

Carr, A., (2005). Research on the therapeutic alliance in family therapy. In C. Flaskas and A. Perlesz & B. Mason, B. (Eds). *The Space Between: Experience, Context and Process in the Therapeutic Relationship* (pp. 187-199). London, UK: Karnac.

**Invited chapter sent in April 2002, revised and resubmitted December 2002; further revised and resubmitted June 2003; further revised and resubmitted in November 2003; final revisions included in October 2004 and the chapter was submitted to:**

Carmel Flaskas, Amaryll Perlesz and Barry Mason

<c.flaskas@unsw.edu.au, barry@bmason.demon.co.uk, [a.perlesz@latrobe.edu.au](mailto:a.perlesz@latrobe.edu.au)>

Editors of *The Therapeutic Relationship: Recent Developments in Theory and Practice* to be published by Karnac Press in the Systemic Thinking and Practice Series.

**Reference as:** Carr, A., (In Press). Research on the therapeutic alliance in family therapy. In C. Flaskas, B. Mason, B. & A. Perlesz (Eds). *The Space Between: Experience, Context and Process in the Therapeutic Relationship*. London. Karnac Books.

**Running head:** Therapeutic Alliance Research.

**Word count:** 5,200 words (including text and references, excluding front matter).

**Formatting:** Referenced using Journal of Family Therapy style and formatted in single space using 12 point Times New Roman.

## RESEARCH ON THE THERAPEUTIC ALLIANCE IN FAMILY THERAPY

### ALAN CARR

Professor Alan Carr is Director of the Doctor of Psychological Science in Clinical Psychology at UCD and Marital and Family Therapist at the Clanwilliam Institute, Dublin. His work includes *Family Therapy Concepts, Process and Practice* and *The Handbook of Child and adolescent Clinical Psychology: A Contextual Approach*.

#### ABSTRACT

The chapter opens with a brief description of therapeutic alliance assessment scales that may routinely be used in clinical practice and then research which highlights the strong relationship between the therapeutic alliance and outcome in marital and family therapy is discussed. The remainder of the chapter is a selective review of process research which points to specific practices that therapists may incorporate into their own styles to improve the quality of therapeutic relationships.

#### INTRODUCTION

In the integrative approach to practice which informs my clinical work (Carr, 2000) I assume that the formulations which emerge from talking with families about their problems and exceptions to these are social constructions. The primary frame of reference for this aspect of the work is observing systems. Since it is possible to co-construct multiple formulations to explain any problem or exception to it, it is important to have a criterion by which to judge the merit of any particular one. In my approach it is the *usefulness* of formulations in suggesting a variety of feasible solutions which are acceptable to families which is the sole criterion for judging the merit of one formulation over another. In deciding about the usefulness of formulations and interventions, I take account of the results of empirical research, such as those reviewed in this chapter, on the process and outcome of couples and family therapy. The primary frame of reference for such research is observed systems. Thus, the integrative approach I have developed attempts to bridge the frames of reference, often referred to within the field of family therapy, as observed and observing systems. A fine harvest may be reaped from both of these fields. This paper is largely concerned with fruits from the field of observed systems. I have tried within the space constraints of the chapter to draw together empirical findings that may be useful to practitioners and which may have important implications for practice.

Recent reviews of the literature on marital and family therapy process have concluded that the relationship between the therapist and family members is important for effective therapy (Frielander, 1998; Liddle, Santisteban, Levant & Bray, 2002; Reimers, 2001; Sprenkle, Blow, & Dickey, 1999). In this chapter, a brief description of therapeutic alliance assessment scales that may routinely be used in clinical practice will first be given before summarizing some illustrative studies which highlight the strong relationship between the therapeutic alliance and outcome in marital and family therapy. The remainder of the chapter will selectively review research which points to specific practices that therapists may incorporate into their own styles to improve the quality of therapeutic relationships.

#### ASSESSING THERAPEUTIC ALLIANCE

The self-report Family Therapy Alliance Scale (Pinsof and Catherall, 1986) and the Family Therapeutic Alliance Observer Rating Scale (Martin & Allison, 1993) are good examples of the best available methods for assessing client-therapist relationships in marital and family therapy. Pinsof and Catherall's (1986) self-report Family Therapy Alliance Scale is designed to measure family members' perceptions of the quality of therapeutic alliances involving (1) themselves and

the therapist; (2) other family members and the therapist; and (3) the family as a whole and the therapist. In each of these three domains it yields a total score and scores on content subscales concerned with therapy tasks, goals and bonds. The following are some sample items from this instrument: 'I trust the therapist'; 'The therapist understands my goals in therapy'; and 'The therapist is helping my family'. For each item, responses are given on 7-point Likert-type scales which ranges from 'completely agree' (7) to 'completely disagree' (1), with a 'neutral' (4) midpoint. Higher scores indicate stronger alliances.

### **MFT THERAPEUTIC ALLIANCE AND OUTCOME**

Studies of couples therapy consistently show that the quality of the therapeutic alliance or the client-therapist relationship reported by clients during therapy is associated with therapeutic outcome (Bourgeois, Sabourin & Wright, 1990; Johnson & Talitman, 1997; Quinn, Dotson & Jordan, 1997; Reif, 1998). For example, Johnson & Talitman (1997) in a study of emotionally focused couples therapy found that the couple's alliance with therapist accounted for 22% of variance in post-treatment satisfaction and 29% of variance in follow-up satisfaction. Studies of family therapy, like those of couples therapy, also show that the quality of the therapeutic alliance reported by clients during therapy is consistently associated with the outcome of therapy (Beck & Jones, 1973; Johnson, 1998; Joseph, 1997; Lyness, 1999; Van Orman, 1996). For example, Beck and Jones (1973) in a study of over 3000 family therapy cases found that the therapeutic alliance was the most powerful service-based predictor of therapeutic outcome and a better predictor of outcome than all client characteristic variables combined.

Convening whole family sessions is a pre-requisite for the development of a good alliance with all family members. Where all family members are motivated to attend therapy, convening whole family session is rarely problematic. But in those cases where only some members of the family wish to attend therapy, then working towards convening whole family sessions becomes the first step in establishing a therapeutic alliance with the family.

### **CONVENING WHOLE FAMILY SESSIONS**

Convening whole family sessions where adolescents have drug problems or adults have alcohol problems can be very challenging. Systemic interventions are particularly effective in helping families whose members have substance use problems engage in therapy and maintain an ongoing therapeutic relationship (Liddle and Dakof, 1995; Stanton & Shadish, 1997).

For adult alcohol abuse, family based engagement techniques such as family intervention (Liepman et al, 1989) and community reinforcement training (Sisson & Azrin, 1986) can help 57-86% of cases engage in treatment (either individual or family based) compared with the typical engagement rate of about 0-31% (Edwards & Steinglass, 1995). Family-based engagement techniques help family members create a context within which the chances of the family member with a drink problem entering treatment are maximised. This involves coaching family members in skills required to motivate the person with the alcohol problem to enter therapy and pinpointing the right time to use these so as to maximise the chances of success. The skills include relationship building, confrontation, requesting treatment entry and supporting sobriety.

In two studies it has been shown that a systemic approach to engaging adolescent drug abusers and their families in therapy can be about twice as effective as routine methods for convening family therapy sessions (Szapocznik et al, 1988; Santisteban et al, 1996). With systemic engagement, the concerned family member was coached in ways to involve other less motivated family members in therapy. The invitations for treatment-resistant family members to participate in therapy were reframed so as to highlight the benefits of attending therapy in terms of the resistant family members' expressed concerns and wishes. Where

appropriate invitations to attend therapy were offered to treatment-resistant family members during home-visits.

These techniques for convening family therapy sessions in substance abuse cases, may probably be adapted for use in other types of cases where convening whole family sessions is problematic (Carr, 2000a). However, once family therapy sessions have been convened, aspects of the therapeutic context such as the use of teams and screens may compromise the formation of a good therapeutic relationship with clients.

### **ENGAGEMENT AND THE USE OF TEAMS AND SCREENS**

There is evidence that certain practices can pre-empt clients' negative reactions to teams and one-way screens. Knott & Espie (1997) in a survey of families attending family therapy service found that clients who felt at ease working with a family therapy team and screen when they had been informed about the team and screen before the first session; had read a leaflet explaining the team and screen; and felt able to discuss concerns about the team and screen with the therapist. Only about half of the participants in this study had read the leaflet they were sent and these tended to be the more motivated clients.

Höger, Teme, Reiter & Steiner (1994) found that families valued the many positive ideas offered from multiple perspectives by reflecting teams. Smith and colleagues in a qualitative study of clients' perceptions of reflecting team processes, found that clients valued the impartial reflections offered by reflecting teams, appreciated mixed-gender reflecting teams, and found teams were less threatening when the team was not behind the one-way screen (Smith, Sells & Clevenger, 1994). Stith in a study of children's views of therapy found that certain practices helped children to be more comfortable with teams and screens. These were showing children how the screen worked; including the team, therapist and family in therapeutic conversations; involving children actively in therapy through the use of charts, board games and homework tasks; and not leaving children in the waiting room while the therapist talked to their parents (Stith, Rosen, McCollum, Coleman & Herman, 1996).

### **QUESTIONING STYLES THAT ENHANCE ALLIANCES**

Much of family therapy, but particularly much of the early sessions involve the therapist asking questions and clients responding to these. Certain styles of questioning, especially those which are based on circular or systemic assumptions, are more supportive of alliance formation than other questioning styles. Scheel & Conoley (1998) investigated the relationship between questioning style and loss of neutrality in three families. After four sessions of family therapy, individual family members viewed videotape replays of moments when questions were posed and rated their perceptions of therapist side-taking and feelings of discomfort for each questioning event. Rating of non-neutrality were associated with interventive questions.

In two analogue studies, non-clinical families viewed brief videotaped vignettes illustrating each of Karl Tomm's (1988) four questioning styles and subsequently rated the quality of the alliance between the therapist and the family for each vignette (Dozier, Hicks, Cornille & Peterson, 1998; Ryan & Carr, 2001). For both studies, compared with strategic and lineal questioning styles, circular and reflexive questions led to higher ratings of therapeutic alliance. These results support Karl Tomm's (1988) hypothesis that questioning styles based on circular assumptions lead to a better therapeutic alliance than do questions based on lineal assumptions.

### **REFRAMING AND ALLIANCE FORMATION**

Building an alliance with families in the early sessions of therapy is challenging because of the potential for punitive blaming to occur when families are explaining their understanding of their difficulties and how these arose. There is a risk that the therapeutic conversation will revolve

around family members' explanations of problems being due to their perceptions of the identified as intrinsically 'bad', 'sad', 'sick' or 'mad'. Such negative framings of problem-behaviour may further reinforce scapegoating and other problem-maintaining family processes. In a study of functional family therapy for delinquent adolescents and their families, Alexander and his team found that reframing was more effective than reflection, questioning or structuring interventions in promoting engagement and reducing defensive family communication and that adolescents responded even more favourably to reframes than mothers and fathers (Robbins, Alexander, Newell & Turner, 1996).

In a qualitative study of the reframing process, Coulehan, Friedlander, and Heatherington, (1998) compared families in which early relational reframing of the problem occurred successfully with families in which it did not. A clear sequence characterized successful relational reframing. In the first stage, family members' individual constructions of the problem and exceptions to it were explored. In the second stage, positive aspects of the child with the problem, family strengths and individual and family factors which contributed to problem formation were acknowledged. During this stage there was an emotional shift from blaming the child to a softer more supportive position. In the third stage, family members expressed hope and recognised that change may be possible.

These studies support the value of using reframing, particularly during the early stages of therapy to strengthen the relationship between the therapist and family members.

### **ENAGAGING ADOLESCENTS**

For adolescents to benefit from family therapy, it is important for them to form good working relationships with their therapists. Often this is challenging, and particular attention needs to be paid to the process of building an alliance with the adolescent. There is evidence that certain techniques are particularly effective in facilitating this process. Diamond, Liddle, Hogue and Dakof (1999) rated videotapes for the presence or absence of a range of alliance-building interventions from five improved and five unimproved cases. In all of these cases families with adolescent drug abusers were participating in multidimensional family therapy. Diamond and his colleagues found that orienting adolescents to the collaborative nature of therapy; helping adolescents to form personally meaningful goals; and generating hope that these tangible goals could be achieved were particularly effective techniques for improving, initially poor, therapist-adolescent alliances.

### **THE IMPORTANCE OF SUPPORT AND COLLABORATION**

There is good evidence for a link between therapists' supportive or collaborative behaviour on the one hand and client co-operation on the other. Frankel and Piercy (1990) showed that client co-operation within therapy was associated with supportive behaviour on the part of the therapist and that this relationship between support and co-operation was strengthened if supervisors in turn were supportive of therapists. Moorehouse and Carr (2001) also found that client co-operation was associated with therapists collaborative behaviour. Verwaaijen and VanAcker's in a study of thirteen families of conduct-disordered female adolescents at risk for institutionalisation, found that in successful cases, therapists put more emphasis on collaborating with parents by elucidating problems, evaluating possibilities, and enhancing commitment, and less on stating conclusions and attempting to directly change clients' experiences (Verwaaijen & VanAcker, 1993).

### **BALANCING SUPPORT AND STRUCTURE**

A principle of systemic practice is that for couples and families to change, alternatives to their problem maintaining routines and beliefs require exploration. There is evidence that a balance of collaborative support on the one hand and providing structure and direction on the other may

help clients explore new ways of resolving their difficulties. In a study of functional family therapy with the families of delinquent adolescents, Alexander and Barton (1976) found that, supportive relationship building skills such as warmth and humour and directive structuring skills together accounted for 60% of the variance in treatment outcome. Relationship skills accounted for 45% of the outcome variance and structuring skills for 15%. Sells, Smith & Moon (1996) in a qualitative study found that clients valued therapy in which the therapist showed competence by being goal-focused rather than directionless and also maintained a warm, trusting, informal, down-to-earth relationship.

### **DIFFERENT STROKES FOR DIFFERENT FOLKS**

In a study of couples therapy, Cline, Mejia, Coles, Klein & Cline (1984), found that middle class couples benefited most when therapists became less directive over the course of therapy. In contrast, working class couples benefited most when therapists became increasingly directive as therapy progressed. Cline and colleagues argued that middle class couples used the increasingly non-directive therapeutic climate to spontaneously increase their emotional expressiveness, acceptance, agreement and approval, while the working class couples used the increasingly directive therapeutic climate to develop a clearer understanding of the dynamics of their marriage.

Hampson and Beavers (1996a,b) in a study of 434 families who participated in Beaver's Family Systems therapy with trainee therapists found that families who benefited most had the following profile. They formed a good therapeutic partnership with the therapist, attended at least six sessions, were rated as more competent and more enmeshed on the Beavers Interactional Scales (Beavers & Hampson, 1990). More competent families who were characterised by a more enmeshed style fared best when their therapists were more open about their therapeutic strategy, more egalitarian in the power differential they established with their clients, and more joined in partnership with families within the therapeutic alliance. Families rated as less competent and more disengaged in their style on the Beavers Interactional Scales made greater therapeutic progress when their therapists were less open about their therapeutic strategy, and established a more hierarchical therapeutic relationship characterised by interpersonal distance and directiveness. These results suggest that partnership, openness, and low power differential are the hallmarks of an effective therapeutic alliance with families rated as more competent on the Beavers' scales. It is only with less competent families, as rated by Beavers' scales, that therapeutic effectiveness is increased by maintaining an overt power differential and by not disclosing therapeutic strategy.

An important concern in interpreting these results is the meaning of 'family competence'. Ratings on the Beavers Interactional Scales, which have good reliability and validity (Beavers & Hampson, 1990) are made from observations of 10-minute family discussions of what family members would like to see changed in their families. Competence within this context refers to a family's overall status on a range of factors such as goal directed negotiation, clarity of expression, conflict resolution and empathy.

### **MANAGING RESISTANCE**

Research on behavioural family therapy for families of aggressive boys conducted by Patterson's group at the Oregon Social Learning Centre has provided some of the most important empirical findings on the process of resistance (Patterson & Chamberlain, 1992). Resistance is elicited by therapists directly instructing clients in parenting skills or confronting them when they do not follow through on the use of such skills. The highest levels of resistance (as assessed by behavioural ratings of noncooperation) occur in the middle phase of therapy and are associated with dropping out of therapy before completion. In successful therapy, midtherapy resistance is gradually resolved and diminishes over the second half of therapy.

Stoolmiller et al (1993) found that this pattern of high resistance in mid-therapy with resolution by termination was associated with reduced arrest rates for aggressive boys two years after the end of therapy. This finding supports a model of therapy in which the first phase is devoted to building an alliance using largely supportive interventions. Once this supportive therapeutic relationship has been formed, the therapist uses the alliance as a context within which to confront and challenge ineffective parenting practices and to teach new ones based on behavioural principles. During this midphase of therapy, resistance is at a maximum. Once clients develop competence in using new parenting skills, their resistance begins to abate and they receive increasing support from therapists for their effective use of behavioural parenting skills.

While parent-therapist conflict about implementing parenting practices is the main type of resistance encountered in working with families containing preadolescent children, parent-adolescent difficulties in engaging in co-operative problem-solving is one of the most common forms of resistance found in working with families of adolescents. Friedlander and Heatherington, identified a series of steps which facilitated therapeutic progress during episodes where families containing adolescents showed resistance to engaging in constructive problem-solving (Friedlander, Heatherington, Johnson & Skowron, 1994). They compared four successful and four unsuccessful cases and found that members of successful families first acknowledged their own contribution to the resistance process. Then they communicated their thoughts and feelings about the impasse to other family members who validated these sentiments. This led to a change in the emotional climate within the family from cold and conflictual to warm and accepting. This new climate created a context within which family members found new ways of understanding each others behaviour and recognised the value of engaging in constructive problem-solving.

In a study of families of adolescent drug abusers in multidimensional family therapy, Diamond and Liddle (1996) identified a similar set of process for dealing with therapeutic impasses where parents expressed frustration and hopelessness and adolescents expressed anger and resentment. First, the therapist supported and contained the adolescents within the therapy session and allowed them to feel understood as being both sad and angry. Next, the parents were supported to help them move from a position of accusation and blame to one of disappointment and loss. This was accompanied by a softening of the emotional tone of the interaction. Then adolescents were helped to articulate their sense of loss (of attachment to parents) underlying the anger and resentment. This 'parent-adolescent re-attachment' process created a context within which constructive-problem solving could be resumed.

These two studies suggest helping families with adolescents disclose beliefs and emotions associated with unresolved attachment issues within a supportive and accepting emotional climate may facilitate a move towards joint dialogue and constructive problem solving when therapy reaches an impasse.

### **IMPLICATIONS FOR PRACTICE**

This review suggests that a strong therapeutic alliance is important for achieving a good therapeutic outcome, because it provides the relational context essential for achieving therapeutic goals (Friedlander, 1998; Liddle, Santisteban, Levant & Bray, 2002; Reimers, 2001; Sprenkle, Blow, & Dickey, 1999). The overriding implication is that all other aspects of marital (Bourgeois, Sabourin & Wright, 1990; Johnson & Talitman, 1997; Quinn, Dotson & Jordan, 1997; Reif, 1998) and family (Beck & Jones, 1973; Johnson, 1998; Joseph, 1997; Lyness, 1999; Van Orman, 1996) therapy should be subordinate to the therapeutic relationship. Probably, the only exception to this rule is where the safety of a family member is at risk and in such cases protection takes priority over alliance building.

Therapists should use a supportive and invitational approach in which family members are invited (not directed) to participate in therapy (Frankel & Piercy, 1990; Moorehouse & Carr, 2001; Verwaaijen & VanAcker, 1993) and in which a style of questioning, based on circular or systemic assumptions is predominantly used (Dozier, Hicks, Cornille & Peterson, 1998; Ryan & Carr, 2001).

Therapists should form a collaborative partnership with families (Moorehouse & Carr, 2001). In this partnership, family members are experts on the specific features of their own family and its difficulties and therapists are experts on general scientific and clinical information relevant to family development and the broad class of problems of which the presenting problem is a specific instance (Carr, 2000). (This is a 'knowing and not-knowing' position.)

There should be an attempt to match the way therapy is conducted to the clients' readiness to change, since to do otherwise may jeopardise the therapeutic alliance (Stoolmiller et al., 1993). Early in therapy the emphasis should be on offering support (rather than direction) and reducing blame through reframing problems in relational terms, and in terms of family members strengths and good intentions (Robbins, Alexander, Newell & Turner, 1996). Later in therapy the emphasis may shift to collaborative problem-solving. There should also be an attempt to match the therapy style to suit the structure and culture of the family (Cline, Mejia, Coles, Klein & Cline, 1984; Hampson and Beavers, 1996a,b).

There should be a balanced focus on individual and family strengths and resilience on the one hand and on problems and constraints on the other (Carr, 2000). A focus on strengths promotes hope and mobilises clients' to use their own resources to solve their problems. However, a focus on understanding why the problem persists and the factors that maintain it is also important, since this information informs more efficient problem-solving.

Explanations of the way teams and screens work and add value to the service families receive may offset any potentially negative impact they might have on the therapeutic alliance (Knott & Espie, 1997) in. For family members who find it difficult to engage in therapy, specific techniques may be valuable. With substance abusers, other family members may be coached in how to help them engage in therapy (Szapocznik et al, 1988; Santisteban et al, 1996). For adolescents, helping them to view therapy as a collaborative process in which they can pursue personally meaningful goals is particularly effective (Diamond, Liddle, Hogue & Dakof, 1999).

There should be an acknowledgement that both therapists and clients inadvertently bring to the therapeutic relationship, attitudes, expectations, emotional responses and interactional routines from other areas of their lives, notably early significant care-giving and care-receiving relationships (Carr, 2000). These relationship habits, if unrecognised, may compromise therapeutic progress and so should be addressed when resistance to therapeutic change occurs.

The degree to which the research findings summarized in this chapter can be generalized to settings outside those in which the studies were conducted is limited. While participants in some studies were from a range of social classes (e.g. Cline et al, 1984) and ethnic minority groups (e.g., Szapocznik et al, 1988; Santisteban et al, 1996) we do not have evidence from controlled empirical studies or narrative qualitative investigations on the impact of broader cultural, contextual and socio-political factors on the therapeutic relationship. Clearly, these huge gaps in our knowledge need to be addressed in future research.

## REFERENCES

- Alexander, J., Barton, C., Schiavo, R. & Parsons, B. (1976) Therapist characteristics, family behaviour and outcome. *Journal of Consulting and Clinical Psychology*, **44**: 656-664.
- Beavers, W.R. and Hampson, R.B. (1990) *Successful Families: Assessment and Intervention*. New York: W.W. Norton
- Beck, D. & Jones, M. (1973) *Progress on Family Problems: A Nation-wide Study of Clients' and*

*Counsellors' Views of Family Agency Services*. New York: Family Service Association of America.

- Bourgeois, L. Sabourin, S. & Wright, J (1990) Predictive validity of therapeutic alliance in group couples therapy. *Journal of Consulting and Clinical Psychology*, **58**: 608-613
- Carr, A. (2000) *Family Therapy: Concepts, Process and Practice*. Chichester: Wiley
- Cline, V., Mejia, J., Coles, J., Klein, N. & Cline, R. (1984). The relationship between therapist behaviours and outcome for middle- and lower- class couples in couples therapy. *Journal of Clinical Psychology*, **40**: 691-704.
- Coulehan, R., Friedlander, M., & Heatherington, L. (1998) Transforming narratives: A change event in constructivist family therapy. *Family Process*, **37**: 17-33.
- Diamond, G. & Liddle, H. (1996) Resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy. *Journal of Consulting and Clinical Psychology*, **64**: 481-488.
- Diamond, G. Liddle, H., Hogue, A., Dakof, G., (1999) Alliance-building interventions with adolescents in family therapy: A process study. *Psychotherapy Theory, Research, Practice & Training*, **36**: 355-368.
- Dozier, R., Hicks, M., Cornille, T. & Peterson, G. (1998) The effect of Tomm's therapeutic questioning styles on therapeutic alliance: A clinical analogue study. *Family Process*, **37**: 189-200
- Edwards, M. & Steinglass, P. (1995) Family therapy treatment outcomes for alcoholism. *Journal of Marital and Family Therapy*, **21**: 475-509.
- Frankel, B. & Piercy, F. (1990) The relationship among selected supervisor, therapist and client behaviour. *Journal of Marital and Family Therapy*, **16**: 407-421.
- Friedlander, M. (1998) Family therapy research: Science into practice, practice into science. In: M. Nichols (ed) *Family therapy: Concepts and methods* (Fourth edition, pp. 503-526). Boston: Allyn and Bacon
- Friedlander, M., Heatherington, L., Johnson, B. & Skowron, E. (1994) Sustaining engagement: A change event in family therapy. *Journal of Counselling Psychology*, **41**: 438-448.
- Hampson, R. & Beavers, W. (1996) Family therapy and outcome: Relationships between therapist and family styles. *Contemporary Family Therapy*, **18**: 345-370.
- Höger, C., Teme, M., Reiter, L. & Steiner, E. (1994) The reflecting team approach: Convergent results of two exploratory studies. *Journal of family Therapy*, **16**: 427-437.
- Johnson, L. (1998) The therapeutic alliance in home-based family therapy: Is it predictive of outcome? *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 59(5-B), 2420.
- Johnson, S. & Talitman, E. (1997) Predictors of success in emotionally focused couples therapy. *Journal of Marital and Family Therapy*, **23**: 135-152.
- Joseph, S. (1997) Exploration of the therapeutic relationship with families. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 57(12-A), 5048.
- Knott, F. & Espie, C. (1997) families perceptions of the one-way screen in the first meeting. *Journal of Family Therapy*, **19**: 431-439.
- Liddle, H. & Dakof, G.(1995) Efficacy of Family Therapy for Drug Abuse: Promising but not definitive. *Journal of Marital and Family Therapy*, **21**: 511-543.
- Liddle, H., Santisteban, D., Levant, R., & Bray, J. (2002) *Family Psychology. Science-Based Interventions*. Washington, DC: American Psychological Association.
- Liepmann, M., Silvia, L. & Nirenberg, T. (1989) The use of family behaviour loop mapping for substance abuse. *Family Relations*, **38**: 282-287.
- Lyness, K. (1999) The role of the therapeutic relationship in successful family therapy outcome. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 60(3-B), 1307.

- Martin, G. & Allison, S. (1993) Therapeutic alliance: a view constructed by a family therapy team, *Australian and New Zealand Journal of Family Therapy*, **14**: 205-214.
- Moorehouse, A. & Carr, A. (2001) A study of live supervisory phone-ins in family therapy: Correlates of client co-operation. *Journal of Marital and Family Therapy*, **27**: 241-250.
- Patterson, G. R., & Chamberlain, P. (1994). A functional analysis of resistance during parent training therapy. *Clinical Psychology: Science and Practice*, **1**, 53-70.
- Pinsof, W. & Catherall, D. (1986) The integrative psychotherapy alliance: Family, couple and individual scales. *Journal of Marital and Family Therapy*, **12**: 137-151.
- Quinn, W., Dotson, D. & Jordan, K. (1997) Dimensions of therapeutic alliance and their associations with outcome in family therapy. *Psychotherapy Research*, **7**: 429-438
- Reif, C. (1998) Therapeutic alliance in couples therapy. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, **58**(10-B), 5653.
- Reimers, S. (2001) Understanding alliances. How can research inform user-friendly practice? *Journal of Family Therapy*, **23**: 46-62.
- Robbins, M. Alexander, J., Newell, R., & Turner, C. (1996) The immediate effect of reframing on client attitude in family therapy. *Journal of Family Psychology*, **10**:28-34.
- Ryan, D. & Carr, A. (2001) A study of the differential effects of Tomm's questioning styles on therapeutic alliance. *Family-Process*, **40**: 67-77
- Santisteban, D., Szapocznik, J., Perez-Vidal, A., Kurtines, W., Murray, E. & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology*, **10**: 35-44.
- Scheel, M. & Conoley, C. (1998) Circular questioning and neutrality: An investigation of the process relationship. *Contemporary Family Therapy*, **20**: 221-235.
- Sells, S., Smith, T. & Moon, S. (1996) An ethnographic study of client and therapist perceptions of therapy effectiveness in a university-based training clinic. *Journal of Marital and Family Therapy*, **22**: 321-342.
- Sisson, R. & Azrin, N. (1986) Family member involvement to initiate and promote treatment of problem drinkers. *Journal of Behaviour Therapy and Experimental Psychiatry*, **17**: 15-21.
- Smith, T., Sells, S. & Clevenger, T. (1994) Ethnographic content analysis of couple and therapist perceptions of a reflecting team setting. *Journal of Marital and Family Therapy*, **20**: 267-286.
- Sprenkle, D., Blow, A., & Dickey, M. (1999). Common factors and other non-technique variables in marriage and family therapy. In M. Hubble, B. Duncan, & S. Miller (Eds). *The Heart and Soul of Change* (pp. 329-360 ). Washington, DC: American Psychological Association.
- Stanton, M. & Shadish, W.(1997) Outcome, attrition and family-couples treatment for Drug Abuse: A Meta-analysis and review of the controlled comparative studies. *Psychological Bulletin*, **122**: 170-191.
- Stith, S., Rosen, K., McCollum E., Coleman, J. & Herman, S. (1996) The voices of children. Preadolescent children's experiences of family therapy. *Journal of Marital and Family Therapy*, **22**: 69-86.
- Stoolmiller, M., Duncan, T., Bank, L. & Patterson, G. (1993) Some problems and solution sin the study of change: Significant patterns of client resistance. *Journal of Consulting and Clinical Psychology*, **61**: 920-928.
- Szapocznik, J., Perez-Vidal, A., Brickman, A., Foote, F.H., Santisteban, D., & Hervis, O. (1988) Engaging adolescent drug abusers and their families in treatment: a strategic structural systems approach. *Journal of Consulting and Clinical Psychology*, **56**: 552-557.
- Tomm, K. (1988) Interventive Interviewing Part 111. Intending to ask linear, circular, strategic or reflexive questions. *Family Process*, **27**: 1-15.

- Van Orman, W. (1996) The relationship between therapeutic alliance and therapy outcome in home based family therapy. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 57(3-B), 2169.
- Verwaaijen, A. & VanAcker, J. (1993) Family treatment for adolescents at risk of placement: II. Treatment process and outcome. *Family Therapy*, **20**: 103-132.
-