maintaining therapeutic relationships, to the ultimate benefit of the couples that they serve.

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APPENDIX

APPENDIX A

Measure Used in Current Study

INFORMED CONSENT

Thank you for taking the time to complete our online questionnaire. As a mental health care practitioner your views about the development of the therapeutic alliance during the course of treatment provides useful information about the process of therapy in general. The following questionnaire will ask you to give your opinion on what factors impact the development of the therapeutic alliance for both individual and couple therapy. For the purpose of this study, "individual therapy" will be defined as psychotherapy sessions directly involving one client and one therapist. "Couple therapy" will be defined as psychotherapy sessions directly involving two members of a romantic partnership and one therapist.

As a participant you should know

- Your participation is voluntary.
- You will not be penalized if you refuse to participate during the completion of the survey.
- Your e-mail address, should you choose to provide it, will be kept strictly confidential and will not be used for any reason other than to provide the results of this study or answer questions. All e-mail addresses will be deleted from our records after you have been contacted.
- For any additional questions concerning this study please contact Nate Tomcik via email: ntomcik@utk.edu or by telephone: (865) 974-9915 or Dr. Kristina Gordon at (865) 974-3347.
- If you have any questions about your rights as a participant, contact the University of Tennessee Compliance Section at (865) 974-3466.

By pressing the "I agree to participate" button below, you are indicating that you understand the statements above and are giving your consent to participate in this study.

Please press the "I agree to participate" button to begin.

Before you begin the survey, please take a few moments to tell us about yourself

1. Number of years practicing: _____
2. Number of individual clients seen (estimate):_____
3. Number of couples seen (estimate):_____
4. Type of Degree: (drop down selection)
5. If other, please specify:
6. Type of License: (drop down selection)
7. If other, please specify
8. Predominant Theoretical Orientation: (drop down selection)
9. Gender: ___
10. Would you like the results of the study sent to you by email: __yes __no
11. E-mail address: (only if you checked "yes" above)_____

PART I:

The following two items are optional. Your input on these items will be very useful, however, if you choose not to answer these items **PLEASE click the "Continue" button** to proceed to the rest of the survey.

Please briefly answer (50 words or less) the following questions in terms of how they relate to therapeutic alliance in COUPLE therapy:

What is your definition of the therapeutic alliance in COUPLE therapy?
[text response]

A rupture occurs when the therapeutic alliance has been damaged in some way. Please describe any ruptures in the therapeutic alliance that may be unique to COUPLE therapy.
[text response]

PART II - CHARACTERISTICS OF THE ALLIANCE:

The following factors have been theorized to be important to the development of the therapeutic alliance. Please rate the degree to which you feel these factors are important to the development of the therapeutic alliance, first for individual therapy and then for couple therapy. Note that all of the following factors have been found through clinical observations and empirical research to be important to the development of the alliance. We are interested in exploring the *relative* importance of these factors for couple therapeutic alliance vs. individual therapeutic alliance, **not** which factors contribute to outcome. If you feel a factor does not apply, or is not at all important, please select "N/A".

1. Collaborative Relationship:

Extent to which therapist and client(s) work together as a team.

	N/A	Important						Absolutely Essential
1) Individual:	0	1	2	3	4	5	6	7
2) Couples:	0	1	2	3	4	5	6	7

2. Support:

Extent to which the client(s) feels the therapist supports them through the process of therapy.

	N/A	Important						Absolutely Essential
3) Individual:	0	1	2	3	4	5	6	7
4) Couples:	0	1	2	3	4	5	6	7

3. Goal Agreement:

The degree to which the therapist and client agree on identified goals of therapy.

	N/A	Important						Absolutely Essential
5) Individual:	0	1	2	3	4	5	6	7
6) Couples:	0	1	2	3	4	5	6	7

4. Client's Perceptions of Working Towards Goals:

Extent to which the client(s) feels they are progressing towards identified goal(s).

	N/A	Important						Absolutely Essential
7) Individual:	0	1	2	3	4	5	6	7
8) Couples:	0	1	2	3	4	5	6	7

5. Therapist's Perceptions of Working Towards Goals:

Extent to which the therapist feels the client(s) is progressing toward identified goal(s).

	N/A	Important						Absolutely Essential
9) Individual:	0	1	2	3	4	5	6	7
10) Couples:	0	1	2	3	4	5	6	7

6. Task Agreement:

Extent to which the therapist and client(s) agree on the specific activities that the client(s) must engage in to benefit from treatment.

	N/A	Important					Absolutely Essential
11) Individual:	0	1	2	3	4	5	6	7
12) Couples:	0	1	2	3	4	5	6	7

7. Therapist's Empathic Connection:

The therapist's ability to form emotional connections with clients by entering emotionally into their experience.

	N/A	Important					Absolutely Essential
13) Individual:	0	1	2	3	4	5	6	7
14) Couples:	0	1	2	3	4	5	6	7

8. Resisting Triangulation:

Therapist's ability to avoid being drawn into the client's interpersonal conflicts in counter-therapeutic ways.

	N/A	Important					Absolutely Essential
15) Individual:	0	1	2	3	4	5	6	7
16) Couples:	0	1	2	3	4	5	6	7

9. Client's Motivation for Therapy:

Degree to which the client(s) sees the need for therapy and wants to be involved in therapy.

	N/A	Important					Absolutely Essential
17) Individual:	0	1	2	3	4	5	6	7
18) Couples:	0	1	2	3	4	5	6	7

10. Client's Attachment Style:

Client's habitual pattern of relating to others in previous key relationships.

	N/A	Important					Absolutely Essential
19) Individual:	0	1	2	3	4	5	6	7
20) Couples:	0	1	2	3	4	5	6	7

11. Therapist Self-Monitoring:

The therapist's ability to observe and appropriately use his/her own reactions to the therapy and to clients.

	N/A	Important					Absolutely Essential
21) Individual:	0	1	2	3	4	5	6	7
22) Couples:	0	1	2	3	4	5	6	7

12. Effective Challenge:

Therapist has freedom to challenge the client(s) without the client(s) feeling attacked.

	N/A	Important					Absolutely Essential
23) Individual:	0	1	2	3	4	5	6	7
24) Couples:	0	1	2	3	4	5	6	7

13. Client's Perceptions of Competence:

Extent to which the client(s) perceives the therapist as having the necessary skills to help them.

	N/A	Important					Absolutely Essential
25) Individual:	0	1	2	3	4	5	6	7

26) Couples: 0 1 2 3 4 5 6 7

14. Therapist's Perceptions of Competence:

Extent to which the therapist perceives he or she has the necessary skills to help the client(s).

	N/A	Important					Absolutely Essential
27) Individual:	0	1	2	3	4	5	6	7
28) Couples:	0	1	2	3	4	5	6	7

15. Genuineness:

Degree to which the therapist and the client(s) are able to be open and honest with each other in the context of therapy.

	N/A	Important					Absolutely Essential
29) Individual:	0	1	2	3	4	5	6	7
30) Couples:	0	1	2	3	4	5	6	7

16. Balance:

If the therapy involves more than one person, Balance refers to the extent to which ALL persons feel supported by the therapist and see the therapist as an appropriately neutral arbiter of therapy.

	N/A	Important					Absolutely Essential
31) Individual:	0	1	2	3	4	5	6	7
32)Couples:	0	1	2	3	4	5	6	7

17. Physical Safety:

Extent to which the client(s) feels that the therapist will effectively intervene on highly negative conflicts.

	N/A	Important					Absolutely Essential
33)Individual:	0	1	2	3	4	5	6	7
34)Couples:	0	1	2	3	4	5	6	7

18. Emotional Safety:

The therapist creates an atmosphere conducive to disclosing vulnerability.

	N/A	Important					Absolutely Essential
34)Individual:	0	1	2	3	4	5	6	7
35)Couples:	0	1	2	3	4	5	6	7

Of the above eighteen components please select the FOUR you consider to be the MOST important to the therapeutic alliance in INDIVIDUAL THERAPY and then select the FOUR you consider to be the MOST important to the therapeutic alliance in COUPLE

THERAPY. If you would like to add another factor that is not included in the list above, please do so in the space labeled "Other".

Individual Therapy	**Couple Therapy**
37). [dropdown selection of above 18 items]	41). [dropdown selection]
38). [dropdown selection of above 18 items]	42). [dropdown selection]
39). [dropdown selection of above 18 items]	43). [dropdown selection]
40). [dropdown selection of above 18 items]	44). [dropdown selection]
Other (please specify): _____	**Other (please specify):_____**

Don't forget to press the "Submit Answers" button to submit your responses

APPENDIX B

Sample Contact Letter

[please excuse cross postings]

Hello everyone,
I am a doctoral student at the University of Tennessee and I'd like to invite you to take my online survey, which will be used for my dissertation project. One of the challenges facing our field is the development of psychotherapy research that draws on the knowledge and experience of practicing therapists. The survey will ask for your views about the development of the therapeutic alliance in couple therapy. Even if you have limited experience working with couples your input is still valuable.

Completion of the survey will take approximately 10-15 minutes depending on how much you choose to write. Please be sure to read the informed consent page on the Web site prior to beginning the survey. There is no identified risk associated with taking part in this study. No monetary incentive will be offered in this study, but your participation will help shape the field's understanding of the therapeutic alliance in couple therapy and ultimately aid us in developing better ways to treat couples and train future therapists. You will be given the option to request a summary of the results of this study to be sent to you via e-mail. All addresses will be kept strictly confidential and will not be used for any reason other than to provide the results of this study or answer questions.

To complete the survey, please enter the following URL into your web browser or click on the link:

http://web.utk.edu/~ntomcik/survey/

Thank you for considering participation in this study. If you have any questions please do not hesitate to contact me at the following email address: ntomcik@utk.edu.

Sincerely,

Nathan D. Tomcik, M.A.
Department of Psychology
University of Tennessee

APPENDIX C

Listservs

-American Association for Marriage and Family Therapy (AAMFT)
    AAMFT-General listserv
    AAMFT-Research
    AAMFT-Student

-American Association of Sex Educators Counselors and Therapists (AASECT)

-Society for Psychotherapy Research (SPR)

-Marriage and Family Therapists-Counselors (MFT-C)- (privately managed listserv)

-Association for Advancement of Behavior Therapy (AABT)
    Couple Therapy and Research Special Interest Group

-Canada Social Work- (privately managed listserv)

-National Association of Social Workers (NASW) State Chapters
    -New York
    -Michigan
    -Colorado
    -California

-Appalachian Psychoanalytic Society (APS)

-American Psychological Association (APA)
    -Division 29, Psychotherapy
    -Division 12, Clinical
    -Division 17, Counseling
    -Division 39, Psychoanalysis
    -Division 42, Independent Practice
    -Division 43, Family Psychology
    -Division 49, Group Therapy
    -Division 37, Child, Youth, and Family
    -NewPsychList

APPENDIX D

Tables

Table A-1

Complete List of Characteristics Selected as Most Important to the Therapeutic Alliance For Couple Therapy

Characteristic	Sum	Percentage
Collaborative Relationship	82	54.6
Resisting Triangulation	78	52.0
Balance	62	41.3
Emotional Safety	54	36.0
Therapist's Empathic Connection	51	34.0
Goal Agreement	46	30.7
Client Motivation for Therapy	39	26.0
Client Perception of Working Toward Goals	32	21.3
Support	24	16.0
Genuineness	23	15.3
Client's Perception of Competence	23	15.3
Effective Challenge	20	13.3
Task Agreement	14	9.3
Therapist Self-Monitoring	14	9.3
Physical Safety	14	9.3
Client's Attachment Style	12	8.0
Therapist's Perception of Competence	6	4.0
Therapist's Perception of Working Toward Goals	2	1.3

Table A-2

Complete List of Characteristics Selected as Most Important to the Therapeutic Alliance For Individual Therapy

Characteristic	Sum	Percentage
Collaborative Relationship	106	77.7
Therapist's Empathic Connection	90	60.0
Emotional Safety	63	42.0
Client Motivation for Therapy	60	40.0
Genuineness	46	30.7
Goal Agreement	43	28.7
Support	37	24.7
Therapist Self-Monitoring	26	17.3
Effective Challenge	25	16.7
Client Perception of Working Toward Goals	24	16.0
Client's Perception of Competence	21	14.0
Task Agreement	16	10.7
Client's Attachment Style	10	6.6
Therapist's Perception of Competence	9	6.0
Physical Safety	6	4.0
Resisting Triangulation	6	4.0
Therapist's Perception of Working Toward Goals	5	3.3
Balance	3	2.0

Table A-3

Means and Standard Deviations of Ratings of Variables in Importance to the Therapeutic Alliance by Theoretical Orientation.

	Triang.		Bal.		Ph.Saf.		Task		Goal		Bond	
Orientation	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
CBT	**4.70**	.72	**4.48**	.85	**4.19**	.90	**3.89**	.73	**3.81**	.88	**4.16**	.54
Psychodynamic	**4.73**	.53	**4.58**	.64	**4.41**	.75	**3.89**	.88	**3.72**	.89	**4.14**	.59
Family Systems	**4.82**	.39	**4.49**	.68	**4.36**	.96	**3.93**	.73	**3.83**	.68	**4.30**	.63
Integrative	**4.64**	.74	**4.34**	.94	**4.39**	.75	**4.03**	.44	**4.15**	.53	**4.21**	.54

Table A-4

Means and Standard Deviations of Ratings of Variables in Importance to the Therapeutic Alliance by Experience Group

	Triang.		Bal.		Ph.Saf.		Task		Goal		Bond	
Experience	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
1-5 Years	**4.75**	.63	**4.41**	.73	**4.42**	.76	**3.95**	.58	**3.88**	.66	**4.25**	.52
6-15 Years	**4.69**	.58	**4.42**	.91	**4.25**	.97	**3.94**	.87	**3.94**	.83	**4.20**	.65
16-41 Years	**4.77**	.56	**4.63**	.57	**4.41**	.75	**3.93**	.71	**3.81**	.74	**4.15**	.57

VITAE

Nathan Daniel Tomcik was born in Painesville, OH on April, 16th 1975. He was raised in Dublin, OH and graduated from Dublin High School in 1993. He then attended The Ohio State University where he graduated with a Bachelor of Arts in Psychology in 1997. He earned a Masters Degree in Clinical Psychology with an emphasis in Marriage and Family therapy in 1999 from Pepperdine University.

Nathan Tomcik is currently pursuing his Ph.D. in Clinical Psychology at the University of Tennessee and is completing his pre-doctoral psychology internship at the Cincinnati VA Medical Center.