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**Therapeutic Alliance Directions in
Marriage, Couple, and Family Counseling**

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Introduction

Therapeutic alliance has been heralded as one of the most important factors in successful individual counseling and is also regarded as an important variable in many types of couple, marital, and family counseling (Friedlander et al., 2006). However, the degree of importance and the extent of the role therapeutic alliance play in couples, marriage, and family counseling is unclear. Originally, therapeutic alliance was described by Bordin (1979) as containing three essential ingredients for the counselor and the client: 1) a commitment to exploring problems, 2) the establishment of a mutual trust, and 3) the identification of a realistic goal of curing or ameliorating the symptoms. Although therapeutic alliance was deemed a statistically and clinically significant factor (Horvath & Bedi, 2002) in successful individual counseling outcome, Wynne (1988) realized additional research was needed to confirm that therapeutic alliances in marital, couples, and family counseling merited a similar status because of the complex session dynamics. The outcome of group marital counseling conducted by female therapists in Canada was linked to the strength of the therapeutic alliance in one study (Bourgeois, Sabourin, & Wright, 1990).

Researchers have continued to explore therapeutic alliance as a viable factor but have not yet been able to declare it as a definitive influence on the counseling outcomes of all individuals involved in families and couples due to limited research (Friedlander et al., 2006; Knobloch-Fedders, Pinsof, & Mann, 2004; Symonds & Horvath, 2004).

Therapeutic Alliance Research Overview

Most of the research to date has reported varied results and utilized different assessment tools and research methods. Studies of multiple family members and couples sessions published recently were primarily qualitative and process/outcome research utilizing YAVIS (young, adult, verbal, intelligent, and stable) samples (Mahaffey & Granello, 2007). This research methodology may have occurred because researchers (Knobloch-Fedders et al., 2004) concluded that when counselors are in the room with multiple people, gaining therapeutic alliance with more than one person simultaneously and then developing a clear understanding of how it happens is equitable to Satir's (1967) communication theory "can of worms" concept.

The study of therapeutic alliance in marital and family therapy has been further complicated due to the nature of interpersonal communication among the counselor(s) and the clients, also called the session dynamics. Couples and families often begin treatment with a multiplicity of presenting problems and differing degrees of interest, motivation, goals, or beliefs about how to change (Patalano, 1997; Rait, 2000).

No study has yet to factor how counselor experience or education (Raytek, McGrady, Epstein, & Hirsch, 1999) and the counseling setting may affect the relationship between counselor and multiple clients (Mahaffey & Granello, 2007). It has been hypothesized that the counselor is expected to develop an alliance with each individual as well as the couple subsystem, within the context of the relationship triangles (Hight, 1997; Rait, 2000). This creates a situation where the therapeutic relationship may not be as

intense as in an individual session, as the counselor may not respond to all the communication triangles in the session. Miscommunication among clients and between counselor(s) and client are a concern as well. For example, comments made by the counselor(s) may be interpreted by clients as indirect messages to other family members (Heatherington & Friedlander, 1990), thus possibly creating misperceptions and shifts in alliance.

Most of the qualitative studies involved client self-reports, or therapist and trained observer checklists/reports, as the data sources contain differing times for assessments (Horvath & Bedi, 2002). There are at least 24 therapeutic alliance scales with recent ones created to adapt to the many caveats of treatment outcomes or special populations (Horvath & Bedi). Martin, Garske, and Davis (2000) noted the original scales attempted to address individual therapeutic alliance based on various theories and were the impetuses for group, couple, and family scales. Pinosof and Catherall (1986) devised therapeutic alliance scales that have been revised specifically for couples, the *Couple Therapeutic Alliance Scale – Revised* (Pinosof, 1994), and families, the *Family Therapy Alliance Scale-Revised* (Pinosof, 1999).

The use of the many therapeutic alliance scales has been problematic for researchers. One problem was that some questionnaires used were designed for a particular group of people or for a related concept, such as empathy (Horvath & Bedi, 2002), which may affect how the results could be construed. A few researchers have suggested changes in research methods. Hight (1997) asserted that measuring therapeutic alliances frequently with detailed history and diversity in rating strategies may help researchers better understand how therapeutic alliance may change with the same clients over time. Comparing any of the instrument's pre- and post-tests scores may provide a deeper understanding about the therapeutic alliance among counselors and clients (Hight).

Strategies and Techniques for Alliance Building

The tools counselors employ to build therapeutic alliance vary by theory. Feller and Cottone (2003) stated empathy was a major component of therapeutic alliance especially in psychoanalytic, client-centered, and existential theories. Therapeutic alliance may be included in other counseling theories as well. For example, in structural theory, the counselor may choose to join with one spouse to act as a co-therapist in the session (Rait, 2000) while in communication therapy, the counselor may advocate clients be treated equally with respect (Satir, 1967). Pinsof and Catherall (1986), family systems theorists, described therapeutic alliance as beginning with each family member, individually, and evolving to a higher order level with the whole family system becoming allied with the counselor. The counselor's goal would be to develop an alliance with each person of the multi-person subsystems (i.e., parents, children), referred to as the subsystem alliance, in a circular or reciprocal fashion.

Counselors could benefit from additional training in strategies that focus on building therapeutic alliance with differing clients. Counselor trainees focus more on mastering the cognitive feats and less attention is paid to the acquisition of affective communication. Alliances between therapist and couples or family members are complicated due to multiple interactions. One recommendation for counselors would be to develop awareness about the dynamics of working with multiple people in the room, the nature of the session's interpersonal communication, the couple subsystem, and the relationship communication triangles (Mahaffey & Granello, 2007). Another strategy would be to utilize knowledge about possible moderating or mediating variables (Horvath & Bedi, 2002; Knobloch-Fedders et al., 2004) to deter client misalliances or premature terminations. Further, counselors could be trained in specific skills that promote therapeutic alliance formation.

There are important components in interpersonal communication that counselors could employ to promote working relationship(s). Trust, empathy, and resistance are factors frequently

associated with therapeutic alliance building. Because client trust is regarded as a factor that strengthens the bond in therapeutic alliance (Patalano, 1997), counselors could intentionally utilize techniques to build trust. Intentional and well-timed empathic responses could also enhance alliances. Learning new ways to work with possible multiple client resistances may also be strategic.

Techniques used to build therapeutic alliance in couples counseling have been asserted. Rugel (1997) wrote for marital interventions to be effective, the counselor would show acceptance, involvement, empathy, empathic probing, and competence with each spouse's marital reality. Based on clinical experience, Rugel emphasized winning the approval of a husband during the marital session by being in tune with husband's distaste of therapy and conveying an understanding of his discomfort. Focusing on the husband, overcoming resistance, and obtaining the husband's cooperation during a session were crucial steps in building the therapeutic alliance (Rugel). Werner-Wilson, Michaels, Thomas, and Thiesen (2003) advised male counselors to "pay attention" to creating a therapeutic alliance as the female therapists in their study had higher bond scores. These researchers, along with Johnson, Wright, and Ketring (2002) posited that it is more advantageous to focus on the couple's relationship than relying on problem solving strategies or techniques.

Information in the empirical literature on techniques to employ with families was scarce. Diamond, Diamond, and Liddle (2000) asserted the first task was for counselors to shift the goal from "fixing" the adolescent to improving the relationships in the family as the first task. The next tasks were building different bonds individually by searching for strengths, showing support, and giving respect to each family member in separate sessions (Diamond et al.). Glueckauf et al. (2002) suggested counselors concentrate on family therapy methods that focus on adolescent priorities and self determination.

Sex differences were explored in a few studies. The level of marital distress for men was a main predictor of therapeutic alliance formation in one study (Knobloch-Fedders et al., 2004) but not a

factor in another study (Bourgeois et al., 1990). Johnson et al. (2002) reported that men's self-rated goal scores predicted the level of symptom distress for fathers in a study of home-based family therapy. Sexual satisfaction and family-of-origin issues were the predictors of therapeutic alliance formation for women (Knobloch-Fedders et al.). Because a couple often may have individual concerns about their relationship, Symonds and Horvath (2004) suggested counselors adopt a *both/and* acceptance position and not an *either/or* position to recognize and address both goals, thus increasing the strength of an alliance. In clinical practice, a counselor utilizing a both/and stance would establish that each person set a goal. Symonds and Horvath also recommended counselors work to strengthen the allegiance of the couple, thus improving the chances for alliance and a better outcome in couples counseling.

Recommendations

Much work will be needed to better understand therapeutic alliance. Areas mentioned in the literature for further investigation were counselor experience (Raytek et al., 1999), gender (Heatherington & Friedlander, 1990; Werner-Wilson et al., 2003), mediator and moderator treatment variables (Horvath & Bedi, 2002), and the course of alliances throughout the duration of treatment (Symonds & Horvath, 2004). Difficulties with attaining therapeutic alliance have been the focus of few empirical and anecdotal reports. For example, the counseling environment is rarely considered as a factor. As Rait (2000) suggested, the sessions being noisier and more conflicted may have deterred alliances in marital counseling when compared to individual counseling.

Recommendations for further research are many. Extensive investigation is needed in the area of dysfunction in therapeutic alliance, known as *misalliances* or *therapeutic ruptures* (Safran & Muran, 1998). Patalano (1997) noted the therapeutic alliance could be weakened by the lack of empathy directed toward the client and by the unmotivated partner consciously or unconsciously sabotaging the alliance. There is an additional gap in the research involving

misalliances of the special populations/diversities in marital and family counseling.

There has been little dialogue about what happens when counselors do not believe in or ignore therapeutic alliances or fail to gain them. Study subjects who drop out of treatment are usually not queried or are reported as lost to the study (Mahaffey & Granello, 2007). This gap has been understandable because clients who no longer show up for sessions, as well as the counselors who treat them, are hesitant to answer questions. For example, the possibility still exists that one of the spouses or family members may be coming to sessions involuntarily (Rait, 2000), a unique yet unexplored area in therapeutic alliance research. Beck, Friedlander, and Escudero (2006) suggested that the therapeutic alliances in family therapy may have been influenced by the participants' diverse motivations to be in therapy.

Missing in the literature was an explanation of how multiple variables could hinder the formation of therapeutic alliances. Information about special populations was the biggest gap in the research. Couple, family, and marital counseling have a myriad of possible client attributes that are variables needing examination (Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989; Robbins, Turner, Alexander, & Perez, 2003; Werner-Wilson et al., 2003). Reimers (2001) suggested new research projects focused jointly on outcomes and therapeutic relationships be initiated to study various approaches. Heatherington and Friedlander (1990) hinted that future studies could examine the differences in theoretical concepts, such as comparing a therapeutic approach that encourages counselor neutrality with one that supports the shifting coalitions within the family. New theoretical advances that utilize different techniques (Coupland & Serovich, 1999) and enhance counselor training (Johnson et al., 2002) warrant future research as well. Adequate sample sizes, random sample assignment strategies, inclusion of the special populations, use of control groups, and attention given to the generalizability of findings in marital and family counseling therapeutic alliance studies are the future challenges for theoreticians, researchers, and practitioners.

Conclusions

Research in couple, marriage, and family counseling, with all its many characteristics, theories, variables, and relationship factors, warrants renewed interest to better define the multiplicity involved in therapeutic alliance. Counselors in all developmental stages may want to augment their skills, knowledge, and awareness in this area. Most importantly, clients would benefit from counselors who role model alliances and focus on relationship building. Overall, it is important to note that the research supports therapeutic alliance as an integral part of couple, marriage, and family counseling, theories, and assessment.

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