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Therapist Behaviors That Predict the Therapeutic Alliance in Couple Therapy

Bryan C. Kubricht

A dissertation submitted to the faculty of  
Brigham Young University  
in partial fulfillment of the requirements for the

Doctor of Philosophy

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## ABSTRACT

### Therapist Behaviors That Predict the Therapeutic Alliance in Couple Therapy

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Doctor of Philosophy

Couple therapy is successful in treating relationship distress. However, couple therapy does not benefit everyone. Consequently, it is important to study factors that predict therapeutic success. One such factor is what predicts the development of the therapeutic alliance in couple therapy. The purpose of this study was to code therapist behaviors, therapist warmth, empathy, presence, validation, collaboration, and technique factors (systemically-based techniques and session structure), in the first session of couple therapy to examine their ability to predict two aspects of the therapeutic alliance, between- and within-alliance, after the session for males and females. The hypotheses were tested utilizing multiple one-way ANOVAs. Results indicated that none of the therapist variables predicted either of the outcome alliance variables for males or females. More research needs to be done to find what therapist behaviors predict the therapeutic alliance.

Keywords: couple therapy, therapist behaviors, between-alliance, within-alliance

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### Therapist Behaviors That Predict the Therapeutic Alliance in Couple Therapy

Couple therapy is successful in treating relationship distress. Reviews of couple therapy effectiveness show that various models of couple therapy produce clinically significant results in treating relational dysfunction (Sprenkle, 2012; Lebow, Chambers, Christensen & Johnson, 2012; Snyder, Castellani, & Whisman, 2006). For example, within couple therapy treatment, clients have decreased destructive emotional arousal in couple conflict (Baucom et al., 2015), increased emotional closeness (Doss, Mitchell, Georgia, Biesen, & Rowe, 2015), and increased marital satisfaction (Dalglish et al., 2015).

However, couple therapy does not benefit everyone. Marín, Christensen, and Atkins (2014) found that many couples in their sample were no longer married at a 5-year follow-up. A study on emotionally focused couple therapy showed that only 46.4% of the whole sample exhibited clinically significant change (Wiebe et al., 2017). One review of therapy treatment for couple distress reported that 70% of clients benefited from couple therapy, while nearly a third did not (Lebow et al., 2012). Another review of couple therapy reported improvement in relational quality in only about half of study samples (Snyder et al., 2006).

Consequently, it is important to study factors that predict therapeutic success. One such factor is the therapeutic alliance, which is the working relationship that therapist and client share (Michel, 2011). This relationship has been conceptualized as consisting of agreement on goals, assignment of tasks, and the development of bonds (Bordin, 1979). In relational therapy, the tasks, goals, and bonds are part of three different alliances: two alliances between each member of the couple and the therapist, which are called between-group alliances, and the alliance between the partners, which is called the within-group alliance (Pinsof, Zinbarg, & Knobloch-Fedders, 2008). Anderson and Johnson (2010) found that both the within-group alliance and the

between-group alliance are important in couple therapy and predict different aspects of therapeutic success.

Research has consistently found that when the therapeutic alliance is strong, couples in therapy are significantly more likely to improve (Knerr, & Bartle-Haring, 2010; Mulligan et al., 2014). However, when the alliance is weak, treatment is more likely to be unsuccessful (Friedlander, Escudero, Heatherington, & Diamond, 2011; Westra, Constantino, & Aviram, 2011). In addition, a weak therapeutic alliance is predictive of higher dropout rates in couple therapy. (Bartle-Haring, Glebova, Gangamma, Gafsky, & Delaney, 2012a; Sharf, Primavera, & Diener, 2010).

Recognizing the importance of the therapeutic alliance in the successful outcome of couple therapy, it is important to understand what factors predict the development of a strong therapeutic alliance. Some couple therapy research on the therapeutic alliance has focused on preexisting client variables, such as attachment styles (Miller et al., 2015) and emotional cut-off (Bernecker, Levy, & Ellison, 2014; Diener & Monroe, 2011). Additional research has incorporated process variables between the clients and therapist, including body and gaze formations and smiling episodes (Darwiche et al., 2008; de Roten, Fivaz-Depeursinge, Stern, Darwish, & Corboz-Warnery, 2000).

In addition, there is some evidence to suggest that therapist characteristics and behaviors are an important predictor of the therapeutic alliance. One study of couple therapy found that the therapist accounted for 10% of the variance of the therapeutic alliance (Owen, Duncan, Reese, Anker, & Sparks, 2014), which is akin to the 9% of explained variance found in a meta-analysis of the relationship between therapist effects and the therapeutic alliance in individual therapy (Chambless et al., 2006). These findings are consistent with the argument made by MFT scholars

that the therapist's behaviors are the most important component of successful treatment (Blow & Karam, 2017; Blow, Sprenkle & Davis, 2007).

However, very little research has examined the in-session behaviors of therapists in couple therapy. Researchers studying individual therapy have focused on therapist behaviors that are usually seen as common across treatment models and have found that therapist warmth (Keijsers, Schaap, & Hoogduin, 2000), empathy (Feinstein, Heiman, & Yager, 2015), presence (Whalen, 2013), validation (de Roten et al., 2000), and collaboration (Boardman, Catley, Grobe, Little, & Ahluwalia, 2006) are important predictors of therapy success.

Although there is considerable research in individual therapy suggesting the importance of the therapist behaviors of warmth, empathy, presence, and collaboration in the development of a strong therapeutic alliance and therapy outcome, no research has examined the effects of these therapist behaviors in predicting the therapeutic alliance in couple therapy. Only two studies have focused on therapist behaviors that produce a good therapeutic alliance in couple therapy (Thomas, Werner-Wilson, & Murphy, 2005; Werner-Wilson, Michaels, Thomas, & Thiesen, 2003). However, these two studies focused on therapeutic skills, such as managing conflict and challenging clients, rather than examining therapist warmth, empathy, presence, and collaboration. Consequently, the purpose of this study was to code the therapist behaviors of warmth, empathy, presence, validation, and technique factors (systemically-based techniques and session structure) in the first session of couple therapy to predict therapeutic alliance immediately after the session.



## Literature Review

### Conceptualization of the Therapeutic Alliance

The therapeutic alliance has been defined as the collaborative relationship between the therapist and client (Bordin, 1979; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998). Michel (2011) describes the therapeutic alliance as a relationship where the client and therapist are allies against distress. In his seminal article, Bordin (1979) stated that the working alliance had three main aspects between client and therapist: agreement on goals, assignment of tasks, and the development of bonds. Agreement on goals means that the therapist and client identifies areas of distress in the client's life, and they agree on practical goals to alleviate that distress. Assignment of tasks focuses on tasks that are relevant to the way the client wishes to change and has a clear link to the goals of therapy. The development of bonds means that the client and therapist build a relationship of trust with a deeper emotional connection. Gaston and associates (1998) stated that the collaboration in the alliance between client and therapist is active and purposeful in nature.

The therapeutic alliance is a key indicator of outcome in therapy (Horvath, Del Re, Flückiger, & Symonds, 2011). A meta-analytic review of 201 studies examined the relationship between therapeutic alliance and outcome in individual therapy (Horvath et al., 2011). They found that the therapeutic alliance significantly predicted outcome in therapy, with an effect size of .28. Another meta-analytic review of 11 studies examined the relationship between the therapeutic alliance and dropout in individual therapy. This study found that clients with weaker alliances were significantly more likely to drop out of therapy, with an effect size of .55 (Sharf et al., 2010).

### **Therapeutic Alliance in Couple Therapy**

The therapeutic alliance in couple therapy is more complex than it is in individual therapy. In individual psychotherapy, the therapist needs only be concerned with the relationship with one client; however, because couple therapy involves two clients in the therapy room, the therapeutic alliance is expanded to involve multiple relationships. MFT scholars have conceptualized the therapeutic alliance in couple therapy as consisting of three different alliances (Pinsof et al., 2008). There are two alliances between each member of the couple and the therapist, which are called between-group alliances, and there is an additional alliance between the partners, which is called the within-group alliance. Pinsof and associates (2008) measured these three different alliances with the self/group (between), other (partner between), and within subscales in the measure the Couple Therapy Alliance Scale-revised (CTAS-r) across the domains of tasks, bonds, and goals. Their research found that the within- and between-alliances seemed to have more weight in couple therapy than the domains of tasks, bonds, and goals, suggesting that clients are more concerned about who is aligned with whom in therapy. However, many studies of the therapeutic alliance in couple therapy follow the pattern of individual studies on the therapeutic alliance, which excludes the within-therapeutic alliance (Bartle-Haring et al., 2012a; Jurek, Janusz, Chwal, & de Barbaro, 2014; Knerr et al., 2011).

There is considerable evidence that overall therapeutic alliance is an important predictor of successful outcome in couple therapy. A meta-analytic review of seven couple therapy studies examined the relationship between therapeutic alliance and outcome. Results of the meta-analysis found that clients with stronger alliances were significantly more likely to improve in couple therapy, with an effect size of .37 (Friedlander et al., 2011). Their review suggests important reasons why couples with a strong alliance are more successful in therapy. Namely,

they are more willing to disclose deeper emotional thoughts and seek support from their spouse when they perceive a safe alliance.

Therapeutic alliance may also increase couple satisfaction and predict general therapeutic outcomes. A study focusing on the between-alliance in couple therapy showed that maintaining a proper therapeutic alliance significantly increases couple satisfaction over the course of therapy (Knerr, & Bartle-Haring, 2010). Another study showed similar results in that overall therapeutic alliance (vs subscales) significantly predicted couple satisfaction for men, while the within-alliance significantly predicted couple satisfaction for women (Knobloch-Fedders, Pinsof, & Mann, 2007). The study also showed evidence that forming the therapeutic alliance at session one predicted strong outcomes, including retention beyond session eight, while those with a weaker alliance at session one were more likely to drop out of therapy.

However, an unbalanced therapeutic alliance in couple therapy, with one partner having a stronger alliance with the therapist than the other, is predictive of poor therapy outcomes (Jurek et al., 2014). The therapist must keep the between-therapeutic alliance with each client balanced to produce healthy outcomes. This often proves difficult, because at the outset of therapy husbands and wives often perceive the therapeutic relationship differently (Knerr et al., 2011). Furthermore, research shows that discrepancies in each partner's perception of the between-therapeutic alliance by session four increase the likelihood of early termination in couple therapy (Bartle-Haring et al., 2012a). Other research shows that, when clients report a split-alliance (one partner's between-alliance is stronger than the other) and when therapists focus on individuals over couples, client dropout in therapy is significantly higher (Jurek et al., 2014). However, when couples agree on the strength of the between-therapeutic alliance, positive outcomes are

more likely (Symonds & Horvath, 2004), and when both partners have a strong between-therapeutic alliance, couple outcomes are greater (Anker, Owen, Duncan, & Sparks, 2010). Furthermore, as couples increasingly agree about the between-therapeutic alliance, clients are significantly more likely to complete therapeutic treatment in agreement that the therapeutic goals have been met (Bartle-Haring, et al., 2012a).

While most research primarily focuses on the between-therapeutic alliance, both the within- and between-alliances are important dimensions of the alliance in couple therapy. Anderson and Johnson (2010) found that the within-group alliance and the between-group alliance predict different aspects of therapeutic success. The within-alliance predicted relational satisfaction more potently than the between-alliance, while the between-alliance significantly predicted individual distress for the wife. This suggests that strengthening different aspects of therapeutic alliance are important for different levels of functioning in the couple system.

### **Predictors of the Therapeutic Alliance**

**Individual therapy.** With the therapeutic alliance being an important factor of success in therapy, it is important to examine potential predictors of the therapeutic alliance. Evidence from studies of individual therapy suggest that therapist behaviors are the most important factor for the development of strong therapeutic alliances. Research indicates that clients most often identify therapist behaviors and interventions delivered by the therapist as more important than client and process variables, suggesting that, from clients' perceptions, the primary responsibility for a strong alliance is allotted to the therapist (Bedi, Davis, & Williams, 2005; Bedi & Duff, 2014). This is supported by a study that found that therapist factors had a significant effect on the therapeutic alliance, while client factors were not significant (Crits-Christoph et al., 2009).

When focusing on therapist behaviors in individual therapy, scholars have commonly based their categorization of behaviors on Rogers' theory (1957) that emphasizes the core therapist behaviors of empathy, warmth, positive regard, and genuineness (Keijsers et al., 2000). Researchers studying individual therapy focused on these therapist behaviors that are usually seen as common across treatment models and have found that therapist warmth (Jung, Wiesjahn, Rief, & Lincoln, 2015; Keijsers et al., 2000), empathy (Boardman et al., 2006; Feinstein et al., 2015), presence (Whalen, 2013), validation (de Roten et al., 2000), and collaboration (Boardman et al., 2006; Feinstein et al., 2015) are important predictors of the therapeutic alliance.

**Couple therapy.** Research points to the importance of therapist variables in the formation of the therapeutic alliance in couple therapy, as well, with one study finding that therapist effects account for 10% of the variance of the therapeutic alliance (Owen et al., 2014). A study that compared the individual therapeutic alliance with 52 individual clients and the couple between-therapeutic alliance with 96 couples, suggested that therapist variables were more important in the development of the between-therapeutic alliance in couple therapy, compared to individual therapy (Bartle-Haring et al., 2012b). With this evidence, studying the effect of therapist behaviors on therapeutic alliance is increasingly important.

Two studies have coded couple therapy sessions to examine therapist-client process predictors of therapeutic alliance. One study looked at the communication process between the three persons in couple therapy, each partner and the therapist, by studying body formation and gaze. They found that when all three participants in the triad were engaged by gazing at each other and displaying welcoming body posture, each person felt included, understood his/her role, and maintained congruent signals resulting in a strong between-therapeutic alliance (de Roten et al., 2000). Another looked at mutual smiling episodes and found that when these were present,

the between-alliance with the therapist was stronger; however, this did not predict the within-alliance between partners (Darwiche et al., 2008).

In regards to specific therapist behaviors, in addition to the Rogerian therapist behaviors of warmth, empathy, presence, and validation, MFT scholars theorize that there are additional core therapist behaviors that are necessary for successful couple and family therapy. Because more than one client is in the therapy session, MFT therapists must conceptualize presenting problems from a systemic perspective and attend effectively to multiple persons. They also must control conflict between partners and make sure that each person has an opportunity to express their perspective and emotions (Blow & Sprenkle, 2001; Sprenkle, Blow, & Dickey, 1999; Sprenkle & Blow, 2004).

Based on this conceptualization of therapist behaviors consisting of warmth, empathy, presence, validation, collaboration, and systemically-based techniques and session control, the author of a dissertation (Evans, 2012) developed a coding system of couple therapist behaviors to examine their moderating effect on couple therapy outcomes. Using her coding system, called the *Ratings of Therapists' General Clinical Skills/Qualities Scale* (TGCSQ; Epstein, McDowell, & Evans, 2009), to code therapist behaviors, she found some, although limited, support for the positive effect of therapist behaviors on overall therapy outcome.

Only two studies have examined specific therapist behaviors as predictors of the therapeutic alliance in couple therapy (Thomas et al., 2005; Werner-Wilson et al., 2003). Both studies used the Working Alliance Inventory, Observer Version (WAI-O; Horvath, 1994) to measure the therapeutic alliance; thus, they only measured the alliances between the therapist and the husband and the therapist and the wife, with the within-alliance being excluded. They coded five-minute increments of the first session at the beginning, middle, and end to examine

different stages of the session. The five therapist behaviors that they coded in both studies were therapist makes a positive statement, makes a negative statement, challenges client, gives advice to the couple, and self-discloses. The first study found that both men and women identified challenging behaviors from the therapist as a predictor of creating a strong between-therapeutic alliance (Werner-Wilson et al., 2003). The study further found that men identified that therapists' positivity influenced the therapeutic bond. However, neither positive nor negative statements made by the therapist affected the between-alliance for women, and making negative statements did not affect the between-alliance for men.

The other study used the same data set as the first study. However, using more sophisticated multivariate statistics, rather than zero-order correlations, they found that therapeutic skills, such as therapists managing partner negative statements for males and challenging for females, predicted a stronger between-alliance in couple therapy. The other therapist behaviors did not predict the between alliance (Thomas et al., 2005). However, neither study examined the Rogerian therapist behaviors of warmth, empathy, presence, validation, collaboration. Moreover, the studies did not examine therapist behaviors that are more systemically oriented.

### **The Current Study**

Although substantial research has been conducted to conceptualize and validate the importance of the therapeutic alliance in couple therapy, less is known about what therapist behaviors predict a strong therapeutic alliance. Theorizing by Carl Rogers and others have focused on the importance of specific therapist behaviors in the development of a strong therapeutic alliance (Keijsers et al., 2000). Considerable research has supported these theories, indicating that therapist warmth (Keijsers et al., 2000), empathy (Feinstein et al., 2015), presence

(Whalen, 2013), validation (de Roten et al., 2000), collaboration (Boardman et al., 2006), and technique factors (Feinstein et al., 2015) are all important predictors. However, the effect of these therapist behaviors on either the within- or between alliance has not been tested in couple therapy.

In addition, no research on predictors of the therapeutic alliance in couple therapy has examined the within-alliance, despite evidence that it is an important component in couple therapy (Anderson & Johnson, 2010). Previous studies have only examined the between-alliance (Bartle-Haring et al., 2012a; Jurek, et al., 2014; Knerr et al., 2011; Thomas et al., 2005; Werner-Wilson et al., 2003). It is possible that different therapist behaviors have different effects on within- and between-alliance. For example, it is possible that collaboration and technique behaviors may directly predict the within-alliance, while the other independent variables may be indirect predictors. Therefore, the purpose of this study was to examine the relationship between the coded behaviors of therapist warmth, empathy, presence, validation, collaboration, and technique factors (systemically-based techniques and session structure) in the first session of couple therapy and two aspects of the therapeutic alliance (between- and within-alliance) immediately after the session for males and females. The following hypotheses were tested:

1. Therapist warmth will significantly predict male and female between-therapeutic alliance and within-therapeutic alliance.
2. Therapist empathy will significantly predict male and female between-therapeutic alliance and within-therapeutic alliance.
3. Therapist presence will significantly predict male and female between-therapeutic alliance and within-therapeutic alliance.



4. Therapist validation will significantly predict male and female between-therapeutic alliance and within-therapeutic alliance.
5. Therapist collaboration will significantly predict male and female between-therapeutic alliance and within-therapeutic alliance.
6. Therapist systemically-based techniques will significantly predict male and female between-therapeutic alliance and within-therapeutic alliance.
7. Therapist session structure will significantly predict male and female between-therapeutic alliance and within-therapeutic alliance.

## **Methods**

### **Participants**

The sample consisted of 34 couples seen at a university MFT clinic located in the northeastern region of the United States. The average age of females was 30.6 ( $SD = 7.6$ ), with a range from 21 to 58 years of age. As for female ethnicity, 81.5% were White, 3.7% were Asian, 7.4% were Latina, and 7.4% were other. As for female education, 17.2% attended high school, 13.8% attended trade school, 27.5% attended college, and 41.3% attended graduate school. The average age of males was 33.4 ( $SD = 8.7$ ), with a range from 18 to 50 years of age. As for male ethnicity, 84.6% were White, 3.8% were Asian, 7.7% were Latina, and 3.8% were other. As for male education, 30.0% attended high school, 13.3% attended trade school, 33.3% attended college, and 23.4% attended graduate school. As for total household income for couples, 25% made less than \$30,000, 28.6% made between \$30,000 to \$69,999, and 39.3% made more than \$70,000, and 7.1% preferred not to answer. The marital status of the couples was not included in the dataset that was used for these analyses; consequently, the marital status of the 34 couples was unknown.

## Procedures

The data for this study came from a university MFT clinic located in the northeastern region of the United States. Clients coming to the clinic for therapy services were given the opportunity to sign an informed consent form to participate in research that stated that assessments, as well as video recordings of therapy, could be used for research purposes. Clients filled out a set of clinical assessments, including an assessment of the therapeutic alliance, each time they came for a session. The completion of regular clinical assessments during the course of therapy was part of the clinic's standard practice of providing high-quality services. Archived data of couples who entered therapy between 2010 and 2014, completed the therapeutic alliance questionnaire immediately after the first session, and had video recordings of their therapy sessions were included in these analyses. This resulted in a dataset containing 34 couples. Many more couples were seen at this clinic during this interval of time, but archived videos were only available for these 34 couples.

IRB approval was first obtained from the University of Connecticut to transfer a copy of the data (video recordings and responses to questionnaires) to BYU. IRB approval was then obtained from Brigham Young University to code the videos and conduct the statistical analysis at BYU. No coding of videos was done at BYU until approval was obtained from the IRB at both universities.

The study utilized the *Ratings of Therapists' General Clinical Skills/Qualities Scale* (TGCSQ; Epstein et al., 2009) to measure therapist behaviors. The principal investigators were trained by the creators of the coding system. The principal investigator predominantly followed the procedures provided by the developers of the coding system. Nine coders were recruited by

providing an undergraduate research class where students could get course credit for coding the video recordings used in this study.

Coders were trained by the principal investigators, who consisted of a university professor and a Ph.D. student. To reach coding proficiency, coders were trained for one month, meeting once a week for two hours, as well as reading about the coding system and practicing outside of the classroom. This deviated from the original developers as they provided four months of training. The coders were first taught the conceptual definition of each code in the TGCSQ. They were then trained by watching three full sessions of therapy twice to understand a live representation of each code in therapy. These videos were of nationally prominent couple therapists doing couple therapy that were made commercially available for training programs for training purposes. After watching a video recording, each coder shared their scores for each code, and the trainers led a discussion about each of the designated codes, with the group coming up with a consensus score. Initially, time spent agreeing on a consensus score ranged between 10 to 20 minutes. During that time, clarification of what qualified as representative of the therapist behaviors measured was provided by the trainers. After four training sessions including watching the three videos and including the work outside of the class, there was a total of 20 training hours. Once the coders could spend less than five minutes on deciding a consensus score as a group, the researchers decided that the coders were ready to code the videos used in these analyses.

Once coding began, coders divided into teams of two and one team of three to code full sessions of therapy. The first session of each case was coded. Because the coding system is based on global codes, where coders assign an overall score for each code based on the entire session, each coder independently watched each session twice and then assigned values for each code.

After independently coding the therapy session, the two coders on the team came together to compare their scores. When there was a discrepancy, each member of the team justified to the other person why they gave the score that they did, explaining their reasoning behind the score. The members then discussed the different scores and often watched relevant parts of the video recorded session together to gain more information. The team ultimately decided upon a consensus score. This method of consensus coding is consistent with the procedures used by the developers of the coding system (Evans, 2012).

**Coder characteristics.** Nine coders were recruited by providing an undergraduate research class where students could get course credit for participating as coders in the study. Therefore, the coders were all students. Of the nine coders, six were female and three were male. Their average age at the time of coding was 21.12. All of them were White. All the coders were either majoring in family life or psychology.

## Measures

**Predictor variables: therapist behaviors.** The therapist behaviors during the initial session of couple therapy were measured using the *Ratings of Therapists' General Clinical Skills/Qualities Scale* (TGCSQ; Epstein et al., 2009). The TGCSQ measures two broad categories of therapist behaviors: **relationship factors** and **technique factors**. The relationship factors dimension of the TGCSQ contains five categories of therapist relational behaviors: warmth, empathy, presence, validation, and collaboration. This part of the measure was developed based on Blow and Sprenkle's (2001) theory that therapist warmth, empathy, presence, validation of the client, and therapist-client collaboration are used by marriage and family therapists, regardless of the specific model of therapy being used. **Warmth** is conceptualized by three behaviors (use of humor to connect with clients, smiling, and voice

tone), **empathy** is conceptualized by one behavior (reflective statements), **validation** is conceptualized by two behaviors (agreement and affirming/legitimizing), **presence** is conceptualized by four behaviors (asking personal questions/showing interest in clients' lives, staying on topic, eye contact, and body language), and **collaboration** is conceptualized by two behaviors (asking clients for their opinions and preferences regarding interventions, tasks, and goals, and collaborative language use displayed by the therapist). The variables are measured on a scale from 0 ("*not at all*," meaning complete absence of the therapist behavior) to 4 ("*very much*," meaning the presence of the therapist behavior to a large degree). Ranges are reported in Table 1. Each of the five variables is a separate independent variable, with a range from 0 to 4.

The **technique factors** of the TGCSQ contain two categories of therapist behaviors: **systemically-based techniques** and **session structure**. The **systemically-based techniques** category contains four behaviors: balance in attention to partners, noting cyclical patterns in couple interaction, circular questioning, and seeking information and/or creating interventions based on multiple environmental levels. The **session structure** category contains four behaviors, as well: control of conflict, pacing and efficient use of time, opportunity for both members of the couple to express concerns and goals, and therapist reinforcement of positive change using positive feedback, encouragement, etc. The variables are measured on a scale from 0 ("*not at all*," meaning complete absence of the therapist behavior) to 4 ("*very much*," meaning the presence of the therapist behavior to a large degree). Each of the two variables is a separate independent variable, with a range of 0 to 4.

Although the seven coded behaviors, had prompts, or examples, for each of them, the prompts were only meant to be a guide. Coders were not to count the frequency of the prompts and then come up with a composite score for the overall behavior, such as empathy. This is

because there might be times when the prompts may not be the best indicators of the behavior. For example, two of the three prompts for warmth are smiling and using humor to connect with clients. However, in a session where the clients are expressing a great deal of sadness or grief, a therapist's warmth would best not include smiling and using humor. Because of that, coders were trained to evaluate the therapist's use of the behavior on a more general level, accounting for context, and then assign a score ranging 0 ("not at all," meaning complete absence of the therapist behavior) to 4 ("very much," meaning the presence of the therapist behavior to a large degree). With five possible choices in the scoring of these measures, these therapist variables are categorical.

**Dependent variable: therapeutic alliance.** The therapeutic alliance was measured by the *Couple Therapy Alliance Scale-revised* (CTAS-r; Pinsof et al., 2008). The CTAS-r consists of twelve items with three subscales: the self/group (between) therapeutic alliance, other (perception of partner between) therapeutic alliance, and the within-couple alliance. Items are measured on a 7-point Likert type scale with higher scores indicating a stronger alliance. Participants completed the CTAS-r after the first session of therapy. Research has shown that the alliance directly after the first session can significantly predict outcome in therapy (Knobloch-Fedders, Pinsof, & Mann, 2004; Knobloch-Fedders et al., 2007; Thomas et al., 2005; Werner-Wilson et al., 2003). The Cronbach's alpha in this sample for the entire scale is .97 for males and .94 for females, showing high reliability. For our analysis, we used the self/group subscale to measure the between-alliance and the within subscale to measure the within-alliance.

*Between-alliance.* The between-alliance in our study refers to the self-score of males and females on the alliance between themselves and the therapist with personal perceptions of the alliance between the couple and therapist included. The self/group between-therapeutic alliance

is measured by six items: “the therapist cares about me as a person,” “the therapist understands my goals in this therapy,” the therapist and I are in agreement about the way the therapy is being conducted,” “the therapist does not understand the relationship between my partner and myself,” “the therapist cares about the relationship between my partner and myself,” and “the therapist does not understand the goals that my partner and I have for ourselves as a couple or co-parents in this therapy.” Each item is rated on a Likert-type scale from 1 (“*Completely Disagree*”) to 7 (“*Completely Agree*”). Items were reverse coded when appropriate, and then all six items were averaged to create a score for the between-alliance scale, with a range of 1 to 7. High scores reflect a stronger between-alliance. The Cronbach’s alpha in our sample for the between-alliance was .93 for males and .95 for females, indicating high reliability.

*Within-alliance.* The within-group alliance is measured by three items: “my partner and I do not accept each other in this therapy,” “my partner and I are in agreement about our goals for this therapy,” “my partner and I are not pleased with the things that each of does in this therapy.” Each item is rated on a Likert-type scale from 1 (“*Completely Disagree*”) to 7 (“*Completely Agree*”). Items were reverse coded when appropriate, and then all three items were averaged to create a score for the within-alliance scale, with a range of 1 to 7. High scores reflect a stronger within-alliance. The Cronbach’s alpha for this sample for the within-group alliance was .90 for males and .87 for females, indicating high reliability.

## **Analysis**

The original plan of statistical analysis was to use structural equation modeling with Bayes estimation, utilizing the statistical program Mplus version 7.4 (Muthén, & Muthén, 1998-2015). However, although the response options for the therapist behaviors had a theoretical range of five, with values ranging from 0 to 4, three of the seven therapist behavior variables had actual

responses in less than five of the categories, and one variable had responses in only three categories (see Table 1). In addition, the responses tended to cluster in the categories of 3 and 4. Consequently, the therapist behavior variables are best characterized as categorical variables.

Because Mplus version 7.4 (Muthén, & Muthén, 1998-2015) does not handle independent categorical variables, we made the decision to conduct the analysis by running multiple One-Way ANOVAs using SPSS. In each ANOVA, there was one independent variable from the seven therapist behavior variables (warmth, empathy, presence, validation, collaboration, systemically-based techniques, and session structure) and one dependent variable from the four alliance variables (female between-alliance, male between-alliance, female within-alliance, and male within-alliance).

Because the values in therapist behavior variables were not evenly distributed, with 11 of the 35 cells (five response options times seven variables) having two or fewer responses, a decision needed to be made about how to best recode the variables. It is possible that one method of recoding could bias the results; therefore, a decision was made to use three different coding schemes and run ANOVAs using each scheme in order to increase the robustness of the findings of the study.

As indicated in Table 2, the first coding scheme included three categories, instead of the original five. The values of 0, 1, and 2 were recoded as 0, the value of 3 was recoded as 1, and the value of 4 recoded as 2. With this method, because most of the original values were either 3 or 4 (see Table 1), combining the values of 0, 1, and 2 created a more even distribution of values. Thus, the first coding scheme resulted in values of 0, 1, and 2. In the second coding scheme, the therapist behaviors were recoded into binary categories to reflect high and low presence of behaviors. Consequently, the values ranging from 0 to 2 were recoded as 0, and the values of 3



and 4 were recoded as 1. Therefore, a value of 0 reflected low presence of therapist behaviors, whereas a value of 1 reflected high presence of these behaviors. In the third coding scheme, the variables were again recoded into binary categories, but this time the goal was to have a more even distribution of responses. Because a high frequency of responses was in the highest category of 4, the therapist behavior values ranging from 0 to 3 were recoded as 0, and the value of 4 was recoded as 1.

## Results

### Preliminary Results

The means for therapist behavior variables are reported in Table 3. These results, as well as the frequencies of the independent variables, which are reported in Table 3, indicate that the values for the therapist behavior variables tended to cluster at the high end of the scales. The values for the within- and between-alliances also clustered at the high end of the spectrum. With a range of 1 to 7 with 1 representing low alliance and 7 representing high alliance and 4 as neutral, the means for alliance variables for husbands and wives were all between 4 and 7. This suggests that the means of the within- and between alliances were at the higher end of the spectrum indicating that the alliance scores were generally rated as more positive for our sample.

### ANOVA Results

**Recoding scheme #1.** The first recoding scheme for the therapist behaviors combined the values of 0, 1, and 2 into a value of 0, with the value of 3 being recoded to 1, and the value of 4 being recoded to 2. Using female between-alliance as the dependent variable, there was no significant difference in alliance for the three levels of warmth [ $F(1, 21) = .31, p = .74$ ], empathy [ $F(1, 21) = .62, p = .55$ ], validation [ $F(1, 21) = .24, p = .79$ ], presence [ $F(1, 21) = .47, p = .64$ ], collaboration [ $F(1, 21) = .86, p = .44$ ], systemically-based techniques [ $F(1, 21) = .40, p = .68$ ],

and session structure [ $F(1, 21) = 1.67, p = .22$ ]. Similarly, there was no difference in male between-alliance for the three levels of warmth [ $F(1, 20) = .24, p = .79$ ], empathy [ $F(1, 20) = 1.48, p = .26$ ], validation [ $F(1, 20) = .70, p = .51$ ], presence [ $F(1, 20) = .32, p = .73$ ], collaboration [ $F(1, 20) = 1.29, p = .30$ ], systemically-based techniques [ $F(1, 20) = .23, p = .80$ ], and session structure [ $F(1, 20) = .57, p = .57$ ].

The ANOVA's for within-alliance yielded similar nonsignificant results. For the means of the female within-alliance, there was no significant difference in the three levels of warmth [ $F(1, 23) = .07, p = .94$ ], empathy [ $F(1, 23) = .75, p = .49$ ], validation [ $F(1, 23) = 1.63, p = .22$ ], presence [ $F(1, 23) = .22, p = .80$ ], collaboration [ $F(1, 23) = .11, p = .90$ ], systemically-based techniques [ $F(1, 23) = .21, p = .81$ ], and session structure [ $F(1, 23) = .01, p = .99$ ]. For the means of the male within-alliance, there was no significant difference in the three levels of warmth [ $F(1, 22) = .69, p = .52$ ], empathy [ $F(1, 22) = .48, p = .63$ ], validation [ $F(1, 22) = .79, p = .47$ ], presence [ $F(1, 22) = .01, p = .99$ ], collaboration [ $F(1, 22) = 1.37, p = .28$ ], systemically-based techniques [ $F(1, 22) = .01, p = 1.00$ ], and session structure [ $F(1, 22) = .10, p = .90$ ]. Therefore, transforming the therapist behaviors into three-level variables and analyzing their relationship with the therapeutic alliance using ANOVAs yielded nonsignificant results.

**Recoding scheme #2.** The second coding scheme combined the values ranging from 0 to 2 to 0, and the values of 3 and 4 to 1. With female between-alliance as the dependent variable, there was no significant difference in alliance for low or high levels of the dichotomous variables of warmth [ $F(1, 21) = .00, p = .98$ ], empathy [ $F(1, 21) = .28, p = .60$ ], validation [ $F(1, 21) = .49, p = .49$ ], presence [ $F(1, 21) = .00, p = .99$ ], collaboration [ $F(1, 21) = .79, p = .38$ ], systemically-based techniques [ $F(1, 21) = .18, p = .68$ ], and session structure [ $F(1, 21) = 1.91, p = .18$ ]. Similarly, there was no difference in male between-alliance for low or high levels of the

dichotomous variables of warmth [ $F(1, 20) = .46, p = .51$ ], empathy [ $F(1, 20) = 1.98, p = .18$ ], validation [ $F(1, 20) = .14, p = .71$ ], presence [ $F(1, 20) = .15, p = .70$ ], collaboration [ $F(1, 20) = .48, p = .50$ ], systemically-based techniques [ $F(1, 20) = .47, p = .50$ ], and session structure [ $F(1, 20) = .92, p = .35$ ].

The ANOVA's for within-alliance yielded similar nonsignificant results. For the means of the female within-alliance, there was no significant difference in low or high levels of the dichotomous variables of warmth [ $F(1, 23) = .12, p = .73$ ], empathy [ $F(1, 23) = .14, p = .71$ ], validation [ $F(1, 23) = .15, p = .71$ ], presence [ $F(1, 23) = .37, p = .55$ ], collaboration [ $F(1, 23) = .19, p = .67$ ], systemically-based techniques [ $F(1, 23) = .40, p = .53$ ], and session structure [ $F(1, 23) = .01, p = .94$ ]. For the means of the male within-alliance, there was no significant difference in low or high levels of the dichotomous variables of warmth [ $F(1, 22) = 1.16, p = .29$ ], empathy [ $F(1, 22) = .10, p = .76$ ], validation [ $F(1, 22) = .00, p = .99$ ], presence [ $F(1, 22) = .01, p = .91$ ], collaboration [ $F(1, 22) = .01, p = .92$ ], systemically-based techniques [ $F(1, 22) = .01, p = .92$ ], and session structure [ $F(1, 22) = .08, p = .78$ ]. Therefore, transforming the therapist behaviors into dichotomous variables per recoding scheme #2 and analyzing their relationship with the therapeutic alliance using ANOVAs yielded nonsignificant results.

**Recoding scheme #3.** The third recoding scheme consisted of collapsing the values of 0,1,2, and 3 into a single category of 0, with the value of 4 being recoded to 1. With female between-alliance as the dependent variable, there was no significant difference in alliance for the dichotomous variables of warmth [ $F(1, 21) = .57, p = .46$ ], empathy [ $F(1, 21) = .22, p = .64$ ], validation [ $F(1, 21) = .05, p = .83$ ], presence [ $F(1, 21) = .89, p = .36$ ], collaboration [ $F(1, 21) = 1.69, p = .21$ ], systemically-based techniques [ $F(1, 21) = .81, p = .38$ ], and session structure [ $F(1, 21) = 2.69, p = .12$ ]. Similarly, there was no difference in male between-alliance for low or high

levels of the dichotomous variables of warmth [ $F(1, 20) = .00, p = .96$ ], empathy [ $F(1, 20) = .00, p = .98$ ], validation [ $F(1, 20) = .72, p = .41$ ], presence [ $F(1, 20) = .26, p = .62$ ], collaboration [ $F(1, 20) = 2.59, p = .12$ ], systemically-based techniques [ $F(1, 20) = .14, p = .71$ ], and session structure [ $F(1, 20) = .62, p = .44$ ].

The ANOVA's for within-alliance yielded similar nonsignificant results. For the means of the female within-alliance, there was no significant difference in low or high levels of the dichotomous variables of warmth [ $F(1, 23) = .00, p = .99$ ], empathy [ $F(1, 23) = 1.34, p = .26$ ], validation [ $F(1, 23) = 3.20, p = .09$ ], presence [ $F(1, 23) = .00, p = .95$ ], collaboration [ $F(1, 23) = .16, p = .70$ ], systemically-based techniques [ $F(1, 23) = .31, p = .58$ ], and session structure [ $F(1, 23) = .01, p = .94$ ]. For the means of the male within-alliance, there was no significant difference in low or high levels of the dichotomous variables of warmth [ $F(1, 22) = .00, p = .97$ ], empathy [ $F(1, 22) = .30, p = .59$ ], validation [ $F(1, 22) = 1.23, p = .28$ ], presence [ $F(1, 22) = .00, p = .96$ ], collaboration [ $F(1, 22) = 2.03, p = .17$ ], systemically-based techniques [ $F(1, 22) = .00, p = .96$ ], and session structure [ $F(1, 22) = .06, p = .80$ ]. Therefore, transforming the therapist behaviors into dichotomous variables per recoding scheme #3 and analyzing their relationship with the therapeutic alliance using ANOVAs yielded nonsignificant results.

### **Discussion**

We hypothesized that the five therapist relationship behaviors (warmth, empathy, presence, validation, and collaboration) and technique factors (systemically-based techniques and session structure) would significantly predict two therapeutic alliance variables (between- and within-therapeutic alliance) for males and females. However, none of the hypotheses was supported. Therefore, our results suggest that there is no relationship between the therapist

variables of warmth, empathy, presence, validation, collaboration, systemically-based techniques, and session structure and the therapeutic alliance.

These results were unexpected. Research on individual therapy has consistently found that therapist traits including warmth, empathy, validation, presence, collaboration and therapist techniques, such as creating an egalitarian relationship with clients, predict a strong alliance (Boardman et al., 2006; Jung et al., 2015). Research further shows that the emotional affect of the therapist can influence the alliance with clients. If affect is positive, it strengthens the alliance (Chui, Hill, Kline, Kuo, & Mohr, 2016), whereas if it is negative it can weaken the alliance (Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2015). Consequently, these results in a study of couple therapy were not consistent with previous studies of individual therapy.

However, the lack of significant results in this study is, in some ways, consistent with the two previous studies of couple therapy that used interactional coding to examine the influence of therapist effects on the therapeutic alliance. Although Werner-Wilson and colleagues (2003), as well as Thomas and colleagues (2005), reported some therapist behaviors that predicted the therapeutic alliance, a closer examination of their results indicates that most of the therapist behaviors were not significantly correlated with the therapeutic alliance. Of the two studies, both of which used the same dataset, the 2005 article used multivariate statistics, which is a more appropriate statistical test than the zero-order correlations that were used in the 2003 study. Results from the 2005 study found that only four of 36 statistical tests that examined the relationship between specific therapist behaviors and the bond, task, and goal dimensions of the therapeutic alliance were statistically significant. In other words, nearly 90% of the tests were nonsignificant.

It should be noted, though, that the therapist behaviors that these authors studied were different from those examined in this study. They examined therapist behaviors, such as positive statements, negative statements, challenging statements, self-disclosure, and advice giving. Consequently, they were examining different therapist behaviors compared to the current study. Nevertheless, their lack of significant results in their examination of the effect of therapist behaviors is comparable to the findings of the current study.

Why did the current study not find significant associations between therapist behaviors and the therapeutic alliance, especially in the context of significant correlations in individual therapy? Maybe these results point to other factors that may be important in forming the between- and within-alliances in couple therapy. For example, Pinsof and colleagues (2008) found that the within- and between-alliances that are unique to systemic therapy seemed to have more weight in couple therapy than the basic conceptualization of bonds, goals, and tasks (Bordin, 1979), suggesting that clients are more concerned about who is aligned with whom in therapy than the tasks, bonds, and goals of therapy. Clients may be concerned with the different relationships in the room and could be responding more to the dynamics in the different relationships than just therapist behaviors. In individual therapy, the focus of the client remains solely on the therapist, whereas multiple relational processes are present in couple therapy.

In addition, perhaps the processes where therapist and clients are reciprocally engaged may be more important in the formation of the therapeutic alliance in couple therapy than therapist behaviors, when viewed in isolation. In fact, research suggests that therapist-client process variables significantly predict the alliance in couple therapy. De Roten and associates (2000) found that when all three participants in the therapeutic triad (therapist and both partners) were engaged by gazing at each other and displaying welcoming body posture, each person felt

included, understood his/her role, and maintained congruent signals resulting in a strong overall therapeutic alliance. Other research suggests that when mutual smiling episodes were present, the between-alliance with the therapist was stronger (Darwiche et al., 2008).

Another possible explanation for the nonsignificant results may concern the decision to code the first session and examine those therapist behaviors with their perception of the therapeutic alliance immediately after the first session. While evidence shows that the alliance begins to form as early as the first session (Knobloch-Fedders et al., 2004; Knobloch-Fedders et al., 2007; Thomas et al., 2005; Werner-Wilson et al., 2003), it may be a possibility that client characteristics are more salient in the early sessions of therapy. Perhaps these characteristics influence client perception of the alliance more so than the actual behavior of the therapist. In fact, evidence shows that clients who are more reticent to show emotions when coming into therapy develop a stronger therapeutic alliance later in therapy (Knerr et al., 2011). This suggests that client willingness and perception may be more important than actual therapist behaviors towards the development of the therapeutic alliance at the beginning stage of therapy. This also points to possibly that examining the relationship between therapist behaviors and the therapeutic alliance in later sessions of couple therapy would be beneficial to study. Moreover, comparing the relationship between therapist behaviors and the therapeutic alliance in early and later sessions could confirm this hypothesis.

Another possible explanation for the nonsignificant results could be that therapist behaviors were not accurately captured in the current study. The coding scale that was used in the study, *Ratings of Therapists' General Clinical Skills/Qualities Scale* (TGCSQ; Epstein et al., 2009), uses a global coding format, meaning that a single value is assigned for each behavioral code after watching the entire session. One study of individual therapy that examined the

relationship between therapist behaviors and the therapeutic alliance provides further support that global coding may be an ineffective method for assessing therapist behaviors. Boardman and associates (2006) used the *Motivational Interviewing Skill Code* (MISC; Miller & Mount, 2001; Moyers, Miller, & Hendrickson, 2005), which has a subscale that utilizes both global coding for therapist behaviors on a scale of 1 to 7 with “1” being a low presence of behaviors and “7” being a high presence of behaviors, as well as a subscale that counts specific behaviors. While some significant results were found using the subscales that counted the frequency of specific behaviors, there were no significant results predicting the therapeutic alliance with the global measure scale. Thus, global coding may lack the specificity necessary to adequately code therapist behaviors.

Another potential disadvantage to using a global coding scheme is the possibility that global coding schemes may lead to low variability in the data. In fact, a look at our data revealed that our predictor variables all had relatively low variation (see Tables 3 and 4). For example, with a range of 0 to 4, the mean of warmth, empathy and validation were all over 3.0, and the standard deviations were modest. In fact, many of the variables had 50% or more of the data as 1 value. Thus, the distribution of the variables was affected by low variation and heavily weighted toward one value. Most of the therapists rated high on the presence of the predictor variables. Having more sessions included where therapists rated low on these behaviors may have produced more variance and may have produced significant results.

Finally, turning our attention to the dependent variable, it is possible that Pinsof’s measurement of the therapeutic alliance may not adequately capture the nuances of the therapeutic alliance in couple therapy. Although the measure developed by Pinsof and associates (2008) makes important contributions by differentiating between- and within-alliances, the items



used in the measure still focus on Bordin's (1979) original conceptualization of the alliance consisting of bonds, tasks, and goals. With the dynamics of the multiple relationships within couple relationships being more important than the issues of bonds, tasks, and goals (Pinsof et al., 2008), it is possible that a different measure of the alliance in couple therapy would better capture the quality of the within- and between-alliances.

### **Limitations**

The results of the study may not be generalizable to all populations. Due to the nature of the study, we only had access to clients seeking therapy from one MFT university-based training clinic located in the northeastern region of the U.S. Also, there may be sampling bias present in the study because the criteria for inclusion in the study were that they needed to be in therapy, completing assessments, and have had the first session of therapy recorded. Another result is that the sample size was small.

Furthermore, the constructs used in the study may not be the best way to measure therapist variables or therapeutic alliance variables. While the choice of what to measure in the TGCSQ is based on previous research, the measure itself has still not been empirically validated. Therefore, more research needs to be done on the measure to validate its use. Also, the way the therapeutic alliance is measured in the CTAS-r may need to shift further away from how the therapeutic alliance is measured for individual psychotherapy because relational components have higher weight in couple therapy. While the research on the therapeutic alliance in individual therapy provides a starting point in studying the alliance in couple therapy, the distinct differences in these modes of treatment needs to be considered in future research of the alliance in couple therapy.

Finally, when considering the issues of sample bias and construct validity in our study, the conclusions from the statistical analyses may not be valid. Perhaps using other methods may have increased our conclusion validity. Our results may be valid, but it may also be possible that we found non-significant results when significance may exist. Further research using more validated measures might confirm significance.

### **Clinical Implications**

MFT scholars have argued that therapist behaviors are important for success in couple and family therapy. Blow and Distelberg (2006) state that the role of the therapist is critical in the delivery therapy, and Blow and Sprenkle (2006) emphasize the importance of skillful therapists using specific models to guide the delivery of factors independent of models. We echo the argument of Sprenkle and Blow (2007) that MFT research needs to focus on therapist behaviors and expand future research to consider all the relational dynamics present in couple therapy. We also know that looking at reciprocal dynamics between therapists and clients could help therapists and researchers understand more about what is important in producing strong therapeutic alliances in couple therapy. Research in MFT on therapist behaviors and the therapeutic alliance needs to focus on the relational process dynamics in therapy.

Although this study suggests that therapist factors do not significantly predict the between- nor the within-therapeutic alliances in couple therapy, there is still a scholarly argument, based on theory and studies from individual therapy, that what the therapist does in session makes a difference in the development of the therapeutic alliance and the ultimate success of therapy. This line of research in MFT should not be abandoned. In fact, it could be expanded by developing measures for other dynamics that the therapist and client participates in

that may be influencing the therapeutic alliance, both between and within, in couple therapy.

Additional research needs to be conducted to better understand these dynamics in our field.

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Table 1

*Frequencies for therapist behaviors: warmth, empathy, presence, validation, collaboration, and technique factors*

	Range	0	1	2	3	4
Therapist Warmth	0-4	2	2	2	13	15
Therapist Empathy	2-4			9	9	16
Therapist Validation	1-4		5	9	11	9
Therapist Presence	1-4		2	2	12	18
Therapist Collaboration	0-4	3	8	8	10	5
Systemic Techniques	0-4	1	4	13	10	6
Session Structure	1-4		6	7	17	4

Table 2

*Recoding schemes for therapist behaviors: warmth, empathy, presence, validation, collaboration, and technique factors*

	Original Values				
	0	1	2	3	4
New values Scheme #1	0	0	0	1	2
New values Scheme #2	0	0	0	1	1
New values Scheme #3	0	0	0	0	1

Table 3

*Means and standard deviations of therapist variables (warmth, empathy, validation, collaboration, presence, and technique factors) and Male and Female alliance variables (between- and within-)*

	Mean	SD
1. Warmth	3.09	1.14
2. Empathy	3.21	.85
3. Validation	2.71	1.03
4. Presence	3.35	.85
5. Collaboration	2.18	1.22
6. Technique	2.51	.88
7. Female Between	5.54	1.23
8. Female Within	5.63	1.13
9. Male Between	5.78	1.04
10. Male Within	5.71	1.12