Therapeutic Alliance
A View Constructed by a Family Therapy Team

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Therapeutic Alliance is a construct which may have value for a family therapy team and influence its day to day practice. This paper discusses whether family therapeutic alliance can be observed, described and measured, and gives an account of the development of the Family Therapeutic Alliance Scale (FTAS) by a brief strategic family therapy team. Our focus is on the use of statistical technique as a means of clarifying the team’s construct of therapeutic alliance, informing the team process without being the final arbiter in development of the scale. The second stage outlines the investigation of the usefulness of the construct with a wider group of family therapists. In individual psychotherapies measures of therapeutic alliance have been shown to predict outcome. Our early work suggests this is also true for family therapies and the FTAS may be a predictor for outcome in family work.

INTRODUCTION
In the family therapy literature over the last few years there has been a resurgence of interest in the therapeutic relationship with papers examining therapeutic alliance in family and marital therapy (Pinsof and Catherall, 1986), the role of the therapist (Hayes, 1990), the use of self by the therapist (Haber, 1990), perceptions of the therapist by the family (Bennun, 1989), and emotional aspects of the Therapist-Family System (Smith et al., 1990; Flaskas, 1989). These authors have begun to rediscover the language and concepts of individual therapy to describe emotional aspects of their experience when working with client families.

There have been many attempts to define therapeutic alliance (‘The Treatment Alliance’, Sandler et al., 1970; ‘The Working Alliance’, Greenson, 1967). Foreman and Marmar (1985) described Therapeutic Alliance as “the observable ability of the therapist and patient to work together in a realistic collaborative relationship based on mutual respect, liking, trust, and commitment to the work of treatment” (page 922). Pinsof and Catherall (1986), family therapy researchers, expanded the concept to “that aspect of the relationship between the therapist system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy” (page 139). They drew on Bordin’s (1979) proposition “that the working alliance between the person who seeks change and the one who offers to be the change agent is one of the keys, if not the key, to the change process” (page 252). He described the working alliance as consisting of “an agreement on goals, an assignment of tasks or a series of tasks, and the development of bonds” (page 253). More behavioural therapies focus on goals and the setting of specific tasks to reach these, whereas therapies derived from psychoanalytic thinking focus more on the development of the relationship in which tasks and goals emerge.

Historically, family therapies appear to have drawn on the full range of these attributes with different schools placing different emphasis on goals, tasks or bonds. However, as family therapists we are perhaps more familiar with the development of tasks toward mutually agreed upon goals; these two elements are understood to have a logical and necessary relationship, and there is a simplifying clarity about them which sidesteps the intricacies and complexities of the family system. Such simplification has been particularly important during the 70s and 80s, with the search being for the most efficient and effective ways of doing family therapy.

It seems that the therapeutic relationship has remained implicit or has not been seen as necessary for change. It might be thought, then, that the relationship between the therapist and the family is of less importance. Two examples suggest that this is not so. First, the engagement or joining process has been acknowledged as important, because there are times when the relationship between therapist and family is so fragile and tenuous that therapy is terminated prematurely. On the other hand, there are occasions when the therapist is so inducted into the family system that they become relatively (and usually temporarily) ineffective as far as change is concerned (Nichols, 1987). Until recently little has been written about the ways in which emotional bonds between therapist and family may interact with, or even underpin, the formulation of tasks and their completion toward reaching goals.

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For individual therapy the importance of therapeutic alliance is its reported ability to predict outcome and dropout rate. Research suggests that the level of alliance or collaboration at the start of therapy predicts outcome (Ryan and Cicchetti, 1985; Morgan et al., 1982). Luborsky et al., in early work (Morgan et al., 1982; Luborsky et al., 1983), found a high correlation between positive patient statements and rated benefits, as well as change in the first target complaints. Later, in a carefully designed study of three methods of therapy within a drug control program, Luborsky came to the conclusion that the therapist’s personal qualities correlated highly with the Helping Alliance measure which in turn correlated with outcome (Luborsky et al., 1985). They stated: “the therapist’s ability to form an alliance is possibly the most crucial determinant of (their) effectiveness” (page 610). Marziali (1984), in exploring three systems of measuring patient and therapist contributions, confirms these relationships: “Within each measurement system, patients’ and therapists’ positive contributions to the relationship were the best predictors of outcome” (page 417).

Grunebaum (1988), in his examination of the Handbook of Psychotherapy and Behaviour Change (Garfield and Bergin, 1986), came to the conclusion that “what matters most is what the therapeutic bond between the couple or family and the therapist is like” (page 197). Better outcomes were achieved by therapists who engaged clients, were more credible, were viewed as warm and empathic and accepting, and he suggested that these findings from individual therapy may be applicable to family therapy. Some confirmation of this comes from an Australian study. Firestone and O’Connell (1980) reported therapists’ belief that they had a good relationship with the family as differentiating ‘Terminating Families’ from those that continued. They used therapist self report with items such as ‘feeling contempt’, ‘liking the family’, ‘having trust’.

Other researchers have sought to develop general family report scales (Pinsof and Catherall, 1986) and they have been used in studies which have shown some correlation with outcome (Bennun, 1989).

No adequate scale exists for rating therapeutic alliance by a family therapy team. However, team members are well placed to observe the formation of bonds and development of tasks in the client therapist relationship. During the life of a team, therapists become sensitized to both verbal and nonverbal interactions occurring on the other side of the screen, make judgements about the quality of the processes and advise the therapist about how to influence the change process toward agreed upon goals.

The Family Therapeutic Alliance Scale developed out of one team’s attempts to improve outcome in family therapy. If what is said to be true for individual therapy is also true for family therapy, and therapeutic alliance does predict outcome, then a number of questions need to be asked. How does therapeutic alliance in family work develop? Can therapeutic alliance be improved in an active way? Does working in a team promote or discourage therapeutic alliance? Three crucial questions come first, however. Can therapist-family (or for that matter therapy team-family) therapeutic alliance be measured? Can team members (either the therapist in the room or team members behind a one way screen) make judgments on therapeutic alliance? Can team members agree on those judgments? These are questions to do with validity of the construct itself, the validity of a set of questions about the construct, and the reliability of the resulting questionnaire. This paper reports on the empirical development and testing of a Family Therapeutic Alliance Scale which could be used by a family therapy team.

**METHOD**

A questionnaire was developed by the authors which included 36 statements concerning possible aspects of therapeutic alliance in family therapy, focusing on Bordin’s concept of *bonds* rather than the other components of *agreed goals* and *assignment of tasks*. Questions were derived from a large pool of statements drawn from review of all of the available published literature, particularly from work in the area of individual therapy. To these were added a range of questions based on empirical ideas considered by team members to be important to the notion of therapeutic alliance, or aspects of the process of the interview related to therapist or family functioning which might have some influence on therapeutic alliance. Statements were designed to measure, as far as was possible, team members’ subjective impressions of the emotional climate and behaviour in an interview. The assumption was made that the judgments formed would be valid and reliable measures of the human relationship made in the interview situation and that these would be a shared construct of therapeutic alliance because the team is a part of this wider system of therapy. Judgements were made according to a seven point time-sampling Likert scale from present ‘all of the time’ to present ‘not at all’.

There have been three phases to the work:

1. Development of the 36 item scale
2. Factor analytic reduction to a 15 item scale
3. Testing with a group of family therapists.

**Phase 1**

The first three drafts of the original scale were piloted during live family therapy sessions with a family therapy team (four members behind a one way screen and the therapist) answering the questionnaire during the team break. Discussion of aspects of validity, rater agreement, the form and content of statements, and redundant or difficult items, occurred at the end of each therapy morning. The 36 item final draft scale then became part of the first phase of the study.

The raters were five members of an established brief strategic family therapy team who had worked together for a minimum of one year. Raters, who were drawn from a range of clinical disciplines within Child and Adolescent Mental Health Services, varied in experience of family therapy from one year to twelve years experience (mean 4.4 years).

For the first phase of the study, 10 videotapes (see appendix 1) of family therapy interviews were chosen, five
of International therapists from varied theoretical backgrounds, five of local South Australian therapists. A 15 minute segment was chosen beginning 30 minutes from the start of each videotaped family therapy session. Each of the videotapes was viewed by the raters as a group with no discussion. The 36 item scale was completed immediately following each segment and collected by an independent research assistant. Viewing of the 10 tapes was completed during one day.

The process was repeated one month after the first trial, with the same raters viewing the same videotapes in a randomized order.

Phase 2
Statistical analysis of items was performed using the Statview II® statistics software program based on the Statistical Package for Social Sciences (Nie et al., 1985). First, scale items failing to reach criteria of sampling adequacy and/or communality were discarded, leaving 24 items. This is a statistical procedure that in effect reflects whether items were scored in an erratic way or not scored at all because they were not observed or could not be judged during the 15 minute segment of video.

Subsequently, a factor analysis was performed on the remaining 24 items which resolved them into five factors. Further evaluation and discussion led to three of the factors (including 9 items) being discarded from the scale, leaving what appeared to be a two factor 15 item scale which represented as it were ‘pure’ therapeutic alliance. Reliability studies were then carried out on this scale.

Phase 3
The ‘final’ Family Therapeutic Alliance Scale of 15 items was then demonstrated to, and tested on, 31 experienced family therapists attending a meeting of the Family Therapy Association of South Australia. In an effort to see whether the scale could differentiate between families, therapists viewed 5 minute segments from four different family videos in which the therapist was the same, subsequently rating the scale with no discussion. The videos were chosen because they appeared to demonstrate difference in style of family behaviour and relationship with the therapist, the segments being taken 10 minutes into the interview with each family. No details of the families or of the presenting problems were available to the therapists attending the FTASA meeting, prior to scoring.

RESULTS
The five team members in the original team had difficulty scoring some of the statements in the 36 item scale. This seemed to be in part to do with how items were phrased although we had always taken the consensus view on wording in the 36 item scale, and had tried to operationalize each statement. In addition, a number of items could not be scored reliably or at all because the perceived emotion or event did not occur during the rather brief segment of video.

These difficulties were mirrored in the sampling analysis. Statistically a sampling adequacy of less than .70 led to discard of an item. Communality is a measure of statistical association between items and suggests that items may be related to a common theme. Items not gaining a communality (alpha) of at least .55 were discarded. In practice, 12 scale items failed to reach criteria of sampling adequacy (s.a. > .70) and/or communality (alpha ≥ .55) (see Appendix 2.) and were removed prior to factor analysis. The remaining 24 items had a variable sampling adequacy for the total matrix of .91 (Bartlett Test for Sphericity, df=299, Chi Square = 2119.37, p = .0001).

Factor Analysis
A Principle Components Analysis with Oblique Primary Pattern Solution - Varimax gave the best resolution of the 24 items into 5 Factors accounting for 75.3% of the total variance (see Table 1). For the factor analysis it was assumed that each scale item had 100 responses (five therapists × ten videotapes × two occasions)'.

Factor 1 (Alliance) contains items on mutual liking and respect, good relationship, closeness-distance, the therapist being caring and well joined. This factor seems to contain the majority of those statements in the literature linked with the bond aspect of the construct of therapeutic alliance.

Factor 2 (Lack of Clarity) contains items on the process of the interview (it was aimless, or the therapist was bogged down). Apparent clarity, and understanding of the therapist, are both negatively correlated. Overall, there is a moderately strong negative correlation (see Table 2) with Factor 1 (-.58) and with Factor 3 (-.54) suggesting (at least statistically) that reduction of clarity and perceived understanding, or an aimless interview, reduce the alliance and/or joining. However, while clarity, understanding and process of the interview may all have an impact on alliance this factor seems to be separate from the essential idea of alliance (as bond).

Factor 3 (Joining) contains 3 items about joining with the family. There is a moderately strong positive correlation (.60) with the ‘core’ Alliance Factor 1.

Factor 4 (Family Response) contains apparent family responses — enjoying the interview, being impressed and/or fascinated by the therapist. There is a moderate positive correlation with Factor 1 (.42) and again with Factor 3 (.41) suggesting that the more the family appear to respond, the better the perception of alliance or joining. Again though, we considered that these items were perhaps more the visible expressions of alliance rather than the nature of the bond itself.

Factor 5 (Shared View) contains two items — a shared view of the problem and inability to accept new ideas. The factor correlates best with factor 2 but then only weakly (.26).

1. Similar analysis was performed separately on results from time 1 and time 2 (one month apart) on the original 36 item scale (each five therapists × ten videotapes × one occasion) in an attempt to verify factor resolution. With each of these, the same 24 items appeared in the final matrix, but there was a tendency for most to group under one factor, with two smaller factors containing only two or three items.
Because of the strong positive correlation between factors 1 and 3 and the conceptual similarity between the ideas of joining and the bonding aspect of alliance, we decided to create a 'final' version of the Family Therapeutic Alliance Scale which consists of only the 15 items from these two factors; we were, as it were, looking for as 'pure' a factor of alliance as we could get. Therefore, although factors 2 and 4 have reasonable statistical correlation with factors 1 and 3 and a case could be made for them having a strong theoretical relationship as well, they were discarded at this point. Factor 5 was discarded because of its poor correlations with other factors.

Table 1.
Factors derived from analysis of 24 item residual scale

<table>
<thead>
<tr>
<th>Eigenvalues</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
<th>Factor 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.84</td>
<td>2.03</td>
<td>1.76</td>
<td>1.35</td>
<td>1.11</td>
</tr>
<tr>
<td>Items (Corr.)</td>
<td>1 (.76)</td>
<td>8 (.82)</td>
<td>19 (-.99)</td>
<td>26 (.61)</td>
<td>29 (.66)</td>
</tr>
<tr>
<td></td>
<td>2 (.89)</td>
<td>13 (-.86)</td>
<td>28 (.94)</td>
<td>34 (.90)</td>
<td>32 (.72)</td>
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<tr>
<td></td>
<td>4 (.76)</td>
<td>25 (1.0)</td>
<td>35 (.69)</td>
<td>36 (.95)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 (.78)</td>
<td>27 (.55)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>10 (.51)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 (.83)</td>
<td></td>
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<td></td>
<td>14 (.64)</td>
<td></td>
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<td></td>
<td>15 (.82)</td>
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<td></td>
<td>16 (.54)</td>
<td></td>
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<tr>
<td></td>
<td>17 (-.92)</td>
<td></td>
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<tr>
<td></td>
<td>18 (-.70)</td>
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<td></td>
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<tr>
<td></td>
<td>33 (-.60)</td>
<td></td>
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<tr>
<td>Proportion of Variance</td>
<td></td>
<td></td>
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<tr>
<td>[Total 36 items]</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>49.3%</td>
<td>8.4%</td>
<td>7.3%</td>
<td>5.7%</td>
<td>4.6%</td>
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</tr>
<tr>
<td>[24 items]</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>42.6%</td>
<td>18.2%</td>
<td>16.0%</td>
<td>14.2%</td>
<td>9.0%</td>
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Table 2. — Factor Intercorrelations

<table>
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<tr>
<th>Factors</th>
<th>1</th>
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<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>-0.58</td>
<td>0.60</td>
<td>0.42</td>
<td>-0.12</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-0.54</td>
<td>0.41</td>
<td>0.03</td>
</tr>
<tr>
<td>3</td>
<td>-0.58</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0.60</td>
<td>-0.54</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>0.42</td>
<td>0.27</td>
<td>0.41</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-0.12</td>
<td>0.26</td>
<td>-0.15</td>
<td>0.03</td>
<td>1</td>
</tr>
</tbody>
</table>

Validity

The remaining items appear to have face validity for therapeutic alliance, and take into account both therapist and family factors. Some idea of content and construct validity can be gained from consideration of the items contained in separate factors, their high item correlations and factor intercorrelations (see Table 2). However, as yet the scale has not been tested against other scales, and further criterion and construct validation awaits further evaluation.

Reliability

This was tested in two ways.

Inter-rater reliability was tested with Spearman Rank correlation coefficients — both for time 1 (see Table 3) and time 2 (see Table 4). Results are presented for the reduced 15 item scale. Considering the reduced set of items, these correlations are high between the therapists, and certainly not a chance event. This may mean that the scale is reliable in itself; conversely it may represent the fact that team members had worked together for some time. It may be true, therefore, that such high correlations may not be achieved by either newer family therapists, or by those who have not worked together for a time. Further work is necessary here.

Reliability was also tested over time (see Table 5). Again, results are presented for the 15 item scale. Again, despite the small dataset, the correlations for each therapist are high and we can have some confidence that these are not chance events.
Table 3. — Inter-rater Reliability at Time 1.
(15 items on 10 cases)
Spearman Rank Correlation Coefficients
(Rho corrected for ties)

<table>
<thead>
<tr>
<th>Rater</th>
<th>1</th>
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<th>3</th>
<th>4</th>
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<tr>
<td>2</td>
<td>.77*</td>
<td>.76*</td>
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<td>.90**</td>
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<td>3</td>
<td>.90**</td>
<td>.82*</td>
<td>.86*</td>
<td>.84*</td>
</tr>
<tr>
<td>4</td>
<td>.76*</td>
<td>.81*</td>
<td>.77*</td>
<td>.86*</td>
</tr>
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</table>

**p < .001, *p < .005

Table 4. — Inter-rater Reliability at Time 2.
(15 items on 10 cases)
Spearman Rank Correlation Coefficients
(Rho corrected for ties)

<table>
<thead>
<tr>
<th>Rater</th>
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<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>.85*</td>
<td>.83*</td>
<td>.92**</td>
<td>.87*</td>
</tr>
<tr>
<td>3</td>
<td>.86**</td>
<td>.89**</td>
<td>.86*</td>
<td>.76*</td>
</tr>
<tr>
<td>4</td>
<td>.82*</td>
<td>.83*</td>
<td>.87*</td>
<td>.86*</td>
</tr>
</tbody>
</table>

**p < .001, *p < .005, †p < .01

Table 5. — Test Retest Reliability
[15 items on 10 cases (randomized order) on two occasions one month apart]
Spearman Rank Correlation Coefficients
(Rho corrected for ties)

<table>
<thead>
<tr>
<th>Rater</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.92**</td>
<td>.95**</td>
<td>.89**</td>
<td>.88**</td>
</tr>
</tbody>
</table>

**p < .001, *p < .005

Sensitivity
A scale may measure with some precision what is intended by its creators — that is, with some specificity — and yet not be able to differentiate between, in this case, different therapist-family relationships. That is, it may not have sensitivity. Phase 3 of this study process was an attempt not just to see whether others outside the therapy team could use the instrument with relative ease and with no prior training; it was also to test sensitivity.

Figure 1 represents the mean global rating for the alliance with each of the families shown with the actual range of responses. As can be seen, it appears that the scale can differentiate between the videotapes (the means being separate and distinct) particularly when it is remembered that the 31 therapists only had 5 minutes of video on which to make their judgments.

Statistically, an analysis of variance of the four global means gives an F Test (3 df) = 19.61, p = .0001. Post hoc Scheffé analysis suggests that the alliance with families 1 and 2 was in each case significantly different from the alliance with families 3 and 4 at the .05 level, although the differences in alliance between families 1 and 2 or 3 and 4 did not reach significance.

Figure 1. — Family Therapeutic Alliance Scale

Figure 2 represents the mean scores from 31 therapists on each of the 15 questions for each family. Analysis of variance suggests that 13 of the 15 questions were able statistically to discriminate between alliances with F Test values ranging from 5.77 to 25.6 and all with a very small probability of these being by chance (p < .001). Only question 8, “The therapist was caring toward the family” and question 15, “The therapist encouraged the family to interact” did not discriminate well between videos. This might have been expected if we surmise that most therapists are caring toward families and that in our style of therapy most therapists encourage the family to interact.

The two families in sessions scoring highest completed therapy successfully. The family from the session scoring highest resolved their presenting problem in two sessions. The other family presented a symptom of recurrent and severe migraine and were able to gain symptom relief for the symptom bearer (amongst other changes in family dynamics) in 13 sessions.

Figure 2. — Family Therapeutic Alliance Scale
In contrast, the third family have been seen by a number of senior and competent therapists from a range of services over a lengthy period and have made little change in the level of family violence. The fourth family have been seen over many years by many welfare and therapy services and little change appears to have occurred in the inter-generational pattern of difficult painful relationships and family chaos.

**DISCUSSION**

The Family Therapeutic Alliance Scale has its origins in the discussions of one family therapy team working together over a period of time. We wanted to address a number of issues which were both philosophy and policy driven in our service. For instance, Southern C.A.M.H.S. has encouraged and supported the development of family therapy teams. But what are the key elements of working in a family therapy team? What is the role of the designated therapist in the therapy room with the family? How does the therapist’s view of the family differ from that of the team members behind the screen? Do such differences matter? How is consensus reached with regard to intervention? These are philosophy-driven questions of great importance. In addition, there are practical and economic issues of importance in a service with public accountability. Can we support the use of several professionals working together at the same time on one family? Is it efficient? Is it effective in terms of change? Specifically, is it effective as far as the target problem or agreed on goals are concerned? Is the process of team functioning more important than the competence of the designated therapist, or is it ultimately team consensus which makes the difference? And what is the place of the one way screen and other technology like videotaping?

This set of complex questions centres around the issue of outcome which is often measured in two ways: did the family stay in therapy, and did the initial complaints or problems resolve? We had the beginnings of an answer to some of these questions. In 1988, members of the service attempted to examine the issue of non-attendance, which was running at about 25% following the first interview. We argued that client satisfaction was of major importance and two hundred consecutive families were asked to respond to a questionnaire. Apparently the ‘technology’ — screens, videos and team process — had a negative impact on some families, making them feel uncomfortable. However, for the rest of the families, the technology appeared to have little meaning. The key factor overall for satisfaction was ‘therapist understanding’ (Wood, 1990; Colhoun et al., 1991).

This was based on a single item and it is not clear precisely what ‘understanding’ means. Does it mean the therapist was clear about how the problem had evolved in the context of the family? Does it mean the therapist was an understanding person — that is, warm, caring, supportive and tolerant? Examination of the literature, particularly the individual psychotherapy literature, supports the latter view. It is the therapist’s contribution to the relationship that promotes ‘bonding’ and this has been shown to be associated with outcome. It appears then that therapist understanding leads to client satisfaction, and there may be a recursive process here. We would argue that both therapist understanding and client satisfaction are aspects of a broader view of therapeutic alliance though not, we believe, part of the core construct.

The process of development of the 15 item Family Therapeutic Alliance Scale provided a means of focusing on the emotional experiences of therapist and family. This seems to be a critical area of the therapy experience, influencing the acceptability and effectiveness of therapy. A recent paper from a group using a Milan-informed model of systemic/strategic team consultations highlights their discoveries in this area (Green and Herget, 1991). They moved away from the positions of therapist neutrality because they found a large percentage of clients dropping out of treatment, and actively began to develop positive therapeutic relationships by “using humour, playfulness and genuinely felt compliments”. They found that ratings of therapist warmth made by leaders of the observing teams were significantly correlated with therapist and client reports of global improvement at 1-month and 3-year follow up. This paper is perhaps representative of a new sensibility within the family therapy field of relationship aspects as opposed to pure technique of therapy. Green and Herget highlight the need in the family therapy field to develop rated and reliable measures of aspects of the therapeutic relationship such as therapist warmth and the ability to structure an interview.

The importance of the observer rating of alliance may not be so much the prediction of the outcome of therapy from observing video tapes, but rather in the ‘active team situation’ where ‘live’ advice to the therapist may improve the therapist’s focus or behaviour. This may be especially important for the therapist in training, as has been suggested by Piercy, Laird and Mohammed (1983). In attempting to rate the performance of 29 graduate family therapy students, they developed a general Family Therapist Rating Scale which includes a Relationship Behaviour subscale. They were able to show that performance was correlated with the rating of these students by their respective doctoral-level supervisors. Other authors have not used specific rating scales but have developed approaches to improving the therapeutic relationship. Jackson and Chable (1985) view engagement as an ongoing process in family therapy treatment and describe a range of strategies used to facilitate engagement, including expressing warmth and empathy. Maurizio Andolfi’s approach emphasizes the relational skills of the therapist and how a therapeutic impasse can develop through repetitive dysfunctional patterns between therapist and family (Haber, 1990). The goal of training is for the therapist to be able to form flexible and clear relationships with different families according to their needs and different demands.

Our experience in developing the 15 item FTAS with a family therapy team was that it provided a useful focus for enhancing therapist-family relationships. The emphasis on
qualities of respect, liking and understanding was complementary to the theoretical base of the Structural/Strategic approach which we were adopting in therapeutic practice.

Therapeutic alliance is a construct. The psychoanalytic and individual psychotherapy literature, as reflected by Bordin’s stated view, is that it is a conglomeration of descriptive terms generally subsumed under the label ‘bond’. In addition, there is a purpose to the bond. The alliance is toward an agreed upon goal and inherent in this is an approved set of tasks which help to reach the goal.

As a team we took a rather narrow view of ‘alliance’ in this study, particularly in the latter stages of testing reliability of the 15 item FTAS. We attempted empirically to reach a construct of alliance, or therapeutic bond or relationship, which had some shared meaning. The fact that the team had worked together was important for the development of the scale. Team work fosters the emergence of shared goals and meaning as part of what Anderson and Goolishian (1988) have called a ‘language system’. Within such a functioning system it may be easier to reach agreement on complex issues particularly where individual perception and judgment are concerned. Anderson and Goolishian write of the series of conversations which develop around certain problems as Linguistic Systems. In this sense, our family therapy team developed a way ‘in language’ of describing their shared meaning of therapeutic alliance. The Family Therapeutic Alliance Scale and the statistical studies are a way of describing the structure and reliability of their concept ‘in language’ and its existence over time within the Linguistic System of the team. Further studies with other groups may extend and elaborate this construction. Constructivist ideas can provide an understanding of the process of scale development and their psychometric properties. It can be seen as a process of co-evolving and developing concepts between various groups, with statistical procedures as ways of describing and investigating these concepts. In abstract areas, this seems a more possible venture than the discovery of objective truth and accuracy. In taking this further, the Family Therapeutic Alliance Scale has face validity according to the concept of therapeutic alliance used by our team.

With the development of the Family Therapeutic Alliance Scale, the team not only played a role in generating empirical ideas as part of the construct, but also had the opportunity to critically analyse concepts drawn from the individual psychotherapy literature. In addition, the teamwork was important for the form of the 36 items in the original scale — that is, the way the questions were asked.

However, this is only one team’s view, one team’s construct. In widening the usefulness of the scale, some items may need to be further defined in the light of other teams’ experience of the scale. For instance, viewing someone else’s completed work on video is very different from the intensity of process and purpose in working with a live family. To a certain extent this may have limited the availability of cues, and account for some of the difficulty team members experienced in coming to conclusions to answer some of the questions. It is possible items were discarded from the scale because of distorted cueing and in further experience with full length live cueing we may find that the information to answer a discarded question is routinely present. Conversely, viewing such a diverse set of videotaped therapy sessions under strict test conditions may have been a good test of the general applicability of the scale. All this remains to be tested further.

The limit of 15 minutes viewing time was frustrating and our particular way of choosing the time did not allow us to see beginnings (introductions and joining) and endings (termination of a session), both of which usually contain important clues about family members, therapist style and therapeutic alliance. In addition, some of our original questions clearly could not be answered because an event or process did not occur for a judgment to be possible. These restraints on sampling may well have limited the development of the scale by influencing the statistical evaluation, for instance in terms of sampling adequacy. Considerable discussion then took place over which factors to include and which to exclude from the final scale.

Only Factor 2 clearly does not fit with the concept we were developing of the alliance construct, or the scale as a whole. It seems to be to do with process of the interview and control issues which might well influence the alliance, but are not in themselves bond. Despite the high negative correlations with factors 1 and 3, we chose to discard factor 2 from the scale at this time.

Factors 4 and 5 both reflect aspects of family response to the therapist which arguably could be part of an alliance scale. However, both factors contained some of the items that team members found most difficult to judge or interpret, despite the apparent high sampling adequacy and communality. In addition, we judged that the items of ‘being impressed’ or ‘fascinated by the therapist’ were more appropriate to the tapes of master therapists but were not necessarily relevant to everyday practice. This and the low moderate correlations with Factors 1 and 3 helped us to decide to discard these two factors.

The very high correlation between Factors 1 and 3 and the strong theoretical links between elements of joining and what could be termed ‘pure’ or ‘core’ alliance, convinced us to include both factors in the final version of the scale which then appears to have both construct and content validity. Further investigation and consequent discussion will show us whether this is true and whether our rationale is the correct one.

With all of these complexities what is surprising is the amount of shared agreement between team members. Inter-rater reliability at both Time 1 and a month later at Time 2 is very high and statistically not the result of chance. What is worth emphasizing here is that these results are based on the final 15 item version of the scale. This provides smaller numbers which tend to reduce the strength of correlations. Inter-rater reliability on the full original 36 item scale and on an interim 24 item scale were even higher.
Test retest correlations are also very high and suggest statistical reliability for the 15 item scale.

The overall implication, despite the concerns and criticisms voiced earlier, is that members of a family therapy team can agree on ratings of relationship, even when made on relatively short segments of videotaped family therapy interviews with therapists who in the main were not members of the team. Further, these ratings were stable over time. We would caution that the agreement and apparent reliability are based on our familiarity with the ideas behind the various items and what could be described as the co-evolution of agreed meanings within the team concerning aspects of therapeutic alliance with the family. It remains to be seen whether others can use the scale (that is make the judgments we ask for each item) and whether similar levels of reliability can be achieved by those unfamiliar with the constructs, the scale or family therapy in general.

The statistical process of factor analysis is a complex one and contains an element of trial and error. Analysis can be performed in a number of different ways and it is often a matter of judgment what appears to be the best ‘fit’ in terms of items. The Oblique Pattern Solution was chosen because we had predicted that items would relate to one another. An argument could be mounted that it is incorrect to include items from two separate occasions to boost the numbers for the factor analysis. Our advice was that this was correct only if analysis on the two separate occasions each essentially supported the final result. As noted in Footnote 1, this condition appears to have been met. We believe that the result we achieved is not only statistically correct, not only the best ‘fit’ that could be achieved, but also seems to make sense in terms of construct development.

What we have called Phase 3 of this study was both exciting and terrifying, but the first public exposure of the 15 item FTAS seems to have provided some support for the scale while also demonstrating the complexities. As previously noted, 31 experienced family therapists were given a brief overview of the development of the scale, and then viewed four 5 minute segments of videotaped family interviews, following each of which the scale was completed with no discussion. In feedback at the end of the session, it was clear that some of the individual therapists had difficulty with some of the items and there appeared to be differences in understanding in how to make the necessary judgments. However, even after a very brief exposure to videotaped sessions with no prior family history or indication of the presented problems, under time pressure, and with a great variety in professional background, the global score for each family therapeutic alliance differentiated between the four family interviews. In particular, two of the family sessions scored high and two scored low. No cutoff point has as yet been decided to determine what may be seen as good or poor alliance. However, the differences in global scoring were mirrored in the 13 out of 15 items which also were capable of differentiating between the family videos.

These four cases and their level of alliance with a therapist appear to support the evidence from individual psychotherapy that therapeutic alliance is related to outcome. However, there are only four cases, they are reported anecdotally and in retrospect. While the family therapists who rated them using the scale had no way of knowing the outcome of the families concerned, a prospective study is required to confirm what, at this point, may only be called an indication of support for the hypothesis that Family Therapeutic Alliance may be predictive of outcome in family therapy.

A further issue demands some discussion. Even if the scale can be shown to have reliability and validity, the issue still remains as to whose alliance is being measured. We have assumed throughout that the family is a unit, a system. A further assumption is that a global measure can apply to a family as a whole. These are enormous leaps of faith. What if one member or more in a family takes a major dislike to the therapist and remains or becomes uncooperative, or in perpetual disagreement? How does this affect the overall sense or impression that team members may gain of the family alliance. What if the therapist in the room decides to focus attention on one member of a family to the exclusion of others? How does this affect other member’s ability to bond and in turn the family’s ability to bond? These are complex questions to which at this stage we have no answers. While the process our team has been through suggests that family therapeutic alliance both exists as a construct, can be perceived and judged and can then be measured, the ground on which the scale is developed, and therefore the validity of the construct and the scale, are shaky and in need of further confirmatory work and discussion.

Finally, some questions with which this work began remain largely unanswered at this time. Many fruitful areas remain for further work, including the use of the scale in a prospective study looking at family therapeutic alliance and outcome, a comparison of the therapist’s view with the composite team’s view, and adaptation of the scale so that a family may report on their own perceived alliance.

This has been a pilot study. In future work we will continue to use the full 36 item scale in our live family work. We believe that where we had difficulties with particular statements we may well be able to answer them more easily in full sessions. These responses may well change the final format of the Family Therapeutic Alliance Scale. In the meantime we would recommend that other therapists and teams use either the pure form of the 15 item FTAS as we have presented it here or the full 36 item scale. We would value the further dialogue that this will engender which will in turn assist our further construction of the scale.

**SUMMARY**

This study examines the construct of therapeutic alliance, reports on the process of empirical development of a fifteen item Family Therapeutic Alliance Scale, and indicates that members of a family therapy team were able to make
reliable ratings of therapeutic alliance using the scale. The scale provides a global rating of the bond between the therapist and family members. This rating was found to have high inter-rater and high test-retest reliability. Factor analysis completed during the development of the scale provided a two factor structure of aspects of therapeutic alliance. The first factor contains items related to the emotional tone of the therapeutic relationship, similar to descriptions of aspects of this relationship within the literature on therapeutic alliance. The second factor contained items related to joining and interaction, concepts which are derived from structural/strategic models of family therapy. These two factors were intercorrelated, as would be expected from a theoretical perspective where appropriate joining techniques encourage the formation of positive therapeutic bonds. Both the factor structure and reliability of the scale suggest its usefulness in rating families. If what is true for individual therapy is also true for family therapy, that is that therapeutic alliance at first interview predicts outcome, then this scale may be of some assistance in predicting family therapy outcome, may point toward a way of improving outcome and may have heuristic value.

Acknowledgements

We would like to thank the other members of the original Child Centred Brief Family Therapy team, Ann MacMillan, Phillip Hazell and Sharon Haarasma, who slaved over a hot video for what seemed endless hours, and were crucial to the development of some of our ideas. We would also like to thank Anthea Krieg, Malcolm Bond and Klee Badcock for help with the process and statistical evaluation. Finally we would like to thank those members of the Family Therapy Association of South Australia who took the time to help us with our further study.

References


APPENDIX 1

Items removed:

Twelve Scale Items were removed prior to final Factor Analysis because they did not reach criteria of sampling adequacy (s.a. > .70) and/or because they did not reach criteria of communality (α > .55).

3. The therapist took responsibility for change in this interview (s.a. = .55, α = .53).
4. The therapist seemed to have a good grasp of how the presented problems fit with this family’s dynamics (α = .51).
5. The therapist seemed hopeful with regard to change for this family (α = .43).
6. The therapist was in control of this interview (s.a. = .62).
7. The family seemed to have a good grasp of how the presented problems fit with this family’s dynamics (α = .49).
8. The family expressed doubts to the therapist about whether therapy could be helpful (α = .28).
9. The family and the therapist disagreed (s.a. = .50, α = .46).
10. The family members expressed anger toward the therapist (α = .42).
11. The family took responsibility for change in this interview (s.a. = .64, α = .32).
12. The therapist faced the family’s views (s.a. = .67).
Items removed following factor analysis (Factors 2, 4 and 5):
8. The therapist appeared bogged down.
13. The therapist's ideas, as expressed to the family, were clear.
25. This interview was aimless.
26. The family seemed to enjoy the session.
27. The therapist understood this family.
29. The family and the therapist shared a common view about the presenting problem.
32. The family seemed unable to accept new ideas from the therapist.
34. The family were impressed by the therapist's personality.
36. The family seemed fascinated by the therapist.

APPENDIX 2
The Family Therapeutic Alliance Scale [F.T.A.S. 15 item (Team Form)]
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<table>
<thead>
<tr>
<th>Family Name</th>
<th>Date</th>
<th>Session No.</th>
<th>Filled in by</th>
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<tr>
<th></th>
<th>All the time</th>
<th>Nearly all the time</th>
<th>Most of the time</th>
<th>Half the time</th>
<th>Some of the time</th>
<th>Almost never</th>
<th>Not at all</th>
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<tbody>
<tr>
<td>The conversation flowed easily in this interview</td>
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<td>The therapist appeared to like this family</td>
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<td>The therapist seemed to have respect for this family's way of doing things</td>
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<td>The therapist had a good relationship with this family</td>
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<td>The family seemed to respect the therapist</td>
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<td>The therapist looked as though they felt very close to this family</td>
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<td>The family appeared to like the therapist</td>
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<td>The therapist was caring toward the family</td>
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<td>Overall the therapist appeared to be well joined with the family</td>
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<td>The therapist appeared to dislike the family</td>
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<td>The family and the therapist appeared distant from one another</td>
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<td>The therapist joined with one or more family members to the exclusion of others</td>
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<td>The therapist joined equally with all family members</td>
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