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The Role of the Therapeutic Alliance on the Successful Outcome of Transfers in
Marriage and Family Therapy Cases

Melanie Louise Cox

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Master of Science

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ABSTRACT

The Role of the Therapeutic Alliance on the Successful Outcome of Transfers in Marriage and Family Therapy Cases

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The transfer of cases is common in the practice of Marriage and Family Therapy (MFT). This is especially true in training clinics, where student interns regularly graduate and transfer their cases to students still in the program. Although some research has examined the effect of transferring cases of individual psychotherapy on the success of therapy outcome, little research has examined transfer cases in MFT settings. The transfer process can be conceptualized as a rupture in the therapeutic alliance. From this perspective, a strong therapeutic alliance may mitigate the negative impact of the rupture. Consequently, it was hypothesized that a strong therapeutic alliance with the initial therapist would predict a successful transfer process. Similarly, it was hypothesized that a strong therapeutic alliance with the new therapist would predict a successful transfer process. To test these hypotheses, data were examined from 49 individual, couple, and family therapy cases that experienced a transfer at an MFT training program at a university in the northeastern part of the United States. Results indicated that the therapeutic alliance with neither the initial or new therapist predicted successful therapy transfer. A possible explanation for the lack of significant results may be the small sample size, which limited the statistical power of the analyses. In addition, because of the small sample size, the individual, couple, and family cases were combined in the analyses. Because the therapeutic alliance in couple and family cases has different dimensions than it does in individual cases, it is possible that the true effect of the therapeutic alliance on transfer success was masked in the combined analysis.

Keywords: therapeutic alliance, dropout, transfer, marriage and family therapy

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The Role of the Therapeutic Alliance on the Successful Outcome of Transfers in Marriage and Family Therapy Cases

Transferring clients from one therapist to another is a reality in psychotherapy. Although not ideal, it sometimes happens where therapists leave an agency, creating the need to transfer clients to new therapists. This is especially true in training clinics, where there is a high turnover of therapists due to graduation (Clark, Robertson, Keen, & Cole, 2011). In fact, one scholar coined the term, “the transfer syndrome” to characterize the pattern of frequent transfers in training clinics (O’Reilly, 1987). This is cause for concern because research on individual psychotherapy has found that there is a high level of dropout in clients following transfer to a new therapist. Research has also shown that dropout rates after transfer range from 10%-69% in various clinics (Wapner, Klein, Friedlander & Andrasik, 1986). In addition, many clients experience negative outcomes such as symptom reoccurrence or increase in other negative symptoms like anxiety or emotional withdrawal after their case is transferred (Clark, Cole, & Robertson, 2014).

Frequent transfers are common in Marriage and Family Therapy (MFT) training clinics, as well. As student therapists, trainees will be at a clinic temporarily, seeing clients for up to a couple of years. However, almost all the research on the process and outcomes of transfers has occurred with clients in individual therapy; very little research has examined this phenomenon among couple and family cases. One exception is a recent study that examined transfers among individual, couple, and family cases (Clark et al., 2011). These researchers found that therapists taking certain preparatory actions, such as having transfer sessions with the new therapist and validating loss of relationship, predicted a more successful transfer (Clark et al., 2011). However, they combined all modalities of treatment in their analysis and they did not look at individual,

couple, and family cases separately. This is problematic because it sets individual cases equal with couple and family cases, even though the later has more people in session and a different therapy structure.

The therapeutic alliance potentially plays a significant role in the successful transfer to a new therapist. Transferring clients from one therapist to another may involve rupturing the vital relationship that was formed when the first therapist built a relationship with her clients. The therapeutic alliance has been studied in depth (Anderson & Johnson, 2010; Anker et al., 2010; Diener & Monroe, 2011; Gelso & Carter, 1994; Miller et al., 2015; Sharf, Primavera, & Diener, 2010) and is predictive of successful therapy outcomes (Ackerman & Hilsenroth, 2001; Friedlander, Escudero, Heatherington, & Diamond, 2011) and a lower dropout rate (Roos & Webart, 2013). MFT scholars have suggested that a good therapeutic alliance with the first therapist may positively influence a successful transfer, especially as the old therapist vouches for the new therapist in transfer sessions (Williams & Winter, 2009). However, the effect of the therapeutic alliance on transfer case outcomes has not been studied among couple and family cases.

The purpose of this study is to analyze the outcome of transfers in marriage and family therapy cases, including individual, couple, and family cases. Also, the study will examine how the therapeutic alliance with the original therapist predicts successful transfer. In addition, it will examine the effect of the formation of the therapeutic alliance with the new therapist on the success of the transfer.

Literature Review

In all types of psychotherapy, clients sometimes shift from one therapist to another. Transfers are a common part of clinical practice. The definition of transfers in psychotherapy is

changing therapists before the client has met therapy goals, with the new therapist continuing treatment (Clark et al., 2014). This happens in all therapy clinics, sometimes due to lack of treatment specialty or a poor therapeutic alliance between one therapist and the client. It is especially common in training clinics, where students regularly graduate.

In psychotherapy, changing therapists often has negative effects on therapy outcome (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008). Specifically, research has found higher dropout rates among transfer cases. For example, studies on transfer in individual therapy have found that changing to a different therapist doubles the likelihood of clients discontinuing therapy prematurely (O'Brien, Fahmy, & Singh, 2009). The high rate of post-transfer dropout is illustrated in a recent study of transfer cases in individual therapy, which found that 34.2% of the transfer cases never came back to therapy after the transfer, 26.8% of the cases attended one to three post-transfer sessions, and 40% came at least four times post-therapy (Sauer, Rice, Richardson, & Roberts, 2016).

A higher rate of dropout, which is best defined as early termination of therapy before accomplishing treatment goals (Swift & Greenburg, 2014), is concerning because premature dropout from therapy has notable negative consequences. Many clients do not attend therapy long enough to reach a clinically significant level of change (Hansen, Lambert, & Foreman, 2002). There are varying reasons for a client dropping out of therapy: he may not have reached desired therapy outcomes, did not trust the therapist, did not like how the therapist talked about things, did not agree on therapeutic goals, or felt like he was not improving. Clients who dropout of therapy often report dissatisfaction with therapy, and feel unmotivated to seek professional help in the future (Roos & Werbart, 2013; Swift & Greenburg, 2015; Swift, Greenberg, Whipple, & Kominiak, 2012). In these cases where symptoms persist, other systems, such as family

members, friends, work associates, and employers, are also negatively impacted (Swift et al., 2012).

When clients dropout of therapy, it also affects the mental health delivery system because it can hinder clinic productivity and waste mental health funding, especially if therapy hours were scheduled for clients who are not showing up for therapy (Barrett et al, 2008; Kazdin, 1996; Swift et al., 2012; Swift & Greenburg, 2015). By skipping these sessions, the clinic has wasted hours that could be scheduled with clients who would benefit from coming to therapy. Also, without an obvious termination, therapists may spend weeks trying to communicate with the client, taking unnecessary space in the case load.

It is also disruptive for the therapist to have clients dropout of therapy. The therapist's own internal system can be impacted by dropouts by decreasing self-worth if the therapist feels they are not effectively helping others (Swift et al., 2012; Swift & Greenburg, 2015). The therapist invests time and energy into relationships, and there is loss in not clearly ending the relationship. Therapists may not know what was unsatisfactory to the client, making improvement difficult for self of the therapist work. Thus, there is importance in working to prevent dropouts from happening in therapy.

Moderators of Outcome in Transfer Cases

Despite the higher likelihood of negative outcomes among transfer cases, there is variation in outcomes, with some transfers even achieving positive outcomes (Sauer et al., 2016). Unfortunately, very little empirical research has examined possible moderating variables. One study examined predictors of successful therapy transfers among 268 individual, couple, and family cases that were seen at an MFT training clinic (Clark et al., 2011). Analysis indicated that 80.6% of the cases were classified as successful transfers, which was operationalized as clients

attending at least four post-transfer sessions. It is important to note, however, that this definition misses the population that ends therapy before completing four post-transfer sessions because they have achieved what they wanted from therapy (Knobloch-Fedders, Pinsof, & Mann, 2004). Results indicated that client gender, client age, presenting problem, therapist age, therapist gender, and therapy modality (individual, couple, or family) were all nonsignificant predictors of successful transfer. On the other hand, the number of co-therapy sessions that included the outgoing and new therapists was a significant predictor of successful transfer. Cases that had four or more co-therapy sessions had an 89.4% success rate, compared to a 77.7% rate among cases with three or fewer co-therapy sessions. In addition, clients who had previously experienced a transfer were more likely to have a successful transfer.

Therapeutic alliance. A potential moderating variable for transfer case outcome is the therapeutic alliance, which is the relationship that is developed between the clients and therapist (Gelso & Carter, 1994; Horvath & Bedi, 2002; Sharf, et al., 2010). Indeed, the APA Division 29 Task force on Empirically Supported Therapy Relationships validated the therapeutic alliance as an important change factor in therapy (Norcross, 2001). One study found that, out of approximately 4,000 cases, the therapeutic alliance was the most important element influencing therapy outcomes, regardless of treatment modality (Horvath, Del Re, Flückiger, & Symonds, 2011). Indeed, the alliance has been found to be two times more important than any other predictor of therapy outcome (Friedlander, Escudero, & Heatherington, 2006; Wampold, 2001).

The alliance has been conceptualized as consisting of three main components: agreement on therapy goals, agreement on the tasks of therapy, and the emotional connection between therapist and client (Bordin, 1979). In addition, it is important that the client feel safe in therapy and feels a sense of trust towards the therapist (Roos & Webart, 2013). Friedlander, Escudero,

and Heatherington (2006) identify four pillars of the alliance, which have some overlap with Bordin's (1979) foundational definition: engagement, connection, safety, and shared purpose. Although the alliance often develops in the first session, it shifts and alters throughout treatment, creating necessity to continually track the alliance (Knobloch-Fedders et al., 2007; Wolfson, 2007).

There is considerable evidence that a strong therapeutic alliance is predictive of successful outcome in couple and family therapy (Anderson & Johnson, 2010; Friedlander et al., 2006; Sprenkle & Blow, 2004). A meta-analysis of seven couple therapy studies found a statistically significant average correlation between therapy alliance and outcome of .37 (Friedlander, Escudero, Heatherington, & Diamond, 2011). One couple therapy study found that the therapeutic alliance predicted 5% of the variance of therapy outcome for men and 17% for women (Knobloch-Fedders et al., 2007). In a study of Emotionally Focused Couples Therapy, alliance accounted for 22% of the variance in couple satisfaction after therapy, and 29% at a later follow up (Johnson & Talitman, 1997).

The effect of the therapeutic alliance on therapy outcome extends to dropout. A meta-analysis of 11 individual psychotherapy studies found an average effect size of $d = .55$ in the relationship between the therapeutic alliance and dropout (Sharf, et al., 2010), with clients more likely to dropout when the alliance was not strong. Moreover, in a study of a 15-session protocol of couple therapy for alcohol addiction (Raytek, McCrady, Epstein, & Hirsch, 1999), couples who had a strong alliance with their therapist were more likely to complete treatment; in addition, regardless of whether they completed treatment or not, therapeutic alliance was positively correlated with the number of sessions attended.

It is important to note that the therapeutic alliance is more complex in couple and family therapy because of the presence of multiple clients, which necessitates the therapist developing a strong alliance with all family members present. In couple therapy, one family member may not feel she chose to come to therapy, may have different goals from the rest of the family, or may not agree with other family members on how she wants change to happen (Rait, 2000). When working with a couple or family, it is possible to have a “split alliance,” where the therapist’s alliance is strong with some family members, but weak with others. “Split alliances” are predictive of poorer therapeutic progress if left unattended (Pinsoff, 1995). Consequently, the therapist must consistently monitor the way joining with one client may become an alliance rupture to other family members (Pinsof & Catherall, 1986; Robbins, Turner, Alexander, & Perez, 2003). Not only is the therapist balancing the alliance with each person in the family unit, but with the couple or family unit as well (Friedlander et al., 2006; Rait, 2000). Indeed, research has shown the importance of the alliance between partners is a stronger predictor of couple therapy outcomes than the alliance between the partners and the therapist (Anderson & Johnson, 2010). However, there is not enough research that looks at alliance in MFT that accounts for all family members. Rather, most of the measures treat the family or couple alliance in an individual mindset, only asking about the perspective of the respondent.

Alliance Rupture

Therapeutic ruptures are a thoroughly researched element of the therapeutic alliance. It is valuable to notice this element of the therapeutic relationship as it may help explain dropout from therapy. Indeed, the effect of the therapeutic alliance on the outcome of transfer cases may be explained by the concept of therapeutic rupture. Therapeutic rupture is defined as decreasing quality or strength in the therapeutic alliance (Ackerman & Hilsenroth, 2001; Safran, 1993).

Ruptures may manifest as clients avoiding homework or therapeutic assignments, being unresponsive to interventions, seeking validation, or refusing to address the therapeutic relationship (Ackerman & Hilsenroth, 2001; Safran, Crocker, McMain, & Murray, 1990). Clients feeling unsafe from a therapeutic rupture may withdraw, distance, or avoid the therapist (Watson & Greenburg, 2000). Additionally, clients may react with passive hostility to the therapist or may say negative things about the therapist in session (Ackerman & Hilsenroth, 2001; Safran et al., 1990; Watson & Greenburg, 2000).

Although alliance ruptures are a normal part of treatment in therapy if the rupture is not addressed or repaired, it can result in dropout (Ackerman & Hilsenroth, 2001; Friedlander et al., 2006; Safran, 1990; Safran et al., 1993). However, when addressed explicitly, working through ruptures increases strength of the therapeutic alliance (Ackerman & Hilsenroth, 2001; Knobloch-Fedders, et al., 2007; Kuhlman, Tolvanen, & Seikkula, 2013; Norcross, 2001; Pinosof, 2005; Rait, 2000; Safran, 1993; Safran, Muran, & Eubanks-Carter, 2011).

Research has found that therapeutic ruptures are more common when the therapist overshares personal emotional experiences or has other inappropriate therapist disclosure, has poor structure and leadership of session, does not pace the session well, does not create safety for all family members, misunderstands clients, and goes against client desired goals or does not meet these goals (Ackerman & Hilsenroth, 2001; Coady & Marziali, 1994; Eaton, Abeles, & Gutfreund, 1993; Price & Jones, 1998; Rait, 2000). These behaviors of the therapist can exacerbate alliance ruptures, creating a deeper disconnect between client and therapist (Ackerman & Hilsenroth, 2001) and increasing the risk for poor therapeutic outcome.

Therapeutic Alliance and the Success of Transfer in Couple Therapy

The concept of the therapeutic rupture may help explain why the therapeutic alliance may have an effect on the success of transfer in individual, couple therapy, or family therapy. It is possible to conceptualize the transfer of clients as a therapeutic rupture, which increases the risk of dropout during the transfer process. When the risk for rupture is minimized, the clients are more likely to successfully transfer to their new therapist. This reasoning is supported by a qualitative study of 11 transfer cases, including individuals, couples, and families, examined clients' perceptions of the transfer experience (Clark et al., 2014). Using grounded theory, their analysis revealed a central category of "Creating a Safety Net." The authors described the core to their theory of successful client transfer by saying

Clients who continued with the transfer process related that the clinicians ... responded to them in various ways that helped them manage their initial concerns and feel safe enough to remain in treatment. In essence, the therapist ... provided a safe holding environment during the stressful transition period. (p. 179)

According to the theory that the authors developed, based on their qualitative interviews, clients' trust of their current therapist was a key ingredient in the creation of a safety net. They stated, "Consistently, the clients reported trusting the outgoing therapist to take care of them during the transition process. The therapist's care and attention to the client's concerns seemed to provide the assurance necessary to allow the client to tolerate the distress of the transition" (Clark et al., 2014, p. 184). Trust and safety have been conceptualized as important components of the therapeutic alliance (Friedlander et al., 2011). In terms of therapeutic alliance rupture, therapists who created a safety net minimized the degree of rupture.

A quantitative study by Clark et al. (2011), found that pre-transfer co-therapy sessions that included the outgoing and incoming therapists were predictive of successful transfers, suggesting that the development of a therapeutic alliance with the incoming therapist may predict successful transfer outcomes. With clients having the opportunity to meet and develop a relationship with their new therapist before the transfer actually occurs, they are able to develop a good therapeutic alliance with them. Consequently, they are less likely to dropout of therapy post-transfer.

This Study

Transfer cases are an unavoidable part of relational therapy, especially in training clinics. However, transferring a case is a significant risk factor for poor therapy outcome and alliance rupture, particularly in terms of post-transfer dropout. Unfortunately, very little empirical research has examined what factors moderate the risk of post-transfer dropout. Based on research indicating that clients' trust of therapist and pre-transfer co-therapy sessions predict successful transfer, the following research questions were examined in this study:

1. What is the percentage of successful transfers in individual, couple, and family cases, as measured by clients failing to attend therapy after the transfer, clients coming to fewer than four post-transfer sessions, and client-initiated termination?
2. Are there significant differences in post-transfer outcomes between individual, couple, and family cases?
3. Does the therapeutic alliance with the original therapist predict successful transfer, as measured by clients failing to attend therapy after the transfer, clients coming to fewer than four post-transfer sessions, and client-initiated termination?

4. Does the therapeutic alliance with the new post-transfer therapist predict successful transfer, as measured by clients coming to fewer than four post-transfer sessions and client-initiated termination?

Methods

Procedures

Data for this study came from an MFT training clinic in the Northeastern region of the United States. Clients were given routine, continuing assessments throughout the course of therapy. Before the initial session, clients took a group of assessment measures that included demographic information. Clients took the assessment packet, again, every four sessions. In addition, after each session, clients completed the Session Rating Scale, to rate their relationship with their therapist, and before each session they completed the Outcome Rating Scale (Miller & Duncan, 2004; Miller et al., 2003) to rate their personal well-being. In addition, information about frequency of therapy, no-shows, cancellations, rescheduling, and transfers to different therapists, were tracked by clinic administrators. Data for this study came from the primary respondent for each case. For couple cases, the primary respondent could be either partner, and in family cases, it could be either parent when both parents participated in family therapy. Data collection was approved by the university IRB.

Participants

The client sample consisted of 49 cases, which included 28 individual cases, 16 couple cases, and 5 family cases. As indicated in Table 1, a majority (57.1%) of the participants who filled out the questionnaires were female. The average age of clients was 31.3 years ($SD=13.3$), and those who were in a relationship had been in the relationship for 6.5 years ($SD = 4.8$). The clients were predominantly white (73.5%), with a wide range of income.

Measures

Dropout. Research has found that dropout can be conceptualized in different ways (Masi, Miller, and Olsen (2003)). Consequently, in order to enhance the conclusion validity of the study, three different measures were used to measure dropout. The first measure was whether or not the clients came back to therapy after the transfer was made. When transfers are made, an explicit agreement is made between the initial therapist and the clients to continue therapy with a new therapist. When clients failed to follow through with the agreement by not coming to session after the transfer, this was considered a dropout, with a 0 indicating that the client dropped out, and a 1 indicating that the clients came back for at least one post-therapy session.

Dropout was also defined as clients coming to three or fewer post-transfer sessions. This definition was based on research on post-transfer dropout that found a natural break in the frequency of post-transfer sessions between the third and sixth sessions, meaning that there were no cases in the study that attended four or five post-transfer sessions (Sauer, et al., 2017). In addition, the study by Clark and associates (Clark et al., 2011) defined post-transfer dropout as attending three or fewer session following a transfer. Consequently, in order to enhance comparability between studies, dropout was operationalized as clients having three or fewer sessions with their new therapists. A score of 0 indicated that the clients failed to attend at least four sessions, and a 1 indicated that they attended four or more sessions.

Based on previous research (Masi et al., 2003), a case was also considered a dropout if the clients initiated termination. On the other hand, if the therapist initiated termination, or if the client and therapist agreed on termination, the case was not counted as a dropout. Participants received a score of 1 if the clients initiated termination; otherwise, the clients received a score of 0.

Session Rating Scale (SRS). The independent variable, therapeutic alliance, was measured using the SRS (Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003), which is a 4-item scale measure. Questions ask clients to mark on a continuum where they respond to questions such as: “I did not feel heard, understood, and respected” (Duncan et al., 2003, p. 6). The scale is scored by summing the responses for a total score, with scores ranging from 0 to 40 points total. Higher scores indicate a stronger alliance, and a total score of 36 or lower may indicate alliance issues or rupture (Duncan et al., 2003).

The SRS has demonstrated strong reliability and validity. The Cronbach’s Alpha coefficient is .88, and the test-retest reliability is .70 (Duncan et al., 2003). In addition, concurrent validity was demonstrated by having a correlation with Helping Alliance Questionnaire of .48. Predictive validity was demonstrated by the SRS being significantly predictive of positive therapy outcome (Duncan et al., 2003),

Control variables. In order to control for the general well-being of clients, the Outcome Rating Scale (ORS) was included as a control variable. The ORS (Miller, Duncan, Brown, Sparks, & Claud, 2003) is a 4-item measure of individual distress, relational well-being, social role satisfaction, and overall life satisfaction. Clients answer by marking a scale from one to 10, with 10 being most satisfied and less distressed. The total score is obtained by adding scores from the 4 questions; higher scores indicate higher overall well-being (Miller et al., 2003). Clients filled out the ORS before each session. Gender was also included as a control variable.

Analysis

Simple descriptive statistics were used to determine the proportion of clients who never came back to therapy after the transfer, the proportion of clients who came to three or fewer sessions, and the proportion of clients who initiated termination. Chi-Square tests were used to

examine differences between individual, couple, and family cases in post-transfer clients who never showed up for treatment, clients who came to fewer than four post-transfer sessions, and clients who initiated termination. The hypotheses regarding the effect of the therapeutic alliance on clients not coming back to therapy post-transfer, coming to fewer than four post-transfer sessions, and clients initiating termination was assessed using logistical regression because the dependent variables were dichotomous. Two sets of logistical regression analyses were conducted, one with pre-transfer therapeutic alliance as the independent variable and one with post-transfer therapeutic alliance as the independent variable. However, no analysis was conducted for the effect of post-transfer therapeutic alliance on clients who did not attend any post therapy sessions because there would be no measure of post-therapy alliance for these cases.

Because of the small sample size, all three groups were combined for the logistical analyses. Gender and personal well-being, as measured by the ORS, were included as control variables. Marital satisfaction was not included as a control variable because many of the clients in the individual and family cases were not married or in a relationship. If the couple cases could have been analyzed separately, it would have been included in those analyses.

Results

Group Differences

Preliminary results indicated that 28.6% of the overall sample came to fewer than four sessions post-transfer, including 10.2% who did not return for any sessions after the transfer.

Nearly one-fourth (24.5.0%) of the clients initiated termination.

When examining differences between the individual, couple, and family cases, 7.1% of the individual cases, 18.8% of the couple cases, and none of the family cases never came back to therapy after the transfer. Twenty-five percent (25.0%) of the individual cases, 37.5% of the

couple cases, and 20% of the family cases came to fewer than four post-therapy sessions.

Twenty-five percent (25.0 %) of the therapists reported that the clients initiated termination in the individual cases, while the percentages were 25.0% for couple cases and 20.0% for family cases.

Statistical comparisons were made to determine if there were differences in dropout rates between individual, couple, and family cases. Chi-Square tests indicated that there were no group differences in the proportion of clients who failed to return for therapy after the transfer ($X^2 = 2.130, p = .345$), the proportion of clients who came to three or fewer sessions ($X^2 = .980, p = .613$), and proportion of therapists who reported that the client initiated termination ($X^2 = .061, p = .970$).

The Effect of the Therapeutic Alliance on Transfer Success

Therapeutic alliance with initial therapist. Using logistical regression, results indicated that the level of alliance with the initial therapist did not have an effect on the likelihood that the clients would dropout out of therapy after the transfer. As indicated in Table 2, the odds ratio of the therapeutic alliance with the initial therapist on the likelihood of failing to show up for therapy after the transfer was .612 ($p = .329$). The odds ratio of dropping out of therapy before the fourth post-transfer session was 1.08, ($p = .381$), and the odds ratio on the client initiating termination was .805 ($p = .061$). Although this odds ratio value failed to reach the standard significant level of .05, it approached significance and suggested that clients who reported a strong therapeutic relationship with their initial therapist were 19% less likely to choose to terminate.

Therapeutic alliance with new therapist. Similar to the results that examined the effect of the therapeutic alliance with the initial therapist, the strength of the therapeutic alliance with

the new therapist did not have an effect on post-transfer dropout. The odds ratio of post-therapy alliance on the likelihood of dropping out before four post-transfer sessions was 1.12 ($p = .221$), and the odds ratio for client-initiated termination was .857 ($p = .118$). (See Table 2.)

Discussion

The findings of the study indicate that the process of transferring clients from one therapist to another puts them at risk for dropping out of therapy. Ten percent of the clients never returned to therapy after the transfer, and 29% failed to attend at least four post-therapy sessions. Similarly, one-fourth of the clients terminated therapy after they were transferred to a new therapist, suggesting that they dropped out. These findings are consistent with other studies (Clark et al., 2011; Clark et al., 2014) that have been conducted in an MFT setting.

However, because there was no comparison group in this study, it is impossible to determine if these dropout rates during the transfer process are higher than other clients who do not experience a transfer. There is evidence from individual therapy that transfer cases experience twice the rate of dropout than non-transfer cases (O'Brien et al., 2013), but there is no empirical evidence that there is a higher rate of dropouts in couple and family cases.

Findings from the study indicated that there were not statistically significant differences in dropout rates between individual, couple, and family cases. The percentage of couple cases who never came back to therapy and who came to fewer than four sessions was substantially higher than the percentages for individual and family cases. However, the differences were not statistically significant, probably due to the small sample size.

Contrary to what was hypothesized, the strength of the therapeutic alliance with the initial therapist or the new therapist did not predict post-transfer dropout. Although nearly thirty percent of clients did not complete the four post-transfer sessions that were necessary to be

considered a successful transfer, the strength of their therapeutic alliance, either pre- or post-transfer, did not differ from those clients who remained in therapy.

There are possible explanations for these unexpected results. The most likely explanation is that the small sample size prevented significant results to emerge from the statistical analysis. With only 49 cases in the sample, the sample size was undoubtedly too small for the logistical and multiple regression analyses to yield significant results.

A second possibility is that the alliance may not be important in the transfer process. Although this study was contextualized from a therapeutic alliance and alliance rupture perspective, perhaps other factors not analyzed in this study better explain why some cases successfully experience the transfer process, while other cases dropout. While Clark et al. (2011) found that cases that have pre-transfer therapy session with the outgoing and incoming therapist predicted successful transfer, perhaps a mechanism other than the therapeutic alliance explains that finding.

Another explanation may be that it may be possible that a change in therapists is a good thing, that clients with a poor alliance with their initial therapist may not experience a rupture. Rather, they look forward to the opportunity to work with a new therapist who may provide an opportunity for a better therapeutic alliance. This may be especially true in couple and family cases where there is a split alliance. The family member who did not feel a strong alliance with the original therapist may see the new therapist as a fresh chance to be heard and understood. The transfer may be the exact shift in therapy that the family member experiencing a poor alliance may need.

Third, because of the small sample size, the individual, couple, and family cases had to be combined when analyzing the effect of the therapeutic alliance on transfer outcome. Research

has found that the elements of the therapeutic alliance differ between individual and couple (and presumably family) cases. Whereas the relationship between the client and therapist is of utmost importance in individual therapy, the relationship, or alliance, between partners is most important in couple therapy (Anderson & Johnson, 2010). Hence, it is likely that the effect of the therapeutic alliance on successful therapy outcomes differs between individual and relational therapy. By combining the individual, couple, and family cases, it is possible that the true effect of the therapeutic alliance on transfer success was suppressed.

Finally, when these cases are combined and data only asks about individuals, it implies that MFTs are no different from other psychotherapists. However, couple and family therapy is founded on systems theory, viewing all relationships and interactions as connected. This also extends to individual clients, where internal, family, and societal systems are all talked about and included in the conceptualization of the case. Not only is the data on families missing the systemic viewpoint, but the individual data misrepresents the way MFTs view therapy and change. It ignores the fact that the development of the alliance is more than just a one-on-one interaction, but is multifaceted and complex, based on a systemic perspective.

Study Limitations

The greatest limitation of the study was the small size of the dataset. This not only impacted the significance level of the research, but also the ability to analyze the effect of the therapeutic alliance on individual, couple, and family cases, separately. In addition, the large amount of missing data among family members in the couple and family cases made it impossible to include them in the analyses. Also, there was substantial missing data with the primary respondent with certain variables, such as gender and length of romantic relationship, which made it necessary to delete these variables from the analyses.

Another limitation of this study was the measure used. Although the SRS assesses the therapeutic alliance, it is not a dyadic measure and does not ask about the systemic aspect of relational therapy, specifically the alliance between family members (Anderson & Johnson, 2010). Using an individual measure with relational data ignores what is known about alliances in systems, split alliances, and ruptures in relational therapy (Anderson & Johnson, 2010; Friedlander et al., 2011; Pinsof, 1995) By not looking at the between-systems alliance (Pinsof, 1995), this study missed the unique elements of relational therapy and the alliance therein.

Additionally, the framework of this paper, though using data from an MFT clinic, was largely conceptualized from an individual mindset. The way alliance and rupture was discussed and the data that were used in the study was from an individual perspective, only between one client and the therapist. This individual perspective lacked the complexity of family therapy, where many clients experience alliance and rupture at once. By not analyzing alliance from a relational standpoint, this study missed the value of multiple family members in the room at once. Change happens more effectively when many family members change together, and perhaps the alliance with the therapist is not as significant as it is talked about here. The between-systems alliance (Pinsof, 1995) may be a more predictive measure of lasting change.

Also, the small sample size from a training clinic in the northwestern part of the United States substantially limits the external validity of the study. It is impossible to generalize these findings to other populations.

Future Directions

Future studies would do well to use a larger, more robust dataset. The Marriage and Family Therapy Practice Research Network (MFT-PRN; Johnson, Miller, Bradford, &

Anderson, 2017) promises the opportunity to obtain a large database of transfer cases from multiple sites. This would greatly increase the size and diversity of the dataset.

Beyond increasing the size of the sample, it is important for future MFT studies to measure and conceptualize the study in a more systemic way. Specifically, a measure of the therapeutic alliance that is designed for relational cases needs to be used.

Clinical Implications

Although the research did not yield significant results concerning the alliance in couple's therapy, this study found that couple and family cases are at risk for dropping out of therapy. Recognizing the frequency of transfers, as well as the negative consequences that may accompany transfers, it is important that MFTs are mindful in how they direct the transfer process (Williams & Winters, 2009). Previous research in an MFT setting provides some guidance in how best to navigate the transfer process. Co-therapy sessions are an important way to help clients feel safe, heard, and cared about. Co-therapy sessions help clients trust the new therapist, which is very important in developing an alliance and maintaining therapy attendance (Clark et al., 2014; Clark et al., 2011).

However, co-therapy sessions are not always realistic. Having four co-therapy sessions—as recommended by Clark et al. (2014)—may only be possible in training clinics. Administrators at other treatment settings may not be willing to pay for have official transfer co-therapy sessions. In these cases, the therapist can be mindful about the transfer by giving clients ample warning time to prepare for a new therapist, perhaps allow clients to be involved in selection of the new therapist, and vouching for the credibility of the new therapist (Clark et al., 2014).

Finally, it is important for MFTs to use measures that match the modality with which they are doing therapy. We cannot use individual, non-systemic measures and theories to guide

research. It is not enough for MFTs to copy how other psychotherapists do studies. The unique contribution of MFT to the mental health field is the systemic, complex, relational way in which change is talked about and happens for MFT clients. This needs to extend to the research done by the MFT community, especially in fundamental elements of therapy like the alliance, which will further validate the place relational therapy fills in the psychotherapy world.

Conclusion

The present study suggests that therapist transfers among individual, couple, and family therapy cases creates a risk for dropout. Although the study failed to find a significant association between the therapeutic alliance and post-transfer dropout, future research using larger, more diverse datasets, and performing research from a relational framework holds the potential to more adequately address this research question.

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APPENDIX OF TABLES

Table 1. Sample Characteristics

Gender	%	M	SD
Male	30.6		
Female	57.1		
Race			
White	73.5		
Latino/a	2.0		
Other	8.2		
Income			
Less than \$10,000	8.2		
\$10,000-19,999	14.3		
\$20,000-29,999	16.3		
\$40,000-49,999	8.2		
\$50,000-59,999	2.0		
\$60,000-69,999	2.0		
\$70,000 +	10.2		
I don't know	18.4		
Age		31.3	13.3
Length in Relationship		6.5	4.8

Table 2. Effect of Therapeutic Alliance on Post-Transfer Dropout

	Post-therapy no sessions		Post-therapy < 4 Sessions		Client-Initiated Termination	
	Odds Ratio	<i>p</i>	Odds Ratio	<i>p</i>	Odds Ratio	<i>p</i>
Pre-transfer Alliance						
Alliance Pre-transfer	.612	.614	1.08	.381	.805	.061
ORS	.999	.992	.919	.168	1.07	.326
Gender	1.99	.614	1.37	.737	.678	.698
Post-transfer Alliance						
Alliance Pre-transfer	*		1.12	.221	.857	.118
ORS			.958	.489	1.03	.628
Gender			1.94	.564	.638	.663

Note: * indicates that analyses were not run on the effect of the post-therapy alliance on not coming back to therapy because there is no data for the post-therapy alliance.