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ALLIANCE-BUILDING INTERVENTIONS WITH ADOLESCENTS IN FAMILY THERAPY: A PROCESS STUDY

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This exploratory, process-research study identified, articulated, and measured therapist behaviors associated with improving initially poor therapist-adolescent alliances in multidimensional family therapy (MDFT). A list of preliminary alliance-building interventions was generated from MDFT theory and adolescent development research. This list was then refined through the observation of videotaped MDFT sessions. A sample of five improved and five unimproved alliance cases was then drawn from a larger treatment study. Participants were primarily African American, male, adolescent substance abusers and their families. Coders rated the first three sessions of each case (30 sessions) to determine the extent to which each alliance-building intervention was employed. By session three, therapists were attending to the adolescent's experience, formulating personally meaningful goals, and presenting as the adolescent's ally more extensively in the improved alliance cases than in the unimproved alliance cases. Using these data, proposed stages of alliance building with adolescents are discussed.

Establishing a strong therapist-client alliance within the first few hours of therapy is critical to the psychotherapeutic process (Horvath, 1994; Horvath & Symonds, 1991). When clients and therapists agree on the goals and tasks of therapy and like, trust, and respect one another early in treatment, outcome, retention, and client satisfaction are enhanced. These findings are consistent across various individual and couples psychotherapies with adults (Bourgeois, Sabourin, & Wright, 1990; Gaston, 1990; Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989; Horvath & Symonds, 1991). Some evidence suggests that alliance formation is also associated with client satisfaction and treatment progress with adolescents (Eltz, Shirk, & Sarlin, 1995; Shapiro, Welker, & Jacobson, 1997; Taylor, Adelman, & Kaser-Boyd, 1986).

While studies of the therapeutic alliance in individual therapy have increased dramatically over the past decade, the role of the therapeutic alliance in family therapy has been generally undervalued (Coady, 1992) and insufficiently researched (Friedlander, Wildman, Heatherington, & Skowron, 1994; Pinsof, 1994). This may be

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due to the systemic (i.e., focus on whole family processes) underpinnings of most family therapy models and their emphasis on behavioral interactions between family members rather than on interactions between individual family members and the therapist. In an attempt to define the construct of the alliance in family therapy, Pinsof (1994) presented an integrative model that accounts for the therapist's working relationship with each family member, with each subsystem, and with the family as a whole. This theoretical model captures the complexity of the therapeutic relationship in family therapy, as therapists attempt to form and maintain multiple, simultaneous, and sometimes competing alliances (Liddle, 1995). Not surprisingly, research has shown that alliance "splits" frequently occur, in which the therapist has a strong alliance with one family member or subsystem and a weaker alliance with others (Heatherington & Friedlander, 1990; Pinsof & Catherall, 1986).

The nature and relative importance of the family therapist's relationship with each family member may vary according to several factors, including the family's interactional style, the presenting problem, the stage of therapy, and the developmental level of each family member. Therapists treating young children, for example, may invest primarily in their relationship with parents, who frequently have the most leverage and, arguably, the most potential to effect change. On the other hand, therapists treating adolescents must recognize teenagers' power to facilitate or challenge the therapeutic process. From a family therapy perspective, a respectful, supportive, yet demanding therapist-adolescent relationship provides an important context in which teenagers can identify and clarify the goals, thoughts, and feelings that they find important and will later introduce in conversations with their parents. Furthermore, a strong therapist-adolescent alliance supports adolescents during emotional and often difficult in-session enactments. This support allows teenagers to disclose to parents what are often vulnerable and previously unspoken thoughts and feelings. When modulated, such disclosures frequently lead to greater understanding and expressions of warmth on the part of parents. This results in more positive, less hostile parent-adolescent interactions and reinforces adolescents' participation in the treatment process (Diamond & Liddle, 1996; Liddle & Diamond, 1991).

Forming workable, good alliances with adolescents, however, is challenging. Between 50% and 75% of children and adolescents referred for therapy either do not initiate treatment or terminate prematurely (Kazdin, 1990; Viale-Val, Rosenthal, Curtis, & Marohn, 1984). The attrition rates for African American and economically disadvantaged adolescents, populations who are overrepresented in clinical samples, may be even higher (Kazdin, Stolar, & Marciano, 1995). Furthermore, many adolescents arrive for therapy unwillingly. Research indicates that adolescents with behavior problems approach therapy reluctantly (Taylor, Adelman, & Kaser-Boyd, 1985) and present with more negativity than other family members (Robbins, Alexander, Newell, & Turner, 1996).

Given the key role of alliance in treatment outcome and the importance of a strong therapist-adolescent alliance to the process of family therapy (Liddle, 1995), transforming adolescents' initial reluctance and negativity into collaboration is one of the first and one of the most critical therapeutic tasks. Improving what often begins as a weak therapist-adolescent alliance requires clinically based, empirically supported strategies. The need to specify and test interventions associated with critical treatment processes, such as alliance formation, has been emphasized in the treatment development literature (Kazdin, 1994).

Unfortunately, there has been a paucity of research on essential treatment processes in family therapy (Diamond & Diamond, in press; Kazdin, 1994) and no published studies on forming alliances with adolescents in family therapy. There have been, however, a number of studies examining the process of alliance formation in individual therapy with adults. In an exemplary study by Safran and colleagues, the authors employed a task-analytic approach to map out therapist-client sequences associated with repairing alliance ruptures (Safran, Muran, & Samstag, 1994). Other studies have compared therapist behavior in initially poor alliances that improved over time with initially poor alliances that did not improve (Foreman & Marmar, 1985; Gaston, Marmar, & Ring, 1988; Kivlighan & Schmitz, 1992). Results of these between-group comparisons suggest that a number of standard psychodynamic techniques, including directly addressing clients' negative feelings toward the therapist, were associated with improved alliances (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992).

The generalizability of these results to adolescents may be limited. A study by Linscott, DiGiuseppe, and Jilton (1993) found that a number of traditional psychodynamic interventions, and other common therapy techniques, were *negatively* correlated with the strength of the therapist-adolescent alliance. For example, the more frequently therapists reported using free association in the here and now, transference interpretations, and silence, the poorer the alliance. Such results, divergent from those found in research with adults, echo Shirk and Saiz's (1992) warning against the simple downward extension of adult-oriented therapeutic procedures with youth. The formulation and testing of alliance-building techniques for teenagers must consider the unique aspects of this developmental stage or risk being ineffective (DiGiuseppe, Linscott, & Jilton, 1996; Holmbeck & Updegrove, 1995; Liddle, Rowe, Dakof, & Lyke, 1998).

One developmental process with implications for alliance formation is adolescent autonomy development. During adolescence, teenagers and parents engage in the mutual and reciprocal process of redefining their relationships so that close ties are maintained while the teenager's individuality emerges (Steinberg, 1990). Healthy autonomy development is facilitated when parents grant adolescents increasing psychological freedom, remain emotionally available, and expect and enforce responsible behavior (Allen, Hauser, Bell, & O'Connor, 1994; Baumrind, 1991; Steinberg, 1990; Youniss & Smollar, 1985). A similar approach by therapists may facilitate the formation of the therapeutic alliance. Church (1994) found that when therapists present themselves as partners, encourage adolescents to work out their own solutions, show a willingness to discuss adolescents' negative feelings about the therapy and the therapeutic relationship, take responsibility for confidentiality, and provide reasonable structure for the session, adolescents respond by talking more about the therapy or the therapeutic relationship and by more frequently asking the therapist for advice. Adolescent clients who experience the enhancement of personal autonomy in therapy show the highest degree of satisfaction with treatment at termination (Taylor et al., 1986).

Cognitive developmental level may also play a role in alliance formation. In their sociocognitive model of alliance formation in child therapy, Shirk and Saiz (1992) asserted that childrens' relationships with their therapists and the extent to which they participate in treatment may be mediated by their beliefs about the need for change, the causal locus of problems, and the contingency of problem solution. Children may become allies in treatment only to the degree that they believe change is necessary or desirable, understand the role they play in the problem's formation or maintenance, and believe that they can effect positive change. Indirect empirical evidence for this formulation exists. Weisz (1986) found that problem resolution during psychotherapy was predicted by adolescents' beliefs about their own competency and about whether people like themselves could resolve problems. Although Weisz did not measure adolescents' behaviors per se, he suggested that it was adolescents' investment of energy in the therapeutic process, which was commensurate with their beliefs about control, that predicted outcome. Promoting adolescents' sense of competence and self-efficacy may enhance the strength of the therapist-adolescent alliance.

This study examined therapist behaviors associated with improving initially poor therapist-adolescent alliances in multidimensional family therapy (MDFT; Liddle, 1991). MDFT is based on structural family therapy (Minuchin, 1974) and on an empirical understanding of normative adolescent development (Liddle, in press). MDFT has been identified as one of few integrative family therapy models with empirical evidence for its efficacy (Lebow & Gurman, 1995; Nichols & Schwartz, 1998; Stanton & Shadish, 1997; Waldron, 1997; Winters, Latimer, & Stinchfield, 1998). The MDFT program of research is summarized elsewhere (Liddle & Hogue, in press).

Because this study represents a step into empirically unchartered territory, our research was exploratory rather than confirmatory in nature. We focused on what we consider a critical-change episode (Greenberg, 1986): initially poor therapist-adolescent alliances that improved by the third session of therapy. The first phase of this study was discovery oriented. We took an intensive, in-depth look at a small number of cases in order to observe, articulate, and measure therapist interventions associated with improved alliances in actual family therapy sessions (Greenberg, 1991; Mahrer, 1988). Such observations lead to the formulation of hypotheses and are an essential first step in the treatment development process (Hill, 1990). The

second phase of this study involved exploratory, empirical analyses of patterns of therapist behaviors. Specifically, we examined whether patterns of therapist behaviors distinguished between improved and unimproved alliance cases.

Methods

Generating a Preliminary List of Alliance-Building Behaviors

First, a preliminary list of proposed therapist alliance-building interventions was constructed. This list, based on MDFT theory, adolescent development research, and clinical experience with substance-abusing and delinquent adolescents, included three interventions: developing a collaborative set, goal formation, and generating hope (see Diamond & Liddle, 1998; Liddle & Diamond, 1991). This preliminary list was designed to guide and organize our observations of therapist behaviors as they occurred in actual cases with improved alliances.

Discovery-Oriented Observation of Instances of Improved Alliances

The next step involved selecting instances of improved alliances for investigation. MDFT therapists participating in a large, controlled clinical trial were each asked to nominate one or two cases most representative of initially poor alliances that improved by the third session of treatment. From these nominations, one case from each therapist was randomly chosen (5 cases in total). Only cases that did not meet inclusion criteria for the later exploratory, empirical phase of this study (e.g., lacked a full set of videotapes, adolescent did not attend three of the first five sessions, etc.) were sampled. Two tapes from among the first three sessions of each case (ten tapes in all) were then randomly chosen.

Once tapes of putatively improved alliances had been selected, we began the process of refining our description of therapist alliance-building interventions to reflect how these behaviors appeared in actual family-therapy sessions. The first author and a research assistant observed the ten improved-alliance sessions. Using the preliminary list of alliance-building interventions as our guide, we sought to discover variations of these interventions, new classes of interventions, and exemplars of these interventions. A description of how we revised the formulating-goals item helps to illustrate this overall process. We observed, for example, that when helping adolescents formulate goals for therapy, therapists varied in the degree to which they verified whether the adolescent endorsed the proposed treatment goals. In some cases, therapists were careful to "check-in" with the adolescent (i.e., Does this sound like something you would like to work on?). In other instances, therapists simply assumed that the adolescent was invested in the formulated goal when, in fact, the adolescent's behavior suggested that he or she was disengaged. Consequently, the formulating-goals item was changed to include only those instances in which the therapist overtly assessed the adolescent's acceptance of the therapy goals. The product of this process was a comprehensive, observation-based articulation of therapist alliance-building techniques in early sessions of MDFT (see Table 1).

Exploratory Empirical Analyses

After describing proposed alliance building interventions, we were interested in whether (a) others (naive raters) could reliably identify and measure these behavior and (b) these behaviors were of empirical importance (i.e., associated with improved alliances). Two new groups of cases that were not included in the discovery-oriented phase of the project, a group of 5 cases with improved alliances and a group of 5 cases with unimproved alliances, were selected from the same, larger clinical trial (see Procedures). The two groups were equivalent on three variables: initial alliance scores, adolescents' pretherapy interpersonal functioning, and the amount of time therapist and adolescent spent together over the first three sessions of treatment. Prior research has shown that client's pretherapy interpersonal functioning predicts the quality of the therapeutic alliance with adults (Horvath, 1994; Moras & Strupp, 1982). Furthermore, relationships require time to build. In MDFT, where therapists periodically work separately with individuals and family subsystems (siblings, parents), the strength of the therapist-adolescent relationship may be, in part, a function of the amount of time the two spend together in sessions.

Trained raters coded the extent to which therapists implemented proposed alliance-building behaviors over the first three sessions of each case (30 sessions in all). Analyses were then conducted to examine the reliability with which raters could code the extensiveness of each item, the interrelationship between therapist interventions, and the patterns in which therapist techniques were imple-

mented over time in the improved and nonimproved groups. We hypothesized that the alliance-building techniques identified in this study's discovery-oriented stage would be implemented more extensively in cases in which initially poor alliances improved.

Participants

Sample. The 10 adolescents who participated in this study were drawn from a sample of 48 adolescents and their families referred for treatment of adolescent substance abuse. Treatment was conducted in an inner-city, university-based clinic. Only adolescents who participated in at least 10 minutes of each of the first three sessions of therapy were eligible for inclusion. Five cases were chosen that represented initially poor therapist-adolescent alliances that improved, and five cases were chosen that represented initially poor therapist-adolescent alliances that did not improve (see *Procedures*). The mean age of the adolescents was 15 (SD = 0.8), 70% were male, and 80% identified themselves as African American. Seventy percent came from single-parent homes and seventy percent came from homes with annual family incomes of less than $35,000.

Therapists. The three therapists in the study had master's degrees in social work, with one also holding a doctorate in developmental psychology. One therapist was an African American female, one an African American male, and one a European American female. Their average age was 44 years (SD = 3). They each had 5 years of postgraduate clinical experience and more than 2 years of family-therapy training and experience. All three therapists were trained in the manualized MDFT approach for at least 3 months (10 hours per week) prior to treating study cases.

Alliance raters. A group of 11 raters was trained to code therapist-adolescent alliance. The group consisted of graduate and undergraduate psychology students. Their mean age was 22, and 10 were female. They ranged from having zero to having one year of clinical experience. The raters included African Americans, Asian Americans, European Americans, one individual from India, and one individual from Puerto Rico.

Therapist-behavior raters. A second group of six raters was trained to code therapist alliance-building behaviors. This group consisted primarily of doctoral counseling-psychology students. They ranged from having one year to having extensive clinical experience. Their mean age was 26, and four were female. This group of raters consisted of one African American and five European Americans.

Measures

Therapist-adolescent alliance. The therapist-adolescent alliance was assessed using two subscales of the Vanderbilt Therapeutic Alliance Scale (VTAS) (Hartley & Strupp, 1983). The VTAS is a 44-item, observer-rated instrument designed to measure the strength of the therapeutic alliance in individual therapy. Items include questions such as, "To what extent did the patient indicate that he or she experiences the therapist as understanding and supporting him or her?"; "To what extent did the therapist and patient work together in a joint effort to deal with the patient's problems?" Each item is rated on a Likert-type scale ranging from 0 (not at all) to 5 (a great deal). The full scale includes three subscales: Therapist Contribution, Patient Contribution, and Therapist-Client Interaction. The VTAS has demonstrated acceptable interrater reliability and internal consistency in several studies (Hartley & Strupp, 1983; Kamin, Garske, Sawyer, & Rawson, 1993; Krupnick et al., 1994). Furthermore, it shows convergent validity with other common alliance measures (Tichenor & Hill, 1989).

We used only the 26 items from the Patient Contribution and Therapist-Client Interaction scales. The Therapist Contribution scale was eliminated in order to distinguish between therapist techniques and the client's participation in the alliance. Defining alliance as *client collaboration*, as distinct from *therapist technique*, has both empirical and theoretical advantages. First, the patient involvement component of the alliance consistently emerges as the best predictor of outcome (Henry & Strupp, 1994). Second, distinguishing between therapist techniques and therapeutic alliance allows researchers to investigate the relationship between these two variables (Frieswyk et al., 1986).

Therapist alliance-building behaviors. The Alliance Building Behavior Scale (ABBS) (Diamond, Liddle, Dakof, Hogue, & Johnson-Leckrone, 1996) was developed to measure therapist behaviors. The ABBS includes descriptions and exemplars of the six therapist alliance-building behaviors identified in the discovery-oriented phase of this study (see Table 1), along with descriptions and exemplars of two generic therapist behaviors. Two generic behaviors were

TABLE 1. Alliance-Building Behavior Scale Items

Alliance-Building Behavior	Description of Behavior	Example
Attend to adolescent's experience.	Therapist clarifies, summarizes, interprets adolescent's feelings, thoughts, or behaviors.	"It sounds like you've been responsible for yourself *and* your brother."
Orient adolescent to the collaborative nature of therapy.	Therapist frames treatment as a vehicle for addressing the teenager's concerns and aspirations.	"Your side of the story is just as important as your parents."
Formulate meaningful goals.	Therapist elicits therapy goals based on adolescent's complaints and aspirations.	"You said your parents don't treat you respectfully. Is that something we can talk about here?"
Present self as an ally.	Therapist indicates a willingness to advocate for adolescent.	"I will help your parents hear how humiliating it is for you to be yelled at."
Challenge control and contingency beliefs.	Therapist challenges adolescent's negative sense of his or her agency.	"You may not believe that your parents are going to listen to you, but there are things you can do to help them take you seriously."
Address issues of trust, honesty, and confidentiality in the therapeutic relationship.	Therapist emphasizes trust and confidentiality issues in a nondefensive fashion.	"I'm not going to run and tell your parents what you say to me in here."
Generic Behaviors	**Description of Behavior**	**Example**
Gather information.	Therapist uses questions to elicit additional information about adolescent's life.	"So, you guys are getting high before school. How do you pay for that?"
Challenge cognitions and behaviors.	Therapist challenges inconsistencies between adolescent's stated wishes or goals and his or her behaviors.	"You would like your mother to stop calling the school to 'check' on you, but you've cut every day this week."

included to insure that raters could not only reliably code alliance-building behaviors but could also reliably distinguish them from other, common therapy techniques. Each therapist behavior is assigned a global extensiveness score ranging from 0 to 6 on a Likert-type scale. "Extensiveness" refers to the thoroughness and the frequency with which the intervention was implemented (Evans, Piasecki, Kriss, & Hollon, 1984; Hill, O'Grady, & Elkin, 1992; Hogue et al., 1998).

Pretherapy interpersonal relations. The Self-Perception Profile for Adolescents (SPPA; Harter, 1988) is a self-report instrument designed to assess adolescents' judgments of their competence or adequacy in eight specific domains, as well as of their global self-worth. One of these domains, Social Acceptance, reflects adolescents' perceptions of how easily they make friends, how popular and accepted they are, and how likable they feel. The Social Acceptance subscale was used as a measure of interpersonal relations. Scores on this scale range from 0 to 4. In prior studies on nonclinical populations, the Social Acceptance Scale subscale demonstrated high levels of internal consistency, with Cronbach's alpha ranging from .77 to .90 (Harter, 1988).

Procedures

Measuring pretherapy levels of interpersonal relations. The SPPA was administered as part of a pretherapy assessment battery.

Coding alliance and defining the groups. Alliance raters received 15 hours of training on the VTAS. After attaining adequate interrater reliability, intraclass correlation coefficient [$ICC_{(2,11)} > .70$] (Shrout & Fleiss, 1979), the raters coded the first- and third-session alliance for all 48 MDFT cases. Raters were assigned to code ses-

sions according to a randomized block design (Fleiss, 1981). No rater coded more than one session of a particular case, and raters were naive to the purpose and hypotheses of the study.

From among the 48 total cases, the 21 lowest first-session alliance scores were identified as having initially poor alliance cases. From this initially poor alliance group, 5 cases were identified as having alliances that improved by Session 3, according to the following standards: Improved alliances increased by at least one standard deviation (SD = 19.30) from Session 1 to Session 3 and, as a group, had a mean third-session alliance score (M = 91.4, SD = 13.78) that did not statistically differ from the mean third-session alliance score of the group of 27 cases with initially adequate alliances (M = 81.48, SD = 20.02; $t(30) = 1.05$, $p < .29$). From the remaining 16 initially poor alliance cases, a group of 5 unimproved alliances was identified as follows: Unimproved alliances did not increase by a full standard deviation from Session 1 to Session 3 and, as a group, had a mean third-session alliance (M = 56.1, SD = 17.60) that was significantly below that of the group of 27 initially adequate alliances ($t(30) = -2.64$, $p < .01$).

Coding alliance-building behaviors. Raters received 20 hours of training on the ABBS. After attaining sufficient interrater reliability for each behavior item, $ICC_{(2,6)} > .60$, raters coded the first three sessions of all ten study cases (30 sessions in total) according to a randomized block design. Two raters coded each session (10 sessions per rater). No rater coded more than one session from each case, and raters were naive to the purpose and hypotheses of the study.

Results

Preliminary Between-Group Comparisons

Analyses were conducted to insure that the improved and unimproved alliance groups did not differ on initial alliance scores, adolescent's pretherapy interpersonal functioning, and time spent with therapist. There was no difference between the improved (M = 64.4, SD = 15.0) and unimproved (M = 60.7, SD = 19.7; $t(8) = .33$, $p < .75$) alliance groups on first-session alliance score. Similarly, there were no differences between the improved (M = 68 min., SD = 71 min.) and unimproved (M = 68 min., SD = 45 min.; $t(8) = .00$, $p < .99$) alliance groups in the amount of time therapists spent with parents and adolescents together across the first three sessions or the amount of time therapists spent alone with the adolescent across the first three sessions (M = 70 min., SD = 32 min. vs. M = 55 min., SD = 31 min.; $t(8) = .77$, $p < .47$). Furthermore, a comparison of mean scores on the Social Acceptance subscale of the SPPA revealed no difference between the improved (M = 1.16, SD = 0.17) and the unimproved (M = 1.12, SD = 0.27; $t(8) = .28$, $p < .78$) groups regarding adolescents' pretherapy interpersonal functioning.

VTAS: Interrater Reliability and Scale Properties

Consistent with prior research on the VTAS, raters were able to achieve a high degree of interrater reliability. Raters achieved a mean $ICC_{(1,11)}$ of .80 for the scale as a whole. An internal consistency analysis performed on the 26 VTAS items produced a Cronbach's coefficient alpha of .95, suggesting that the two VTAS subscales measure a single underlying construct defined as alliance. These results suggest that the VTAS is a reliable measure of therapist-adolescent alliance for this population.

ABBS: Interrater Reliability and Scale Properties

In order to determine how reliably coders had measured each type of therapist behavior, we calculated separate interrater correlation coefficients$_{(1,6)}$ for each ABBS category. Except for challenging control and contingency beliefs, which were clearly unreliable ($ICC_{[1,6]}$ .08), the seven remaining therapist behaviors showed adequate reliabilities, with $ICCs_{(1,6)}$ ranging from .52 to .74. Reliability estimates of this magnitude are typical for studies of this nature, in which raters are asked to provide global scores for complex and comprehensive therapist interventions (Barber, Crits-Christoph, & Luborsky, 1996; Barber, Mercer, Krakauer, & Calvo, 1996; DeRubeis & Feeley, 1990; Startup & Shapiro, 1993). Because the behavior-challenge control and contingency beliefs could not be reliably coded, it was eliminated from all subsequent analyses.

We then investigated whether the seven remaining ABBS items were distinct. For example, can the behavior "Formulating personally meaningful goals" be distinguished from "Orienting the adolescent to the collaborative nature of therapy"? In particular, we were interested in whether the five reliable alliance-building categories were measuring distinguishable, yet related constructs or whether they were each measuring a single,

common alliance-building approach (e.g., a "good therapist effect"). We performed a correlational analysis to measure the relations between all seven ABBS items (five alliance-building and two generic). This analysis produced a Cronbach's coefficient alpha of .29, which suggests that the seven ABBS items do not represent a single underlying construct but, rather, reflect somewhat distinct behaviors. Furthermore, Pearson's correlations were computed to determine the intercorrelations among all seven items. After employing a Bonferonni correction, .0024 (.05/21), only one correlation (Trust, honesty, & confidentiality × Orient to the collaborative nature of therapy) was significant and positive. These results support the contention that ABBS items represent somewhat distinct therapist interventions that can be measured independently. The small sample size prohibited the use of factor analytic techniques that might have further clarified the relationships between alliance-building behaviors.

Exploratory Between-Group Analyses of Therapist Behaviors

In order to examine the patterns in which alliance-building behaviors were implemented across the first three sessions of MDFT, and whether these patterns distinguished between improved and unimproved alliances, five repeated-measure ANOVAS were performed. For each ANOVA, alliance status (improved vs. unimproved) was the between-group factor, time was the repeated measure, and one of the five reliable alliance-building behaviors served as the dependent variable. Means are depicted in Figures 1–7.

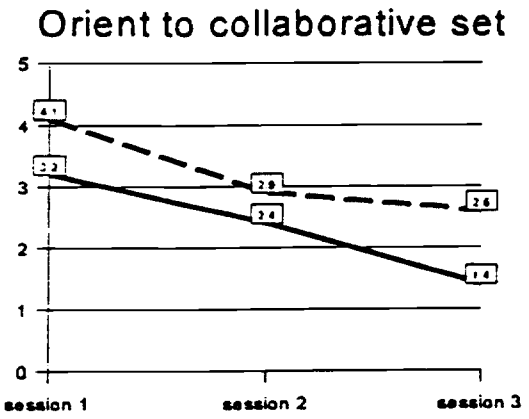

Figure 1. Orient to a collaborative set.

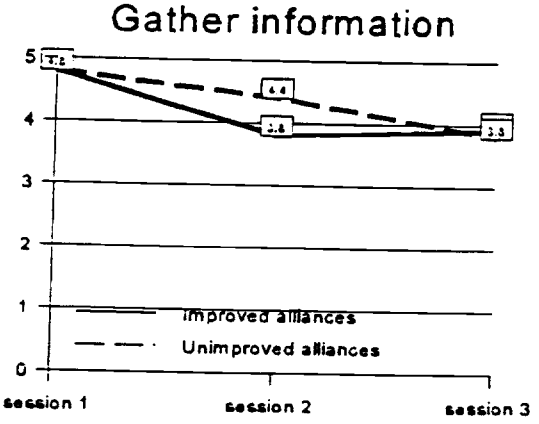

Figure 2. Gather information.

It is important to remember that our small sample size significantly reduced the power of these analyses. Consequently, post-hoc analyses were limited to a series of planned, pairwise *t* tests conducted at each of the three points (sessions) in time. In order not to capitalize on chance, a Bonferonni correction was employed and the *p* value for planned post-hoc *t* tests was set at .017 (.05/3). Because the nature of this study was exploratory, results are reported as both *p* values and effect sizes. Only significant *p* values and significant effects sizes are reported. For eta squared, effect sizes of .01 are considered small, .06 medium, and .16 large. For Cohen's *d*, effect sizes of .2 are considered small, .5 medium, and .8 large (Cohen, 1988). Reports of effect sizes can help uncover what may be clinically important phenomena, such as the impact of therapist behaviors, that do not reach statistically significant levels because of low power (Cohen, 1988).

Results showed a significant main effect for time for addressing trust, honesty, and confidentiality in the therapeutic relationship, $F(1,8) = 6.45$, $p = .03$, $n^2 = .65$. Across both groups, therapists decreased the extent to which they emphasized the sensitive and confidential nature of the therapeutic relationship across the first three sessions of treatment. Although the group by time interaction did not reach statistical significance, $F(1,8) = 1.56$, $p = .27$, $n^2 = .31$, the effect size was large. A visual inspection of the means (see Figure 7) suggests that, from Session 1 to Session 2, therapists more dramatically decreased the extent to which they addressed trust, honesty,

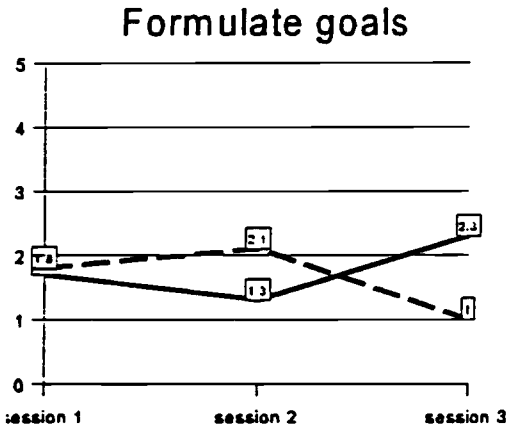

Figure 3. Formulate goals.

and confidentiality in the improved alliance group than in the unimproved alliance group.

Two interventions, orienting the adolescent to the collaborative nature of therapy and attending to the adolescent's experience, had main effects for time that evidenced large effect sizes, $F(1,8) = 2.74, p = .13, n^2 = .44$ and $F(1,8) = 2.37, p = .16, n^2 = .40$, respectively. Across both groups, therapists decreased their use of orienting interventions over time. In regard to attending to the adolescent's experience, the main effect is qualified by a group by time interaction that approached significance and evidenced a particularly large effect size, $F(1,8) = 4.25, p = .06, n^2 = .55$. The pairwise t test at Session 3 also evidenced a small to moderate effect size, $t = 1.99, p = .08, d = .32$. By Session 3, therapists were attending to the adolescent's experience more in the improved alliance group than in the unimproved alliance group. A visual inspection of the means (see Figure 6) suggests that, while in both groups the therapists increased their use of this behavior over the first two sessions, between-group differences evolved from Session 2 to Session 3. In the improved-alliance group, therapists continued to increase their attention to the adolescent's experience, whereas in the unimproved-alliance group, therapists decreased the extent to which they attended to the adolescent's experience.

The results for presenting as the adolescent's ally show a similar pattern. Although there was a large effect for time, $F(1,8) = 1.07, p = .39, n^2 = .23$, this effect must be interpreted in the context of the significant time by group interaction, $F(1,8) = 7.12, p = .02, n^2 = .67$. By Session 3, therapists were presenting themselves as allies much more in the improved-alliance group than in the unimproved-alliance group, $t = 2.76, p = .02, d = .55$. A visual inspection of the means (see Figure 5) suggests that, whereas in the improved-alliance group therapists dramatically increased their use of this intervention from Session 2 to Session 3, by Session 3 therapists in the unimproved-alliance group appeared to have all but abandoned their attempts to present as the adolescent's ally.

Once again, a similar pattern appears for formulating personally meaningful goals. Although not statistically significant, the time by group interaction bears a large effect size, $F(1,8) = .83, p = .48, n^2 = .19$. Pair-wise t tests revealed a small to moderate effect size at Session 3, $t = 1.88, p = .10, d = .30$. By Session 3, therapists in the improved-alliance group were helping adolescents to form personally meaningful goals more than therapists in the unimproved-alliance group. Much like the results for presenting as the adolescent's ally, between-group differences appear to be the result of an increase in therapists' focus on formulating personally meaningful goals in the improved-alliance group and a decrease in this intervention in the unimproved-alliance group (see Figure 3).

Discussion

This study represents a first step in articulating and measuring developmentally based strategies for improving initially poor alliances with adolescents in family therapy. An iterative, discovery-

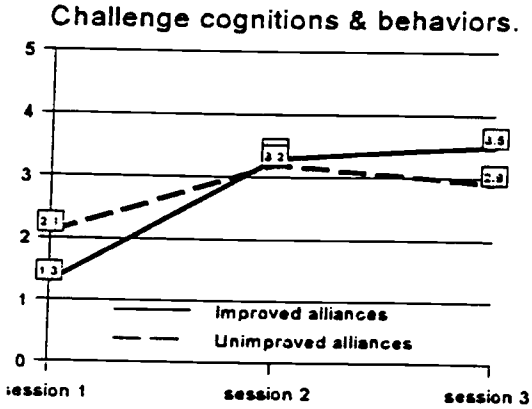

Figure 4. Challenge cognitions & behaviors.

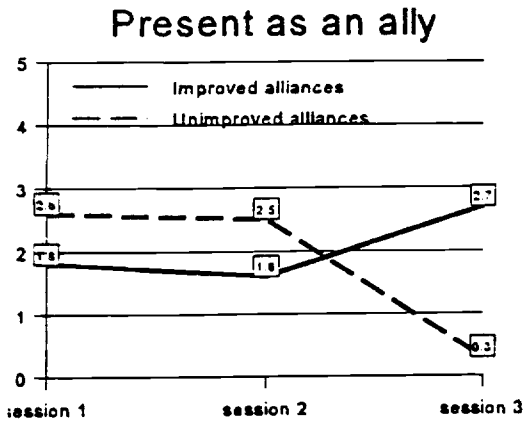

Figure 5. Present as an ally.

oriented, observation-based methodology yielded detailed, narrative descriptions of six alliance-building interventions as they actually occurred in family-therapy sessions. Raters were able to reliably code the extent to which therapists implemented 5 of these interventions: orient adolescent to the collaborative nature of therapy; formulate personally meaningful goals; attend to the adolescent's experience; present self as an ally; and address trust, honesty, and confidentiality.

Results of exploratory between-group analyses suggest that by the third session of therapy, therapists attended to the adolescent's experience, presented themselves as the adolescent's ally, and helped the adolescent formulate personally meaningful goals more extensively in cases in which the alliance improved than in cases in which the alliance did not improve. The finding that attending to the adolescent's experience is associated with improved alliances complements the results of earlier research with adults on therapist attunement. Empathic resonance, defined as "being on the same wavelength" as the client, and as the client being "fully heard," has been found to contribute to positive treatment outcome with adults (Orlinsky & Howard, 1986, p. 344). Being "heard" may be particularly important to adolescents, in that self-expression is essential to identity formation and autonomy development. Furthermore, adolescents who abuse drugs and evidence problem behaviors frequently do not feel "heard," understood, or acknowledged. They are often socially ineffective and become easily frustrated in their conversations with adults (Shedler & Block, 1990). This study suggests that when therapists listened carefully to teenagers, an initially poor therapeutic alliance improved.

The fact that alliances improved when clinicians helped the adolescent to formulate personally meaningful goals is syntonic with research on client goal-setting behavior in adult psychotherapy. The more adult clients are involved in setting the goals for therapy, the higher their level of satisfaction with treatment (Willer & Miller, 1976). DiGiuseppe and his colleagues suggest that adolescents may be even *more* concerned than adults about "agreement on the goals and tasks of therapy because of the importance of developmental issues such as dependence, independence, and self-determination for teenagers" (DiGiuseppe et al., 1996, p. 87). Similarly, in our clinical work we have found that the therapeutic alliance is enhanced when therapists, together with the teenager, can identify a goal that makes therapy acceptable, or even desirable, to the adolescent (Liddle, in press). We have not found it helpful to assume that teenagers come to therapy to reduce their drug use or to find a way to improve their school performance. These matters may be important to parents or involved others, but they are not necessarily important to the teenager (Liddle, in press). Improving initially poor therapist-adolescent alliances may depend on helping the teenager define a personally meaningful treatment agenda.

What most characterized improved alliances was the therapist's presentation of himself or herself as the adolescent's ally. When therapists showed a willingness to advocate for teenagers and commit to helping them meet their goals,

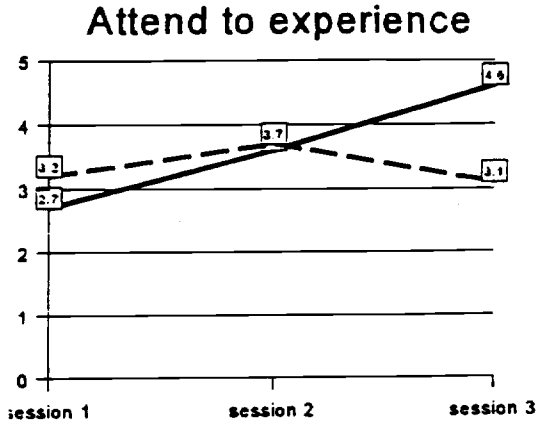

Figure 6. Attend to adolescent's experience.

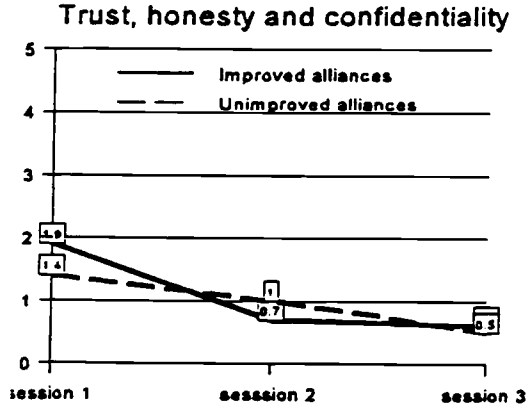

Figure 7. Trust, honesty, & confidentiality.

adolescents participated more fully in the therapeutic process. Therapists' advocacy took many forms, such as offering to meet with school officials to help the teenager change a class or supporting the adolescent during negotiations with parents around issues such as curfew or respect. Further research is needed, however, to explore the nature of the relationship between advocacy and the therapeutic alliance. Weisz (1986) suggested that teenagers' disbelief in their ability to influence change diminished their motivation to participate in treatment. Perhaps the promise of an understanding and influential adult ally generated hope about the possibility of change and aroused adolescents' desire to engage in treatment.

These between-group differences appear to be the function of contrasting trends in the two groups (see Figures 3, 5, and 6). While in improved-alliance cases, therapists increased their use of alliance-building interventions from Session 2 to Session 3, therapists in the unimproved-alliance group *decreased* their use of these interventions over the same time frame. In the improved-alliance group, therapists persevered in their effort to build a collaborative relationship, while in the unimproved-alliance cases, therapists appeared to have "given up." This contrast is most evident in regard to presenting as the adolescent's ally. Because one cannot infer causality from these analyses, it is unclear whether therapist alliance-building behaviors led to improved alliances or were the function of improved alliances. It may be that increased adolescent participation and receptivity allowed therapists to aid in the formation of goals and attend to and advocate for these teenagers. In any event, the decrement in the use of alliance-building interventions in the unimproved-alliance group suggests how difficult it can be to manage the therapeutic relationship with clinically referred adolescents and underscores the potential for negative therapist responses to this challenge (Strupp, 1995).

Not surprisingly, therapists in both groups placed greater emphasis on therapy socialization interventions such as orienting the adolescent to the collaborative nature of therapy and defining the confidential nature of the therapeutic relationship in the first session than in later sessions. Socialization to the treatment setting is naturally a first session task. One key differentiating feature of the improved vis-à-vis the unimproved-alliance group is the therapist's systematic progression from therapy socialization interventions to instrumental, action-oriented interventions such as goal formation and advocacy. These data suggest that alliance building with clinically referred adolescents is a two-step process. The first step appears to involve transforming adolescents' negative expectations about treatment into the credible promise of a collaborative endeavor. The second step appears to be more agency-focused and involves helping the teenager to recognize quickly what tangible benefit he or she can get out of therapy.

This study is a first step in developing an empirically based approach to improving therapist-adolescent alliances in family therapy. It's strengths include the following: a theory-guided therapy model based on current developmental research; the reliable, rigorous measurement and demarcation of improved versus unimproved alliances; the observation-based articulation of therapist alliance-building behaviors as they actually occurred with adolescents in a manualized family therapy; and the distinction between therapist behaviors and the therapist-adolescent alliance.

At the same time, results of this study should be interpreted cautiously. First, the results require replication using larger samples. Second, the correlational design does not allow for making causal inferences. For example, we cannot infer whether therapist behaviors led to improved alliances or whether client's increased participation in therapy elicited different behaviors from therapists. Questions also remain as to whether improving alliances early in therapy with teenagers is associated with outcome at the end of treatment. This study examined the relationship between therapist inter-

ventions and the alliance-building process. Research is also needed to explore the role of the therapist-adolescent alliance in relation to the therapist-parent alliance in family therapy. Finally, the role of race requires further investigation. This sample was primarily African American. The question remains as to what degree these results are population specific. More studies are needed to examine the interaction between race, therapist interventions, and adolescent engagement. For example, there is preliminary evidence suggesting that the introduction of particular culturally relevant themes such as rage, alienation, respect, and journey from boyhood to manhood may help to engage African American, male adolescents in family therapy (Jackson-Gilfort, Liddle, & Dakof, 1999). Such studies, in conjunction with this investigation of therapist alliance-building behaviors with teenagers, can advance our understanding of what constitutes effective family therapy with clinically referred adolescents.

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