Published in final edited form as:

J Marital Fam Ther. 2015 October ; 41(4): 401–414. doi:10.1111/jmft.12094.

THE MULTISYSTEMIC AND MULTILEVEL INVESTIGATION OF THE EXPANDED THERAPEUTIC ALLIANCE-PSYCHOLOGICAL FUNCTIONING RELATIONSHIP IN INDIVIDUAL THERAPY

Eli A. Karam, PhD,

University of Louisville

Mei-Ju Ko, PhD,

Texas Tech University

Bill Pinsof, PhD,

The Family Institute at Northwestern University

Daniel Mroczek, PhD, and

Northwestern University

Douglas Sprenkle, PhD

Purdue University

Abstract

The expanded therapeutic alliance, consisting of multiple interpersonal alliance relationships, is a common factor inherent to the practice of all systemic therapies. The following study has three specific aims: (a) Bring an expanded, multisystemic emphasis to the study of the therapeutic alliance in individual therapy; (b) Understand better the session-by-session relationship between alliance and psychological functioning, including distinguishing within-person from between-person variability by using multilevel modeling techniques; and (c) Explore the role of early attachment relationships and family-of-origin experiences in moderating the alliance-psychological functioning relationship. Instead of taking only one or two alliance measurements throughout treatment like in the majority of previous research, we measured both alliance and psychological functioning continuously at each session for 296 subjects.

THE EXPANDED, SYSTEMIC VIEW OF THE THERAPEUTIC ALLIANCE IN INDIVIDUAL THERAPY

The therapeutic alliance has been clearly established as a strong predictor of outcome in psychotherapy across diverse treatment orientations and modalities (Horvath, 2006; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Although this construct has been described in a variety of different ways, we will focus on Bordin's (1979) pantheoretical conceptualization of the therapeutic alliance as composed of three distinct content

dimensions: *tasks*, *goals*, and *bonds*. The first of these dimensions, *Tasks*, targets the degree to which the therapist and client agree about how the process of therapy will be structured. The second dimension, *Goals*, refers to how the client and therapist converge on the goals of therapy. The *Bonds* dimension taps into how strongly the client feels empathically connected to the therapist.

Although task, goals, and bonds provided a common language on which many therapist and researchers could agree, this conceptualization did not fully fit for those systemic thinkers who viewed the therapeutic relationship through a more complex relational lens. With his notion of the Integrative Psychotherapy Alliance, Pinsof and Catherall (1986) and Pinsof (1995) evolved the theoretical work of Bordin into a systemic framework with four interpersonal dimensions. Within the context of individual therapy, the first interpersonal dimension, *Self*, addresses the alliance between the therapist and the individual (“The therapist and me”). The *Other* focuses on the alliance between the therapist and the “other” members of the client’s family and does not include the responding client (“The therapist and the people who are important to me”). The *Group* dimension focuses on the alliance between the therapist and the client’s relevant group or important relationships (“The therapist and us—my important relationships”). *Within* covers the alliance between the client and the people who are important to him/her (“The people who are important to me”). This concept of the expanded therapeutic alliance is considered to be a common factor essential to the practice of all systemic-based therapies (Sprenkle, Blow, & Dickey, 1999; Sprenkle & Blow, 2004; Sprenkle, Davis, & Lebow, 2009).

THE INDIRECT SYSTEM IN INDIVIDUAL THERAPY: OUT OF SIGHT, BUT NOT OUT OF MIND

Many marriage and family therapists (MFTs), although trained to work with multiple people at the same time, may have a significant number of individual clients in their caseload. In a national survey, Doherty and Simmons (1996) reported that one-half of the clients treated by MFTs were seen in individual sessions. The trend continues as a more recent sample detailed MFTs seeing clients individually 54% of the time (Northey, 2002). Even while working with individuals, these systemic therapists view their clients through a relational and contextual lens. Influential MFT theorists, including Bowen (1978), McGoldrick and Carter (2001) pioneered the concept of “coaching” individual clients and doing family therapy with only one member present in the room.

Client systems include key members that may participate in maintaining or resolving the presenting problem. In individual therapy, many times these key members are not present in the room. While they are important to the treatment, they reside in the indirect system (Pinsof, 1995). Owen (2012) has recently referred to all of the members in the indirect system in individual therapy as a client’s “social network.” In addition to friends and colleagues, a client’s family of origin represents an important part of the indirect system.

An improperly managed relationship with members in the indirect system in individual therapy may degenerate into a “split alliance” (Pinsof, 1995), in which the therapist has a strong alliance with one subsystem and a weak alliance with another subsystem of the client

system. Even if the client is motivated and fully engaged in therapy, members of the indirect system who do not either adequately understand or believe in the treatment may counteract therapeutic gains and momentum. For instance, if the therapist has a strong alliance with the individual client, he is seeing, but disregards that person's significant others outside the room, a split alliance may occur between the direct and indirect system. Those in the indirect system might feel threatened that the therapist is trying to change or negatively impact their loved one. Both Owen (2012) and Pinsof, Zinbarg, and Knobloch-Fedders (2008) found that higher alliances with members in the indirect system were related to better therapy outcomes. The tracking of the therapeutic alliance with the indirect system, therefore, should be of specific importance to MFTs working on building alliances in individual therapy.

ADVANCING MEASUREMENT: USING MULTILEVEL MODELING TO EXPLORE THE ALLIANCE–PSYCHOLOGICAL FUNCTIONING RELATIONSHIP

Alliance is usually measured early in treatment (within the first four sessions), and occasionally is measured at the midpoint or at the conclusion of treatment if possible. Most alliance and psychological functioning outcome measurements are taken independently at different points during the therapy. Existing research has failed to explore adequately how the alliance–psychological functioning relationship changes on a session-by-session basis or if clients vary as much from themselves as they do from one another. Baldwin, Wampold, and Imel (2007) assert that relying exclusively on the total correlation between outcome and alliance may provide misleading results and fail to capture important variables that may vary among both therapist and clients.

Therapeutic alliance should be studied in way consistent with how therapy naturally unfolds. The majority of previous alliance research, however, has been conducted as part of a randomized controlled trial or larger outcome study. Studying therapeutic alliance in a real world, naturalistic setting is different than evaluating the therapeutic relationship under the strict (sometimes artificial) confines of a RCT. The typical clinician is not practicing therapy with a manual that limits ability to respond flexibly, in the moment to the ever-changing, idiosyncratic nature of psychotherapy. Alliance data in these controlled studies, while important, are secondary to outcome and proving the treatment in question is superior to another.

The psychotherapy field has recently called for longitudinal studies that measure both alliance and psychological functioning at several times over the course of treatment to explore further this relationship (Knobloch-Fedders, Pinsof, & Mann, 2007; Pinsof & Wynne, 2000). Most of the previous research, however, has looked at the alliance at only one or two points during the course of treatment. The therapeutic alliance is not an isolated phenomenon that can be adequately quantified by one or even two measurements; rather it is a developing process that needs to be measured continually over time. Previous research designs, therefore, cannot capture session-by-session fluctuations in the alliance–psychological functioning relationship.

Multilevel models could be beneficial to advance how the alliance–psychological functioning relationship is studied in the following ways: (a) they account for the hierarchical nature of therapy data; (b) they allow between- and within-client correlations to be modeled simultaneously; and (c) they use estimation procedures that are robust for unequal session numbers with the sample of clients (Mroczek, Spiro, & Almeida, 2003).

ADVANCING THEORY: USING ATTACHMENT FRAMEWORK AND FAMILY-OF-ORIGIN EXPERIENCE TO EXPLORE ALLIANCE-PSYCHOLOGICAL FUNCTIONING RELATIONSHIP IN INDIVIDUAL THERAPY

Horvath (2005) has argued that we need to use theory to drive further research around the therapeutic alliance. In addition to exploring further Pinsof's (1995) integrated alliance theory, research outside of psychotherapy, from related disciplines, may be useful in explaining the alliance–psychological functioning link. Attachment theory offers a helpful framework for exploring the development of the therapeutic alliance between therapist and client. By developing an internal working model of Self and others through interactions with primary caregivers, usually in one's family of origin, individuals form an attachment style that shapes their ability to regulate distance and closeness in both familial and romantic relationships into adulthood (Bowlby, 1988; Hazan & Shaver, 1987; Johnson, 1996). Clients with secure attachment styles are thought to be more able to take personal accountability for their actions, engage in self-disclosure, and critically evaluate past and current relationships patterns (Daniel, 2006). Alternately, clients with insecure attachment styles may avoid interpersonal closeness with the therapist or be anxious about feedback, therefore constraining the development of a healthy therapeutic alliance (Mikulincer & Nachshon, 1991).

When thinking about the factors that may influence why the strength of this alliance–psychological functioning relationship is stronger for some clients than others, attachment bonds and other early relationships in a client's life may be important to study. The literature documents that family-of-origin relationships are the relationships that are the greatest source of both social support and conflict (Argyle, 1999). Evidence from the attachment literature suggests that clients' relationships with their family of origin may impact their ability to form therapeutic alliances (Eames & Roth, 2000). In a study of couple therapy, higher levels of self-reported family-of-origin distress were related to male clients' ability to form strong alliances and predicted split alliances for women early in treatment (Knobloch-Fedders, Pinsof, & Mann, 2004). It may well be that the strength of the alliance–outcome association in individual therapy will be influenced by early attachment experiences in the client's family of origin.

CURRENT STUDY

The purpose of this exploratory study is to test the hypothesis that the association between psychological functioning and alliance covaries over time with session in an integrative systemic-based therapy for individuals. Specifically, we predict (a) there will be a significant and positive relationship between the overall alliance and individual psychological

functioning (IPF). In other words, in sessions in which alliance is strong/high, so also will be the overall psychological functioning score within-persons; (b) this alliance-psychological functioning relationship will be significantly stronger for some individuals than for others (between-person variability). We predict that this same within and between-persons variability will be significant for each of the four interpersonal dimensions (Self, Group, Other, & Within) of the integrative psychotherapy alliance-psychological functioning relationship; and (c) the association between Self alliance and psychological functioning will covary with clients' recollected level of family-of-origin positivity. In other words, this alliance-psychological functioning relationship will be significantly stronger for individuals who recall secure attachment bonds with family members during childhood than for those individuals who do not have the same positive experiences to draw from.

METHOD

Data were collected for this project from 2005 to 2008 as part of an ongoing research project at a large Midwestern outpatient clinic and smaller Midwestern university clinic specializing in individual, couple, and family therapy. Participants were seeking help for various presenting problems.

Research administrators recruited clients for the project over the phone before therapists would arrange the first session. Clients were invited to participate in a study of how people change during therapy. If clients agreed to participate, they were to complete the Individual Therapy Alliance Scale Revised—Short Form (ITASr-SF) and the Individual Problems and Strengths (IPS) scale (as a part of the larger Systemic Therapy Inventory of Change (STIC) assessment battery) approximately 24 hr before each therapy session (Pinsof et al., 2009). This STIC instrument contains a demographic questionnaire, several questions about the clients' attitudes toward therapy and five specific "system" scales that tap multiple dimensions of client functioning in different domains or systems. The STIC measures both therapeutic psychological functioning and alliance in the direct and indirect client systems. The rationale for measuring prior to each session is based previous psychotherapy research that documents change occur in clients' lives (Tang, DeRubeis, Beberman, & Pham, 2005) and in the therapeutic relationship (Pinsof, 1995; Safran, Muran, Samstag, & Stevens, 2001), over a one to two week or session period. Less frequent measurement may obscure these time-sensitive, change events.

This was an exploratory, naturalistic study of client change and integrative therapeutic alliance development in psychotherapy; therefore, random assignment and control group procedures did not apply. Moreover, the treatment was not time-limited; however, for the purposes of this study, treatment generally lasted between 2 and 30 sessions. The mean number of sessions was 11, and the median was 15. Data collection with each individual participant was stopped at treatment termination.

Participants

Two hundred and ninety-six individuals participated in this study. There were nearly twice as many women (65.9%) as men (34.1%) enrolled. The majority of the clients were Caucasian (73.6%), but other ethnic groups were represented as well (African Americans—

9.1% and Hispanics—11.8%). This sample was highly educated, as 15.6% of this population had master's or professional degrees, 49.3% had received college degrees, 26% had some college experience, while only 7.4% obtained a high school diploma or less. Over half of these clients were single and had never been married (53.7%), while 19.3% were married, 8.1% were cohabiting, and 16.3% were either divorced or separated.

Therapists represented a wide variety of professional affiliations and experience levels. The sample consisted of a few licensed therapists (3%) and postgraduate fellows (8.1%), but was composed primarily of MFT master's and doctoral students (55.4%). Additionally, a number of therapists-in-training in both a doctoral program in clinical psychology (13.5%) and a master's program in counseling psychology (20%) participated.

Measures

Alliance—The Individual Therapy Alliance Scale Revised—Short Form (ITASr- SF), incorporated as part of the larger Systemic Therapy Inventory of Change (STIC) assessment measure, is a 16-item self-report questionnaire designed to measure the integrative therapeutic alliance in individual therapy (Pinsof et al., 2008). Completed by the client before every session, it is rated on a 7-point Likert scale ranging from (1) “completely agree” to (7) “completely disagree.” These scores are added up to create an ITASr-SF total score. Based on the empirically derived constructs first articulated in Integrative Problem Centered Therapy (Pinsof, 1995), this overall alliance measure was broken down further into the self, group, other, and within interpersonal dimensions. The Cronbach's alphas suggest that with the exception of the Tasks subscale, the subscales had adequate (0.62 or better) internal consistency reliability (Pinsof et al., 2008).

Individual psychological functioning (IPF)—Used to measure psychological functioning in this study, STIC Individual Problems and Strengths (IPS) are composed of 13 items on a 5-point Likert scale. These items appear on the STIC Intersession. Higher scores on this scale indicate increased levels of psychological functioning, instead of psychopathology. To preliminarily assess the convergent validity of this outcome measure, the IPS was administered along with two other well established individual clinical research outcome measures—the Beck Depression Inventory—BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Beck Anxiety Inventory—BAI (Beck, Epstein, Brown, & Steer, 1988) to clients presenting for therapy. Seven of the eight empirically derived IPS subscales correlated significantly (at least $p < .05$) with the BDI, while six of the eight correlated with the BAI. Substance abuse was the only subscale predicted to be largely uncorrelated with the BDI and BAI, and it indeed did not correlate significantly with either established measure. IPS subscale reliabilities ranged from 0.54 (substance abuse) to 0.89 (Pinsof et al., 2009). The factor structure of this IPS scale has been tested with a confirmatory factor analysis (CFA) in two outpatient clinical samples and in a normal, nationally representative sample of the United States (Pinsof et al., 2009). Additionally, the factor structure of the IPS differentiated the clinical and normal samples, which supports the discriminant validity (Pinsof et al., 2009).

Alliance-psychological functioning predictor variables—Family-of-origin predictor variables were drawn from the STIC. Family-of-origin positivity, a five item factor on the STIC Initial Family-of-Origin scale, was measured prior to beginning therapy by items based on a 5-point Likert scale designed to assess primary attachment relationships and positive feelings about client recollections from childhood. The alpha reliability for the family-of-origin positivity subscale was 0.90 (Pinsof et al., 2009).

Data Analysis

Building on the HLM methodology pioneered by Bryk and Raudenbush (1992), mixed models were used to analyze these data. In the within-person variation model, researchers are interested in variation over time that is due to some measured predictor (in this example, alliance), rather than systematic change that occurs with time or age. Data were arranged in “person-session,” nesting alliance and psychological functioning scores within-persons. Thus, alliance and psychological functioning scores could vary over sessions within persons.

At level 1, the within-person alliance-psychological functioning association was modeled, and at level 2, the between-person variable, such as family-of-origin (FOO) positivity was introduced. These models are summarized in the following equations:

$$\text{Level1:IPF}_{ij}=B_{0j}+B_{1j}(\text{alliance}_{ij})+e_{ij}$$

$$\text{Level2:}B_{0j}=\tilde{a}_{00}+\tilde{a}_{01}(\text{FOO positivity})+u_{0j}$$

$$B_{1j}=\tilde{a}_{10}$$

At level 1, the psychological functioning measurement, IPF_{ij} is the individual psychological functioning level on session i for person j . It is a function of B_{0j} , the person's own intercept on IPF, and B_{1j} , the person's own slope, which characterizes the association between alliance and IPF psychological functioning for that individual. $Alliance_{ij}$ is the alliance score on session i for person j , and e_{ij} is a within-person error or residual term. B_{0j} is the person's predicted level of IPF for an average session. In this case, it is the amount of IPF when alliance = 0. At level 2, B_{0j} is expressed as a function of the between-persons intercept ($\tilde{a}_{00}$), the effect of the between-persons variable, FOO positivity ($\tilde{a}_{01}$), and a between-persons error term (u_{0j}). The within-persons slopes, B_{1j} , are a function of the mean alliance—IPF slope between persons ($\tilde{a}_{10}$) and between-persons error term (u_{1j}) that captures individual differences in the alliance—IPF slopes. Expressed in a single equation, these within- and between-person models are solved simultaneously (Raudenbush & Bryk, 2002). This combined equation is expressed as:

$$IPF_{ij}=\tilde{a}_{00}+\tilde{a}_{01}(\text{FOO positivity})+\tilde{a}_{10}(\text{alliance})+u_{0ij}+u_{1ij}(\text{alliance})+e_{ij}$$

This equation above shows IPF for a given person and session as a function of within- and between-person variables, as well as within- and between-person errors. PROC MIXED is used to analyze this model and will display the following: (a) a significance test of individual differences in the within-person variability, (b) a significance test to determine whether the data show between-person variability in means; (c) an estimate of the size of that variability (as a variance or standard deviation) (S.A.S. Institute, 1999).

RESULTS

Mixed models (Raudenbush & Bryk, 2002) were used to determine whether IPF rises with alliance on a session-by-session basis. At the first co-occurring measurement occasion, clients had an IPF mean of 2.65 ($SD = 0.24$) on a five point scale and a total alliance mean of 4.78 ($SD = 0.50$) on a seven point scale. As displayed in Table 1, all variables in the overall alliance-psychological functioning model were significant. The top of the table gives the fixed effects (pooled intercepts and slopes). The intercept represents the predicted amount of IPF psychological functioning on an average alliance session, because alliance was person-centered. The coefficient for alliance represents the amount of IPF over one's average amount of IPF psychological functioning, that is, associated with a one unit increase in alliance. Specifically, a one unit change in alliance is associated with a 0.03 change in IPF psychological functioning. Random effects are also displayed in Table 1, indicating the relationship between total alliance and IPF varied significantly across persons. This MLM methodology also permits examination of the proportion of between-person variability in the alliance-psychological functioning relationship. After computing this intraclass correlation coefficient for IPF-alliance, we found that 53% is between-person variation while the remaining 47% is the within-person variability.

Table 2 shows that while the fixed effects were not significant for the relationship between Self alliance and IPF psychological functioning, random effects indicated that this relationship varied significantly across persons. In other words, the magnitude of the Self alliance–IPF psychological functioning relationship is greater for some clients than for others.

Table 3 explains IPF as a function of the Group alliance. Again in this model, the fixed effects were insignificant, but the random effects indicated the alliance-psychological functioning relationship was significant between individuals.

Table 4 shows that the fixed effects were significant for the relationship between Within alliance and IPF, even though that the random effects proved insignificant. Thus, this alliance–psychological functioning relationship varied significantly within persons, but not between them.

In Table 5, random effects were significant, but the fixed effects were not. In other words, the magnitude of the Other alliance–IPF psychological functioning relationship is greater for some clients than others.

Given that the psychological functioning–alliance relationship is greater for some clients than others, we estimated a model to test a previous hypothesis where IPF on a given session

was a function of Self alliance and the interaction of Self alliance and family-of-origin positivity. Table 6 shows that the Self alliance by family-of-origin positivity interaction was significant, indicating that the magnitude of the Self alliance–psychological functioning relationship was moderated by the client’s feelings of positivity and attachment in their family-of-origin relationships.

This relationship is graphically depicted in Figure 1 below. The association between Self alliance and IPF was smaller for those clients higher in family-of-origin positivity than those lower in family-of-origin positivity. The slope of the line depicting the Self alliance–IPF relationship was steeper among clients low in family-of-origin positivity than those high on this construct. As also shown in Figure 1, having a strong self alliance seemed to be a buffer and protective factor against low family-of-origin positivity in regard to IPF score.

DISCUSSION

The purpose of this study was to examine the session-by-session relationship between alliance and therapeutic psychological functioning. The overall relationship between psychological functioning and total alliance is consistent with previous research documenting the positive alliance–psychological functioning association (Horvath & Symonds, 1991; Martin et al., 2000; Owen, 2012; Pinsof et al., 2008). In other words, in sessions in which client-rated alliance was strong, so too was the overall IPF score. This finding applies to the relationship both within and between individuals.

When we collapsed the total alliance into Pinsof’s four interpersonal dimensions and explored the alliance–psychological functioning relationship, only the *within* alliance dimension had significant fixed effects. Given that there were no significant findings in the fixed effects (within-person variation) for the psychological functioning–group, psychological functioning–self, and psychological functioning–other alliance relationships, fluctuation over sessions for some clients in this relationship appears minimal. When examining the total alliance–IPF psychological functioning relationship; however, individuals varied significantly both within- and between- persons. Thus, the total alliance in an individual integrative, systemic-based therapy may be greater than the sum of its parts for some clients.

The following clinical scenario could be one possible explanation for this lack of alliance–psychological functioning variation within clients for these interpersonal dimensions. A moderately distressed client enters therapy with a positive expectation about both the therapeutic relationship and presenting problem. Early on in treatment the client endorses highly both the IPF and alliance measures. The therapy progresses nicely and session-after-session, the client completes these measures in a similar way, thus creating a “ceiling effect”. If the client feels better about the alliance over time, his earlier high ratings leave little or no room for improvement. This scenario could be a good fit with our data, as the entire sample reported approximately 5 of 7 on a Likert scale at the initial alliance measurement point. Another explanation could be that a client habituates to the survey over time, filling out the questionnaire automatically in a similar manner at each administration.

Even though there is a paucity of research surrounding participants' experience of completing such repeated measures or self-report questionnaires, reactance and habituation are possible effects of completing these types of repeated measures (Bolger, Davis, & Rafaeli, 2003). Although participants reported being aware of the constructs being measured, Litt, Cooney, and Morse (1998) found that they did not react negatively or stop participation in the study. Habituation, or developing a patterned response style, may lead to clients completing the measures in the same way before each session. With repeated exposure to questionnaires, participants may become more aware of the constructs being measured. In the case of the therapy, client and therapist awareness of alliance and IPF constructs may aid in facilitating discussion about the therapeutic process.

Although both fixed and random effects in the overall alliance–psychological functioning relationship were significant, at first examination these results do not indicate a great fluctuation between sessions. A one unit change in alliance is associated with only a 0.03 change in IPF. Thus, growth in the alliance–psychological functioning relationship is generally slow but steady over the duration of treatment. While this finding may not seem impressive at first glance, one must multiply this rate of change times the number of total sessions. Therefore, if the client remains in treatment for an average of 11 sessions, these gains in the alliance–psychological functioning relationship become more clinically significant.

Despite a few studies lauding “sudden gains,” (see Tang & DeRubeis, 1999) change in psychotherapy is generally more gradual. According to Howard's dose–response data (1996), clinicians can expect most clients to overcome their symptoms within 4 months and to make changes in how they live more slowly—between six months to a year. This rate of change would seem to be a good fit for our data. Sudden gains may be the exception to the rule, occurring in CBT more frequently than in traditional MFT approaches due to the straightforward techniques and generalizability of the skills (Tang, Luborsky, & Andrusyna, 2002).

The overall impact of the alliance's relationship to psychological functioning may appear larger when measured only a few times (usually before the beginning and at the conclusion of treatment) in traditional controlled outcome studies, as opposed to evaluating psychological functioning on a session-by-session basis. Even though some research has shown a “V”-shaped rupture-repair pattern in the alliance (Stiles et al., 2004) for some clients, these ratings were not taken at every session and have not been widely replicated in other alliance research (Castonguay, Constantino, & Holtforth, 2006; Roten et al., 2004). Thus, it appears from our study that for most clients, if a strong therapeutic alliance–psychological functioning association is clearly established at the onset, it remains fairly stable throughout the duration of treatment. This conclusion is consistent with the overall findings that the alliance is particularly predictive of outcome when measured early in treatment (Klein et al., 2003).

The interaction with the significant level 2 variable indicates that family-of-origin positivity may moderate the association between Self alliance and IPF. This finding has important clinical ramifications for MFTs working with individuals, as it pertains to monitoring

important relationships in the indirect system (Pinsof, 1995). Clients who cannot form strong working relationship inside the room with the therapist (low Self alliance) and do not have positive memories and secure attachment bonds with family members outside of session (low family-of-origin positivity), tend to have lower IPF scores. Conversely, clients do the best on the measure of IPF when they have strong attachments to both their therapist (high Self alliance) and their family while growing up (high family-of-origin positivity). Having a strong alliance with the therapist in the direct system, however, may protect against negative memories and insecure attachment relationships with family-of-origin members in the indirect system. In other words, clients with low family-of-origin positivity can still have a high IPF score, as long as the alliance is strong with the therapist.

With this finding in mind, MFTs should always remember to ask their individual clients about both their indirect system and their important family-of-origin attachment relationships to build the therapeutic alliance. A therapist may be able to monitor the client's alliance with the indirect system by asking some of the following questions: a) How does your relationship with important people outside of this therapy room affect your progress in therapy?; b) How is your current individual and relationship satisfaction impacted by your early family-of-origin experiences?; c) What would the people who are important to you think about the way your therapy is being conducted?; d) How is our therapist/client relationship similar or different from the one you had with primary attachment figures in your family-of-origin?; and e) How do you feel about what important people in your life think about your therapy? If the therapist feels like therapeutic progress is being jeopardized by involvement from a family-of-origin member or a primary attachment figure in the indirect system after this assessment, he or she could either engage in boundary making work with that client or intentionally reach out to the negative person, in essence moving the family member from the indirect into the direct system to address the conflict (Karam, Sprenkle, & Davis, 2014).

Limitations

A limitation is that the present study included only one perspective on alliance. Because the study relied on client-self-report only, it is possible within and between alliance–psychological functioning coefficients would be different if rated by the therapist or another independent observer. Future alliance research, therefore, should compare this alliance–psychological functioning relationship from multiple perspectives.

Another limitation stems from the fairly homogeneous sample. Because the participants were predominantly Caucasian (73.6%) and highly educated, it is unclear how these results would generalize to more ethnically diverse groups. Although therapists were trained and supervised using an integrative systemic model, treatment adherence was not measured. This is a common limitation of collecting naturalistic data (Baldwin et al., 2007).

Even though we are not trying to prove causation in this observational research, the relationship between alliance and psychological functioning could also be influenced by a mediating, third variable not previously accounted for or measured in the study. For example, someone with a high emotional intelligence may have the inherent skills to develop an effective alliance and be less likely to be depressed or anxious than someone with low-

emotional intelligence. Therefore, it could be that IPF scores have more to do with the individual than with the alliance itself.

Although not necessarily a limitation in this study, a potential barrier to adapting repeated measures designs into psychotherapy research is the greater commitment level placed on clients and therapists. For clients that are in distress, filling out a survey before each session might place an unnecessary burden or hamper engagement. Therapists may also be hesitant to take to the necessary time during session incorporate such questionnaires. Brown, Dreis, and Nace (1999) found that the majority of clinicians would not consider using any measure or assessment tool that took more than five minutes to complete, score, and clinically interpret. Therefore, this type of design requires a level of client and therapist commitment rarely displayed in other clinical research. To adequately address this potential constraint, measures should be brief by design. In our study, it only takes several minutes for a participant to complete both the alliance and the psychological functioning measure.

Future Directions

One possible direction for the future research would be to continue to focus on the therapeutic alliance on a “micro” rather than a “macro” level (Horvath, 2006). On a micro-level, it is possible to examine both the within and between-persons variation instead of the crude total correlation of the macro approach. The results indicate that some individuals vary both within themselves and from others in the association between alliance and therapeutic psychological functioning.

The majority of the previous research in this area has tried to tease out causality from correlational data, while spending significantly less time examining what makes this alliance–psychological functioning relationship stronger for some clients than others (Crits-Christoph, Connolly-Gibbons, & Hearon, 2006). Even though this research indicates that early attachment bonds and family-of-origin positivity may explain differences between clients in the alliance–psychological functioning relationship, we are still uncertain about other specific predictor variables that moderate this relationship. Future research should continue to explore relationships with important social support structures that reside in the indirect client system. These supports, which Owen (2012) refers to as a client’s social network, include friends, mentors, spouses, and significant others that may influence a client’s engagement and psychological functioning in individual therapy. Perhaps good experiences with family and significant other may be a protective factor in current relationships, while negative relationships with loved ones may significantly hinder future interpersonal relationships, including the alliance one needs to form with his or her therapist. In addition to these level 2 predictor variables, level 3 variables (data nested within therapists) should be explored to examine whether level of experience or other therapist factors could account for some of the variability in the alliance–psychological functioning relationship between participants.

Another interesting outgrowth of this emerging methodology would be to replicate the findings from this study in different therapeutic modalities that are historically more associated with MFT. Perhaps, Pinsof’s conceptualization of the integrative psychotherapy

alliance is more intuitive when applied to couples and families rather than to just individuals like in this sample.

CONCLUSION

In addition to bringing an expanded, multisystemic emphasis to the study of the therapeutic alliance in individual therapy, this study has highlighted the emergence of new methodological and statistical ways to study the alliance–psychological functioning relationship. Instead of taking only one or two alliance measurements throughout treatment like in the majority of previous research, this naturalistic study explored the association between alliance and psychological functioning continuously at each session. In the past, researchers have relied almost exclusively on the total correlation between psychological functioning and alliance, which may provide misleading results and fail to capture important variables that may vary among both therapists and clients. Specifically, these results encourage future research to consider within and between-person correlation coefficients because those correlations may differ. This research has also highlighted the importance of studying alliances clients have with significant people outside of the therapy room in the indirect system, as well as the role of early attachment relationships and family-of-origin experiences in moderating the alliance–psychological functioning relationship.

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Figure 1. Family-of-origin positivity moderates the association between self alliance and individual psychological functioning.

Table 1

Individual Psychological Functioning as a Function of Total Alliance

	Estimate (SE)
Fixed effects	
Intercept	2.491 (.065) ***
Total alliance	0.033 (.013) **
Random effects	
Intercept	0.227 (.077) **
Total alliance	0.009 (.003) **
Residual	0.026 (.001) ***

Note.

**
p < .01;***
p < .001.

Table 2

Individual Psychological Functioning as a Function of Self Alliance

	Estimate (SE)
Fixed effects	
Intercept	2.576 (.048) ***
Self alliance	0.012 (.008)
Random effects	
Intercept	0.140 (.043) **
Self alliance	0.003 (.001) **
Residual	0.026 (.001) ***

Note.

**
p < .01;***
p < .001.

Table 3

Individual Psychological Functioning as a Function of Group Alliance

	Estimate (SE)
Fixed effects	
Intercept	2.628 (.043) ***
Group alliance	0.005 (.009)
Random effects	
Intercept	0.105 (.033) **
Group alliance	0.004 (.001) **
Residual	0.026 (.001) ***

Note.

**
p < .01;***
p < .001.

Table 4

Individual Psychological Functioning as a Function of Within Alliance

	Estimate (SE)
Fixed effects	
Intercept	2.575 (.026) ***
Within alliance	0.016 (.005) **
Random effects	
Intercept	0.017 (.011)
Within alliance	0.001 (.001)
Residual	0.027 (.001) ***

Note.

**
p < .01;***
p < .001.

Table 5

Individual Psychological Functioning as a Function of Other Alliance

	Estimate (SE)
Fixed effects	
Intercept	2.665 (.018) ***
Other alliance	0.007 (.005)
Random effects	
Intercept	0.045 (.007) ***
Other alliance	0.001 (.001) **
Residual	0.026 (.001) ***

Note.

**
p < .01;***
p < .001.

Table 6

Individual Psychological Functioning as a Function of Self Alliance and Interaction with Family-of-Origin Positivity

	Estimate (<i>SE</i>)
Fixed effects	
Intercept	2.122 (.181) ***
Self alliance	0.063 (.029) *
Self alliance × FOO Functioning	−0.016 (.009) *
Random effects	
Intercept	0.141 (.043) **
Self alliance	0.004 (.001) **
Residual	0.026 (.001) ***

Note.

*
p < .05;

**
p < .01;

p < .001.