THE THERAPY ALLIANCE: A MODERATOR IN THERAPY OUTCOME FOR FAMILIES DEALING WITH CHILD ABUSE AND NEGLECT

Lee N. Johnson
University of Georgia
Scott A. Ketring
Auburn University

The role of the therapy alliance in therapy outcome for families dealing with child abuse and neglect was examined using the family as the unit of analysis. The alliance was tested as a moderator in relationship to posttreatment levels of symptom distress and physical violence. Results show that the bonds, goals, and tasks subscale scores are significantly related to posttreatment levels of symptom distress and that the goals subscale score is significantly related to posttreatment level of violence. There is an interaction between bonds and level of violence at intake, suggesting that the greater the level of violence at intake, the more important the bonds domain.

There is little doubt that the alliance between the therapist and family members is consistently related to therapy outcomes (e.g., Alexander, Barton, Schiavo, & Parsons, 1976; Bennun, 1989; Diamond, Liddle, Hogue, & Dakof, 1999; Green & Herget, 1991; Heatherington & Friedlander, 1990; Johnson, Wright, & Ketring, 2002; Shirk & Karver, 2003). Current alliance research typically focuses on individual family members as the unit of analysis. However, there is limited knowledge about how the alliance influences family therapy and how the alliance is formed in family therapy (Johnson & Wright, 2002). Specifically, no research has looked at the relationship between the alliance and outcome using the family as the unit of analysis. Thus, the purpose of this study is to examine the relationship between the severity of symptoms at intake, level of therapy alliance, and outcome using statistics that permit the family to be the unit of analysis. This will provide clinicians and researchers with information on the influence of the alliance in families. Prior to presenting the study a brief review of the alliance conceptual framework is necessary.

Prior to the work of Bordin (1979) therapists focused on the relationship between a client and therapist in terms of trust, transference, and countertransference. However, Bordin (1979) defined the relationship in terms of a working alliance comprising three domains: bonds, goals, and tasks. Bonds represents the trust, respect, and caring between a therapist and client. The tasks domain is the agreement and collaboration around the activities that occur during therapy, along with the timing and pacing of activities. Tasks also encompass the client’s perception of the therapist’s ability to help them. Goals focus on the mutual agreement about, and investment in, achieving set goals (Bordin, 1979). To conceptualize the alliance more consistently with family therapy, Pinsof and Catherall (1986) added the interpersonal dimension to Bordin’s original conceptualization. The interpersonal dimension focuses on with whom the therapist may develop...
an alliance. Thus, in family therapy an alliance can exist between the therapist and individual family members, the therapist and subgroups of family members, or the therapist and the whole family. Although the framework proposed by Pinsof and Catherall provided an avenue for looking at the alliance with the whole family only a limited amount of research has looked at how the alliance between family members and the therapist interacts to influence therapy (Robbins, Turner, Alexander, & Perez, 2003).

Clarifying the role of how the alliance influences treatment within the family as a whole will advance research in family therapy (Robbins et al., 2003) and provide clinicians with additional information on how the alliance affects family therapy. For example, there seems to be a profound relationship between the severity of the presenting problem and the importance of the therapy alliance, especially when considering therapy outcomes (Clarkin & Levy, 2004; Khetring, Johnson, Capers, & Salts, n.d.). One stigmatizing problem that may require that more emphasis be placed on specific domains of the alliance is child abuse. Parents who have abused their child need to trust their therapist enough to tell them about the past abuse and any ongoing occurrences of abuse. This may be difficult for them because parents know that additional incidences of abuse will be reported. Therefore in this situation the level of trust or bonds may be more important than the level of tasks or agreement on therapeutic goals.

In summary, therapists know that the alliance is an important part of therapy and a necessary precursor for change. However, if the level of alliance is influential on therapy outcomes, then additional attention needs to be given to therapy mechanisms that improve the therapy relationship. Further, therapists need to be able to determine the strength of the alliance and future research and therapy training needs to focus on the skills necessary to reach the level of alliance needed for change. To build on alliance research, this study will address the following research questions.

1. Are the alliance subscales related to families’ posttreatment level of symptom distress?
2. Are the alliance subscales a moderator of posttreatment level of symptom distress?
3. Are the alliance subscales related to families’ posttreatment level of violence?
4. Are the alliance subscales a moderator of posttreatment level of violence?

METHOD

Participants

Participants in this study were 470 individuals who were part of 225 families that were reported to the state social service agency for child abuse and neglect. The state social service agency offered the families optional family therapy from an outside agency. If a child had been removed from the home for abuse and neglect, then the case was not referred for therapy services. Participants lived mainly in rural communities in 26 counties in a Midwestern state. On average, adult participants were 34.3 years old and adolescent participants were 14.4 years old. Sixty-four percent of adult participants were female and 60.1% reported being married, whereas 26.1% reported being separated or divorced. Eighty-five percent reported being Caucasian; adolescent and adult participants did not differ in terms of ethnic background.

Most adult participants reported completing high school or a high school equivalency exam as their highest level of education (52.2%) and report annual incomes of < $20,000 (60.3%). Of all participants 43.6% are mothers, 24.7% are fathers, and 31.7% are adolescents Various family types are represented in this research including, single-parent- and two-parent-headed homes. There were no differences between single-parent-headed homes and two-parent-headed homes on intake variables of interest in this study. The average size of the family that received therapy was four members.

Three separate agencies provided services to families. Therapists’ experience ranged from doctoral-level therapy students to licensed therapists with multiple years of experience. One of the agencies was housed in a university training facility and the other two agencies were social service agencies that provided a number of services including family therapy. Families referred to the university-based agency were seen by cotherapy teams comprised of a family therapist and a case manager. Doctoral students served as the therapists and master’s students served as case managers and were responsible for finding community resources for the family and coordinating services with other mental health agencies. Generally, doctoral students were in the third year of the marital and family therapy (MFT) program, and had a master’s degree
in MFT or other related field. Therapists from all three agencies, including the doctoral students, had either a license or temporary license.

**Instruments**

*Family Therapy Alliance Scale (FTAS; Pinsof & Catherall, 1986).* The FTAS is a client self-report instrument designed to assess clients’ perceptions of their relationship with their therapist. It comprises three subscales (bonds, goals, and tasks), which are scored by summing the items on the subscale. The instrument contains 29 items rated on a 7-point Likert-type scale with responses ranging from (1) completely disagree to (7) completely agree. The authors report test–retest reliability of \( r = .83 \). Others (Heatherington & Friedlander, 1990) have also reported the reliability of the FTAS: bonds (\( \alpha = .81 \)), goals (\( \alpha = .80 \)), tasks (\( \alpha = .90 \)), and total scale (\( \alpha = .94 \)). The authors argue that the FTAS has content validity, and previous research has established the predictive validity of the FTAS (Heatherington & Friedlander, 1990; Johnson et al., 2002). In this study, internal consistency was .90 for bonds, .78 for goals, and .92 for tasks.

*Conflict Tactics Scale—Physical Aggression Subscale (CTS—PAS; Straus, 1979).* The CTS—PAS measures the level of self-reported physical violence. The author reports good reliability for the physical aggression subscale (\( \alpha = .87 \)). The physical aggression scale has established concurrent validity by correlating the subscale with family member’s reports of violence with correlations ranging from .33 to .64 depending on who is reporting the violence (Straus, 1979). In addition, many studies have established the construct validity of the CTS and its subscales (Schumm & Bagarozzi, 1989). Internal consistency of the physical aggression subscale for this sample was (\( \alpha = .87 \)).

*Outcome Questionnaire 45.2—Symptom Distress subscale (OQ—SD; Lambert et al., 1996).* The OQ—SD measures symptoms related to anxiety and depression. The OQ—SD has 25 items scored on a 5-point Likert-type scale with close to one-half of the items being reverse scored. Responses range from “never” to “almost always.” The authors report that the subscale has good test–retest reliability (\( r = .78 \)) and an internal consistency coefficient of \( \alpha = .91 \). The authors also provide evidence of the concurrent validity of the symptom distress subscale (correlations with other measures of anxiety and depression ranging from .49 to .88). The symptom distress subscale has also demonstrated construct validity (Umphress, Lambert, Smart, Barlow, & Clouse, 1997). Internal consistency for the symptom distress subscale for this sample was \( \alpha = .92 \).

**Procedures**

Before starting the research, institutional review board approval was obtained. Therapists were required to initiate services with a family within 36 hours after the referral. During the initial contact with the family, all family members aged 12 and older read and signed the informed consent form, filled out demographic information, the CTS—PAS, and the OQ—SD. The demographic information collected from parents differed from what was collected from adolescents because adults were asked about past relationships and family financial information. Other intake assessments were completed but are not part of this study.

The majority of therapy sessions included all family members, but no standard criterion was used by the therapists to decide if enough family members were present to hold a session. Once assigned to a family, the same therapist or cotherapy team worked with the family throughout treatment. Therapy was to follow a home-based ecosystemic approach (Johnson & Ketring, 2000) that focused on individual development, changing family patterns, and improving family members’ interactions with community agencies and resources. No attempts were made to check therapists’ adherence to the model.

The therapists or cotherapy team was instructed to set the frequency of therapy based on family needs. Generally, therapy was conducted twice weekly during the initial 6–8 weeks of service and then reduced to once weekly with progress toward goal achievement. On average each family received 19.1 sessions that accounted for 24.1 therapy hours.

At the end of treatment, family members again completed the CTS—PAS and the OQ—SD. They also completed the FTAS for each therapist who conducted therapy with the family (families who were seen by a cotherapy team completed the FTAS once for each therapist).
The decision to administer the FTAS at the end of treatment was made in consultation with the agencies providing therapy services who requested that research procedures be as simple and nonintrusive as possible. Having clients complete the therapy alliance scale at the end of treatment eliminated the need for an additional assessment after the fourth to sixth session. Although assessing the alliance at the end of treatment is not ideal, Horvath and Symonds (1991) found that effect sizes (ES) for the alliance and outcome were very similar for the alliance taken early in treatment (ES = .31) and at the end of treatment (ES = .30). Shirk and Karver (2003) reported similar findings. Even though effect sizes are similar, it is important to note that measuring the alliance late in treatment does not account for development or variations in the alliance over the course of treatment. This is partially limited, given that Martin, Garske, and Davis (2000) found that clients tend to view the alliance as stable and not changing over time.

An additional concern of measuring the alliance at the end of treatment is that it is highly related to changes made during therapy (Freeley, DeRubeis, & Gelfand, 1999). To explore this potential confounding factor, ratings of bonds, goals, and tasks, were correlated with changes made in symptom distress and violence. Correlations show that the alliance subscales are correlated with changes in symptom distress with correlations ranging from .11 to .12 (p < .05). The alliance subscales were not related to changes in violence (all correlations were < .02 and all were nonsignificant). Therefore, these correlational analyses demonstrated that there is only a slight association with changes in symptom distress and no association with violence. Thus, although measuring the alliance at the end of treatment is not ideal it would appear that this potential confound is minimized to the extent possible.

Preliminary Analyses

Preliminary analyses were used to evaluate concerns about differences among the three areas of service, differences between alliance ratings of therapists working on the same case, and to establish nonbiased response based on response rates. Because this study used data from three different agencies it was necessary to determine the equivalence of cases from each agency. A one-way analysis of variance (ANOVA) found that there were no significant differences across agencies in pretest symptom distress and violence. For families seen by a cotherapy team, analysis of the two therapy alliance scores show similar client ratings for both therapists (correlations between therapy alliance scores and subscales \( r = .80 \) to .84 and \( t \)-tests show no significant differences). The similar therapist ratings offered no additional information, so only the primary therapist’s scores were used.

Finally, as in all clinical research, missing data were an issue in this study. Results demonstrated that 51% of family members within the program provided complete data. The reason for the low response rate varied, but generally, therapists failed to give families the posttests to complete or failed to return posttests to the agency. Further analyses show that not completing a posttest was independent of income, race, and position in the family, but not area of service. Two of the three service areas had higher rates of not turning in posttests. To test for biases across areas of service on FTAS subscale scores a one-way ANOVA was used. Results showed that one area of service with a higher rate of not completing posttests had a statistically lower therapy alliance scores for mothers on the tasks scores (\( F[2, 216] = 3.86, p < .05 \)). To account for this bias, area of service was recoded into two groups (the areas not significantly different on the alliance were combined). This variable was then entered into the analyses to account for potential geographical area bias. The inclusion of the variable did not change the results; therefore the bias in area did not affect the results and the more parsimonious results are presented throughout the article.

RESULTS

The alliance was examined as a moderator for the relation between pretest symptom distress, pretest levels of violence, and therapy outcomes to test whether the differing levels of alliance were beneficial to therapy outcomes. In testing the moderator qualities of the alliance, the recommendations of Baron and Kenny (1986), Aiken and West (1991), and Holmbeck (2002) were followed.

As stated earlier, this study examined the influence of the alliance in family therapy using the family as the unit of analysis. In using the family as the unit of analysis the nonindependence of family
members’ reports needs to be addressed. With multiple family members participating in therapy together and responding to the same questionnaire it is highly possible that one member’s score could actually be providing information about another family member’s score. To account for the nonindependence across family members, mixed models were analyzed using SPSS 12.0 (SPSS, Chicago, IL) with each family score entered into the analyses as a random effect and the individual family member’s scores entered into the analysis as the repeated effect. Each research question comprised three separate analyses, one for each alliance subscale. For example, research question one examined the alliance subscales and symptom distress. Thus, three mixed models were analyzed using symptom distress and violence with each of the alliance subscales.

Before answering the research questions, the changes in each outcome variable were examined using a paired *t*-test. Both reports of symptom distress and reports of violence declined over the course of treatment (symptom distress, *t* [462] = 5.61, *p* < .001; physical aggression, *t* [461] = 5.54, *p* < .001). Descriptive statistics are provided in Table 1.

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presymptom distress</td>
<td>463</td>
<td>31.92</td>
<td>15.49</td>
</tr>
<tr>
<td>Postsymptom distress</td>
<td>463</td>
<td>28.49</td>
<td>15.05</td>
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<tr>
<td>Previolence</td>
<td>462</td>
<td>5.56</td>
<td>6.24</td>
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<tr>
<td>Postviolence</td>
<td>462</td>
<td>4.02</td>
<td>6.15</td>
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<tr>
<td>Bonds</td>
<td>457</td>
<td>56.43</td>
<td>11.68</td>
</tr>
<tr>
<td>Goals</td>
<td>456</td>
<td>32.55</td>
<td>7.26</td>
</tr>
<tr>
<td>Tasks</td>
<td>457</td>
<td>70.07</td>
<td>16.67</td>
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</table>

Research Question One

Are the alliance subscales related to families’ posttreatment level of symptom distress? Separate models were tested to see if the bonds, goals, and tasks subscales were related to change in the overall level of symptom distress for the family. Results of all three models demonstrated that the alliance subscales alone were significantly related to posttest symptom distress regardless of level of distress at intake (see Table 2).

Research Question Two

Are the alliance subscales a moderator of posttreatment level of symptom distress? Separate models were tested to see if the bonds, goals, and tasks, moderated symptom distress. Moderation was determined by the significance of the interaction term (pretest symptoms distress X alliance subscale) in the model. None of the interaction terms were significant, suggesting that the alliance and its subscales do not moderate posttreatment level of symptom distress (see Table 2). The covariance parameters for all the models were also significant, suggesting that the analyses were accounting for a significant amount of nonindependence among family members.

Research Question Three

Are the alliance subscales related to families’ posttreatment level of violence? Separate models were tested to see if the alliance subscales were related to the level of violence within the family posttreatment. Results showed that the goals subscale was significantly related to the level of violence, but tasks and bonds were not significant (see Table 3).
Research Question Four

Are the alliance subscales a moderator of posttreatment level of violence? Separate models were tested to see if the bonds, goals, and tasks moderated changes in violence. Moderation is determined by the significance of the interaction term (pretest violence X alliance subscale) in the model. The interaction between bonds and pretest violence was significant (see Table 3). This suggested that reporting more violence at intake required that the therapist develop a greater bond or a more trusting relationship to facilitate change. The same relationship does not exist for higher violence rates and agreement on therapeutic goals or tasks. The covariance parameters for the family effects were not significant.

Table 2

<table>
<thead>
<tr>
<th>Model</th>
<th>Variable</th>
<th>Estimate</th>
<th>Std. Error</th>
<th>T (df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds and SD</td>
<td>SD</td>
<td>0.53**</td>
<td>0.16</td>
<td>3.24 (423.4)</td>
</tr>
<tr>
<td></td>
<td>Bonds</td>
<td>−0.22*</td>
<td>0.11</td>
<td>−2.03 (443.2)</td>
</tr>
<tr>
<td></td>
<td>SD X Bonds</td>
<td>0.001</td>
<td>0.003</td>
<td>0.46 (428.6)</td>
</tr>
<tr>
<td>Tasks and SD</td>
<td>SD</td>
<td>0.53**</td>
<td>0.13</td>
<td>3.93 (405.1)</td>
</tr>
<tr>
<td></td>
<td>Tasks</td>
<td>−0.16*</td>
<td>0.07</td>
<td>−2.19 (439.0)</td>
</tr>
<tr>
<td></td>
<td>SD X Tasks</td>
<td>0.001</td>
<td>0.002</td>
<td>0.48 (418.4)</td>
</tr>
<tr>
<td>Goals and SD</td>
<td>SD</td>
<td>0.49**</td>
<td>0.16</td>
<td>3.01 (428.9)</td>
</tr>
<tr>
<td></td>
<td>Goals</td>
<td>−0.38*</td>
<td>0.18</td>
<td>−2.13 (441.5)</td>
</tr>
<tr>
<td></td>
<td>SD X Goals</td>
<td>0.003</td>
<td>0.005</td>
<td>0.68 (436.9)</td>
</tr>
</tbody>
</table>

Note. SD in this table is symptom distress and not standard deviation
* p < 0.05. ** p < 0.01.

Table 3

<table>
<thead>
<tr>
<th>Model</th>
<th>Variable</th>
<th>Estimate</th>
<th>Std. Error</th>
<th>t (df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds and Violence</td>
<td>Violence</td>
<td>0.82**</td>
<td>0.15</td>
<td>5.46 (445.6)</td>
</tr>
<tr>
<td></td>
<td>Bonds</td>
<td>−0.04</td>
<td>0.03</td>
<td>−1.40 (414.2)</td>
</tr>
<tr>
<td></td>
<td>Violence X Bonds</td>
<td>−0.01*</td>
<td>0.003</td>
<td>−2.28 (428.6)</td>
</tr>
<tr>
<td>Tasks and Violence</td>
<td>Violence</td>
<td>0.69**</td>
<td>0.14</td>
<td>4.87 (445.3)</td>
</tr>
<tr>
<td></td>
<td>Tasks</td>
<td>−0.04</td>
<td>0.02</td>
<td>−1.90 (419.3)</td>
</tr>
<tr>
<td></td>
<td>Violence X Tasks</td>
<td>−0.003</td>
<td>0.002</td>
<td>−1.45 (445.8)</td>
</tr>
<tr>
<td>Goals and Violence</td>
<td>Violence</td>
<td>0.61**</td>
<td>0.14</td>
<td>4.23 (444.1)</td>
</tr>
<tr>
<td></td>
<td>Goals</td>
<td>−0.10†</td>
<td>0.04</td>
<td>−2.24 (406.1)</td>
</tr>
<tr>
<td></td>
<td>Violence X Goals</td>
<td>−0.004</td>
<td>0.005</td>
<td>−0.84 (444.8)</td>
</tr>
</tbody>
</table>

* p < 0.05. † p < 0.01.
DISCUSSION

As expected, the alliance is related to the posttreatment level of symptom distress and violence. In the explanation of posttreatment symptom distress all of the alliance subscales were significant; however, none of the alliance subscales acted as moderators with pretreatment symptom distress; thus the level of symptom distress at intake did not influence the impact of the alliance. In treating symptom distress the alliance was necessary, but because there was no interaction between alliance and symptom distress, higher levels of pretreatment symptom distress did not require an increase in the level of alliance. As long as therapy proceeded in a positive direction with therapeutic activities that seemed useful, family members gained skills necessary for change. However, the findings were subtly different for the therapy alliance and violence.

In explaining posttreatment violence, agreement between the therapist and family on therapy goals was significant. Thus, it was important for therapists to work to set goals agreeable to the family, which was no easy task when dealing with potentially violent situations. For example, it can be a challenge to set a mutually agreeable goal when the therapist was advocating a goal of no physical discipline and the parents believed that physical discipline could be beneficial. The negotiation of a goal agreeable to the therapist and family appeared to be important in determining outcome.

The most intriguing finding of the study was that the bonds subscale was a moderator of posttreatment violence. It seems that families that reported higher levels of violence needed to experience the therapist as a warm and trusting person to make necessary changes. The same relationship did not hold for the agreement on therapy goals or the timing and pacing of therapy tasks and activities. One explanation of these results seems plausible. For family members to admit that they had been violent, face the shame of the action, and report that action to the therapist, a high level of trust and connection with the therapist was required. This was particularly true when taking into account the mandated reporting laws (in the case of child abuse). Further, in families in which physical aggression or violence was present there is a degree of apprehension and shame associated with receiving services. These families were often hesitant to speak freely of family interactions especially those that focus on an acutely violent episode.

One such example is a father trying to maintain control of his adolescent children who were experimenting with alcohol and marijuana. His attempts to control his children's behaviors were met with contemptuous behavior. Negative interactions became more dominant in the relationship until one day the father found his daughter smoking cigarettes. He became upset and proceeded to drag her down the stairs and throw her out of the house. Neighbors called the police and the family was referred to state social services.

The therapists assigned to work with this family were met by a defensive father and quiet family who only provided cursory details about themselves and why they were referred for services. Although scant detail was provided it was evident that the father personally identified with his children's rebellious streak. He saw parallels with their actions and his own as an adolescent. He told stories of discipline that often merged into abuse and contrasted his attempts at fathering with the apathy and abuse of his own father.

As therapy progressed, the children were aided in dropping their defensive postures and connecting with their father's pain. The therapists successfully reframed the father's lectures and stories as his attempt to process and come to an understanding of his children's behaviors. It was during this time that his children saw him trying to show love and be a good father. The adolescents' fears and insecurities were concurrently highlighted in therapy along with some of their addictions. Treatment focused on the abusive past, the addictions within the family, and improved interactions. As therapy progressed the family was able to move beyond the superficial no-violence contract to a more permanent and harmonious living arrangement. Over the course of therapy, more detailed versions of the violent event that precipitated the referral were told. Different family members' perspectives permeated the re-storying of the violence.

The trust between the family members and the therapists moved the therapy more toward resolution and helped the family feel safe focusing on the aggressive and violent patterns in the family. Even the parents started to discuss their marital problems with the therapists, which allowed more extensive changes to be made with the family. Without a high level of trust the family would not have felt comfortable taking
about past violent situations and the parents may not have brought up their issues and the family changes would not have been as encompassing.

**Implications**

This research highlights the fact that in a family therapy setting, therapists needed to be mindful of the alliance and specifically to increase their level of trust and caring when dealing with families who exhibited violence. Clinicians needed to be aware that under specific conditions being able to effectively structure sessions may not be sufficient. This research shows that the amount of trust necessary to produce change was a key component for decreasing violence in families. In this particular study, participants who reported the highest levels of violence experienced the best outcomes when the therapist exhibited higher levels of trust and caring with the family. The ability to negotiate goals agreeable to the therapist and family was also important in helping families who report violence.

To decrease violence more effectively within families there was a need for a higher level of alliance formation in the bonds domain. In contrast, helping a person to improve symptom distress seemed only to require that an alliance be formed. It could be that clients took bonding with a therapist for granted, except when facing more severe problems or in the absence of bonds. If there was an absence of bonds, and the client did not perceive the therapist to be trustworthy or caring, then it would be safe to assume that the client was likely to discontinue therapy. The fact that clients continue in therapy suggested that they at least have an acceptable connection with the therapist or they did not perceive a close connection with the therapist as a necessary component of treatment.

Obviously, clinicians needed to be mindful of the level of trust they had with families and to realize that this is a key component when treating violence in families. It is up to clinicians to determine how to build trust necessary to produce change with clients who present with difficult to treat problems. Clinicians should also remain cognizant that this influence was not unidirectional. Both therapists and clients play a role in interactions that lead to trust formation. However, limitations exist concerning the formation of the therapeutic bond (Johnson & Wright, 2002). Because the therapeutic relationship was a match between the experiences and expectations of therapists and clients (Bordin, 1979) in conjunction with the expertise of the therapist in providing services, it is important to evaluate client characteristics affecting alliance formation.

**Limitations**

Although the findings of this study contain useful information, there are some limitations that must be considered. First, measuring the alliance at the end of therapy affects the conclusions. Although the decision was based on agency requests and published research (Horvath & Symonds, 1991; Martin et al., 2000; Shirk & Karver, 2003), the impact of measuring the alliance at the end of treatment is unknown in this study. Although correlations showed that the alliance at the end of treatment was not related to changes in violence, this does not rule out all the potential confounding factors between the alliance measured at the end of therapy and therapy outcomes. Further, the findings of this research were also based on the alliance taken at one point in time. Thus, no conclusions can be made about the influence or moderation of the alliance over the course of therapy. Another study with the alliance taken earlier in therapy and assessed at multiple points along the course of treatment will provide additional valuable information on the timing of alliance measurement and alliance development.

Another limitation of the study was the fact that symptom distress and violence were only measured at two times—the beginning and end of treatment. Thus, this research assumed that the relationship between the alliance and symptom distress and the moderating relationship between bonds and violence was linear. Although the results were helpful and valuable to clinicians, further research needs to examine these relationships and determine the linear or nonlinear nature of alliance and outcome.

Finally, the lack of adherence checks on the prescribed model of therapy was a potential limitation. It is known that the type of therapy practiced has an impact on the alliance (Bordin, 1979). This can be especially true for this model, given that therapists conducted sessions twice a week early in treatment, sessions often lasted longer than the traditional 50 minutes, and sessions were held in clients’ homes. Each
of these practices may have had an influence on the domains of the alliance. As future research addresses these limitations, information on the alliance in family therapy will be strengthened.

**Future Research**

Research on the alliance in family therapy is not as prevalent as research on the alliance in individual therapy. Much of family therapy alliance research analyzed data from each family member individually. Although this practice produced valuable information on the alliance, it did not tell the picture for the whole family. Future research needs to build on this study to better understand how the alliance operates within families as a whole (Johnson & Wright, 2002; Robbins et al., 2003). This statement is not made in an attempt to diminish the findings of research focusing on understanding individual alliances within a family therapy setting, but rather as a call for more to be done to understand the alliance development within the family system.

Understanding how the alliance functions within families also requires more understanding of how various aspects of families influence the alliance. It is well known that client variables affect therapy outcomes (Beutler, Bongar, & Shurkin, 1998; Miller, Duncan, & Hubble, 1997). However, similar research on family variables would also be helpful. For example, the level of family cohesion versus family disengagement could have an impact on the alliance development and therapy outcome. This type of research would be especially important with difficult to treat families.

One area of research that focuses on both the alliance and family variables is on split alliances (Pinsof, 1994, 1995; Pinsof & Catherall, 1986). Split alliances within the family are defined as one or more members of the family having a more positive alliance and one or more members having a more negative alliance. The study of splits in family member’s alliance place the attention of the alliance on the whole family rather than solely evaluating individuals receiving family therapy. Future research should also examine family variables, such as cohesion, that contribute to split alliances.

Finally, researchers need to do more to identify what actions by the therapist increase trust. Specifically, what actions and attributes of the therapist need to be emphasized so that violent family members express an increased level of bonding with the therapist and more importantly decreased violence? This requires that more research be conducted on the alliance in the context of presenting problem and more research that identifies “mechanisms of change,” to improve alliance, and in particular, bonds development (Sexton & Ridley, 2004).

**CONCLUSION**

First, the alliance continues to be an important factor of change in family therapy, this holds true when the family is analyzed as a whole. Second, although the alliance is necessary to produce change, the type of alliance necessary appears to be, in part, determined by the severity of problems at intake. Changes in some of the more serious presenting problems, such as violence, require a certain level of alliance to facilitate change. Finally, more needs to be done to evaluate the bonds domain of the therapy alliance, and the impact this can have on families dealing with serious problems, such as child abuse and neglect.

**REFERENCES**


