THERAPEUTIC ALLIANCE IN COUPLES THERAPY: THE INFLUENCE OF GENDER, WHO INITIATED THERAPY, SPLIT ALLIANCE, AND THE PRESENTING PROBLEM

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy
in the Graduate School of The Ohio State University

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The Ohio State University
2006

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ABSTRACT

Therapeutic alliance is an essential component of successful therapy. All forms of individual psychotherapy have demonstrated a connection between outcome and therapeutic alliance. Despite the fact that therapeutic alliance is an acknowledged area of importance in individual therapy, little research has been conducted regarding how gender, the initiation of therapy, a split alliance, and the type of presenting problem impact outcome and alliance in couples therapy. It was the specific aim of this study to determine how those factors impacted therapeutic alliance for clients in couples therapy.

Results of this study indicated that many couples dropped out of therapy, women initiated therapy more often than men, split alliances did impact outcome, and whose therapeutic alliance was different, higher or lower, mattered more than how different. This study demonstrated that who initiated therapy and the type of presenting problem (a couple problem versus an individual problem) did not impact therapeutic alliance in couples therapy. Possible explanations and further hypotheses are explored and areas of future research are suggested. Strengths and limitations are identified and clinical implications are noted.
Dedicated to my little one on the way
ACKNOWLEDGMENTS

I want to acknowledge and express my appreciation to my advisor, Julianne Serovich, Ph.D., for all that she has taught me about research, writing, and the many other things I never expected to learn at OSU, for her support throughout my doctoral program, and, especially, for all of her support during the dissertation process. She is a very experienced researcher who was willing to take me under her wing as a blank slate. I am very grateful to her for all that she has done to get me to this point in my academic career.

I also want to express my appreciation to the other members of my committee, Suzanne Bartle-Haring, Ph.D. and Gilbert Greene, Ph.D. Dr. Bartle-Haring helped me extensively with the data set, she walked me through the statistical analysis, and she was always available to answer my questions, no matter how trivial. Chapter Four would not have been possible without her help. Dr. Greene was willing to join my committee without knowing much about me. He took an interest in my dissertation topic and I am grateful for his willingness to serve on my committee.

I want to thank all of the couples who were clients at the Couples and Family Therapy Clinic at The Ohio State University who were willing to participate in the research project. I also want to thank the therapists, my classmates, for collecting the data and working to make the data set as complete as possible.
Thank you to my family and close friends for your continued support through all of life’s adventures, especially during the dissertation process. Your words of encouragement, your support, and just knowing that you have been there for me have meant more than you know. I could not have reached this point in my life without you. I would especially like to thank my mom, dad, and sisters, Jill and Dawn, for their supportive phone calls and having confidence in me throughout my time at Ohio State. I am very fortunate to come from such a wonderful family.

Now, for the biggest thank you. Thank you to my wonderful husband, Kevin, for your endless support. You have been such a fabulous cheerleader, you have never doubted me, and you helped me hang in there when the dissertation process got rather overwhelming. I sure did get a lot more than a degree by coming to OSU and I am forever thankful for that!
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PUBLICATIONS

Research Publication


FIELDS OF STUDY

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        Human Development and Family Science Graduate Program
Minor Field: Marriage and Family Therapy
        Cognate: At-risk Youth
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CHAPTER 1

INTRODUCTION

Researchers suggest that, in general, all therapeutic treatments are equally effective (Greenberg & Pinsof, 1987). This finding supports the idea that there may be common variables among and between the therapeutic treatments that contribute to their effectiveness, including therapeutic alliance (Horvath & Greenberg, 1989). Therapeutic alliance has been related to successful therapy outcomes in all forms of psychotherapy (Bordin, 1979; Horvath & Symonds, 1991) and its importance goes beyond the specifications of one particular theory (Wolfe & Goldfried, 1988). In other words, the therapeutic alliance is a “pantheoretical” factor of treatment (Glazer, Galanter, Megwinoff, Dermatis, & Keller, 2003).

It has been found that a stronger alliance between the client and the therapist can lead to greater therapeutic change (Horvath & Bedi, 2002). Some researchers have argued that alliance is more important than the type of treatment employed in predicting positive therapeutic outcomes (Safran & Muran, 1996). Therapeutic alliance has become so important to change that it has even been referred to as a “quintessential integrative variable” (Wolfe & Goldfried, 1988, p. 449).

Although it has been determined that therapeutic alliance is an essential component of therapy and there is much discussion about how to achieve a positive therapeutic alliance, little is known about the impact that gender, who initiates therapy,
the type of presenting problem, and split alliance have on outcome, and alliance itself, in
couples therapy. This study seeks to answer four research questions. The first question is
how does gender impact alliance in couples therapy? The second question is does who
initiated therapy (the caller versus the non-caller) impact alliance? The third question is
how does a split alliance impact outcome in couples therapy? The fourth question is does
the type of presenting problem impact alliance and outcome? In this study, outcome is
assessed by measuring marital satisfaction and commitment.

Definitions

There are several terms in the literature that refer to the relationship between the
client and the therapist, including therapeutic alliance, working alliance, therapeutic
bond, ego alliance, and helping alliance (Martin, Garske, & Davis, 2000). Some
researchers use the term working alliance, drawing attention to the working part of the
relationship that indicates that the client and therapist interact collaboratively and
purposefully while maintaining a connection (Hanson, Curry, & Bandalos, 2002). Others
define a therapeutic bond as maintaining open and clear communication that conveys
understanding, support, and respect to the client and focuses more on the personal
closeness (Horvath, 2001). Ego alliance is defined as the connection between the
reasonable aspects of both the therapist and the client (Sterba, 1934). Therapeutic
alliance, working alliance, and helping alliance tend to be used interchangeably in the
literature. Throughout this review, the term therapeutic alliance will be used to maintain a
consistency with what is typically used in the marriage and family therapy literature.
Although definitions of therapeutic alliance differ, a general consensus does exist. For the
purposes of this study, alliance is a form of collaboration between the therapist and client
that is necessary to negotiate an understanding of the process of therapy (Horvath & Symonds, 1991).

**Alliance in Relational Therapy**

Most research on therapeutic alliance up to the present day has been based on therapy with individual clients (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000). Not until the middle 1980’s was the therapeutic alliance conceptualized from a systemic theoretical basis, which was introduced by Pinsof and Catherall (1986). The definition of alliance, to be applied to family therapy and that fits with the systemic paradigm, was changed to account for a client system rather than just an individual client. Using a systems theory perspective, the therapeutic alliance in marriage and family therapy is defined as “that aspect of the relationship between the therapeutic system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy” (Pinsof & Catherall, 1986, p. 139).

**Couples Therapy: More Challenging Than Individual Therapy**

The concept of the therapeutic alliance in marriage and family therapy is very complex yet is an important facet for therapeutic success (Rait, 1995). The therapeutic alliance is conceptually different for couples than for clients in individual therapy. When doing couples therapy, the therapist needs to work with two clients and multiple systems simultaneously, bringing about unique challenges, demands, and processes (Garfield, 2004; Quinn, Dotson, & Jordan, 1997). In other words, the couple therapist needs to build and maintain an alliance with both partners, as well as with the couple system (Bourgeois, Sabourin, & Wright, 1990).
The therapist has to carefully and tactfully negotiate when and how to form an alliance with both members of the couple (Rait, 1995). Each individual’s alliance has the possibility to impact and be impacted by every other individual’s alliance with the therapist (Heatherington & Friedlander, 1990). When working with couples, there is the individual alliance (where each member has his or her own alliance with the therapist), there is the subsystem alliance (the alliance with the therapist as a couple), and the system alliance (the alliance with, among, and between the couple and the therapist) (Heatherington & Friedlander, 1990). Consequently, there is a greater likelihood in couples therapy than in individual therapy for at least one relationship to develop poorly and, thus, increase the risk for premature termination (Masi, Miller, & Olson, 2003).

Not every member of the couple system is entering therapy with equal motivation and some clients may even be coming to therapy involuntarily (Rait, 2000). De Shazer would refer to this as a visitor, a client who is not able to describe the problem and there is little expectation of change (de Shazer, 1988). He terms the opposite type of client a customer, a client who describes the problem and wants to work on building a solution to a problem (de Shazer, 1988). Therefore, there may be one member of the couple who is a customer and one who is a visitor, which could make forming an alliance with the couple system rather difficult. Regardless of what brought them into therapy, both partners may attempt to form individual alliances with the therapist in hopes of the therapist taking his or her side. Likewise, the couples tend to blame each other while the therapist sees it as a relational problem (Masi et al., 2003). These differences in viewpoint and conceptualization of the problem have been linked with higher dropout rates (Allgood & Crane, 1991).
PURPOSE

Empirical research supports the association between therapeutic alliance and outcome across diverse forms of individual treatment (Horvath & Symonds, 1991; Martin et al., 2000). Despite the fact that therapeutic alliance is an acknowledged area of importance in individual therapy, little research has been conducted regarding how gender, the initiation of therapy, a split alliance, and the type of presenting problem impact outcome and alliance in couples therapy. The severity of the problem has affected the importance of the alliance for therapeutic change in individual psychotherapy (Bordin, 1979) and one of the goals of this study is to determine how the type of problem relates to couples therapy. In addition to those factors, split alliance has been researched in family and couples therapy but more needs to be done to determine how a split alliance within a couple impacts outcome as measured by marital satisfaction and commitment. Therefore, there is a paucity of research concerning therapeutic alliance when working with couples seeking couples therapy and what impacts the alliance in order for couples to remain in therapy until their problems are alleviated. Noted family therapy researcher, Wynne (1988), suggested that the therapeutic alliance should be a central construct in empirical research in marriage and family therapy and that the interactions between the therapist and the clients are crucial to adequately study process. Building on this obvious gap in the literature and the need to more clearly understand therapeutic alliance when working with couples, the specific aim of this study is to identify how gender, who initiated therapy, split alliance, and the type of presenting problem impact therapeutic alliance and outcome (see Appendix A).
Objectives

Objective 1

The first objective of the study is to empirically identify the differences between men and women with regards to their therapeutic alliance in couples therapy. One research question is proposed.

Research Question 1: How does gender impact alliance in couples therapy?

Objective 2

The second objective of the study is to empirically identify how therapeutic alliance is impacted by the role of the client (e.g. initiator of therapy versus non-initiator of therapy). One hypothesis is proposed.

Hypothesis 1: It is hypothesized that the person who initiated therapy will have a stronger alliance with the therapist, regardless of gender, than the non-initiator. The hypothesis is based on de Shazer’s concept of visitor versus customer and the initiator is more inclined to be a customer whereas the non-initiator may be a visitor.

Objective 3

The third objective of the study is to empirically identify if therapeutic alliance impacts dropout. One hypothesis is proposed.

Hypothesis 2: It is hypothesized that those who dropped out of therapy will have a significantly lower therapeutic alliance than those who do not drop out of therapy.

Objective 4

The fourth objective of the study is to empirically identify how a split alliance between both members of the couple would impact outcome. One hypothesis is proposed.
Hypothesis 3: It is hypothesized that couples whose alliance scores differ more than two standard deviations will show no improvement in marital satisfaction or commitment. In fact, the greater they differ, the less positive their outcome.

**Objective 5**

The fifth objective of the study is to empirically identify if and how the type of presenting problem impacts alliance and outcome (e.g. marital satisfaction and commitment). One hypothesis is proposed.

Hypothesis 4: It is hypothesized that couples with problems that can be referred to as a “couple problem” (e.g. communication problems, lack of intimacy, problems with roles) will have greater therapeutic alliance and outcome when compared to couples who have problems that are more “individual problems” or thought to be one person’s problem (e.g. substance abuse, infidelity, discontent with work).
CHAPTER 2

LITERATURE REVIEW

History

The therapeutic alliance has been identified as the most important determinant in treatment continuance and success (Rogers, 1957) as well as the most frequently identified factor contributing to the outcome of therapy (Beutler & Harwood, 2002; Horvath & Symonds, 1991). Evidence has demonstrated that development and maintenance of a productive therapeutic alliance is predictive of positive outcome (Bourgeois et al., 1990; Gaston, 1990). In fact, interventions beyond just the therapist being caring and supportive do not seem to have any greater impact on alliance or outcome (Andrews, 2000). The strength, more than just the type of alliance, is a major factor in achieving change through therapy and that strength can dictate the effectiveness of a therapy (Bordin, 1979).

Freud and Psychoanalytic Theory

Therapeutic alliance is not a new concept for clinicians and it has a long and rich history. The term therapeutic working alliance originated in psychoanalytic theory and the recognition of the importance of the collaborative aspects of therapy can be traced back to writings by Freud (Gaston, 1990). Freud recognized the value of the contract between client and therapist and the significance that the therapist’s attitude had on
outcome. He explained that when the therapist invested in a relationship with the client, the client was able to form an attachment with the therapist. In addition, he recognized the importance of that relationship from the beginning by explaining that any therapeutic success would be lost without it (Freud, 1912; 1966b).

The central component of Freud’s analytic work was the interpretation of transference, the client displacing repressed wishes, fantasies, and aspects of past relationships from childhood onto the therapist (Freud, 1912; 1966a). The therapist then used this transference, interpreted it, and assisted the client in being able to rationally see that projection as distorted. Freud began to question why a client would endure this and still remain in therapy (Freud, 1912; 1966b). He concluded that the client was able to view the therapeutic relationship as positive aspects of previous relationships and that the client could bond with, or have an alliance with, the therapist to work together to fight against the client’s negative past experiences. In other words, it was the alliance that brought about positive outcomes. Freud then viewed this as an aspect of the client’s positive ego that was capable of forming a real, true bond with the therapist’s rational ego (Freud, 1912; 1966b).

*Sterba and Ego Alliance*

Sterba (1934) defined ego alliance as the relationship between the reasonable aspects of both the therapist and the client (Sterba, 1934). In order for alliance to be positive transference, the client’s ego needed to be strengthened in its interactions with the therapist. This happened through cooperation and the therapist and the client worked together against the presenting problem (Sterba, 1934). It is through this alliance that the client could begin to contemplate and accept the therapist’s interpretations (Sterba, 1934).
Zetzel, Rogers, and Greenson

Zetzel (1956), Rogers (1957), and Greenson (1967) conceptualized alliance by moving away from transference and towards the concept of a conscious attitude of cooperation and trust. Zetzel (1956) introduced the term “therapeutic alliance” to describe the authentic object relationship which promoted the client’s ability to withstand analysis. The therapeutic alliance was thought to bring about a corrective emotional experience in which the client could experience a situation differently than the client had previously experienced (Zetzel, 1956). Zetzel believed that it was the ability to foster and maintain this alliance with even the most disturbed clients that would allow for a successful analysis of the transference and the success of the treatment (Zetzel, 1956).

Rogers (1957) pursued the idea of a client-centered approach. He placed the therapeutic relationship at the center of the healing process and believed that it was necessary for the therapist and client to have an authentic relationship, initiated by the therapist, for therapy to be successful. The therapist’s main task was to establish a relationship that was accepting, empathic, supportive, and genuine and the remaining elements of a successful relationship came from the client (Rogers, 1957). He believed that for personality change to occur, certain conditions had to exist and continue over a period of time. Those conditions were: two people had to be in psychological contact, the client would be vulnerable and anxious, the therapist needed to be genuinely invested in the relationship, the therapist needed to have unconditional positive regard (accepting each aspect of the client’s experience without any conditions) for the client and an empathic understanding of the client, and the client perceived the therapist’s interactions as acceptance and empathy (Rogers, 1957).
Rogers was the influence behind numerous clinical studies in the late 1950’s to test the importance of being client-centered (Horvath, 2001). The results of those studies demonstrated that the relationship conditions offered by the therapist, with empathy being the most reliable condition, were associated with better outcomes in therapy. Even further, it was not the actual behaviors of the therapist that made the difference but it was the client’s perception of those behaviors that was important (Horvath, 2001).

Greenson (1967) referred to the alliance as the client’s ability to work purposefully and decisively in treatment and, thus, was the first person to use the term “working alliance.” The client was seen as contributing to the alliance by being motivated, willing to cooperate, and being able to follow the instructions and insights of the therapist. He maintained that positive collaboration between client and therapist was one of the essential components for therapeutic success (Greenson, 1967). The belief was that if this relationship was adequately established and maintained, it would prevent transference reactions (Greenson, 1967).

Luborsky’s Redefinition

Luborsky (1976) worked to redefine alliance by formulating a concept that integrated previous theories. He poised that alliance begins with the therapist exhibiting qualities to help the client feel safe and accepted. Once established, the client is asked to collaborate and cooperate with the therapist regarding therapeutic tasks (Luborsky, 1976). Once a shared investment in the therapeutic relationship existed, the client would be motivated to change (Luborsky, 2000).
Bordin’s Three Factors

Bordin (1979) took all of these views into consideration and fused their contributions to redefine the working alliance. According to Bordin (1979, 1994), the alliance is a conscious, collaborative relationship between the client and the therapist. He distanced himself from the idea that a working alliance accompanies transference and viewed the alliance as a vehicle that facilitates the effectiveness of therapeutic techniques and processes (Bordin, 1979).

A successful therapeutic alliance consists of having an agreement on tasks and goals, and a mutual fondness, attachment, and trust between the client and the therapist (Bordin, 1979). The agreement on tasks includes activities that the participants engage in during their therapeutic sessions, such as role play and cognitive restructuring. The tasks need to fit the clients’ lifestyle, worldview, and expectations for therapy (Johnson & Wright, 2002). Agreement on goals occurs when the clients and the therapist agree about the targets of change while in therapy. The clients must also perceive that the therapist is truly invested in helping them to achieve their goals, aided by a mutual fondness, attachment and trust (Bordin, 1979). All three components illustrate the respective roles and responsibilities of each participant in successfully achieving the goals of therapy (Bordin, 1979). From Bordin’s view, the working alliance is what makes it achievable for the client to accept and follow treatment and, in order to be most effective, the alliance needs to be mutual (Bordin, 1979).

Roles in Psychotherapy

With such an involved history, it is not surprising that therapeutic alliance plays a very salient role in therapy. Three major roles have been proposed (Gaston, 1990). The
first role, emerging from Rogers (1957), is that the alliance is therapeutic in and of itself. This relationship offered to the client by the therapist signifies a necessary and, at times, sufficient element for change to occur. The second role, influenced by Freud (1912; 1966b) and Greenson (1965), is that the alliance is a prerequisite for therapeutic interventions to be effective. The relationship allows the client to actively and cooperatively work with the interventions provided by the therapist. From a psychoanalytic point of view, having this alliance provides a safe place for the client to work through the therapist’s interpretations, which can then promote change (Freud, 1912; 1966a). The third role, complementing the work of Zetzel (1956), is that alliance brings about success for diverse clients using a variety of therapeutic interventions. The alliance would need to be flexible to meet the varied levels of functioning for each individual client, some needing more support than others, as well as the varied technical and therapeutic interventions of the therapist (Gaston, 1990).

Therapeutic alliance is impacted by what the therapist does to bring about change and the interpersonal stance that the therapist takes when treating the client (Beutler & Harwood, 2002). It has been hypothesized that when the client and the therapist work together to establish the tasks and goals in therapy the results will be deeper and more meaningful (Heatherington & Friedlander, 1990). These collaborative efforts will also strengthen their bond, thus making sessions more productive and with fewer problems.

Empirical Evidence

Researchers have found a statistically significant association between alliance and positive therapeutic outcome in treatment with individuals (Horvath & Symonds, 1991; Martin et al., 2000). In fact, there are indications that the alliance could account for up to
45% of the variance in measurable outcomes in individual therapy (Horvath & Greenberg, 1989) and it seems that the alliance is a significant component of the therapeutic relationship regardless of the theoretical approach (Sexton & Whiston, 1994). Therapeutic alliance has been shown to be positively correlated with positive outcome in many forms of therapy, such as individual therapy for cocaine abuse (Glazer et al., 2003), couples in emotionally focused therapy (Johnson & Talitman, 1997), cognitive-behavioral treatment of children with behavioral problems (Kazdin, Marciano, & Whitley, 2005), retention of couples in conjoint alcoholism treatment (Raytek, McCrady, Epstein, & Hirsch, 1999), and in multidimensional family therapy with substance-abusing adolescents and their parents (Shelef, Diamond, Diamond, & Liddle, 2005). Therapeutic alliance has most predominantly been shown to predict outcome in marital therapy (Bourgeois et al., 1990; Brown & O’Leary, 2000; Johnson & Talitman, 1997; Quinn et al., 1997; Raytek et al., 1999). The alliance itself appears to have therapeutic properties due to the relationship between client and therapist, involving collaboration and acceptance, providing a mode for treatment that is beneficial in its own right (Patton, Kivlinghan, & Multon, 1997).

Horwitz (1974) conducted a study of 42 patients, half of whom were treated with individual psychotherapy and the other half were treated with individual psychoanalysis. He found that there were no differences in the outcomes of the two methods but that there was a marked difference due to therapeutic alliance. The results of the study demonstrated that therapeutic alliance was not only necessary to begin therapeutic work but that it was actually the main vehicle of change.
The following section discusses some key studies regarding the impact of therapeutic alliance on various aspects of the therapeutic process. The studies have researched effect size, when to measure and establish alliance, the presenting problem, variables of a positive therapeutic alliance, differences in alliance for men and women, as well as the impact of splits and ruptures on the alliance.

*When to Assess Alliance and From Whose Perspective*

There is evidence from research conducted in individual therapy (Horvath & Greenberg, 1989), in couples therapy (Johnson & Talitman, 1997), and with group marital therapy (Bourgeois et al., 1990; Brown & O’Leary, 2000) that early development and maintenance of a positive therapeutic alliance produces positive outcome. In the process of developing an instrument to empirically examine alliance and outcome, Horvath and Symonds (1991) reported on 24 clinical studies involving diverse forms of individual therapy. Their findings indicated that alliance accounted for 26 percent of the variance when looking at outcome, meaning that alliance is a significant predictor of individual therapy outcome (Horvath, 2001). Horvath and Symonds (1991) also found that the predictive value of alliance was even more strongly correlated with outcome when the clients’ reports of their alliance with the therapist were assessed between sessions three and five.

Due to empirical evidence, it has been recommended that the optimal time to document the relation between outcome and alliance is during the early phase of the therapeutic process (Horvath & Greenberg, 1989; Horvath & Greenberg, 1994; Pinsof & Catherall, 1986), defined as between the second and fourth session (Horvath & Greenberg, 1989) and between the third and sixth session (Pinsof & Catherall, 1986).
Johnson and Talitman (1997) found that a strong alliance at the end of the third session was predictive of greater outcome at termination and at follow-up as measured by gains in marital satisfaction and intimacy.

In order for change to occur and for clients to be motivated to change, it seems most beneficial for an alliance to be established as early as the first session (Brown & O’Leary, 2000; Horvath & Symonds, 1991). If the therapeutic relationship lacks this alliance from the beginning, a positive outcome is less likely (Brown & O’Leary, 2000). When compared to the middle and late phases of therapy, the alliance that is established in the beginning phase of therapy is more predictive of outcome and dropout (Horvath & Symonds, 1991). Horvath and Greenberg (1994) address a “good enough” alliance in which the alliance that develops at the beginning of therapy is a window of opportunity to draw the client into the process and that window shuts a little more with each session. Therefore, the beginning phase of the alliance seems to be the most critical and the most important time to establish a relationship with the client to last the duration of treatment. In addition, it is most important to assess the client’s perception of the alliance because the client’s assessment of alliance is more predictive of treatment outcome (Horvath & Symonds, 1991).

In another meta-analysis of 79 studies involving individual therapeutic treatment, therapeutic alliance had a moderate relationship (an effect size of .22) with outcome (Martin et al., 2000). These results demonstrate that alliance is consistently related to outcome and that, if a strong alliance is established, the client will experience that relationship as therapeutic. Throughout the meta-analysis, the clients’ views of the alliance remained stable, versus those of the therapists and the observers that indicated
more change. Due to this finding, clients are more likely to view the alliance positively at termination if they viewed it positively from early on in the therapeutic process (Martin et al., 2000).

**Presenting Problem**

A study of 474 couples in marital therapy found that three variables were significant in accounting for couples who would drop out of therapy (Allgood & Crane, 1991). The three variables were: having less than two children, having a male intake clinician, and a presenting problem relating only to one spouse. They also found that when the men had high anxiety and the presenting problem was related to parenting, the couples had a greater chance of dropping out of therapy. Furthermore, couples were more likely (17%) to drop out of therapy versus continue (4%) if they had an individual dysfunction. That is, due to the men’s high anxiety being associated with dropping out of therapy, the authors concluded that the men may have a larger role in the decision to continue in therapy or to drop out. This is consistent with other findings that report that women tend to initiate therapy and to continue with therapy (LeFave, 1980; Ross & Lacey, 1961). Other researchers found that couples in conjoint alcoholism treatment had greater retention when the couple and the therapist were able to build a therapeutic alliance (Raytek et al., 1999). These findings highlight the point that even the presenting problem can impact alliance and alliance may impact retention.

**Variables of a Positive Therapeutic Alliance**

In a study conducted by Bedi, Davis, and Williams (2005), 40 participants were interviewed and asked to describe observable behaviors and expressions that they thought were significant in building alliance. The results indicated that there was a discrepancy
between the client’s perspective of the alliance and the therapist’s perspective. Thus, the results focused on the client’s perspective. After conducting a factor analysis, 74% of the variability attributed to the alliance emerged into two factors. The first factor was a personal alliance in which the environment was warm, the therapist was personable and self disclosed. The second factor was a professional alliance in which the therapist challenged the clients but also worked collaboratively with them (Bedi et al., 2005). Therefore, all of these factors seem to be valued by clients in forming and maintaining an alliance.

A positive working alliance with the clients provides a foundation for the clients’ willingness and ability to change (Brown & O’Leary, 2000). Tasks and goals are the parts of therapy that involve work while collaboration between the client and therapist in establishing the tasks and goals can result in a more personal, deeper experience (Heatherington & Friedlander, 1990).

Techniques cannot be divorced from the therapeutic alliance. Clients see clinical interventions as impacting the relationship and potentially strengthening the alliance (Bedi et al., 2005). For example, in psychodynamic therapy, accurate interpretations led to improved alliances while less accurate, and especially inaccurate, interpretations led to declines in the strength of the alliance (Luborsky, 1976).

Differences for Men and Women

Most conclude that the influences of therapeutic alliance are different by gender (Thomas, Werner-Wilson, & Murphy, 2005) but there is little agreement about how alliance is associated with outcome for men versus women. Some researchers have found that the strength of the therapeutic alliance was a more influential determinant of success
in couples therapy for men than for women (Bourgeois et al., 1990; Symonds & Horvath, 2004) and that their degree of conflict before seeking therapy did not impact that (Bourgeois et al., 1990). They also found that men’s alliance is a better predictor of outcome than the alliance for women (Brown & O’Leary, 2000; Symonds & Horvath, 2004). This may be explained in clinical literature as it has been found that men are less likely than women to talk to others about their problems (Berger, 1979) and men tend to be the ones who cancel therapy sessions (Berg & Rosenblum, 1977).

Due to the fact that therapy deals mostly with emotions and relationships, men are seen as coming to therapy at a disadvantage and that a power differential will already exist (Garfield, 2004). Due to this disadvantage from the beginning, it seems that men will be more successful in therapy if they are drawn into the process earlier. Some researchers have shown more positive outcomes are likely when men have a stronger alliance than women at the beginning of therapy and they both continue together with a positive alliance (Symonds & Horvath, 2004). Therefore, according to these findings, in order to establish a balanced therapeutic alliance, it is important to attempt to engage the male partner more strongly at the onset of therapy while continuing to stay engaged with the female partner throughout therapy (Garfield, 2004). The literature that supports this idea states that men are seen as having power over resources while women are seen as having power over the emotional and intimate aspects of the relationship (Symonds & Horvath, 2004).

On the other side of the argument, conflicting with previous findings, Quinn and colleagues (1997), found that the association between alliance and outcome is stronger for women than men in couples therapy. They also found that the outcome of therapy is
more positive when the women’s alliance is higher than the men’s versus when the men’s alliance scores are higher than the women’s scores. Using a measure assessing tasks, goals, and bonds, it was found that there were more positive outcomes when women reported a higher task alliance but that therapy had more negative outcomes when men reported a higher task alliance. Although men and women reported similar feelings on the bond subscale, it has been found that women have higher scores on the goal and the task subscales in marital therapy (Werner-Wilson, 1997). These conflicting findings leave us without a clear picture of how gender impacts alliance and without guidance of whom to align with when. Due to this discrepancy in the literature, it is a goal of this study to further explore how gender impacts therapeutic alliance.

*Splits and Ruptures in the Alliance*

There is evidence to suggest that the success of therapy is dependent upon the therapist and client being able to resolve any strains or ruptures in the alliance (Patton et al., 1997; Safran & Muran, 1996). A rupture is considered a negative change in the quality of the alliance or a continuous problem being able to form an alliance (Eames & Roth, 2000) (see Figure 2.1). Ruptures may vary from a subtle misunderstanding to a huge disconnect that makes establishing an alliance very troubling from the start. Although, if the initial alliance is strong, the alliance tends to be more repairable after ruptures occur (Patton et al., 1997).
While a rupture is a disconnect between the client and the therapist, a split alliance is when family members’ attitudes differ notably towards therapy and/or the therapist (Pinsof & Catherall, 1986) (see Figure 2.2). An intact alliance describes a situation in which family members’ attitudes are uniformly positive (Pinsof & Catherall, 1986). Researchers have found split alliances, differing more than two standard deviations, in 14% (Heatherington & Friedlander, 1990) and in 6% (Coupland & Serovich, 1999) of couples.

In a study conducted by Symonds and Horvath (2004), agreement between partners about the strength of the alliance influenced the relation between the alliance and outcome. Surprisingly, agreement between the partners and the therapist did not have any influence on that relation. When partners agree that their alliance is strong there tends to be a positive outcome, when the partners agree that the alliance is weak a poor outcome is more likely, both examples of a non-split alliance (see Figure 2.3), but when they disagree, or have a split alliance, the outcome tends to be more unpredictable (Symonds
& Horvath, 2004). Thus, it is most beneficial when clients agree that their alliance is strong.

A split alliance can be a result of the partners in the couple trying to manipulate the therapeutic relationship to have the therapist side with them and to determine who is right and who needs to make changes. If a client experiences the therapist taking sides, a split alliance may exist where one client has aligned with the therapist and the other does not. If the relationship becomes too unbalanced, the partner who feels sided against or estranged by the therapist may not return to therapy. Therapy is more productive for both partners when they both feel heard and valued, thus, when a split alliance is avoided. It is predictive of a positive outcome when the partners agree about the strength of their alliance rather than their individual assessments (Symonds & Horvath, 2004).

Split Alliances

NOTE: --------- = problematic/ negative therapeutic alliance; ----------- = positive therapeutic alliance.

Figure 2.2: Split Alliances
Non-Split Alliances

NOTE: -------- = problematic/ negative therapeutic alliance; ------ = positive therapeutic alliance.

Figure 2.3: Non-Split Alliances
CHAPTER 3

METHODS

The following is a discussion of methodology that was employed to conduct this study. Procedures are discussed including recruitment procedures, informed consent procedures, the instruments used, procedures, and information regarding the collection and analysis of the data.

Sample

Participants were solicited from client populations seeking couples therapy services at an outpatient couples and family therapy clinic located on the campus of a large Midwest university. On average, the clinic serves about 90 new cases each year, including individuals, couples, and families. In order to serve a wide range of clients, the fees of the clinic are based on a sliding fee scale, ranging from $10 to $65 per session. The clinic is staffed by doctorate level students who are enrolled in a COAMFTE (Commission on Accreditation for Marriage and Family Therapy Education) accredited program. The data for this study was collected from November of 2002 through February of 2006. Only couples were chosen to be included in this study due to the fact that the research questions address couple processes, experiences, and presenting problems. Couples did not need to be married or cohabitating in order to be included, although, due to the comparison based on gender, both the man and the woman needed to be willing to
participate in the research project to be included in this study. Due to the small number of
same-sex couples and the comparison based on gender, only heterosexual couples were
included. Eighty-two couples met criteria for inclusion.

*Demographic Characteristics*

The majority of analyses compared men and women of each couple and analyzed
differences based on gender. Therefore, the demographics for the sample were also
analyzed comparing men and women (see Tables 3.1 and 3.2). Men ranged in age from
20 to 71 ($M = 32.10; SD = 9.02$). Participants identified across various racial/ethnic
groups that are consistent with local demographics. The majority of the men identified as
Caucasian (69.5%), followed by African American (14.6%), Other (4.9%), Hispanic
(3.7%), Asian (3.7%), and Native American (1.2%). The majority of men were either
married for the first time or remarried (67.0%). A smaller percentage were cohabitating
(17.1%) and the remainder were widowed (2.4%), single and never married (2.4%),
divorced (1.2%), or declined to answer (9.8%).

Household income was measured by asking participants to indicate the range in
which their annual income fell. The majority of the men reported a household income of
less than $30,000 per year (61.0%). Over three quarters (78.1%) earned less than $50,000
annually and only 15.9% reported earning more than $50,000 per year. These numbers
reflect incomes that are expected due to the sliding fee scale offered at the clinic. The
highest level of education was assessed by having the participants choose from a list. The
largest proportion of the men indicated having some college (24.4%) or a bachelor’s
degree (34.1%) and 13.4% of the sample indicated having a master’s degree, professional
degree, Ph.D., MD, or JD. A small percentage (11.0%) indicated having a high school
diploma or a GED and 9.8% of the men indicated not having graduated from high school.

Women ranged in age from 18 to 71 years ($M = 30.19; SD = 8.52$). The majority
of the women identified as Caucasian (68.3%), followed by African American (11.0%),
Other (7.3%), Hispanic (6.1%), Asian (3.7%), and Native American (1.2%). The majority
of women were either married for the first time or remarried (67.1%). A smaller
percentage were cohabitating (17.1%) and the remainder were single and never married
(2.4%), widowed (2.4%), or declined to answer (11.0%). No women identified
themselves as divorced.

The majority of the women in the sample reported a household income of less
than $30,000 per year (59.7%). Over three quarters of the women (79.2%) earned less
than $50,000 annually and only 13.5% reported earning more than $50,000 per year. The
largest proportion of the women indicated having some college (32.9%) or a bachelor’s
degree (25.6%) and only 1.2% indicated not having graduated from high school. A small
percentage of the women (11.0%) indicated having a high school diploma or a GED and
21.9% indicated having a master’s degree, professional degree, Ph.D., MD, or JD.

<table>
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<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Standard Deviation</th>
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<tbody>
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<td>71.00</td>
<td>32.10</td>
<td>9.02</td>
</tr>
<tr>
<td>Women’s Age</td>
<td>18.00</td>
<td>71.00</td>
<td>30.19</td>
<td>8.52</td>
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</table>

Table 3.1: Age of Sample
<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Men Frequency</th>
<th>Percent</th>
<th>Women Frequency</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>African American</td>
<td>12</td>
<td>14.6%</td>
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<td>11.0%</td>
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<tr>
<td>Asian</td>
<td>3</td>
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<td>3</td>
<td>3.7%</td>
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<td>Caucasian</td>
<td>57</td>
<td>69.5%</td>
<td>56</td>
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<tr>
<td>Hispanic</td>
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</tr>
<tr>
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<td>1.2%</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Other</td>
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<td>6</td>
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<tr>
<td>Missing</td>
<td>2</td>
<td>2.4%</td>
<td>2</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th>Men Frequency</th>
<th>Percent</th>
<th>Women Frequency</th>
<th>Percent</th>
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<tr>
<td>Married First Time</td>
<td>48</td>
<td>58.5%</td>
<td>50</td>
<td>61.0%</td>
</tr>
<tr>
<td>Cohabitating</td>
<td>14</td>
<td>17.1%</td>
<td>14</td>
<td>17.1%</td>
</tr>
<tr>
<td>Remarried</td>
<td>7</td>
<td>8.5%</td>
<td>5</td>
<td>6.1%</td>
</tr>
<tr>
<td>Single, never married</td>
<td>2</td>
<td>2.4%</td>
<td>2</td>
<td>2.4%</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>2.4%</td>
<td>2</td>
<td>2.4%</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>1.2%</td>
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<td>0.0%</td>
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<tr>
<td>Missing</td>
<td>8</td>
<td>9.8%</td>
<td>9</td>
<td>11.0%</td>
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</table>

<table>
<thead>
<tr>
<th>Annual Household Income</th>
<th>Men Frequency</th>
<th>Percent</th>
<th>Women Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10,000</td>
<td>10</td>
<td>12.2%</td>
<td>10</td>
<td>12.2%</td>
</tr>
<tr>
<td>10-19,000</td>
<td>16</td>
<td>19.5%</td>
<td>16</td>
<td>19.5%</td>
</tr>
<tr>
<td>20-29,000</td>
<td>24</td>
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<td>23</td>
<td>28.0%</td>
</tr>
<tr>
<td>30-39,000</td>
<td>9</td>
<td>11.0%</td>
<td>9</td>
<td>11.0%</td>
</tr>
<tr>
<td>40-49,000</td>
<td>5</td>
<td>6.1%</td>
<td>7</td>
<td>8.5%</td>
</tr>
<tr>
<td>50-59,000</td>
<td>6</td>
<td>7.3%</td>
<td>3</td>
<td>3.7%</td>
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<td>60-69,000</td>
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<td>3.7%</td>
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<td>70-79,000</td>
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<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>80-89,000</td>
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<td>0.0%</td>
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<td>1.2%</td>
</tr>
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<td>90-99,000</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>100,000 or more</td>
<td>4</td>
<td>4.9%</td>
<td>4</td>
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<tr>
<td>Missing</td>
<td>5</td>
<td>6.0%</td>
<td>6</td>
<td>7.3%</td>
</tr>
</tbody>
</table>

Table 3.2: Sample Demographics
Table 3.2: (continued) Sample Demographics

<table>
<thead>
<tr>
<th>Highest Level of Education</th>
<th>Men Frequency</th>
<th>Men Percent</th>
<th>Women Frequency</th>
<th>Women Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than HS diploma</td>
<td>8</td>
<td>9.8%</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>High School diploma</td>
<td>4</td>
<td>4.9%</td>
<td>8</td>
<td>9.8%</td>
</tr>
<tr>
<td>GED</td>
<td>5</td>
<td>6.1%</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Some college</td>
<td>20</td>
<td>24.4%</td>
<td>27</td>
<td>32.9%</td>
</tr>
<tr>
<td>Associates</td>
<td>3</td>
<td>3.7%</td>
<td>4</td>
<td>4.9%</td>
</tr>
<tr>
<td>Bachelors</td>
<td>28</td>
<td>34.1%</td>
<td>21</td>
<td>25.6%</td>
</tr>
<tr>
<td>Masters</td>
<td>6</td>
<td>7.3%</td>
<td>11</td>
<td>13.4%</td>
</tr>
<tr>
<td>Professional Degree</td>
<td>1</td>
<td>1.7%</td>
<td>2</td>
<td>2.4%</td>
</tr>
<tr>
<td>Ph.D., MD, or JD</td>
<td>4</td>
<td>3.6%</td>
<td>5</td>
<td>6.1%</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>3.7%</td>
<td>2</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Procedure

Before the first session, therapists met with the couple briefly, described the study, and solicited their informed consent to participate. Clients who agreed to participate completed the intake questionnaire before their first appointment in the clinic waiting room. It was estimated to take about 30 minutes to complete. The initial intake questionnaire contained several instruments not pertinent to this study. Specific to this study, participants completed questionnaires at intake regarding demographics, marital satisfaction and commitment. Clients who participated were given a $10 reduction in fee for their first session. Once complete, the clients placed their questionnaires in the envelope provided and their therapist then gave the envelope to an assistant to enter the data. Then after sessions 2 though 6, the clients were asked to complete a one page questionnaire regarding marital satisfaction, commitment, and therapeutic alliance.
Confidentiality

To keep their answers confidential, the members of the couples completed the measures separately, were asked not to discuss their answers with each other, and placed their assessments in a locked box on their way out of the clinic. This was also done to ensure that the therapist did not see the answers to the therapeutic alliance questions. Clients may have been less willing to complete this part of the questionnaire honestly unless they were assured that their therapist would not be able to see their answers. No names appeared on the questionnaires so the questionnaires were identified with case numbers only. Only clinic staff were able to attach the case number to a name. Given the nature of the clinic services, all of this information remained confidential and all intake data was kept in the client files which were locked in a filing cabinet.

Instruments

*The Working Alliance Inventory – Shortened Version* (WAI-S; Tracey & Kokotovic, 1989) was developed and validated in relation to Bordin’s transtheoretical model of alliance (Bordin, 1994) and is a modified version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). It was developed specifically to be used in the early phase of therapy and was developed to apply across theoretical orientations, thus making it an appropriate instrument for this study. The shortened version of the WAI is a 12-item self-report measure that uses a 7-point Likert-type scale (1 = never, 7 = always) (Fischer & Corcoran, 1994). Alpha for the scale = 0.88.

The WAI-S is made up of three sub-scales: development of bonds, agreement on goals, and agreement on tasks (see Appendix E). The bond subscale \( n = 4; \alpha = 0.84 \) assesses the emotional bond of trust and attachment between patient and therapist (e.g.
“My therapist and I trust one another”). The goals subscale ($n = 4$; alpha = 0.65) assesses the degree of agreement concerning the overall goals of treatment (e.g. “My therapist and I are working toward goals that we both agree on”). The tasks subscale ($n = 4$; alpha = 0.71) assesses the degree of agreement concerning the tasks relevant for achieving these goals (e.g. “My therapist and I agree about the things I will need to do in therapy to help improve my situation”). The subscale scores can range from 4 to 28 and all three subscale scores can be combined for a total score. Therefore, total scores can range from 12 to 84 with higher scores reflecting more positive ratings of working alliance. The shortened version reveals a factor structure similar to the full-length version, as well as an acceptable internal consistency (ranging from .90 to .92 for the client version; .98 for the total score) and reliability estimates (test-retest reliability of .83 across a two-week period) (Horvath & Greenberg, 1994; Tracey & Kokotovic, 1989).

Researchers have found that therapist views of the alliance may substantially differ from those of the client (Bedi et al., 2005). The therapeutic alliance views of the clients have been most consistent with treatment outcome (Bourgeois et al., 1990; Sexton & Whiston, 1994). In other words, the perception of the client, more so than the perception of the therapist and observers, regarding therapeutic conditions, including the therapeutic alliance, is substantially related to and predictive of treatment outcomes (Gurman, 1977; Horvath & Symonds, 1991). As influenced by these findings, this study assessed therapeutic alliance after the third session (considered the early part of therapy) and therapeutic alliance was assessed only from the client’s perspective.
\textit{Split Alliance}

Empirical evidence has shown that split alliance can be identified using alliance scales (Heatherington & Friedlander, 1990). The split alliance can be measured using a difference between partner’s scores of one standard deviation although that will only reflect a small measurement difference. The problem with using just one standard deviation is the difference may be accounted for by the subjects’ response styles rather than a true difference in alliance. It has been recommended to use a difference of two standard deviations that will indicate a considerable margin of differences between individuals (Heatherington & Friedlander, 1990). Therefore, in this study, split alliance was defined as a difference of at least two standard deviations.

\textit{Presenting Problem}

Data regarding the presenting problem was extracted from the clients’ intake form (see Appendix B). The presenting problem was then coded based on whether it was deemed, from the client’s perspective, to be a couple problem (e.g. communication problems, lack of intimacy, problems with roles) or an individual problem (e.g. substance abuse, infidelity, discontent with work). The presenting problem was dummy coded for couple problem (0) or individual problem (1).

\textit{Gender of Initiator}

Data regarding the gender of the initiator was extracted from the clients’ initial intake form under the section “who called”. The gender was dummy coded for male (0) or female (1).
Marital Satisfaction

Marital satisfaction was assessed through a question on the intake form and then again on the questionnaires after sessions 2 through 6 (see Appendix D). The clients were asked to rate their marital satisfaction on a 10-point likert scale from 1 = not at all satisfied to 10 = completely satisfied.

Commitment

Commitment was assessed through a question on the intake form and then again on the questionnaires after sessions 2 through 6 (see Appendix D). The clients were asked to rate their commitment to the relationship on a 10-point likert scale from 1 = not at all committed, to 10 = completely committed.

Drop Out

The circumstances regarding termination were dummy coded from 0 to 4 and were recorded from the client’s case file on the termination form completed by the therapist (see Appendix F). The therapists recorded if their clients ended therapy for the following reasons: by therapist and client agreement (0), against therapist recommendation (1), the client no-showed (2), the clients moved or went elsewhere for therapy (3), or the relationship ended due to a break-up or divorce (4). The clients labeled as “dropped out” were those who no-showed or terminated against the therapist’s recommendation (coded 1 and 2).

Demographics

Demographic information about each participant was collected from the intake questionnaire (see Appendix C). The information that was collected included age, sex, race, relationship status, education level, and annual income.
CHAPTER 4

RESULTS

Data Analysis of Specific Research Questions and Hypotheses

The following section addresses the data analysis procedures used to test the research questions and hypotheses for each of the research objectives. Descriptive statistics, independent sample t-tests, paired t-tests, and repeated measure analysis of variance (ANOVA) were used to analyze the data. For each analysis, therapeutic alliance was collected from questionnaires after the third session from the client’s perspective. Due to the fact that many of the client’s data regarding therapeutic alliance were missing at Time 3 (either due to drop-out or the assessment not being administered by the therapist), the intent-to-treat (IT) analysis was conducted. IT principles mandate that all cases be included in the analysis, regardless if they are complete or incomplete (Mazumdar, Liu, Houck, & Reynolds, 1999). Two options utilizing IT analysis are multiple imputation (MI) and last observation carried forward (LOCF). MI imputes missing data by utilizing available information from the study (Mazumdar et al., 1999), such as scores from other phases of the study. LOCF uses all subjects in the sample and imputes the missing data with the last observed value, thus assuming that there would be no change from the last observed value (Houck et al., 2004). Researchers have found that the clients’ views of the alliance remained stable, versus those of the therapists and the
observers that indicated more change (Martin et al., 2000). Therefore, for this study, both MI and LOCF were utilized. The most recent score was imputed for Time 3 for participants who were missing the score for their therapeutic alliance at Time 3, but had therapeutic alliance scores for Time 1 or Time 2.

Impact of Gender on Therapeutic Alliance and Outcome

The first objective of the study was to empirically identify the differences between men and women with regards to their therapeutic alliance in couples therapy and to determine how gender impacts alliance in couples therapy. Differences empirically identified include alliance and outcome. To analyze the impact of gender on therapeutic alliance, a paired t-test was conducted. The t-test indicated significant difference between men and women on their therapeutic alliance scores at Time 3 ($p = 0.01$). Men’s scores ($M = 66.64; SD = 9.71$) were significantly lower than women’s ($M = 69.99; SD = 8.55$). Based on this analysis, for this sample, therapeutic alliance does vary by gender.

A paired t-test was then conducted pairing men and women of each couple and then testing for the differences of the impact of gender on outcome (marital satisfaction and commitment) (see Table 4.1). To demonstrate change or improvement, the analysis used outcome data from Time 2 and Time 3. The t-test demonstrated a significant difference in marital satisfaction at Time 2 ($t = 4.09; p < .01$) and at Time 3 ($t = 3.14; p = .003$) but there was no significant difference in commitment. At Time 2, men’s marital satisfaction ($M = 6.89; SD = 2.10$) was higher than women’s marital satisfaction at Time 2 ($M = 5.91; SD = 2.36$) and it continued to be higher ($M = 6.81; SD = 2.16$) than women’s marital satisfaction ($M = 6.02; SD = 2.48$) at Time 3. Although it was not statistically significant, men had higher commitment scores ($M = 8.60; SD = 2.05$) than
women ($M = 8.41; SD = 2.18$) at Time 2 and also at Time 3 (men: $M = 8.77; SD = 1.67$; women: $M = 8.26; SD = 2.39$). Therefore, gender seemed to impact therapeutic alliance and improvement of marital satisfaction but it does seem to impact commitment.

The second objective of the study was to empirically identify how therapeutic alliance was impacted by the role of the client (e.g. initiator of therapy versus non-initiator of therapy. It was hypothesized that the person who initiated therapy would have a stronger alliance with the therapist, regardless of gender, than the non-initiator. The hypothesis was based on de Shazer’s concept of visitor versus customer and the initiator would be more inclined to be a customer whereas the non-initiator may be a visitor.

Two factors led to the analysis. One was the undeniable interrelatedness between gender and who initiated therapy (the initiator would either be the man or the woman and, thus, be related to gender) and, therefore, they could not be analyzed separately. In addition, gender needed to be analyzed within couples rather than between couples to see if who initiated made a difference within each couple. Accordingly, a repeated measures ANOVA was conducted. This analysis demonstrates the difference (or slope) between variables

<table>
<thead>
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<th>Men</th>
<th>Women</th>
<th>$t$</th>
<th>$p$</th>
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<td>TA Score Time 3</td>
<td>66.64</td>
<td>69.99</td>
<td>-2.65</td>
<td>0.01*</td>
</tr>
<tr>
<td>Satisfaction Time 2</td>
<td>6.89</td>
<td>5.91</td>
<td>4.09</td>
<td>&lt;.01***</td>
</tr>
<tr>
<td>Satisfaction Time 3</td>
<td>6.81</td>
<td>6.02</td>
<td>3.13</td>
<td>&lt;.01*</td>
</tr>
<tr>
<td>Commitment Time 2</td>
<td>8.60</td>
<td>8.41</td>
<td>0.71</td>
<td>0.48</td>
</tr>
<tr>
<td>Commitment Time 3</td>
<td>8.77</td>
<td>8.26</td>
<td>1.73</td>
<td>0.09</td>
</tr>
</tbody>
</table>

* $p < .05$. *** $p < .001$

Table 4.1: Paired T-test Results for The Impact of Gender on Therapeutic Alliance and Outcome.
members of a dyad (Maguire, 1999), thus analyzing the difference between men and women within the same couple.

Therapy was predominantly initiated by women as men initiated therapy only 29% of the time. A repeated measures ANOVA was conducted to test the hypothesis that the person who initiated therapy would have a stronger alliance with the therapist than the non-initiator. This was done by pairing the initiator with the non-initiator and determining the impact that had on therapeutic alliance. The analysis demonstrated no significance ($F(1,80) = 4.01; p = 0.33$) between who called and therapeutic alliance. Therefore, the hypothesis that the person who initiated therapy would have a stronger alliance than the non-initiator was not supported.

*Therapeutic Alliance and Dropout*

The third objective of the study was to empirically identify if therapeutic alliance impacted dropout. It was hypothesized that those who dropped out of therapy would have a significantly lower therapeutic alliance than those who do not drop out of therapy. An independent sample t-test was conducted to test this hypothesis. The t-test compared two groups, those who did ($N = 122$) and those who did not drop out of therapy ($N = 42$). Dropout was defined as those clients who terminated against the therapist’s recommendation and those who no-showed for future appointments. Those who did not drop out were those who ended therapy by therapist and client agreement, moved or went to another clinic, and those whose relationships ended.

The t-test showed no statistically significant difference in therapeutic alliance between those who dropped out of therapy (men: $M = 67.44; SD = 9.09$; women: $M = 70.24; SD = 9.09$) and those who did not drop out (men: $M = 65.63; SD = 11.42$; women: 36
Based on these results, the hypothesis that those who dropped out of therapy would have a significantly lower therapeutic alliance than those who did not drop out of therapy was not supported. Actually, although it was not a significant difference, those who dropped out of therapy had a higher therapeutic alliance than those who did not drop out.

**Split Alliance and Outcome**

The fourth objective of the study was to empirically identify how a split alliance between both members of the couples impacted outcome. It was hypothesized that couples whose alliance scores differed more than two standard deviations would show no improvement in marital satisfaction or commitment. In fact, the greater they differ, the less positive their outcome. To test this hypothesis, a one-way ANOVA was conducted with three groups: couples whose scores differed less than one standard deviation, those differing one standard deviation, and those differing two standard deviations (see Table 4.2). The independent variable was split alliance and the dependent variables were the male’s marital satisfaction, the male’s commitment, the female’s marital satisfaction, and the female’s commitment. The analysis was run both between men and women across all couples as well as within couples to see if there was a specific difference within the couples with a split alliance.

Of the 82 couples, 38 couples had less than one standard deviation difference in their therapeutic alliance scores, 30 couples had a difference of one standard deviation, and 14 couples had a difference of two standard deviations. Based on the one-way ANOVA, the hypothesis was not supported. There was no statistically significant difference in marital satisfaction for women ($p = 0.24$) or for men ($p = 0.71$) or in
commitment for women \((p = 0.73)\) or for men \((p = 0.81)\) with a therapeutic alliance differing less than one standard deviation, differing one standard deviation, or those differing two standard deviations. Although it was not significant, the mean scores did demonstrate that women’s marital satisfaction \((M = 6.57; SD = 2.60)\), men’s marital satisfaction \((M = 7.10; SD = 2.02)\), women’s commitment \((M = 8.48; SD = 2.16)\) and men’s commitment \((M = 8.95; SD = 1.15)\) were higher when their therapeutic alliance scores differed only one standard deviation versus those who differed two standard deviations.
<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
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<td></td>
<td></td>
<td>58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA &lt; 1 SD</td>
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<td>2.61</td>
<td></td>
<td>1.45</td>
<td>0.24</td>
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<tr>
<td>TA 1 SD</td>
<td>6.57</td>
<td>2.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA 2 SD</td>
<td>5.10</td>
<td>2.28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Commitment</strong></td>
<td></td>
<td></td>
<td>58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA &lt; 1 SD</td>
<td>7.90</td>
<td>2.89</td>
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<td></td>
</tr>
<tr>
<td>TA 1 SD</td>
<td>8.48</td>
<td>2.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA 2 SD</td>
<td>8.20</td>
<td>2.35</td>
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<tr>
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<td></td>
<td>58</td>
<td></td>
<td></td>
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<tr>
<td>TA &lt; 1 SD</td>
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<tr>
<td>TA 1 SD</td>
<td>7.10</td>
<td>2.02</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Men’s Commitment</strong></td>
<td></td>
<td></td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA &lt; 1 SD</td>
<td>8.64</td>
<td>2.08</td>
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<td></td>
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</tr>
<tr>
<td>TA 1 SD</td>
<td>8.95</td>
<td>1.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA 2 SD</td>
<td>8.90</td>
<td>1.29</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: TA < 1 SD = couples who had less than one standard deviation difference in their therapeutic alliance scores; TA 1 SD = couples differing one standard deviation; TA 2 SD = couples differing two standard deviations.

Table 4.2: One-Way ANOVA Results for the Impact of a Split Alliance on Outcome at Time 3.

**Impact of Presenting Problem on Therapeutic Alliance and Outcome**

The fifth objective of the study was to empirically identify if and how the type of presenting problem impacted alliance and outcome (e.g. marital satisfaction and commitment). It was hypothesized that couples with problems that could be referred to as a “couple problem” (e.g. communication problems, lack of intimacy, problems with roles) would have greater therapeutic alliance and outcome when compared to couples who had problems that were more “individual problems” or thought to be one person’s problem (e.g. substance abuse, infidelity, discontent with work). To test this hypothesis, a
t-test was conducted between couples to analyze whether or not the presenting problem impacted therapeutic alliance, marital satisfaction, and commitment. For each couple, the presenting problem was coded based on whether it was considered a couple problem \((N = 64)\) or an individual problem \((N = 18)\). The t-test indicated no significant difference in therapeutic alliance for women \((t = 1.55; p = 0.13)\) or men \((t = 0.19; p = 0.85)\), in marital satisfaction for women \((t = -0.74; p = 0.46)\) or men \((t = -1.46; p = 0.15)\), or in commitment for women \((t = -0.11; p = 0.91)\) or men \((t = -0.13; p = 0.90)\) based on the type of presenting problem. Therefore, the hypothesis that, when compared to couples with individual problems, couples with couple problems would have greater therapeutic alliance and outcome was not supported.

**Post Hoc Analyses**

**Therapeutic Alliance: A Continuous Variable**

Post hoc analyses were conducted to determine the impact of a split therapeutic alliance on marital satisfaction and commitment if therapeutic alliance was a continuous variable, rather than as a variable limited by differing one and two standard deviations. In addition to determining the level of “splitness,” this analysis was conducted to determine what the effect was based on whose scores were higher (the man’s versus the woman’s). The Reliability Change Index (RC) was used to determine the cutoff point of the scores that would be considered significant. An RC exceeding 1.96 is the \(p\) value that is considered statistically significant (Jacobson, Follette, & Revenstorf, 1984 as cited in Hawley, 1993). Therefore, any participant scores with an absolute value of less than 1.96 was not included as significant. Based on the RC, very few couples had “equal”, or not statistically different, therapeutic alliance scores (9.7%).
Whose Therapeutic Alliance is Higher? Does it Make a Difference?

A repeated measures ANOVA was conducted to determine whose therapeutic alliance was different within each couple. Based on this analysis, two of the cases were equal and were, therefore, not considered split and six of the couples fell below the 1.96 absolute value cutoff. The majority of the couples that were included in the analysis demonstrated that the woman’s therapeutic alliance score was higher than the man’s \( (n = 47) \) and a little more than one-third of the couples demonstrated that the man’s therapeutic alliance score was higher than the woman’s \( (n = 27) \). The analysis indicated no significance in marital satisfaction and commitment based on whose therapeutic alliance was higher.

Although it did not seem to matter who had a higher alliance, a linear regression was conducted to analyze four questions with regard to marital satisfaction and the same four questions with regard to commitment: 1) If women’s scores are different, does how different they are impact the men’s marital satisfaction/commitment? 2) If women’s scores are different, does how different they are impact their own marital satisfaction/commitment? 3) If men’s scores are different, does how different they are impact the women’s marital satisfaction/commitment? 4) If men’s scores are different, does how different they are impact their own marital satisfaction/commitment. The dependent variables were marital satisfaction at Time 2 and Time 3 and then, for the second analysis, commitment at Time 2 and Time 3. The independent variables were the within couple differences in therapeutic alliance scores at Time 3 and who was different (meaning whose scores were higher or lower).
After controlling for the fact that marital satisfaction and commitment at Time 2 explained the majority of the variance at Time 3, the analysis indicated that who was different made a difference but not necessarily how different. There was a significant $F$ when looking at men’s marital satisfaction ($p = .02$) but not for anything else, not even for the man’s commitment. Using the RC index, when there was a split alliance, the man’s improvement in marital satisfaction was better when his score was higher than the woman’s as compared to when the woman’s was higher than the man’s. Therefore, it did not seem to matter how different they were but, rather, who was different.

**Controlling for Therapeutic Alliance**

A second linear regression was conducted to see what would happen if therapeutic alliance was controlled for in general (see Tables 4.3 and 4.4). Would who was different still matter? Even when therapeutic alliance was controlled for, the analysis indicated that, no matter how low or how high the therapeutic alliance was, who was different still mattered ($p = .02$). The significance was found for the man’s change in marital satisfaction between Time 2 and Time 3. There was no significance regarding who was different and its impact on men’s commitment.

The analysis also indicated that, for the women, as the therapeutic alliance increased there was less change in marital satisfaction ($p = .04$). In addition, who is different made a difference in commitment. The linear regression demonstrated that commitment at Time 2 accounted for a significant amount of the variance but who was different was significant in accounting for change in women’s commitment ($p = .03$). When the women had higher therapeutic alliance scores than the men at Time 3, the
women's change in commitment went up. When the men had higher therapeutic alliance scores than the women at Time 3, the change in the women's commitment decreased.

<table>
<thead>
<tr>
<th>Variable</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>R² Change</th>
</tr>
</thead>
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<tr>
<td><strong>Dependent Variable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men's Satisfaction Time 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction Time 2</td>
<td>.53</td>
<td>3.99</td>
<td>&lt;.001***</td>
<td>.280</td>
</tr>
<tr>
<td>Women's TA Time 3</td>
<td>.37</td>
<td>1.75</td>
<td>.088</td>
<td></td>
</tr>
<tr>
<td>Men's TA Time 3</td>
<td>-.28</td>
<td>-1.16</td>
<td>.255</td>
<td></td>
</tr>
<tr>
<td>Who is Different</td>
<td>.64</td>
<td>2.49</td>
<td>.017*</td>
<td></td>
</tr>
<tr>
<td>TA Difference</td>
<td>-.04</td>
<td>-.26</td>
<td>.794</td>
<td>.109</td>
</tr>
</tbody>
</table>

R² of accepted model = .424; F(5,37) = 5.45, p = .001

| Dependent Variable               |     |      |       |           |
| Men's Commitment Time 3          |     |      |       |           |
| Commitment Time 2                | .74 | 6.87 | <.001*** | .541     |
| Women's TA Time 3                | -.06| -.32 | .754  |           |
| Men's TA Time 3                  | .10 | .48  | .635  |           |
| Who is Different                 | .07 | .33  | .741  |           |
| TA Difference                    | -.07| -.52 | .606  | .003     |

R² of accepted model = .581; F(5,36) = 10.00, p<.001

*p < .05 ***p < .001

Table 4.3: Linear Regression Results for the Impact of Who is Different and How Different They Are on Outcome for Men.
<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$R^2$ Change</th>
</tr>
</thead>
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<tr>
<td>Dependent Variable</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s Satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction Time 2</td>
<td>.80</td>
<td>8.47</td>
<td>&lt;.001***</td>
<td>.636</td>
</tr>
<tr>
<td>Women’s TA Time 3</td>
<td>-.20</td>
<td>-2.12</td>
<td>.040*</td>
<td></td>
</tr>
<tr>
<td>Men’s TA Time 3</td>
<td>-.01</td>
<td>-.05</td>
<td>.963</td>
<td></td>
</tr>
<tr>
<td>Who is Different</td>
<td>.10</td>
<td>.50</td>
<td>.620</td>
<td></td>
</tr>
<tr>
<td>TA Difference</td>
<td>-.03</td>
<td>-.27</td>
<td>.791</td>
<td>.002</td>
</tr>
</tbody>
</table>

$R^2$ of accepted model = .678; $F(5,37) = 15.55, p < .001$

| Dependent Variable   |        |       |      |              |
| Women’s Commitment   |        |       |      |              |
| Commitment Time 2    | .80    | 8.44  | <.001*** | .635 |
| Women’s TA Time 3    | -.25   | -1.67 | .103  |      |
| Men’s TA Time 3      | .27    | 1.48  | .149  |      |
| Who is Different     | -.43   | -2.28 | .029* |      |
| TA Difference        | -.04   | -.33  | .747  | .060 |

$R^2$ of accepted model = .698; $F(5,37) = 17.08, p < .001$

$p < .05$ ***$p < .001$

Table 4.4: Linear Regression Results for the Impact of Who is Different and How Different They Are on Outcome for Women.
CHAPTER 5

DISCUSSION

Empirical research supports the association between therapeutic alliance and outcome across diverse forms of individual treatment (Horvath & Symonds, 1991; Martin et al., 2000). Despite the fact that therapeutic alliance is an acknowledged area of importance in individual therapy, little research has been conducted regarding how gender, the initiation of therapy, a split alliance, and the type of presenting problem impact outcome and alliance in couples therapy. The present study investigated how gender, who initiated therapy, split alliance, and the type of presenting problem impacted therapeutic alliance and outcome. This study provides a working foundation for continued empirical research in the area of couples therapy and therapeutic alliance.

Within this chapter, gender, who initiated therapy, split alliances, and the type of presenting problem and their impact on therapeutic alliance, marital satisfaction, and commitment are discussed. Next, possible explanations and further hypotheses are explored and areas of future research are suggested. Finally, strengths and limitations of the present empirical investigation are identified and clinical implications are noted.
Results of the Research Questions and Hypotheses and Future Research

Impact of Gender on Therapeutic Alliance and Outcome

Most conclude that the influences of therapeutic alliance are different by gender (Thomas et al., 2005) but there is little agreement about how alliance is associated with outcome for men versus women. This study attempted to empirically identify the differences between men and women with regards to their therapeutic alliance in couples therapy and to determine how gender impacted alliance and outcome in couples therapy. The analysis indicated that the difference between men and women’s therapeutic alliance scores was significant. Men’s therapeutic alliance scores were lower than women’s. This may be explained in clinical literature as it has been found that men are less likely than women to talk to others about their problems (Berger, 1979) and men tend to be the ones who cancel therapy sessions (Berg & Rosenblum, 1977). Due to the fact that therapy deals mostly with emotions and relationships, men are seen as coming to therapy at a disadvantage and that a power differential will already exist (Garfield, 2004). Men may eventually warm up and buy into the process. Given that, for this study, therapeutic alliance was assessed at Time 3, future research assessing men’s therapeutic alliance over time may show an increase in their scores further along.

Further analysis demonstrated a significant difference in marital satisfaction at Time 2 and at Time 3 but there was no significant difference in commitment. At Time 2, men’s marital satisfaction was higher than women’s marital satisfaction at Time 2 and it continued to be higher than women’s marital satisfaction at Time 3. Although it was not statistically significant, men had higher commitment scores than women at Time 2 and also at Time 3. Therefore, gender does not seem to impact commitment but it does seem
to impact therapeutic alliance and the improvement of marital satisfaction. It has been found previously that, in general, men are more satisfied in marriage than women (Blair, 1993; Orbuch & Custer, 1995; Orbuch, Veroff, & Holmberg, 1993) so this finding is not unique to this study.

Using a systems theory perspective, therapeutic alliance is defined as “that aspect of the relationship between the therapeutic system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy” (Pinsof & Catherall, 1986, p. 139). Therefore, each individual’s alliance has the possibility to impact and be impacted by every other individual’s alliance with the therapy (Heatherington & Friedlander, 1990). The results from this study found significance in the impact of gender on therapeutic alliance, finding that women’s therapeutic alliance scores are significantly higher than men’s. From a system’s perspective, the varying levels of alliance between the members of the couple may impact that process and it is important for the therapist to attempt to pull both members of the couple into the therapeutic process. Maybe it is not the gender of the client that should be the focus but rather how the client feels they are invested in and collaborating on the process. Rather than assessing therapeutic alliance through a confidential paper-and-pencil measure, it would be beneficial for future research to study the impact of verbally assessing the therapeutic alliance with the clients after each session. This would allow the therapist to see how involved, understood, and listened to each client feels in the process. These conversations would give the therapist and the clients an opportunity to process feelings of being left out, sided against, or not valued. The therapist could adjust the sessions accordingly and work to improve the alliances with all clients. These discussions could possibly impact therapeutic alliance
scores, retention, and outcome. It has been hypothesized that when the client and the therapist work together to establish the tasks and goals in therapy the results will be deeper and more meaningful (Heatherington & Friedlander, 1990). Future research is needed to determine if this hypothesis is supported.

The Impact of Who Initiated Therapy

Not every member of the couple system enters therapy with equal motivation and some clients may even be coming to therapy involuntarily (Rait, 2000). This study attempted to empirically identify how therapeutic alliance was impacted by the role of the client (e.g. initiator of therapy versus non-initiator of therapy). It was hypothesized that the person who initiated therapy would have a stronger alliance with the therapist, regardless of gender, than the non-initiator. The hypothesis was based on de Shazer’s concept of visitor versus customer and the initiator would be more inclined to be a customer whereas the non-initiator may be a visitor.

Therapy was predominantly initiated by women and the analysis demonstrated no significance between who called and therapeutic alliance. The person who initiated therapy did not have a stronger alliance than the non-initiator. Future research should investigate why women are more inclined to initiate therapy and what prevents more men from being the initiator. It may be the way in which therapy is marketed or perceived that influences people from coming to or avoiding therapy. Additionally, who initiated therapy was assessed in a rather primitive way, as it was extracted from the intake form based on who called. This method assumed that the person who called initiated therapy and that may not be true. It may have been that the non-caller initiated the idea of therapy but due to other circumstances, such as not having access to a phone during the day,
wanting the other partner to take some responsibility, or not having time to make the call, the non-initiator may have actually been the person who called to set up the first appointment. Future research should directly ask the clients who initiated therapy.

An additional measure to assess “visitor” versus “customer” may also be more relevant to determine if there is a difference in attitude towards therapy from the initial session and how that attitude impacts therapeutic alliance. This would especially be important over time to determine if the visitor ever became a customer and, if so, what characteristics of the therapeutic relationship contributed to that transformation.

**Therapeutic Alliance and Dropout**

Differences in viewpoint and conceptualization of the problem have been linked with higher dropout rates (Allgood & Crane, 1991). When compared to the middle and late phases of therapy, the alliance that is established in the beginning phase of therapy is more predictive of outcome and dropout (Horvath & Symonds, 1991). This study attempted to empirically identify if therapeutic alliance impacted dropout. Seventy-five percent of the participants dropped out of therapy. Even when analyzed at Time 3, which is considered to be in the beginning phase of therapy, the analysis showed no statistically significant difference in therapeutic alliance between those who dropped out of therapy and those who did not drop out. Therefore, for this sample, therapeutic alliance does not seem to impact dropout. Actually, although it was not a significant difference, those who dropped out of therapy had a higher therapeutic alliance than those who did not drop out.

The high dropout rate may be due to external reasons, such as financial reasons, conflict with work schedules, problems with transportation, possibly not wanting to come to a training facility, or they may not be ready to change. Clients may not be motivated to
change or they may feel more comfortable with the “known” rather than the new and “unknown”. Motivation has been found to predict successful outcome in therapy (Luborsky, Crits-Christoph, Mintz, & Auerback, 1986). Even more explicit than motivation, research has been conducted to show seven precursors that are necessary for change to occur: 1) a sense of necessity, 2) willingness to experience anxiety, 3) awareness of the problem, 4) confronting the problem, 5) effort, 6) hope, and 7) social support (Hanna, 1996; Hanna & Ritchie, 1995). It is possible that, regardless of therapeutic alliance, if these precursors are not in place clients will either drop out of therapy or there will be limited or no progress.

Based on the finding that those who dropped out actually had a higher therapeutic alliance than those who remained, as well as such a high dropout rate, demonstrates a need to assess this further. In addition to readiness to change, it may be that clients are not motivated to change themselves but were motivated to come to therapy to change their partners. They may have very high therapeutic alliance and are very excited to come to therapy to “help” or to “fix” their partner. Thus, when that client is also asked or expected to change, he or she may drop out. Another possibility for a higher alliance for those who dropped out may be that the clients feel comfortable with the therapist, got what they wanted for the time being, and now know that the therapist is there for them when they need it, and, thus, can come back at a later time. For future research, it would be useful to have clients complete an exit questionnaire to determine why clients dropped out. This assessment could provide useful information for therapists to know what could be addressed or changed to decrease the number of clients who drop out before therapy is deemed successful and it may also change the way in which “successful” is defined.
Future research may even show that therapeutic alliance is not as important as once thought. Other factors, such as addressing the clients’ readiness to change, may actually be more important to increase retention.

Split Alliance and Outcome

Agreement between partners about the strength of the alliance influences the relation between the alliance and outcome (Symonds & Horvath, 2004). It is predictive of a positive outcome when the partners agree about the strength of their alliance rather than their individual assessments (Symonds & Horvath, 2004). This study attempted to empirically identify how a split alliance between both members of the couples impacted marital satisfaction and commitment. Of the 82 couples, 38 couples had less than one standard deviation difference in their therapeutic alliance scores, 30 couples had a difference of one standard deviation, and 14 couples had a difference of two standard deviations. The analysis demonstrated no statistically significant difference in marital satisfaction or commitment for women or for men with a therapeutic alliance differing less than one standard deviation, differing one standard deviation, or those differing two standard deviations. Although it was not significant, the mean scores did demonstrate that women’s and men’s marital satisfaction and commitment were higher when their therapeutic alliance scores differed only one standard deviation versus those who differed two standard deviations.

The results may have shown more significance if marital satisfaction and commitment had been measured after more than three sessions. It may have been difficult to demonstrate improvement in such a short period of time and the lack of difference between the two groups may have also been attributed to a lack of progress within all
three groups. Possibly, as mentioned before, therapeutic alliance may not be the factor that impacts outcome as greatly as previously thought. It would be prudent to research other factors, including de Shazer’s concept of visitor versus customer along with the concept of a client’s readiness to change, to determine if those factors may actually have a greater impact on outcome.

Another result that was interesting yet statistically insignificant was that marital satisfaction and commitment scores were lower for both men and women when their therapeutic alliance scores differed less than one standard deviation versus those that differed one standard deviation. Those differing less than one standard deviation also had lower commitment scores than those differing two standard deviations. These results do not show whether the scores differed less than one standard deviation because the couple was close to agreement that they had a negative or a positive alliance with the therapist. They may have agreed that they were not interested in, benefiting from, or in need of therapy, thus they both could have had low therapeutic alliance scores but still higher marital satisfaction and commitment scores than those who greatly did not agree about their therapeutic alliance or their need to be coming to therapy. Further research should be conducted to address this surprising finding.

The post hoc analysis was conducted to determine the impact of therapeutic alliance as a continuous variable. This analysis evaluated the level of “splitness” rather than dividing split alliance based on varying by one or two standard deviations. This analysis provides a new way of thinking about therapeutic alliance as it is seen on a continuum of splitness and provides more information about couples who do not agree about their therapeutic alliance but are not necessarily extremely different. Future
research should continue to view differences in therapeutic alliance as a continuous variable rather than as a variable differing by standard deviations.

The post hoc analysis demonstrated that who was different, versus how different, was significant. Women’s change in commitment increased when their therapeutic alliance scores were higher than the men’s. Although, women’s commitment decreased when the women’s scores were lower than the men’s. This finding may be due to a coalition being formed between the therapist and the other client. Maybe, as the man’s therapeutic alliance increases, the woman feels sided against. By definition, a coalition is a negative alliance between two members against another member (Minuchin, 1974). This feeling of being sided against may even be more strong when the women initiated therapy and felt that she had established a relationship with the therapist before the first session. Having her partner, possibly a “visitor” who was not wanting to come to therapy from the beginning, establishing an alliance with the therapist may cause the woman to feel that they are forming an alliance against her. More research in therapeutic alliance with couples needs to be conducted to determine why who is different seems to be more significant than how different.

Impact of the Presenting Problem on Therapeutic Alliance and Outcome

It has been found that couples with a presenting problem relating only to one spouse had a greater chance of dropping out of therapy (Allgood & Crane, 1991). It has been well documented that the presenting problem is related to retention (Allgood & Crane, 1991; LeFave, 1980; Ross & Lacey, 1961) but this study attempted to empirically identify if and how the type of presenting problem impacted alliance and outcome (e.g. marital satisfaction and commitment). Seventy-eight percent of the couples presented
with a couple problem (e.g. communication problems, lack of intimacy, problems with roles) and, therefore, less than a quarter of the sample presented with an individual problem (e.g. substance abuse, infidelity, discontent with work). The analysis indicated no significant difference in therapeutic alliance, marital satisfaction, or commitment for women or men based on the type of presenting problem.

Differences in viewpoint and conceptualizations of the problem, as well as having a presenting problem that is viewed as relating only to one spouse, have been linked with higher dropout rates (Allgood & Crane, 1991). Hence, an interesting addition to this analysis, and a suggestion for future research, would have been asking an additional question on the intake questionnaire regarding what the presenting problem was as reported by each member of the couple, as opposed to just the opinion of the person who first called to set up therapy, and whether or not the members of the couple agreed about their presenting problem. Comparing couples who agreed about the presenting problem with those who disagreed and seeing how that impacted outcome may have brought about different, more telling results.

Strengths and Limitations

**Strengths**

This study had many strengths, thus adding to the research conducted on therapeutic alliance when doing couples therapy. The results demonstrated that gender and whose therapeutic alliance scores are different does matter. The results also indicated that who initiated therapy did not matter, thus possibly decreasing the importance of the role of initiator, that the presenting problem does not impact therapeutic alliance, and that therapeutic alliance did not impact outcome or dropout. The results of the study also may
bring about change when conceptualizing therapeutic alliance and outcome. The first change may be in viewing and analyzing differences in therapeutic alliance on a continuum and to measure within couple differences based on degree of “splitness”. The second change may be reducing the emphasis of therapeutic alliance and its impact on drop out rates. Rethinking the role of the relationship between the clients and the therapist and how that may impact retention, thus leading to new ways of researching the concept, is a great contribution of this study.

Limitations

This research was limited in several ways. First, although the sample was representative of couples seeking couples therapy in an outpatient treatment setting, caution must be taken when generalizing the findings to other therapeutic settings and populations. Part of that consideration is due to the fact that the clinic is a training facility and, naturally, the therapists were predominantly trainees and, additionally, they were predominantly females. Another factor limiting the generalizability of this study is that a high percentage of the sample was Caucasian and rather well educated. Therefore, these findings may not be easily generalizable to other treatment settings, therapists, or samples. Although, studies have been conducted to demonstrate that findings in a couples and family therapy clinic are comparable to both community and private practice settings (Ward & McCollum, 2005) so the findings may not be limited solely based on the setting.

Second, the impact of the gender of the therapist was not analyzed. This is another limitation to the study seeing that gender of the client impacted therapeutic alliance, the gender of the therapist may have also had an impact on therapeutic alliance and possibly
on other aspects, such as drop out. This analysis was not done due to a very limited number of male therapists. An overwhelming majority of the therapists were females.

Third, the sample was self-selected due to only including those who were willing to participate in the study. This is a limitation as it is not known how this affected the results. It is possible that those who did not participate in the study would have had vastly different therapeutic alliance, marital satisfaction, or commitment scores than those who completed the study.

Fourth, some of the instruments used were another limitation. Both marital satisfaction and commitment were one-item measures. Having only one item to assess something so complex may have reflected a reporting bias, as couples had only one subjective item to measure their satisfaction and commitment at that time. These measures were given to the participants immediately following the session. Depending on how the session went, those feelings could have greatly influenced the participants’ reports about their relationship. Multiple items reflecting various aspects of the relationship may have provided a more accurate picture of their day-to-day relationship satisfaction and commitment.

Clinical Implications

The findings of this research have several implications for the clinical practice of marriage and family therapy. As demonstrated through the results of this study, therapeutic alliance does not impact dropout but many couples drop out of therapy before their problems are resolved. This finding demonstrates a need for therapists to have more conversations with their clients about obstacles that may prevent them from coming to therapy as well as conversations about their committing to a certain number of sessions.
The findings also demonstrated a difference in marital satisfaction and commitment for couples whose therapeutic alliance scores were more different than similar as well as an importance regarding whose scores were higher. Therapists need to pay attention to the couple as a system and how their alliances are impacting each other as well as the therapeutic process. Aligning with clients cannot be viewed as a task with each individual but rather a necessity with the client system. It is important for both members to have a high therapeutic alliance and it is most beneficial for the clients to agree and have an intact alliance. The therapist also needs to keep in mind that there may be other factors beyond therapeutic alliance impacting the clients that need to be addressed to help the clients move towards change. The therapist needs to be aware of coalitions and needs to only side with clients when it is done purposefully as a therapeutic intervention. While ruptures in the therapeutic alliance can present a hurdle to therapeutic progress, they also provide the therapist and the clients with valuable information and the opportunity to discuss the alliance and to move towards improving the current relationship (Safran, 1993). This may also be true for split alliances and therapists should view information regarding a split alliance as an opportunity for useful conversations to take place. The split alliance may give the therapist more information for how the couple functions and communicates, not just about the alliance itself.

As a marriage and family therapist, the main objective is to maintain a systemic perspective whether the clients present with an individual, couple, or family problem. Although the presenting problem was not found to impact therapeutic alliance, which may have been due to uneven comparison groups, it is important for the therapist to view an individual problem as a system problem. Once therapists buy into the mentality of a
problem only impacting or being caused by one member of the couple they will ostracize and shut out the other member. This can then begin to feel like a coalition which, as was demonstrated, can lead to a split alliance.

Conclusions

Therapeutic alliance has been thought to be an extremely important factor in the success of therapy; it is considered the main vehicle of change (Horwitz, 1974). It has been related to successful therapy outcome in all forms of psychotherapy (Bordin, 1979; Horvath & Symonds, 1991) and its importance extends beyond the specifications of one particular theory (Wolfe & Goldfried, 1988). It has been identified as the most important determinant in the continuance and success of treatment (Rogers, 1957) as well as the most frequently identified factor contributing to the outcome of therapy (Beutler & Harwood, 2002; Horvath & Symonds, 1991). The alliance has been shown to be a prerequisite for therapeutic interventions to be effective (Gaston, 1990). Is it truly as important when working with couples? May there be other factors that impact the success and continuance of therapy? The field of marriage and family therapy was advanced by this research by questioning this very concept that seems to have just been accepted. As a result of this study, we know that many couples drop out of therapy, women tend to initiate therapy, split alliances do impact outcome, and whose therapeutic alliance is different matters more than how different. This study demonstrated that gender, who initiated therapy, and the presenting problem did not impact therapeutic alliance in couples therapy. What can therapists do to decrease dropout rates? Why are women initiating therapy more than men? How can therapists work to make both members of the couple feel equally heard, understood, and included in the process? Therapeutic success
is too important to stop here. More needs to be done to inform therapists and to improve the marriage and family therapy field.


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APPENDIX A

MODEL CONCEPTUALIZING RESEARCH QUESTIONS AND HYPOTHESES
Model Conceptualizing Research Questions and Hypotheses

- Role of Client (initiator vs. non-initiator)
- Gender
- Presenting Problem (couple vs. individual)

Therapeutic Alliance/Split Alliance

Outcome (Marital Satisfaction and Commitment)

Dropout
APPENDIX B

INTAKE FORM
Date: ______________________  Time: ____________________ Initials: ___________

How did you hear about the clinic? ___________________________________________

Person Calling the Clinic: ________________________ OK to leave messages?

Contact Information:  (H) YES  NO
                    (W) YES  NO
                    (Cell) YES  NO

Address:________________________________________________________________

Client Information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Race</th>
<th>Work @ OSU</th>
<th>Student @ OSU</th>
<th>Relationship</th>
</tr>
</thead>
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Family Income: $ ______________________ # of Dependents: _______ Fee: $ ______

Days Available: Monday Tuesday Wednesday Thursday Friday

Time Available: _______________________________________________________

Presenting Issue: _____________________________________________________

Type of Therapy: Relationship Status

<table>
<thead>
<tr>
<th>Individual</th>
<th>Single</th>
<th>Married</th>
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<tbody>
<tr>
<td>Couple</td>
<td>Dating</td>
<td>Divorced</td>
</tr>
<tr>
<td>Family</td>
<td>Cohabitating</td>
<td>Remarried</td>
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</tbody>
</table>

Length of Relationship: ________________________________________________

Log of Phone Activity

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>What occurred?</th>
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APPENDIX C

INTAKE QUESTIONNAIRE
General Information

Case #: 
Therapist Code: 
Person: 

1. What is your age? _______________ 

2. What is your gender? (Circle one) 
   Male   Female

3. What is your current relationship status? 
   Married (first time) 
   Remarried 
   Cohabiting 
   Divorced 
   Widowed 
   Single (never married)

4. Circle your highest degree earned: 
   Less than high school 
   High school diploma 
   GED 
   Some college 
   Associates degree 
   Bachelor’s degree 
   Master’s degree 
   Professional degree 
   Ph.D., MD, JD

5. Which best describes your race/ethnicity? 
   Native American 
   Asian 
   Hispanic 
   Caucasian 
   African American 
   Other ________________

6. What is your annual family income? 
   Less than 10,000 
   10,000-19,000 
   20,000-29,000 
   30,000-39,000 
   40,000-49,000 
   50,000-59,000 
   60,000-69,000 
   70,000-79,000 
   80,000-89,000 
   90,000-99,000 
   100,000 or more
APPENDIX D

MARITAL SATISFACTION AND COMMITMENT QUESTIONS
Instructions: Please circle the number closest to how you have been feeling over the past month.

On a scale from 1 to 10, how satisfied would you say you are with your relationship, 1 meaning not satisfied at all and 10 meaning completely satisfied?

1 2 3 4 5 6 7 8 9 10

On a scale from 1 to 10, how committed would you say you are to your relationship, 1 meaning not committed at all and 10 meaning completely committed?

1 2 3 4 5 6 7 8 9 10
APPENDIX E

THE WORKING ALLIANCE INVENTORY – SHORTENED VERSION
The Working Alliance Inventory – Shortened Version

Directions for the client: Thinking about how you are feeling about this session, please answer the following questions about you and your therapist by writing the number that corresponds to your answer in the space provided on the following scale:

1  2  3  4  5  6  7
not at all true  a little true  slightly true  somewhat true  moderately true  considerably true  very true

Development of Bonds Subscale

1. I believe my therapist likes me. _______
2. I am confident in my therapist’s ability to help me. _______
3. I feel that my therapist appreciates me. _______
4. My therapist and I trust one another. _______

Agreement on Goals Subscale

1. My therapist and I are working towards mutually agreed upon goals. _______
2. My therapist and I have different ideas on what my problems are. _______
3. We have established a good understanding of the kind of changes that would be good for me. _______
4. My therapist does not understand what I am trying to accomplish in therapy. _______

Agreement on Tasks Subscale

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation. _______
2. What I am doing in therapy gives me new ways of looking at my problem. _______
3. We agree on what is important for me to work on. _______
4. I believe the way we are working on my problem is correct. _______
Termination Summary Form

Client #: 
Date of This Report: 

Relationship and Age of family members attending therapy sessions: 

Date of Initial Contact: 

Time span of treatment (beginning and end dates): 

Total number of sessions: 

Therapist: Supervisor(s): 

Problem(s) presented by family: 

Goals of treatment: 

Treatment outcome at termination: 

_____ The goals of therapy were successfully met/problems resolved. 

_____ Some positive changes have occurred regarding the presenting problems. 

_____ No positive changes occurred regarding the presenting problem(s). 

_____ The presenting problem(s) became worse. 

Reason for Termination: 

_____ Therapy ended by therapist and client agreement. 

_____ Client terminated against therapist recommendation. 

_____ Clients no-showed and never returned (dropped out of therapy) 

_____ Was necessary to refer out of clinic to _______________________________. 

_____ Other: ____________________________________________________________________