

Meta-Analysis of the Alliance–Outcome Relation in Couple and Family Therapy

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This article reviews meta-analytic evidence for the alliance–outcome relation in couple and family therapy (CFT), with implications for clinical practice. We begin by describing the unique features of CFT alliances and their measurement, followed by two case descriptions. We explain that due to the systemic context of CFT, each patient’s personal alliance with the therapist affects and is affected by other family members’ levels of collaboration. Because family members often seek help when they are in conflict with one another, “split” alliances are common, as are problematic within-system alliances, defined as the degree to which family members agree on the nature of their problems and value participating in therapy together to achieve shared goals. In our meta-analysis of 48 studies with 40 independent samples, we used a three-level random effects model ($Ns = 2,568$ families, 1,545 couples, and 491 effect sizes) and found $r = .297$. In another analysis with seven independent samples and 31 effect sizes, the split alliance–outcome association was also significant, $r = .316$, indicating that the more split or unbalanced the alliance, the poorer the outcome. Moderator analyses showed that alliance–outcome associations did not differ for couple versus family therapy, but correlations were significantly stronger in samples with younger problem children, older adults, proportionally more male youth and adults, and when the families voluntarily sought help (as compared with involuntary or mandated families). The article concludes with research-informed strategies for building and sustaining strong systemic alliances in CFT.

Clinical Impact Statement

Question: This article describes the unique aspects of the therapeutic alliance in couple and family therapy, measures of the alliance that are most often used in research on this topic, and the patient characteristics that most clearly contribute to a strong alliance. **Findings:** In a meta-analysis of 48 therapy studies, we found a significant correlation between (a) patients’ therapeutic alliances with the therapist and among themselves (in terms of collaborating on shared goals) and (b) the reported success of therapy. This correlation was statistically significant across the major theoretical approaches and in both couple and family therapy. More split or unbalanced alliances across patients significantly predicted poorer outcomes. **Meaning:** Taken together, these findings have implications for the kinds of therapist strategies that seem most likely to foster and maintain balanced alliances between partners in a couple or among multiple individuals in a family. **Next Steps:** Future research should focus on important patient contributions and therapist practices that enhance alliances in conjoint therapy, particularly for family members who are in conflict with one another.

Keywords: couple therapy, family therapy, systemic therapy, working alliance, therapeutic alliance

All psychotherapists need to make a judgment about whether an individual client is ready and motivated for therapeutic work, but

therapists conducting conjoint couple and family therapy (CFT) need to concern themselves with each family member’s level of

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This article is adapted, by special permission of Oxford University Press, by the same authors in J. C. Norcross & M. J. Lambert (Eds.). (2018). *Psychotherapy relationships that work* (3rd ed.). New York, NY: Oxford

University Press. The Interdivisional APA Task Force on Evidence-Based Psychotherapy Relationships and Responsiveness was cosponsored by the APA Division of Psychotherapy/Society for the Advancement of Psychotherapy.

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motivation and readiness, which often are at odds. If the therapist does not define the treatment goals and tasks in such a way that everyone can “sign on,” or if she is unable to connect empathically with each individual, the treatment may never get off the ground.

Here is the crux of the matter: In concept and in practice, the working alliance in CFT is both similar to and different from the working alliance in individual psychotherapy. In both treatment formats, therapeutic goals and tasks need to be discussed and agreed upon early on and continually as the process evolves, and in both formats, the therapist needs to “click” emotionally with the patient(s). Only in conjoint CFT, however, does the therapist need to develop and nurture multiple alliances simultaneously. The challenge is that these multiple alliances interact with one another in covert as well as overt ways, particularly when family members are in conflict with one another or when one patient’s alliance is notably stronger than that of another patient. “Split” alliances can be pernicious because family members who view their experience with the therapist very differently can wind up becoming polarized about the value of the therapy itself.

Definitions and Measures

Pinsof and Catherall (1986) expanded Bordin’s (1979) tripartite conceptualization to distinguish among a client’s personal alliance with the therapist, the client’s view of other family members’ personal alliances with the therapist, and the client’s view of the alliance between the therapist and the family as a whole. In this integrative psychotherapy alliance model, a 3×3 matrix crossed client perspective (*self*, *other*, and *group*) with three alliance components (*goal*, *task*, and *bond*). Subsequently, this matrix was expanded to include the *within-system alliance*, a construct that refers to (a) the alliance between partners or family members and (b) the alliance between cotherapists or between one therapist and the institution or agency delivering the treatment (Pinsof, 1994).

In more recent literature, what has emerged as more salient than the group–therapist alliance is the alliance or allegiance (Symonds & Horvath, 2004) between partners or among family members apart from their collaboration with the therapist (cf. Lambert, Skinner, & Friedlander, 2012). This *within-family alliance*, alternately called the family’s *shared sense of purpose within the family* (Friedlander, Escudero, & Heatherington, 2006), refers to the family members’ agreement on the nature of their problems and the anticipated goals of treatment, as well as the value they place on working together in a therapeutic context.

Within-family alliance, or shared sense of purpose within the family, is one of four CFT alliance dimensions within the System for Observing Family Therapy Alliances (SOFTA; Friedlander et al., 2006). This conceptual model, which was developed empirically and clinically, contains one dimension that is similar to Bordin’s (1979) bond component, *emotional connection to the therapist*. Another dimension, *engagement in the therapeutic process*, refers not only to client–therapist agreement on goals and tasks but also to a family member’s hope or sense of optimism that the therapeutic collaboration will lead to change. The SOFTA dimension *safety within the therapeutic system* is unique to the conjoint treatment format. Although feeling safe in therapy applies to a client’s experience of individual therapy as well, in conjoint CFT, clients are present in the sessions with their partners or other family members. Whereas seemingly intractable conflicts can be

addressed and potentially resolved with the help of a professional neutral party (the therapist), conflicts sometimes escalate out of hand. Unfortunately, alliances with the therapist can be compromised when family members feel less safe with one another upon returning home from a session.

Recently, the alliance rupture and repair process in the individual psychotherapy literature (Safran & Muran, 2000) has influenced CFT researchers. In the first published case study of alliance rupture in CFT (Escudero, Boogmans, Loots, & Friedlander, 2012), a rupture was defined as occurring when a split alliance was in evidence or when a patient responded to the therapist or to other family members with confrontation or withdrawal behavior. The authors defined a repair as occurring when (a) the family member demonstrates positive alliance-related behavior, (b) the therapist and patient discuss the rupture directly or indirectly, and (c) move past it with productive collaboration on the goals or tasks of treatment.

Of the various measures in CFT alliance research, two measures are most often used to assess individual family members’ personal alliances with the therapist, the observational Vanderbilt Therapeutic Alliance Scale–Revised (VTAS-R; Diamond, Liddle, Dakof, & Hogue, 1996) and the self-report Session Rating Scale–Version 3 (SRS V.3.0; Duncan et al., 2003). Three measures have features that specifically tap into family system dynamics: The Integrative Alliance Scales’ versions for couple (CTASr) and family therapy (FTASr; Pinsof, Zinbarg, & Knobloch-Fedders, 2008), the couples version of the Working Alliance Inventory (WAI-Co; Symonds & Horvath, 2004), and the SOFTA (Escudero & Friedlander, 2017; Friedlander et al., 2006), which has observer (SOFTA-o) and self-report (SOFTA-s) measures.

In selecting instruments for a particular study, researchers should consider which aspect of the alliance (e.g., agreement on goals or within-family alliance) and which perspective (self-report or observer) is of most importance for their specific purposes. Aside from the SRS, all of the self-report measures have client and therapist versions and assess the alliance between each patient and the therapist, as well as some system dynamics. All measures ask therapists about their alliance with the couple/family as a unit, but only the CTASr/FTASr and Working Alliance Inventory ask patients to report on how they see the therapist’s alliance with their partner or other family members. The VTAS-R and SOFTA-o are observer measures, but only the SOFTA-o grounds raters’ judgments in observed alliance-related behaviors. Unlike the VTAS-R, which is only an observational measure, the SOFTA-o has both observational and self-report versions that allow researchers to compare patient-perceived with observed alliances (cf. de la Peña, Friedlander, & Escudero, 2009). Finally, the within-couple or within-family alliance can be assessed using either the CTASr/FTASr or the SOFTA-o/SOFTA-s, but the safety aspect of alliance is uniquely measured by the latter.

Clinical Examples

To illustrate how CFT alliances are manifested in practice, we selected two published case studies (Escudero et al., 2012; Friedlander, Lee, Shaffer, & Cabrera, 2014). Each case had multiple indicators of treatment success and repeated self-reported and observed alliances measured over the course of 10 sessions. Both of these relatively brief cases were conducted in naturalistic set-

tings with highly experienced family therapists. The therapeutic approaches were nonmanualized and broadly systemic in nature.

A Spanish Family in Crisis

Rosa (16 years old) was a troubled youth whose attitude and behavior at home and in school exasperated her mother (Escudero et al., 2012). By the fourth family session, Rosa had noticeably improved in all areas, in large part due to a strong alliance with the therapist. At the beginning of this session, however, Ms. M responded with sarcasm and intense anger when the therapist began challenging her repeated blaming of her daughter and then suggested they have an individual session to discuss how Ms. M's "personal stressors" might be affecting Rosa and the mother-daughter relationship.

Recognizing the various ruptures (a split alliance, the mother's lack of safety in the session, and the problematic within-family alliance), the therapist asked Ms. M to step out of the room for a brief period. During his time alone with Rosa, the therapist assessed the strength of their bond in light of the new therapeutic focus he had just proposed to her mother. Upon returning to the session, Ms. M continued to express her anger toward the therapist. In an arrogant and sarcastic tone, she responded to his suggestion that they discuss her personal problems. The rupture expanded when Ms. M. returned to blaming Rosa for all her problems.

To repair this within-family alliance rupture, the therapist made several pointed interventions by drawing attention to Ms. M's and Rosa's shared experiences, needs, and feelings. He said, for example,

Some stress comes from the relationship between you two, from your [Ms. M.'s] problems, then there's Rosa's adolescent stress, and there's stress coming from you, which is normal. . . . You're both in a situation of . . . You're both a lot . . . which is normal because you're a family. . . . I mean it [stress] affects both of you, and that's something you have in common. There's an isolation in your family . . . that affects both of you.

The session ended on a positive note, but when the alliance rupture resurfaced in the following session, the therapist apologized to Ms. M saying, "I shouldn't have said this in front of [Rosa], that I was afraid you were burned out." All of the outcome data indicated that the case concluded successfully.

An American Family at Impasse

Eleanor (32 years old) and Jim (33 years old) Beale had been estranged for a short while due to Eleanor's decision to live with another man while she took some time to consider the future of her marriage (Friedlander et al., 2014). Their daughter Shawna (12 years old) was extremely angry over the situation; her relationship with her mother was severely strained. Although Jim took responsibility for his part in the couple's problems and desperately wanted Eleanor to return to the family, she refused to allow the marital impasse to be discussed in the therapy sessions.

In the first session, the therapist connected with Shawna about her experience of the family crisis and encouraged her to express her feelings. In the third session, the therapist asked Shawna to step out of the room to set a boundary between the marital and parental subsystems while she spoke with Jim and Eleanor about

their opposing motivations and goals for the therapy. Notably, the therapist focused on increasing her personal bond with each parent in turn. Additionally, the therapist used several shared purpose interventions to address the problematic within-couple alliance. These interventions included her perception that despite their years together, the parents had never really learned to argue productively, to come to a compromise or a resolution. The therapist concluded by saying, ". . . for two really young people . . . you never had a chance to really learn how to be a couple."

In Session 6, when the therapeutic alliances were well-established, the therapist encouraged Eleanor and Jim to consider couple therapy after the 10th agreed upon family session. This renegotiation of the therapy goals and tasks followed the therapist's compliment to the couple regarding their improvements in problem-solving. Eleanor and Jim agreed to continue couple treatment, which eventually resulted in their reconciliation.

The alliance questionnaires, session evaluations, and outcome data converged to reveal a successful case in which the within-family bonds were severely strained. Observational analyses of the sessions showed no evidence of a split alliance, possibly because the therapist did not insist that the marital stalemate be addressed in the conjoint family sessions but rather agreed to work with the family on the one mutually agreed upon goal, to improve the parents' individual relationships with their angry daughter.

Results of Previous Meta-Analyses

Our previous meta-analysis (Friedlander, Escudero, Heatherington, & Diamond, 2011) of 24 published CFT alliance-retention/outcome studies ($N = 1,416$ clients), most of which assessed alliances early in treatment, showed a weighted aggregate, $r = .26$, $z = 8.13$ ($p < .005$); 95% CI [0.33, 0.20]. This small-to-medium effect size was almost identical to the one reported by Horvath, Del Re, Flückiger, and Symonds (2011) for the alliance-outcome relation in individual adult psychotherapy. A separate analysis of the 17 family studies ($n = 1,081$ patients) showed a similar average weighted effect size, $.24$ ($p < .005$), and the analysis of the seven couple therapy studies ($n = 335$ patients) indicated $r = .37$, $p < .005$. A test of the homogeneity of the CFT subsamples revealed unaccounted for variability. The studies with observed alliances (using SOFTA-o and VTAS-R), roughly half the sample, were the most homogeneous.

A recent meta-analysis of the alliance-outcome relation in "family-involved treatment" for youth problems used multilevel modeling to account for within- and between-study variability in 28 studies, with 21 independent samples and 2,126 families (Welmerts-van de Poll et al., in press). Alliance quality was significantly associated with treatment outcome, $r = .183$, $p < .001$. Moderator analyses showed stronger correlations when alliances measured at different times were averaged or added, when families were help-seeking rather than receiving mandated care, and when the families had relatively younger children.

Meta-Analytic Review

Sample

We included all of the studies in Friedlander et al. (2011) and Welmerts-van de Poll et al.'s (in press) meta-analyses with a few

additions, located using relevant keywords in Google Scholar, Wiley Online Library, Eric, Academic Search Premier, PubMed, Medline, PsycInfo, PsycBooks, Web of Science, and ProQuest. We also visually searched each electronic issue (from 2009 to mid-2017) of 11 CFT/systemic journals. Inclusion criteria were CFT published and unpublished English-language studies on alliance (self-reported or observational) in family or couple treatments, treatments-as-usual, group marital therapy, home-based family therapy, and family psychoeducation in which an effect size for the alliance–outcome association was available or could be calculated. We excluded studies with no intermediate or distal outcome variables, as well as studies that did not distinguish between conjoint family therapy and individual psychotherapy. Outcomes included retention in treatment (versus dropout), as well as midtreatment improvement and client change.

Our sample (Table 1) included 48 studies with 40 independent samples (32 of family therapy and eight of couple therapy) and a total of 2,568 families and 1,545 couples. We also conducted a separate analysis of seven studies (Table 2; total $N = 250$ families) that specifically reported on the association between outcomes and split or unbalanced alliances. Six of these seven studies were also included in the major meta-analysis; the seventh study (Bartle-Haring, Glebova, Gangamma, Grafsky, & Delaney, 2012) only tested the association between split alliance and outcome.

All studies were coded by the second or third authors using the guidelines provided by Lipsey and Wilson (2001) to identify the various features used in our 21 moderator analyses. For the 28 studies in Welmers-van de Poll et al.'s (in press) meta-analysis, we used the same coding for the present analyses. Coding of the 20 additional studies was carried out by the second author. Coding difficulties were negotiated to consensus.

We coded an effect size as positive if the Pearson's correlation was in the expected direction, that is, higher alliance (or lower split alliance) associated with retention rather than dropout and/or more positive outcomes. Correlations not in the expected direction were coded as negative. When a nonsignificant correlation was reported but the information was insufficient for calculating an effect size, we assigned a value of zero to the correlation.

Due to the conjoint nature of CFT, most studies had multiple informants, measurements, and outcomes. In total, we computed 491 effect sizes for the association between alliance and outcome, and 31 effect sizes for the split alliance–outcome association.

Statistical Analyses

We used a multilevel random effects model to account for dependent effect sizes, a method that has been shown to be superior to more traditional meta-analytic approaches when moderators are studied (Van den Noortgate & Onghena, 2003). The three-level random effects model (with $\alpha = .05$) had the following sources of variance: sampling variance of the observed effect sizes (Level 1), variance between effect sizes from the same study (Level 2), and variance between studies (Level 3). This model was also used for the moderator analyses.

All analyses were conducted using *R* software (Version 3.3.1; R Core Team, 2016) in the *metafor* package. To test moderators with three or more categories, we used an omnibus *F* test of the null hypothesis. Before conducting these analyses, we centered each continuous variable around its mean and created dummy variables

for categorical data. All of the model parameters were estimated using the restricted maximum likelihood method.

Results

As shown in Table 3, the meta-analytic correlation between the quality of the alliance and outcome was significant, $r = .297$, 95% CI [0.223, 0.351], $p < .001$, $d = .622$, indicating that stronger alliances were predictive of better outcomes. The correlation between split alliance and outcome was also significant, $r = .316$, 95% CI [−0.157, 0.458], $p < .001$, $d = .666$, indicating that more split/unbalanced alliances contributed significantly to worse treatment outcomes. Cohen's d in both analyses indicated medium meta-analytic effects.

As shown in Table 3, significant percentages of the total variance (all $ps < .001$) between effect sizes was found within (Level 2) and between studies (Level 3). For the alliance–outcome association, Level 2 = 35.4%, Level 3 = 50.7%. For the split alliance–outcome association, Level 2 = 10.4%, Level 3 = 40.7%.

To address the file drawer problem (Rosenthal, 1995), we performed trim and fill analyses for the two meta-analyses (alliance–outcome and split alliance–outcome) using *R* in the *metafor* package and all available effect sizes to test for indicators of overestimation and underestimation of the true overall effect size (Duval & Tweedie, 2000; Viechtbauer, 2015). As shown in Figures 1 and 2, the funnel plots showed missing effect sizes on the left sides of the distribution, indicating that in both meta-analyses, the effect sizes may be overestimating the true effects. Comparisons of confidence intervals revealed that the effect size for alliance–outcome was significantly smaller after the trim and fill analysis, $r = .167$, $p < .001$. On the other hand, this analysis showed that the effect size for split alliance–outcome did not vary significantly from the overall meta-analytic effect size, $r = .314$, $p < .001$.

Mediators and Moderators

We located a single study of mediation in our sample (Friedlander, Lambert, & de la Peña, 2008), an investigation of 17 low-income families with at-risk children, whose purpose was to disentangle aspects of first session alliance-related behavior from midtreatment progress. The parents' behaviors on two SOFTA dimensions, safety and shared sense of purpose within the family (i.e., the within-system alliance), were observed in Session 1, and parent-rated improvement so far was reported after Session 3. Results indicated that observers' ratings of the families' shared purpose significantly mediated the relation between parental safety and improvement. In other words, the degree to which parents felt comfortable in the family context in the first session significantly contributed to within-family collaboration in that session, which in turn predicted parent-rated progress after the third session, $p < .05$, $R^2 = .23$, adjusted $R^2 = .16$.

Table 4 summarizes the 21 moderator analyses in terms of sample characteristics, treatment characteristics, and methodological characteristics (related to alliance measurement and outcome measurement). In terms of clients, the average ages of the problem youth (or adult child) and adults participating in the therapy (parents/caregivers or partners in couple therapy) significantly moderated the alliance–outcome association for youth and adults, although only two studies provided the ages of adults. Specifically,

Table 1
Alliance–Outcome Studies in the Meta-Analysis

| Study | Treatment characteristic | | | | Alliance measurement | | | Outcome measurement | | | Calculations of ES | | | | |
|---|--------------------------|--|-----------------|---------|----------------------|-------|-----------|---------------------|-------|--------|--------------------|-----------|------------------------|------------------------|------------------|
| | Modality | Problem type | Treatment model | Setting | Referral status | Type | Measure | Time | Rater | Domain | Timing | Rater | N families/ couples | N clients ^b | Weighted mean ES |
| | | | | | | | | | | | | | | | |
| Anderson and Johnson (2010) | Couple | Relational distress | Combined Models | C | HS | I | CTASr | M | SR | GT | DT | SR | 173 | 346 | .29 |
| Anker, Owen, Duncan, and Sparks (2010) ¹ | Couple | Relational distress | Combined models | C | HS | I | SRS | L | SR | GT | DT | SR | 250 | 500 | .13 |
| Bachler et al. (2016) | Family | Multiproblem families | TAF | HB | Mnd | I | CP-TAF | Imp | T | GT, IF | EOT | SR | 304 | n.r. | .36 |
| Bennun (1989) | Family | Mixed | FT | C | HS | I | TS | E | SR | GT, IF | EOT | SR | 35 | 26 | .46 |
| Bourgeois, Sabourin, and Wright (1990) | Couple | Relational distress | FB CBT | C | R | I, WS | CTAS | M | SR | FF | EOT | SR | 63 | 126 | .65 |
| Brown and O’Leary (2000) | Couple | Maltreatment by husband | FB CBT | C | R | I | WAI-O | E, M, L | O | GT | EOT | SR | 70 | 140 | .54 |
| Chinchilla (2007) ^{a2} | Family | Substance use | MDFT | n.r. | Mx | I | VTAS-R | E | O | R, IF | EOT, FU | SR, OM | 68 | 66 | -.06 |
| Dauber (2004) ^{a2} | Family | Substance use | MDFT | n.r. | Mx | I | VTAS-R | E | O | IF | EOT, FU | SR | 63 | 61 | .41 |
| Escudero, Friedlander, Varela, and Abascal (2008) | Family | Mixed | FT | C | HS | I, WS | SOFTA-o | E, M | O | GT | DT | SR | 37 | 82 | .21 |
| Escudero et al. (2018) | Family | Internalizing and externalizing problems | AEFT | C | Mx | I | SOFTA-s | E, M, L | SR | GT | EOT | O, T | 44 | 88 | .37 |
| Feder and Diamond (2016) | Family | Internalizing problems | ABFT | C | HS | I | VTAS-R | M | O | IF | EOT | SR | 19 | 19 | .24 |
| Flicker, Turner, Waldron, Brody, and Ozechowski (2008) | Family | Substance use | FFT | C | Mx | I | VTAS-R | E | O | R | EOT | T | 86 | 43 | -.05 |
| Fonsberg et al. (2014) ³ | Family | Eating disorders | FBT | C | HS | I | WAI-O | E | O | IF | EOT | OM | 38 | 61 | .42 |
| Forsberg (2011) ^{a3} | Family | Eating disorders | FBT | C | HS | I | WAI-O | E | O | IF | EOT | SR | 38 | 99 | .62 |
| Friedlander, Lambert, and Muñiz de la Peña (2008) ⁴ | Family | Mixed | FT | C | R | WS | SOFTA-o | E | O | GT | DT | SR | 27 | n.r. | .45 |
| Friedlander, Kivlighan, and Shaffer (2012) ⁴ | Family | Mixed | FT | C | R | I | SOFTA-s | E, M | SR | GT | DT | SR | 20 | 36 | .46 |
| Glebova et al. (2011) | Couple | Relational distress | FT | C | HS | I | WAI-S | M | SR | FF | DT | SR | 195 | 390 | .26 |
| Glueckauf et al. (2002) | Family | Epilepsy with behavioral problems | IFCM or PG | n.r. | R | I | WAI-S | E + M (A) | SR | IF, GT | EOT | SR | 19 | 19 | .19 |
| Hawley and Weisz (2005) | Family | Mixed | CB MH | C | HS | I | TASC | L | SR | R, IF | EOT | OM, T, SR | 65 | 65 | .12 |
| Hogue, Dauber, Stambaugh, Cestero, and Liddle (2006) ² | Family | Substance use | MDFT | n.r. | Mx | I | VTAS-R | E | O | IF | EOT, FU | SR | 44 | 44 | -.02 |
| Isserlin and Couturier (2012) | Family | Eating disorders | FBT | C | HS | I, WS | SOFTA-o | E, M, L | O | IF, R | EOT | OM, SR | 14 | 14 | .33 |
| Johnson and Taliman (1997) | Couple | Relational distress | EFT | C | R | I, WS | CTAS | E | SR | FF | EOT | SR | 32 | 64 | .46 |
| Johnson et al. (2006) ⁵ | Family | Multiproblem families | HB FT | HB | Mnd | I | FTAS | L | SR | IF | EOT | SR | 225 | 456 | .03 |
| Johnson et al. (2002) ⁵ | Family | Multiproblem families | HB FT | HB | Mnd | I | FTAS | L | SR | IF, FF | EOT | SR | 43 | 45 | .19 |
| Keeley, Geffken, Ricketts, McNamara, and Storch (2011) | Family | Internalizing problems | FB CBT | C | HS | I | TASC, WAI | E, M Imp. | SR, T | IF | EOT | SR | 23 | 22 | .51 |
| Kim (2007) ^a | Family | Mixed | SFBT | C | HS | I | RRS | E | SR | IF | EOT | SR | 25 | 21 | .12 |
| Knobloch-Fedders, Pinsof, and Miami (2007) ⁶ | Couple | Relational distress | IPCT | C | HS | I, WS | CTASr | M | SR | FF | DT, EOT | SR | 35 | 80 | .39 |
| Kuhlman, Tolvanen, and Seikkula (2013) | Couple | Depression | FT | C | HS | I | SRS | M | SR | IF | DT, EOT | SR | 29 | 58 | .38 |
| Lange et al. (2018) | Family | Externalizing problems | MST | HB | Mnd | I | TAM-R | Imp., E, M, L | SR | IF | EOT, FU | SR | 848 | 774 | .00 |
| Owen, Duncan, Reese, Anker, and Sparks (2014) ¹ | Couple | Relational distress | Combined models | C | HS | I | SRS | L | SR | FF | EOT | SR | 158 | 316 | .57 |
| Owen, Rhoades, Stanley, and Markman (2011) | Couple | Relational distress | PREP | C | HS | I | WAI-S | L | SR | FF | FU | SR | 118 | 236 | .19 |
| Pereira, Lock, and Oggins (2006) | Family | Eating disorders | FBT | C | R | I | WAI-O | E, L | O | R, IF | EOT, DT | OM | 41 | 36 | .18 |
| Pinsof, Zinbarg, and Knobloch-Fedders (2008) ⁶ | Couple | Relational distress | IPCT | C | HS | I, WS | CTASr | M | SR | GT | DT | SR | 60 | 120 | .29 |

Table 1 (continued)

| Study | Treatment characteristic | | | | Alliance measurement | | | | Outcome measurement | | | | Calculations of ES | | |
|--|--------------------------|---------------------|-----------------|---------|----------------------|-------|-------------|-----------|---------------------|--------|---------|--------|------------------------|------------------------|------------------|
| | Modality | Problem type | Treatment model | Setting | Referral status | Type | Measure | Time | Rater | Domain | Timing | Rater | N families/ couples | N clients ^b | Weighted mean ES |
| Quinn, Dotson, and Jordan (1997) | Family | Mixed | FT | C | HS | I, WS | CTAS | E | SR | GT | EOT | SR | 17 | 34 | .59 |
| Quirk, Owen, Inch, France, and Bergen (2014) | Couple | Relational distress | PREP | C | R | I | WAI-S | Mid | SR | FF | EOT | SR | 122 | 244 | .27 |
| Raytek, McGrady, Epstein, and Hirsch (1999) | Couple | Alcohol abuse | MBT | C | Mx | I | VTAS-R | E | T | R | EOT | O | 90 | 180 | .37 |
| Rienecke, Richmond, and Lebow (2016) | Family | Eating disorders | FBT PHP | C, H | HS | I | WAI-S | E, L | SR | R, IF | EOT | O | 56 | 56 | .07 |
| Robbins et al. (2006) ² | Family | Substance use | MDFT | n.r. | Mx | I | VTAS-R | E | O | R | EOT | OM | 30 | n.r. | .17 |
| Robbins et al. (2008) | Family | Substance use | BSFT | n.r. | n.r. | I | VTAS-R | E | O | R | EOT | OM | 31 | 23 | .25 |
| Robbins, Turner, Alexander and Perez (2003) | Family | Substance use | FFT | n.r. | Mx | I | VTAS-R | E | O | R | EOT | OM | 34 | 29 | -.18 |
| Shelef and Diamond (2008) ⁷ | Family | Substance use | MDFT | n.r. | Mx | I | VTAS-R(SF) | E, Mid, L | O | R, IF | EOT | OM, SR | 86 | 68 | .23 |
| Shelef, Diamond, Diamond, and Liddle (2005) ⁷ | Family | Substance use | MDFT | n.r. | Mx | I | WAI, VTAS-R | E | SR, O | IF, R | EOT, FT | OM, SR | 91 | 110 | .18 |
| Smerud and Rosentfarb (2008) | Family | Schizophrenia | PG | H | HS | WS | SOFTA-o | Mid | O | IF | EOT | O | 28 | n.r. | .74 |
| Sotero, Moura-Ramos, Escudero, and Relvas (2017) | Family | Mixed | FT | C | Mx | I, WS | SOFTA-o | E, Mid | O | GT | EOT | T | 29 | 87 | .37 |
| Symonds and Horvath (2004) | Couple | Relational distress | n.r. | C | R | I | WAI-co | Mid | SR | FF | EOT | SR | 44 | 88 | .44 |
| Yoo, Bartle-Haring, and Gangamma (2016) | Couple | Relational distress | n.r. | C | HS | I | VTAS-R | E, Mid | O | FF | EOT | R | 34 | 68 | .20 |
| Zaitsoff, Doyle, Hoste, and le Grange (2008) | Family | Eating disorders | FBT | C | n.r. | I | HRQ | Mid, L | SR | IF | EOT | SR | 40 | 40 | .00 |

Note. TAF = therapeutische ambulante familienbetreuung; FT = family treatment as usual; AEFT = alliance empowerment family therapy; MDFT = multidimensional family therapy; EFT = emotion-focused therapy; ABFT = attachment-based family therapy; FBT = functional family therapy; FFT = functional family therapy; IPCT = integrative problem-centered therapy; IFCM = issue-specific single-family counseling; PG = multi-family psychoeducational group; CBMH = community-based mental health; PREP = Prevention and Relationship Enhancement Program; HB FT = home-based family therapy; FB CBT = family-based cognitive-behavioral therapy; SFBT = solution-focused brief therapy; FBT PHP = family-based therapy partial hospitalization program; BSFT = brief strategic family therapy; MBT = marital behavioral therapy; C = clinic; HB = home-based; H = hospital; HS = help-seeking; R = recruited for the study; Mnd = mandated; Mx = mixed; I = individual client; WS = within-system; CP-TAF = Compliance-Collaboration Scale (in the therapeutische ambulante familienbetreuung); TS = therapist scale; VTAS(-R) = Vanderbilt Therapeutic Alliance Scale (-Revised); SOFTA-o/s = System for Observing Family Therapy Alliances (-observer/-self-report); SRS = Session Rating Scale; WAI(-S/-O) = Working Alliance Inventory (-short form /-observer version); TASC = Therapeutic Alliance Questionnaire; TAS = Therapeutic Alliance Scale; FTAS(r) = Family Therapy Alliance Scale (-Revised); CTAS(r) = Couple Therapy Alliance Scale (-revised); HAQ = Helping Alliance Questionnaire; RRS = Relationship Rating Scale; HRQ = Helping Relationship Questionnaire; E = early in treatment; Mid = midtreatment; L = late in treatment; Imp = improvement in alliance; A = multiple sessions averaged or added; SR = self-report; T = therapist; O = observer; IF = individual functioning/symptom severity; FF = family/couple functioning; R = retention; GT = goal attainment or therapeutic progress; CBMH = community based mental health; MST = multisystemic therapy; TAM-R = Therapist Adherence Measure-Revised; DT = during treatment; EOT = End of Treatment; FU = follow-up; OM = objective clinical log measure (e.g., weight gain); Wid = weighted; n.r. = not reported.

^a Unpublished dissertation. ^b Sample sizes and effect sizes are based on the mean of all available reported analyses.

1, 2, 3, 4, 5 Studies with the same numbered superscript used the same or overlapping samples.

Table 2
Studies in the Split Alliance–Outcome Meta-Analysis

| Study | N (families/couples) | N (clients) | Weighted mean ES |
|---|----------------------|-------------|------------------|
| Bartle-Haring, Glebova, Gangamma, Gafsky, and Delaney (2012) ^a | 72 | 144 | .44 |
| Escudero et al. (2018) ^a | 44 | 88 | .57 |
| Flicker et al. (2008) ^b | 86 | 43 | .02 |
| Kim (2007) ^a | 25 | n.r. | .27 |
| Forsberg et al. (2014) ^b | 38 | 99 | .18 |
| Robbins et al. (2003) ^b | 34 | n.r. | .33 |
| Robbins et al. (2008) ^b | 31 | n.r. | .23 |

Note. Except Bartle-Haring et al. (2012), descriptions of the other six studies appear in Table 1. n.r. = not reported, ES = effect size.

^a Self-reported split alliances. ^b Observer-rated split alliances.

correlations were stronger when the targeted child in family therapy was relatively younger and when the adults in the family (whose ages were averaged) were relatively older. Additionally, alliance–outcome correlations were significantly stronger when the patients were either specifically recruited for the study or help-seeking, as compared with involuntary or mandated patients.

Furthermore, adult gender was a significant moderator, indicating stronger correlations between alliance and outcome when the study (sub)sample included relatively more fathers/male caregivers or male partners. Therapist gender (percent of male therapists in the sample) did not significantly moderate the alliance–outcome association.

Notably, therapy modality (couple versus family) did not significantly moderate the alliance–outcome association. In other words, because the overall meta-analytic effect size was not significantly different for couples, the alliance–outcome association found in the full analysis was comparable across the two modalities.

We also tested treatment model as a moderator variable, reasoning that because specific therapeutic strategies are intricately related to alliance development and maintenance, patients' collaborative efforts may differ depending on the therapist's theoretical orientation. Results showed the strongest correlations for cognitive-behavioral couple/family therapies as compared with either attachment/emotion-focused or integrative therapies. The lowest correlations emerged for structural/functional and multisystemic models. Despite these differences, the significant correlations indicate that alliance predicted outcome within each of these four major approaches to couple and family work.

In terms of method, three specific alliance characteristics significantly moderated the alliance–outcome association: (a) type of

alliance, with the highest correlation for systemic alliances and outcome, as compared with an individual client's alliance with the therapist or the sum or average of different family members' alliance scores; (b) a comparison of alliance measures, with the SOFTA-o/SOFTA-s yielding significantly greater average effect sizes than other instruments; and (c) alliance measurement, with the addition or average of alliance scores over multiple time periods emerging as a stronger predictor of outcome than alliances measured at a single point (i.e., early, middle, late).

Finally, among the three outcome characteristics assessed for moderation (domain, informant, and timing), the only significant moderating effect emerged for outcome domain. Specifically, alliance correlated most highly with outcome measures that assessed parental skills or family/couple functioning, as compared with retention in treatment versus dropout, measures of goal attainment/progress, and measures of individuals' symptom reduction.

Patient Contributions

Patients' Characteristics

In psychotherapy with heterosexual couples, most of the evidence indicates that when it comes to self-reported perceptions of alliance, gender matters (Glebova et al., 2011; Halford, Owen, Duncan, Anker, & Sparks, 2016; Knobloch-Fedders, Pinsof, & Mann, 2007). Generally, but not unequivocally (Heatherington & Friedlander, 1990), male partners' alliance perceptions early in treatment tend to be more strongly associated with outcome than those of their female partners. One study found that outcomes were enhanced when the man's alliance perceptions exceeded those of his female partner (Symonds & Horvath, 2004). Less frequently,

Table 3
Results of the Three-Level Mixed Effects Meta-Analyses

| Analysis | Studies ^a | # ES | Mean r (SE) | [95% CI] | p | d | % var. (1) | σ ² (2) | % var. (2) | σ ² (3) | % var. (3) |
|------------------------|----------------------|------|----------------|-----------------|-------|------|------------|--------------------|------------|--------------------|------------|
| Alliance–outcome | 39 | 491 | .297 (.036) | [0.223, 0.351] | <.001 | .622 | 14.0 | .029*** | 35.4 | .041*** | 50.7 |
| Split alliance–outcome | 7 | 31 | .316 (.083) | [−0.157, 0.458] | <.001 | .666 | 48.9 | .009*** | 10.4 | .034*** | 40.7 |

Note. # ES = number of effect sizes in the meta-analysis. (1) = level 1; (2) = level 2; (3) = level 3; σ²(2) = variance between effect sizes (within studies); σ²(3) = variance between effect sizes (2; between studies); CI = confidence interval.

^a Number of independent samples (some studies reported on the same sample).

*** p < .001.

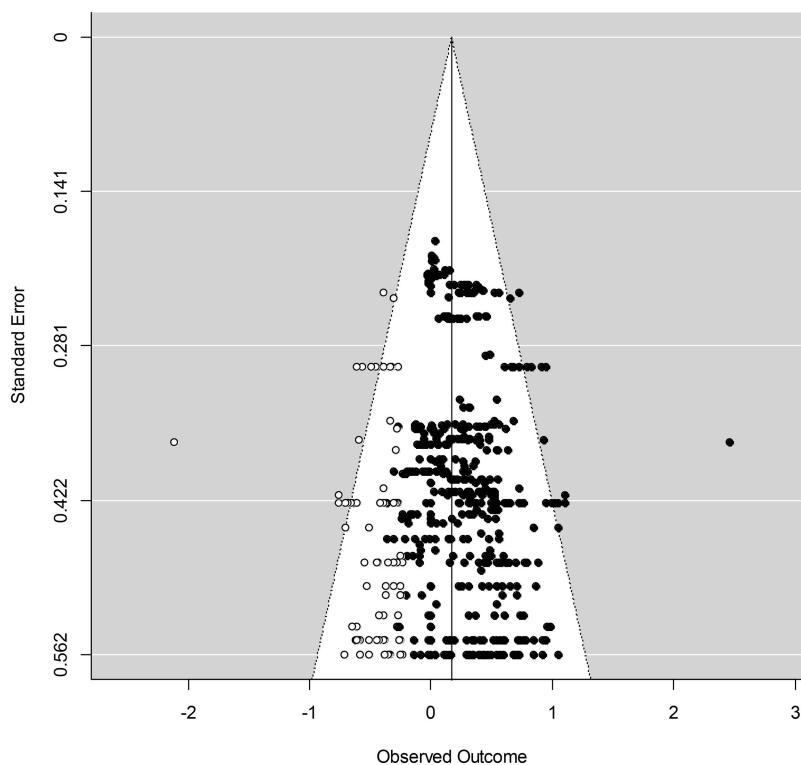


Figure 1. Trim and fill plot for the alliance–outcome association.

the woman's alliance has been the stronger predictor of outcome, but timing of the alliance measurement also plays a role. Some authors speculated that,

[p]erhaps when couples invest in longer term commitments to therapy, women's alliances emerge as the more critical, and when couples invest in a shorter term of therapy because of a reluctant partner (usually the man), men's alliance becomes more predictive. (Anker, Owen, Duncan, & Sparks, 2010, p. 642)

Indeed, in our meta-analysis gender, defined as percent of adult male patients in a study's (sub)sample, emerged as a significant moderator variable. Specifically, the correlations between alliance and outcome were stronger when the sample was composed of relatively more fathers/male caregivers or male partners. This finding notwithstanding, gender needs to be considered in light of other, largely unknown factors. In one study (Miller et al., 2015), for example, only the female partner's level of avoidant attachment was associated with (poor) alliance development. By contrast, in a study of problem-focused therapy (Biesen & Doss, 2013), gender did not significantly predict retention. Rather, when partners viewed their problems similarly before therapy began (one aspect of the within-couple alliance), both men and women engaged more substantively in the therapy process.

Levels of personal and relational distress also play an important role in couples' alliances with the therapist. Maintenance of a strong alliance over the course of couple therapy seems to be negatively associated with the severity of clients' difficulties, including their experience of relational distress in the family of origin (Knobloch-Fedders, Pinosof, & Mann, 2004). As shown in

one study, fluctuations in a partner's depressive symptoms from one session to the next were reciprocally associated with fluctuations in the couple's average alliance scores (Kuhlman, Tolvanen, & Seikkula, 2013). Although other authors found no association between individuals' symptoms and alliance development (Knobloch-Fedders et al., 2004; Mamodhousen, Wright, Tremblay, & Poitras-Wright, 2005), partners who are less dissatisfied (Anderson & Johnson, 2010), especially with the sexual aspect of their relationship (Knobloch-Fedders et al., 2004), and who are more trusting of one another (Johnson & Talitman, 1997) seem to have a greater capacity for developing a strong alliance with the therapist, possibly because they begin treatment relatively more satisfied with their relationships (Knerer & Bartle-Haring, 2010; Symonds & Horvath, 2004).

In family treatment, family role (parent versus child) is consistently associated with the alliance–outcome relationship. That is, the strength of alliance depends on who is asked or observed. For example, in a study of family therapy for anorexia nervosa, observers' ratings of adolescent alliances (but not parent alliances) predicted early weight gain (Pereira, Lock, & Oggins, 2006). Rather, the parents' alliance behavior in later therapy sessions was associated with their children's overall weight gain. In an investigation of multidimensional family therapy for adolescent substance abuse, observed (but not self-reported) alliances predicted adolescent outcomes but only when the parent's alliance with the therapist was moderate to strong (Shelef, Diamond, Diamond, & Liddle, 2005). Additionally, in community-based treatment as usual (individual sessions with the adolescent paired with conjoint family sessions), adolescents' alliance perceptions predicted their

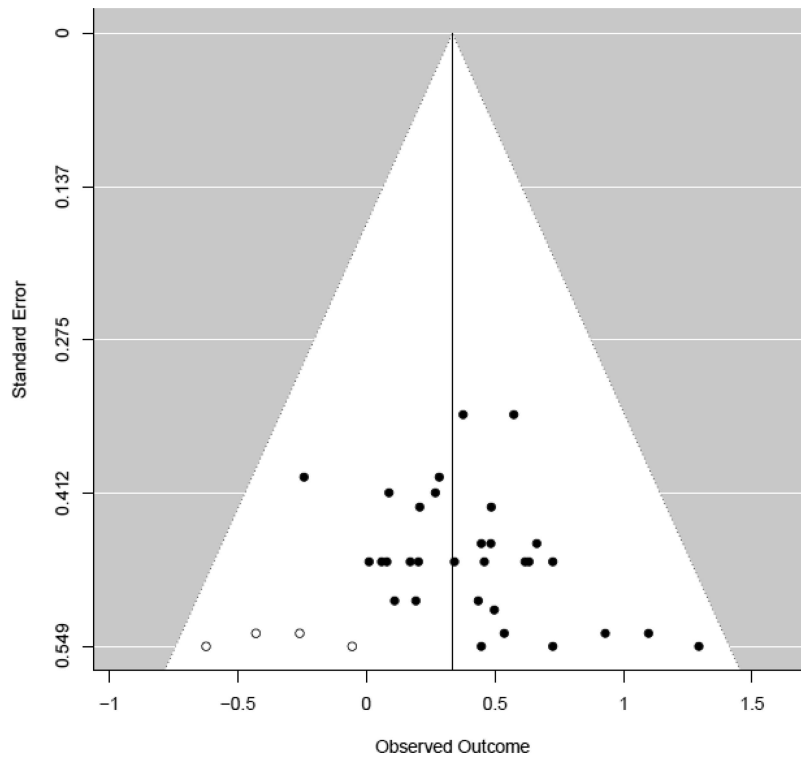


Figure 2. Trim and fill plot for the split alliance–outcome association.

parents' and their own self-reported outcomes (symptom reduction and family functioning), whereas the parents' alliance perceptions were only associated with their own perspective on outcome (Hawley & Garland, 2008).

Similarly, the adolescents and parents in a study of treatment as usual viewed their progress differently in an actor-partner study (Friedlander, Kivlighan, & Shaffer, 2012). Whereas parents saw improvements when their children rated the alliance positively, the adolescents' views were not associated with those of their parents. Moreover, when adolescents' alliances were strong, they saw their sessions as relatively more valuable, but parents saw the sessions as considerably *less* valuable when their children's alliance scores were high.

Family role also plays a part in the development of split or unbalanced alliances. Although alliances in which the adolescent has a much closer bond with the therapist than does the parent seem to occur just as often as the reverse pattern (Muñiz de la Peña et al., 2009), the type of unbalanced pattern has often been associated with retention. In a study of brief strategic family therapy, for example, unbalanced mother–father alliances and increasingly unbalanced mother–adolescent alliances characterized families that dropped out of therapy (Robbins et al., 2008).

As in couple therapy, family members' levels of personal distress seem to play a role in alliance development. In a study of family therapy for anorexia nervosa, for example, adolescents who had significant weight and eating concerns found it more difficult to establish an alliance with the therapist (Pereira et al., 2006). On the other hand, in a study of multidimensional family therapy, the externalizing versus internalizing nature of the adolescents' prob-

lems was not related to alliance development (Shelef & Diamond, 2008).

According to Bowen (1978), adults' personal distress is a reflection of their levels of self-differentiation, which seems to be influential for alliance development. Theoretically, more differentiated adults are better able to balance togetherness with aloneness. In one study, parents' perceptions of the family's alliance after Session 3 were associated with their pretreatment differentiation scores (Lambert & Friedlander, 2008). One aspect of self-differentiation, emotional reactivity, was most closely associated with parents' self-reported safety on the SOFTA-s. That is, parents who reported less reactivity tended to behave in a way that suggested greater comfort.

More differentiated adults are also able to separate their personal concerns from the concerns of others, notably their children (Bowen, 1978). In the Beale family (described earlier; Friedlander et al., 2014), the parents were able to put aside their marital instability and confusion during the family sessions to focus on their daughter's intense distress. In this successful case, the parents' shared concern for their child seems to have allowed each person's alliance with the therapist to develop favorably without ruptures or split alliances. By contrast, in the other case study (Escudero et al., 2012), Ms. M found it particularly difficult to separate her own problems from those of her daughter. It seems likely that this mother's apparently poor self-differentiation contributed to the severe within-family alliance rupture observed in this case.

Finally, in comparisons of observed alliances (on the SOFTA-o) in four sessions with voluntary (self-referred) and involuntary

Table 4
Results of the Moderator Analyses

| Moderator | Studies ^d | # ES | Mean <i>r</i> (SE) | [95% CI] | β [95% CI] | <i>F</i> (<i>df</i>) | <i>p</i> | σ^2 (2) | σ^2 (3) |
|--|----------------------|------|--------------------|-----------------|--------------------------|------------------------|----------|----------------|----------------|
| Sample characteristics | | | | | | | | | |
| Problem type | 39 | 491 | | | | 2.007 (6, 484) | .063 | .029*** | .036*** |
| Drug abuse | 7 | 114 | .190 (.067)** | [0.060, 0.314] | | | | | |
| Eating disorders | 5 | 116 | .203 (.078)** | [0.053, 0.344] | .022 [−0.205, 0.250] | | | | |
| Internalizing/externalizing behavior | 5 | 61 | .309 (.097)** | [0.127, 0.510] | .240 [−0.205, 0.250] | | | | |
| Mixed/diverse | 7 | 73 | .249 (.069)*** | [0.116, 0.371] | .083 [−0.122, 0.289] | | | | |
| Multiproblem families | 2 | 33 | .213 (.099)* | [0.031, 0.386] | .048 [−0.258, 0.354] | | | | |
| Relational distress | 12 | 92 | .330 (.057)*** | [0.227, 0.426] | .180 [0.002, 0.358]* | | | | |
| Mental illness | 1 | 2 | .360 (.131)** | [0.099, 0.552] | .754 [0.217, 1.292]** | | | | |
| Average age of youth | 20 | 346 | .790 (.302)*** | [0.429, 0.934] | −.060 [−0.102, −0.018]** | 7.744 (1, 344) | .006 | .038*** | .015*** |
| Average age of adults | 2 | 42 | .999 (.939)* | [0.289, 1.000] | .099 [−0.193, −0.004]* | 4.465 (1, 40) | .041 | .004 | .270* |
| Percentage of male youth | 19 | 313 | .254 (.084)** | [0.094, 0.402] | −.160 [−0.463, 0.144] | 1.074 (1, 311) | .301 | .040*** | .030*** |
| Percentage of male adult clients | 28 | 220 | .235 (.041)*** | [0.156, 0.310] | .100 [0.016, 0.185]* | 5.486 (1, 218) | .020 | .011*** | .033*** |
| Percentage of clients of color | 29 | 337 | .279 (.043)*** | [0.202, 0.355] | −.171 [−0.380, −0.038] | 2.602 (1, 335) | .108 | .032*** | .019*** |
| Percentage of male therapists | 24 | 258 | .310 (.074)*** | [0.172, 0.435] | −.089 [−0.480, 0.303] | −.198 (1, 256) | .656 | .039*** | .027*** |
| Referral source | 37 | 479 | | | | 2.844 (3, 475) | .037 | .029*** | .036*** |
| Recruited for study | 8 | 83 | .400 (.074)*** | [0.272, 0.514] | | | | | |
| Help-seeking | 19 | 241 | .335 (.088)*** | [0.235, 0.405] | −.089 [−0.262, 0.084] | | | | |
| Mandated | 2 | 32 | .235 (.138) | [−0.034, 0.473] | −.184 [−0.494, 0.126] | | | | |
| Mixed (mandated/help-seeking) | 8 | 123 | .137 (.072)* | [−0.004, 0.273] | −.286 [−0.488, −0.083]** | | | | |
| Treatment characteristics | | | | | | | | | |
| Therapy modality | 39 | 491 | | | | 2.947 (1, 489) | .087 | .029*** | .038*** |
| Couple therapy | 14 | 104 | .359 (.058)*** | [0.257, .453] | | | | | |
| Family therapy | 25 | 387 | .248 (.043)*** | [0.166, 0.325] | −.124 [−0.265, 0.018] | | | | |
| Therapy model | 39 | 491 | | | | 7.082 (3, 487) | <.001 | .029*** | .026*** |
| Structural/functional and multisystemic | 7 | 106 | .115 (.065)* | [−0.012, 0.238] | | | | | |
| Integrating and mixed | 19 | 282 | .288 (.040)*** | [0.216, 0.357] | .181 [0.037, 0.325]* | | | | |
| Attachment and emotion-focused | 7 | 68 | .246 (.071)*** | [0.112, 0.371] | .135 [−0.053, 0.324] | | | | |
| Cognitive-behavioral | 6 | 35 | .533 (.083)*** | [0.407, 0.639] | .479 [0.273, 0.685]*** | | | | |
| Treatment integrity | 39 | 491 | | | | 2.096 (1, 489) | .148 | .029*** | .040*** |
| Not monitored or reported | 16 | 176 | .233 (.054)*** | [0.129, 0.331] | | | | | |
| Monitored | 23 | 315 | .327 (.046)*** | [0.245, 0.405] | .103 [−0.037, 0.242] | | | | |
| Treatment setting | 34 | 387 | | | | 2.186 (3, 383) | .089 | .012*** | .037*** |
| Home-based | 3 | 50 | .150 (.113) | [−0.070, 0.356] | | | | | |
| Outpatient clinic | 28 | 297 | .355 (.039)*** | [0.287, 0.420] | .220 [−0.014, 0.455]* | | | | |
| Mixed home-based/clinic | 2 | 23 | .244 (.095)** | [0.062, 0.410] | .098 [−0.192, 0.388] | | | | |
| Hospital/residential | 1 | 17 | .211 (.085)* | [0.046, 0.364] | −.184 [−0.614, 0.246] | | | | |
| Alliance characteristics | | | | | | | | | |
| Type | 39 | 491 | | | | 3.950 (2, 488) | .020* | .029*** | .032*** |
| Individual patient–therapist | 20 | 267 | .230 (.039)*** | [0.157, 0.301] | | | | | |
| System–therapist | 21 | 171 | .345 (.040)*** | [0.275, 0.412] | .125 [0.038, 0.213]** | | | | |
| Family members'/partners' scores averaged or added | 9 | 53 | .316 (.037)*** | [0.250, 0.378] | .026 [−0.058, 0.110] | | | | |
| Informant | 39 | 491 | | | | 1.076 (2, 488) | .342 | .029*** | .041*** |
| Client self-report | 24 | 262 | .279 (.041)*** | [0.204, 0.351] | | | | | |
| Therapist report | 14 | 26 | .377 (.078)*** | [0.239, 0.499] | .109 [−0.037, 0.256] | | | | |
| Observer ratings | 15 | 203 | .282 (.052)*** | [0.186, 0.338] | −.003 [−0.108, 0.114] | | | | |
| Alliance measure | 39 | 491 | | | | 2.713 (4, 486) | .029 | .029*** | .035*** |
| FTAS/FTASr | 6 | 62 | .379 (.084)*** | [0.229, 0.511] | | | | | |
| WAI/WAI-O/WAI-Co | 11 | 139 | .353 (.061)*** | [0.229, 0.441] | −.046 [−0.251, 0.159] | | | | |
| VTAS/VTAS-R | 8 | 99 | .127 (.074) | [−0.019, 0.266] | −.272 [−0.493, −0.051]* | | | | |
| SOFTA-o/SOFTA-s | 6 | 119 | .396 (.120)*** | [0.245, 0.529] | .021 [−0.216, 0.258] | | | | |
| Other | 8 | 72 | .214 (.072)** | [0.073, 0.342] | −.185 [−0.402, 0.033] | | | | |
| Development of measure | 39 | 491 | | | | .001 (1, 489) | .981 | .029*** | .043*** |
| For individual therapy | 12 | 171 | .290 (.064)*** | [0.171, 0.401] | | | | | |
| For couple/family therapy | 27 | 320 | .289 (.044)*** | [0.208, 0.365] | −.002 [−0.154, 0.151] | | | | |
| Alliance construct | 39 | 491 | | | | .490 (5, 485) | .784 | .029*** | .041*** |
| Bond | 5 | 24 | .208 (.077)** | [0.059, 0.349] | | | | | |
| Goal | 3 | 15 | .222 (.090)* | [0.050, 0.383] | .015 [−0.161, 0.191] | | | | |
| Task | 3 | 15 | .251 (.090)** | [0.080, 0.407] | .044 [−0.131, 0.220] | | | | |
| Bond, goal, and task (total) | 35 | 339 | .293 (.037)*** | [0.225, 0.358] | .091 [−0.131, 0.220] | | | | |
| Systemic (within & between) | 6 | 44 | .330 (.080)*** | [0.184, 0.462] | .131 [−0.056, 0.318] | | | | |
| Other | 2 | 54 | .295 (.099)** | [0.110, 0.460] | .092 [−0.124, 0.308] | | | | |
| Alliance timing | 39 | 491 | | | | 3.3390 (4, 486) | .010 | .028*** | .040*** |
| Early in treatment | 18 | 235 | .236 (.042)*** | [0.158, 0.313] | | | | | |
| Midtreatment | 17 | 112 | .308 (.047)*** | [−0.171, 0.017] | .077 [−0.017, 0.171] | | | | |
| Late in treatment | 9 | 71 | .254 (.057)*** | [0.147, 0.356] | .019 [−0.088, 0.126] | | | | |
| Improvement in alliance | 3 | 15 | .286 (.087)*** | [0.122, 0.435] | .053 [−0.117, 0.223] | | | | |
| Averaged or added over time | 7 | 58 | .423 (.065)*** | [0.312, 0.522] | .210 [0.089, 0.330]*** | | | | |
| Outcome characteristics | | | | | | | | | |
| Outcome domain | 39 | 491 | | | | 3.052 (3, 487) | .028 | .028*** | .034*** |

(table continues)

Table 4 (continued)

| Moderator | Studies ^a | # ES | Mean <i>r</i> (SE) | [95% CI] | β [95% CI] | <i>F</i> (<i>df</i>) | <i>p</i> | $\sigma^2(2)$ | $\sigma^2(3)$ |
|---|----------------------|------|--------------------|----------------|-----------------------|------------------------|----------|---------------|---------------|
| Individual symptom severity/ functioning | 19 | 243 | .238 (.041)*** | [0.163, 0.315] | | | | | |
| Parental skills, family/couple functioning | 11 | 78 | .388 (.051)*** | [0.300, 0.471] | .166 [0.054, 0.277]** | | | | |
| Retention versus dropout | 11 | 78 | .227 (.050)*** | [0.127, 0.315] | -.018 [-0.101, 0.066] | | | | |
| Goal attainment/therapeutic progress | 12 | 92 | .315 (.051)*** | [0.222, 0.402] | .081 [-0.032, 0.194] | | | | |
| Outcome informant | 39 | 491 | | | | .228 (3, 487) | .877 | .029*** | .042*** |
| Client self-report | 29 | 344 | .306 (.038)*** | [0.228, 0.364] | | | | | |
| Therapist report | 3 | 11 | .321 (.098)*** | [0.133, 0.482] | .027 [-0.156, 0.210] | | | | |
| Observer ratings | 5 | 33 | .272 (.075)*** | [0.124, 0.396] | -.034 [-0.177, 0.109] | | | | |
| Other ^b | 11 | 103 | .267 (.055)*** | [0.165, 0.364] | -.032 [-0.133, 0.069] | | | | |
| Outcome timing | 39 | 491 | | | | 2.155 (2, 488) | .117 | .029*** | .040*** |
| End of treatment | 21 | 293 | .287 (.040)*** | [0.213, 0.357] | | | | | |
| Follow-up | 16 | 136 | .335 (.044)*** | [0.255, 0.409] | .053 [-0.025, 0.113] | | | | |
| Midtreatment | 8 | 62 | .205 (.080)** | [0.080, 0.325] | -.087 [-0.222, 0.048] | | | | |

Note. # ES = number of effect sizes in the analysis; $\sigma^2(2)$ = variance between effect sizes (within studies); $\sigma^2(3)$ = variance between effect sizes (between studies); FTAS(r) = Family Therapy Alliance Scale (–Revised); WAI(–S/O) = Working Alliance Inventory (–short form /–observer version); VTAS(–R) = Vanderbilt Therapeutic Alliance Scale (–Revised); System for Observing Family Therapy Alliances (–observer/–self-report); CI = confidence interval, WAI-Co = Working Alliance Inventory–Couples.

^a Number of independent samples (several studies reported on the same sample). ^b Other = objective clinical log measures (weight gain, days of cannabis use, and attending fewer sessions than scheduled).

* $p < .05$. ** $p < .01$. *** $p < .001$.

families (referred by a public or private institution service), more positive overall differences were found in Session 1 on all four alliance dimensions, particularly shared purpose and engagement (Sotero, Major, Escudero, & Relvas, 2016). By Session 4, however, only engagement was lower in the involuntary group than the voluntary group.

Patients' Behavior

Just as in individual psychotherapy, the behavior of partners or family members who are most successful in CFT suggests that they feel comfortable, have a trusting emotional bond with their therapists, and stay engaged in the negotiation and renegotiation of therapy goals and tasks as treatment unfolds. In one study, for example, in sessions rated as relatively deeper or more valuable by both patients and therapists, the patients' behaviors reflected a high degree of connection with the therapist as well as active engagement and a sense of safety in the therapeutic process (Friedlander, Bernardi, & Lee, 2010). Family members who demonstrate safety in the therapeutic context with one another tend to be emotionally expressive and vulnerable; they ask each other for feedback, encourage openness, and disclose thoughts, feelings and memories that may never before have been shared (Escudero & Friedlander, 2017; Friedlander et al., 2006). For parents in particular, safety is closely associated with the family's shared sense of purpose or within-family alliance (cf. Friedlander, Lambert, Escudero, & Cragun, 2008), the alliance aspect that seems most vital for successful outcomes.

On the other hand, hostility, sarcasm, and prolonged cross-blaming tend to signal a troubled within-family alliance. Of course, in-session family conflict does not always signal that a therapy session has gone awry. Some patients (and therapists) see therapy sessions as more valuable when conflict is expressed, whereas other patients see the process as more valuable when there is less overt conflict (Friedlander et al., 2010). This variability is likely due either (a) to the nature of the conflict, that is, whether it

is due to dissimilar views on the family's problems or on the value of therapy as a way to resolve those problems or (b) to the family's general comfort with overt expressions of conflict.

Overall, little is known about adolescent behavior in relation to family therapy alliances. It seems likely that how an adolescent behaves is highly dependent on the attitudes and behavior of the parents. In a mixed methods study of problematic within-family alliances (Lambert et al., 2012), the adolescents resisted their parents' attempts at engagement when they disagreed with their parents about the nature of problems or when they felt hostility toward or a lack of connection with their parents. Simply put, patients contribute mightily to the formation of multiple alliances in CFT, and their contribution rivals, if not exceeds, that of the therapist's contribution.

Limitations of the Research

Although the findings from this meta-analysis dovetail in most substantive ways with our previous results (Friedlander et al., 2011), several limitations raise concerns and prompt recommendations for future research. First, among the 48 studies, double the number (24) in our previous meta-analysis, we found little evidence for causality. As a group, these 48 studies varied in terms of when the alliance was assessed. Although many of the effects emerged in studies of early- or midtherapy alliances, a sizable percentage (26%) of the 71 individual effect sizes were based on late-therapy measurements of the alliance.

Second, although we located only a handful of studies on split or unbalanced alliances, a medium effect size was found for their association with patient outcome. Although this meta-analytic finding is intriguing, more research is needed on this topic. Persistent inconsistencies in this line of inquiry have to do with how a split alliance is defined and operationalized (Bartle-Haring et al., 2012).

Third, an essential challenge concerns the lack of systems-level analyses. Although use of the actor–partner model to study CFT is

a recent advance, CFT researchers have yet to come to consensus about how to operationalize the couple/family alliance as a unit. Future researchers might consider methods that specifically take into account system dynamics: the latent group model (Kivlighan, 2007), the common fate model (Ledermann & Kenny, 2012), and response surface analysis (Shanock, Baran, Gentry, Pattison, & Heggstad, 2010).

Fourth, increasing diversity in the characteristics of patient samples is a necessary step toward increasing the formal testing of demographic and individual differences as moderators. Significant patient moderators in the current meta-analysis were limited to age (of youth and parents), gender (% of adult male patients) and referral status.

Diversity Considerations

In general, CFT attention to diversity has focused primarily on patient characteristics rather than therapist characteristics or the demographic composition of the therapist/patient system. Overall, the gender findings in family therapy are complex, while in couple therapy, gender typically yields significant effects. Since our previous meta-analysis, there has been a significant advance in untangling gender effects using actor-partner and multilevel analyses to study both partners' alliances within the same model. Taken together, these findings are strong enough to have spawned some useful recommendations for the complex task of building alliances in couple therapy. Of note, same-gender couples have rarely been sampled.

A number of studies included racially and ethnically diverse U.S. samples, mostly African American, Latino/a, and Euro American families. Research with predominantly racial/ethnic minority samples is lacking, however, with a handful of exceptions. On the other hand, the literature is increasingly geographically diverse. The studies listed in Table 1 were carried out in Austria/Germany, Canada, Finland, Ireland, Israel, the Netherlands, Norway, Spain and Portugal, as well as in different locations within the United States.

Finally, because poverty is a particularly pernicious family stressor, we encourage increased sampling of low-income families. Although many, if not most, samples in the present meta-analysis included single-parent families, we have no information about whether alliances operate similarly in these families as in two-parent families. We suspect that single heads of household who seek help for problem children likely develop qualitatively different relationships with their family therapists.

Therapeutic Practices

- Aristotle said, "The whole is more than the sum of its parts." Based on the results of past and present meta-analyses, the crucial practice point is that strong, balanced therapeutic alliances improve the outcomes of CFT. By *outcomes*, we mean not only final, outcomes but also treatment retention, session evaluations, and intermediate (improvement-so-far) results.
- The therapeutic alliance, by definition, is the result of patient(s) and therapist reciprocity. It is essential for therapists to identify markers of patients' receptivity to therapeutic change attempts in the ongoing stream of behavior.
- The alliance-outcome relationship in CFT is decidedly transtheoretical, cutting across theoretical approaches in manualized therapies and treatment as usual.
- Our results highlight the need for therapists to develop and closely monitor their alliances with each partner or family member throughout the course of treatment. Despite the normal pull to identify with, or feel a greater affinity to one partner or family member rather than another, CFT alliances interact, and patients closely observe how their family members are relating to the therapist. It is particularly important not to ignore but rather to pull in quiet or reluctant family members.
- Therapists are advised to be particularly alert to the strength of the alliance within the couple or family unit, as evidence increasingly suggests that it is the most crucial aspect of alliance for engagement and retention in treatment, as well as for ultimate treatment success. Couples and families who enter CFT with a strong shared sense of purpose seem to have the greatest chance of successful outcomes.
- The within-family aspect of alliance tends to strengthen over time in successful cases. For this reason, it is short sighted to simply consider each patient's alliance separately without being attuned to the within-couple or within-family alliance. Research has shown that even highly experienced therapists tend to use more engagement and connection behaviors to address individual family members and fewer shared purpose behaviors addressed to the system as a whole, thereby overlooking the quintessential systemic feature of couple and family work.
- Identifying family members' shared feelings ("You both describe yourselves as victims of the other") and experiences ("As children, neither of you seems to have gotten what you needed in terms of nurturing from your own parents") and validating their common struggle can strengthen the within-family alliance. After doing so, the therapist can suggest overarching goals ("You all seem to want strategies to problem solve more successfully with one another so that conflict doesn't keep escalating and get out of control" or "We can work together on helping you find your way back to the close feelings you had for each other at the beginning of your relationship").
- Although split alliances occur frequently, therapists can take steps to repair the alliance and prevent dropout. Therapists can be aware, however, that when a patient's behavior suggests a mildly split alliance, the family member who views the therapy and/or the therapist most negatively may have more unfavorable feelings than his or her in-session behavior suggests. Focusing on the emotional bond with the disaffected patient may prove most helpful in repairing a split alliance.
- Even when therapists avoid responding in ways that detract from the alliance, dropout can occur when a therapist fails to use alliance-enhancing responses when a rupture is evident.
- When a rupture occurs, such as when a patient questions the value of treatment or responds to another family member defensively or sarcastically, the therapist is advised to respond with a deliberate alliance-enhancing intervention

to repair the rupture. Examples include indicating that some positive change has already taken place, expressing interest in the patient's life apart from the therapeutic concerns, acknowledging that psychotherapy involves taking risks, or emphasizing family members' commonalities or shared experiences.

- Parents and children, particularly adolescents, tend to develop different alliances with the therapist. Parents closely observe their children's reactions to the therapeutic process and tend to evaluate improvements based on their assessment of the child's alliance with the therapist, but the reverse is generally not the case. Rather, adolescents tend to be more attuned to their own reactions to the therapist than to the reactions of their parents. Thus, CFT practitioners will wisely attune to these different developments of the alliance and the potentially disparate alliances themselves.
- Even mandated and involuntary patients can form strong working alliances in CFT. Therapists can enhance these patients' active involvement by asking, rather than imposing, in-session and homework tasks. Once meaningfully engaged in the therapy process, involuntary patients can benefit considerably.
- Therapists are advised to use safety and emotional connection interventions to enhance the within-family alliance and individuals' levels of engagement in the conjoint treatment process. When engagement is low, the therapist can respectfully (i.e., nondefensively) explore the reasons behind a patient's resistance.
- With adolescents, therapists can improve a poor alliance by taking a one-down position—avoiding domineering or authoritarian responses. On the other hand, by aligning too strongly with an adolescent, a therapist may unwittingly harm her alliance with the parents, particularly if the parents view the treatment only in terms of change in the adolescent and do not expect the therapist to challenge their own behavior.
- Therapists typically enjoy the most success in engaging reluctant adolescents by helping them define their personal treatment goals, by presenting themselves as the adolescent's ally, by not challenging their resistance forcefully, and by encouraging the parent(s) to support the adolescent's involvement in the treatment process with empathy and a lack of defensiveness.
- With heterosexual couples, a key to success may involve working early on to create a particularly strong alliance with the male partner, particularly if the female partner was the one to initiate the request for help. Later on, it seems important to ensure that the female partner continues to be invested in therapy. These patterns are, of course, not universal.
- In CFT when there is high emotional reactivity and conflict, possibly the most important safety intervention is either to ask one (or more) patients to step out of the room for a brief period or to conduct alternating sessions with different family subsystems. When parents feel highly unsafe, the therapy has a large chance of resulting in dropout.
- Therapists can enhance the alliance by asking patients to complete a brief self-report measure of alliance after each session. It seems likely that when family members provide

information about their private experience of the conjoint context, the therapist is better prepared to directly address any alliance strains or ruptures.

- In short, each person's alliance matters, and family alliances are not interchangeable. Psychotherapists are strongly advised to recognize that balanced alliances facilitate the therapeutic process and that continual monitoring of the strength of the alliance with each family member and within the family unit is essential for therapeutic success.

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Received January 25, 2018

Accepted January 30, 2018 ■

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