Therapeutic Alliance in Couple and Family Therapy: Therapist Experiences and Perspectives on Multidirected Partiality

by

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Abstract

THERAPEUTIC ALLIANCE IN COUPLE AND FAMILY THERAPY: THERAPIST EXPERIENCES AND PERSPECTIVES ON MULTIDIRECTED PARTIALITY

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The therapeutic alliance in couple and family therapy (CFT) is not only different from that in individual psychotherapy, but is highly complex, interactional and multidimensional. Given the unique challenges when working relationally, research on building and maintaining multiple simultaneous alliances is important to undertake. The current study adopts a qualitative research design to capture therapists’ perceptions and understandings of how they develop balanced and multi-partial therapeutic alliances with couples and families and the strategies they use to do so. Eighteen therapists from a variety of disciplines participated in an online, open-ended questionnaire. Thematic analysis was used in the analysis of their responses. Findings highlight how therapists understand the therapeutic alliance when working relationally, the ways the alliance is intentionally created and maintained, as well as the importance of ensuring balance and multidirected partiality. Limitations of the study and implications for both experienced and novice therapists working with families are discussed.

Keywords: therapeutic alliance, couple and family therapy, multidirected partiality
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It has been consistently demonstrated that the therapeutic relationship is one of the strongest predictors of success in individual psychotherapy, regardless of theoretical orientation or type of treatment (Horvath & Bedi, 2002). While there has been extensive research into the therapeutic alliance within individual therapy (Beck, Friedlander, & Escudero, 2006), significantly less research has examined it within the context of couple and family therapy (CFT¹; Escudero, Friedlander, Varela, & Abascal, 2008), although equally promising results have emerged from this literature (Rait, 2000; Sprenkle, Davis, & Lebow, 2009).

The therapeutic alliance in CFT has been understood as not only different from that in individual psychotherapy but also as highly complex, interactional and multidimensional (Friedlander, Escudero, Heatherington, & Diamond, 2011b; Thomas, Werner-Wilson, & Murphy, 2005). These unique aspects of alliance in CFT pose additional challenges for the therapist working with relational systems. Given the challenges and complexities associated with negotiating strong and balanced alliances with all members in CFT, research on building and maintaining multiple simultaneous therapeutic alliances is important to undertake. This study begins to address the limited research in this area, specifically focusing on the views and experiences of therapists on developing multiple alliances in the context of CFT. I will first explore the CFT literature examining the therapeutic alliance as it pertains to working relationally.² In addition, I will introduce the notion of multidirected partiality as a therapeutic stance involved in developing multiple alliances in CFT, where the therapist strives to be

¹ For the sake of simplicity, throughout this paper I will be using the terms couple and family therapy and family therapy interchangeably and the term family to encompass work with both couples and families.
² I use the term `working relationally` in therapy to refer to working with couples and families, in line with a systemic/CFT framework. This should not be confused with feminist oriented relational-cultural therapy or psychoanalytically oriented relational therapy.
balanced and fair to all family members and engage with all members equally (Boszormenyi-Nagy & Krasner, 1980; 1986). I aimed to capture therapists’ perceptions and understandings of how they develop balanced (multi-partial) therapeutic alliances with families and what strategies they use to do so.

**Therapeutic Alliance in Couple and Family Therapy**

Within the literature, there is no universally accepted definition of the therapeutic alliance (Horvath & Bedi, 2002) and different authors have used different definitions across time. In general, however, the therapeutic alliance typically refers to the quality and strength of the collaborative relationship that exists between therapist and client (Horvath & Bedi, 2002; Pinsof & Catherall, 1986). Within the individual psychotherapy literature, Bordin’s tripartite theory (1994) has been influential in delimiting what the therapeutic relationship entails. Bordin (1994) suggested that there are three key aspects of this relationship: (a) *bonds* or the quality of the relationship between therapist and client, including the clients’ perception that therapist accepts and cares about them, (b) *goals* or the extent to which the therapist and client agree on and are working towards the same objective and (c) *tasks* or the specific activities that the therapist and client engage in to facilitate change. Pinsof and Catherall (1986) expanded upon this and other work within individual psychotherapy and introduced the concept of the therapeutic alliance into the field of CFT while adopting a more systemic, relational framework. These authors recognized that unlike in individual therapy, in CFT the alliance is a multidimensional and fluid construct, representing an interactive and collaborative phenomenon (Pinsof & Catherall, 1986).

Friedlander and colleagues have offered a slightly different conceptualization of the therapeutic alliance in CFT, reflected in the development of their observational rating system: the System for Observing Family Therapy Alliances (SOFTA; Friedlander, Escudero, &
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Heatherington, 2006; Friedlander, Escudero, Horvath et al., 2006). These authors have identified four unique aspects of the therapeutic alliance: engagement, safety, emotional connection and shared purpose. The engagement in the therapeutic process dimension reflects the therapeutic collaboration between the therapist and client and the agreement on tasks and goals (Bordin, 1994). Safety within the therapeutic system reflects the client’s feelings of safety and comfort within the therapeutic context and their willingness to take risks and be vulnerable and open to explore and manage conflict. The dimension of emotional connection to the therapist is similar to Bordin’s (1994) conceptualization of bonds and reflects the affective component that exists between the clients and therapist. Finally, the shared sense of purpose within the family dimension reflects the collaboration among members in therapy in working towards common goals and improving relationships among members, or what Pinsof (1994) describes as the within-system alliance (Friedlander, Escudero, & Heatherington, 2006; Friedlander, Escudero, Horvath et al., 2006).

Challenges Associated with the Formation of Multiple Alliances in CFT

As stated previously, there are numerous challenges associated with developing strong relationships with each member in CFT, as well as with the family as a whole that are not present when working with individual clients. The development of a strong therapeutic alliance across all members in therapy is a fluid process and each alliance may shift in strength or importance over the course of therapy (Friedlander, Escudero, & Heatherington, 2006). It begins from the very first meeting between the family and therapist (Friedlander, Lambert, Escudero, & Muniz de la Pena, 2008) and there is no set way to form a strong alliance. Escudero and colleagues (2008) suggested that, “it is reasonable to conjecture that different trajectories of alliance development could be associated with successful outcomes” (195).
When there are multiple clients in the therapy room, the therapist must navigate forming a strong relationship with each member of the family, as well as the family as a whole (Friedlander, Escudero, & Heatherington, 2006; Sprenkle et al., 2009). This is complicated by the fact that alliances are not formed in a vacuum and each person’s alliance both influences and is influenced by every other member’s alliance with the therapist. The therapist must be cognisant of how joining with any one member of the family may influence their relationship with the other members in the therapy room (Friedlander et al., 2011a). All of the alliances in the therapy room must be carefully nurtured throughout treatment, especially given that each alliance may develop at different rates for different individuals, subsystems (ex. parent-child, couple), and with the family as a whole (Friedlander, Escudero, & Heatherington, 2006; Rait, 2000). Alliance development is further complicated by the addition or subtraction of family members across sessions (Friedlander, Escudero, & Heatherington, 2006). This poses significant challenges for the therapist that are not present in individual therapy, who then must negotiate when, how and with whom they join while ensuring that all alliances are attended to simultaneously and are balanced overall (Beck et al., 2006; Rait, 2000).

Couples and families often enter into therapy with significant problems or when the conflicts between members seem irreconcilable (Friedlander, Escudero, & Heatherington, 2006). Emotions typically run high in these sessions, often making them noisier and more openly conflictual than individual psychotherapy (Friedlander et al., 2011b; Rait, 2000). Particularly in family therapy, each member may be at a different developmental level or life stage which complicates any joining or bonding that may occur with the therapist (Friedlander, Lambert, Escudero, & Muniz de la Pena, 2008). Moreover, forming multiple relationships with the clients in relational therapy may also be hindered when the motivations or desire for seeking therapy are
discrepant or when family members are in disagreement over the cause or importance of the issue that brought them to therapy (Kindsvatter & Lara, 2012; Lambert, Skinner, & Friedlander, 2012). Members may also enter therapy with varying levels of commitment to therapy (Beck et al., 2006) and therapists need to be attuned to the fact that there may be members who are to some degree involuntary clients, being brought to session at the request or persuasion of someone else (Rait, 2000).

It has been demonstrated that retention rates in CFT are lower than that in individual psychotherapy, which is problematic given that attendance is significantly related to how successful therapy is (Rait, 2000). This necessitates the development of a strong alliance across all members, as any one member’s dissatisfaction with therapy and/or the therapist can lead to premature termination of therapy and potentially poor outcomes for the couple or family as a whole (Friedlander, Escudero, Heatherington, & Diamond, 2011a). However, given the complexity of CFT and the unique challenges associated with having multiple members in the room, alliance development is often slower than that in individual therapy (Knerr et al., 2011). It therefore becomes imperative that the therapist is able to effectively morph individual goals into group goals so that the family is able to come to some sort of agreement about the purpose of therapy and work towards strong alliances right from the beginning of therapy (Kindsvatter & Lara, 2012; Knerr et al., 2011). Despite this, in their study, Lambert and colleagues (2012) found that while therapists were generally aware of the discrepancies among family members in terms of perceptions of the problem and in the goals of therapy, there were many instances where the therapists failed to facilitate a strong sense of shared purpose, instead focusing on an individual’s feelings or perspectives. Findings such as these have implications for the therapeutic alliance and overall outcomes of therapy.
Within CFT, there is the unique challenge of creating a sense of safety within the therapeutic context and among all family members that does not exist to the same extent in individual psychotherapy (Friedlander, Escudero, & Heatherington, 2006). The degree of safety that exists has been demonstrated to uniquely contribute to client’s self-reported alliance within therapy (Escudero et al., 2008). The creation of a safe therapeutic environment has been suggested to be necessary before progress can be made in CFT, including in the formulation of and work towards therapeutic goals (Kindsvatter & Lara, 2012). Family members need to feel secure in knowing that what they disclose in therapy will not be used against them once they leave the session (Friedlander et al., 2011a; 2011b). In line with this, in their study examining client’s perceptions of the therapeutic alliance, Beck and colleagues (2006) found that when relationships among family members were weak (i.e. poor within-system alliance), concerns about safety were very salient. Friedlander and colleagues suggest that the therapist can enhance safety within session by encouraging compromising and mutual respect for all members present, finding a common goal that the couple or family can work towards, redirecting blame, setting limits, preventing hostile attacks on one another and by enhancing the emotional connection that exists among family members (Friedlander, Lambert, Escudero, & Muniz de la Pena, 2008).

Unfortunately, breaches of safety are common and these serve to undermine therapeutic progress and the alliances already formed. The family’s sense of safety may ebb and flow over the course of treatment as new issues arise, painful secrets emerge or as members leave or join therapy which pose additional challenges for the therapist in creating a safe therapeutic space (Beck et al., 2006). The therapeutic bond needs to be strong enough to weather these ups and downs, such that minor ruptures in safety as a result of members taking emotional risks with
each other do not significantly interfere with the overall progress of therapy (Friedlander, Escudero, & Heatherington, 2006).

When the various alliances in CFT are not developing at the same rate, or if there is a rupture or a negative shift in alliance formation or in the perceived safety of therapy, a split alliance may occur. In contrast to an intact alliance, where all members in CFT perceive the alliance with the therapist equally (Knobloch-Fedders, Pinsof, & Mann, 2004; 2007), a split alliance occurs when one member of the couple or family has a particularly stronger and/or weaker alliance with the therapist than the others (Pinsof, 1994; Pinsof & Catherall, 1986). This has significant implications for therapeutic outcomes with negative impacts on treatment retention and outcome (Friedlander et al., 2011b; Lambert et al., 2012).

Split alliances are a relatively common experience in CFT and often vary in severity given the quality of the previous relationships among family members and the point in therapy when the split occurred (Friedlander, Escudero, & Heatherington, 2006). Ruptures may occur when clients perceive the therapist to be taking sides or when therapy overall is not seen as fair or balanced to all members present in the room (Friedlander, Escudero, & Heatherington, 2006). A split may also indicate progress within therapy; as family members get more comfortable within the therapeutic context, greater risks may be taken, secrets may emerge and new areas may be explored which may contribute to the rupture for any of the members present in therapy (Friedlander et al., 2011b). Split alliances must be repaired skillfully and with attention to the quality of the relationships that exist among members and with the therapist (Friedlander et al., 2011a). However, repairing split alliances is difficult and many therapists are ill-equipped to intervene appropriately for successful resolution of the rupture (Couthinho, Ribeiro, Hill, &
Safran, 2011). That said, the successful repair of a rupture can serve to strengthen the therapeutic alliance and enhance the therapeutic work afterwards (Sprenkle et al., 2009).

Assessing the Quality and Strength of the Alliance

As mentioned previously, the therapeutic alliance in CFT is a dynamic, fluid and constantly evolving process (Knobloch-Fedders et al., 2004). Therefore an understanding of how the quality and strength of the alliance are assessed is important as this information can be fed back to the therapist, influencing their future work with families. Alliance strength can change over the course of therapy and even within a single session, and alliance measures taken across time typically do not correlate well with one another (Knobloch-Fedders et al., 2004). Different factors tend to play a more or less prominent role in establishing the alliance at different stages of therapy and in predicting treatment outcome. Escudero and colleagues (2008) demonstrated that while individual factors associated with each family member, such as engagement in therapy and the creation of a safe environment played a larger role in the initial formation of the alliance, family collaboration and working towards shared goals (i.e. a sense of shared purpose) was more important later on.

Some authors have suggested that there is a reciprocal relationship between the therapeutic alliance in CFT and the progress made in therapy, such that a strong alliance promotes gains in therapy and gains in therapy strengthen existing alliances between all members and the therapist (Friedlander, Lambert, Escudero, & Muniz de la Pena, 2008). Other authors, however, have suggested that the alliance-outcome relationship in CFT is more complex than this (Knobloch-Fedders et al., 2007; Symonds & Horvath, 2004). Symonds and Horvath (2004) demonstrated that when couples or family members agree on the strength of the alliance, regardless of whether they perceive it to be strong or weak, the alliance-outcome correlation is
The agreement between clients and therapists regarding the strength of the alliance, however, did not seem to influence the strength of the association. In addition, for heterosexual couples, the man’s alliance was more strongly associated with outcome than the female partner’s (Symonds & Horvath, 2004).

Similar to that found in individual psychotherapy, client-reported measures of alliance in CFT have been found to be a better predictor of treatment outcome than therapist assessments and these two ratings have often been found to be discrepant (Friedlander, Lambert, Escudero, & Cragun, 2008; Summers & Barber, 2003). In addition, observational measures of alliance have been found to relate more closely with the client’s perception of alliance than that of the therapist (Friedlander, Lambert, Escudero, & Cragun, 2008). These authors suggest that whereas therapists may be focused on intervening with the family, outside observers are more able to notice the finer cues of changing alliances (Friedlander, Lambert, Escudero, & Cragun, 2008).

Given the complexities of developing alliance in CFT, it appears as though more nuanced instruments assessing alliance are needed to predict outcomes of treatment. In particular, those that measure at both the individual and system levels are necessary, as the average of all family member’s alliances with the therapist does not appear to predict retention or outcome of therapy (Friedlander, Lambert, Escudero, & Cragun, 2008). Each individual’s and subsystem’s alliance with the therapist and the family’s alliance with each other not only affect all other alliances present in the room but also influence the alliance-outcome relationship (Friedlander et al., 2011a; 2011b). In addition, Friedlander and colleagues call for more self-report and observational research in order to fully gauge alliance. The authors suggest that client and therapist self-reports typically reflect the overall nature of the alliance and incorporate events both across sessions and, for the family, those that occur between sessions, whereas observer
data is more limited to solely the session of assessment. In order to fully understand the
development of alliance, the authors conclude, the study of both types of data is necessary
(Friedlander, Lambert, Escudero, & Cragun, 2008).

**Therapists’ Contributions to the Therapeutic Alliance**

Therapists have an important influence on the therapeutic alliance which has been
documented in the literature. However, much of the research examining the role of the therapist
in both individual psychotherapy and in CFT focuses on the therapist’s personal characteristics.
Research has consistently documented the importance of certain traits in the development of a
strong alliance, such as attachment style, theoretical orientation, empathy, responsiveness, and
communication skills (e.g. Black, Hardy, Turpin, & Parry, 2005; Horvath & Bedi, 2002; Nissen-
Lie, Monsen, & Rønnestad, 2010; Thomas et al., 2005). Other therapist traits, such as gender and
race/ethnicity have not been found to consistently relate to the strength of the alliance, nor has
the therapist-client match on these variables (Garfield, 2004; Friedlander et al., 2011a; 2011b).
There have been mixed results on the importance of experience and training on alliance strength
(Horvath & Bedi, 2002), although some authors have suggested that novice therapists become
more attuned to the therapeutic alliance and more comfortable directly negotiating this in
session, especially with more complex cases or severely impaired clients, as they gain more
experience (Horvath & Bedi, 2002; Summers & Barber, 2003). In general, however, clients
typically prefer therapists who are warm, open, caring, down-to-earth, and someone they can
trust (Friedlander, Escudero, & Heatherington, 2006).

It is important to note here that clients also contribute to the therapeutic alliance and that
the alliance should be understood as a collaborative entity that both the therapist and client
contribute to (Sprenkle et al., 2009). While much of the research on client contributions has been
conducted in the area of individual psychotherapy practice, the research in CFT suggests that client factors do influence the alliance, although this relationship is harder to discern, given the necessity to consider the influence of the family member’s interaction and collaboration in CFT measures of alliance (Friedlander et al., 2011b). While a full review of this literature is beyond the scope of this paper, some of the research has suggested that active behaviours on the part of the client, including responding favourably to therapists’ alliance building interventions have been linked with strong alliances in CFT (Friedlander et al., 2011b). As well, certain individual traits, such as gender (Garfield, 2004; Symonds & Horvath, 2004; Thomas et al., 2005) have been linked in to alliance formation whereas others such as psychiatric symptoms have not (Friedlander et al., 2011b; Knobloch-Fedders et al., 2004). Finally, early family-of-origin experiences, including distress and relational disturbances, have a negative effect on the formation of alliance in couple’s therapy (Garfield, 2004; Knobloch-Fedders et al., 2004).

**Therapist Perspectives on the Therapeutic Relationship**

In contrast to the abundance of research on therapist qualities that influence the therapeutic alliance, there is a striking lack of qualitative research examining how therapists conceptualize the therapeutic alliance, attune to the strength and development of it across time, and actively contribute to building strong relationships and/or repairing weaker ones. A notable limitation of this body of literature is that it focuses mainly on the alliance within individual therapy (e.g. Angell & Mahoney, 2007; Bressi Nath et al., 2012; Couthinho et al., 2011; Sullivan et al., 2005) and does not highlight the differences or challenges associated with developing multiple alliances simultaneously. As well, while it covers a range of helping professionals including social workers, counselling interns, psychiatric and community mental health nurses,
“master” therapists and case managers, it has yet to focus specifically on the perspectives of therapists who work with relational systems.

**Importance of the therapeutic bond.** Therapists frequently highlight the importance of the therapeutic bond and the necessity of it for change (Binder, Holgersen, & Hostmark Nielsen, 2008a; Bressi Nath, Alexander, & Solomon, 2012; Hunter, 2012; Scanlon, 2006; Sullivan, Skovholt, & Jennings, 2005). Participants in Knei-Paz (2009)’s study on the therapeutic bond between social workers and families in distress conceptualized this bond as both the process and a product of change for these clients and indicative of successful work in and of itself. Several qualitative explorations have also suggested that the development of a strong therapeutic relationship is not a linear process, but rather is reciprocal in nature and one that develops over time (Halstead, Wagner, Vivero, & Ferkol, 2002; Scanlon, 2006).

**An intentional process.** The therapeutic alliance has been conceptualized by therapists as an intentional process they engage in and something that they actively work to develop and strengthen (Campbell & Simmonds, 2011; Spiers & Wood, 2010). They highlight certain behaviours that contribute to a strong bond with their clients, including working towards common goals, being fully present during sessions and adopting a client-centred approach (Campbell & Simmonds, 2011; Knei-Paz, 2009; Scanlon, 2006). Therapists recognized the importance of genuine warmth, trust, respect, openness and empathy in establishing a strong bond (Campbell & Simmonds, 2011; Halstead et al., 2002). The necessity of creating a safe therapeutic environment was also commented on as an important feature in the development of a strong alliance (Campbell & Simmonds, 2011; Sullivan et al., 2005). In examining the significant aspects of building a therapeutic alliance with children and adolescents, the participants in Campbell and Simmonds’ (2011) study suggested that in order to effectively join
with their young clients, they had to rely on their intuition as to what the child or adolescent needed at any particular moment in therapy. It was also important for them to establish a positive relationship with the parent or caregiver, especially with their youngest clients, in order to form a close bond with the child.

Research has also highlighted the importance of staying client-focused. Community mental health nurses doing brief therapy with their clients suggested that it was important to recognize each client’s strength in creating positive solutions for themselves and to not let previous experience with similar cases influence their relationship with their current clients (Spiers & Wood, 2010). As well, in their study on how therapists join with their adolescent clients, Binder and colleagues (2008a) found that most participants highlighted the importance of staying close to their adolescent clients and their conceptualization of the presenting concern. However, there were varying understandings of when this was particularly salient or important over the course of therapy (i.e. earlier, later, throughout; Binder et al., 2008a).

Across these studies, including Sullivan and colleagues’ (2005) study on master therapists’ conceptualizations of the therapeutic relationship, it was found that therapists often used the therapeutic bond as a means of increasing the client’s motivation for therapy and as a means to develop intrinsic reasons for attending therapy. Case managers working with consumers diagnosed with severe mental illnesses reported using numerous strategies for motivating clients to work towards treatment goals and often used this success as an indicator of the strength of their bond with their clients (Bressi Nath et al., 2012; see also Angell & Mahoney, 2007). Therapists in another study proposed that fluctuations in attendance by their adolescent clients may be an indicator of changes in that adolescent’s motivation for therapy and thus a conversation surrounding client motivation may be an effective means to address larger
relationship concerns within the therapeutic relationship (Binder, Holgersen, & Hostmark Nielsen, 2008b).

**Challenges.** The challenges associated with forming strong therapeutic alliances have been amply highlighted in these studies. A prominent challenge to creating the type of relationship the therapist would like to have with their clients reflects workplace stressors, including high case loads, multiple roles and functions and the lack of time to devote to each client, as recognized by case managers (Bressi Nath et al., 2012), psychiatric nurses (Scanlon, 2006), community mental health nurses (Spiers & Wood, 2010) social workers (Knei-Paz, 2009) and counselling interns (students) alike (Halstead et al., 2002). Other challenges these therapists identified included when the client has been mandated into therapy (Scanlon, 2006; Spiers & Wood, 2010), when they have severe and/or chronic presenting symptoms (Spiers & Wood, 2010), or when they demonstrate significant ambivalence towards the therapeutic process (Binder et al., 2008a). It is likely that these challenges are further compounded when there are multiple members in the room, although this has yet to be examined in the literature.

These therapists also identified strategies they used to counteract these challenges, including highlighting the importance of being flexible, working to engage the client and openly discussing a lack of progress so that joint solutions could be found (Binder et al., 2008a; Sullivan et al., 2005). Across several studies, therapists have also suggested that it is easier to form bonds with “likable” clients, often those who were motivated to engage in therapy and work towards goals whereas it is more difficult to join with other clients who may be more ambivalent, secretive, challenging or aggressive (Angell & Mahoney, 2007; Bressi Nath et al., 2012; Spiers & Wood, 2010; Sullivan et al., 2005). Some of the case managers in Angell and Mahoney (2007) study reported that they would engage in “effortful liking” (p. 180) with their more challenging
clients in order to try to get to know them better so that they could find their client’s more likable aspects. Other community mental health nurses reported simply working harder to join with such clients and being more intentional in this process (Spiers & Wood, 2010).

**Ruptures.** As mentioned previously, ruptures of the alliance are a common experience in therapy (Friedlander, Escudero, & Heatherington, 2006), and the research exploring therapist perspectives supports this claim. Even master therapists recognized that sometimes ruptures were inevitable in their practice, although they also reported that by working through these ruptures, a stronger and deeper therapeutic relationship could form (Sullivan et al., 2005). Several therapists also recognized their own factors involved in weakening relationships, including being tired, being less present or engaged or feeling frustrated or angry (Binder et al., 2008b; Couthinho et al., 2011). After a rupture, it was common for therapists to report feelings of confusion, guilt, incompetence, and vulnerability (Binder et al., 2008b; Couthinho et al., 2011).

In Couthinho and colleagues’ (2011) study of both client and therapist perceptions of therapeutic ruptures, the clinical psychology student interns reported that ruptures often occurred after they had tried a new intervention, offered a new perspective that the client was not ready for or after discussing painful memories on the part of the client. The authors highlighted the importance of exploring where the client was at that particular moment and offering additional support and reassurance so that the therapeutic bond could be successfully repaired (Couthinho et al., 2011). The therapists in Binder and colleague’s (2008b) study on ruptures with adolescent clients also advocated for this and suggested it was important to explore the rupture from the adolescent’s point of view. The authors suggested that ruptures may reflect the adolescent’s developmental stage or the enactment of the interpersonal patterns they experience in their other relationships versus something unique to the therapeutic bond (Binder et al., 2008b). This was
also found by Sullivan and colleagues (2005) and these master therapists suggested that how ruptures are repaired in session may be a useful tool for the client to repair similar ruptures in their personal relationships.

In examining the qualitative literature reviewed above, it is important to keep in mind that these studies have not examined the unique aspects of developing an alliance when there are multiple clients present in the therapy room, such as in CFT. It is likely that the important or salient features of developing these alliances are different reflecting the increased complexity of CFT and these views have yet to be captured by the current literature.

**The Therapeutic Stance in CFT**

When working with couples and families, it is important for therapists to recognize the stance they are adopting. Traditionally, the suggested stance was that of neutrality, where the therapist actively avoids siding with any member of the family over the others (Butler, Brimhall, & Harper, 2011). Both Cecchin (1987) and Butler and colleagues (2011) recognized, however, that this detached neutrality can lead to the therapist being perceived as uninvolved, cold, and aloof. Cecchin (1987) thus proposed a more active definition of neutrality where the therapist adopts a stance of curiosity leading to the exploration of alternate perspectives and an accompanying nonattachment to the various positions within the family. In line with this view, other authors have defined neutrality as “a stance of non-blame and an openness to multiple perspectives” (Scheel & Ivey, 1998, p. 315) where “the end result of the successive alliances is that the therapist is allied with everyone and no one at the same time” (Selvini, Boscolo, Cecchin, & Prata, 1980, p. 11), allowing for balanced emotional engagement with each member of the family (Butler et al., 2011). Tomm (1984) also suggested that rather than being distant or inactive, a neutral therapist adopts a meta-position to the family in order to avoid becoming a
member of the system. He highlighted the importance of a non-judgemental, curious and accepting stance towards the family (Tomm, 1984). Other authors have criticized adopting a neutral stance in therapy because it ignores larger issues of power within relationships and assumes that all parties enter the therapy room relatively equal in power (Knudson-Martin & Huenergardt, 2010; Scheel & Ivey, 1998). In this way, adopting a traditionally neutral stance fail to address the ways in which each family member’s social locations intersect and influence their relative power and privilege within family relationships (Parker, 2009).

Boszormenyi-Nagy (1997) suggests that in order to avoid the dehumanizing attitude of therapeutic neutrality in the traditional sense of the word, one should adopt the therapeutic stance of multidirected partiality. The therapist sides with all clients at various points and holds all members accountable to each other with a strong focus on justice and fairness for the family (Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). The therapist, too, is held accountable to anyone who their interventions may affect, whether they are present in session or not, which serves to build trust with the family (Boszormenyi-Nagy & Krasner, 1986). The notion of multidirected partiality highlights the importance of a therapist taking a stance of non-blame and equally validating each member’s perspectives while “taking all sides and working within all views simultaneously” (Anderson & Goolishian, 1988, p. 379).

In conceptualizing the therapeutic alliance in CFT, the therapist being balanced and fair to all members present and engaging with all members equally (Boszormenyi-Nagy, 1997; Boszormenyi-Nagy et al., 1991; Boszormenyi-Nagy & Krasner, 1980; 1986) is not only an important task to undertake but a formidable one, challenging the therapist to hold onto multiple aspects of the therapeutic relationship simultaneously (Stancombe & White, 2005). The therapist must work within the fine line between being non-judgemental or silent, which may be perceived
by the clients as dismissive or rejecting, and empathetically responding, which may be read by
the other family members as taking sides with that person (Stancombe & White, 2005). The
therapist needs to create a safe space where all members’ versions can be shared and
acknowledged while shifting them towards a non-blaming, accountability-neutral and inclusive
version of the problem (Stancombe & White, 2005) in order to navigate multiple alliances
simultaneously (Butler et al., 2011). This dual task places the therapist in the precarious place of
ensuring each member feels heard while also preventing unequal joining or blaming on their part
(Stancombe & White, 2005). Butler and colleagues (2011) calls this stance dynamic neutrality
and suggests that multidirected partiality is key in balancing alliances in CFT.

**The Current Study**

The purpose of this research was to address the current gap in the literature focusing on
the unique aspects of developing multiple, simultaneous therapeutic alliances. This study
involved an in-depth exploration of therapists’ perspectives of multiple alliances, shedding light
on how they conceptualized alliance and multidirected partiality and negotiated being balanced
or fair to all members in CFT. More specifically, I was interested in understanding:

1. How do therapists conceptualize, understand or experience the development and
   sustainment of balanced (multi-partial) therapeutic alliances with couples or families?
2. In what ways do therapists adopt a multi-partial stance when working with couples or
   families?
3. Are there specific strategies they use to build strong alliances, negotiate balanced
   relationships that are fair and equal for all members (i.e. maintain multidirected
   partiality) and to repair or strengthen weaker bonds with clients?
It was hoped that the outcomes of this research would be relevant for professionals who work with couples or families in a therapeutic context in the formation and strengthening of alliances and in training new therapists to work with families more effectively.

**Method**

The therapeutic alliance in CFT poses unique challenges and complexities that are not present to the same extent in individual psychotherapy. As such, it is important to consider how therapists build and maintain multiple alliances that are balanced and fair across all members when working relationally. Much of the research that has examined how therapists conceptualize the therapeutic alliance has been conducted from an individual psychotherapy framework and not from a CFT perspective. Therefore, the purpose of the current study was to address this gap by inviting therapists who work with relational systems to comment on how they build and sustain multiple alliances in session. I will now review the methods used in this qualitative thematic analysis, including a description of my theoretical/conceptual framework as it relates to the current study, the current study’s research design and participants, and the data collection and analytic procedures used.

**Theoretical/Conceptual Framework**

Throughout the current study, I worked from a constructivist/interpretativist paradigm (Lincoln & Guba, 2000), reflecting my ontological and epistemological stance. I adopted a relativist ontological perspective which suggests that meanings and understandings are developed locally and are socially constructed rather than being external to observers (Lincoln & Guba, 2000). As it could be understood that reality and knowledge are constructed by individuals as they interact and assign meaning to the world around them, my interpretations reflected the mutual creation of meaning grounded in my interpretation of the participant’s narratives and meanings (Lincoln & Guba, 2000). I held a reflexive stance as I attempted to be
aware of what I brought into my interpretations of the data and I attempted to be transparent of this in the presentation of results. As such, it was important for me to situate myself as a researcher and as a clinician. At the time this study was conducted, I was a Master’s student in the Couple and Family Therapy program at the University of Guelph. In this role, I also acted as a therapist-intern, providing counselling to individuals, couples and families and was trained in dialogic, solution-focused, narrative and emotionally focused therapy models. The ways in which these roles were accounted for in the data analytic process are discussed further below.

Research Design

In order to address the current gap in the literature, I used a qualitative research design to gain a rich description of how therapists conceptualize and develop the therapeutic alliance when working with couples and families in a way that captures the multiplicity of perspectives grounded in their lived experiences. A qualitative research method was deemed the most suitable approach to address the research questions given its exploratory and descriptive nature (Creswell, 2009). Qualitative research allows for a rich, in-depth exploration of a phenomenon and can provide new insights into the participant’s meanings and lived experience (Creswell, 2013).

I used an online open-ended questionnaire as this allowed me to more easily access research data and reach a broader range of participants across a wide geographical area to be involved in this study. With the increasing accessibility of the Internet, using such a design allowed me to access participants I would otherwise not have had access to if I were to use interviews (Granello & Wheaton, 2004; Van Selm & Jankowski, 2006). It was my hope that by being able to target a wide range of participants, my results would be more diverse and reflect various perspectives. Furthermore, an online questionnaire allowed for increased anonymity and the ability of each participant to complete the questionnaire at their leisure which may have
increased participation rates given the busy schedules of the participants I targeted (Granello & Wheaton, 2004).

Participants

After receiving ethics approval from the University of Guelph Research Ethics Board (Appendix A), I used purposeful sampling, or the recruitment of participants specifically because they hold knowledge or understanding of the phenomenon of interest (Creswell, 2013), to target a variety of helping professionals who work with couples and/or families, including couple and family therapists, counsellors, social workers, psychologists and other mental health professionals. The purpose of this approach was to have a diverse sample reflecting a variety of backgrounds, educational levels, and experience in order to get a broad understanding of the range of experiences in alliance and multidirected partiality. I anticipated that the depth of knowledge gathered from this diverse sample of professionals with a shared focus on relational therapy would allow for more meaningful data analysis. Participation was entirely voluntary.

This study used an emergent qualitative design, whereby there was no strict initial research plan (Creswell, 2013). As a result, there was no pre-set number of participants in this study. Rather, the end-point of data collection stemmed from my analysis of the data and reflected my attempts to reach saturation or the point where no new properties of the categories were generated (Creswell, 2013).

Recruitment. Participants were recruited through three main recruitment strategies. First, a recruitment post (Appendix B) was posted on various electronic websites including the Post Your Calls for Research Participants forum and the Member Research Projects directory on the American Association for Marriage and Family Therapy website, and on the CFT Alumni Virtual Connections website. Second, counselling agency managers and directors were approached over
email and informed of the project. They were then asked if they would be willing to distribute the recruitment post (Appendix B) at the clinic/organization, acting as a gatekeeper. Finally, recruitment flyers (Appendix C) were distributed at the OAMFT Conference in November 2013.

Demographics. In total, 18 participants completed the online survey (14 female, two male, two unspecified). In terms of ethnic background, 15 participants described themselves as White/European, one as Aboriginal/First Nations/Métis, one as Southeast Asian and one as Arab and White/European. Participants indicated having a mixed educational background (seven with PhDs, two PhD students, five with Master’s degrees, and four Master’s level students). The majority of the participants indicated that they work in the couple and family therapy field (15 of 18 participants) and some indicated they also identified as social workers, pastoral counsellors, medical family therapists, and nurses. In addition, two participants described themselves as psychologists and one as a psychotherapist. The experience of the participants ranged from 1-40 years, with an average of 13 years of experience. Ten participants indicated that they worked primarily in an agency setting, five in private practice, two in a hospital/clinic/treatment centre setting and one indicated working in another setting. The most commonly cited models or theoretical orientations the participants indicated they worked from were narrative, dialogic, solution-focused therapy, emotionally-focused therapy and cognitive behavioural therapy. Fewer participants indicated they also used collaborative, Bowen, psychodynamic, Gottman or integrative models. Finally, participants indicated that they worked with a diverse population base, including a range of socioeconomic statuses, across the age range, and of all ethnicities. Each participant was given a unique participant identification number that was used in the analysis and reporting of the results. Please see Table 1.
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Data Collection

Participants were directed to the secure, online survey posted on Qualtrics, a web-based system for creating online surveys supported by the FRAN department (Qualtrics, 2014). The opening screen was the informed consent form (Appendix D), which outlined the purpose of the study and gave potential participants the details regarding the procedure. Risks and benefits to their participation were explicitly stated and they were ensured of the confidentiality of their data. Potential participants were informed that they could withdraw from the study at any time without consequence and that they could chose to not respond to any questions they did not wish to answer. If the person was interested in participating, they were asked to electronically “sign” the informed consent form by clicking the “I Agree” button.

Once signed, the participants gained access to the open-ended questionnaire (Appendix E) which they could complete at their preferred time. The survey took approximately 15-20 minutes to complete. Participants were first asked to provide some demographic information and comment upon their training, experience and general description of their client work (e.g. theoretical orientation, therapy modality, client characteristics). Participants then moved on to two sets of open-ended questions. The first set of summarizing questions were designed to have the participants to reflect upon their conceptualization of the therapeutic relationship while working with couples or families, including defining the therapeutic alliance, discussing whose responsibility it was to form the alliance and if there are unique considerations in forming the alliance with couples or families. The second set of case-study questions asked participants to reflect upon a specific session with a couple or family and discuss the important aspects of the alliance that were present, the ways in which the alliance was developed, maintained or repaired across the session and whether there were any challenges present in this process. At the end of
the survey, participants had the option of saving their answers and submitting them, closing the survey and coming back at a later time, or discarding their answers. They were thanked for their participation and my email was provided if they had any questions or wanted to follow up with the study. There were no incentives for participating in this research and there were no consequences for not participating or discarding their answers.

During the data collection process, I realized that for the first 10 participants, questions 11 to 14 on the open-ended questionnaire (Appendix E) had been omitted. After consulting with my committee, it was determined that no ethical issue had arose, and we decided that we would add in the questions for future participants. As these were summarizing questions, it was decided that we could look for these answers in how the participants answered the case-study questions. This was accounted for in the analysis of the data.

**Ethical Considerations**

Ethics approval was granted by the University of Guelph’s Research Ethics Board (13AU006) prior to engaging with participants to ensure that the data were collected in an ethical manner, safeguarding the confidentiality of the participants (Appendix A). Further ethics approval was sought when the recruitment strategy changed as well as when we decided to use the computer program Dedoose (2013) to assist in the data analysis. There was no collection of identifying information (e.g., names or emails) and all participants were given participant ID numbers that were used during the analysis and in the reporting of the data. Participants were also instructed to provide pseudonyms for any client they referenced in their responses or to simply identify them by their position in the family (e.g., father, daughter) to ensure that the identities of their clients were protected. As no identifying information was collected, once their answers were submitted, it was not possible for the participants to withdraw their data. They
were informed of this prior to submitting their answers. All online data collected was kept secure through survey passwords and computer encryption and only accessible to the research team (Neustifter and Watkins).

Data Analysis

Thematic analysis as outlined by Braun and Clarke (2006) was used in this study in order to increase knowledge of how therapists conceptualize, perceive and understand the therapeutic alliance and multidirected partiality in CFT. The theoretical freedom of thematic analysis allowed for the rich, detailed and complex interpretation of the data (Braun & Clarke, 2006). Joffe (2011) stated that thematic analysis “is best suited to elucidating the specific nature of a given group’s conceptualization of the phenomenon under study” (p. 212). Thus, this data-driven approach lent itself well to attaining thick and rich description of the participants’ perspectives and understandings of the differences or challenges associated with developing multiple alliances simultaneously in CFT. I chose to do a dual deductive-inductive thematic analysis (Joffe, 2011). I combined a theoretical thematic analysis, guided by theory and previous research, with an inductive approach, where codes were drawn from the data set itself and not based on a predetermined theoretical coding frame (Braun & Clarke, 2006). This allowed me to be guided by the notion of multidirected partiality in the design of my survey questions and the analysis of the results but I also could remain open to other aspects of the data as well.

It was important for me to “give voice” to the participants in my interpretation and analysis of their responses and their experiences of the therapeutic alliance and multidirected partiality while working with couples and families. I worked from the assumption that there are multiple perspectives and understandings of this phenomenon held across participants and even for an individual participant across time or with different clients (Charmaz, 2003). I held in my
awareness the fact that it was inevitable my self-as-researcher and self-as-clinician would be brought into my analysis and interpretation of the data. However, I believe this influence was of value as a part of the co-construction of meaning and not something to be controlled for or bracketed out (Charmaz, 2003). I made the decision to identify themes at the latent level which goes beyond the surface level and begins “to identify or examine the underlying ideas, assumptions, and conceptualizations – and ideologies – that are theorized as shaping or informing the semantic content of the data” (Braun & Clarke, 2006, p. 84). This decision was made as it was in line with the constructivist stance that guided the research project and because it was aligned with the goals and purpose of the project, contributing to an in-depth exploration and analysis of how therapists conceptualize and understand the therapeutic alliance when working with families.

While I present the following procedure in a linear fashion, it is important to note that I went back and forth across the entire data set, the coded extracts and my analysis in a recursive process numerous times, as set out by Braun and Clarke (2006). In addition to paper/pencil analysis, I also used the computer program Dedoose to assist in the qualitative analysis of the data. This program is an encrypted cloud-based system for analyzing both quantitative and qualitative research (Dedoose, 2013). In consultation with my committee, it was decided that this program would assist in a more fine-grained analysis and would be an easier way to manage the amount of data collected.

I began my analysis by immersing myself in the data sets, reading and re-reading the participants’ responses as I searched for patterns and areas of interest, recording these in my preliminary notes. I then worked systematically through the data sets to identify the initial codes of interest and any repeated themes across the set, remaining open to all possible interpretations
of the data. The coding unit that was chosen for analysis were sentence segments that expressed a complete idea or concept and each coding unit received at least one code. When creating excerpts in Dedoose, the context surrounding each code was kept (usually the entire sentence, but sometimes several sentences surrounding the code) so that I could avoid one of the common pitfalls of qualitative analysis – that is, losing the context of the codes (Braun & Clarke, 2006).

I did several thorough and independent initial codings on the transcripts, which allowed me to compile and compare across coding times and refine my coding process to ensure I was working as consistently as possible. I then went over the data again to sort codes into preliminary themes. A codebook (Joffe, 2011) was created which included the definition of each code and theme, as well as one or two excerpts for each (Appendix F).

Once the initial codes and themes were identified, I went over the participants’ responses again to ensure all relevant codes were under each theme and re-examined the codes and themes in order to consider the potential links or relationships across themes. This iterative analysis refined the themes to ensure they were sufficiently delimited such that codes within themes were meaningfully connected and there were identifiable distinctions between themes. Once I was satisfied with the themes, a thematic map (Appendix G) was created, representing the themes that I identified in my analysis and their interconnections (Braun & Clarke, 2006).

I engaged in frequent memo writing throughout the entire analytic process so that I could document my decision making process in regards to how I chose to develop codes and themes and if/how they changed over time. I recorded my experiences, assumptions, and insights made throughout the research process, which assisted me in acknowledging the role I play in the research process and analytic outcomes. As well, I met regularly with my committee for guidance and feedback on my coding and analysis.
Using an online, open-ended questionnaire, the current study aimed to capture a rich description of how therapists conceptualize and build the therapeutic alliance when working with couples and families. The results from 18 participants were analyzed using thematic analysis (Braun & Clarke, 2006) and these results will be presented in the next section.

Findings

The results presented are from a qualitative thematic analysis of 18 participant’s responses to an open-ended online questionnaire designed to gain a rich description of the ways therapists conceptualize and develop the therapeutic alliance when working with couples or families and the strategies they use to do so. In conceptualizing and developing the therapeutic alliance with families, participants discussed six main themes that were found during the data analytic process: (1) how therapists understand the alliance, (2) what influences the therapeutic relationship, (3) creating and maintaining the alliance, (4) how therapists contribute to the alliance, (5) therapist perceptions of clients’ behaviours contributing to the alliance, and (6) ensuring balance and multidirected partiality (see Appendix E for a summary of the main themes). A thematic map depicting these themes and their interconnections is presented in Appendix G. The names I gave to the codes and themes identified here and below attempted to reflect participants’ language wherever possible, although at times my own terms were used to ensure clarity. All quotes presented below are directly taken from the participant’s responses and appear as written. They are not edited for content, spelling or grammar. Each participant was given a unique participant identification number that was used in the analysis and reporting of results (101-118).

How Therapists Understand the Alliance

How the participants conceptualized or understood the alliance was reflected in how they described the therapeutic alliance and the various aspects or elements they suggested that make it
up. This theme included the subcategories of challenging, connection, conversation, importance, safe and comfortable, strong, trust, and balance.

**Challenging.** Nine participants in 20 instances described the alliance as challenging or commented on the various challenges to building and sustaining the therapeutic relationship. Some of the challenges noted including struggling to connect with certain members of the family or having an unbalanced alliance, differences in social location, previous negative experiences with helping professionals and ensuring balance was present in the room.

I worked with a family in which it took a while to develop a relationship with the mother but the son had not developed a good relationship with me. (102)

the biggest challenge was previous negative experiences with helping professionals. - other challenges were social location (they were hesitant to work with me because I did not identify as a parent) and hostility. (109)

It was also challenging to still try and create a balance between those who were arguing and to allow the one that was not having much of a voice to still feel heard and able to express themselves. (110)

In addition, several participants highlighted the *complex* nature of the therapeutic alliance and how they have a lot to attend to when working with families, which at times was challenging. One suggested, “There is a lot that I have to be attentive to and many details factor into creating the alliance” (118). Another participant highlighted the difference between working with families and working individually,

 Always remember that working relationally is more than just individual therapy with more people in the room. It's much more dynamic and dimensional. (108)

Finally, the fact that there are *multiple relationships* in the room makes establishing the therapeutic alliance complicated or challenging. One participant wrote, “There were so many relationships to attend to and that made it complicated” (111). Another wrote:
it was also somewhat challenging because I think that they come in as their own alliance already, and so it can be tricky breaking through that to create a new therapeutic one with all three of us. (112)

**Connecting.** Eight participants made ten references to how the connection between therapist and client was an important aspect of the therapeutic alliance. Several participants used the word connection in their definition of the therapeutic alliance. One wrote, “The therapeutic alliance refers to the connection that you have with your clients” (117). Other participants described how they worked to build connection in session.

By changing my tone, facial expressions, bodily expressions, and language use I felt that I was more "playful" in my approach to the child which I felt helped to build connection (104)

**Conversation.** Five participants discussed the importance of conversation in the development, maintenance and repair of the therapeutic alliance or how conversation could be used as an indicator of the strength of the alliance.

[I] also tried to build our relationship through genuine conversations - for example, taking interest in their children and other aspects of their life. (109)

They reported that the conversation felt safe. They could talk about things in the therapy room that they could not discuss at home. (116)

**Important.** Eight participants highlighted the importance of the therapeutic alliance in their work with clients or to the therapeutic process, describing it as “the centrepiece” (111) or the “core of the therapeutic work” (112), and as playing a “huge role with major significance” (118) in therapy. One participant also stated, “The therapeutic relationship is the most important contributor to change, regardless of the therapeutic techniques/model used” (115).

**Safe and Comfortable.** Eight participants made 14 references to how safety and comfort were key aspects of the therapeutic relationship and how clients needed to feel safe and comfortable in session and with the therapist.
if clients don't trust, don't feel safe with, or don't feel comfortable with their therapist, they will be less likely to be able to talk about things and experience emotions in the therapy room that are often necessary in order to make progress (117)

[…] the fact that they find me to be a "safe person" with whom to discuss their deepest concerns (105)

**Strong.** Three participants highlighted the need for the therapeutic relationship to be strong. One wrote, “If relationships are not strong then little progress can be made” (111).

**Trusting.** Twelve participants made 24 references that trust was an integral part of the therapeutic alliance or referenced the need for the client to trust the therapist.

In my own experience, I would say a lot of it is based on trust, [g]enuineness, therapists' guiding values, and personality factors. (112)

Couples and families are allowing the therapist into their intimate relationships, and need to be able to trust the therapist. […] Creating an environment of trust is essential for genuine insight, change and movement to occur. (114)

I think once Mom and Dad knew they could trust me they felt more capable of working (109)

**Balance.** In addition, balance emerged as an important aspect of the therapeutic alliance but also as something that therapists intentionally worked towards in session. As an important theme found in the current study, it will be discussed further below.

**What Influences the Therapeutic Relationship**

Participants also made references to the various influences they identified as impacting the development of the therapeutic relationship such as client considerations, role of physical space, role of power, therapist-client fit, and therapist considerations.

**Client considerations.** Participants highlighted numerous client considerations that impacted the therapeutic relationship. As one participant indicated:

I think there is a huge amount of stuff to pay attention to- where the client is at, culture and cultural ways of communicating, trauma, mental health factors,
personality of the individual, stage of life, etc. attentiveness to self and self energy, sincerity, being grounded and caring are huge. (118)

Client age, particularly when working with young clients, was identified by three participants.

As one participant stated, “The languaging needed to be appropriate to include a child and an adolescent” (111). As well, two participants discussed the role of client culture.

Building trust with a couple from a visible minority immigrant population took time, as therapy was not something either partner had experienced, and was not seen as "normal" (their word) in their culture. (114)

One participant also discussed the need to account for client ability/disability in session:

working with a client who was profoundly deaf, accommodating the presence of a third party (the translator from Canadian Hearing Services) entailed some adjustments to the process of therapy. (114)

The role of gender and gender scripts was also noted as a consideration in therapy by two participants and in how therapists worked to build the therapeutic relationship.

I try to maintain an awareness of the impact of gender and other personal characteristics or similarities between myself and the clients that may impact my likelihood of being more joined with one person than the other. (117)

[...] but having these gender scripts that were being played into was hard to push up against or argue against (102)

The influences of the broader system on the family, including social location, and how this impacts the alliance were discussed by two participants.

Given the complexity of relational dynamics, the situation rarely seems just black and white and it's challenging to keep all the ways the systems all impact the clients clear in one's mind (e.g., family of origin, family of creation, couple subsystem, parent-child subsystem, work system, etc.). (108)

One participant commented on the challenges of building an alliance with mandated clients:

When mandated to attend therapy, clients often refuse to join with the therapist in the beginning sessions. I see this as a conscious choice, made because they feel the need to protect themselves from the system. (117)
Four participants on 12 occasions made reference to how client \textit{personality} can either enhance or make it more difficult to establish the alliance.

It's struggle with different personalities (having people who identify and extroverts and introverts) in the room and balancing each person's needs and making sure everyone has a voice. (102)

the son had not developed a good relationship with me. The son was very disrespectful to women in general, including me. (117)

Finally, two therapists discussed the \textit{influence of who attends therapy} or the constellation of the family that is in session impacts the alliance. One participant indicated, “I think that having families who have separated and coming in together is a struggle” (102).

\textbf{Role of physical space}. Two participants discussed how the physical space of the therapy room may have contributed to developing the alliance with the family.

But I really struggled with making that connection with the dad. It could have been the way my office is set up - he was a bit excluded physically from the two females that were sitting side by side (102)

\textbf{Role of power}. Two therapists on four occasions made reference to how therapist and client power entered into session and influenced the development of the therapeutic relationship.

They were also not going to allow the power imbalance of the therapist and client in a session room quiet their concerns, and expressed right away that they were different and held worries about the implications of their differences. (101)

It is for this reason that I not only seek to employ multi-lateral partiality (Nagy) and empathic attunement (Greenburg; Johnson) but I employ questions that promote a sense of inter-couple attunement. My goal in doing tis is to reduce any need they may feel to compete for my attention because the other is presenting them in a poor light. When I can effectively use my "power" in this manner couples and families generally begin to use their power for the good of the whole rather than the protection of self-interest. (105)

\textbf{Role of therapist}. Six therapists highlighted how they influenced the development of the therapeutic alliance or discussed how therapist self could impact the relationship. As one
participant highlighted, “It is important that the therapist recognize the part that they play in this relationship and the ways in which they may be hampering its development” (117).

**Therapist-client fit.** Five therapists discussed how the fit between the therapist and client influences the development of the alliance, including how much the therapist likes a client.

I also tell clients, in the first session of on-going therapy, that the fit with the therapist is very important. I offer them the option of requesting a different therapist if they do not think I am someone they can work with. (116)

Be alert to one's emotional response (positive/affiliative or negative) toward clients when there are multiple clients in the room. (115)

**Creating and Maintaining the Therapeutic Alliance**

The analysis of the data suggested that the creation and maintenance of the therapeutic alliance was an important theme in the current study. Participants discussed building the alliance, the ways in which the alliance develops over time and starts from the beginning of working together, how the alliance is intentionally created, how it requires attention and maintenance, how they deal with and repair ruptures in the relationship, and the sequence of how the alliance is developed in relation to the overall therapeutic process.

**Building.** Six therapists on 11 occasions described how the alliance is something that is built or created in session.

The responsibility of building and maintaining the therapeutic relationship lies largely with the therapist. (112)

[I] tried to build our relationship through genuine conversations (109)

In addition, 10 participants made 15 references to the *positive outcomes* of their attempts to further build the therapeutic relationship.

I believe that each felt affirmed by me, and that my intervention created receptivity to their noticing change in the other. (115)

Our relationship became much better after this point. (117)
Developing over time. Eight participants made 11 references that described how the therapeutic alliance took time to develop and strengthen.

Clients were responsive, as time went on they were much happier about working together. (109)

we had been working with them for about six sessions so had a fairly solid therapeutic relationships with them. (110)

From the beginning. Despite the alliance taking time to develop or strengthen, three participants also suggested that the alliance starts to develop from the very beginning of working with the family.

I hate to say that first impressions are always accurate but I think that beginning to build a positive relationship from the beginning is important to creating trust between all parties involved. (110)

I seek to build that therapeutic alliance at the beginning. (114)

I believe a therapeutic relationship is very quickly formed - I do not believe that it takes several session to form the alliance. (116)

Intentionally creating the alliance. In discussing the creation of the therapeutic alliance, participants highlighted that this is an intentional process, not something that is created spontaneously or by accident. When explicitly asked whose responsibility it was for creating and developing the therapeutic alliance, participants indicated that it was either a joint process that both the therapist and clients contributed to or that it was primarily the responsibility of the therapist. Four participants made eight references that indicated that the responsibility of creating and sustaining the alliance was a joint process, between the client and therapist, although a few participants indicated it should be facilitated by the therapist.

[In reference to repairing the relationship after a rupture occurred] I was trying to keep the responsibility on all of us, keeping the work relational and inclusive of all participants. (111)
I feel that it is a mutual responsibility, but that the therapist has to create the context for a partnership to occur. (114)

Four participants indicated that the therapist holds the majority of the responsibility for developing and maintaining the relationship.

It is a deliberate process - this is a 'one sided ' relationship focused on the client (116)

The responsibility of building and maintaining the therapeutic relationship lies largely with the therapist. (112)

Despite the participants’ explicit statements, when therapists commented on the development of the alliance more generally (such as in the case-study questions), many participants indicated that both therapists and clients contributed to the therapeutic alliance. In discussing who contributes to the therapeutic alliance, three participants made six comments that explicitly mentioned the ways they perceived clients to be active or intentional in contributing to the alliance, not including other specific client behaviours they saw that might contribute to the alliance (which will be discussed further below).

When we met as a family that same session, the mother attempted to help by reminding the son that it was important to pay attention to what I was saying and to be respectful towards me. (117)

Ten participants in 22 instances made reference to the ways in which therapists were active or intentional in building the alliance, again, not including their other behaviours that had indirect effects on the alliance (also discussed below).

The therapeutic relationship should be intentional on the part of the therapist (117)

I think each individual has different needs and goals, and we have a responsibility to accommodate and negotiate in a therapeutic relationship based on the client's best interests. (109)

Participants also discussed the reciprocal nature of the alliance. As one participant indicated, "This is a reciprocal process" (116) where both clients and therapists respond to one
another’s attempts to build the alliance. Demonstrating this, five participants indicated nine times that their clients expressed appreciation over something they said or did.

The female of the couple stated that she was glad that I brought that up, and she visibly became more animated as she talked about this. (101)

The clients stated that they appreciated my self-disclosure and they seemed to be more open to discussing their own experiences. (112)

Nine participants indicated that their clients appeared responsive to their actions:

Clients were responsive, as time went on they were much happier about working together. (109)

The client immediately calmed down and began to join with me, stating that she had probably overreacted. (117)

In addition, six therapists also indicated that they were responsive to client’s actions.

I responded with respectful listening but also quite directive in helping them to plummet every detail of their pain. (107)

I respond to these situations by telling clients that I would like the sessions to be as helpful as possible, even though they don't necessarily want to be there. I ask them what I can do for them to make their time most helpful and try to incorporate this into therapy. (117)

Requires attention and maintenance. Seven participants made 13 references to how the therapeutic alliance is something that requires on-going attention and maintenance over the course of therapy. One participant indicated that, “the therapist should be alert to indications that the alliance is viable or not” (115) while another wrote that the therapeutic relationship “…requires constant vigilance, is deliberate, and ongoing throughout the time of working together” (111).

Rupture and repair. Given the dynamic nature of the therapeutic alliance, participants also recognized that ruptures, or a noticeable break in the therapeutic alliance, were common, especially when working with families, and that repair was often necessary afterwards to rebuild
the alliance. Five participants made 12 references to the role of rupture and repair in their work with families.

A client who was required to go to therapist called me names and explicitly stated that she did not want to come to therapy. I asked her to tell me what I had done that was so upsetting to her so I would know to not do it again in the future. (117)

I have worked hard to repair the fracture in my relationship with the parents. (106)

I am acutely aware of the tenuous-ness of our relationship at all junctures, and find myself feeling more ineffective and self-doubting than I typically am. […] Just when I think the damage in our relationship feels more "repaired", I'll notice something that leads me to believe that it has been fractured again. (106)

**Sequence.** Through how participants discussed the alliance, it was inferred that participants felt there was a sequence to how the therapeutic alliance was formed with families and its involvement in the therapeutic process overall. The participants suggested that they believed that the formation of a relationship occurs before trust, which is necessary before the ‘work’ of therapy can begin, which leads to the outcome, success or growth of therapy.

In order to gain their trust I put a lot of time and work into the relationship. (109) *(Relationship before trust)*

If a client relates to me, then therapy proceeds well. (113) *(Relationship before work)*

Creating an environment of trust is essential for genuine insight, change and movement to occur. (114) *(Trust before work and outcome)*

The therapeutic relationship largely determines how successful therapeutic outcomes will be. (117) *(Relationship promotes success in therapy)*

In addition, participants highlighted that repair would be used as necessary along this process (as was discussed above). Finally, four participants made six references to how once the therapeutic alliance was present and strong, they could *use the alliance* to encourage progress in therapy or promote growth for the family.
I was intentional during the session about drawing in his parents perspective and sometimes ever using my alliance with the son to challenge him in ways his parents seemed to be uncomfortable doing. (103)

As we talked, I drew upon both the trust we have built… (105)

Furthermore, two participants discussed how they would intentionally side with one member over another.

However, there may be times that it is important to be more aligned with one member of the family than the other for certain therapeutic purposes. (117)

As I told the clients, when working with a couple or family, there will inevitably be times where each may feel challenged specifically while the other seems momentarily off the hook. (108)

How Therapists Contribute to the Alliance

In discussing how they were involved in the creation of the alliance, the participants made reference to numerous specific behaviours that they used to contribute to the therapeutic alliance. These included: addressing client concerns, being attentive/attuned, maintaining awareness of self, balance, using body language, collaboratively working with clients, being direct, expressing empathy, engaging clients, expressing care, facilitating couple/family relationships, facilitating the therapeutic process, focusing on strengths, joining, meeting clients where they are, demonstrating multidirected partiality, being open and honest, adopting a relational perspective, being tentative, therapist use of self, using language, using questions, using goals and validation. Many participants also made reference to the ways in which they ensured that their actions were balanced and multi-partial and this is discussed further below.

**Addressing client concerns.** Five participants made eight references to how it was important for them to address and respond to client concerns expressed in session.

I verbally validated client concerns, offered in my own words what that might be like for them so that I could give my understanding genuinely and be open to their correcting my assumptions. (101)
One nearly bolted (left) a few times). We were able to note, ask about the feeling, address it and have open comfortable discussion about it. (118)

**Being attentive/attuned.** Nine participants on 17 occasions indicated that they were attentive and attuned to the clients in session and would express interest in their lives as a means to facilitate their relationship.

Expressed interest in child's favourite video game which I felt helped the child to feel more relaxed and comfortable with me. (104)

Attentiveness to everyone, noticing each family member, giving space and time to each and attending to the different ways of joining and communication. (118)

Related to this, three participants on five occasions indicated that they actively listened to clients and suggested this was important to the development of the therapeutic relationship.

I try to convey warmth and non-judgmental listening and I try to instill hope as we move along. (108)

I had to listen very closely to what they were saying and making sure that I was understanding the meanings they wanted to convey. (111)

As well, three participants suggested that trying to understand the clients or expressing understanding also contributed to the relationship. As one participant wrote, “I show empathy, understanding and the ability to develop quick rapport” (107).

**Maintaining awareness of self.** Six participants made 15 references to how they had to maintain awareness of themselves and what was going on for them in session, including how the clients were impacting them, their feelings in particular moments in session and their intentions/goals in certain behaviours or techniques they used in session.

I was aware of feeling like at least one of them was interested in drawing me into the role of "mediator" of their dispute. (105)

It feels stressful and I find myself apologizing despite the fact that I know (intellectually) that I have done nothing "wrong". (106)
I felt highly sensitive and my senses were heightened. I think I was picking up on their apprehension and their anxiousness. (101)

**Using body language.** Four participants indicated that they would shift or change their body language to promote the alliance, including changing eye contact, facial expressions and tone of voice.

During this session, at times when one partner was speaking more than the other and I did not think it was appropriate to interrupt, I would make more eye contact with the other partner while still acknowledging what the other partner was saying, and then give the partner who was not speaking time to respond. (112)

**Collaboratively working with clients.** Four participants discussed how they worked collaboratively with clients throughout the therapeutic process.

In general we collaboratively agreed that "cooperation" was the main goal for the family. (114)

The client has confidence in my ability to support them and to assist them in explore concerns and finding workable solutions. (116)

**Being direct.** Six therapists commented on being direct with clients in session, some of whom indicated that this promoted the therapeutic alliance, while others indicated that being too direct hindered the formation of the alliance.

but in the end allowed us, as training therapists, to practice how to gently but directly discuss concerns with clients while not making them feel as though they are to blame" (110)

If they [the therapist] push too hard, this may hurt the relationship between the therapist and the client. (117)

**Expressing empathy.** Four participants suggested they tried to be empathetic and would express concern or compassion for the family. One participant indicated that it was important “to express empathy/concern for each person's experience” (116) in order to build the alliance.

**Engaging clients in session.** Four participants on nine occasions stated how they worked to engage the clients in session and how this impacted the therapeutic relationship.
The therapist is primarily responsible for engaging the client(s) and maintaining/tending to the client relationship. (115)

In addition to this, I would add that my willingness to "enter into the client story" and "engage them in a conversation about what they are talking about" contributes to them experiencing the therapeutic relationship as a safe relationship. (105)

**Expressing care.** Four participants referenced how they expressed caring in session to facilitate the therapeutic alliance. One participant indicated, “I think that showing clients that you genuinely care for them and being yourself in therapy can help the therapeutic alliance” (117).

**Facilitating couple/family relationship.** Three participants made 11 references to how they worked to promote the couple or family relationship in session.

Each seems to know that I want to help them repair their marriage. (108)

My rationale, which I explained to them, was that I see my role as a relational therapist not to take sides or to "change the other person" but rather to help them to find ways to "heal the space between them (i.e., the couple relationship)." (105)

**Facilitating therapeutic process.** Seven participants recounted 11 examples of how they actively facilitated the therapeutic process or managed/guided the session.

Attentiveness to the couple dynamics being played out in the room; managing them. (118)

I think it is easier and more helpful to interrupt and help facilitate balance between couples and families when you are transparent about your intentions from the beginning. (110)

**Focusing on strengths.** Two participants on five occasions suggested how they looked beyond the problem and focused on the family’s strengths, resources, abilities etc.

Mother seemed to relax more with the playful approach and strength-based approach. (104)

My own emphasis over the years has been to encourage the strengths and resources of each client/couple/family to become all that they desire to be. (114)
Joining. Nine participants made 15 references to how they actively worked to join with the family and indicated the importance of building rapport and developing a personal relationship with the family to enhance therapeutic relationship.

I worried that they would look at me and without a conversation about my age, that there was a possibility [that] the client would not join with me. (101)

I also think that getting to know the person (in a sense) can be helpful at the beginning of the therapeutic relationship so that they can see "real" aspect of you if you have something that you can chat about that isn't exactly part of their concerns (i.e. seeing the same movie recently, or whatever). (110)

In addition, three participants suggested they used humour and laughter in session to join with clients. One participant discussed how she used this to join with younger clients: “[I] was able to share laughs and smiles with the child” (104).

Meeting clients where they are. Four participants made eight references to how they were intentionally trying to meet clients where they were, instead of being too far ahead or behind. In addition, four participants on six occasions suggested they would change their behaviours or ways of interacting to best suit the clients and to enhance the relationship.

In these situations, the therapist must back off in order to give the client space to change when they are ready. (117)

I was certain to commend them on these efforts and offered to modify things in their best interests. (109)

I expected the daughter to be quieter based on my experience lately of teenage girls being seemingly unable to talk (response like "I don't know" or "I don't know how to talk about it") seem to have become pretty common in my practice lately. Therefore I just tried to be patient and ask a lot of simple (e.g. what do you like to do for fun, what grade are you in?) and open-ended questions to keep the conversation going. (102)

Finally, two participants made references to how they would change the pacing of the session given where the clients were at. One participant indicated that it was important for her to pay attention to “pacing and timing and attentiveness to where each individual was at” in her work
with families (118). As well, another participant commented on how she was trying to meet clients where they were at:

Mainly by structuring the sessions the way I did; by ensuring that the son had an important voice in the process, and by going at the pace that the family viewed as necessary in order to adjust to the slow process of disability services. (114)

**Being open and honest.** Four participants discussed how they tried to be open and honest in session. One participant commented, “When clients see that I am vulnerable and open they respond positively” (113). Another participant highlighted the importance of “being open, honest, noting and addressing what I was noticing” in session with families (118).

**Adopting a relational perspective.** Eight participants made 11 remarks indicating how they adopted a relational focus when working with families, considering the relationships and interactions among members and how it was more than just several individuals in session.

Talk and attention to the spaces amidst the members of the family versus attention to individuals (111)

[...] place the emphasis for change on the patterns that happen between people in the relationship (116)

**Being tentative.** Two participants discussed how they were tentative in what they offered to clients. One participant wrote, “I am always tentative with my suggestions and summations, checking in to make sure that the clients can disagree with or augment my perspective with their own experience” (103).

**Therapist use of self.** Many participants discussed the ways they used themselves in therapy to promote the therapeutic alliance. Six therapists commented how it was important for them to be *genuine* in session and the ways in which this facilitated the therapeutic alliance.

I think that showing clients that you genuinely care for them and being yourself in therapy can help the therapeutic alliance. (117)
As well, two participants mentioned relying on their *intuition* in session.

> [It] was comforting to know that we listened to our instincts on not shifting the interaction right away. (110)

> I was also intuitively going with the indescribable signals and taking chances myself, for example, with self-disclosure (101)

Five participants discussed how they would *offer their help or support* as way to strengthen the therapeutic relationship.

> I helped them in a time of need (when they got bed bugs, I spent an entire evening helping them facilitate relief for their children and new mattresses from O/W). (109)

Three participants made 10 references of the ways in which they used *self-disclosure* to facilitate the alliance they had with families.

> I have also used self-disclosure as a way to strengthen the therapeutic relationship in with this same couple. (112)

> I then started to use things like self-disclosure and changing my tactics so they weren't as direct. (102)

In addition, five participants commented on the ways in which they used their knowledge, resources or *expertise* as a therapist to help clients and enhance the therapeutic bond.

> The therapist must not just be passive but must also be willing to gently but firmly confront when necessary, show direction and make suggestions out of his or her knowledge and experience. (107)

> [...] clarifying that I am not so much an "expert" as a facilitator who may have some insights or resources (eg; articles/books; handouts I have created over time) which could be of help. (114)

Four participants made eight comments surrounding how they *maintained their voice* throughout the therapeutic process, including times where they would raise their concerns in session.

> My cotherapist and I each felt as though we could let the arguing go on for a while (as it is sometimes necessary) but were cogniscent of the fact that the youngest daughter may be at risk with what she was hearing. We were able to voice these concerns, despite feeling intimidated [...] (110)
I also maintained my voice by asking clarifying questions and asking about possible misunderstandings about our progress. (111)

Finally, seven participants made 12 comments on how they were transparent with clients in session and the ways in which they made their approach to therapy clear from the beginning.

[I] offer the clients opportunity if they so desire to ask me about my work, experience, and perspective. I also describe to them how I work, that I see myself as working alongside them in their healing process. (114)

**Using goals.** Five participants on 10 occasions indicated they strategically used goals in session to facilitate the therapeutic alliance, including working together to find common family goals, and using goals to join with the family.

I find it is most useful if I focus on a common goal shared by the family members when I summarize their perspectives, rather than getting caught up on the details of their disagreement. (103)
Focusing the therapy conversation on the mutually agreed upon goals of the session. (116)

**Using language.** Three participants discussed how they were intentional in using language to join with clients and enhance the alliance.

Felt myself changing my tone to be more expressive, changing my facial expressions to be more expressive and animated, changing my word choice to me more appropriate to the age of the child (simpler sentences, "cool"). (104)

It is very important to use language in such a way as to convey that you do not adopt one person's perspective as fact, but affirm their perspective AS a perspective. (115)

**Using questions.** As well, five participants made eight references to how they used questions intentionally to promote the therapeutic relationship.

[...] and it is not just based on social talk. Every interaction in therapy is about developing that alliance; every question must be in the service of helping the therapeutic system progress. (111)

I also observed that the type and order of questions and follow up questions I asked provoked trust and openness. (101)
Validating. Eight participants on 13 occasions commented on how they used validation in session, including how they validated the client and their experiences, emotions, and perspectives. One wrote, “I want to validate each perspective without taking sides” (103), while another indicated:

I put those questions aside and asked him about his life, his history of abuse, and his wishes for his life, and to his answers I was able to validate his emotions and to show him that his context mattered. (101)

Therapist Perceptions of Clients’ Behaviours Contributing to the Alliance

Not only did participants comment on how their behaviours or actions contributed to the alliance, participants also discussed the client behaviours they perceived as possibly contributing to the therapeutic relationship or was indicative of the strength of the alliance. These included: using body language, being engaged and contributing, expressing concerns, being guarded or defensive, listening, maintaining couple or family relationship, being open and honest, taking risks and testing the therapeutic relationship.

Using body language. Three participants made nine references to the client’s body language in session and what that meant for the therapeutic alliance.

physically they presented as hostile - sitting far away from me, arms crossed, swearing, typically louder voices. (109)

I was paying attention to their body language, the communication signals between both of the individuals in the couple. (101)

Engaged and contributing. Eleven participants commented 21 times on the ways in which clients appeared to be engaged in session and how they were actively contributing to the therapeutic process.

They contributed by being honest about their reactions, responding thoughtfully to questions. (116)
Mother attentively watched and seemed pleased with my engagement with the child. (101)

**Expressing concerns.** Three participants mentioned five instances where clients expressed concerns over therapy or brought up blocks to progress. One participant wrote, “She stated that she was hesitant to come in as she was fearful that she had done something wrong” after the therapist had asked the client to come in for an individual therapy session (110).

**Being guarded or defensive.** Six participants mentioned how at time clients were being guarded and not disclosing information as a means of protecting self. For instance, one participant stated, “It is my perception that the parents are much more guarded when describing their parenting than in the past” (106) after they had to make a report to children’s aid. Another remarked, “Mom and Dad were very hostile to begin with, did not want to work with me and were hesitant to share information” (109).

**Listening.** Three participants noted the ways in which clients were listening in session, to the therapist and to each other. One wrote, “The clients listened to me when I had contributions and offered their disagreements and feedback” (103).

**Maintaining the couple or family relationship.** Six participants described the ways in which clients maintained or valued their relationships with one another or engaged in positive interactions serving to strengthen their relationship in session.

They consequently became more vulnerable to each other and open and thus experiencing compassion towards each other. (107)

As he reflected on his life his wife observed him crying and affirmed both his value and inquired if "a brick had been dislodged". She also reached out to touch and reassure him. (105)

**Being open and honest.** Fourteen participants made 26 comments surrounding their perceptions of clients being open and honest in session and expressing vulnerability.
But when the process of therapy was understood, they became more comfortable with me, and with opening up about their lives, and we have established a strong relationship (114)

The clients became open, vulnerable and willing to share deeply about their past respective pain and childhood trauma. (107)

**Taking risks.** Three participants noted how they saw clients taking risks in session and how this contributed to the development of the therapeutic alliance.

Clients contributed to the therapeutic relationship but taking risks to share difficult/painful details of their lives. (106)

The clients contributed to a therapeutic relationship by taking chances as well. They let themselves out, little by little (101)

**Testing the relationship.** Two participants indicated that they noticed times where the clients may have been testing the strength of the alliance or its boundaries. As one participant noted:

I think they were testing the therapeutic relationship in a sense...I don't want to say taking advantage of it, but perhaps expected that because we were encouraging and understanding, that we would not be able to voice that this was inappropriate. (110)

**Ensuring Balance and Multidirected Partiality**

The theme of balance and multidirected partiality was an important theme in how participants understood the therapeutic alliance and in how they intentionally acted in ways to ensure balance and multidirected partiality when working with couples and families. In fact, all 18 participants made a reference to balance and/or multidirected partiality, although some participants commented on it more extensively than others.

**Balance.** The notion of balance was discussed by participants both as something the therapist actively worked towards in session (i.e. the ways in which the therapist ensured balance, fairness, or equitability across family members) and as an important aspect or
characteristic of the therapeutic alliance, one that can be challenging to maintain in session with families. Fifteen of the 18 participants made a total of 40 references to the notion of balance.

The therapist needs to consider the extent to which they are aligned with all members in the therapy room. It is important to balance this alliance. (117)

Balancing perspectives when there are disagreements between family members. (103)

Balancing time between clients, helping to facilitate more equitable communication (for example, interrupting clients when they are speaking more than the other clients). (112)

**Enacting multidirected partiality.** Related to this, 16 participants made 58 comments that directly discussed multidirected partiality or implied how they enacted a multi-partial stance in session (i.e. the therapist being balanced and fair to all members present and engaging with all members equally). Participants made reference to the subcategories of avoiding blame or judgement, avoiding taking sides, ensuring all voices are heard, and multiple perspectives.

Four participants used the term “multidirected partiality” (or a similar term) explicitly. For instance, one participant indicated, “Multipartiality is a must--no side taking with a family” (111), while another wrote, “I found myself working hard to ensure multipartiality was evident at all times” (106).

Four participants discussed how they worked to *avoid blame or judgement* in session, ensuring that the clients did not feel blamed or judged by them and that they were not blaming one member for the ‘problem’ the family had come in to address.

> I made it a point to side step their process of blame and counter-blame and engaged them in a process of dyadic (circular) questioning which invited them to think of the other and the other's perspective. (105)

> Each seems to know that I want to help them repair their marriage and I am not trying to undermine either [o]f them, pick on anyone and I'm not judging them. (108)
Eight participants made 12 references to how they worked to avoid taking sides within the family.

did not permit myself to become aligned with one partner against the other. (105)

The importance of attending to each person's point of view, to not take sides over the course of therapy (116)

Nine participants on 29 occasions discussed how they actively worked to ensure all voices were heard. They indicated that they tried to hear from all family members and would be intentional in creating the space to facilitate this in session.

It is important to attempt to call upon family members to speak as equally as possible. (115)

When I heard very little from the father during the session, I made a point to ask him directly if there was anything he would like to contribute. (103)

For each person to have a "voice" and feel that they are being heard. (114)

Nine participants made 17 references to how it was important to recognize and work with the multiple perspectives in the room, highlighting that each family member may have a different understanding of the experience and ensuring they make space to include this in session.

I started with the youngest and both teens opened up about the problems in the family. Mom and Dad were asked for their perspective on what their children had said, and this opened up a very wonderful dialogue. (114)

I affirmed each person's perspective, attempted to give each about equal air time. (115)

Throughout the session, I checked in with each member of the family to ensure that they felt their perspective was being heard and understood. (103)

To summarize, six main themes were found that reflected the participants’ perspectives on how they conceptualized and created the therapeutic alliance in session with couples and families. These included: how therapists understand the therapeutic alliance with families, what influences the relationship, creating and maintaining the alliance, how therapists contribute to the
therapeutic relationship, therapist perceptions of clients’ behaviours contributing to the alliance, and how therapists ensure balance and multidirected partiality in session.

Discussion

In an effort to better understand how therapists conceptualize and develop the therapeutic alliance when working with couples and families, the current study conducted a qualitative thematic analysis of 18 therapists’ responses to a series of open-ended questions. I was interested in exploring three things: (1) how therapists conceptualized, understood or experienced the development of balanced (multi-partial) therapeutic alliances with couples or families, (2) the ways they adopted a multi-partial stance when working relationally, and (3) the specific strategies they used to build strong alliances, negotiate balanced relationships that were fair and equal for all members and repair or strengthen weaker bonds with clients. From the participant’s responses, six themes were found: (1) how therapists understand the therapeutic alliance, (2) what influences the alliance, (3) creating and maintaining the alliance, (4) how therapists contribute to the alliance, (5) therapist perceptions of clients’ behaviours contributing to the alliance, and (6) ensuring balance and multidirected partiality. These themes and their interconnections were depicted in the thematic map (see Appendix G). The results from the current study reinforce the previous literature on the therapeutic alliance in CFT and extend what is known about therapist perspectives on the formation and sustainment of the alliance by focusing specifically on the challenges when working relationally, something not addressed previously.

How Therapists Understand the Alliance in CFT: As Important, Challenging and Complex

Previous literature on the therapeutic alliance in general (Friedlander, Escudero, & Heatherington, 2006; Rait, 2000), as well as the research, mainly from an individual therapy framework, highlights the importance of the therapeutic bond (Binder, Holgersen, & Hostmark
Nielsen, 2008a; Bressi Nath, Alexander, & Solomon, 2012; Hunter, 2012; Scanlon, 2006; Sullivan, Skovholt, & Jennings, 2005). Similar to this, the participants in the current study understood the alliance to be very important in relational therapy and suggested that the formation of a strong alliance was necessary before the ‘work’ of therapy could begin. Participants went as far as describing the alliance as the “centrepiece” or “core” of the therapeutic process and as necessary for growth or a successful outcome in therapy.

The participants in the current study also explored some of the unique challenges they face when working relationally such as the complexity of forming and balancing multiple relationships in session and across time while ensuring all voices are heard and maintaining a sense of balance. Such challenges largely correspond with the specific challenges in establishing and maintaining alliances previously identified in the theoretical literature in CFT (see Beck et al., 2006; Friedlander, Escudero, & Heatherington, 2006). Authors previously have described the therapeutic alliance in CFT as highly complex, interactional and multidimensional (Friedlander et al., 2011b; Thomas et al., 2005), and the results of the current study support such a claim, with the participants indicating that there is a lot to attend to when working relationally, describing this work as more “dynamic and dimensional” (108) than individual psychotherapy.

It should be noted, however, that the findings of the current study do not entirely correspond with the challenges identified in the previous research addressing therapist perspectives on alliance development. Much of this research, conducted from an individual psychotherapy perspective, was not focused on working with multiple people in the room and, as such, most of the identified challenges were more individualistic in nature, including workplace stressors, mandated clients and clients with severe presenting concerns (Bressi Nath et al., 2012; Knei-Paz, 2009; Halstead et al., 2002; Scanlon, 2006; Spiers & Wood, 2010). That
is not to say that these concerns did not impact these participants, they just were not explicitly commented on. Therefore, the findings of the current study provide further support for the notion that there is something unique and complex that therapists perceive as influencing their ability to form strong therapeutic alliances when working relationally.

**Ensuring Balance and Multidirected Partiality**

Ensuring balance and multidirected partiality was one of the most salient themes in the current study. Participants referenced how balance was an important aspect of the therapeutic relationship when working with couples and families, even if it was challenging, and discussed how they intentionally strived to ensure balance, fairness, or equitability in session and across family members. In addition, participants also mentioned the term “multidirected partiality” directly, or recounted how they adopted a multi-partial stance (i.e. how the therapist was balanced and fair to all members and engaged with all members equally) when working with families. They indicated that they tried to avoid blame or judgement, avoided taking sides, ensured all voices were heard, and recognized/worked with the multiple perspectives in the therapy room. In fact, all 18 participants made reference to how they worked to ensure balance and/or multidirected partiality, although for some participants, it was commented on more extensively than others. As participants were not asked to explicitly comment on the role of balance or multidirected partiality in the therapeutic alliance, it seems likely that this finding is somewhat independent of the questions posed and thus reflects a significant feature of the alliance according to the participants in the current study.

The findings of the current study are in line with previous literature in the CFT field that has also highlighted the need for therapists working with couples and families to ensure an overall level of balance across family members (Rait, 2000; Sprenkle et al., 2009). This
theoretical literature emphasized the need to join equally with all members (Friedlander et al., 2011a/b) and how ruptures may occur when members of the family perceive the therapist as taking sides or as not being fair towards all members in the room (Friedlander, Escudero, & Heatherington, 2006). Furthermore, the theoretical literature on the therapeutic stance of multidirected partiality highlights similar concerns when working with families as was found in the current study. Specifically, such literature focused on the importance of therapists holding onto multiple aspects of the therapeutic relationship simultaneously (Stancombe & White, 2005), responding to clients in a way that is perceived as balanced and fair to the family, not taking sides, avoiding judgement, ensuring all voices are heard (Anderson & Goolishian, 1988; Stancombe & White, 2005) and balancing multiple alliances (Butler et al., 2011).

The previous theoretical literature would suggest that multidirected partiality is an important stance to adopt when working relationally and this was reaffirmed by the results of the current study. However, no previous research has been found that explicitly links the concept of multidirected partiality with the therapeutic alliance in CFT, with the exception of Sutherland (2005). The current study, therefore, offers support for the ways in which multidirected partiality is linked with the alliance in CFT, extending what has been previously described in the literature. The salient features of multidirected partiality, as suggested by the theoretical literature (Anderson & Goolishian, 1988; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991; Butler et al., 2011; Stancombe & White, 2005), could be inferred from the participants’ responses in this study and closely align with the subcategories under this theme, providing further support that balance and multidirected partiality may be key features of the therapeutic alliance in CFT.
Power

In their conceptualization of the therapeutic stance of multidirected partiality, Boszormenyi-Nagy and colleagues highlighted the importance of attending to power, relational justice and fairness when working with families (Boszormenyi-Nagy, 1997; Boszormenyi-Nagy et al., 1991; Boszormenyi-Nagy & Krasner, 1980; 1986). While participants made some reference to the role of power in their work with clients, this was not commented on as explicitly as might be expected, as only two participants on four occasions made a direct comment on how they saw power entering the therapy session with families and impacting the therapeutic alliance. On the other hand, participants indirectly discussed how power relations and differences/similarities in social locations across clients and between the therapist and clients impacted the therapeutic alliance. For instance, participants noted how various client characteristics reflecting differences in social location (age, gender, mental health, whether they were mandated or not, disability, culture etc.) impacted their ability to form strong alliances with certain family members. In addition, in examining the therapist behaviours that impact the therapeutic alliance, several participants identified behaviours are in line with those identified in the previous literature exploring how therapists attend to issues of power in session with couples, including using therapist voice to ensure balance and creating space for individuals who hold lesser power to speak/ ensuring all voices are heard (Ward & Knudson-Martin, 2012).

Therefore, it appears that some therapists may be enacting balance and multidirected partiality in ways that account for power relations and differences in social locations, but that they did not always identify their behaviours as such. It is possible that the role of power and differences in social location did not emerge as a salient theme in the current study because of how the survey was constructed, not because therapists do not view this as an important issue in
considering the therapeutic alliance. As this was an open-ended online survey, it did not allow for further clarification on answers or following up for more details. As well, the survey did not explicitly ask participants to address how they attend to the issues of power in session with families. Perhaps participants would have spoken more extensively on the complexities and tensions in addressing power relations in families and its impact on the therapeutic alliance if an in-depth interview had been conducted instead. Alternatively, previous research suggests that therapists differ in the degree to which they are aware of how issues of social location and power enter into therapy (Knudson-Martin et al., 2014) and so even with an in-depth interview this may not have been the case for all therapists. Further research should explore the ways in which therapists account for differences/similarities in social location and address power imbalances in family therapy and how this impacts the formation of multiple alliances in CFT.

**Intentionally Creating the Alliance**

In describing how the alliance is created and maintained while working with couples and families, participants highlighted how it is an intentional process. The participants indicated that this relationship is not something that emerges spontaneously or by accident and that they actively contribute to the development of the alliance. In addition, participants recognized the role clients played in this process, describing the client behaviours they saw as possibly contributing to the relationship or that were indicative of the alliance’s strength. Such findings correspond with the previous research examining the alliance in individual therapy, where therapists have also indicated that they were intentional in how they built or sustained the alliance (Campbell & Simmonds, 2011; Spiers & Wood, 2010). Moreover, these findings fit with Bordin’s (1994) conceptualization of how both therapist and client are active partners in building the alliance.
However, a difference was noted when participants were asked explicitly in the summary questions or implicitly through the case study questions. When asked explicitly whose responsibility it was to create and develop the alliance, some participants suggested it was a joint process facilitated by both the therapist and the client, while others described how it was primarily the therapist’s responsibility to facilitate it. On the other hand, when asked indirectly, participants noted both therapist and client behaviours that may have contributed to the alliance. Although more specific therapist behaviours were named than client behaviours, there did not appear to be a distinction with regards to whose behaviours held greater importance to development of the alliance. It was also highlighted in their responses that this was a reciprocal process where the therapist and clients would respond to the other’s alliance building efforts. These findings may suggest that some therapists are not always aware of or do not explicitly recognize the full extent of client behaviours on the alliance. Another interpretation is that therapists recognize the importance of client contributions to the process of therapy but do not directly connect those contributions to the strength of the therapeutic alliance. In addition, it is unclear whether the clients were intentionally trying to contribute to the therapeutic relationship through the behaviours the participants commented on. Future research is needed in order to better understand the relationship of client behaviours on the therapeutic relationship.

The findings of the current study, for the most part, correspond with what others have indicated in the mainly theoretical literature which suggests both therapists and clients influence and play an active role in the creation of the therapeutic alliance (Thomas et al., 2005). Sprenkle and colleagues (2009) suggest that the therapeutic alliance a collaborative phenomenon, even though there is the misperception that it is something that the therapist brings to the clients. In general, the CFT literature has had a stronger focus on therapist behaviours, with less focus on
client behaviours, although it is possible to conceptualize all client (and therapist) behaviours as influencing the alliance (Friedlander et al., 2011b). Additionally, the findings of the present study fit with Sutherland (2005)’s constructionist perspective on the therapeutic alliance which highlights how the relationship emerges and evolves from the interactions between therapists and clients and how both parties play a role in ensuring that multiple perspectives and multipartiality exist in session and in their conversations.

**How Therapists Contribute to the Alliance**

The participants in the current study also discussed the specific behaviours they used in session to foster the alliance with couples and families. Some of these behaviours included addressing client concerns, being attentive/attuned, balance, collaboratively working with clients, expressing empathy and care, focusing on strengths, joining and using humour, meeting clients where they are, enacting multi-partiality, being open and honest, adopting a relational perspective, therapist use of self (being genuine, offering help or support, using self-disclosure, using their expertise, and being transparent), using goals and validation (for the complete list, see Appendix H).

The findings of the current study which adopts a relational perspective to the therapeutic alliance supports the previous research on therapist reports of the behaviours they use in session to facilitate the alliance (mainly in individual psychotherapy), including working towards common goals, being present and attuned, genuine warmth, trust, openness, and empathy (Campbell & Simmonds, 2011; Halstead et al., 2002; Knei-Paz, 2009; Scanlon, 2006). Broader literature on the therapeutic alliance in CFT also found similar behaviours contributing to the therapeutic alliance, including genuineness, warmth, joining, humour, expertise, good listening skills and changing one’s behaviour to fit the client’s needs (e.g. Sprenkle et al., 2009). Further,
the therapist’s use of themselves in session has been highlighted in the previous CFT literature (e.g. Sprenkle et al., 2009) but also in the qualitative research of therapist experiences of the alliance (Sullivan et al., 2005). In session, therapists indicated that they would intentionally use humour and their expertise to build the alliance (Scanlon, 2006; Spiers & Wood, 2010), as well as being honest and genuine in their presence with clients (Binder et al., 2008b; Hunter, 2012).

Such findings reinforce and extend the previous literature on therapist behaviours that influence the therapeutic alliance and support that there are numerous ways therapists attempt to build the alliance in session with couples and families. Other authors have suggested that there is not a specific way to build the therapeutic alliance in CFT. Instead, it must be based on the clients in the room and the tailoring of therapist behaviours to fit the clients and their context (Escudero et al., 2008; Sprenkle et al., 2009). The findings of the current study bear significance because previous research has indicated that therapist behaviours in session not only contribute to the therapeutic alliance but also are associated with more positive therapy outcomes for clients (see Thomas et al., 2005). In addition, Friedlander and colleagues (2011b) call for further research in CFT surrounding the specific therapist behaviours that optimally promote the therapeutic relationship with families over time to enhance what is known from the theoretical literature. The current findings contribute further knowledge to the field regarding the specific behaviours that therapists use in session to facilitate this alliance.

Safety

Previous research in CFT has highlighted the necessity of a sense of safety in session for the establishment of a strong therapeutic alliance when working with families (Escudero et al., 2008; Friedlander, Escudero, & Heatherington, 2006; Kindsvatter & Lara, 2012). As well, therapists themselves have commented on how they have worked to create a sense of safety in
session (Campbell & Simmonds, 2011; Scanlon, 2006; Sullivan et al., 2005). In the current study, some participants did mention the need for the clients to feel safe and comfortable both in session and with the therapist, however, it was not highlighted to the same extent with only eight participants making comments indicating the need for safety. These results were surprising given the extensive focus on safety in the previous literature.

It is possible that if participants had been asked explicitly about the need for safety when working with couples and families, they would have commented more extensively on the ways in which they work in session to facilitate this and whether these behaviours were similar or different when working relationally compared to working with an individual client. That said, the ways Friedlander and colleagues suggested that therapists could facilitate safety in session with couples and families align with some of the behaviours reported by the therapists in the current study, such as finding common goals, enhancing the emotional connection within the family, and structuring the session intentionally to prevent blame or attacks (Friedlander, Lambert, Escudero, & Muniz de la Pena, 2008). Therefore, it is possible that the therapists in the current study were commenting on the behaviours they used in session to facilitate the alliance, they just did not articulate that these behaviours also had the effect of promoting a sense of safety in session.

Limitations

As the current study was exploratory and preliminary, there were several limitations that are important to note in the interpretation of the results. As mentioned previously in the methods section, for the first 10 participants, the summary questions (questions 11 to 14 on the open-ended questionnaire [Appendix E]) had been omitted. While I had made attempts to account for this in the analysis of the results, there is no way to know how those participants would have responded to the omitted questions. During the data analytic process, I attempted to notice the
ways in which the data were similar or different when asked explicitly in the summarizing questions versus implicitly in the case study questions. The only difference that was noted occurred under the sub-theme intentionally creating the therapeutic alliance (as discussed above). Some participants seemed to make the distinction between the therapist and client’s responsibility for the alliance when asked directly, but there did not appear to be this difference when asked indirectly, suggesting that therapists saw both their own behaviour and clients’ behaviour as contributing to the alliance. While we cannot conclude that this would have been the only difference in the answers to the summary versus case study questions if all 18 participants had been exposed to all of the questions, the results that were found did highlight some of the unique aspects of the alliance in CFT and are worthy of consideration.

In addition, the demographics of the participants reflected a limitation of the current study. There were only two participants who identified as male (and two who chose not to specify their gender) and only three participants who identified something other than White/European as their ethnicity. Also, the majority of participants indicated that they work in the CFT field (15 of 18 participants). Therefore, the findings of the current study may not be reflective of the diversity of therapists working in a Canadian context. However, participants indicated working with a diverse population of clients, reflecting various socioeconomic backgrounds, ethnicities and ages. In examining the research, there has been mixed evidence regarding whether therapist traits such as experience (Horvath & Bedi, 2002; Summers & Barber, 2003) or gender and ethnicity (Garfield, 2004; Friedlander et al., 2011a; 2011b) consistently relate to the strength of the therapeutic alliance. On the other hand, some authors suggest that client culture may have a substantial impact on the therapeutic relationship (e.g. Sprenkle et al., 2009), especially when it differs from that of the therapist (Kindsvatter & Lara,
2012), although not all authors have come to this conclusion (see Garfield, 2004; Friedlander et al., 2011a; 2011b). It is possible that while the lack of therapist diversity is a limitation, the fact that there was diversity in reported client population may be a strength of the present study.

It is possible that the data collection method also served as a limitation. I had chosen an online questionnaire as the means of data collection as it enabled participants from a wide geographic area to be involved in the study and allowed participants to complete the survey at their leisure, thereby including participants that I otherwise might not have had access to. However, as is common in online data collection, the current study experienced a lack of diversity in respondents and the response rate was low (Granello & Wheaton, 2004; Van Selm & Jankowski, 2006), meaning the data collection phase of the project took longer than anticipated at the beginning of the study. As well, while 44 participants had initiated the survey, only 18 participants completed it through to the end and submitted their answers for analysis. Finally, as it was not possible for the researcher to follow up with the participants or clarify responses, the level of detail in the answers to the questionnaire varied between participants and may have been limited.

As this was a qualitative study, it is always possible that a different researcher would have come to different conclusions based on the data collected. In order to increase the credibility and trustworthiness of the data, I engaged in frequent memo-writing throughout the data analytic process and I attempted to be consistent in how I conducted the thematic analysis and made this explicit in the write-up of the findings. To ensure I was coding consistently, I relied on a codebook with clear definitions of the themes and codes (see Appendix F) and I consulted with my advisory committee to seek their feedback on this process.
Future Research

While the current study reinforces and extends the previous findings both in the CFT literature and the qualitative research (mainly from individual psychotherapy) examining therapist perceptions on the development of the alliance, future research should focus on a more comprehensive exploration on how therapists conceptualize and understand the role of multidirected partiality and the therapeutic alliance when working relationally. For instance, it may be useful to conduct in-depth interviews with therapists who work with families, asking about the ways in which they adopt a multi-partial stance in session and how they ensure balance across family members in pursuit of the therapeutic alliance. Such research may further extend the findings of the current study and the other literature in the field in ways that were not possible in this study, given the study’s limitations.

In addition, more research is needed from a CFT perspective that addresses both the therapist and client perspectives on the therapeutic alliance and the specific behaviours both use in session to contribute to the relationship and to multidirected partiality. Such research could use a variety of measures, including therapist and client self-report, observational and quantitative measures, possibly comparing across these different measures to more fully understand the phenomenon of interest. As well, it might be interesting to explore the differences in developing the alliance and ensuring multidirected partiality when working with various family constellations (ex. couples versus families, different family groups or number of family members present in session and with specific populations, such as families with young children, children/parents with special needs or mental health concerns, adult children and their parents etc.). As Friedlander and colleagues (2011b) suggest, the therapeutic alliance is inherently a collaborative and interactive phenomenon and exploring either therapist or client
contributions to the alliance in isolation is somewhat artificial. Therefore, it might be useful to compare therapist and client perceptions of the therapeutic alliance and multidirected partiality and the ways in which each party contributes to this in session to identify areas of convergence or divergence and the ways in which this is a reciprocal process, as identified in the current study, in order to gain a more holistic understanding of the therapeutic alliance in CFT.

Conclusions

The findings of the current study suggest that therapists recognized the importance of the therapeutic alliance in CFT and were intentional in how they built and maintained the relationship, while striving to act in ways that ensured balance and multidirected partiality. The findings of the current study hold implications for therapists who work with couples and families, but particularly for novice therapists. These findings may help therapists at any stage refine their skills in developing and strengthening the alliance with families and highlights the specific behaviours one could use to do so. Given that there is no single way to develop the alliance when working relationally (Escudero et al., 2008; Sprenkle et al., 2009), how therapists go about doing this may be reflective of their individual style as a therapist. For newer therapists, these findings may draw their attention to the types of behaviours that fit with their personal style which they can use to facilitate stronger alliances in session or help identify areas that impact their alliance with families that they may not have previously been aware of or addressed in their work.

Furthermore, the findings draw one’s attention to the importance of balance and adopting a multi-partial stance when working with families. Therapists can use such findings to be more intentional in session, considering both the therapist and client influences on and contributions to the therapeutic relationship. These findings highlight the ways in which both therapist and
client behaviours interact in the formation of the alliance and the role this plays for the outcome of therapy. This could aid novice therapists in developing stronger alliances with the families they work with and encourage them to be more intentional in ensuring balance in session. In line with this, after reviewing the literature on the therapeutic alliance in psychiatry, Summers and Barber (2003) concluded that certain aspects of the therapeutic alliance could be taught and that trainee’s skills in this area can be developed. Therefore, such findings may hold implications for the training of new therapists in CFT.

Overall, the findings of the current study support and extend the previous literature that suggests that the therapeutic alliance plays a crucial role in CFT and the unique challenges and complexities of working relationally. The therapists in the current study highlighted the importance of ensuring that balance and multidirected partiality are actively created and maintained in session. These findings are noteworthy given the limited research that has examined the concept of multidirected partiality in relation to the therapeutic alliance in CFT and hold implications for therapists at all stages in their career, but particularly for therapists in training. Due to the preliminary nature of the current study and the associated limitations, future research will be needed to further understand how therapists develop and maintain the therapeutic alliance in CFT and the role multidirected partiality plays in this process.
Reference


## Appendix A

### Ethics Approval Forms

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**APPROVAL PERIOD:** September 27, 2013 to September 27, 2014  
**REB NUMBER:** 13AU006  
**TYPE OF REVIEW:** Delegated Type 1  
**RESPONSIBLE FACULTY:** Neustifter, Ruth (rneustif@uoguelph.ca)  
**DEPARTMENT:** Family Relations & Applied Nutrition  
**SPONSOR(S):** N/A  
**TITLE OF PROJECT:** Therapeutic alliance in couple and family therapy: Therapist experiences and perspectives on multidirected partiality

The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human subjects in the above-named research project and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that you adhere to the protocol as last reviewed and approved by the REB. The REB must approve any modifications before they can be implemented. If you wish to modify your research project, please complete the Change Request Form. If there is a change in your source of funding, or a previously unfunded project receives funding, you must report this as a change to the protocol.

Unexpected events and incidental findings must be reported to the REB as soon as possible with an indication of how these events affect, in the view of the Responsible Faculty, the safety of the participants, and the continuation of the protocol.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research protocols.

The Tri-council Policy Statement, 2nd Edition, requires that ongoing research be monitored by, at a minimum, a final report and, if the approval period is longer than one year, annual reports. Continued approval is contingent on timely submission of reports.

### Membership of the Research Ethics Board - General:

S. Banerjee, Community Member; J. Carson, Community Member; S. Chuang, FRAN (alt); K. Chuong, Graduate Student; J. Clark, PoliSci (alt); J. Dwyer, FRAN; M. Dwyer, Legal; B. Ferguson, CME (alt); B. Giguere, Psychology (alt); B. Gottlieb, Psychology; S. Henson, OAC (alt); S. Hickson, COA; L. Kuczynski, Chair; A. Lauzon, OAC; R. Ragan, Legal (alt); C. Rice, FRAN; V. Shalla, SOAN (alt); R. Stansfield, SOAN; S. Yi, CME.

Approved:  
per Chair, Research Ethics Board- General  
Date: September 27, 2013
RESEARCH ETHICS BOARD – General

REB-G
Certification of Ethical Acceptability of Research Involving Human Participants

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Approved:
per
Chair, Research Ethics Board- General Date: October 21, 2013
RESEARCH ETHICS BOARDS
Certification of Ethical Acceptability of Research Involving Human Participants

APPROVAL PERIOD: September 27, 2013
EXPIRY DATE: September 27, 2014
REB: G
REB NUMBER: 13AU006
TYPE OF REVIEW: Delegated Type 1
PRINCIPAL INVESTIGATOR: Neustifter, Ruth (rneustif@uoguelph.ca)
DEPARTMENT: Family Relations & Applied Nutrition
SPONSOR(S): N/A
TITLE OF PROJECT: Therapeutic alliance in couple and family therapy: Therapist experiences and perspectives on multidirected partiality


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The REB requires that researchers:
- Adhere to the protocol as last reviewed and approved by the REB.
- Receive approval from the REB for any modifications before they can be implemented.
- Report any change in the source of funding.
- Report unexpected events or incidental findings to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants, and the continuation of the protocol.
- Are responsible for ascertaining and complying with all applicable legal and regulatory requirements with respect to consent and the protection of privacy of participants in the jurisdiction of the research project.

The Principal Investigator must:
- Ensure that the ethical guidelines and approvals of facilities or institutions involved in the research are obtained and filed with the REB prior to the initiation of any research protocols.
- Submit a Status Report to the REB upon completion of the project. If the research is a multi-year project, a status report must be submitted annually prior to the expiry date. Failure to submit an annual status report will lead to your study being suspended and potentially terminated.

The approval for this protocol terminates on the EXPIRY DATE, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature: Date: January 6, 2014

L. Kuczynski
Chair, Research Ethic Board-General

Page 1 of 1
Therapeutic alliance in couple and family therapy

Hello, my name is Hanna Watkins and I am a Master of Science student in the Family Relations and Applied Nutrition department at the University of Guelph, specializing in Couple and Family Therapy. As a part of my Master’s Thesis, I am conducting a qualitative study, under the supervision of Dr. Ruth Neustifter, entitled Therapeutic alliance in couple and family therapy: Therapist experiences and perspectives on multidirected partiality.

I am interested in learning more about how helping professionals understand, conceptualize and experience the therapeutic alliance/relationship in their clinical work with couples or families as there is limited research on this topic. I would like to invite you to participate in my online questionnaire that should take approximately 15-20 minutes to complete. Participants may save their responses and come back to them at a later time and may choose not to answer any questions they do not feel comfortable answering.

Eligibility:
- Be a helping professional (i.e. marriage/couple and family therapist, social worker, counsellor, psychologist etc.)
- Work with couples and/or families
- Be willing to reflect upon your clinical work and answer some open-ended questions

This research project has been approved by the University of Guelph Research Ethics Board. If you have any questions about this project, please feel free to contact me via email at hwatkins@uoguelph.ca or my advisor, Dr. Ruth Neustifter at 519-824-4120 x 53975.

Thank you for your time and participation. If you would like to participate, please click on the link below.

http://goo.gl/ZIZ6at

Sincerely,

Hanna Watkins
MSc. Student
Department of Family Relations and Applied Nutrition - Couple and Family Therapy
University of Guelph
hwatkins@uoguelph.ca
Appendix C
Recruitment Flyer

Therapeutic Alliance in Couple and Family Therapy

Are you a helping professional who works with couples or families in a therapeutic context and interested in furthering the research in the field?

You are invited to participate in an online questionnaire that should take approximately 15-20 minutes to complete. This research project has been approved by the University of Guelph Research Ethics Board.

Eligibility:
- Be a helping professional (i.e. marriage/couple and family therapist, social worker, counsellor, psychologist etc.)
- Work with couples and/or families
- Be willing to reflect upon your clinical work and answer some open-ended questions

Thank you for your time and participation. If you would like to participate, please visit the link below or email me for more information.

http://goo.gl/ZIZ6at

Sincerely,

Hanna Watkins
MSc. Student
Department of Family Relations and Applied Nutrition - Couple and Family Therapy
University of Guelph
hwatkins@uoguelph.ca
Appendix D
Informed Consent

CONSENT TO PARTICIPATE IN RESEARCH

**Project Title:** Therapeutic alliance in couple and family therapy: Therapist experiences and perspectives on multidirected partiality.

You are asked to participate in a research study conducted by Dr. Ruth Neustifter and Hanna Watkins from the Department of Family Relations and Applied Nutrition – Couple and Family Therapy at the University of Guelph as a part of Hanna Watkins’s Master’s Thesis. If you have any questions or concerns about the research, please feel free to contact Dr. Ruth Neustifter (CFT 251, 519-824-4120 x 53975) or Hanna Watkins at hwatkins@uoguelph.ca. This research project has been approved by the University of Guelph Research Ethics Board.

**PURPOSE OF THE STUDY**

The purpose of this study is to examine helping professional’s understanding, perspectives and experiences of developing multiple therapeutic alliances in couple and family therapy.

**PROCEDURES**

If you volunteer to participate in this study, we would ask that you complete an open-ended online questionnaire that should take between 15-20 minutes to complete and is completely anonymous. You may save your responses at any time and come back to finish them later and you do not have to answer any questions you do not wish to answer.

You will first be asked to answer some demographic questions pertaining to your experience, training and general description of your client work (i.e. theoretical orientation, client composition – individuals, relational or group etc.). You will then be asked to respond to some open ended questions that invite you to reflect upon your conceptualization of the therapeutic alliance in general and more specifically from a recent session with a couple/family. At the end of the survey, you will have the option of saving your answers and submitting them, saving them for later, or discarding your answers.

**POTENTIAL RISKS AND DISCOMFORTS**

There are some psychological risks involved in participating in this study; however they should be no greater than you would experience if you were to reflect upon your clinical work outside of this study. It is important to note that for some individuals, some of the survey questions may seem personal or may elicit some discomfort when reflecting upon their clinical work. You may choose not to answer any questions that you do not feel comfortable to answer.
POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

The benefits of participating in this research may include having the opportunity to reflect upon your clinical work and how you negotiate the therapeutic alliance. This self-reflection may be used to feed back onto your work with clients so that you may be better able to form and balance relationships with the couples/families you work with in the future.

It is hoped that the results of this study will provide insight into how therapists navigate, balance and understand the therapeutic alliance in relational therapy. This can be used to further research in the field and may hold clinical implications for those working with relational systems, including for the formation of stronger alliances with couples/families or in training new therapists to work more effectively with couples/families. The results of this study will be published in peer-reviewed journals for dissemination.

PAYMENT FOR PARTICIPATION

There is no payment for participating in this study.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any indirectly identifying information (i.e., age, gender, ethnicity) that is obtained in connection with this study. There will be no collection of directly identifying information (ex. names or emails). Please do not provide any identifying information in your answers to any question in this study, including but not limited to your name, personal email or place of employment. Your answers may be quoted in the reporting of the results of this study, but your identity will never be revealed. Quotes will only be associated with the given fictional name that will be assigned to each completed survey.

All online data collected will be kept secure through survey passwords and computer encryption and only accessible to the aforementioned research team (Neustifter and Watkins). Data will be kept for no longer than three years, at which point it will be destroyed.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may do this by simply discarding your answers and not submitting them at the end of the survey. You may also refuse to answer any questions you do not want to answer and still remain in the study. However, as there is no identifying information collected (ex. a name or email), once your answers are submitted, it will not be possible for you to withdraw your data.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research.
study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Director, Research Ethics
University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236

SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I have read the information provided for the study “Therapeutic alliance in couple and family therapy: Therapist experiences and perspectives on multidirected partiality” as described herein. I have asked any questions I have, and I agree to participate in this study. If I would like a copy of this form, I understand that I may print this page for my personal records. By electronically ‘signing’ this informed consent form by clicking the “I Agree” button below, I am freely giving my consent to participate in this study.

☐ “I Agree”
(Continue with the Study)

☐ “I Disagree”
(Exits the Survey)
Appendix E
Open-Ended Questionnaire

Demographics

Please provide us with some basic information about yourself:

1. Please specify your gender.

2. Which of the following BEST describes your ethnic background? Please TICK ALL THAT APPLY.
   a. Aboriginal/First Nations/Métis
   b. White/European
   c. Black/African/Caribbean
   d. Southeast Asian (e.g., Chinese, Japanese, Korean, Vietnamese, Cambodian, Filipino etc.)
   e. Arab (Saudi Arabian, Palestinian, Iraqi, etc.)
   f. South Asian (East Indian, Sri Lankan, etc.)
   g. Latin American (Costa Rican, Guatemalan, Brazilian, Columbian, etc.)
   h. West Asian (Iranian, Afghani, etc.)
   i. Other (please specify) _____________________________

3. What are your credentials? (ex. MA, MSW, PhD. etc.)

4. What is your current profession/discipline? (Ex. nurse, MFT/CFT, social worker, psychologist, counsellor etc.)

5. How many years of clinical experience do you have?

6. Is there a model or theoretical orientation within which you primarily work? (ex. narrative, solution focused, psychoanalytic, cognitive behavioural etc.)

7. In what setting do you conduct this work?
   a. Agency
   b. Hospital/ clinic/ treatment centre
   c. Private practice
   d. Other (Please specify) _____________________________

8. How would you classify the majority of your work?
   a. Individual
   b. Relational (ex. couples, families)
   c. Group

9. Please describe the client population with whom you work (i.e. age range, ethnicity etc.).

10. How many sessions do you typically see your clients for (ex. single session case consultations, 5-10 brief therapy sessions, long-term therapy, 20+ sessions etc.)?
Open-ended Questions

Please reflect upon your experiences working with couples or families in a therapeutic context and answer the following questions. Please provide as much detail as you feel comfortable providing and use as much space as you need.

11. In general and based on your clinical experience, how would you define the therapeutic alliance?

12. What is the role and significance the therapeutic relationship plays in therapy?

13. Where does the responsibility lie in forming the therapeutic relationship/alliance: in the therapist, within the client(s), both? Is this an unintentional process or a deliberate one?

14. Which unique considerations or factors apply to developing and sustaining strong relationships/alliances when there are multiple clients in the room (such as in couple or family therapy)?

Specific Example

Please think about a specific session with a couple or family and answer the following questions with this session in mind. Think about what you were experiencing and doing and what the clients were doing. If referring to a specific client, please either use a pseudonym or simply identify them by their position in the family (ex. father, daughter, male partner, etc.) to ensure that no clients can be identified from your responses. Please provide as much detail as you feel comfortable providing and use as much space as you need.

15. Keeping this session in mind, please describe your observations of the various aspects of the therapeutic relationship. Please be as specific as possible.

16. How did you as a therapist contribute to the development, maintenance or repair of the therapeutic relationship with the couple/family members? Please explain/elaborate as necessary.

17. How did the clients respond? Please explain/elaborate as necessary.

18. In this session, how did the clients contribute to the therapeutic relationship? Please explain/elaborate as necessary.

19. How did you respond to these client contributions? Please explain/elaborate as necessary.

20. What challenges or considerations unique to working with multiple clients in the room were evident to you in this session? Please explain/elaborate as necessary.
**Last question**

21. Do you have anything else you would like to add on your experiences or understandings of the therapeutic alliance/relationship when working with couples or families that could help novice therapists? Please use as much space as you need.

**Submitting Screen**

This concludes the study. Thank you very much for your time in completing this questionnaire. If you would like to save and submit your answers, please click the “Submit” button below. If you are not quite done the survey, you may come back and finish the survey at a later date. If you no longer wish to participate in this study, please click the “Exit” button below and your answers will be discarded. As there is no identifying information collected (ex. a name or email), once your answers are submitted, it will not be possible for you to withdraw your data.

☐ Submit

☐ Exit and Clear Survey

**Closing Screen**

Thank you very much for your participation in this research study. By taking part in this study you are contributing to the literature and filling in the gap of what is known about the therapeutic alliance in couple and family therapy. It is hoped that the outcomes of this research will be relevant for professionals who work with couples or families in a therapeutic context in the formation and strengthening of alliances and in training new therapists to work with families more effectively. Your participation is extremely valuable. If you have any questions about this research, please contact Hanna Watkins at hwatkins@uoguelph.ca.

Sincerely,

Hanna Watkins
MSc. Student
Department of Family Relations and Applied Nutrition - Couple and Family Therapy
University of Guelph
hwatkins@uoguelph.ca
Appendix F  
Codebook

(#/#) = (number of codes/in how many participants)

<table>
<thead>
<tr>
<th>How Therapists Understand the Therapeutic Alliance</th>
<th>The various aspects or elements that describe or make up the alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Challenging (20/9)</strong></td>
<td>The therapist commenting on various challenges to building and sustaining the alliance; describing the alliance as challenging</td>
</tr>
<tr>
<td><strong>Complex (5/3)</strong></td>
<td>The alliance is something that is not simple, but rather complex and has lots to attend to</td>
</tr>
<tr>
<td><strong>Multiple relationships (4/3)</strong></td>
<td>The fact that there are multiple relationships in the rooms makes it complex</td>
</tr>
<tr>
<td><strong>Connecting (10/8)</strong></td>
<td>The therapeutic alliance as the connection between therapist and client</td>
</tr>
<tr>
<td><strong>Conversation (8/5)</strong></td>
<td>The mechanism through which the alliance is built, maintained and repaired, both the therapist and client contribute to and use; an indicator of the strength of the therapeutic relationship</td>
</tr>
</tbody>
</table>

- "I worked with a family in which it took a while to develop a relationship with the mother but the son had not developed a good relationship with me." - 117
- "the biggest challenge was previous negative experiences with helping professionals. - other challenges were social location (they were hesitant to work with me because I did not identify as a parent) and hostility." - 109
- "It was also challenging to still try and create a balance between those who were arguing and to allow the one that was not having much of a voice to still feel heard and able to express themselves." - 110
- "There is a lot that I have to be attentive to and many details factor into creating the alliance" - 118
- "Always remember that working relationally is more than just individual therapy with more people in the room. It's much more dynamic and dimensional." - 108
- "... it was also somewhat challenging because I think that they come in as their own alliance already, and so it can be tricky breaking through that to create a new therapeutic one with all three of us." - 112
- "There were so many relationships to attend to and that made it complicated" - 111
- "The therapeutic alliance refers to the connection that you have with your clients" - 117
- "By changing my tone, facial expressions, bodily expressions, and language use I felt that I was more "playful" in my approach to the child which I felt helped to build connection" - 104
- "They reported that the conversation felt safe. They could talk about things in the therapy room that they could not discuss at home" - 116
- "[I] also tried to build our relationship through genuine conversations - for example, taking interest in their children and other aspects of their life" - 109
<table>
<thead>
<tr>
<th>Important (11/8)</th>
<th>TH describing how important the alliance is in their work/ to the therapeutic process</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The therapeutic alliance is the most important part of my practice&quot; - 113</td>
<td></td>
</tr>
<tr>
<td>&quot;I would say it forms the core of the therapeutic work.&quot; - 112</td>
<td></td>
</tr>
<tr>
<td>&quot;huge role with major significance&quot; - 118</td>
<td></td>
</tr>
<tr>
<td>&quot;The therapeutic relationship is the most important contributor to change, regardless of the therapeutic techniques/model used&quot; - 115</td>
<td></td>
</tr>
<tr>
<td>&quot;It is the centerpiece; it is the connective tissue of our work.&quot; - 111</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safe and comfortable (14/8)</th>
<th>A key feature of the alliance and the therapeutic process; clients need to feel comfortable and safe in session and with the therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;If clients don't trust, don't feel safe with, or don't feel comfortable with their therapist, they will be less likely to be able to talk about things and experience emotions in the therapy room that are often necessary in order to make progress&quot; - 117</td>
<td></td>
</tr>
<tr>
<td>&quot;...the fact that they find me to be a &quot;safe person&quot; with whom to discuss their deepest concerns&quot; - 105</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strong (4/3)</th>
<th>Strong as a characteristic of the therapeutic relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;If relationships are not strong then little progress can be made.&quot; - 111</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Trusting (12/24)</th>
<th>Trust as an integral feature of therapeutic relationship and the therapeutic process</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;In my own experience, I would say a lot of it is based on trust, genuineness, therapists’ guiding values, and personality factors.&quot; -112</td>
<td></td>
</tr>
<tr>
<td>&quot;Couples and families are allowing the therapist into their intimate relationships, and need to be able to trust the therapist.&quot; - 114</td>
<td></td>
</tr>
<tr>
<td>&quot;I think once Mom and Dad knew they could trust me they felt more capable of working&quot; - 109</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>What Influences the Therapeutic Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>The various influences that participants identified as acting on the developing alliance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client considerations</th>
<th>The various aspects of the client’s “facts” that must be considered; the ways they facilitate or constrain the alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (4/3)</td>
<td>Accounting for the age of the client; particularly young clients</td>
</tr>
<tr>
<td>&quot;Plus the languaging needed to be appropriate to include a child and an adolescent&quot; - 111</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Culture (2/2)</th>
<th>Accounting for the role of the client’s culture in session</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Building trust with a couple from a visible minority immigrant population took time, as therapy was not something either partner had experienced, and was not seen as &quot;normal&quot; (their word) in their culture&quot; - 114</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability (5/1)</th>
<th>Accounting for the role of the client’s ability/disability in session</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;working with a client who was profoundly deaf, accommodating the presence of a third party (the translator from Canadian Hearing Services) entailed some adjustments to the process of therapy&quot; - 114</td>
<td></td>
</tr>
<tr>
<td>&quot;... by ensuring that the son had an important voice in the process, and by going at the pace that the family viewed as necessary in order to adjust to the slow process of disability services&quot; - 114</td>
<td></td>
</tr>
<tr>
<td>Gender (3/2)</td>
<td>Accounting for the role of gender in session (which genders, gender scripts etc.)</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------------------------------------</td>
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<td></td>
<td>&quot;I try to maintain an awareness of the impact of gender and other personal characteristics or similarities between myself and the clients that may impact my likelihood of being more joined with one person than the other and deliberately try to join with the client that I am less joined with when this occurs.&quot; - 117</td>
</tr>
<tr>
<td></td>
<td>&quot;but having these gender scripts that were being played into was hard to push up against or argue against&quot; - 102</td>
</tr>
<tr>
<td>Influence of broader systems (3/2)</td>
<td>Needing to consider broader influences on the family, including social location</td>
</tr>
<tr>
<td></td>
<td>&quot;Given the complexity of relational dynamics, the situation rarely seems just black and white and it’s challenging to keep all the ways the systems all impact the clients clear in one’s mind (e.g., family of origin, family of creation, couple subsystem, parent-child subsystem, work system, etc)&quot; - 108</td>
</tr>
<tr>
<td>Mandated clients (2/1)</td>
<td>Accounting for how willing the clients were in coming to session (ex. mandated)</td>
</tr>
<tr>
<td></td>
<td>&quot;When mandated to attend therapy, clients often refuse to join with the therapist in the beginning sessions. I see this as a conscious choice, made because they feel the need to protect themselves from the system.&quot; - 117</td>
</tr>
<tr>
<td>Mental Health (2/1)</td>
<td>Accounting for the ways in which mental health enter the session</td>
</tr>
<tr>
<td></td>
<td>&quot;I think there is a huge amount of stuff to pay attention to- where the client is at, culture and cultural ways of communicating, trauma, mental health factors, personality of the individual, stage of life, etc. attentiveness to self and self energy, sincerity, being grounded and caring are huge&quot; - 118</td>
</tr>
<tr>
<td>Personality (12/4)</td>
<td>Considering the personalities of the clients</td>
</tr>
<tr>
<td></td>
<td>&quot;the son had not developed a good relationship with me. The son was very disrespectful to women in general, including me.&quot; - 117</td>
</tr>
<tr>
<td></td>
<td>&quot;It's struggle with different personalities (having people who identify and extroverts and introverts) in the room and balancing each person's needs and making sure everyone has a voice&quot; - 102</td>
</tr>
<tr>
<td>Role of who attends therapy (3/2)</td>
<td>The influence of the constellation in session and its effects on the TR</td>
</tr>
<tr>
<td></td>
<td>&quot;I think that having families who have separated and coming in together is a struggle&quot; - 102</td>
</tr>
<tr>
<td>Role of physical space (2/2)</td>
<td>The ways in which the physical space of the therapy room impacts alliance</td>
</tr>
<tr>
<td></td>
<td>&quot;But I really struggled with making that connection with the dad. It could have been the way my office is set up - he was a bit excluded physically from the two females that were sitting side by side&quot; - 102</td>
</tr>
</tbody>
</table>
### Role of power (4/2)

The ways in which the role of power in session impacts alliance

- "They were also not going to allow the power imbalance of the therapist and client in a session room quiet their concerns, and expressed right away that they were different and held worries about the implications of their differences." - 101
- "When I can effectively use my "power" in this manner couples and families generally begin to use their power for the good of the whole rather than the protection of self-interest." - 105

### Role of therapist (8/6)

The ways in which the therapist's self influences the relationship

- "It is important that the therapist recognize the part that they play in this relationship and the ways in which they may be hampering its development." - 117

### Therapist - client fit (5/5)

The ways in which the fit between the therapist and client influence the development of the alliance, including how much the therapist likes a client

- "Be alert to one’s emotional response (positive/affiliative or negative) toward clients when there are multiple clients in the room." - 115
- "I also tell clients, in the first session of on-going therapy, that the fit with the therapist is very important. I offer them the option of requesting a different therapist if they do not think I am someone they can work with." - 116

### Creating and Maintaining the Alliance

The ways that the therapeutic alliance is created and maintained in session

#### Building (11/6)

The therapist describing the alliance as something that is built/created

- "The responsibility of building and maintaining the therapeutic relationship lies largely with the therapist." - 112
- "[I] tried to build our relationship through genuine conversations" - 109

#### Positive outcome (15/10)

Positive outcomes of an attempt to build the therapeutic alliance

- "I believe that each felt affirmed by me, and that my intervention created receptivity to their noticing change in the other" - 115
- "Clients were responsive, as time went on they were much happier about working together." - 109
- "Our relationship became much better after this point." - 117

#### Developing over time (11/8)

Describing how the alliance took time to develop and to strengthen

- "we had been working with them for about six sessions so had a fairly solid therapeutic relationships with them" - 110
- "Clients were responsive, as time went on they were much happier about working together." - 109

#### From the beginning (4/3)

Describes how the relationship begins almost immediately at the beginning of working together

- "I hate to say that first impressions are always accurate but I think that beginning to build a positive relationship from the beginning is important to creating trust between all parties involved" - 110
|| "I seek to build that therapeutic alliance at the beginning" - 114  
|| "I believe a therapeutic relationship is very quickly formed - I do not believe that it takes several session to form the alliance." - 116  
| Intentionally creating the alliance | The development of the alliance is an intentional process, it is not created accidentally or spontaneously  
| Whose responsibility? | When asked explicitly, who's responsibility is it to create the alliance?  
| Joint process (8/4) | The process of creating and sustaining the alliance is a joint process by the client and therapist  
| Responsibility of the therapist (5/4) | A large responsibility of the relationship is on the therapist  
| "It is a deliberate process - this is a 'one sided' relationship focused on the client" - 116  
| "The responsibility of building and maintaining the therapeutic relationship lies largely with the therapist." - 112  
| Who contributes? | Who actually contributes to the therapeutic alliance?  
| Client actively contributing (6/3) | The ways the client was active or intentional in building (or not) the alliance; not coded under other behaviours that impact alliance  
| "When mandated to attend therapy, clients often refuse to join with the therapist in the beginning sessions. I see this as a conscious choice, made because they feel the need to protect themselves from the system." - 117  
| Therapist as actively/intentionally building relationship (22/10) | Ways the therapist was active or intentional in building relationship; a deliberate process; not coded under other behaviours that impact alliance  
| "I think each individual has different needs and goals, and we have a responsibility to accommodate and negotiate in a therapeutic relationship based on the client's best interests." - 109  
| Reciprocal nature of the alliance (1/1) | The ways in which the therapist and client respond to one another's statements/actions and each other's attempts to build the alliance  
| "This is a reciprocal process - I respond to the client's responses" - 116
<table>
<thead>
<tr>
<th><strong>Client appreciative of therapist's actions (9/5)</strong></th>
<th>Clients expressing appreciation over something the therapist said or did</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The female of the couple stated that she was glad that I brought that up, and she visibly became more animated as she talked about this&quot; - 101</td>
<td></td>
</tr>
<tr>
<td>&quot;The clients stated that they appreciated my self-disclosure and they seemed to be more open to discussing their own experiences&quot; - 112</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Client responsive to therapist (10/9)</strong></th>
<th>The clients responding to something the therapist did or said</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Clients were responsive, as time went on they were much happier about working together.&quot; - 109</td>
<td></td>
</tr>
<tr>
<td>&quot;I was monitoring their reactions to me, and what they would give me(in terms of information and the nature of it)&quot; - 101</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Therapist responsive to client's actions (6/6)</strong></th>
<th>The therapist’s response to the client’s actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I respond to these situations by telling clients that I would like the sessions to be as helpful as possible, even though they don’t necessarily want to be there. I ask them what I can do for them to make their time most helpful and try to incorporate this into therapy.&quot; - 117</td>
<td></td>
</tr>
<tr>
<td>&quot;I responded with respectful listening but also quite directive in helping them to plummet every detail of their pain&quot; - 107</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Requires attention/maintenance (13/7)</strong></th>
<th>The therapeutic relationship is something that requires the therapist to be aware of and pay attention to throughout the process of therapy; requires maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The therapist should be alert to indications that the alliance is viable or not&quot; - 115</td>
<td></td>
</tr>
<tr>
<td>&quot;It requires constant vigilance, is deliberate, and ongoing throughout the time of working together.&quot; - 111</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Rupture and repair (12/5)</strong></th>
<th>A noticeable break in the relationship and the repair that occurs after</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I have worked hard to repair the fracture in my relationship with the parents&quot; - 106</td>
<td></td>
</tr>
<tr>
<td>&quot;A client who was required to go to therapist called me names and explicitly stated that she did not want to come to therapy. I asked her to tell me what I had done that was so upsetting to her so I would know to not do it again in the future.&quot; - 117</td>
<td></td>
</tr>
<tr>
<td>&quot;I am acutely aware of the tenuous-ness of our relationship at all junctures, and find myself feeling more ineffective and self-doubting than I typically am. [...] Just when I think the damage in our relationship feels more &quot;repaired&quot;, I'll notice something that leads me to believe that it has been fractured again&quot; - 106</td>
<td></td>
</tr>
</tbody>
</table>
### Sequence

<table>
<thead>
<tr>
<th>The sequence: Relationship &gt; Trust &gt; Work &gt; Outcome/Success; Repair (as needed), use of the alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship and trust for repair (1/1)</strong></td>
</tr>
<tr>
<td><strong>&quot;I hate to say that first impressions are always accurate but I think that beginning to build a positive relationship from the beginning is important to creating trust between all parties involved, which can be important both for creativity and repair&quot;</strong> - 110</td>
</tr>
<tr>
<td><strong>Relationship before trust (3/2)</strong></td>
</tr>
<tr>
<td><strong>&quot;In order to gain their trust I put a lot of time and work into the relationship&quot;</strong> - 109</td>
</tr>
<tr>
<td><strong>Relationship before work (4/4)</strong></td>
</tr>
</tbody>
</table>
| **"If a client relates to me, then therapy proceeds well."
**"If relationships are not strong then little progress can be made."** - 113 - 111 |
| **Alliance promotes effectiveness (5/3)** | A strong therapeutic relationship promotes effectiveness in therapy |
| **"a significant factor in the effectiveness of therapy"** - 112 |
| **"The therapeutic relationship largely determines how successful therapeutic outcomes will be"** - 117 |
| **Trust before work (4/4)** | Trust is needed before work can begin |
| **"I think once Mom and Dad knew they could trust me they felt more capable of working"** - 109 |
| **"Creating an environment of trust is essential for genuine insight, change and movement to occur."** - 114 |
| **Use of the alliance (6/4)** | The therapist intentionally using the alliance in order to move forward in therapy or promote growth |
| **"As we talked, I drew upon both the trust we have built..."** - 105 |
| **"I was intentional during the session about drawing in his parents perspective and sometimes ever using my alliance with the son to challenge him in ways his parents seemed to be uncomfortable doing."** - 103 |
| **Intentional siding (3/2)** | Intentionally siding with one member over another to promote movement in therapy |
| **"As I told the clients, when working with a couple or family, there will inevitably be times where each may feel challenged specifically while the other seems momentarily off the hook"** - 108 |
| **"however, there may be times that it is important to be more aligned with one member of the family than the other for certain therapeutic purposes."** - 117 |
# How Therapists Contribute to the Alliance

The specific behaviors therapists used in session that contributed to the alliance

<table>
<thead>
<tr>
<th>Addressing client concerns (8/5)</th>
<th>Therapist responding to clients expressed concerns in session</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I verbally validated client concerns, offered in my own words what that might be like for them so that I could give my understanding genuinely and be open to their correcting my assumptions.&quot; - 101</td>
<td></td>
</tr>
<tr>
<td>&quot;One nearly bolted (left) a few times. We were able to note, ask about the feeling, address it and have open comfortable discussion about it.&quot; - 118</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Being attentive/attuned (17/9)</th>
<th>Being attentive and attuned to the clients in session; expressing interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Expressed interest in child's favourite video game which I felt helped the child to feel more relaxed and comfortable with me&quot; - 104</td>
<td></td>
</tr>
<tr>
<td>&quot;Attentiveness to everyone, noticing each family member, giving space and time to each and attending to the different ways of joining and communication.&quot; - 118</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Listening (5/3)</th>
<th>The therapist actively listening to all clients; conveying the importance of listening to the alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I try to convey warmth and non-judgmental listening and I try to instill hope as we move along&quot; - 108</td>
<td></td>
</tr>
<tr>
<td>&quot;I had to listen very closely to what they were saying and making sure that I was understanding the meanings they wanted to convey&quot; - 111</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Understanding (3/3)</th>
<th>Trying to understand the clients; being understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I show empathy, understanding and the ability to develop quick rapport&quot; - 107</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maintaining awareness of self (15/6)</th>
<th>Being aware of what’s going on for them in session, including how the clients were impacting them, their feelings in particular moments in session and their intentions/goals in certain behaviors or techniques they used in session.</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I was aware of feeling like at least one of them was interested in drawing me into the role of &quot;mediator&quot; of their dispute&quot; - 105</td>
<td></td>
</tr>
<tr>
<td>&quot;It feels stressful and I find myself apologizing despite the fact that I know (intellectually) that I have done nothing &quot;wrong&quot;&quot; - 106</td>
<td></td>
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<tr>
<td>&quot;I felt highly sensitive and my senses were heightened. I think I was picking up on their apprehension and their anxiousness.&quot; - 101</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Using body language (4/4)</th>
<th>How the therapist uses their body language in session to promote the alliance, including eye contact, facial expressions and tone of voice</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;During this session, at times when one partner was speaking more than the other and I did not think it was appropriate to interrupt, I would make more eye contact with the other partner while still acknowledging what the other partner was saying, and then give the partner who was not speaking time to respond&quot; - 112</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaboratively working with clients (6/4)</th>
<th>The therapist working collaborative with clients in therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;In general we collaboratively agreed that &quot;cooperation&quot; was the main goal for the family.&quot; - 114</td>
<td></td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
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</tr>
<tr>
<td><strong>Being direct (7/6)</strong></td>
<td><em>Being direct with clients</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;but in the end allowed us, as training therapists, to practice how to gently but directly discuss concerns with clients while not making them feel as though they are to blame&quot;</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;If they [the therapist] push too hard, this may hurt the relationship between the therapist and the client.&quot;</em></td>
</tr>
<tr>
<td><strong>Expressing empathy (6/4)</strong></td>
<td><em>Expressing empathy, concern or compassion in session to facilitate the alliance</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;To express empathy/concern for each person’s experience&quot;</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;I show empathy, understanding and the ability to develop quick rapport&quot;</em></td>
</tr>
<tr>
<td><strong>Engaging clients (9/4)</strong></td>
<td><em>The ways the therapist engages clients in session</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;The therapist is primarily responsible for engaging the client(s) and maintaining/tending to the client relationship&quot;</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;In addition to this, I would add that my willingness to “enter into the client story” and “engage them in a conversation about what they are talking about” contributes to them experiencing the therapeutic relationship as a safe relationship&quot;</em></td>
</tr>
<tr>
<td><strong>Expressing care (4/4)</strong></td>
<td><em>Expressing caring in session</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;I think that showing clients that you genuinely care for them and being yourself in therapy can help the therapeutic alliance.&quot;</em></td>
</tr>
<tr>
<td><strong>Facilitating couple/family relationship (11/3)</strong></td>
<td><em>Working to promote the family’s relationships</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;Each seems to know that I want to help them repair their marriage&quot;</em></td>
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<td></td>
<td><em>&quot;My rationale, which I explained to them, was that I see my role as a relational therapist not to take sides or to “change the other person” but rather to help them to find ways to “heal the space between them (i.e., the couple relationship)”&quot;</em></td>
</tr>
<tr>
<td><strong>Facilitating therapeutic process (11/7)</strong></td>
<td><em>Examples of the therapist actively facilitating the therapeutic process/managing/guiding the session; doesn’t include other therapist actions or collaboratively working with clients</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;Attentiveness to the couple dynamics being played out in the room; managing them.&quot;</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;I think it is easier and more helpful to interrupt and help facilitate balance between couples and families when you are transparent about your intentions from the beginning&quot;</em></td>
</tr>
<tr>
<td><strong>Focusing on strengths (5/2)</strong></td>
<td><em>Looking beyond problem to the family’s strengths, resources, abilities, interests etc.</em></td>
</tr>
<tr>
<td></td>
<td><em>&quot;Mother seemed to relax more with the playful approach and strength-based approach&quot;</em></td>
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<tr>
<td></td>
<td><em>&quot;My own emphasis over the years has been to encourage the strengths and resources of each client/couple/family to become all that they desire to be&quot;</em></td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
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</tr>
<tr>
<td>Joining (15/9)</td>
<td>The importance of joining/building rapport/ a personal relationship with clients to build the alliance</td>
</tr>
<tr>
<td></td>
<td>&quot;I also think that getting to know the person (in a sense) can be helpful at the beginning of the therapeutic relationship so that they can see &quot;real&quot; aspect of you if you have something that you can chat about that isn't exactly part of their concerns (i.e. seeing the same movie recently, or whatever).&quot; - 110</td>
</tr>
<tr>
<td>Humour/laughter (3/3)</td>
<td>Using humour in session to promote joining</td>
</tr>
<tr>
<td>Meeting clients where they are (8/4)</td>
<td>Therapist working in accordance to where the client is, not being too far ahead</td>
</tr>
<tr>
<td></td>
<td>&quot;In these situations, the therapist must back off in order to give the client space to change when they are ready&quot; - 117</td>
</tr>
<tr>
<td>Changing behaviour to fit clients (6/4)</td>
<td>The therapist changing their behaviours or ways of interacting to best suit the clients and to enhance the relationship</td>
</tr>
<tr>
<td>Pacing (4/2)</td>
<td>Going at an appropriate pace given where the clients are at</td>
</tr>
<tr>
<td></td>
<td>&quot;Mainly by structuring the sessions the way I did; by ensuring that the son had an important voice in the process, and by going at the pace that the family viewed as necessary in order to adjust to the slow process of disability services.&quot; - 114</td>
</tr>
<tr>
<td>Being open/honest (6/4)</td>
<td>Being open and honest in session</td>
</tr>
<tr>
<td></td>
<td>&quot;Being open, honest, noting and addressing what I was noticing&quot; - 118</td>
</tr>
<tr>
<td>Adopting a relational perspective (11/8)</td>
<td>Adopting a relational focus; considering the relationship and interactions among members; more than just the individuals in session</td>
</tr>
<tr>
<td></td>
<td>&quot;place the emphasis for change on the patterns that happen between people in the relationship&quot; - 116</td>
</tr>
<tr>
<td>Being tentative (2/2)</td>
<td>Being tentative, not too direct</td>
</tr>
<tr>
<td>Therapist use of self</td>
<td>How the therapist uses themselves in session</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Being genuine (6/6)</strong></td>
<td>Being their genuine and authentic self in session</td>
</tr>
<tr>
<td>&quot;I think that showing clients that you genuinely care for them and being yourself in therapy can help the therapeutic alliance.&quot; - 117</td>
<td></td>
</tr>
<tr>
<td><strong>Using intuition (2/2)</strong></td>
<td>Relying on their intuition in session</td>
</tr>
<tr>
<td>&quot;[It] was comforting to know that we listened to our instincts on not shifting the interaction right away&quot; - 110</td>
<td></td>
</tr>
<tr>
<td>&quot;I was also intuitively going with the indescribable signals and taking chances myself, for example, with self-disclosure&quot; - 101</td>
<td></td>
</tr>
<tr>
<td><strong>Offering help/support (5/5)</strong></td>
<td>Offering one’s help/support as a therapist</td>
</tr>
<tr>
<td>&quot;The client has confidence in my ability to support them and to assist them in explore concerns and finding workable solutions.&quot; - 116</td>
<td></td>
</tr>
<tr>
<td>&quot;I helped them in a time of need (when they got bed bugs, I spent an entire evening helping them facilitate relief for their children and new mattresses from O/W)&quot; - 109</td>
<td></td>
</tr>
<tr>
<td><strong>Self-disclosing (10/3)</strong></td>
<td>Self-disclosure as a means to promote the therapeutic relationship</td>
</tr>
<tr>
<td>&quot;I then started to use things like self-disclosure and changing my tactics so they weren’t as direct&quot; - 102</td>
<td></td>
</tr>
<tr>
<td>&quot;I have also used self-disclosure as a way to strengthen the therapeutic relationship in with this same couple&quot; - 112</td>
<td></td>
</tr>
<tr>
<td><strong>Using therapist expertise (8/5)</strong></td>
<td>Using their knowledge, resources or expertise to help clients and facilitate the alliance</td>
</tr>
<tr>
<td>&quot;The therapist must not just be passive but must also be willing to gently but firmly confront when necessary, show direction and make suggestions out of his or her knowledge and experience.&quot; - 107</td>
<td></td>
</tr>
<tr>
<td>&quot;... clarifying that I am not so much an &quot;expert&quot; as a facilitator who may have some insights or resources (eg; articles/books;handouts I have created over time) which could be of help&quot; - 114</td>
<td></td>
</tr>
<tr>
<td><strong>Using therapist voice (8/4)</strong></td>
<td>The TH using their voice in session, including to voice concerns</td>
</tr>
<tr>
<td>&quot;My cotherapist and I each felt as though we could let the arguing go on for a while (as it is sometimes necessary) but were cogniscent of the fact that the youngest daughter may be at risk with what she was hearing. We were able to voice these concerns, despite feeling intimidated [...]&quot; - 110</td>
<td></td>
</tr>
<tr>
<td>&quot;Listening and using our voices are both important.&quot; - 111</td>
<td></td>
</tr>
<tr>
<td>&quot;I also maintained my voice by asking clarifying questions and asking about possible misunderstandings about our progress.&quot; - 111</td>
<td></td>
</tr>
<tr>
<td><strong>Being transparent (12/7)</strong></td>
<td>Being transparent with the clients about their approach to therapy</td>
</tr>
<tr>
<td>&quot;[I] offer the clients opportunity if they so desire to ask me about my work, experience, and perspective. I also describe to them how I work, that I see myself as working alongside them in their healing process&quot; - 114</td>
<td></td>
</tr>
<tr>
<td><strong>Using goals (10/5)</strong></td>
<td>Working with the family to find common goals; using goals a way to join with the family and facilitate TR</td>
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<tr>
<td>&quot;Focusing the therapy conversation on the mutually agreed upon goals of the session&quot; - 116</td>
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<tr>
<td>&quot;I find it is most useful if I focus on a common goal shared by the family members when I summarize their perspectives, rather than getting caught up on the details of their disagreement&quot; - 103</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Using language (4/3)</strong></th>
<th>The way the therapist is intentional in how they use language to join with clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;It is very important to use language in such a way as to convey that you do not adopt one person's perspective as fact, but affirm their perspective AS a perspective.&quot; - 105</td>
<td></td>
</tr>
<tr>
<td>&quot;Felt myself changing my tone to be more expressive, changing my facial expressions to be more expressive and animated, changing my word choice to me more appropriate to the age of the child (simpler sentences, &quot;cool&quot;)&quot; - 104</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Using questions (8/5)</strong></th>
<th>How the therapist uses question in session to facilitate the alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I also observed that the type and order of questions and follow up questions I asked provoked trust and openness.&quot; - 101</td>
<td></td>
</tr>
<tr>
<td>&quot;...and it is not just based on social talk. Every interaction in therapy is about developing that alliance; every question must be in the service of helping the therapeutic system progress&quot; - 111</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Validating (13/8)</strong></th>
<th>Validating the client and their experiences, emotions, perspectives etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I put those questions aside and asked him about his life, his history of abuse, and his wishes for his life, and to his answers I was able to validate his emotions and to show him that his context mattered&quot; - 101</td>
<td></td>
</tr>
<tr>
<td>&quot;I want to validate each perspective without taking sides&quot; - 103</td>
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</tbody>
</table>

### Therapist Perceptions of Clients' Behaviours Contributing to the Alliance

The therapist noting client behaviours in session that possibly contributed to or impacted the therapeutic relationship or was reflective of the strength of the alliance

<table>
<thead>
<tr>
<th><strong>Using body language (9/3)</strong></th>
<th>Client’s body language in session</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;physically they presented as hostile - sitting far away from me, arms crossed, swearing, typically louder voices.&quot; - 109</td>
<td></td>
</tr>
<tr>
<td>&quot;I was paying attention to their body language, the communication signals between both of the individuals in the couple&quot; - 101</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Engaged and contributing (21/11)</strong></th>
<th>Clients are engaged with the therapist and the therapeutic process</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;They contributed by being honest about their reactions, responding thoughtfully to questions.&quot; - 116</td>
<td></td>
</tr>
<tr>
<td>&quot;Mother attentively watched and seemed pleased with my engagement with the child&quot; - 101</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Expressing concerns (5/3)</strong></th>
<th>Clients expressing any concerns over therapy or potential blocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;She stated that she was hesitant to come in as she was fearful that she had done something wrong&quot; - 110</td>
<td></td>
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<tr>
<td>Being guarded/defensive (7/6)</td>
<td>Clients being guarded and not disclosing information as a means of protecting self</td>
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</tr>
<tr>
<td>&quot;Mom and Dad were very hostile to begin with, did not want to work with me and were hesitant to share information&quot;</td>
<td>109</td>
</tr>
<tr>
<td>&quot;It is my perception that the parents are much more guarded when describing their parenting than in the past&quot;</td>
<td>106</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Listening (3/3)</th>
<th>Clients listening in session to the therapist and each other</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The clients listened to me when I had contributions and offered their disagreements and feedback&quot;</td>
<td>103</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maintaining couple/family relationship (8/6)</th>
<th>The ways in which clients maintain/value their relationships with one another; positive interactions serving to strengthen their relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;As he reflected on his life his wife observed him crying and affirmed both his value and inquired if &quot;a brick had been dislodged&quot;. She also reached out to touch and reassure him&quot;</td>
<td>105</td>
</tr>
<tr>
<td>&quot;They consequently became more vulnerable to each other and open and thus experiencing compassion towards each other&quot;</td>
<td>107</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Being open/ honest (26/14)</th>
<th>Clients being open and honest in session, vulnerable</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The clients became open, vulnerable and willing to share deeply about their past respective pain and childhood trauma.&quot;</td>
<td>107</td>
</tr>
<tr>
<td>&quot;But when the process of therapy was understood, they became more comfortable with me, and with opening up about their lives, and we have established a strong relationship&quot;</td>
<td>114</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taking risks (4/3)</th>
<th>Clients taking risks in session</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The clients contributed to a therapeutic relationship by taking chances as well. They let themselves out, little by little&quot;</td>
<td>101</td>
</tr>
<tr>
<td>&quot;Clients contributed to the therapeutic relationship but taking risks to share difficult/painful details of their lives.&quot;</td>
<td>106</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Testing relationship (2/2)</th>
<th>Clients using the alliance and testing its boundaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I think they were testing the therapeutic relationship in a sense...I don't want to say taking advantage of it, but perhaps expected that because we were encouraging and understanding, that we would not be able to voice that this was inappropriate&quot;</td>
<td>110</td>
</tr>
</tbody>
</table>

### Ensuring Balance and Multidirected Partiality

Balance and multidirected partiality both as important aspects of the therapeutic alliance and also something that therapists work intentionally towards ensuring in session

<table>
<thead>
<tr>
<th>Balance (40/15)</th>
<th>The ways in which the therapist ensures balance, fairness, or equitability in session and across family members; balance as an aspect of the therapeutic alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Balancing time between clients, helping to facilitate more equitable communication (for example, interrupting clients when they are speaking more than the other clients)&quot;</td>
<td>112</td>
</tr>
<tr>
<td>Enacting multidirected partiality</td>
<td>&quot;Balancing perspectives when their are disagreements between family members&quot; - 103</td>
</tr>
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<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>&quot;The therapist needs to consider the extent to which they are aligned with all members in the therapy room. It is important to balance this alliance&quot; - 117</td>
</tr>
<tr>
<td>Term (4/4)</td>
<td>Uses term directly</td>
</tr>
<tr>
<td></td>
<td>&quot;Multipartiality is a must--no side taking with a family&quot; - 111</td>
</tr>
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<td></td>
<td>&quot;I found myself working hard to ensure multipartiality was evident at all times&quot; - 106</td>
</tr>
<tr>
<td>Avoiding blame/ judgement (5/4)</td>
<td>The therapist ensuring that they don’t fall into blaming one member for the ‘problem’ and ensuring clients don’t feel blamed by the therapist</td>
</tr>
<tr>
<td></td>
<td>&quot;Each seems to know that I want to help them repair their marriage and I am not trying to undermine either f them, pick on anyone and I'm not judging them&quot; - 108</td>
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<tr>
<td></td>
<td>&quot;I made it a point to side step their process of blame and counter-blame and engaged them in a process of dyadic (circular) questioning which invited them to think of the other and the other's perspective&quot; - 105</td>
</tr>
<tr>
<td>Avoiding taking sides (12/8)</td>
<td>The therapist not taking sides of any member over any other member</td>
</tr>
<tr>
<td></td>
<td>&quot;did not permit myself to become aligned with one partner against the other&quot; - 105</td>
</tr>
<tr>
<td></td>
<td>&quot;The importance of attending to each person’s point of view, to not take sides over the course of therapy&quot; - 116</td>
</tr>
<tr>
<td>Ensuring all voices are heard (29/9)</td>
<td>The therapist actively working to hear from all members in the family, including making the space for this to happen; balance</td>
</tr>
<tr>
<td></td>
<td>&quot;It is important to attempt to call upon family members to speak as equally as possible&quot; - 115</td>
</tr>
<tr>
<td></td>
<td>&quot;For each person to have a &quot;voice&quot; and feel that they are being heard&quot; - 114</td>
</tr>
<tr>
<td></td>
<td>&quot;Throughout the session, I checked in with each member of the family to ensure that they felt their perspective was being heard and understood. When I heard very little from the father during the session, I made a point to ask him directly if there was anything he would like to contribute.&quot; - 103</td>
</tr>
<tr>
<td>Multiple perspectives (17/9)</td>
<td>Recognizing and working with the multiple perspectives in the room</td>
</tr>
<tr>
<td></td>
<td>&quot;I affirmed each person's perspective, atte+C39mpted to give each about equal air time.&quot; - 115</td>
</tr>
<tr>
<td></td>
<td>&quot;Throughout the session, I checked in with each member of the family to ensure that they felt their perspective was being heard and understood.&quot; - 103</td>
</tr>
<tr>
<td></td>
<td>&quot;I started with the youngest and both teens opened up about the problems in the family. Mom and Dad were asked for their perspective on what their children had said, and this opened up a very wonderful dialogue.&quot; - 114</td>
</tr>
</tbody>
</table>

(#/#) = (number of codes/in how many participants)
Appendix G
Thematic Map

Therapeutic Alliance

How therapists understand the alliance

Creating and maintaining the alliance

What influences the therapeutic alliance

Ensuring balance and multidirected partiality

How therapists contribute to the alliance

Therapist perceptions of clients’ behaviours
# Appendix H
## Main Themes

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Definition</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>How therapists understand the alliance</td>
<td>The various aspects or elements that describe or make up the alliance</td>
<td>Challenging; Connecting; Conversation; Important; Safe and comfortable; Strong; Trusting; Balance</td>
</tr>
<tr>
<td>Influences on the development of the alliance</td>
<td>The various influences that participants identified as acting on the developing alliance</td>
<td>Client considerations; Role of physical space; Role of power; Therapist-client fit; Therapist considerations</td>
</tr>
<tr>
<td>Creating and maintaining the therapeutic alliance</td>
<td>The ways that the therapeutic alliance created and maintained in session</td>
<td>Building; Developing over time; From the beginning; Intentionally creating the therapeutic alliance; Requires attention and maintenance; Rupture and repair; Sequence</td>
</tr>
<tr>
<td>How therapist contribute to the therapeutic alliance</td>
<td>The specific behaviours therapists used in session that contributed to the alliance</td>
<td>Addressing client concerns; Being attentive and attuned; Maintaining awareness of self; Balance; Using body language; Collaboratively working with clients; Being direct; Expressing empathy; Engaging clients; Expressing care; Facilitating family relationship; Facilitating the therapeutic process; Focusing on strengths; Joining; Meeting clients where they are; Multi-partiality; Being open/honest; Adopting a relational perspective; Being tentative; Therapist use of self; Using language; Using questions; Using goals; Validating</td>
</tr>
<tr>
<td>Therapist perceptions of clients’ behaviours contributing to the alliance</td>
<td>The therapist noting client behaviours in session that possibly contributed to or impacted the therapeutic relationship or was reflective of the strength of the alliance</td>
<td>Using body language; Engaged/contributing; Expressing concerns; being guarded/defensive; Listening; Maintaining family relationship; Being open/honest; Taking risks; Testing the therapeutic relationship</td>
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</tr>
<tr>
<td>Ensuring balance and multidirected partiality</td>
<td>Balance and multidirected partiality both as important aspects of the therapeutic alliance and also something that therapists work intentionally towards ensuring in session</td>
<td>Balance; Enacting multidirected partiality</td>
</tr>
</tbody>
</table>