



Working (on) Alliances

A Systemic Perspective on Alliances
and their Relation to Outcome in
Home-Based Family Treatment
for Youth Problems

Marianne Welmers-van de Poll

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*"My advice would be:
if you can solve problems, do it.
But first and foremost
listen to the family's stories
about their suffering
and about their attempts
to be happy together."*

Peter Rober

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General Introduction

Home-Based Family Treatment: Key Service in Youth Care

Most children and adolescents are functioning well, growing up in families that foster a stimulating environment helping them to thrive. However, annually about 9% of youth younger than 23 years old in the Netherlands receive some form of professional treatment because of developmental, behavioral, or mental health problems and risks (CBS, 2020). As in many other countries, public policy in the Netherlands aims at providing youth care “as at home as possible”, assuming that professional help for children at risk is most effective and efficient when it aims at empowering the family and is provided in their own environment (Lee et al., 2014; Rijksoverheid, 2021). Given these policy principles, it may not be surprising that home-based family treatment (HBFT) is the most provided service in youth care (CBS, 2020; Child Welfare Information Gateway, 2014; Yorgason, 2005).

HBFT is generally provided to a highly heterogeneous population of families in terms of demographic features and presenting problems. In general, families receiving HBFT typically experience persistent problems in child behavior or mental health, parenting skills, and family interactions (Assen et al., 2020). These child and parenting problems have often accumulated with problems in other domains, such as parent mental health, parent substance abuse, poverty, or the lack of a supporting social network (Assen et al., 2020; Visscher, 2020). Involvement in HBFT can be either voluntary or mandated by court order. Either way, engagement in treatment is often challenging, as many families have had prior negative experiences with professional care (Bodden & Deković, 2016).

HBFT includes both ‘name-brand’ services (e.g., Home Builders, Multidimensional Family Treatment, Multisystemic Treatment) and more generic HBFT services, yet most HBFT programs have comparable program designs (Lee et al., 2014). Moreover, recent research has shown that different home-based programs are more alike than unique (Visscher et al., 2020). One main common characteristic is that care is provided in the family’s home environment, providing the care worker with the opportunity to better understand and accommodate treatment to the family’s everyday reality (Assen et al., 2020; Waisbrod, 2012). Another important common characteristic is the systemic approach focusing on the family system to optimize the child’s development by promoting family functioning, parental competencies, and the family’s self-reliance (Child Welfare Information Gateway, 2014; Lee et al., 2014; Visscher et al., 2020).

Optimizing Home-based Family Treatment: Alliance as a Key Factor

Although several studies support the effectiveness of HBFT programs (Bachler et al., 2016; Barth et al., 2007; De Greef et al., 2018b; Lay et al., 2001; Veerman & De Meyer, 2015; Veerman et al., 2005; Yorgason et al., 2005), positive outcomes are not a given. A recent meta-analysis synthesized results of 50 studies on effectiveness of various HBFT programs for families experiencing complex and multiple problems (Assen et al., 2020). Study findings revealed a moderate decrease in children's emotional and behavioral problems and stressful experiences after receiving HBFT, but also indicated significant heterogeneity between children and interventions in outcomes, and in many cases considerable problems remained at treatment termination. Considering these results, identifying factors in the treatment process that enhance treatment outcome seems vital in optimizing HBFT, and may well serve the interests of families receiving home-based care. Surprisingly, however, generic HBFT services have undergone relatively little empirical process research (De Greef et al., 2018; Sexton et al., 2014).

One factor that may play an important role in positive treatment outcome is the therapeutic or working alliance. This pan-theoretical concept refers to the therapeutic relationship between therapist and client, consisting of an emotional bond and agreement on what should be the central goals and tasks of treatment (Bordin, 1979; Elvins & Green, 2008). The role of the working alliance has been studied for decades in numerous forms of psychotherapy, and the current body of research convincingly indicates its contribution to positive outcome of youth, adult and family treatment (Flückiger et al., 2018; Friedlander et al., 2018; Murphy & Hutton, 2018). Moreover, of all known factors related to treatment success, the alliance is considered one of the largest contributors (Norcross & Lambert, 2019).

However, given its specific and heterogeneous context, results of studies on alliance in other forms of treatment cannot readily be generalized to the context of HBFT. Although a handful of studies confirm the predictive value of alliance for HBFT effects on youth and parent symptom distress (Johnson et al., 2002; 2006), parent and family functioning (De Greef et al., 2018b; Johnson et al., 2006), or more general evaluations of treatment success (Bachler et al., 2016; De Greef et al., 2018b), the role of working alliance in this specific context – like in the broader field of generic youth and systemic family care – remains largely understudied. As a result, important questions about the process of building multiple interacting alliances with different family members and the association of alliances with treatment outcome remain largely unanswered. The current dissertation aims at addressing these questions by investigating the dynamic process of building alliances with families receiving home-based family treatment, and the association between alliance and treatment outcome.

Investigating Alliances in Systemic Family Treatment

In systemic family treatment programs like HBFT, building strong alliances with families is complex for several reasons. First, the therapist faces the task of building and maintaining multiple alliances with family members who differ in their developmental stages, motivation, and aims and needs in treatment. These differences between family members may easily result in unbalanced or *split* alliances, that is: alliances notably differing in strength from one family member to another (Friedlander et al., 2006a; Kindsvatter & Lara, 2012; Robbins, 2003). To complicate matters further, these multiple alliances are interacting and interdependent, as family members observe and influence each other during treatment. Building a strong alliance with one family member, may negatively impact the alliance with another family member, for example when these two family members are in continuous conflict (Friedlander et al., 2006a; Kindsvatter & Lara, 2012). Furthermore, the presence of other family members may lead to feelings of unsafety and may impact a person's willingness to open up and co-operate during treatment sessions (Friedlander et al., 2006a; Escudero & Friedlander, 2017). After all, when the session has ended, family members continue to interact with each other, and what is said during a treatment session may have repercussions afterwards. A final complexity in systemic family treatment is that defining treatment goals and tasks is not an agreement between a therapist and one individual client, but rather a complex interactional contract between multiple individuals. In this complex interplay, collaboration of family members on shared goals seems of vital importance (Escudero et al., 2008; Friedlander et al., 2008; Isserlin & Couturier, 2012; Sotero et al., 2018).

In summary, the working alliance in family treatment is not defined by the interactions and relationship between two individuals (i.e., client and therapist), but comprises a complex therapeutic system with multiple interacting relationships. Thus, systemic aspects of the alliance, such as a balance between multiple family members' alliances, their sense of safety in treatment, and their collaboration on shared goals, may play an important role in enhancing treatment outcome through the alliance (Escudero & Friedlander, 2017; Friedlander et al., 2006a; Kindsvatter & Lara, 2012; Pinsof & Catherall, 1986). Consequently, when investigating the alliance in family treatment, applying an approach that reflects this systemic complexity seems vital. However, an important deficit in systemic treatment research is that studies often investigate one individual perspective (e.g. the parent's perspective) rather than the family perspective (Vilaça & Relvas, 2014). This also applies to the handful of studies on alliance in HBFT so far, where alliance is often investigated from one individual perspective. As a result, little is known about the process and effect of systemic aspects of the alliance, such as the occurrence and development of unbalanced alliances or the within-family alliance.

One specific knowledge gap regarding alliance processes in systemic family treatment is the effect of therapist characteristics and behaviors on alliances with family members. Prior research in adult psychotherapy convincingly underlines the key role of the therapist in building strong alliances (e.g., Baldwin et al., 2007; Dinger et al., 2008; Nissen-Lie et al., 2010), and indicates that therapists differ substantially in how much they succeed in building alliances with their clients (Dinger et al., 2008; Nissen-Lie et al., 2010). Thus, investigating therapist characteristics and behaviors that contribute to better alliances may increase our understanding of between-therapist differences in treatment effectiveness. However, the specific role of the therapist in building alliances in family treatment seems largely understudied (Sotero et al., 2017). Given the complex systemic nature of building alliances in family treatment, more knowledge on therapists' contributions to the alliance seems essential in optimizing training and supervision of (future) providers of systemic family treatment.

Alliance as a Dynamic Process: The Added Value of Observational Research

When investigating the alliance, it is important to realize that alliance is a dynamic process that evolves over time. This process unfolds both *intrapersonally* (within therapists' and clients' thoughts and feelings) as well as *interpersonally* (within the therapist – client interactions; Horvath, 2006). Most studies on alliance in youth and family treatment focus on the intrapersonal aspect by using alliance questionnaires (Barnhoorn et al., 2013). Although providing valuable insight into therapists' and clients' alliance perceptions, the use of questionnaires fails to do justice to the behavioral and interactional nature of the alliance. This behavioral, interpersonal aspect of alliance is typically addressed by using observations of therapists' and clients' in-session behaviors and interactions. An important benefit of observational process research is that it provides data that most closely reflect real-world phenomena. Thus, combining questionnaires with observational data can be of great added value in connecting research to practice (Oka & Whiting, 2013).

There are several observation instruments available to investigate the alliance, most of them designed for the context of individual therapy (Friedlander et al., 2019). A unique instrument specifically designed for the context of conjoint family treatment, is the *System for Observing Family Therapy Alliances – observer version* (SOFTA-o; Friedlander et al., 2006a). Two individual alliance domains of the model reflect Bordin's (1979) definition of the working alliance: *Engagement in the Therapeutic Process*, referring to goal and task elements of the alliance, and *Emotional Connection to the Therapist*, referring to bond elements of the alliance. The other two SOFTA domains concern systemic aspects of

the alliance unique to conjoint family treatment. *Safety within the Therapeutic System* refers to family members experiencing the therapeutic environment as a safe place where they can take risks, be open and flexible, and handle family conflicts without risking harm. Finally, *Shared Sense of Purpose within the Family* refers to the within-family alliance, or a sense of unity and collaboration between family members on shared goals (Friedlander et al., 2006a).

Using the SOFTA-o provides the opportunity of measuring the strength of alliances as reflected in family members' behaviors by using the client version, as well as to measure therapists' behavioral contributions to the alliance with the therapist version. Several studies illustrated the SOFTA-o's reliability and validity (e.g. Friedlander et al., 2006b; Sotero et al., 2017). In prior research, the SOFTA-o has been used to study alliances in family therapy as usual (Beck et al., 2006; Escudero et al., 2008; 2012; Friedlander et al., 2008a; 2008b; 2012; 2014; Higham et al., 2012; Lambert et al., 2012; Lambert & Friedlander, 2008; Muñiz de la Peña et al., 2009; 2012), Brief Strategic Family Therapy (Sheehan & Friedlander, 2015), family therapy with involuntary referred families (Sotero et al., 2016; 2017; 2018), family-based treatment of adolescent anorexia (Isserlin & Couturier, 2012), and family psycho-education for parents of a daughter or son with a severe mental illness (Levy-Frank et al., 2011). However, to my knowledge no studies have been carried out using the SOFTA-o – or any other observational measure – to study alliances in the context of home-based family treatment.

Dissertation Aims and Scope

The current dissertation focusses on alliances in a clinically representative context of home-based family treatment for youth problems. The central aim is to investigate alliance processes in home-based family treatment and their relation to treatment outcome, paying particular attention to the therapists' role and to the systemic complexity of building multiple interacting alliances with and within the family. To meet these study aims, I reviewed the current body of research on alliance in relation to outcomes of family-involved treatment for youth problems, and collected longitudinal, multi-informant questionnaire and observational data with 61 families receiving a Dutch home-based family treatment program called *Intensieve Pedagogische Thuishulp* (IPT; Van der Steege, 2007). IPT serves families dealing with complex child behavior and parenting problems, often accumulated with problems in other domains (e.g., financial problems, parental psychopathology, or lack of a supporting social network). It has an empowering, systemic approach, and building a strong working alliance with the family is a key principle (Van der Steege, 2007).

Results presented in this dissertation should provide tools for building, monitoring, and strengthening alliances with families in systemic (home-based) family treatment, as well as for enhancing training and supervision of (future) providers of systemic family treatment. These tools may help in optimizing the complex everyday practice of home-based family treatment serving families with severe child and parenting problems. Moreover, increased knowledge on how alliance processes may contribute to desirable treatment outcomes, may serve a wide range of youth and family care professionals, regardless of specific target problems or applied models and approaches (Barth et al., 2012).

Outline of the Dissertation


As a first step towards a better understanding of the importance of the alliance in family-involved treatment, **Chapter 2** presents results of a meta-analytic review on the alliance-outcome association in family-involved treatment for youth problems. In this review, including 28 studies ($N = 2126$ families), three multi-level meta analyses examined the effect of the quality of the alliance, alliance improvement over the course of treatment, and unbalanced or *split* alliances within the family on treatment outcome. I also examined the moderating effect of several methodological, treatment, and sample characteristics to investigate whether the alliance may be extra important under certain conditions or for specific groups.

Subsequently, Chapters 3, 4, and 5 present empirical studies investigating the process of alliances during treatment (Chapters 3 and 4), and the association between systemic aspects of the alliance and outcome (Chapter 5). Given the vital role of the therapist in building strong alliances, **Chapter 3** presents a study on therapists' contributions to the alliance. In a sample of 57 families receiving IPT provided by 33 therapists, the contribution of therapists' personality traits, years of clinical experience, and observed in-session alliance building behaviors to family members' and therapists' mid-treatment reports of the alliance was examined. **Chapter 4** presents results of a study on the occurrence and development of alliance discrepancies between family members and the therapists' perspective. In this study, observer-, therapist-, and family members' self-reported alliances of 61 families receiving IPT were analyzed. To investigate alliance discrepancies, the strength of alliances with the therapist between family members were compared. I also compared different perspectives (i.e. therapist, client, observer) on alliance discrepancies and investigated whether congruence between the therapist- and the family member's self-report of the alliance differed between family members. The final empirical study, presented in **Chapter 5**, aimed at identifying the importance of systemic alliance aspects in enhancing long-term treatment outcome in a sample of 29

families receiving IPT. In this explorative study, I examined the association between (a) family members' unbalanced alliances and the within-family alliance or *shared sense of purpose*, and (b) the decrease of youth behavior problems from baseline to 18 months post-treatment.

Finally, in **Chapter 6** findings of the four studies are integrated into general conclusions. Limitations of the study and its implications for clients, therapists, educators, policy makers, and future research are discussed in the light of current knowledge on alliances in family treatment.





Alliance and Treatment Outcome in Family-Involved Treatment for Youth Problems: A Three Level Meta-Analysis

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Abstract

Background Alliance has been shown to predict treatment outcome in family-involved treatment for youth problems in several studies. However, meta-analytic research on alliance in family involved treatment is scarce, and to date no meta-analytic study on the alliance – outcome association in this field has paid attention to moderating variables.

Methods We included 28 studies reporting on the alliance - outcome association in 21 independent study samples of families receiving family-involved treatment for youth problems ($N = 2126$ families, M age youth ranging from 10.6 – 16.1). We performed three multilevel meta-analyses of the associations between three types of alliance processes and treatment outcome, and of several moderator variables.

Results The quality of the alliance was significantly associated with treatment outcome ($r = .183, p < .001$). Correlations were significantly stronger when alliance scores of different measurement moments were averaged or added, when families were help-seeking rather than receiving mandated care, and when studies included younger children. The correlation between alliance improvement and treatment outcome just failed to reach significance ($r = .281, p = .067$), and no significant correlation was found between split alliances and treatment outcome ($r = .106, p = .343$). However, the number of included studies reporting on alliance change scores or split alliances was small.

Conclusions Our findings demonstrate that alliance plays a small but significant role in the effectiveness of family-involved treatment. Future research should focus on investigating the more complex systemic aspects of alliance to gain fuller understanding of the dynamic role of alliance in working with families.

Introduction

In the treatment of mental health or behavior problems of children and adolescents, involving the family can be an important part of the intervention. Given the influence of family functioning on child and adolescent development (Rutter, 2002), treatment to target problematic family functioning and to enhance protective family factors can be vital in reducing youth psychopathology. Indeed, results of several randomized controlled trials support the effectiveness of family-based treatment models for youth problems, such as Attachment Based Family Therapy (ABFT; Diamond et al., 2010), Multidimensional Family Therapy (MDFT; Henderson, Dakof, Greenbaum, & Liddle, 2010; Rigger et al., 2013), Functional Family Therapy (FFT; Hartnett, Carr, & Sexton, 2016; Sexton & Turner, 2011) and Family Based Therapy (FBT; Couturier, Kimber, & Szatmari, 2013; Lock, Le Grange & Agras, 2010). Moreover, in comparative meta-analytic reviews on the effectiveness of treatment for youth delinquency (Latimer, 2001), adolescent substance abuse (Tanner-Smith, Wilson, & Lipsey, 2013) and anorexia nervosa (Lock, Le Grange, & Agras, 2010), family treatment models have been shown to be more effective than interventions for youth only.

Over the past years, delivery of family-based interventions for youth has become more integrative and flexible, and interventions that combine individual therapy, family treatment and sometimes medication have become increasingly popular (Diamond & Josephson, 2005). An example of such an integrative intervention is Family-Based Cognitive-Behavioral Therapy (FBCBT), which has shown to be efficacious for treatment of pediatric obsessive-compulsive disorder (O'Leary, Barrett, & Fjermestad, 2009; Storch et al., 2007) and anxiety disorders (Ginsburg & Schlossberg, 2002; Kendall, Hudson, Flannery-Schroeder, & Suveg, 2008).

In order to gain better understanding of the effectiveness of family-involved interventions, it is important to know what components or conditions of treatment cause positive outcomes. Previous research has shown that the alliance between therapists and clients is a significant predictor of treatment outcome in individual youth psychotherapy as well as family therapy (Friedlander, Escudero, Heatherington, & Diamond, 2011; McLeod, 2011; Shirk, Karver, & Brown, 2011).

Most research on alliance is based on Bordin's (1979) definition of the alliance which he developed for the individual therapy context, also referred to as therapeutic or working alliance. Bordin argues that the professional relationship between a therapist and client consists of three components: (a) an emotional bond between therapist and client based on mutual trust and sympathy, (b) agreement on which problems and goals are the central issue in therapy and (c) agreement on tasks that need to be performed by therapist and client in order to achieve central goals.

The process of building and maintaining an emotional bond and agreement on tasks and goals raises several complexities in working with families. In family-involved treatment, the therapist simultaneously develops multiple alliances with family members who are in treatment together, but who differ in their characters, needs, and treatment expectations (Kindsvatter & Lara, 2012; Rait, 2000). For instance, in a study on alliance and treatment outcome in home based family therapy by Johnson, Wright, and Ketring (2002) the correlation between alliance and outcome was stronger for fathers than for mothers. For fathers, the agreement with the therapist about treatment goals was more predictive of treatment outcome than the agreement on tasks and the emotional bond, whereas for mothers agreement on tasks was relatively more predictive of treatment effectiveness. In addition, research showed that treatment effectiveness can be reduced when the therapist develops a stronger alliance with one family member than with the other: these unbalanced or so called 'split' alliances increase the risk of treatment drop out (Flicker, Turner, Waldron, Brody, & Ozechowski, 2008; Robbins et al., 2003).

Another complicating aspect of building and maintaining alliances in family-involved treatment is that each person's alliance with the therapist is observed and influenced by the other participating family members (Friedlander, Escudero, & Heatherington, 2006; Kindsvatter & Lara, 2012). These observations might cause feelings of unsafety or anxiety, since what is said during a session can have repercussions outside therapy sessions. For example, a teenage son who tells the therapist about a relapse in drug abuse with his parents present, might be worried about getting punished at home for this relapse. Thus, the therapist needs to provide guidelines or discuss basic rules of safety and confidentiality in order to gain confidence and trust from all participating family members (Friedlander et al., 2006).

A third aspect of alliance specific to family-involved treatment is that treatment outcome is not only affected by multiple individual alliances between therapist and family members, but also by the alliance with family as a whole (Escudero, Friedlander, Varela, & Abascal, 2008; Friedlander, Lambert, & Muñoz de la Peña, 2008; Kindsvatter & Lara, 2012). When family members perceive themselves as a group collaborating to improve family functioning and achieve other therapeutic goals, treatment is more likely to be effective. Therefore, family therapists must leverage different views on problems and solutions within the family and try to bring about a shared sense of common family goals by for example emphasizing shared values and experiences (Escudero et al., 2008; Friedlander et al., 2006; Rait, 2000).

Perhaps because of these complexities in alliance processes specific to family-involved treatment, research on alliance in this field emerged later and received far less attention than research on alliance in individual psychotherapy. In the 1980s, Pincus and Catherall (1986) applied Bordin's definition of alliance to three interpersonal levels by measuring

bonds, tasks, and goals for three relationships: self-with-therapist, other-with-therapist, and group-with therapist. This approach was elaborated on by Pinsof (1994) when he added the *within-family alliance*, namely, the extent to which family members collaborate on goals and tasks and experience an emotional bond with each other during therapy. Symonds and Horvath (2004) defined this concept as *allegiance*. Friedlander, Escudero, and Heatherington (2006) elaborated on Bordin's definition of alliance as well as family therapy-specific alliance processes, such as allegiance, by distinguishing four domains of alliance in family therapy: (a) emotional connection to the therapist, (b) engagement in the therapy, (c) shared sense of purpose within the family (similar to Pinsof's *within-family alliance*), and (d) safety within the therapeutic system. The two latter domains are said to be unique to conjoint family therapy.

To date, only one meta-analytic review on the association between alliance and outcome in family-involved treatment has been published (Friedlander et al., 2011). This study investigated the alliance-outcome correlation in 16 family therapy studies and 8 couple therapy studies. The result of the analysis was an average weighted effect size of $r = .24$ for the family therapy studies, demonstrating that higher levels of alliance are associated with more positive treatment outcome. This overall effect size is comparable to the effect size in meta-analyses on alliance and outcome in individual adult and youth psychotherapy (Horvath, Del Re, Flückiger, & Symonds, 2011; Shirk, Karver, & Brown, 2011).

Although Friedlander et al.'s (2011) meta-analysis provides a valuable test of the association between alliance and outcome in family therapy, the study also underlines the importance of further meta-analytical research on alliance in family-involved treatment for two reasons. First, the study included only 16 family therapy studies published until 2008. Since then, scientific attention for alliance processes in family-involved treatment research has burgeoned, resulting in an increase of studies on the subject. Second, the study reported significant variability in the correlation between alliance and outcome. This is not surprising, because the studies that were included in the meta-analysis showed a large heterogeneity with regard to alliance measures and other methodological aspects. This variety within and between studies was dealt with by collapsing several alliance measures (e.g., multiple types of alliance, informants, measurement instruments and measurement moments) into one effect size per study. No distinction was made between different types of alliance processes and no moderator analyses were conducted. Therefore, the reported variability between studies remained unexplained.

Different types of Alliance Processes in Family Involved Treatment

In research on the association between alliance and outcome in family-involved treatment, different types of alliance processes can be distinguished. A first type of alliance is the more traditional fixed moment measure of the level of alliance. Alliance can be measured at

the start, middle or end of therapy, or at multiple moments, emphasizing that alliance is an ongoing process rather than a fixed state concept (Horvath, 2006; Karver & Carporino, 2010). In addition, some studies use alliance change scores to investigate whether the improvement of alliance during the therapy process influences treatment outcome (e.g., Bachler et al., 2016; Keeley et al., 2011). The relevance of this second type of alliance is illustrated by a study on alliance in adolescent psychotherapy, demonstrating that alliance change scores explain more variance in treatment outcome compared to single moment measures or an average of multiple single moment measures (Owen, Miller, Seidell, & Chow, 2016).

A third type of alliance refers to so-called 'split' or unbalanced alliances, and addresses the systemic aspect of alliance in family-involved treatment. Multiple family members form alliances with the therapist, which might differ in strength. When one family member has a better alliance with the therapist than other family members (i.e., alliances with the therapist are unbalanced between family members), this is generally referred to as a 'split alliance'. Some studies have investigated whether these split alliances affect treatment outcome by subtracting family members' single alliance scores and correlating these discrepancy scores with treatment outcome. When discrepancy scores are investigated, a negative correlation with treatment outcome is expected (i.e., higher levels of unbalance lead to less favorable treatment outcomes) instead of a positive correlation, as is the general hypothesis in research on the level of individual- or family alliance and outcome.

Moderators of the Alliance – Outcome Association

The association between alliance and outcome can be moderated by several factors. Several methodological aspects of studies might have a moderating effect, as has been reported in meta-analyses on alliance and outcome in youth and adult psychotherapy (Horvath et al., 2011; McLeod, 2011; Shirk & Karver, 2003; Shirk, Karver, & Brown, 2011). First, it is important to investigate whether study quality moderates the alliance – outcome association: when higher quality studies indicate a stronger effect, this might be an indication of the robustness of the association. Second, timing of alliance measurement can be an important moderator. Alliance might be a predictor of outcome early in treatment, underlining the importance of alliance as a facilitator of successful therapy. On the other hand, meta-analyses in youth psychotherapy (McLeod, 2011; Shirk & Karver, 2003) and adult psychotherapy (Horvath et al., 2011) have indicated that alliance might be more predictive of outcome when assessed in a later stage of treatment, as it may need some time to build.

It might furthermore be of influence whose perspective on alliance as well as on outcome is measured (parent, youth, therapist or observer). Especially in family-involved treatment, with multiple family members involved, it is important to know what perspective is most predictive of successful treatment. Meta-analyses on alliance in youth psychotherapy

either suggest that the parents' or the therapists' perspective on the alliance is most predictive of outcome (McLeod, 2011; Shirk & Karver, 2003) and that children's reports on the alliance show very little variability (Shirk & Karver, 2003). In addition, alliance seems to be most predictive of therapeutic outcome as perceived by either the parent (McLeod, 2011) or the therapist (Shirk & Karver, 2003) when compared to youth or observer reported outcome.

A methodological feature specific for studies on alliance in family-involved treatment is whether the alliance is measured at an individual (e.g., parent-therapist, youth-therapist) or family level (the alliance between the therapist and the family as a whole) using instruments specifically designed for family interventions. These instruments not only investigate individual alliances between family members and therapist, but additionally address the within group or group with therapist aspects of alliance typical of family interventions. The moderating effect of type of alliance in family therapy is illustrated in a study by Escudero et al. (2008), in which the within-family alliance was correlated more strongly with outcome than the individual alliances. However, not all studies on alliance in family-involved treatment use instruments designed to measure family-aspects of the alliance as well as individual alliances. As pointed out by McLeod (2011), the correlation between alliance and outcome in family-involved treatment might be stronger when the alliance measure is designed to investigate alliance-processes typical of working with multiple family members.

Aside from methodological features of studies, several treatment aspects could moderate the effect of alliance on outcome. First, treatment models differ in the extent to which alliance building aspects of treatment are specified. Some treatment models explicitly describe alliance building stages of treatment (ABFT, Feder & Diamond, 2016) or therapeutic practices to build multiple alliances (FFT, Sexton & Alexander, 2004; MDFT, Liddle, 2002). For other treatment models, such as family-based CBT (Freeman et al., 2003), no specific alliance building stages or techniques are described. For the latter, the correlation between alliance and outcome might be smaller than for treatment models with a strong emphasis on alliance building practices.

Also, referral to treatment was shown to have a moderating effect in a meta-analytic review on alliance in youth psychotherapy in a way that correlations between alliance and outcome were found to be stronger for help-seeking youth than for youth receiving mandated treatment (McLeod, 2011). Another moderating treatment aspect might be the setting in which treatment is conducted. When treatment is (partially) home-based, the therapist enters the home environment of the family. Effectiveness of the treatment might therefore be more dependent on the degree to which the family feels at ease with and trusts the therapist.

Furthermore, sample characteristics can moderate the association between alliance and outcome. In three meta-analytic reviews on alliance in youth psychotherapy it has been shown that the nature of patients' problems was a moderating factor: in two reviews, alliance correlated more strongly to outcome for youth with externalizing problem behavior than for youth with internalizing problems (McLeod, 2011; Shirk & Karver, 2003). A third review indicated that for youth dealing with substance abuse and mixed problems alliance correlated more strongly to treatment outcome than for youth dealing with eating disorders (Shirk, Karver, & Brown, 2011). In two of these meta-analytic reviews, age of youth also proved to have a moderating effect, with stronger correlations between alliance and outcome for younger children compared to adolescents (McLeod, 2011; Shirk & Karver, 2003). Another moderating sample characteristic is shown in a study on alliance and outcome in home-based family therapy, where a stronger correlation between alliance and outcome was found for fathers than for mothers (Johnson et al., 2002). This suggests that gender can moderate the effect of alliance on outcome.

Lastly, it can be reasoned that cultural differences play a role in how important the alliance is in enhancing favorable treatment outcomes, especially in family-involved treatment. For example, in more collectivist cultures the within-family alliance or the extent to which alliances with multiple family members are unbalanced might be of more influence on treatment outcome compared to more individualist cultures. This is illustrated in a study on ethnic background, therapeutic alliance and retention in Functional Family Therapy (FFT), in which unbalanced alliances between family members predicted treatment dropout for Hispanic American families, but not for Anglo-American families (Flicker et al., 2008).

Present study

To date, no meta-analytic review of alliance and outcome in family-involved treatment for youth problems has been published that also focused on moderators of the association between alliance and outcome and included studies published since 2008. The present study meta-analytically summarizes research findings on alliance and treatment outcome in family-involved treatment for youth problems over the past three decades. The purpose is to provide accurate estimates of the associations between the level of alliance and treatment outcome, alliance change scores and treatment outcome, and split alliances and treatment outcome, paying particular attention to both within and between study variability by performing moderator analyses in a multi-level meta-analysis. The analyses therefore ensure maximum use of the available data and provide valuable insight into the process of building, maintaining and measuring alliance in order to enhance positive outcome in family-involved treatment for youth problems.

Methods

Sample of studies

To obtain studies for this article, we conducted the search as prescribed by PRISMA (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009). Nine databases relevant to the field of this study were searched: Wiley Online Library, Eric, Academic Search Premier, PubMed, Medline, PsycInfo, PsycBooks, Web of Science and ProQuest. The following combination of search terms was used for titles, abstracts and keywords: ("alliance" OR "bond") AND ("youth" OR "child*" OR "adolescent*" OR "teen*" OR "parent*") AND ("famil*" OR "system*" OR "multisystem*") AND ("outcome" OR "effect*" OR "efficacy" OR "dropout" OR "retention"). In addition, retrieved articles were cross-referenced, and Google Scholar was hand-searched. Scholars with an expertise on alliance in family therapy were asked if they had any unpublished data of interest for this study. If studies were not retrievable from databases, authors were contacted. Four unpublished dissertations could not be included, because we could not trace the authors or the authors did not respond to our request. The search was completed in October 2017.

Studies were included in the meta-analysis if: (a) treatment was conducted for youth problems or for youth being at risk as a result of parental or family problems, (b) treatment was family-involved: in addition to the targeted youth at least one other family member was actively involved in multiple therapy sessions, resulting in multiple interdependent alliances during treatment, (c) targeted youth had an average age under 21, (d) one or more measures of alliance, working alliance, therapeutic alliance, or another measure regarding the emotional bond between client and therapist, agreement or collaboration on goals or tasks between client and therapist, within-family alliance or family-therapist alliance were included, (e) one or more measures of treatment outcome on youth, parent or family functioning or retention measured during, at the end or at follow-up of treatment were included, (f) a correlation between the measures mentioned in criteria (d) and (e) was examined regardless of study design, (g) the study report was available in full text, and (h) the study report was written in English, Dutch or German. A flow diagram of the search strategy and screening process is depicted in Figure 1.

We included 28 studies ($k = 23$ published studies, $k = 4$ unpublished dissertations, $k = 1$ unpublished paper), reporting on 21 independent samples comprising a total of $N = 2126$ families. An overview of included studies and their characteristics is shown in Table 1. An overview of sample characteristics for each study is shown in Table 2.

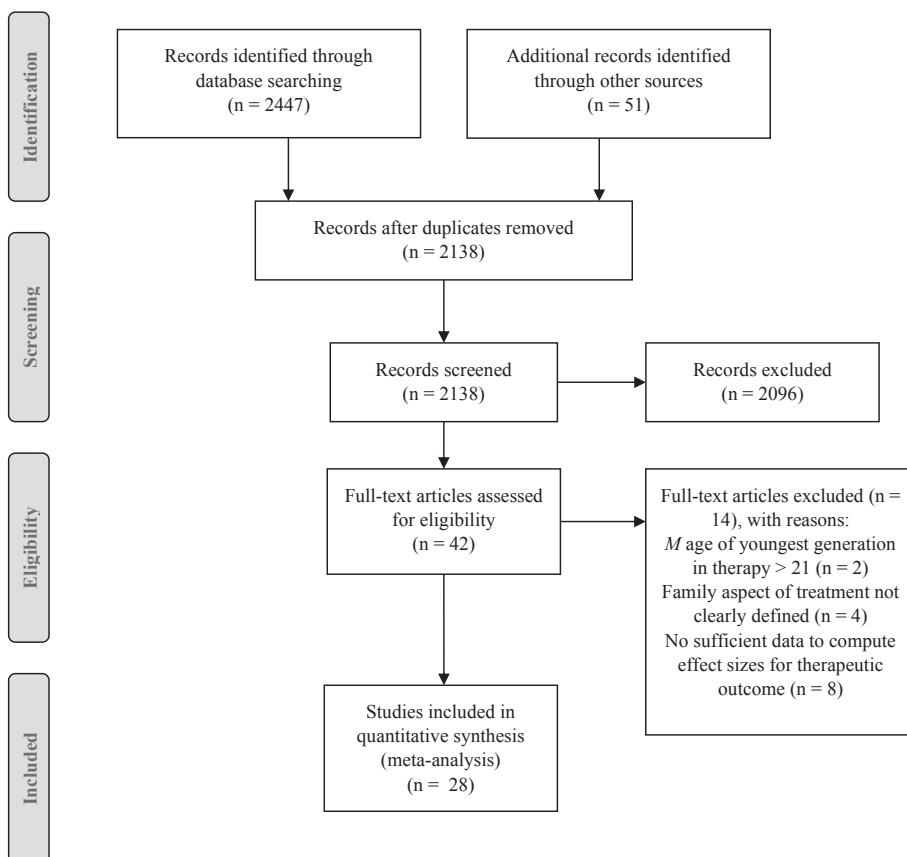


Figure 1

Flow Diagram for the Search and Identification of Studies

Coding of Studies

In order to code effect sizes and moderating variables of included studies, we developed a coding form, following guidelines as described by Lipsey and Wilson (2001). All study, sample, and methodological features shown in Table 1 and 2 were coded for moderator analyses. If information on certain moderating variables was missing in the study report, authors were contacted to retrieve additional information. All studies that met inclusion criteria were coded by the first author. For 39% ($k = 11$) of the 28 studies effect sizes and all included moderator variables other than study quality (see the next paragraph) were independently coded by the second author in order to assess interrater reliability. The Intraclass Correlation Coefficient (ICC) for double coded effect sizes ($n = 127$) was .82, average ICC for continuous moderator variables was .95, and average Cohen's Kappa for categorical moderator variables was .70. Differences in scores for effect sizes were discussed until agreement was reached.

Study quality was coded and assessed using a Study Quality Checklist (SQC) developed by the third and first author of this article based on the Quality Assessment Tools for Quantitative Studies (QATQS; Thomas, Ciliska, Dobbins, & Micucci, 2004), the Quality Index (QI; Downs & Black, 1998), and the Cochrane Collaboration's tool for assessing risk of bias (Higgins et al., 2011). The SQC allows the rating of 15 criteria per study on publication status, selection bias, pretest differences, missing data, reliability and validity of process measures, reliability and validity of outcome measures, attrition, study-dropouts and report on treatment and sample size characteristics. Total SQC scores ranged from 6 to 30 on a 0 (low) to 45 (high) scale. In order to assess interrater reliability of the SQC, 22 out of 28 included studies were independently coded by the first author and a master's graduate student in Forensic Child and Youth Care Sciences. The ICC was .95.

Calculation of Effect Sizes and Statistical Analyses

For each study, Pearson's r was calculated to estimate the correlation between alliance and outcome. In cases where two treatments were compared with one of them being a family-involved treatment, Pearson's r was calculated only for the sample that received family-involved treatment. Most effect sizes were calculated based on reported standardized regression coefficients, Pearson's r correlations, and means and standard deviations for treatment completers and dropouts. All calculations were based on formulas of Borenstein, Hedges, Higgins, and Rothstein (2009), Lipsey and Wilson (2001), Rosenthal (1991), Rosenthal (1994), and Rosenthal and DiMatteo (2001). If effect sizes could not be calculated based on the information in the study report, authors were contacted to retrieve additional information. In seven studies, the study reported non-significant correlations, but did not provide sufficient data to calculate an effect size. In these cases, the value of zero was assigned ($n = 47$ effect sizes), which is considered a conservative estimate of the true effect size (Rosenthal, 1995). Furthermore, effect sizes were coded as positive if correlations were in the expected direction (i.e., higher levels of alliance, alliance improvement, or lower levels of unbalanced alliance were related to more positive therapy outcome), whereas correlations not in the expected direction were coded as negative. In total, 361 effect sizes were computed. Effect sizes on alliance change scores and outcome ($n = 15$, $k = 3$ studies) and on split alliance and outcome ($n = 17$ from $k = 5$ studies) were each analyzed in separate meta-analyses because of the different nature of the alliance.

To prevent extreme effect sizes or moderating variables from having a disproportionate influence on the statistical analyses, we searched effect sizes and continuous moderators for outliers (standardized scores higher than 3.29 or below -3.29; Assink & Wibbelink, 2016). No outliers were found.

Table 1

Summary of Studies Included in the Meta-Analysis

Study	Study Quality**	Treatment model	Treatment setting	Type of TA	TA Measure
Bachler et al. (2016)	30	TAF	HB	P/Y ***	CP-TAF
Bennun (1989)	6	FT	C	P Y	TS TS
Chinchilla (2007)* ¹	27	MDFT	n.r.	Y	VTAS-R
Dauber (2004)* ¹	25	MDFT	n.r.	Y	VTAS-R
Escudero et al. (2008) ^	24	FT	C	Y+P F	SOFTA-O SOFTA-O
Feder & Diamond (2016)	20	ABFT	C	P	VTAS-R
Flicker et al. (2008) ^	22	FFT	C	Y P S	VTAS-R VTAS-R VTAS-R
Forsberg et al. (2014) ²	18	FBT	C	P S	WAI-O WAI-O
Forsberg et al. (2011)* ²	15	FBT	C	Y+P	WAI-O
Friedlander et al. (2008) ^{^3}	19	FT	C	F	SOFTA-O
Friedlander et al. (2012) ³	17	FT	C	Y P	SOFTA-S SOFTA-S
Glueckauf et al. (2002)	22	IFCM	n.r.	Y P	WAI-S WAI-S
Hawley & Weisz (2005)	29	CB MH	C	Y P	TASC TASC
Hogue et al. (2006) ^{^1}	28	MDFT	n.r.	Y P	VTAS-R VTAS-R
Isserlin & Couturier (2012)	18	FBT	C	Y P F	SOFTA-O SOFTA-O SOFTA-O
Johnson et al. (2006) ^{^4}	27	HB FT	HB	Y+P	FTAS
Johnson, Wright, & Ketring (2002) ^{^4}	27	HB FT	HB	Y P	FTAS FTAS
Keeley et al. (2011)	27	FB CBT	C	Y P	TASC WAI
Kim (2007)*	11	SFBT	C	Y P Y+P S	RRS RRS RRS RRS

TA timing	TA Rater	Outcome domain	Outcome timing	Outcome rater	N families	N individuals ****	NES *****
Imp	T	GT, PF, YS	EOT	P	304	n.r.	8
E	P	GT, YS+PF	EOT	P	35	26	5
E	Y	YS+PF	EOT	P	17	17	
E	O	R, YS	EOT, FU	Y, P, OM	68	66	11
E	O	YS	EOT, FU	Y	63	61	6
E, M	O	GT	DT	Y, P	37	82	16
E, M	O	GT	DT	Y, P		82	
M	O	YS	EOT	Y	19	19	2
E	O	R	EOT	T	86	43	6
E	O	R	EOT	T		43	
E	O	R	EOT	T		43	
E	O	YS	EOT	OM	38	61	3
E	O	YS	EOT	OM		99	
E	O	YS	EOT	Y	38	99	1
E	O	GT	DT	P	27	n.r.	2
E, M	Y	GT	DT	Y, P	20	20	4
E, M	P	GT	DT	Y, P		36	
E+M (A)	Y	YS, GT	EOT	Y	19	19	20
E+M (A)	P	YS, GT	EOT	P		19	
L	Y	R, YS	EOT	OM, T, Y, P	65	65	10
L	P	R, YS	EOT	OM, T, Y, P		65	
E	O	YS	EOT, FU	Y, P	44	44	20
E	O	YS	EOT, FU	Y, P		n.r.	
E, M, L	O	YS, R	EOT	OM, Y, P	14	14	75
E, M, L	O	YS, R	EOT	OM, Y, P		n.r.	
E, M, L	O	YS, R	EOT	OM, Y, P		n.r.	
L	Y, P	YS	EOT	Y+P	225	456	6
L	Y	YS, PF	EOT	Y	43	16	18
L	P	YS, PF	EOT	P		45	
E, M	C, T	YS	EOT	Y, P	23	22	16
E, M	P, T	YS	EOT	Y, P		22	
E	Y	YS	EOT	Y	25	21	20
E	P	PF	EOT	P		22	
E	Y, P	PF	EOT	Y, P		n.r.	
E	Y, P	PF	EOT	Y, P		n.r.	

Table 1

Continued

Study	Study Quality**	Treatment model	Treatment setting	Type of TA	TA Measure
Lange (in prep.)	29	MST	HB	P	TAM-R
Pereira et al. (2006) [^]	17	FBT	C	Y P	WAI-O WAI-O
Rienecke et al. (2016)	23	FBT PHP	C, H	Y P	WAI-S WAI-S
Robbins et al. (2006) ^{^1}	20	MDFT	n.r.	Y+P	VTAS-R
Robbins et al. (2008) [^]	23	BSFT	n.r.	Y P Y+P S	VTAS-R VTAS-R VTAS-R VTAS-R
Robbins et al. (2003) [^]	16	FFT	n.r.	Y P Y+P S	VTAS-R VTAS-R VTAS-R VTAS-R
Shelef & Diamond (2008) ^{^5}	26	MDFT	n.r.	Y P Y+P	VTAS-R(SF) VTAS-R(SF) VTAS-R(SF)
Shelef et al. (2005) ^{^5}	27	MDFT	n.r.	Y P Y+P	WAI, VTAS-R VTAS-R VTAS-R
Zaitsoff et al. (2008)	20	FBT	C	Y	HRQ

Note * Indicates doctoral dissertation. ** Study Quality reflects the Study Quality Checklist score
 *** Alliance was measured for the primary participant of the therapy, which could be either parent or adolescent. **** Sample sizes are based on a mean of all available reported analyses. ***** Number of computed effect sizes per study. ^Study was included in previous meta-analysis on alliance in Family Therapy (Friedlander et al., 2011)^{1,2,3,4,5} Studies reported on the same or overlapping samples. TAF = Therapeutische Ambulante Familienbetreuung; FT = Family Therapy, no specific model; MDFT = Multidimensional Family Therapy; ABFT = Attachment Based Family Therapy; FFT = Functional Family Therapy; FBT = Family Based Treatment; IFCM = Issue-Specific Single-Family Counseling; CB MH = Community-based Mental Health; HB FT = Home-based Family Therapy; FB CBT = Family Based Cognitive Behavioral Therapy; SFBT = Solution-focused Brief Therapy; FBT PHP = Family Based Therapy Partial Hospitalization Program; BSFT = Brief Strategic Family Therapy; C = Clinic; HB = Home Based; H = Hospital; TA = Therapeutic Alliance; Y = youth;

TA timing	TA Rater	Outcome domain	Outcome timing	Outcome rater	N families	N individuals ****	NES *****
Imp, E, M, L	P	YS	EOT, FU	P	848	774	18
E, L	O	R, YS	EOT, DT	OM	41	36	18
E, L	O	R, YS	EOT, DT	OM		31	
E, L	Y	R, YS	EOT	O	56	56	17
E, L	P	R, YS	EOT	O		40	
E	O	R	EOT	OM	30	n.r.	1
E	O	R	EOT	OM	31	23	14
E	O	R	EOT	OM		23	
E	O	R	EOT	OM		n.r.	
E	O	R	EOT	OM		n.r.	
E	O	R	EOT	OM	34	29	13
E	O	R	EOT	OM		29	
E	O	R	EOT	OM		n.r.	
E	O	R	EOT	OM		n.r.	
E, M, L	O	R, YS	EOT	OM	86	45	4
E, M, L	O	R	EOT	OM		34	
E, M, L	O	R	EOT	OM, Y		68	
E	Y, O	YS, R	EOT, FT	Y, OM	91	59	23
E	O	R	EOT	OM		65	
E	O	R	EOT, FU	OM		110	
M, L	Y	YS	EOT	Y	40	40	4

P = Parent; Y+P = averaged or added scores of youth and parent; F = within family; S = Split: difference scores (youth and parent scores subtracted); T = Therapist; O = Observer; CP-TAF = Compliance-collaborationo scale for Therapeutische Ambulante Familienbetreuung; TS = Therapist Scale; VTAS(-R) = Vanderbilt Therapeutic Alliance Scale (- Revised); SOFTA (-O/S) = System for Observing Family Therapy Alliances (- Observer / Selfreport); WAI(-S / O) = Working Alliance Inventory (- Short Form / Observer version); TASC = Therapeutic Alliance Scale for Children; FTAS = Family Therapy Alliance Scale; HAQ = Helping Alliance Questionnaire;; TAS = Therapeutic Alliance Scale; RRS = Relationship Rating Scale; HRQ = Helping Relationship Questionnaire; E = Early treatment; M = Midtreatment; L = Late treatment; A = multiple moments Averaged or Added; Imp = Improvement (alliance change scores); YS = Youth Symptom Severity or Functioning; PF = Parental or Family Functioning; R = Retention; GT = Goal Attainment or Therapeutic Progress; EOT = End of Treatment; FU = Follow Up; DT = During Treatment; OM = Objectified Measure; n. r. = Not Reported.

Table 2
Sample Characteristics of Studies Included in the Meta-Analysis

Study	N families	Problem Type
Bachler et al. (2016)	304	Multi-problem Families
Bennun (1989)	35	Mixed
Chinchilla (2007) ¹	68	Substance Abuse
Dauber (2004) ¹	63	Substance abuse
Escudero et al. (2008)	37	Mixed
Feder & Diamond (2016)	19	Internalizing problems
Flicker et al. (2008)	86	Substance Abuse
Forsberg et al. (2014) ²	38	Eating Disorders
Forsberg et al. (2011) ²	39	Eating Disorders
Friedlander et al. (2008) ³	27	Mixed
Friedlander et al. (2012) ³	20	Mixed
Glueckauf et al. (2002)	19	Epilepsy with behavioral problems
Hawley & Weisz (2005)	65	Mixed
Hogue et al. (2006) ¹	44	Substance Abuse
Isserlin & Couturier (2012)	14	Eating Disorders
Johnson et al. (2006) ⁴	225	Multiproblem Families
Johnson, Wright & Ketring (2002) ⁴	43	Multiproblem Families
Kim (2007)	25	Mixed
Lange (in prep.)	848	Externalizing Problems
Pereira et al. (2006)	41	Eating Disorders
Rienecke et al. (2016)	56	Eating Disorders
Robbins et al. (2006) ¹	30	Substance Abuse
Robbins et al. (2008)	31	Substance Abuse
Robbins et al. (2003)	34	Substance Abuse
Shelef & Diamond (2008) ⁵	86	Substance Abuse
Shelef et al. (2005) ⁵	91	Substance Abuse
Zaitsoff et al. (2008)	40	Eating Disorders

Note^{1,2,3,4,5} Studies reported on the same or overlapping samples; HS = Help Seeking; R = Recruited (for study); M = Mandated; Mx = Mixed; n.r. = not reported.

Referral to treatment	Mean Age youth	% Male youth	% Male adult	% Non-caucasian	% Non-caucasian therapists
M	14.6	49	35	n.r.	n.r.
HS	n.r.	n.r.	n.r.	n.r.	n.r.
Mx	15.3	80	n.r.	83	50
Mx	15.3	79	n.r.	81	60
HS	15.0	40	36	0	0
HS	15.5	5	16	74	0
Mx	15.7	84	n.r.	50	33
HS	14.0	13	41	24	n.r.
HS	14.0	13	41	24	n.r.
R	10.2	n.r.	33	7	10
R	13.2	33	41	10	11
R	13.9	53	41	11	n.r.
HS	11.9	59	11	63	n.r.
Mx	15.47	81	n.r.	80	60
HS	14.0	0	n.r.	n.r.	n.r.
M	14.4	n.r.	36	15	n.r.
M	14.0	n.r.	27	19	n.r.
HS	13.1	48	19	4	n.r.
M	15.3	66	17	n.r.	n.r.
R	15.1	9	n.r.	26	n.r.
HS	15.8	7	37	7	0
Mx	14.9	80	n.r.	83	20
n.r.	15.7	71	43	100	n.r.
Mx	15.0	59	n.r.	n.r.	n.r.
Mx	16.0	73	n.r.	51	33
Mx	16.0	85	n.r.	53	33
n.r.	16.1	3	n.r.	36	n.r.

Next, each correlation was transformed to Fisher's Z before combined effect sizes were calculated and moderator analyses were conducted (Assink & Wibbelink, 2016), and transformed back into Pearson r after analyses for ease of interpretation. Effect sizes were interpreted following Cohen's (1988) guidelines: The effect is considered small if r is at least .10, medium if r is at least .30 and large if r is at least .50.

Most included studies report on multiple informants of alliance, multiple times of measurement and multiple outcomes. Therefore, for most studies more than one effect size was calculated. Traditional meta-analytic approaches are based on the principle that the included subject samples are independent and thus, including multiple effect sizes based on the same sample violates this principle (Lipsey & Wilson, 2001). However, following other recent meta-analyses (e.g., Assink et al., 2015; Van der Stouwe et al., 2014), a multilevel random effects model was used for the calculation of combined effect sizes and for the moderator analyses in order to account for dependency of effect sizes. This approach has been shown as superior to the fixed-effects approaches employed in traditional meta-analysis for models with moderators (Van den Noortgate & Onghena, 2003).

In the present study, a three-level meta-analytic model was used for analysis of the data, modeling three sources of variance: sampling variance of the observed effect sizes (Level 1), variance between effect sizes from the same study (Level 2), and variance between studies (Level 3). This model was used to calculate an overall estimate of the association between level of alliance and therapeutic outcome, the association between alliance change scores and outcome and the association between split alliances and outcome in family therapy. Furthermore, it was used to obtain estimates of effect sizes by including moderator variables in the model to determine whether the observed variation was explained by study, sample or methodological characteristics of studies.

To perform the statistical analyses using a three-level model, we followed guidelines as described by Assink and Wibbelink (2016). We used the function "rma.mv" of the metafor package in the R environment (version 3.3.1; R Core Team, 2016). The R syntax and protocol was written so that during the analyses three sources of variance were modeled. We used the t -distribution for testing individual regression coefficients of the meta-analytic models and for calculating the corresponding confidence intervals.

To determine whether moderator analyses should be conducted, we applied the 75% rule of Hunter and Schmidt (1990). They state that when less than 75% of the total variance can be attributed to random sampling error (level 1), heterogeneity at level 2 (within studies) and 3 (between studies) can be considered substantial, and moderator

analyses should be conducted. Because of the small number of studies and effect sizes included in our meta-analyses on split alliance – outcome, and alliance improvement – outcome, the more traditional approach of log-likelihood-ratio-tests might not lead to significant results when in reality there is substantial variance. Applying the 75% rule of Hunter and Schmidt is an appropriate solution to this power problem (Assink & Wibbelink, 2016). For the sake of completeness, we also report results of two separate one-tailed log-likelihood-ratio-tests in which the deviance of the full model was compared with the deviance of a model excluding one of the variance parameters. The sampling variance of observed effect sizes (Level 1) was estimated by using the formula of Cheung (2014), as is appropriate for multilevel analysis (Assink & Wibbelink, 2016). The log-likelihood-ratio-tests were one-tailed, whereas all other tests were two-tailed.

When models were extended with categorical moderators consisting of three or more categories, the omnibus test of the null hypothesis that all group mean effect sizes are equal, followed an *F*-distribution. We estimated all model parameters using the restricted maximum likelihood estimation method, and before we conducted the moderator analyses, each continuous variable was centered around its mean. To enable analysis of categorical variables with three or more categories, we created (dichotomous) dummy variables (Tabachnick & Fidell, 2012). These dummies contain all information included in the original categorical variable. Given that our moderators were tested in multilevel regression analyses, the intercept is the reference category, while the dummies (the number of categories minus one) reveal if, and to what extent, the other categories deviate from the reference category.

Analysis of Publication Bias

A problem in the overall estimates of effect sizes in a meta-analysis is that studies with non-significant or negative results are less likely to be accepted for publication by journals. Rosenthal (1995) referred to this problem as the ‘file drawer problem’. Although obtaining and including unpublished studies as best as possible should resolve this problem, we examined file drawer bias by applying two conventional methods. First, we performed Egger regression (Egger, Smith, Schneider, & Minder, 1997), which tests the degree of funnel plot asymmetry as measured by the intercept from regression of standard normal deviates (effect size divided by its standard error) against the estimate’s precision (the inverse of the standard error). A significant Egger regression test is an indicator of funnel plot asymmetry. We performed the funnel plot asymmetry test using the “regtest” function of the metafor package in R (Viechtbauer, 2015). To account for the dependency of effect sizes, we added the standard error of the effect size as a moderator to the Egger regression model.

In addition, we performed a trim and fill procedure, as described by Duval and Tweedie (2000), to test for indications of overestimation or underestimation of the true overall effect size. By using the trim and fill procedure a funnel plot can be drawn, showing whether studies or effect sizes are missing on the left or right side of the distribution of effect sizes. A funnel plot with missing effect sizes on the left side of the distribution is an indication that the overall estimate is an overestimation of the true effect. When the funnel plot indicates missing effect sizes on the right side of the distribution, it is expected that the overall effect size is an underestimation of the true effect. These trim and fill analyses were performed for all associations using all available effect sizes in R with the function “trimfill” of the metafor package (Viechtbauer, 2015).

Results

Correlation between Alliance and Outcomes

Table 3 shows the overall effect sizes for the meta-analyses on level of alliance and outcome, split alliances and outcome and alliance change scores and outcome. The effect size for the relation between level of alliance and outcome was significant ($r = .183$; 95% CI .100, .265; $p < .001$), indicating that higher levels of therapeutic alliance are related to better outcomes of family-involved treatment. The estimate was calculated from data of 20 independent samples reporting on 329 effect sizes. The effect size for the correlation between split alliance and outcome was not significant ($r = .106$; CI -.124, .327; $p = .343$). This estimate was calculated from 5 study samples reporting on 17 effect sizes. The effect size for the correlation between alliance change scores and outcome just failed to reach significance, showing a trend ($r = .281$, CI -.023, .538; $p = .067$), which suggests that alliances that improve during the treatment process might lead to more favorable treatment outcomes. This estimate was calculated from 3 study samples reporting on 15 effect sizes.

Moderator Analyses

When applying the 75% rule of Hunter and Schmidt (1990), we concluded that for all three meta-analyses less than 75% of the total variance could be attributed to random sampling error (level 1), and heterogeneity at level 2 and 3 could be considered substantial. We therefor conducted moderator analyses for all three meta-analyses.

Moderator analyses on level of alliance and outcome correlation

The results of the moderator analyses on the level of alliance and outcome correlation are depicted in Table 4.

Alliance characteristics. Alliance timing showed a significant moderating effect, with higher correlations when several moments of measurement were averaged or added than for early, midtreatment or late treatment measurement alone. There were no significant moderator effects for type of alliance, alliance rater (informant), alliance construct or alliance measures specifically developed for family therapy.

Treatment characteristics. Treatment model just failed to reach significance, showing a trend indicating a larger effect for alliance in the context of Family Based Cognitive Behavioral Therapy compared to alliance in the context of other treatment models. There were no significant moderating effects for treatment setting.

Outcome characteristics. There were no significant moderating effects for outcome domain, outcome rater or outcome timing.

Sample characteristics. A significant moderating effect was found for referral source, indicating a larger effect for help-seeking clients compared to other populations. Furthermore, a significant moderating effect was found for average age of youth in the sample, indicating that for younger children the correlations between alliance and outcome were higher. There were no significant moderating effects for percentage of male youth, male adults, non-caucasian clients and non-caucasian therapists. Also, there was no significant moderating effect for problem type.

Study Quality just failed to reach a significant moderating effect.

Moderator analyses on split alliance and outcome correlation

Results of the moderator analyses on the association between split alliance and outcome are depicted in Table 5. Categorical variables with only one category represented in the total sample and continuous variables with data on less than one third of effect sizes in the total sample were excluded from analyses.

A moderating effect was found for study quality, indicating that higher correlations between split alliance and outcome were found within studies with lower study quality. Problem type also showed a significant moderating effect, with higher correlations between split alliance and outcome for populations with mixed problem types compared to populations dealing with drug abuse or eating disorders. No moderating effects were found for other sample characteristics or for treatment, alliance or outcome characteristics.

Table 3

Results for the overall mean effect sizes based on three-level mixed effects models

Type of Effect Size <i>r</i>	# Studies ^a	# ES	Mean <i>r</i> (SE)	95% CI
Level of alliance - outcome ¹	20	329	.183 (0.044)	.100, .265
Split alliance - outcome ²	5	17	.106 (0.109)	-.124, .327
Alliance change scores - outcome ³	3	15	.281 (0.145)	-.023, .538

Note. ES = effect size; CI = confidence interval; σ^2 level2 = variance between effect sizes (within studies); σ^2 level3 = variance between effect sizes (between studies);

Table 4

Results of Moderator Analyses based on Three-level Mixed Effects Models for Level of Alliance and Treatment Outcome

Moderator	# Studies ^a	# ES	Mean <i>r</i> (SE)
Study Quality	20	329	.421 (.160)**
Sample Characteristics			
<i>Problem type general</i>	20	329	
youth problems	16	278	.154 (.048)**
mixed youth parent/family problems	4	51	.299 (.096)**
<i>Problem type</i>	20	329	
drug abuse youth	3	77	.112 (.093)
eating disorders youth	4	116	.206 (.086)*
internalizing problems youth	1	14	.444 (.156)**
externalizing problems youth	1	15	-.004 (.172)
multi-problem families	2	34	.118 (.125)
mixed	5	73	.203 (.077)**
<i>Average age youth</i>	18	313	.794 (.286)***
% Male youth	18	298	.424 (.084)**
% Male adult	11	105	.140 (.049)**
% Non-caucasian	17	238	.199 (.059)***
% Non-caucasian therapists	7	110	.193 (.081)*
<i>Referral source</i>	18	317	
recruited for study	3	44	.264 (.100)**
help-seeking	9	154	.277 (.061)***
mandated	1	24	.116 (.160)
mixed mandated / help-seeking	5	95	.011 (.075)

Sig. Mean r	% Var. Level 1	σ^2 level 2	% Var. Level 2	σ^2 level 3	% Var. Level 3
<.001***	19.6	.044***	48.2	.029***	32.2
.343	42.2	.015	15.3	.042*	42.5
.067	5.2	.004	6.4	.058***	88.3

^a The number of studies reflects the number of independent samples. * $p < .05$, ** $p < .01$, *** $p < .001$. Results of Egger analysis: ¹ $t = 12.58, p < .001$; ² $t = -0.48, p = .64$; ³ $t = 6.85, p < .001$

95% CI	β (95% CI)	Test Statistic	p	σ^2 level 2	σ^2 level 3
.130, .645	-.012 (-.027, .002)	$F(1, 327) = 2.872$	.091	.043***	.031***
.060, .244		$F(1, 327) = 2.031$	.155	.044***	.028***
.117, .461	.152 (-.058, .350)				
-.070, .287		$F(5, 323) = 1.139$	.339	.044***	.027***
.040, .361	.097 (-.151, .332)				
.167, .656	.350 (-.007, .619)*				
-.347, .326	-.116 (-.466, .265)				
-.128, .352	.007 (-.293, .319)				
.054, .344	.093 (-.143, .319)				
.465, .930	-.062 (-.101, -.022)**	$F(1, 311) = 9.435$	.002**	.045***	.011***
.082 (.390)	-.158 (-.431, .140)	$F(1, 296) = 1.098$	.296	.045***	.029***
.044, .234	.059 (-.094, .211)	$F(1, 103) = 0.584$	.446	.000	.016***
.085, .309	-.071 (-.320, .178)	$F(1, 236) = 0.315$	.575	.047***	.020***
.035, .341	-.186 (-.671, .299)	$F(1, 108) = 0.579$	.448	.078***	.013
.073, .436		$F(3, 313) = 2.937$	.033*	.044***	.023***
.161, .383	.014 (-.214, .239)				
-.198, .411	-.151 (-.527, .219)				
-.136, .159	-.253 (-.466, -.012)*				

Table 4

Continued

Moderator	# Studies ^a	# ES	Mean <i>r</i> (SE)
Treatment characteristics			
<i>Treatment model</i>	20	329	
MDFT	2	65	.114 (.102)
FBT	5	116	.204 (.075)**
FB CBT	1	12	.523 (.164)***
FFT	2	15	-.124 (.123)
MST	1	15	.183 (.074)*
other	5	58	.119 (.160)
<i>Treatment setting</i>	15	225	
Home-based	2	39	.018 (.136)
Outpatient clinic	12	169	.265 (.060)***
Hospital or residential treatment	1	17	.067 (.194)
Alliance characteristics			
<i>Type of alliance</i>	20	329	
youth-therapist	17	116	.195 (.050)***
parent-therapist	18	132	.168 (.048)***
(within) family / therapist	4	33	.208 (.081)**
youth + parent - therapist (added or averaged)	8	48	.191 (.060)**
<i>Alliance rater</i>	20	329	
youth	10	58	.179 (.059)**
parent	9	67	.184 (.063)**
therapist	1	6	.347 (.165)*
observer	11	193	.186 (.056)***
youth + parent averaged or added	2	5	.007 (.153)
<i>Development of measure</i>	20	329	
for individual therapy	16	208	.272 (.092)**
for family therapy	4	121	.158 (.049)**
<i>Alliance construct</i>	20	329	
bond	5	24	.154 (.080)
goal	3	15	.182 (.096)
task	3	15	.145 (.096)
goal and task	2	54	.275 (.106)**
bond, goal and task	16	182	.164 (.047)***
within-family alliance	3	39	.300 (.099)**

95% CI	β (95% CI)	Test Statistic	p	σ^2 level 2	σ^2 level 3
		$F(7, 321) = 1.886$	.071	.044**	.019**
-.088, .308					
.059, .340	.091 (-.159, .330)				
.256, .720	.435 (.083, .691)*				
-.353, .119	-.235 (.506, .078)				
.040, .319	.070 (-.178, .310)				
-.194, .410	.005 (-.355, .364)				
		$F(2, 222) = 364.015$	.175	.000	.037***
-.246, .288					
.152, .371	.248 (-.045, .498)				
-.319, .309	.049 (-.399, .478)				
		$F(3, 325) = 0.028$	.891	.045***	.029***
.100, .288					
.075, .259	-.028, (-.106, .052)				
.052, .354	.013 (-.134, .159)				
.075, .301	-.005 (-.108, 0.99)				
		$F(4, 324) = 0.649$	.628	.044***	.029***
.065, .289					
.063, .300	.005 (-.105, .115)				
.035, .598	.179 (-.145, .468)				
.078, .289	.007 (-.126, .140)				
-.289, .301	-.172 (-.445, .129)				
		$F(1, 327) = 1.340$	.248	.044***	.028***
.099, .429					
.063, .250	-.119 (-.313, .084)				
		$F(5, 323) = 0.445$	.817	.045***	.026***
-.004, .303					
-.006, .355	.028 (-.167, .221)				
-.043, .323	-.009 (-.203, .187)				
.071, .457	.153 (-.069, .360)				
.072, .253	.126 (-.109, .350)				
.112, .465	.011 (-.151, .173)				

Table 4

Continued

Moderator	# Studies ^a	# ES	Mean <i>r</i> (SE)
<i>Alliance timing</i>	20	329	
early treatment	15	204	.153 (.047)**
midtreatment	6	35	.205 (.069)**
late treatment	7	56	.208 (.067)*
averaged or added	4	34	.326 (.079)***
Outcome characteristics			
<i>Outcome domain</i>	20	329	
youth symptom severity or functioning	15	222	.167 (.045)***
parental or family functioning	1	6	0.020 (.150)
retention	9	69	.141 (.055)*
goal attainment, therapeutic progress	4	32	.323 (.089)***
<i>Outcome rater</i>	20	329	
youth	11	111	.163 (.054)**
parent	9	77	.235 (.057)***
therapist	3	14	.176 (.103)
observer	2	10	.175 (.112)
objectified measure	7	89	.132 (.062)*
youth and parent combined	4	27	.167 (.084)*
youth and data combined	1	1	.567 (.298)*
<i>Outcome timing</i>	20	329	
end of treatment	18	257	.189 (.046)***
follow-up	3	42	.165 (.067)*
during treatment	3	30	.168 (.069)

Note. ES = effect size; CI = confidence interval; σ^2 level2 = variance between effect sizes (within studies); σ^2 level3 = variance between effect sizes (between studies); a. The number of studies reflects the number of independent samples. * $p < .05$, ** $p < .01$, *** $p < .001$.

95% CI	β (95% CI)	Test Statistic	p	σ^2 level 2	σ^2 level 3
		$F(3, 325) = 997.763$	.014*	.041***	.029***
.062, .242					
.072, .330	.053 (-.070, .174)				
.021, .278	-.001 (-.124, .122)				
.228, .496	.230 (.090, .360)**				
		$F(3, 325) = 1.609$	.187	.044***	.025***
.081, .251					
-.270, .306	-.148 (-.410, .136)				
.033, .245	-.027 (-.121, .067)				
.158, .470	.164 (-.017, .335)				
		$F(6, 322) = 0.890$	.502	.044***	.030***
.059, .265					
.125, .337	.074 (-.026, .171)				
-.027, .364	.012 (-.200, .224)				
-.047, .380	.011 (-.200, .222)				
.010, .250	-.032 (-.143, .079)				
.004, .322	.004 (-.169, .176)				
.039, .847	.445 (-.132, .796)				
		$F(2, 326) = 0.117$	.890	.044***	.031***
.099, .275					
.036, .289	-.024 (-.128, .082)				
-.019, .344	-.021 (-.209, .168)				

Table 5

Results of Moderator Analyses based on Three-level Mixed Effects Models for Split Alliances and Treatment Outcome

Moderator	# Studies	# ES	Mean <i>r</i> (SE)
Study Quality	5	17	.839 (.282)*
Sample Characteristics			
<i>Problem type</i>	5	17	
drug abuse youth	2	8	-.137 (.093)
eating disorders youth	1	2	.179 (.157)
mixed problem types	2	7	.308 (.105)*
<i>Average age youth</i>	5	17	.970 (.898)
% Male youth	5	17	.327 (.274)
% Male adult	3	13	.046 (.175)
% Noncaucasian	4	15	-.106 (.215)
Treatment characteristics			
<i>Treatment model</i>	5	17	
FBT	1	2	.177 (.307)
FFT	2	4	.179 (.220)
other	2	11	.018 (.211)
Alliance characteristics			
<i>Alliance rater</i>	5	17	
observer	4	12	.062 (.127)
youth + parent averaged or added	1	5	.274 (.244)
Outcome characteristics			
<i>Outcome domain</i>	5	17	
youth symptom severity or functioning	2	7	.229 (.171)
retention	3	12	.024 (.139)
<i>Outcome rater</i>	5	17	
youth	1	5	.274 (.385)
therapist	1	2	.022 (.390)
objectified measure	2	8	.046 (.281)
youth and objectified measure combined	1	2	.177 (.423)

Note. ES = effect size; CI = confidence interval; σ^2 level2 = variance between effect sizes (within studies); σ^2 level3 = variance between effect sizes (between studies); a. The number of studies reflects the number of independent samples. * $p < .05$, ** $p < .01$, *** $p < .001$.

95% CI	β (95% CI)	Test Statistic	p	σ^2 level2	σ^2 level3
.217, .897	-.041 (-.074, -.008)*	$F(1, 15) = 7.122$	.018*	.015	.007
		$F(2, 14) = 5.347$	.019*	.017	.002
-.325, .060					
-.160, .477	.307 (-.076, .611)				
.083, .487	.419 (.146, .633)**				
-.769, 1.000	-.135 (-.335, .076)	$F(1, 15) = 1.871$	.191	.016	.030
-.253, .734	-.395 (-.887, .517)	$F(1, 15) = 0.809$	.383	.016	.042
-.330, .410	.069 (-.377, 0.514)	$F(1, 11) = 0.115$	.741	.000	.069*
-.518, .346	.370 (-.076, .816)	$F(1, 13) = 3.207$	.097	.000	.140
		$F(2, 14) = 31.544$	.849	.016	.078*
-.464, .696					
-.291, .580	.002 (-.681, .684)				
-.414, .444	-.159 (-.754, .578)				
		$F(1, 15) = 0.610$	.447	.016	.046
-.207, .323					
-.245, .671	.216 (-.362, .816)				
		$F(1, 15) = 0.886$	.361	.016	.041
-.134, .538					
-.267, .311	.206 (-.593, .258)				
		$F(3, 13) = 0.100$	.959	.017	.149*
-.535, .821					
-.869, .723	-.260 (-.907, .758)				
-.578, .585	-.235 (-.865, .687)				
-.615, .791	-.102 (-.876, .818)				

Moderator analyses on alliance change scores and outcome correlation

Results of the moderator analyses on the association between alliance change scores and outcome are depicted in Table 6. Categorical variables with data for only one category, continuous variables with data on less than one third of effect sizes in the total sample, and variables with data for only one study were excluded from analyses.

Alliance characteristics. There was a significant moderating effect for alliance rater, with stronger correlations between alliance improvement and outcome for youth informed alliance improvement than for therapist or parent informed alliance improvement. There was no moderating effect for type of alliance.

Treatment characteristics. A significant moderating effect was found for treatment model, with higher correlations between alliance improvement and outcome for Family Based CBT compared to MST and other forms of family-involved treatment. There was no moderating effect for treatment setting.

Sample Characteristics. Problem type was a significant moderator: correlations between alliance improvement and outcome were higher for families in treatment for internalizing problems of their children and for multi-problem families compared to families receiving treatment for externalizing problems of their children. Referral source was also a significant moderator, with higher correlations between alliance improvement and outcome for help-seeking or recruited clients than for clients mandated for treatment or populations with mandated as well as help-seeking clients. Furthermore, percentage of male adults within the study sample was a significant moderator, demonstrating higher correlations between alliance change and outcome within samples with a higher percentage of male adults.

There were no significant moderating effects for *outcome characteristics* or for *study quality*.

Analyses of Publication Bias

In order to investigate whether publication bias might have distorted the results of our meta-analyses, we applied two methods. Table 3 shows the results of the Egger regression test for each analyzed association. The association between level of alliance and outcome and the association between alliance change scores and outcome showed significant Egger regression tests, indicating funnel plot asymmetry. The funnel plots showing the results of the trim and fill procedure are depicted in Figures 2, 3, and 4. Both trim and fill plots for the level of alliance – outcome association and the alliance change scores – outcome association show missing

effect sizes on the left side of the distribution, indicating that the overall effect sizes in these meta-analyses may be an overestimation of the true effect. Comparison of confidence intervals revealed that the overall effect size of the level of alliance – outcome association was significantly smaller after trim and fill analysis ($r = .05$, $p < .05$) compared to the overall effect size before trim and fill analysis. The overall effect size of the correlation between alliance change scores and outcome did not significantly vary from the overall effect size before trim and fill analysis.

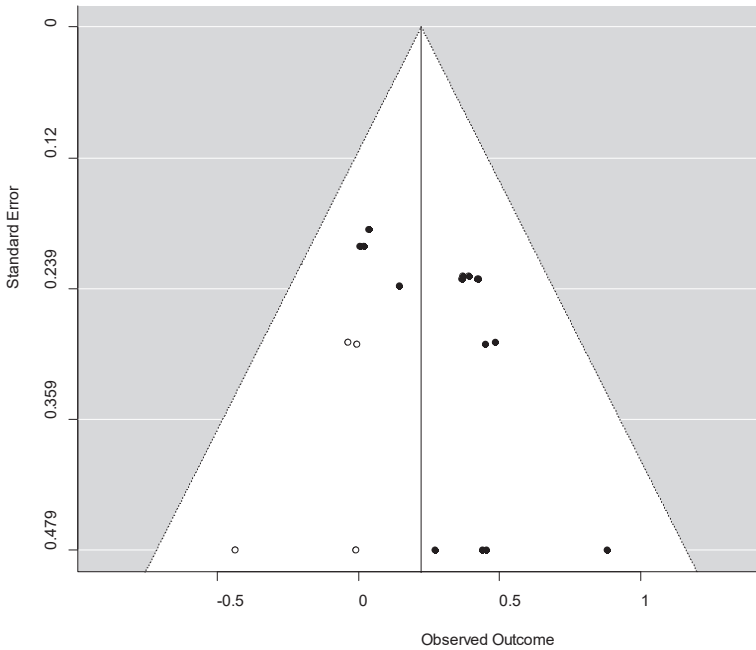


Figure 2
Trim-and-fill Plot Level of Alliance – Outcome Association

Table 6

Results of Moderator Analyses based on Three-level Mixed Effects Models for Alliance Change Scores and Treatment Outcome

Moderator	# Studies	# ES	Mean <i>r</i> (SE)
Study Quality	3	15	.981 (1.000)
Sample Characteristics			
<i>Problem type general</i>	3	15	
youth problems	1	8	.248 (.240)
mixed youth and parent/family problems	2	7	.357 (.325)
<i>Problem type</i>	3	15	
internalizing problems youth	1	4	.471 (.135)**
externalizing problems youth	1	3	.020 (.078)
multi-problem families	1	8	.357 (.072)***
<i>Average age youth</i>	3	15	.878 (.709)
% Male youth	3	15	.908 (.762)
% Male adult	2	11	-.812 (.278)**
% Noncaucasian	3	15	.374 (.328)
<i>Referral source</i>	3	15	
help-seeking	1	4	.471 (.135)**
mandated	1	8	.357 (.072)***
mixed mandated / help-seeking	1	3	.020 (.078)
Treatment characteristics			
<i>Treatment model</i>	3	15	
FB CBT	1	4	.471 (.135)**
MST	1	3	.020 (.078)
other	1	8	.357 (.072)***
<i>Treatment setting</i>	3	15	
Home-based	2	11	.195 (.175)
Outpatient clinic	1	4	.471 (.268)
Alliance characteristics			
<i>Type of alliance</i>	3	15	
youth-therapist	1	2	.488 (.232)*
parent-therapist	1	5	.151 (.165)
youth + parent-therapist (averaged or added)	2	8	.357 (.208)
<i>Alliance rater</i>	3	15	
youth	1	1	.707 (.235)**
parent	2	4	.034 (.043)
therapist	2	10	.375 (.031) ***

95% CI	β (95% CI)	Test Statistic	p	σ^2 level 2	σ^2 level 3
-1.000, 1.000	-0.070 (-.380, .254)	$F(1, 13) = .211$	.653	.004	.100***
		$F(1, 13) = .084$	.777	.004	.113**
-270, .654					
-355, .801	.121 (.653, .771)				
		$F(2, 12) = 7.681$	.007**	.004	.004
.212, .668					
-150, .188	-.455 (-.682, -.149)**				
.214, .485	-.136 (-.440, .194)				
		$F(1, 13) = 1.526$	.239	.004	.045**
		$F(1, 13) = 1.534$	.237	.004	.045
		$F(1, 9) = 22.858$	<.001***	.004	.001
		$F(1, 13) = 0.139$	.715	.004	.107***
		$F(2, 12) = 7.681$	.007**	.004	.004
.212, .668					
.214, .485	-.136 (.440, .194)				
-.150, .188	-.455 (-.682, -.149)**				
		$F(2, 12) = 7.681$	.007**	.004	.004
.212, .668					
-.150, .188	-.491 (-.833, -.149)**				
.214, .485	-.136 (-.440, .194)				
		$F(1, 13) = 0.918$	.355	.004	.061***
-.183, .523					
-.082, .802	.303 (-.374, .769)				
		$F(2, 12) = 1.588$	.244	.004	.043
.018, .781					
-.208, .515	-.364 (-.700, .105)				
-.086, .682	-.158 (.691, .485)				
		$F(2, 12) = 23.918$	<.001***	.004	.000
.347, .886					
-.060, .126	-.848 (-.880, -.310)**				
.291, .414	-.468 (-.775, .016)				

Table 6

Continued

Moderator	# Studies	# ES	Mean <i>r</i> (SE)
Outcome characteristics			
<i>Outcome domain</i>	3	15	
youth symptom severity or functioning	3	8	.302 (.160)
parental or family functioning	1	4	.212 (.174)
goal attainment or therapeutic progress	1	3	.277 (.175)
<i>Outcome rater</i>	3	15	
youth	1	1	.275 (.201)
parent	2	10	.192 (.171)
youth and parent combined	1	4	.471 (.264)
<i>Outcome timing</i>	3	15	
end of treatment	1	2	.301 (.136)*
follow-up	3	13	.241 (.154)

Note. ES = effect size; CI = confidence interval; σ^2 level2 = variance between effect sizes (within studies); σ^2 level3 = variance between effect sizes (between studies); a. The number of studies reflects the number of independent samples. * $p < .05$, ** $p < .01$, *** $p < .001$.

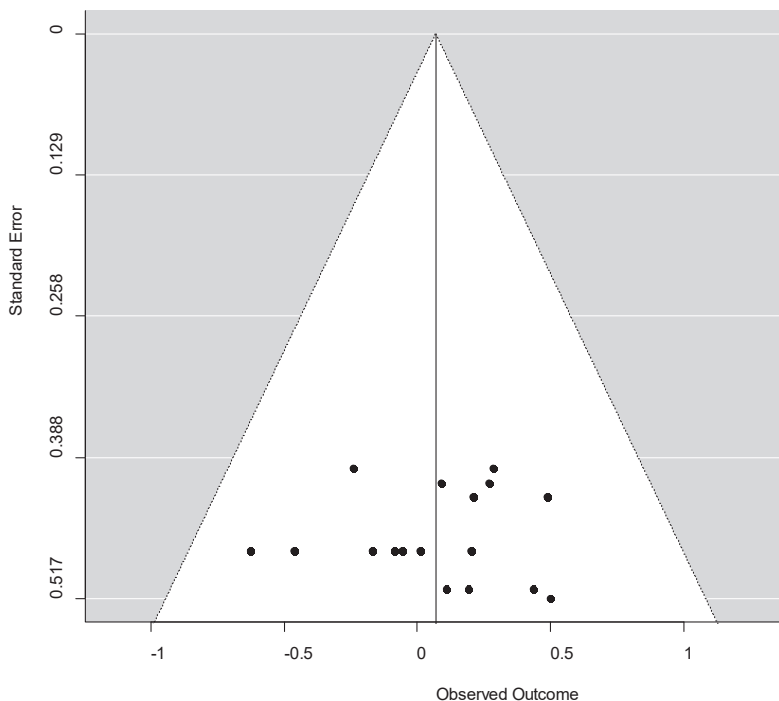


Figure 3

Trim-and-fill Plot Split Alliance – Outcome Association

95% CI	β (95% CI)	Test Statistic	p	σ^2 level 2	σ^2 level3
		$F(2, 12) = 0.750$	.493	.004	.069 **
-0.039, .580					
-0.167, .536	-0.097 (-.324, .142)				
-0.100, .598	-0.028 (-.265, .213)				
		$F(2, 12) = 0.782$	.479	.004	.059**
-0.161, .621					
-0.182, .517	-0.088 (-.322, .156)				
-0.077, .800	.225 (-.469, .747)				
		$F(1, 13) = 0.308$	.588	.006*	.049*
.004, .535					
-0.090, .523	-0.055 (-.264, .159)				

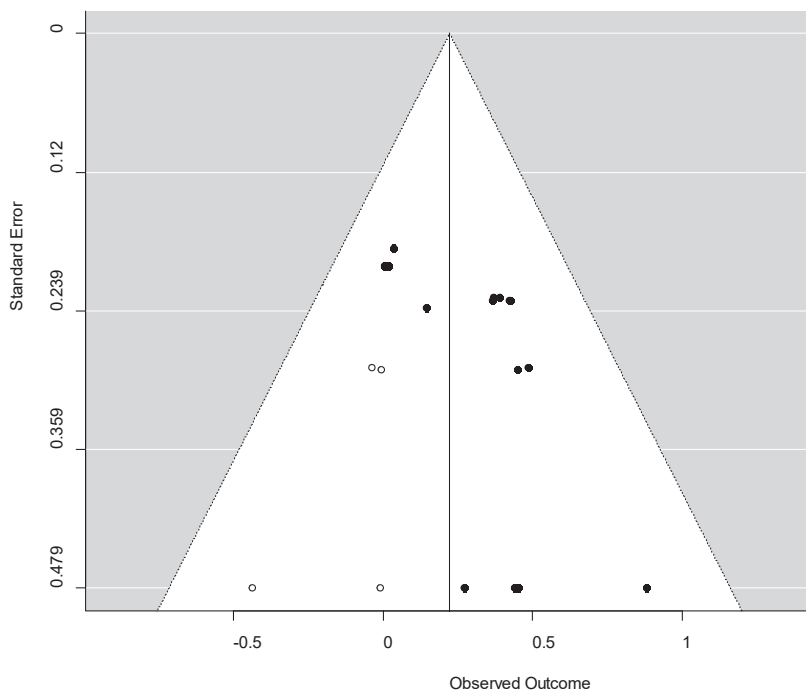


Figure 4
Trim-and-fill Plot Alliance Change Scores – Outcome Association

Discussion

The association between alliance and treatment outcome

Our findings revealed a significant small to medium correlation between the level of alliance and treatment outcome ($r = .18$), indicating that higher levels of alliance between the therapist and the family lead to more favorable treatment outcomes. This finding is in line with previous meta-analyses on alliance and treatment outcome in youth psychotherapy, showing comparable overall effect sizes, ranging from $r = .14$ to $r = .22$ (Karver et al., 2006; McLeod, 2011; Shirk & Karver, 2003; Shirk, Karver, & Brown, 2011). Meta-analyses on alliance in adult psychotherapy have consistently shown somewhat larger overall effect sizes, ranging from $r = .21$ to $r = .28$ (Horvath & Bedi, 2002; Horvath et al., 2011; Martin, Garske, & Davis, 2000). Friedlander et al. (2011) performed a meta-analysis on alliance in couple and family therapy, and found an overall effect size of $r = .26$ for both couple and family therapy, and an overall effect size of $r = .24$ for family therapy only.

The fact that the present meta-analysis yielded a somewhat smaller overall effect size for family-involved treatment than the meta-analysis by Friedlander et al. (2011) can be explained by several factors. First, we used stricter inclusion criteria for the family aspect of treatment and included unpublished studies as well as published studies. Second, we used a multilevel model instead of a traditional single-level model as used by Friedlander et al. (2011). It can therefore be expected that the present study provides a more accurate estimate of the overall effect size.

Furthermore, the previous meta-analysis by Friedlander et al. (2011) did not report an analysis of publication bias, which may have led to an overestimation of the true effect size. In the present study correlations between alliance and treatment outcome reported in studies as non-significant without sufficient data to calculate the true effect size were included, with a conservative estimation of zero. As Rosenthal (1995) pointed out, this conservative estimate of the effect size might lead to an underestimation of the true effect, but simply not using these effect sizes might lead to overestimation of the true effect. To test the hypothesis of underestimation in the present study, we again calculated the overall effect size for the association between the level of alliance and treatment outcome with exclusion of all effect sizes estimated to be zero. The result was a higher overall effect size of $r = .22$ ($p < .001$). However, the Egger and trim and fill analyses indicated that the original overall effect size we found for the association between level of alliance and outcome may still be an overestimation of the true effect size due to publication bias.

Contrary to our expectations, we found only a small correlation between split or unbalanced alliances and outcome, which failed to reach significance. This could indicate that for positive treatment outcome it is irrelevant whether the therapist develops balanced therapeutic relationships with all family member or develops a stronger therapeutic relationship with one of the family members compared to other family members. However, when interpreting the results of the meta-analysis on split alliance and treatment outcome, it should be noted that research on split alliances often lacks a clear definition of the central concept as well as a valid and reliable methodology to the concept. Often, raw difference scores are used to investigate the role of split alliances in treatment outcome. Previous research however, has shown that these difference scores cannot provide valid and reliable tests of informant discrepancy as a predictor (Bartle-Haring et al., 2012; Laird & De Los Reyes, 2013).

Results of the analysis on the association between alliance change scores and treatment outcome showed a trend toward significance indicating a moderate association of $r = .281$, which is considerably larger than the correlation between level of alliance with fixed moment measures and treatment outcome ($r = .18$). This might indicate that for the therapist in order to enhance positive treatment outcome, improving alliances with family members during the treatment process might even be more important than developing alliances that remain stable throughout treatment. However, research on alliance change scores related to treatment outcome in family-involved treatment is scarce, and only three studies reporting on alliance change scores could be included in the meta-analysis. This is surprising, given that previous research on alliance in several contexts has shown that alliance can develop in different trajectories during treatment, such as a linear increase of alliance, a fading linear increase of alliance, or sudden non-linear decreases (ruptures) or increases (gains) of alliance (Lange et al., in prep.). How these different developmental trajectories of alliance relate to treatment outcome remains unclear.

Moderating variables

The results of our study reveal that the association between alliance and outcome was moderated by several characteristics of alliance measures, treatment, and study sample. With regard to alliance measures, we found that the correlation between the level of alliance and outcome was stronger when alliance measures at several time points were averaged or added compared to only early, mid- or late treatment measures of alliance. This finding is in line with a study on the alliance–outcome association in psychotherapy for depressed adults, where the average of alliance score measured at session 3 to 9 explained 14.7% of the outcome variance, whereas single alliance measures of session 3 explained only 4.7% of the outcome variance (Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2012). Meta-analytic reviews on the alliance–outcome association in adult

and youth psychotherapy have consistently reported stronger correlations between alliance measured during late-treatment compared to alliance measured during early or mid-treatment (Horvath et al., 2011, McLeod, 2011, Shirk & Karver, 2003). However, none of these studies reported on multiple alliance measures averaged or added as a category for timing of alliance measure. If we take into account that our meta-analysis on alliance-change scores and treatment outcome showed a marginally significant larger effect size compared to the association between level of alliance and outcome, our findings underline the importance of viewing the alliance as a dynamic process rather than a static, single-moment entity.

No moderating effects were found in any of our analyses for type of alliance informant (youth, parent or observer) or alliance construct. These findings are in line with the findings from the meta-analytic review of Shirk, Karver, and Brown (2011), that did not show moderating effects for any characteristics of the alliance measure. Also, Horvath et al. (2011) found no moderating effect for alliance rater in the association between alliance and outcome in individual adult psychotherapy. However, other meta analytic reviews have reported larger effect sizes for therapist rated alliance compared to other sources of alliance measurement (Shirk & Karver, 2003), or for parent rated alliance compared to other sources of alliance (McLeod, 2011). This might indicate that no consistent conclusion can yet be drawn about the role of alliance source in the alliance-outcome association.

Contrary to our expectations, in the association between level of alliance and outcome we found no moderating effect for type of alliance informant (youth, parent or observer), type of alliance (youth-therapist, parent- therapist or family alliance), construct of alliance (bond, goal, task, within-family), or alliance measures designed specifically for family therapy in order to capture systemic aspects of the alliance. Previous studies that found a smaller or less significant effect on treatment outcome for alliance in family-involved treatment compared to individual treatment have underlined the importance of studying alliance in family therapy with instruments that capture systemic aspects of alliance typical of working with multiple family members (Lange et al., in prep.; McLeod, 2011). The rationale behind this point of view is that alliance instruments designed for family therapy might lead to a better understanding of the alliance-outcome association in family-involved treatment. However, research on alliance and outcome using specific family therapy alliance measures is still scarce, and in the present study only four independent samples using a specific family therapy measure of the alliance could be included in the meta-analysis on level of alliance and outcome. Furthermore, out of these four study samples, three samples contained only a small number of families ($n < 50$).

Most of the significant moderating variables were sample characteristics, with different moderators for the three separate meta-analyses. The association between level of alliance and treatment outcome was significantly moderated by average age of youth in the sample, demonstrating stronger correlations when youths were younger. This is in line with findings of McLeod (2011), and Shirk and Karver (2003) showing that in youth psychotherapy associations between alliance and outcome were stronger for younger children compared to adolescents. However, it should be noted that in the present study variance in average age of youth in study samples was small, with the lowest average age of 10.6 and the highest average age of 16.1. Most study samples comprised only families with adolescents, some samples comprised adolescents as well as younger children, and no studies were included with families with children in primary school age only. It is unclear whether our study findings can be generalized to families receiving therapy or treatment due to concerns regarding much younger children. In families with younger children, the role of the child in therapy might not be as active as compared to older youth, resulting perhaps in lower correlations between youth alliance and outcome and higher correlations between parent alliance and outcome.

Another moderating sample characteristic in the association between level of alliance and treatment outcome was referral source, showing stronger correlations between alliance and outcome for clients who were help-seeking or recruited for the study compared to samples with mandated clients or a combination of mandated and help-seeking clients. This finding was replicated in the meta-analysis on alliance change scores and treatment outcome. Two recent studies compared alliance processes in family therapy between voluntary and involuntary clients. These studies revealed that initial between-group differences in the emotional bond with the therapist and the within-family alliance did disappear after four sessions of therapy (Sotero et al., 2016; 2017). Between-group differences in agreement on therapeutic goals and tasks, however, remained after the fourth session. Thus, the difference in the alliance – outcome association between self-referred and involuntary clients might be explained by both timing and dimension of alliance measure. However, no research has yet been published on the relation between specific aspects of alliance processes with mandated clients in relation to treatment outcome. Furthermore, in the present meta-analysis only one study could be included with mandated clients only. Five other included studies reported on samples of both mandated and help-seeking clients, with no reports of specific effect sizes for both groups.

It was surprising that no moderating effects were found for problem type or treatment model in the association between level of alliance and outcome. Several meta-analyses have demonstrated moderating effects for problem type (McLeod, 2011; Shirk & Karver, 2003; Shirk, Karver, & Brown, 2011). In the present study, the sample of included studies

was very heterogeneous with regard to problem type and treatment model. As a result, several categories for these variables were represented by only one or two studies. Thus, the fact that the moderating effect of problem type and treatment model failed to reach significance might partly be explained by a lack of statistical power. Nevertheless, this finding underlines the importance of training and supervision for therapists in alliance building techniques in addition to training and supervision of specific treatment model techniques.

In contrast to our expectations, both gender and ethnicity of clients did not moderate the association between level of alliance and outcome. With regard to gender, two previous studies on alliance and outcome in family therapy and couple therapy demonstrated that for male adults other aspects of alliance are important in relation to treatment outcome compared to females (Johnson, Wright, & Ketring, 2002), and that the correlation between alliance and outcome might be stronger when males have a higher level of alliance with their therapist than their female partners (Symonds & Horvath, 2004). With regard to ethnicity, one included study on split alliance and outcome shows a stronger correlation between alliance and outcome for Hispanic families compared to Anglo-American families (Flicker et al., 2008). It should be noted, however, that most of the studies included in the present study made no distinction between alliance-outcome correlations for boys and girls, or father and mothers, or between different ethnical groups. Thus, there was no variance between effect sizes within studies with regard to gender or ethnicity. We did, however, find a significant moderating effect for percentage of male adults in the association between alliance change scores and treatment outcome, demonstrating stronger correlations in samples with less male adults. This might indicate that for fathers, the process of alliance improvement is more predictive of treatment outcome than for mothers.

For outcome measures characteristics no moderating effects were found in any of the investigated associations in contrast to findings of previous meta-analyses on alliance and outcome in youth or adult psychotherapy (Horvath et al., 2011; McLeod, 2011; Shirk & Karver, 2003). This indicates that alliance is a significant small predictor of treatment outcome in family-involved treatment, regardless of how and when outcome is measured.

Lastly, there was no moderating effect for study quality in the associations between level of alliance and outcome, and alliance change scores and outcome, although there was a trend toward significance in the first association indicating stronger correlations in studies of less quality. This moderating effect was significant in the association between split alliances and outcome.

Limitations of the study

The present study has several limitations. An important methodological limitation is the small number of studies included in the meta-analyses that investigated the association between split alliances and treatment outcome (five studies reporting on 17 effect sizes) and the association between alliance change scores and treatment outcome (three studies reporting on 15 effect sizes). Therefore, conclusions from these analyses should be interpreted with caution, and require future re-evaluation when a larger body of evidence has accumulated.

Second, some categorical variables in the moderator analyses contained relatively few studies, which resulted in insufficient statistical power of the analyses. This was the case for all moderator variables in the associations between split alliances and outcome, and alliance change scores and outcome as a result of the small number of studies included in these meta-analyses. For the association between level of alliance and treatment outcome, the problem of insufficient statistical power might especially apply to problem type, treatment setting, treatment model, referral source and several outcome characteristics.

A final limitation is that in the current meta-analysis, alliance-outcome associations were analyzed across a variety of research designs, ranging from uncontrolled pre-post designs to quasi-experimental designs. It could be reasoned that the strength of alliance-outcome associations differs considerably across research designs. Therefore, future research –based on a larger body of evidence than is currently available– may benefit from a finegrained analysis of the moderating effect of research designs on the alliance-outcome association in general.

Implications for future research

The sample of studies included in the present study shows that the association between alliances processes and treatment outcome has received less attention within specific treatment contexts. Treatment contexts that differ from the regular context of family-involved treatment for youth problems (i.e., family therapy in an outpatient clinic with families seeking help for a specific problem of their adolescent) might lead to different behaviors of clients, demanding different alliance building skills from therapists. Research on alliance in specific contexts, such as home-based interventions, interventions for multi-problem families or families receiving mandated treatment, might lead to a better understanding of how alliance processes are related to outcome within these specific contexts.

Future research on alliance in family-involved treatment could also benefit from investigating the more complex systemic and dynamic aspects of alliance typical of working with families. One of these systemic aspects is the occurrence of split alliances. As pointed out before, the scarce research on split alliances that is available often lacks a clear definition of the concept, and applied methodology in most of these studies might not be appropriate for investigating the role of split alliances in treatment effectiveness. For research on split alliances, applying methods other than using discrepancy scores is recommended, such as multilevel modeling (Bartle-Haring et al., 2012) or polynomial regression (Laird & De Los Reyes, 2013).

Furthermore, the use of alliance measures designed specifically for the context of family therapy, such as FTAS (Pinsof et al., 2008) or SOFTA (Friedlander et al., 2006), may help to gain a better understanding of systemic dynamics of alliance in family-involved treatment related to outcome. Although it has been reasoned before that clarifying these systemic dimensions of alliance may help to produce a more accurate estimate of the association between alliance processes and treatment outcome (Friedlander et al., 2006; McLeod, 2011), the present study shows that research investigating the within-family or family-therapist alliance is still scarce.

Our findings furthermore indicate that research on the role of alliance in family-involved interventions in treatment effectiveness could benefit from viewing the alliance as a dynamic process rather than a static measure at a single time point. However, research on the evolvement of alliance during treatment is still scarce, and questions remain in particular about the relation between specific developmental trajectories of alliance, such as alliance ruptures or sudden alliance gains, and treatment outcome.

Lastly, research on family-involved treatment might benefit from investigating the role of other common factors that have been hypothesized to be important in determining treatment outcome, such as client motivation, expectancies about services and family empowerment (Hoagwood, 2005; Karver et al., 2006; Sprenkle & Blow, 2004).

Conclusions

We investigated the association between alliance and treatment outcome in family-involved treatment for youth problems by analyzing data from 28 studies reporting on 21 independent study samples. Our findings demonstrate that a stronger alliance is a small but significant predictor of better treatment outcomes, underlining the importance for therapists to develop strong alliances with family members during treatment. The


association between alliance and treatment outcome was stronger when youth in treatment were in their early adolescence compared to late adolescence, when clients in the study sample were help-seeking or recruited for the study instead of mandated for treatment, and when alliance measures of several time points during treatment were averaged or added.

Results of our study furthermore indicate that growth of alliance during the treatment process might be a stronger predictor of treatment outcome than alliance measured at a single time point or an average of alliance measures over time. The occurrence of split alliances did not predict treatment outcome. However, only few studies reported on the association between split alliances and outcome and most studies lack a clear definition and appropriate methodology to measure split alliances.

Our study underlines the importance for therapists to build strong individual alliances with all family members involved in treatment as well as to pay attention to systemic aspects of the alliance, such as the within-family alliance, when delivering family-involved treatment for youth problems. Furthermore, our study implicates that training and supervision of (family) therapists should not solely focus on specific treatment model techniques, but also on alliance building techniques in the context of working with multiple family members. Building these multiple alliances remains important throughout the treatment process, regardless of the treatment model. Therapists might enhance treatment outcome by monitoring individual as well as within-family alliances, in order to intervene when alliances are problematic.

Future research should focus on the association between alliance and outcome in specific treatment contexts of family-involved treatment, such as homebased interventions and therapy with involuntary clients. Furthermore, future research could benefit from investigating complex aspects of alliance within family-involved treatment, such as the role of within-family alliance, the occurrence of split alliances and alliance ruptures, to gain fuller understanding of the dynamic role of alliance in family-involved treatment in order to enhance positive treatment outcome.





**Therapists' Contributions
to the Alliance in Home-Based
Family Treatment:
The Role of Alliance
Building Behaviors, Personality,
and Clinical Experience**

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Abstract

Background Alliance is a robust contributor to the outcome of adult, youth, and family therapy, but little is known about therapists' contributions to the alliance in conjoint family treatment.

Methods We investigated the predictive value of therapists' personality, clinical experience and observed alliance building behaviors for mid-treatment alliance as reported by therapists and family members. Participants were 77 parents and 21 youth from 57 families receiving home-based family treatment from 33 therapists.

Results Therapist *openness to experience* and *agreeableness* as well as therapists' in-session *engagement* and *emotional connection* behaviors predicted more positive therapists' and family members' reports of the alliance. Therapist *neuroticism*, *extraversion* and *conscientiousness* predicted more negative alliance-reports. In-session *safety* behaviors also predicted more negative alliance-reports, but this finding was only significant for therapists' and not family members' reports of the alliance. Clinical experience did not predict quality of alliances.

Conclusions We conclude that training and supervision of family therapists could benefit from focusing on emotional connection with and active engagement of family members in treatment, and from increasing self-awareness of the impact of their personality on alliances with family members.

Introduction

Do some therapists have more success with their clients than others, and if so, what factors might explain this between-therapist difference? This question has received growing attention in psychotherapy research, and several studies indeed indicate substantial between-therapist variability in explaining treatment outcome (Crits-Cristoph, & Mintz, 1991; Huppert et al., 2001; Zuroff et al., 2010). Previous studies have indicated that the extent to which they succeed in building alliances might be an important factor in explaining variability in therapy success between therapists (Baldwin et al., 2007; Zuroff et al., 2010).

Alliance is generally defined as a professional relationship between a therapist and his or her client, consisting of an emotional bond and agreement on what goals and tasks should be central during treatment (Bordin, 1979; Elvins, & Green, 2008). It has shown to be a significant contributor to psychotherapy outcome in adults, youth and families (Flückiger et al., 2018; Murphy, & Hutton, 2018; Welmers – van de Poll et al., 2018). However, several studies have shown that therapists differ substantially in how much they succeed in building alliances with their clients (Dinger et al., 2008; Nissen-Lie et al., 2010). Thus, identifying therapist characteristics and behaviors that contribute to better alliances can be an important step towards a better understanding of between-therapist differences in treatment effectiveness. In the current paper, we aim to investigate the contribution of therapists' observed alliance building behaviors, personality, and years of clinical experience to the alliance in home-based family treatment.

Alliances in Family Treatment

In conjoint family treatment, building alliances is complex for several reasons. First, the therapist simultaneously develops multiple alliances with different family members, who often have different or even conflicting needs and expectations of the treatment and the therapist. Second, family members observe and influence each other in their alliances with the therapist. Consequently, knowing they are observed by their partner, father, mother or children, family members might feel unsafe and reluctant to be open and collaborative with the therapist (Friedlander et al., 2006a). A final complexity in building alliances in family treatment is that treatment outcome is not only affected by family members' individual bond and collaboration with the therapist, but also by the extent to which family members form an alliance with each other, also referred to as the *within-system alliance* (Pinsof, & Catherall, 1986), or *shared sense of purpose within the family* (Escudero et al., 2008; Friedlander et al., 2006; Isserlin, & Couturier, 2012).

In order to encompass these systemic complexities in a comprehensive model of the alliance in family therapy, Friedlander et al. (2006a) developed the System for Observing Family Therapy Alliances (SOFTA). This assessment system is based on a four domain model of the alliance, with two individual alliance domains reflecting (a) goal and task elements (*Engagement in the Therapeutic Process*), and (b) bond elements of the alliance (*Emotional Connection to the Therapist*), similar to Bordin's (1979) definition of the alliance for individual psychotherapy. The other two domains concern systemic aspects of the alliance unique to conjoint family treatment, that is, (c) *Safety within the Therapeutic System*, referring to family members experiencing the therapeutic environment as a safe place where they can take risks, be open and flexible, and handle family conflicts without risking harm, and (d) *Shared Sense of Purpose within the Family*, which is the agreement and cooperation between family members on shared goals (Friedlander et al., 2006a).

Several studies using the SOFTA to observe client behaviors indicate the importance of family members' sense of safety and their shared sense of purpose in promoting positive outcomes of family therapy (e.g. Escudero et al., 2008; Friedlander et al., 2008b; Isserlin & Couturier, 2012; Sotero et al., 2018). Moreover, results of a recent meta-analysis on the association between alliance and outcome in couple and family therapy indicate that aspects of the alliance typical of systemic treatment, such as safety within the therapeutic system or the family's shared sense of purpose, are more predictive of outcome as compared to individual alliances with the therapist, even when these individual alliances of multiple family members are averaged to measure a family unit of alliance (Friedlander et al., 2018). This indicates that study findings on therapists' contributions to alliance in individual therapy cannot simply be generalized to family treatment, which emphasizes the importance of a systemic approach to the alliance in family therapy practice and research. However, studies examining therapists' contributions to the alliance in systemic family treatment are scarce (Sotero et al., 2017).

Therapists' Alliance Building Behaviors

Therapists' observed in-session behavior could be an important contributor to the alliance, as has been shown in several studies in individual youth therapy (Creed, & Kendall, 2005; Fjermestad et al., 2020; Ovenstad et al., 2020). For conjoint family treatment however, studies on alliance building behaviors are scarce. Diamond et al. (1999) examined ten cases of adolescents in Multidimensional Family Therapy (MDFT) with initially poor alliances, and compared five improved cases with five unimproved cases. They found that in the improved cases, therapists more extensively presented themselves as the adolescent's ally, attended to the adolescent's experience, and formulated personally meaningful goals. In a comparable study on the alliance with adolescents in a Spanish setting of brief family therapy, Muñiz de la Peña et al. (2012) found that therapists showed significantly more

competitive responding in poor alliance sessions. Competitive responding reflects two speakers' opposing views on who is in control in their relationship, resulting for example in not answering a question or interrupting the other speaker when he or she changes the conversation topic (Muñiz de la Peña et al., 2012). In the same study, cases with improved alliances showed a decrease in the therapist's competitive responding. Although both of these studies concerned family therapy, the studies did lack a systemic focus on the alliance, as they examined individual alliances with adolescents only.

Two other observational family therapy case studies examining alliances with the family describe how alliances improved when the therapist (a) explained a rationale for introducing new goals and tasks, (b) fostered emotional bonds with each family member, for example by reassuring and empathizing, (c) focused on family members' shared experiences and agreed upon goals, and (d) highly invested in family members' sense of safety during sessions (Escudero et al., 2012; Friedlander et al., 2014). Although providing valuable insight into good practices of alliance building and repairing in the context of family therapy, both case studies did not provide a statistical test of the association between alliance building behaviors and the alliance. Consequently, the effect of therapists' observed behaviors on alliances in family therapy remains unclear.

Personality and Clinical Experience

Besides observable therapists' behaviors, relatively stable individual characteristics of the therapist might influence alliance processes. Two reviews of studies on therapists' contributions to the alliance in individual psychotherapy indicated that warmth, trustworthiness, flexibility, being interested, alert, relaxed, confident and respectful, are therapist characteristics associated with a stronger alliance (Ackerman & Hilsenroth, 2003), whereas being rigid, aloof, tense, uncertain, self-focused, and critical are associated with poorer alliances (Ackerman & Hilsenroth, 2001). However, few studies comprehensively examined associations between therapists' stable individual (personality) characteristics and alliance, while to our knowledge, no such studies exist for conjoint family treatment.

A well validated model that can be used to describe the therapist's personality characteristics, is The Five Factor Personality Model (McCrae, & Costa, 1987; Chapman et al., 2009). This model distinguishes between *neuroticism*, *extraversion*, *openness to experience*, *agreeableness*, and *conscientiousness* as five basic personality domains (McCrae, & Costa, 1987). *Neuroticism* is likely to negatively impact the therapist's ability to build strong alliances, as it refers to emotional instability and anxiety, lacking confidence, and being tense rather than relaxed (Hoekstra & De Fruyt, 2014). Neuroticism has been shown to negatively impact job performance more generally (Lado, & Alonso, 2017), as well as the quality of intimate and social relationships (e.g. Karney, & Benjamin, 1995;

Lopes et al., 2003; Schaffhuser et al., 2014). In a recent study clients were asked to report on their ideal therapists' personality, and they particularly valued low neuroticism and high conscientiousness (Russell et al., 2020). *Conscientiousness* refers to being targeted, organized, ambitious, disciplined, and trustworthy (Hoekstra & De Fruyt, 2014), which positively impacts job performance (Barrick & Mount, 1991; Lado, & Alonso, 2017). The review by Ackerman and Hilsenroth (2003) indicated that therapists' trustworthiness was associated with stronger alliances, which supports the hypothesis that therapists' conscientiousness may positively impact the alliance. However, a recent study on personal style and personality dimensions of therapists providing individual, group or family therapy found that conscientiousness negatively impacted therapists' emotional closeness with their clients, possibly hampering the building of a strong alliance (Casari et al., 2019).

The remaining three domains of the Big Five Model all represent traits likely to positively impact the alliance. *Extraverted* individuals enjoy social interaction and tend to be warm (Hoekstra & De Fruyt, 2014), showing higher perceived quality of social relationships (Lopes et al., 2003). *Agreeableness* refers to being empathic, trusting, sincere, and caring (Hoekstra & De Fruyt, 2014), and is associated with having less conflicts in social relationships (Assendorpf & Wilpers, 1998). Finally, when therapists are more *open to experience*, they are more flexible, curious, and open to differing values of other people (Hoekstra & De Fruyt, 2014). This may help clients feel more accepted, which in turn can strengthen the therapeutic bond.

Chapman et al. (2009) used the Five Factor Personality (FFP) model to investigate the association between individual psychotherapy trainees' personality and alliance in a sample of 34 trainees and 64 clients. They found that three of the FFP domains were associated with the alliance. Highly *neurotic* therapist trainees received better alliance reports of their clients, but reported on poorer alliances themselves. Highly *agreeable* trainees also reported poorer alliances, but this was not the case in client reports. Finally, higher levels of *openness* of trainees were associated with less positive client-reports of the alliance. Chapman and others explained these somewhat surprising findings by the low levels of *neuroticism* and high levels of *openness* and *agreeableness* in their trainee sample as compared to national norms. Consequently, lower *neuroticism* and higher *agreeableness* and *openness* represented extreme levels of these traits, which may particularly explain their negative effect on the alliance. In the light of these findings, it is interesting to mention a study by Delgado et al. (2020), which showed that anxious and depressed clients individually treated by more *agreeable* and *open* psychologists had poorer treatment outcomes. Notably, therapists' means on these dimensions were exceeding national norms.

Although therapists' personality traits might help or hamper bonding and collaborating effectively with clients, clinical experience might help therapists to enhance those interpersonal skills that do not come naturally. Especially in family therapy, skills required for balancing multiple alliances and enhancing systemic aspects of the alliance are complex, and thus might benefit from extensive clinical experience. To our knowledge, there are no studies available examining the effect of the therapist's clinical experience on alliances in conjoint family treatment. Previous studies of other forms of therapy show mixed results. For example, Mallinckrodt and Nelson (1991) found that experienced post-graduate therapists had stronger alliances with their clients as compared to both novice and advanced psychotherapy trainees. Hersoug et al. (2009) found that in long-term psychotherapy more experienced therapists rated the alliance to be lower. However, in another study, with a larger sample of therapists, no effect was found for years of clinical experience on alliance (Dunkle & Friedlander, 1996). These equivocal results underline the relevance of further investigating the role of the therapists' clinical experience in building alliances.

Present Study

This study aimed to examine the contribution of therapists' observed alliance building behaviors, personality, and clinical experience to the alliance in a home-based family treatment for youth problems. Empirical evidence suggests that the client's perspective on the alliance seems most predictive of outcome (Horvath et al., 2011). However, several studies support the predictive value of therapist reports as well (Flückiger et al., 2018; De Greef et al., 2018b; Zilcha-Mano et al., 2015). Also, it is the therapist who is responsible for managing the therapeutic process, including the process of building alliances and repairing problematic alliances if they occur (Hartmann et al., 2015). In this study we thus focused on predicting both family members' and therapists' experiences of the alliance. Because we were interested in alliance as a dynamic process that develops over time (Horvath, 2006; Welmers-van de Poll et al., 2018), we investigated mid-treatment alliance, taking into account the possible effects of early treatment therapist behavior and alliance.

We hypothesized that the therapist's personality, clinical experience, and observed alliance building behaviors would be significantly associated with mid-treatment alliance as reported by family members and therapists. More specifically, we expected that therapists' *extraversion*, *openness to experience*, and *agreeableness* would positively, and *neuroticism* would negatively predict quality of the alliance. As previous findings regarding *conscientiousness* (-related traits) as well as years of clinical experience were inconsistent, we did not formulate hypotheses for the direction of the association with the alliance for these characteristics. Finally, we expected that therapists' observed *engagement*, *emotional connection*, *safety*, and *shared sense of purpose* behaviors would predict more positive mid-treatment alliance reports.

Methods

Participants and Treatment

Participants were 77 parents ($n = 54$ (step)mothers, $n = 23$ (step)fathers) and 21 children from 57 families. The mean age of the child for whom the treatment was indicated was 10 ($SD = 4.4$, range 0 – 16.7). The mean age of the children participating in the study was 11.7 years ($SD = 2.7$, range 5 – 16), and the mean age of parents was 39 years ($SD = 7.8$, range 25 – 55). The study was carried out in the Netherlands, and most participants were born in the Netherlands. In 3 families, one or both parents were born in a western country other than the Netherlands, and in 4 families one or both parents were born in a non-western country. Participating families received home-based family treatment for youth problems, designated as *Intensieve Pedagogische Thuishulp (IPT, Van der Steege, 2007)*. They were seen by 33 IPT-workers (12% male; M age 42.7, $SD = 9.3$), hereafter referred to as ‘therapists’. All therapists had a social work related (post-) bachelor’s degree and an average of 8.4 years of clinical experience ($SD = 4.7$). Each therapist saw 1 – 6 families ($M = 1,73$, $SD = 1,15$).

Intensieve Pedagogische Thuishulp (IPT, Van der Steege, 2007) designates home based family treatment in the Netherlands for families dealing with complex child behavior and parenting problems. Most families experience problems in other domains as well, such as financial problems, parental psychopathology or lack of a supporting social network. An important treatment principle is that effective treatment for youth problems cannot be provided to a child isolated from parents and other family members and is best provided in the child’s daily living environment (Van der Steege, 2007). Consequently, the treatment applies a systemic approach and is provided in the family’s home. Furthermore, it is characterized by a solution-focused, empowering approach, focusing on improving parenting skills and enhancing social support. During treatment, an IPT-worker visits the family at their homes once or twice a week or once every two weeks, depending on the families’ needs and stage of treatment. Families in this study received IPT for an average period of 50 weeks ($SD = 30.2$; *Median* = 45,5; range 12-168), with the majority of families (80%) receiving treatment with a length between 14 and 78 weeks.

Measures

Working Alliance Inventory – Short Form (WAI-s) To assess the alliance, we used the Working Alliance Inventory, Short Form (WAI-s; Horvath & Greenberg, 1989; Killian et al., 2017). The 12 items in this questionnaire (e.g. “My family counselor and I agree upon what I should do in order to improve the way things are going in my family” for the client version or “This client agrees upon what family members should do in order to improve

the way things are going in the family" for the therapist version) are scored on a 5 point Likert-type scale ranging from 1 (*never*) to 5 (*always*). In the current sample, Cronbach's alpha for the therapists' version was .82 at T1 and .85 at T2, and for the clients' version .89 at T1 and .92 at T2.

NEO-FFI We used the NEO Five Factor Inventory (NEO-FFI) to assess therapists' personality traits, which is a short version of the full length NEO-Personality Inventory, Revised (NEO-PI R; Costa, & McCrae, 1992). The questionnaire contains 60 items scored on a 5-point Likert-type scale (strongly disagree – strongly agree). Subscales contain 12 items each and measure Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. Both the English and Dutch version show favorable validity and reliability (Hoekstra & De Fruyt, 2014). In the current sample, Cronbach's alpha was .69 for Neuroticism and for Extraversion, .58 for Openness to experience, .74 for Agreeableness, and .60 for Conscientiousness.

System for Observing Family Therapy Alliances (SOFTA-o) – Therapist version. To assess therapists' alliance building behaviors we analyzed videotaped sessions using the therapist version of the SOFTA-o (Friedlander et al., 2006a). This instrument has been developed to assess four dimensions of alliance-related behavior from videotaped family or couple therapy sessions. Two dimensions reflect the individual alliance between a family member and the therapist similar to Bordin's (1979) classical definition of the alliance, i.e., Engagement in the Therapeutic Process, representing task and goal elements of the alliance, and Emotional Connection. The two other dimensions – Safety within the Therapeutic System, and Shared Sense of Purpose within the Family – reflect aspects of the alliance that are unique to conjoint family treatment. The therapist version, which we used for this study, measures the therapist's in-session contributions to these four dimensions.

When using the SOFTA-o, a trained coder observes a session and notes the frequency of specific positive and negative alliance-related behaviors along the four dimensions. Some examples for positive and *negative (italized hereafter)* behavioral indicators include "Therapist encourages client(s) to articulate their goals for therapy" or "*Therapist argues with the client(s) about the nature, purpose, or value of therapy*" for Engagement, "Therapist expresses interest in the client(s) apart from the therapeutic discussion at hand" or "*Therapist has hostile, sarcastic, or critical interactions with the client(s)*" for Emotional Connection, "Therapist acknowledges that therapy involves taking risks or discussing private matters" or "*Therapist does not attend to overt expressions of client vulnerability (e.g. crying, defensiveness)*" for Safety, and "Therapist encourages clients to ask each other for their perspective" or "*Therapist fails to address one client's stated concerns by only discussing another client's concern*" for Shared Sense of Purpose.

The Shared Sense of Purpose dimension can only be observed when two or more family members are in a session together, the other three dimensions can also be scored with only one family member present in a session. After observing the session, based on the frequency, intensity and clinical meaningfulness of the marked behaviors, coders assign global ratings on each dimension on a 7 point Likert scale ranging from -3 (*extremely problematic*) to +3 (*extremely strong*). For the purpose of this study, the SOFTA-o was translated from English to Dutch, following guidelines as prescribed by Van Widenfelt, Treffers, De Beurs, Siebelink, and Koudijs (2005).

For coding the videotaped IPT-sessions with the SOFTA-o, we used the training manual by Friedlander et al. (2005) as a guideline. The first author received training from Valentín Escudero, one of the developers of the SOFTA. After training and translation of the manual, first author coded 12 videotapes with at least two family members in the session to provide a coding standard for training other coders. Coding dilemmas from these 12 videotapes were discussed with Valentín Escudero. Next, 3 master students of Educational Sciences were trained, receiving 15 hours of coder training over five weeks. They were introduced to the theoretical framework of the SOFTA, coding guidelines, practice material from the developers and Dutch practice material taken from the drama-series *In Therapie (In Therapy)*. Trained coders independently coded at least 10 videotapes to increase their reliability as coders compared to the golden standard codings by first author and received feedback on each coding. As advised by Friedlander et al. (2005), training continued until coders differed no more than one point in their scale scores in 90% of the cases.

After their training, each coder rated a random selection of the videotapes. Coding dilemmas were discussed and difficult parts were consensus coded during meetings with the coding team every two weeks. In total, 90 sessions were independently coded after training. Of these sessions, 14 random selected sessions (16.6%) were double coded by the first author, coders were blind to these double coded sessions. To assess interrater reliability, we calculated intra-class coefficients for the 14 double coded sessions using the single measures of a two-way mixed effect model based on absolute agreement (Koo & Li, 2016). We first assessed reliability of the subscale scores as originally developed, that is, with a rating from -3 to +3 based on observed behaviors. Because these regular subscale scores had very little variance and because of this did not achieve sufficient interrater reliability, we chose to use a score for each subscale reflecting the number of observed positive behaviors per 60 minutes. ICC's for these scores were .637 for Engagement, .551 for Emotional Connection, .558 for Safety, and -.129 for Shared Sense of Purpose. According to Cicchetti (1994), ICC's are fair when $>.4$, good $>.6$ and excellent $>.8$. The negative ICC for Shared Sense of Purpose could be explained by a low number of random selected sessions for double coding with two or more family members

present in the session ($n = 6$) and by low variance (range = 0-3). For this scale we therefore additionally analyzed percentage of agreement between coders and found that for 67.7% of the sessions there was 100% agreement on number of observed SSP behaviors, for 16.7% ($n=1$) of the sessions the difference between coders was 1, and in the remaining 16.7% the difference was 2. However, preliminary results showed that not only interrater reliability, but also variance was low for observed SSP behaviors. Therefore, we excluded this domain from our main analyses.

Procedures

Participating families were drawn from four IPT-teams of two Dutch youth care organizations. Each family that started treatment was informed about the research project by the IPT-worker or institution and received a letter with information. In one team, all IPT-workers directly asked their clients to participate. In the remaining three teams families were invited to participate by telephone by a research assistant. Participating family members of 12 years and older signed an informed consent letter, and the project was approved by the ethical review board of the university faculty where authors of the study were employed. All participating families received a €10 gift card and by draw, two families received a voucher for visiting a zoo or fun park of their own choice.

For each participating family two IPT-sessions at the family's home were videotaped. For T1—in the early treatment phase—the third session (and by exception the fourth or fifth) was filmed. We chose the third session because families were informed about the research and asked to consider participation in the first session. By choosing the third session they had some time to consider participation, but treatment was still in its starting phase, which lasts about six weeks (Van der Steege, 2007). The second video-observation (T2) was two months later, when treatment was in the phase of active change. Immediately after both video-recorded sessions, the therapist and participating family members were asked to independently fill out the Work Alliance Inventory (WAI). Children who were 8 years or older were asked to complete the Working Alliance Inventory (WAI). In some families, children above 8 did not want to participate in the research, and in other families the therapist saw one or two parents without a child for at least a part of the sessions, including the observed session. Therapists were asked to reflect on alliances with all family members actively involved in treatment, regardless of age. For 9 families there were no T2 measures available because the treatment had already ended ($n = 3$), or therapist or clients wished to end their participation after T1 because the situation had changed ($n = 6$), and for 1 family there was no T1 measure. Study dropouts were not excluded because this might have decreased the clinical representativeness of our study. We compared all measures at T1 as well as therapist personality measures and clinical experience for dropout and completer cases by performing a multilevel regression

analysis of a dichotomous dropout variable at T2 on T1 client- and therapist reported alliance, T1 therapist observed alliance behaviors, therapist clinical experience and therapist neuroticism, extraversion, openness, agreeableness, and conscientiousness. We found no significant differences on any of these variables, except for therapists' observed safety behaviors ($\beta = 1.231, p = .001$), indicating that therapists showed more safety behaviors at T1 in the dropout cases.

Statistical Analyses

First, we imputed missing values using expectation maximalization (Tabachnick, & Fidell, 2013). After removing one case with T1 alliance measures as well as therapist variables missing, a MCAR test as proposed by Little (1988) indicated that missing values were completely at random ($\chi^2 = 415.076 (370, N = 98), p = .053$). Next, we tested for collinearity to enable a multivariate test of the relative importance of multiple independent variables by calculating a Variance Inflation Factor (VIF). All calculated VIF's were below 3, indicating that there was no multicollinearity problem.

For our main analyses we used a two level model to account for dependency of data (Tabachnick & Fidell, 2013), as family members (level 1) were nested within therapists (level 2). Level 1 concerns variance of alliance measures between family members within the family, while level 2 accounts for variance between families. Because of the short-term longitudinal nature of the study (i.e., client- and therapist reports as well as therapist's alliance building behaviors were measured early and mid-treatment), we controlled for T1 alliance as well as T1 observed alliance building behaviors. We differentiated between parent-therapist and youth-therapist alliance by adding a parent/youth variable to the model. Because some studies indicate that the strength of the alliance may differ between male and female therapists (e.g. Welmers- van de Poll et al., 2018), and that therapist age is associated both with years of clinical experience and observed interpersonal skills (Anderson et al., 2009), we also controlled for therapist age and gender. Within the two-level model, we performed two stepwise multiple regression analyses to sequentially identify whether family role (parent vs. youth), therapist age and gender, clinical experience, personality traits, mid-treatment alliance building behaviors, early alliance, and early treatment alliance building behaviors (independent variables) were significantly associated with therapist reported mid-treatment alliance or with client reported mid-treatment alliance (dependent variables).

Results

Preliminary Analyses

Table 1 shows the distribution of therapists' alliance building behaviors. Results indicate that therapists mainly invested in *engagement* and *emotional connection*, the two individual domains of the SOFTA model. Therapist behaviors contributing to *safety* and *shared sense of purpose*, the two systemic alliance domains of the SOFTA-model, were scarcely observed. As argued above, we excluded the *shared sense of purpose* domain from our main analyses.

Table 1
Therapists' alliance building behaviors

	T1		T2	
	<i>n</i>	Mean (SD)	<i>n</i>	Mean (SD)
Engagement in the Therapeutic Process	54	12.4 (5.6)	45	12.3 (6.1)
Emotional Connection	54	14.5 (10.0)	45	14.4 (8.5)
Safety within the Therapeutic System	54	1.1 (1.4)	45	0.6 (1.1)
Shared Sense of Purpose	30	0.5 (0.8)	20	0.4 (0.7)

Note. Scores on SOFTA-o therapist version, number of alliance building behaviors per 60 minutes. T1 = starting phase of treatment; T2 = mid-treatment. *n* = number of families with a score of observed therapist behaviors on the designated SOFTA domain.

Table 2 shows the distribution of therapists' scores on the NEO-FFI, as compared to a general sample of Dutch adults in the development sample of the measure (Hoekstra & De Fruyt, 2014). Therapists in our sample reported notably higher levels of *extraversion*, *agreeableness*, and *conscientiousness*, lower levels of *neuroticism*, and similar levels of *openness to experience* as compared to the general Dutch sample.

Table 2
NEO-FFI scores

	Therapist Sample (<i>n</i> = 29)	General Dutch sample ¹ (<i>n</i> = 1715)
	Mean (SD)	Mean (SD)
Neuroticism	27.5 (5.1)	34.0 (7.5)
Extraversion	44.0 (4.4)	39.3 (5.8)
Openness to Experience	39.9 (5.2)	38.9 (5.7)
Agreeableness	48.8 (4.1)	41.1 (5.6)
Conscientiousness	46.7 (4.0)	43.4 (5.7)

Note. ¹General sample of Dutch adults in the development sample of the measure (Hoekstra & De Fruyt, 2014).

Table 3 shows the distribution of WAI-therapist and WAI-client scores. Results indicate that family members' reports of the alliance were somewhat higher as compared to therapist reports. Differences between T1 and T2 were very small.

Table 3
Scores on Working Alliance Inventory

	T1		T2	
	<i>n</i>	Mean (SD)	<i>n</i>	Mean (SD)
Therapist reports	87	3.9 (0.4)	77	4.0 (0.4)
Client reports	86	4.2 (0.6)	69	4.3 (0.6)

Note. T1 = starting phase of treatment; T2 = mid-treatment. *n* = number of individual family members with a therapist or client report on the alliance.

Predictors of Therapist-reported Alliance

We found that several variables significantly predicted therapist reports of mid-treatment alliance (Table 4). Family role predicted therapist reports of the alliance ($\beta = -.156, p = .003$), with therapists reporting stronger alliances with parents as compared to youth. As for demographic therapist features, only gender predicted therapist reports of the alliance, with female therapists reporting stronger alliances as compared to male therapists ($\beta = .331, p < .001$). Therapist age did not predict therapist reports of the alliance.

As for therapist personality, all five personality domains were significant predictors of therapist-reported mid-treatment alliance, which was in line with our hypothesis. As expected, *openness to experience* ($\beta = .517, p < .001$) and *agreeableness* ($\beta = .306, p < .01$) were positively associated with therapists reports of the alliance, and *neuroticism* ($\beta = -.472, p < .001$) was negatively associated. In contrast to our expectations, *extraversion* ($\beta = -.304, p = .001$) was also negatively associated, as was *conscientiousness* ($\beta = -.230, p = .006$), of which we had no previous expectations on the direction of the association. Our hypothesis on the contribution of therapists' clinical experience was not confirmed, as clinical experience was not significantly associated with therapist reports of mid-treatment alliance.

As hypothesized, therapist alliance building behaviors predicted therapist reports of the alliance. Observed in-session therapist *engagement* ($\beta = .374, p < .001$) and *emotional connection* ($\beta = .318, p < .001$) behaviors at T2 were positively associated with therapist reports of the alliance right after the observed session. In contrast to our hypothesis, observed in-session therapist *safety* behaviors ($\beta = -.806, p < .001$) were negatively associated. Early therapist-reported alliance positively predicted therapists mid-

treatment reports of the alliance ($\beta = .398, p < .001$), whereas early treatment observed in-session alliance building behaviors did not. This indicates that there was no longitudinal contribution of observed early treatment in-session alliance building behaviors to therapist reports of mid-treatment alliance.

Predictors of Client-reported Alliance

As depicted in Table 5, several variables significantly predicted family members' reports of mid-treatment alliance. There were no significant differences in alliance reports between parents and youth. Therapist gender was the only demographic feature that significantly predicted family members' reports of the alliance, with higher alliance reports for female therapists as compared to male therapists ($\beta = .404, p < .001$).

In line with our hypothesis, all five personality domains significantly predicted family members' reports of mid-treatment alliance, but directions of the association were only partly as hypothesized. As expected, *openness to experience* ($\beta = .202, p = .010$) and *agreeableness* ($\beta = .181, p = .024$) were positively associated with family members' alliance reports, whereas *Neuroticism* was negatively associated ($\beta = -.264, p < .001$). In contrast to our expectations, *extraversion* ($\beta = -.196, p = .006$) was also negatively associated with family members' alliance reports, as was *Conscientiousness* ($\beta = -.169, p = .028$), on which we had no previous expectation for the direction of the association. These associations were all in the same direction as the associations with therapists' alliance reports. Our hypothesis on the contribution of therapists' clinical experience was not confirmed, as clinical experience was not significantly associated with therapist reports of mid-treatment alliance.

As hypothesized, therapist alliance building behaviors predicted family members' reports of the alliance: observed in-session therapist *engagement* ($\beta = .305, p = .001$) and *emotional connection* ($\beta = .237, p < .001$) behaviors at T2 were positively associated with family members' reports of the alliance right after the observed session. In contrast to our hypothesis, therapists' in-session *safety* behaviors were negatively but not significantly associated.

Early alliance as reported by family members positively predicted their mid-treatment reports of the alliance ($\beta = .464, p < .001$). Early treatment in-session therapist alliance building behaviors were not significantly associated, indicating that there was no longitudinal contribution of therapists' early treatment alliance building behaviors to family members' reports of mid-treatment alliance.

Table 4

Results of step wise multilevel regression modeling for predicting therapist-reported alliance at T2

Family role (0 = parent, 1 = youth)

Therapist age

Therapist gender (0 = male, 1 = female)

Therapist experience

Therapist personality

*Neuroticism**Extraversion**Openness**Agreeableness**Conscientiousness*

Therapist behavior T2

*Engagement**Emotional Connection**Safety*

Alliance T1

Therapist behavior T1

*Engagement**Emotional Connection**Safety*X² (Δ improvement compared to previous model)X² (Δ improvement compared to null-model)N= 57 families, *n* = 77 parents, *n* = 21 youth, N = 33 therapists, **p* < .10, ***p* < .05, ****p* < .001

Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
β	β	β	β	β	β
-.282***	-.273***	-.292***	-.263***	-.175**	-.156**
	.143	-.049	-.063	-.050	-.069
	.442**	.435***	.361***	.360***	.331***
		.388**	.154	-.024	-.040
		-.245*	-.423***	-.458***	-.472***
		-.109	-.239*	-.251**	-.304**
		.161	.347**	.462***	.517***
		.140	.272	.243**	.306**
		-.297**	-.287**	-.265***	-.230**
			.195 ⁺	.343***	.374***
			.370***	.290***	.318***
			-.551***	-.692***	-.806***
				.407***	.398***
					.037
					-.019
					-.130 ⁺
15.975***	7.558	21.192*	28.616**	27.711**	-6.932***
15.975***	23.515***	44.707***	73.323***	101.034***	94.102***

Table 5

Results of step wise multi-level regression modeling for predicting client-reported alliance at T2

Family role (0 = parent, 1 = youth)
Therapist age
Therapist gender (0 = male, 1 = female)
Therapist experience
Therapist personality
<i>Neuroticism</i>
<i>Extraversion</i>
<i>Openness</i>
<i>Agreeableness</i>
<i>Conscientiousness</i>
Therapist behavior T2
<i>Engagement</i>
<i>Emotional Connection</i>
<i>Safety</i>
Alliance T1
Therapist behavior T1
<i>Engagement</i>
<i>Emotional Connection</i>
<i>Safety</i>
X ² (Δ improvement compared to previous model)
X ² (Δ improvement compared to null-model)
N = 57 families, n = 77 parents, n = 21 youth, N = 33 therapists, *p < .10, *p < .05, **p < .01, ***p < .001

Discussion

We examined the role of therapists' personality, years of clinical experience, and observed alliance building behaviors in predicting mid-treatment alliance in home-based family treatment for youth problems, controlling for family role (parent vs. youth), therapist age and gender and early treatment alliance. We found that therapist *openness to experience* and *agreeableness* as well as therapists' in-session *engagement* and *emotional connection* behaviors predicted more positive therapists' and family members' reports of the alliance. Therapist *neuroticism*, *extraversion* and *conscientiousness* predicted more negative alliance-reports. In-session *safety* behaviors also predicted more negative alliance-reports, but this finding was only significant for therapists' and not family members' reports of the alliance. Clinical experience did not predict quality of alliances.

Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
β	β	β	β	β	β
-.134	-.121	-.149*	-.154*	-.062	-.045
	-.180*	-.361***	-.338**	-.189*	-.161 ⁺
	.694***	.752***	.689***	.425***	.404***
		.279**	.149	.057	.001
		-.055	-.141 ⁺	-.243***	-.264***
		-.258**	-.321**	-.211**	-.196**
		.193*	.265**	.207**	.202*
		.264**	.304**	.203**	.181*
		-.029	-.026	-.128**	-.169*
			.110	.299***	.305**
			.226**	.220***	.237***
			-.219 ⁺	-.162 ⁺	-.198 ⁺
				.467***	.464***
					.083
					.030
					.006
-0.152***	41.961***	9.286	3.422	41.685***	-8.975***
-0.152***	41.809***	51.095***	54.517***	96.202***	87.227***

Our finding that therapists' personality traits predicted alliance was mostly in line with our hypotheses. As hypothesized, we found that both therapists and family members reported stronger alliances when therapists were more *agreeable* and *open to experience*. This is in contrast with findings of Chapman et al. (2009) in individual psychotherapy, indicating that more *openness to experience* was associated with less positive client-reports of the alliance, and that more *agreeable* trainees in their sample reported on weaker alliances themselves. The authors reason that, given the high levels of *openness* and *agreeableness* in their trainee sample, it seems plausible that only extreme levels of these traits did negatively influence the alliance. In our sample however, therapists also reported their levels of *openness* to be somewhat higher, and their levels of *agreeableness* a standard deviation higher than that of the general Dutch population. This indicates that even extremely agreeable and open therapists may be more successful

in building alliances as reported by family members and by themselves. Our findings on *neuroticism* were also in line with our expectations, and in contrast with findings of Chapman et al. (2009) in their trainee sample. Our findings indicate that therapists who perceive themselves as emotionally stable rather than neurotic have stronger alliances as perceived by themselves and family members. This seems to apply even for extremely emotionally stable therapists, because in our sample therapists reported their levels of *neuroticism* to be almost a standard deviation lower than that of the general Dutch population.

We furthermore found that therapists' *extraversion* and *conscientiousness* negatively predicted both therapists' and family members' reports of the alliance. The negative contribution of *conscientiousness* could be explained by the fact that highly conscientious people are predominantly task-oriented, orderly, and less inclined to operate off the beaten track (Hoekstra & De Fruyt, 2014). This may hamper therapists' abilities to be flexible and accommodate treatment protocols to their clients' differing needs. Our finding on *extraversion* was surprising, given that extraverted individuals tend to be sociable, warm and optimistic. Our finding is also in contrast with previous findings of Chapman et al. (2009), indicating that extraversion did not impact the alliance. However, in our sample therapists rated their levels of *extraversion* almost a standard deviation higher compared to national norms. It is thus not precluded that average *extraversion* may help therapists in bonding with their clients, but that higher levels may become counterproductive. Perhaps a highly extraverted therapist, who is likely to be very talkative, energetic, and optimistic, can be overwhelming and difficult to relate to for clients, who may feel rather depressed and pessimistic when receiving help for serious child and parenting problems. Another explanation that highly extraverted therapists were found to have less strong alliances with families in our sample, could lie in cultural background: perhaps extraversion is valued less in some cultures than in others (Hofstee et al., 1997).

We found no contribution of therapists' years of clinical experience to alliance. Initially, there was a significant association when clinical experience was first added to both our regression models, but it disappeared when we added alliance building behaviors to these models. This indicates that any assumed contribution of the therapists' clinical experience to alliances should rather be explained by what therapists' do during a session to strengthen the alliance. It could thus be reasoned that therapists' clinical experience contributes to their in-session alliance building behavior. Indeed, Raytek et al. (1999) found that in a conjoint couple alcoholism treatment more experienced therapists showed more alliance fostering behaviors and less nonfacilitative behaviors as compared to less experienced therapists. A previous study on therapists' contributions to alliance in home-based family treatment showed that therapists' clinical experience positively impacted only early treatment

engagement behaviors (Welmers – van de Poll & Stams, 2019). There was no effect of clinical experience on any observed mid-treatment behaviors or for early treatment *emotional connection* and *safety* behaviors. Note that in the present study we only examined therapists' and family members' ratings of their individual alliances, since there were no therapist- or self-reports on *safety* or *shared sense of purpose*. Future research could investigate whether perhaps the more complex aspects of alliance in conjoint treatment, such as creating a safe therapeutic environment for each family member or enhancing the within-family alliance, are more affected by the therapists' clinical experience.

Regarding therapists' observed in-session alliance building behaviors in the present study, we found that observed *engagement* and *emotional connection* behaviors predicted both their own and family members' reports of the alliance, which was in line with our hypotheses. In a previous study investigating observations of client behaviors in relation to self- and therapist-reports of alliance, *engagement* and *emotional connection* behaviors of family members were also positively associated with their self-reports, but not with therapist-reports (Friedlander et al., 2006b). Our finding indicates that when the therapist actively engages family members in the treatment process and connects with them at an emotional level, both the therapist and the family evaluate the alliance as more positive.

In contrast to our expectations, therapists' and family members' reports of the alliance were negatively associated with therapists' in-session *safety* behaviors, such as providing structure and guidelines for safety and confidentiality or actively protecting one family member from another. This is remarkable given the low occurrence of these behaviors in the included observed sessions. The negative direction of the association was replicated in predicting family members' reports of the alliance, although this association just failed to reach significance. Our finding could indicate that therapists' *safety* interventions have a negative effect on the alliance, even when applied scarcely. However, two previous studies including observations of family members' in-session safety behaviors indicate that a sense of safety in the therapeutic context does promote positive outcome of systemic family treatment (Friedlander et al., 2008b; Sotero et al., 2018). An alternative explanation for our finding may be that therapists increase their investment in safety when they perceive their alliance with family members as less favorable. This presumed mechanism is in line with Escudero and Friedlander's (2017) proposed strategy for navigating alliances in challenging contexts of family treatment. They argue that a sense of safety among family members who are in treatment together is an essential precondition for facilitating strong bonds between the therapist and each family member, as well as for facilitating family members' engagement in the treatment process and their shared sense of purpose.

The fact that our findings on the therapists' personality and alliance building behaviors in predicting mid-treatment alliance were significant even after controlling for early treatment alliance reports underlines the robustness of our findings. It indicates that regardless of fluctuations in alliance from early to mid-treatment, alliances are still relatively stronger when therapists are more agreeable, open and emotionally stable, and when they emotionally connect with family members and actively engage them in the treatment process. We also controlled for early treatment alliance building behaviors, but found no longitudinal contribution of therapist behaviors during early treatment to mid-treatment alliance reports of therapists and family members. This indicates that what therapists do during a specific session to strengthen the alliance only impacts therapists' and family members' evaluation of the alliance shortly after this session.

Although not a specific focus of our study, it was interesting to find that therapists mainly invested in individual alliances with family members, but scarcely in systemic aspects of the alliance (*safety and shared sense of purpose*). This finding is in line with indications of Friedlander et al. (2019) that even highly experienced family therapists tend to focus mainly on individual alliances with family members, overlooking the importance of systemic aspects of the alliance, such as in-session safety and a shared purpose among family members. Although in our study more safety-promoting behaviors of the therapist were associated with less favorable therapist-reports of the alliance, several studies on alliance in family therapy indicate that family members' in-session experience of safety (Friedlander et al., 2008b; Sotero et al., 2018) as well the family's shared purpose (Escudero et al., 2008; Friedlander et al., 2008b; Sotero et al., 2018) promote positive treatment outcomes of systemic family treatment. Recent meta-analytic findings show that these systemic aspects of the alliance seem to be even more vital for positive treatment outcomes than family members' individual alliances with the therapist (Friedlander et al., 2018). These combined study findings emphasize the need for a systemic focus on the alliance in training and supervision of family therapists.

This study has some limitations. First, because the subscale scores as originally developed for the SOFTA resulted in little variance and insufficient interrater reliability, we instead used behavioral frequencies for each SOFTA alliance domain, with moderate interrater reliability. This means we only investigated the quantitative contribution of positive alliance building behaviors, whereas negative behaviors as well as clinical importance and context of certain therapist behaviors can also impact the alliance (e.g. Ackerman & Hilsenroth, 2001; Boardman et al., 2006; Friedlander et al., 2006a; Muñiz de la Peña et al., 2012).

Second, despite the vital importance of systemic aspects of the alliance in conjoint family treatment, such as a shared purpose among family members and a sense of safety during treatment (Friedlander et al., 2019), we had no data on family members' and therapists' experience of these systemic aspects. This was due to the fact that we only had self- and therapist reported data from the WAI measure, designed for individual therapy, and the fact that measures of therapists' observed *shared sense of purpose* behaviors had to be excluded from this study due to insufficient reliability. Regarding differences between family members in their alliance with the therapist – another systemic complexity in building alliances in family treatment – the number of included youth in our sample did not provide sufficient statistic power to differentiate between therapists' contributions to alliances with parents and alliances with youth. We did however include multiple family members as informant of the alliance, controlled for family role (parent vs. youth) in our models, and included observations of therapists' *safety* behaviors, and thus to some extent accounted for systemic alliance complexity.

A final limitation is that we only investigated therapists' unilateral contributions to the alliance, and not the interaction between therapists' and family members' contributions. This might imply that there is such a thing as a universal set of therapist characteristics that are best for every client or family. However, not only differences *between* therapists in their alliances with clients impact treatment outcome, alliance differences between clients treated by the same therapist can also be of substantial influence (Baldwin, & Imel, 2013). Future research could benefit from explaining why a given therapist has above average alliances with some families and family members, but below average alliances with other families and family members. This involves investigating families' and family members' characteristics contributing to the alliance (e.g. De Greef et al, 2018a; Sotero et al., 2017), as well as the effect of interaction or 'match' between therapist and family members' characteristics and behaviors (e.g. Friedlander et al., 2008a).


Despite its limitations, to our knowledge our study was the first to investigate therapists' contributions to the alliance in family treatment including therapist personality and years of clinical experience. Although therapists' observed in-session alliance building behaviors have been studied before in family therapy (Diamond et al., 1999; Escudero et al., 2012; Friedlander et al., 2014; Muñiz de la Peña et al., 2012), our study adds to this body of knowledge by studying a larger sample, and providing empirical evidence for the association between therapist behaviors and family members' as well therapists' reports of the alliance. The multi-informant character strengthens the robustness of our study findings. Another strength is the (short-term) longitudinal design, investigating the alliance as a process that evolves during treatment rather than as a static phenomenon.

Considering the small body of research on therapists' characteristics contributing to the alliance in family treatment, a replication of our study findings is vital to build a stronger evidence base. Future studies could benefit from investigating family effects as well as effects of interaction between therapist and family members' characteristics or behaviors in relation to the alliance. Our finding that safety-promoting behaviors of the therapist were associated with less favorable therapist-reports of the alliance seems somewhat contradictory to previous findings on family members' in-session safety in relation to treatment outcome: further research on the role of safety during treatment may particularly benefit from studying interactions between therapist and client behaviors. Finally, given the vital importance of alliance aspects typical of systemic treatment, an important next step is to investigate therapists' contributions predicting these systemic aspects. This includes investigating therapists' contributions to the family's shared sense of purpose, their sense of safety and problematic differences between family members in their alliance with the therapist.

For clinical practice, our results implicate that training and supervision of family therapists could benefit from focusing on behaviors that enhance family members' engagement in treatment and emotional connection to the therapist. More occurrences of these behaviors in treatment sessions may positively influence family members' alliances with the therapist, which in turn is likely to improve treatment outcomes. Additionally, training and supervision could be more effective when accommodated to the trainees' personality profiles. Increasing trainees' self-awareness and monitoring of the way their neurotic, extraverted, or conscientious tendencies become too manifest in expressed behavior during sessions might enhance the ability of family therapists in building strong alliances with family members in order to increase treatment effectiveness.



4



Alliance Discrepancies in Home-Based Family Treatment: Occurrence, Development, and the Therapist's Perspective

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Abstract

Background In family treatment, building and evaluating multiple alliances with family members is complex.

Methods We investigated the occurrence and development of discrepancies between alliances of different family members, and the therapists' evaluation of multiple alliances and discrepancies. Participants were 92 parents and 61 youths from 61 families receiving home-based family treatment. Family members, therapists, and observers reported early and mid-treatment alliance.

Results We found significant discrepancies, with strongest alliances for mothers, followed by fathers, and then youths. Differences became smaller during treatment. Therapist-reports yielded similar discrepancies as compared to client self-reports and observer-reports. At T1, the correlation between therapist- and client self-reports was moderate and significant for alliances with mothers, but insignificant for alliances with fathers and youths. At T2, these correlations were large for alliances with mothers and fathers, but not for youths.

Conclusions Our findings demonstrate that therapists have stronger alliances and are more congruent in their alliance perspective with parents (especially mothers) versus youths.

Practitioner Points

- Our findings demonstrate that in family treatment, differences in alliances between the therapist and family members are the rule rather than the exception. Therapists tend to have stronger alliances with mothers than with fathers, and especially youths. The awareness that building alliances with some family members (most often youths) demands an extra effort might enhance the process of building and balancing multiple alliances in family treatment.
 - Although a shared perspective on the alliance might improve treatment outcome, our findings indicate that therapists tend to be more congruent in their perspective on the alliance with parents and lack a shared perspective on the alliance with youths. Therapists could ask family members' feedback on the alliance to gain a more shared perspective, and pay particular attention to children's and adolescents' feedback.
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Introduction

The therapeutic or working alliance has been long studied, and both clinicians and scholars assume that building strong alliances with clients is a significant contributor to positive outcomes of psychotherapy. Generally, alliance is defined as a professional relationship between a therapist and his or her patient, consisting of an emotional bond and agreement on what goals and tasks should be central in therapy (Bordin, 1979; Elvins & Green, 2008). Indeed, the alliance has proven to be a significant common factor in determining effectiveness of psychosocial treatment of adults (Flückiger et al., 2018), youths (Karver et al., 2018; Murphy & Hutton, 2018), and families (Friedlander et al., 2018; Welmers-van de Poll et al., 2018).

In conjoint family treatment, building alliances is complex, because the therapist simultaneously develops alliances with different family members (Friedlander et al., 2006). Given the differences between family members in their expectations of the treatment and the therapist, the strength of these alliances might differ and thus, discrepancies between alliances of different family members with the therapist might occur. Previous studies indicate that alliance discrepancies within the family contribute to treatment dropout (Muñiz de la Peña et al., 2009; Robbins et al., 2008; Robbins et al., 2003). Moreover, in a meta-analytic study on alliance in couple and family therapy, such alliance discrepancies have been found to be an even stronger predictor of unfavorable treatment outcome as compared to problematic individual alliances with the therapist (Friedlander et al., 2018).

Although research on alliance in family treatment has burgeoned during the last two decades (for a meta-analysis, see Welmers-van de Poll et al., 2018), there is only scarce research that captures aspects of the alliance typical of family treatment, such as alliance discrepancies. Important questions on how alliance processes in a systemic context evolve, interact, and can most favorably be assessed during treatment yet remain unanswered. First, the development of discrepancies in alliance between family members over the course of treatment is still underresearched. Second, despite the notion that the therapist is likely to play a key role in the alliance–outcome association (Baldwin, Wampold, & Imel, 2007), and should detect and repair problematic alliance discrepancies, it is yet unclear if and how the therapist takes account of multiple alliances and their discrepancies in family treatment. To solve these issues, in this study we aimed to examine the occurrence and development of alliance discrepancies in a Dutch home-based family treatment for youth problems, paying particular attention to the therapist's evaluation of multiple alliances and their discrepancies.

Alliance Discrepancies in Family Treatment

A first objective of this study was to investigate if discrepancies between alliances of different family members with the therapist occurred, and how they developed over the course of family treatment. Given differences between family members and their role during treatment, discrepancies in alliance might be expected to be the rule rather than the exception. For example, in family treatment parents are most often the initiating party for treatment, and children or adolescents do not always participate voluntarily (Friedlander et al., 2019; Shirk, Caporino, & Karver, 2010). This might negatively affect the alliance between therapists and youths, as was illustrated in a study on family therapy by Robbins et al. (2006). In this study, mothers had significantly stronger alliances with the therapist than their sons. Furthermore, similar to many other cultures, mothers in the Netherlands are in general more involved in child rearing as compared to fathers (Sociaal Cultureel Planbureau, 2018), and prior research has indicated that youth and care professionals consult or involve mothers more often than fathers in matters concerning their children (Hoogeveen, 2018). Therefore, in family treatment therapists might form stronger alliances with mothers as compared to fathers.

Although alliance discrepancies are likely to occur during family treatment, the extent to which alliances are discrepant is likely to vary during the treatment process. Several studies have shown that the strength of the alliance changes during treatment (Ardito & Rabellino, 2011; Horvath, 2006; Karver, & Carporino, 2010; Weiss et al., 2014). Subsequently, the extent to which alliances of different family members are discrepant might also change during treatment. Ideally, as the treatment process evolves, the therapist attempts to balance different alliances and improve weak alliances, resulting in a decrease of alliance discrepancies.

Therapist's evaluation of alliances in family treatment

A second objective of this study was to investigate the therapist's perspective on multiple alliances and their discrepancies in family treatment. As the therapist is expected to play a key role in improving alliance processes, it is important that he or she be able to assess and monitor alliances during family treatment. However, the therapist's perception of alliances may not always be accurate due to personal involvement with the family and be biased by strong personal reactions to family members (Muñiz de la Peña, Friedlander, & Escudero, 2009). In this study, we highlighted two particular aspects of the therapist's perspective on alliances in family treatment.

A first aspect is the correct evaluation of alliance discrepancies by the therapist in order to repair problematic alliance discrepancies. A study in which therapist reports of the alliance were compared with client self-reports showed that therapists systematically overestimated weak alliances and underestimated strong alliances (Hartmann et al.,

2015). This could also be the case in family treatment, leading to an underestimation of alliance discrepancies by the therapist. Furthermore, the most overt indicator of the strength of the alliance for a therapist is behavior of family members during sessions. In family treatment, however, family members observe each other in their interactions with the therapist, which might cause feelings of shame and a reluctance to display inner thoughts and feelings (Friedlander et al., 2006). This was illustrated in a small-scale study on within-family differences in the emotional bond with the therapist. In this study, discrepancies in the emotional bond with the therapist were reported by clients as well as by observers, but the discrepancies were largest for self-reports, indicating that clients' observed interactions with the therapist only partially mirrored their self-reports (Muñiz de la Peña, Friedlander, & Escudero, 2009).

A second aspect of therapists' evaluations of alliances is the extent to which their perspective is congruent with family members' perspectives on the alliance. Studies of adult and youth psychotherapy indicate that congruence between therapist and client alliance evaluations leads to more favorable treatment outcomes (Bachelor, 2013; Fjermestad et al., 2016; Kivlighan, 2007; Rozmarin et al., 2008; Zilcha-Mano et al., 2017). In family treatment, monitoring the alliance with less involved family members might be more difficult than monitoring the alliance with highly involved family members. This may result in differences between family members in the extent to which the therapist and a family member agree upon their alliance. As we argued above, parents most often initiate treatment and mothers are generally more involved in child rearing matters as compared to fathers. Therapists might therefore be primarily focused on the alliance with parents (especially mothers) instead of youths, and subsequently be more congruent in their evaluation of the alliance with parents (especially mothers) than with youths.

Present study

The aim of the present study was to gain insight regarding alliance discrepancies and the therapist's evaluation of multiple alliances and discrepancies in family treatment. Our first research question was: do discrepancies between alliances of different family members in family treatment occur, and how do they develop over the course of treatment? Based on the reviewed literature we formulated the following hypotheses: (1) there are significant discrepancies in the strength of the alliance between family members, more specifically: parents have stronger alliances with the therapist as compared to youths, and mothers have stronger alliances with the therapist as compared to fathers; and (2) discrepancies in alliance decrease over the course of treatment.

Our second research question was: how does the therapist evaluate multiple alliances and alliance discrepancies? Here, we formulated the following hypotheses: (1) when therapists report on multiple alliances of different family members, discrepancies between these alliances are smaller as compared to alliance discrepancies in observer reports and family members' self-reports; and (2) therapist-reported alliance is associated more strongly with parent-reported alliance as compared to youth-reported alliance, and therapist-reported alliance is correlated more strongly with mother-reported alliance as compared to father-reported alliance.

Results of this study may serve as a framework to further investigate the alliance as a common therapeutic factor in family treatment, and help therapists to monitor and optimize alliance processes in order to enhance treatment outcome.

Methods

Participants and Treatment Setting

Participants were 92 parents ($n = 57$ (step)mothers, $n = 35$ (step)fathers) and 61 children from 61 families. The mean age of the child for whom the treatment was indicated was 10.2 ($SD = 4.5$; range 0.3 – 17.8). The mean age of the children participating in the study was 11.0 ($SD = 3.1$; range 4-17), and the mean age of parents was 39.6 ($SD 8,3$; range 25-57). In three families, one or both parents were born in another western country, and in four families one or both parents were born in a non-western country. Participating families received home-based family treatment for youth problems, called *Intensieve Pedagogische Thuishulp (IPT, Van der Steege, 2007)*. They were seen by 36 IPT-workers (14 % male, M age 42.7; $SD = 9.6$), with an average of 8.4 ($SD = 4.6$) years of experience as IPT-worker. All had a social work related (post-) bachelor's degree.

Intensieve Pedagogische Thuishulp (IPT, Van der Steege, 2007) is a home based family treatment in the Netherlands for families dealing with complex child behavior and parenting problems. Most families experience problems in other domains as well, such as financial problems, parental psychopathology or lack of a supporting social network. The treatment has an empowering, solution-focused and systemic approach, focusing on improving parenting skills and enhancing social support (Van der Steege, 2007). During treatment, an IPT-worker visits the family once or twice a week or once every two weeks, depending on the families' needs and stage of treatment. Families in this study received IPT for an average period of 49 weeks ($SD = 29,7$; range 12-168).

Procedures

Participating families were drawn from four teams specialized in IPT of two Dutch youth care organizations. When a family started treatment with an IPT-worker of a participating team, they were informed about the research project by the IPT-worker or institution and received a letter with information. In one team, all IPT-workers directly asked their clients to participate. In the remaining three teams a member of the research team called the family to ask them to participate. Children were asked to complete the Working Alliance Inventory (WAI) and were included in coding observations using the System for Observing Family Therapy Alliances (SOFTA) when they were 8 years or older. Therapists were asked to reflect on alliances with all family members involved in treatment, regardless of age. Participating family members of 12 years and older signed an informed consent letter and the project was approved by the ethical board of the Faculty of Social and Behavioral Science of the University of Amsterdam. All participating families received a €10 gift card and two families were randomly selected to receive a voucher for visiting a zoo or fun park of their own choice.

When a family participated, two sessions with an IPT-worker at the family's home were videotaped. For T1—in the early treatment phase—the third session (and exceptionally the fourth or fifth) was filmed. We chose the third session because families were informed about the research and asked to consider participation in the first session. By choosing the third session they had some time to consider participation, but treatment was still in its starting phase, which lasts in this model of treatment about six weeks (Van der Steege, 2007). The second video-observation (T2) was two months later, when treatment was in the phase of active change. For 14 families there was no T2 measure available because the treatment had already ended ($n = 5$), or therapist or clients did not want to participate anymore because the situation had changed ($n = 9$). There was no T1 measure for 2 families, and 4 families only participated by completing the WAI and had no video-observations. None of these 4 families responded to the request to complete the WAI at T2. Study dropouts were not excluded because this might have decreased the clinical representativeness of our study. We compared alliance measures at T1 for dropouts and completers by performing a multilevel regression analysis of a dichotomous dropout variable at T2 on client-reported, therapist-reported and observer reported alliance at T1, and found no significant differences ($p = .586$), which indicates that selective attrition was unlikely.

Measurements

Working Alliance Inventory – Short Form (WAI-s) To assess the alliance as perceived by therapists and family members, we used the Working Alliance Inventory, Short Form (WAI-s; Horvath & Greenberg, 1989; Killian, Forrester, Westlake, & Antonopoulou, 2017). The questionnaire consists of 12 items (e.g. “My family counselor and I agree upon what I should do in order to improve the way things are going in my family” for the client version

or "This client agrees upon what family members should do in order to improve the way things are going in the family" for the therapist version) and measures task-, goal- and bond-elements of the alliance on a 5 point Likert scale ranging from 1 (never) to 5 (always). In the current sample, Cronbach's alpha for the therapists' version was .85 at T1 and .88 at T2, and for the clients' version .91 at T1 and .92 at T2.

System for Observing Family Therapy Alliances (SOFTA-o). The SOFTA-o (Friedlander, Escudero, & Heatherington, 2006) has been developed to assess four dimensions of alliance-related behavior from videotaped family or couple therapy sessions. Two dimensions reflect the individual alliance between a family member and the professional based on Bordin's (1979) classical definition of the alliance, i.e., Engagement in the Therapeutic Process, representing task and goal elements of the alliance, and Emotional Connection. The two other dimensions, Safety within the Therapeutic System, and Shared Sense of Purpose within the Family, reflect aspects of the alliance that are unique to conjoint family treatment.

When using the SOFTA-o, a trained coder observes a session and notes the frequency of specific positive and negative alliance-related behaviors along the four dimensions. Some examples for positive and *negative* behavioral indicators include "Client describes or discusses a plan for improving the situation" or "*Client shows indifference about the tasks or process of therapy (e.g., paying lip service, "I don't know", tuning out)*" for Engagement, "Client shares a lighthearted moment or joke with the therapist" or "*Client avoids eye contact with the therapist*" for Emotional Connection, "Client implies or states that therapy is a safe place" or "*Client expresses anxiety nonverbally*" for Safety, and "Family members ask each other for their perspective" or "*Family members blame each other*" for Shared Sense of Purpose. After observing the session, based on the frequency, intensity and clinical meaningfulness of the marked behaviors, coders assign global ratings on each dimension on a 7 point Likert scale ranging from -3 (*extremely problematic*) to +3 (*extremely strong*). For the purpose of this study, the SOFTA-o was translated from English to Dutch, following guidelines as prescribed by Van Widenfelt, Treffers, De Beurs, Siebelink, and Koudijs (2005).

For coding the videotaped IPT-sessions with the SOFTA-o, we used the training manual by Friedlander et al. (2005) as a guideline. The first author received training from professor Escudero, one of the developers of the instrument. After training and translation of the manual, she coded 12 videotapes with at least two family members in the session to use as a golden standard. Coding dilemmas were discussed with professor Escudero. Next, 3 master students of Educational Sciences of the University of Amsterdam were trained, receiving 15 hours of coder training over five weeks. They were introduced to

the theoretical framework of the SOFTA, coding guidelines, practice material from the developers and Dutch practice material taken from the Dutch drama series *In Therapie (In Therapy)*. Trained coders independently coded at least 10 videotapes to increase their reliability as coders compared to the golden standard codings by first author and received feedback on each coding. As advised by Friedlander et al. (2005), training continued until coders differed no more than one point in their scale scores in 90% of the cases.

After their training, each coder rated a random selection of the videotapes. Coding dilemmas were discussed and difficult parts were consensus coded during meetings with the coding team every two weeks. In total, 90 sessions were independently coded after training. Of these sessions, 15 random selected sessions (16.7%) were double coded by the first author, with coders blind to these double coded sessions. To assess interrater reliability, we calculated intra-class coefficients for the 15 double coded sessions using the single measures of a two-way mixed effect model based on absolute agreement (Koo & Li, 2016). Because the present study focuses on discrepancies in individual alliances, we only used the Engagement and Emotional Connection subscales of SOFTA and averaged these two scales into one combined scale. Scores of these two subscales were significantly correlated (T1: $r = .306, p = .003$, T2: $r = .421, p < .001$). Intraclass Correlation Coefficient (ICC) for the combined scale was .44. According to Cicchetti (1994), ICC's are fair when $>.4$, good $>.6$ and excellent $>.8$.

Statistical Analyses

Discrepancies were tested using a two level model to increase statistical power and account for dependency of data, as family members (level 1) were nested within therapists (level 2). Level 1 concerns variance of alliance measures between family members within the family, while level 2 accounts for variance between families. To analyze discrepancies we extended this model with a categorical moderator, namely family member (mother, father, youth). To enable analysis of this categorical variable, we created dummy variables containing all the information included in the original categorical variable. To analyze the development of differences between family members, we calculated ICCs in the two-level model for T1 and T2. To analyze whether discrepancies differed across reporters, we analyzed interactions between two moderating variables, namely, family member and alliance reporter (therapist, client, observer). To test for congruence between the therapist reports and family members' self-reports of the alliance, we calculated Pearson's r for all therapist – family member dyads. We compared these correlations by calculating the test statistic z and its corresponding p -value (Lenhard & Lenhard, 2014).

Results

Preliminary Analyses

To begin, we calculated alliance means and standard deviations for all family members and all reporters. Results are depicted in Table 1. Overall, across different reporters (therapists, clients, and observers) alliances with mothers were strongest both at T1 and T2, followed by fathers and then youths. Clients provided the highest alliance ratings, followed by observers and then therapists, except for alliances with fathers and mothers at T2 (therapists had higher scores than observers, but still lower than clients). To test if differences between reporters were significant, we extended our two-level model with alliance reporter as a moderating variable. As shown in Table 2, we found significant differences between different reporters of the alliance, indicating that therapists generally reported weaker alliances as compared to clients and observers both at T1 and T2.

Alliance Discrepancies

Table 3 shows the results of multilevel regression analyses of alliances with family role as moderating variable. We found significant differences in alliances with the therapist between mothers, fathers, and youths. In line with our first hypothesis, alliances with parents were stronger as compared to youths both at T1 and T2, and alliances with mothers were stronger as compared to fathers both at T1 and T2.

To test whether discrepancies between family members decrease over the course of treatment, we calculated the ICC between all different alliances across reporters in the multilevel model. At T1 the ICC was .12 ($p < .01$), indicating a small within family correlation between alliances with different family members. At T2, the ICC was .35 ($p < .05$), indicating that within family alliance differences became smaller, as was in line with our hypothesis.

Therapists' Evaluation of Alliances

With regard to the therapists' evaluations of alliance discrepancies, results of multilevel interaction analyses between family member and alliance reporter showed no significant differences in the reports of alliance discrepancies between therapists, clients, and observers. In contrast to our hypothesis, this indicates that therapists report alliance differences between family members comparable with clients' self-reports and observer reports.

Our hypothesis that the therapists' perspective is more congruent with self-reports for parents' alliances as compared to youths, and for mothers' alliances as compared to fathers' was partially confirmed. As shown in Table 4, therapist-reports of the alliance with mothers had a moderate positive correlation with mothers' self-reports at T1 and a large correlation at T2, with both correlations significant. Therapists' ratings of alliances with fathers were slightly negatively correlated with fathers' self-reports at T1, just as therapists' ratings of alliances with youths were slightly negatively correlated with youths' self-reports at T1. However, both correlations were not significant. The difference between mothers and fathers in the strength of the correlation between therapist- and self-reports was trend-significant ($z = 1.533, p = .063$). The differences between mothers and youths ($z = 1.064, p = .144$) and between fathers and youths ($z = -0.246, p = .403$) in the strength of the correlation between therapist- and self-report were both not significant. These findings were partially in line with our hypothesis, as they indicate to some extent that therapists were more congruent in their alliance perspective with mothers as compared to fathers, but do not indicate that therapists were significantly more congruent in their alliance perspective with parents as compared to youths.

At T2, correlations between therapist- and self-reported alliance increased for both mothers and fathers, while the difference in the strength of these correlations was not significant ($z = -0.632, p = .264$). In contrast to our hypothesis, this indicates that the therapist's perspective on the alliance was just as congruent with the perspective of mothers as with fathers when treatment was in the active change phase. For alliances with youths, the correlation between therapist-report and self-report at T2 was small and not significant. Differences in therapist-report and self-report correlations were significant both between mothers and youths ($z = 1.793, p = 0.036$) and fathers and youths ($z = 1.771, p = .038$). This indicates, as hypothesized, that in the active change phase of treatment therapists were more congruent in their perspective on the alliance with parents as compared to youths.

Table 1

Alliance scores

<i>Informant (time)</i>	Client (T1) Mean (SD, <i>n</i>)	Therapist (T1) Mean (SD, <i>n</i>)	Observer (T1) Mean (SD, <i>n</i>)
<i>Family Member</i>			
Mother	8.815 (3.772, 55)	7.301 (2.958, 53)	7.787 (4.697, 54)
Father	7.037 (4.166, 21)	5.149 (3.378, 25)	6.000 (2.351, 20)
Youth	6.074 (5.107, 13)	4.632 (3.364, 40)	5.417 (3.237, 18)

Note. T1 = starting phase of treatment; T2 = active change phase of treatment. For descriptive purposes, WAI-scores (client and therapist informed) and SOFTA-scores (observer informed) were transformed to a common scale through a linear transformation.

Table 2

Results of multilevel regression analyses of alliances with alliance reporter as moderating variable

Moderator variable	b^0	t^0	b^1	t^1	χ^2
Alliance T1					18.600***
therapist (RC, intercept)	5.886	14.809***			
client			2.205	4.332***	
observer			1.103	2.192*	
Alliance T2					19.595***
therapist (RC, intercept)	7.067	15.931***			
client			1.944	4.178***	
observer			0.134	0.291	

Note. T1 = starting phase of treatment, X^2 (2, $N = 299$); T2 = active change phase of treatment, X^2 (2, $N = 227$); RC = reference category.

* $p \leq .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Client (T2) Mean (SD, <i>n</i>)	Therapist (T2)	Observer (T2)
9.275 (3.796, 40)	8.223 (2.669, 41)	7.317 (2.461, 41)
8.180 (3.428, 14)	7.012 (2.983, 22)	6.250 (2.887, 16)
7.931 (4.772, 10)	4.406 (4.406, 34)	6.944 (6.588, 9)

Table 3

Results of multilevel regression analyses of alliances with family member as moderating variable

Moderator variable	b^0	t^0	b^1	t^1	X^2
<i>Family member</i>					
Alliance T1					32.755***
youth (RC, intercept)	4.972	10.235***			
father			1.250	1.903 ⁺	
mother			2.923	5.508***	
Alliance T1					32.398***
mother (RC, intercept)	7.899	24.112***			
father			-1.686	-3.088**	
youth			-2.921	-5.528***	
Alliance T2					22.293***
youth (RC, intercept)	5.873	10.958***			
father			1.760	2.842**	
mother			2.400	4.710***	
Alliance T2					21.525***
mother (RC, intercept)	8.273	20.566***			
father			-0.643	-1.234	
youth			-2.403	-4.742***	

Note. T1 = starting phase of treatment, X^2 (2, $N = 299$); T2 = active change phase of treatment, X^2 (2, $N = 227$); RC = reference category.

⁺ $p \leq .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table 4Pearson's *r* correlations between alliances: *r*(*n*)

	1	2	3
1. Mother (therapist)	-	.315* (50)	.816*** (22)
2. Mother (client)	.671*** (41)	-	.152 (20)
3. Father (therapist)	.803*** (21)	.433* (19)	-
4. Father (client)	.710** (11)	.683** (11)	.758** (11)
5. Youth (therapist)	.523** (25)	.354* (25)	.693** (11)
6. Youth (client)	-.239 (10)	.332 (10)	.333 (4)

Note. Correlations for T1 measures are reported above diagonal, correlations for T2 measures below diagonal.

* $p \leq .10$. ** $p \leq .05$. *** $p \leq .01$. **** $p \leq .001$ (one-tailed)

Discussion

We investigated (a) if discrepancies between alliances with different family members in family treatment occur, and how they develop over the course of family treatment, and (b) how the therapist evaluates multiple alliances and their discrepancies in a Dutch home-based family treatment for youth problems.

Alliance Discrepancies in Family Treatment

Our study findings confirm our hypotheses that discrepancies between family members occur, but become somewhat smaller during treatment. We found that, regardless of who reported on the alliance, mothers had stronger alliances with their therapist as compared to fathers. This finding might partially be explained by the impression that contacts during treatment tend to be most intensive with mothers, that is: in our study mothers were present in 93% of the observed sessions, whereas fathers were present in only 35% of the observed sessions. When contacts with mothers during treatment are more frequent as compared to those with fathers, alliances with mothers may also have more time and opportunity to evolve, and therefore might be stronger.

Differences in alliance strength between fathers and mothers might also be explained by a gender match between mothers and therapists, given the fact that most therapists (86%) in the current sample were female. This hypothesis is further supported by findings of previous studies on the effect of gender match on alliance or on satisfaction with the therapeutic relationship, indicating that female client-therapist dyads have the strongest alliance in adult and adolescent substance abuse treatment (Kuusisto & Artkoski, 2013; Wintersteen et al., 2005), marriage and family therapy (Johnson & Caldwell, 2011), and a collection of varying psychosocial treatments for adults (Bhati, 2014). Bhati (2014), however, speaks of a

	4	5	6
	-.200 (15)	.500** (27)	-.472* (12)
	.614** (16)	.105 (27)	-.282 (12)
	-.168 (15)	.322 (11)	-.645 (4)
	-	-.630* (6)	-.491 (3)
	.141 (7)	-	-.061 (12)
	1.000** (2)	.075 (10)	-

general 'female effect' rather than a gender match effect, as in her study dyads with female therapists - even dyads with male clients - had stronger alliances compared to dyads with male therapists. It should be noted that in all these study samples, as in our study, male therapists were underrepresented or even absent. Therefore, further research including more male therapists is needed to draw valid conclusions on the effect of gender match on alliance.

With regard to discrepancies in alliance, we also found that parents had stronger alliances as compared to youths. This was in line with our hypothesis and with meta-analytic findings of Roest et al. (2021b). They argue that building alliances with children and adolescents can be complicated by developmental issues, such as cognitive limitations in understanding the necessity of treatment for younger children. For teenage youths, conflicts with parents on need and aim of treatment and problems with accepting authority might be a complicating factor. In family treatment, forming an alliance with children or adolescents might be even more complex, as they are less powerful interaction partners as compared to adults, and the presence of parents in sessions (even when in part) might cause feelings of shame and a hesitation to be open (Escudero & Friedlander, 2017). Although being heard during treatment appears to be very important for youths in family therapy (Strickland-Clark et al., 2000), playing an active role in a conjoint treatment process with adults is challenging for children and adolescents, and should therefore be carefully guided by the therapist both verbally and non-verbally (Escudero & Friedlander, 2017; O'Reilly, 2008).

Therapists' Evaluation of Alliances in Family Treatment

We found no significant differences in alliance discrepancies between therapist-, client-, and observer-reports, indicating that therapists assess differences in alliances comparable with both observers and family members' self-reports. This finding underlines both the robustness of the occurrence of alliance discrepancies as well as the therapists'

ability to detect differences between family members' alliances. Notably, our study is probably the first to include observed, self-reported, and therapist-reported measures when investigating alliance discrepancies. More research is needed to build a stronger evidence base on the therapists' ability to accurately recognize alliance discrepancies.

Therapist reports of the alliance were moderately associated with mothers' self-reported alliance in the early stage of treatment, but there was no therapist- and self-report correlation for fathers and youths. This indicates that at the beginning of treatment, therapists lack a shared perspective on the alliance with both fathers and youths. It seems that in the early stage of treatment therapists' perspectives on the alliance are closest to mothers' perspectives, who in our sample were the most involved party in treatment. These results should, however, be interpreted with caution, as differences in the therapist-self-report correlation at T1 were only trend significant for the difference between fathers and mothers, and not significant for the differences between parents and youths.

It was interesting to find that the association between therapist reports of the alliance with fathers and their self-reports became notably stronger during treatment. At T2 there was a significant and large correlation, which was comparable with the association between therapist- and self-reports of mothers' alliances at T2. Apparently, when therapists spend more time in treatment with fathers, a more shared perspective on their alliance evolves. In contrast, correlations between therapist- and self-reports of the alliance with youths barely increased during treatment, indicating that even when the treatment process evolves, therapists still lack a shared perspective on the alliance with youths. This finding is in contrast with meta-analytic findings of Roest et al. (2021a), who found a moderate correlation between therapist reported and self-reported alliances with youths in youth psychotherapy. Perhaps our finding on the lack of a shared perspective between therapists and youths is specific to the alliance with youths in conjoint family treatment, where therapists might have a stronger focus on the alliance with parents. It should be noted, however, that in our sample the number of youths with self-reports of the alliance was small, and further research is required to draw valid conclusions about the association between therapist- and self-reports of the alliance with youths in family treatment.

Limitations, Strengths, and Future Directions

Several limitations of this study should be considered when interpreting our study findings. First, we analyzed data from a highly heterogeneous sample in terms of targeted problems, age of referred children, and present family members at observed sessions. Also, only a small number of fathers and youths with self-reports and observer reports of the alliance was included in the sample. Furthermore, in comparing alliance reports of therapists, clients, and observers, it could be that results are to some extent confounded

by informant bias. That is, differences between alliances from family members' self-reports might be a result of different informants reporting on different alliances (e.g., mother reporting on mother's alliance, father reporting on father's alliance, etc.), whereas for therapist- and observer reports different alliances are evaluated by the same person (e.g., therapist reporting on both mother's and father's alliance).

A final limitation of the study is that the interrater reliability of observer-reports of the alliance was small ($ICC = .44$), albeit sufficient (Cicchetti, 1994). However, according to Koo and Li (2016) a relatively low ICC score could be explained by low variability among sampled subjects, a small number of subjects ($k < 30$) or a small number of raters ($n < 3$). They suggest that a reliability study should include at least 30 heterogeneous samples being tested by at least 3 raters before low ICC scores should be interpreted in terms of poor reliability. In our study, we single-coded most sessions, which automatically generates lower agreement as compared to consensus coding by two or three coders.


Despite its limitations, our study adds to the body of knowledge on alliance in family treatment in several ways. To our knowledge, it is the first study on alliance in the unruly context of home-based family treatment focusing on multiple alliances with different family members, including observations as well as both therapist-reports and client self-reports. Furthermore, we used a multilevel model to account for statistical dependency, allowing us to compare alliances of different family members regardless of who reported on the alliance, and to compare different perspectives (i.e., therapist, client, observer) on alliance discrepancies. Finally, the use of two different measure moments enabled analyses of the development of alliance discrepancies between family members and of congruence between therapist-reports and client self-reports of the alliance.

Future research on alliance in family treatment should focus on investigating the effect of alliance discrepancies between family members as well as the effect of congruence between therapist- and self-reports of the alliance on treatment outcome. Ideally, in this kind of research a developmental approach is applied, as our study findings demonstrate that alliance discrepancies and congruence between therapist-report and client self-report of the alliance evolve during treatment. With regard to alliance discrepancies, previous studies provide some evidence that discrepancies between family members within the family contribute to treatment dropout (Friedlander et al., 2018; Muñiz de la Peña et al., 2009; Robbins et al., 2003; Robbins et al., 2008). However, to date there is only a handful of studies on alliance discrepancies in relation to treatment outcome, with various definitions and often problematic methodologies (Welters-van de Poll et al., 2018), and none of these studies investigated how the development of alliance discrepancies (i.e., increase or decrease of discrepancies) can affect treatment outcome.

Studies on the effect of congruence in therapist- and self-reported alliance have shown somewhat ambiguous results, ranging from no effect in adult psychotherapy (Fitzpatrick, Iwakabe, & Stalikas, 2005) to better outcomes when ratings are more congruent in adult psychotherapy (Bachelor, 2013; Kivlighan, 2007; Rozmarin et al., 2008; Zilcha-Mano, Snyder, & Silberschatz, 2017) or when congruence increases during treatment in youth CBT (Fjermestad et al., 2016). However, studies on the effect of congruence between therapist and client ratings of the alliance in conjoint family treatment are sparse. In family treatment, perhaps congruence of one family member with the therapist might be more important for positive treatment outcome as compared to other family members. Our finding that therapist- and self-reports of the alliance with parents were more congruent as compared to those of youths underline the importance of this issue.

Our findings underline the complexity of building and monitoring multiple alliance processes in conjoint family treatment. Our findings demonstrate that the therapist's perspective on the alliance with a specific family member is not necessarily comparable with that family members' own perspective, especially with youths. To gain a more shared perspective on the alliance, therapists could consider asking family members' feedback on the alliance, which has proven to be effective in several settings (e.g. Mihalo, & Valenti, 2018; Van Hennik, 2020; Zilcha-Mano, & Errazuriz, 2015). In doing so, it is recommended to pay particular attention to children's and adolescents' feedback on the alliance (for an example, see Rober et al., 2020). Our findings also demonstrate that differences in alliances with the therapist between family members are the rule rather than the exception. The awareness that building alliances with some family members (most often youths) demands an extra effort might enhance the process of building and balancing multiple alliances in family treatment.





A Systemic Perspective on Alliances in Home-Based Family Treatment: Exploring Associations with Outcome

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Abstract

Background Home-based family treatment (HBFT) is a widely implemented youth care service. Alliance has been shown to predict treatment outcome of HBFT, however, studies so far failed to account for systemic complexity in alliance that is typical of systemic family treatment.

Objectives Investigating associations between family members' unbalanced alliances and the within-family alliance or *shared sense of purpose* (SSP), and improvement of youth behavior problems in a Dutch HBFT for youth problems.

Methods Participants were 29 families receiving HBFT for youth problems. We performed correlation analyses between observed early- and mid-treatment SSP, differences between family members in observer-, therapist- and self-reported early and mid-treatment alliances, and youth behavior problems 18 months post-treatment. Considering the small sample size and resulting limited statistical power, we also reported trend-significant and substantial non-significant correlations that might be of theoretical importance.

Results A greater imbalance in observed early-treatment alliances was associated with less externalizing and total youth behavior problems at follow-up. At mid-treatment this association was in the opposite direction, although small and not significant. Higher levels of mid-treatment SSP were moderately but not significantly associated with the decrease of youth internalizing behavior problems 18 months post-treatment.

Conclusions Our findings suggest clinical significance of unbalanced alliances and the family's shared purpose that warrant further exploration. Ongoing research should examine effects of the interaction between multiple family members' alliances and of the family's shared purpose, their development over treatment, and their predictors, to allow for further understanding of the complex role of alliance in HBFT.

Introduction

Home-based family treatment (HBFT) is a key service provided to families dealing with problematic child behavior and parenting problems, oftentimes at risk for a child's out-of-home-placement. HBFT includes both 'name-brand' services (e.g., Home Builders, Multidimensional Family Treatment) and more generic HBFT services, but the commonality is that they aim at promoting parental competencies and family functioning, and thereby optimizing children's development and the family's self-reliance (Jordan et al., 2001; Lee et al., 2014). HBFT is typically characterized by a systemic and eclectic approach, and serves a highly heterogeneous sample of families. During the last decades, the number of families receiving HBFT has increased notably, and nowadays it is the most provided service to families in youth care (CBS, 2020; De Greef et al., 2018b; Veerman, Janssens, & Delicat, 2005; Yorgason, 2005). This may not be surprising, given the potential advantages of the family's home as a treatment context (Slesnick, & Prestopnick, 2008; Waisbrod, 2012). Indeed, HBFT has been found to be effective in the treatment of youth behavior problems (Barth et al., 2007; De Greef et al., 2018b; Lay et al., 2001; Yorgason et al., 2005), multi-problem families (Bachler et al., 2016; Veerman, & De Meyer, 2015; Veerman, Janssens, & Delicat, 2005), and mothers suffering from depression (Beeber et al., 2004).

In order to optimize HBFT services, it is important to know what components or factors of treatment cause positive outcomes. Surprisingly however, generic HBFT services have undergone relatively little empirical research (De Greef et al., 2018b). One factor that may play an important role in HBFT is the therapeutic or working alliance. This pantheoretical concept refers to the therapeutic relationship between therapist and client, consisting of an emotional bond and agreement on what should be the central goals and tasks of treatment (Bordin, 1979; Elvins, & Green, 2008). Therapeutic alliance has been shown to predict treatment outcome in adult-, youth-, and family-therapy (Flückiger et al., 2018; Friedlander et al., 2018; Murphy, & Hutton, 2018; Welmers – van de Poll et al., 2018). For HBFT, a handful of studies support the predictive value of the alliance for post-treatment decreases in youth behavioral problems and youth and parent symptom distress (Johnson et al., 2006; Johnson, Wright, & Ketring, 2002), improved parent or family functioning (De Greef et al., 2018b; Johnson et al., 2006) or more general evaluations of treatment success (Bachler et al., 2016; De Greef et al., 2018b).

Although providing valuable evidence for the importance of building strong alliances with families, most studies on the alliance-outcome association in HBFT in general do not account for the systemic complexity of building alliances, which is inherent to systemic treatment formats such as HBFT. In systemic family treatment, the therapist faces the complex task of simultaneously building multiple alliances with different family members.

These family members often differ largely in their treatment aims and motivation, and problematic communication patterns may hinder the within-family collaboration on shared goals (Kindsvatter & Lara 2012; Friedlander et al., 2006). Given this systemic complexity, family members' individual alliances with the therapist may not tell the whole story when investigating the alliance as a common factor in family treatment.

A recent meta-analysis on the alliance outcome association in couple and family therapy indicates that systemic aspects of the alliance more strongly predict outcome than any family member's individual alliance with the therapist, even when multiple individual alliances are averaged to measure a family's alliance (Friedlander et al., 2018). These systemic aspects include a balance in strength of multiple alliances among family members and the quality of the within-family alliance. This finding underlines the importance of a systemic approach when investigating the alliance in home-based family treatment. Consequently, in the present study we aim to investigate the association between two systemic aspects of the alliance typical of systemic family treatment and outcome in HBFT for youth problems: unbalanced alliances and shared sense of purpose (SSP).

Unbalanced Alliances

The first systemic aspect central in this study concerns unbalanced alliances within the family. In conjoint family treatment differences between family members in their characters, motivation, needs and expectations of the treatment and the therapist may easily result in alliances notably differing from one family member to another (Kindsvatter & Lara, 2012; Welmers-van de Poll et al., 2020). Moreover, family conflicts often encroach family members' opinions on the need and aim for treatment, increasing the risk for the therapist to unintentionally 'take sides' and consequently causing or increasing a disbalance in alliances with different family members. This phenomenon of notable differences between family members in their alliance with the therapist is generally referred to as *unbalanced* or *split alliances* (Friedlander et al., 2006; Pinsof, & Catherall, 1986; Robbins et al., 2003). Studies on *split alliances* generally refer to a *split* when two family members' alliances with the therapist differ at least one standard deviation (e.g. Muñiz de la Peña et al., 2009). Other studies apply a more continuous approach by investigating *unbalanced alliances* as the degree of difference or congruence between family members in their alliance with the therapist (e.g. Robbins et al., 2003).

Although modest imbalances in alliances are thought to be common in family therapy, a handful of studies indicate that a greater imbalance in alliances increases the risk of treatment dropout (Flicker et al., 2008; Muñiz de la Peña, Friedlander, & Escudero, 2009; Robbins et al., 2003, Robbins et al., 2008). Thus, a sufficient balance in multiple alliances with different family members seems important for retaining families in treatment, and may

positively impact treatment outcome. To our knowledge, only three studies investigated the effects of within-family differences in alliance on treatment outcomes in terms of improvement of child functioning or symptom distress. Forsberg et al. (2014) found no effect of observed parent-child and mother-father alliance differences on recovery of Anorexia Nervosa in a sample of 38 adolescents receiving family-based treatment. Likewise, Glebova et al. (2018) found no effect of similarity in parent and youth emotional bonds with the therapist on families' treatment retention nor on therapists' and families' perceptions of treatment success at the end of treatment in a sample of 164 parent-youth dyads receiving Multisystemic Therapy (MST). The authors of the latter study reason that in family treatment formats with mainly conjoint treatment sessions, a balance in family members' strength of the alliance might be more important as compared to treatment formats with a primary focus on caregivers for example. It should also be noted that Glebova et al. (2018) only investigated the effect of discrepancies between family members in emotional bonds, not in goal- or task-aspects of the alliance. In another study with 156 families receiving Alliance Empowerment Family Therapy (AEFT), differences in alliances between the (maltreated) child or adolescent and the caregiver were studied. Results showed that sessions with split alliances were reported as less successful, and that families with worse treatment outcome had more sessions with split alliances (Escudero et al., 2021).

In a recent meta-analytic study on alliance and outcome of family treatment for youth problems, five of the before-mentioned studies investigating unbalanced or split alliances were included in a separate meta-analysis on the effect of unbalanced or split alliances on treatment retention and other outcome (Welters – van de Poll et al., 2018). The overall effect was small and not significant. Friedlander et al. (2018) meta-analytically examined the effect of unbalanced or split alliances in couple and family therapy. They extended the previous meta-analysis with one study on couple therapy outcomes and one unpublished family therapy study, and found a significant moderate effect size, indicating that unbalanced or split alliances predict less favorable treatment outcomes in terms of retention vs. drop-out or symptom reduction. In both meta-analyses, the number of included studies was small, and given this small body of evidence authors of both meta-analyses point to the importance of further investigating the effect of unbalanced alliances on family treatment outcome. The present study aims to address this plea by investigating the association between unbalanced family members' alliances and improvement of youth behavior problems after receiving home based family treatment for youth problems.

Shared Sense of Purpose within the Family

The second systemic aspect of alliance we aim to investigate in this study is the within-family alliance, or *shared sense of purpose*. In conjoint family treatment, outcome is not only affected by family members' differing individual alliances with the therapist, but also by the extent to

which family members bond with each other in treatment and collaborate on shared family goals. This *within-family alliance* was first introduced in the literature by Pinsof and Catherall (1986), and elaborated on by Friedlander et al. (2006) as *shared sense of purpose within the family* (SSP). Studies on the effect of the family's shared purpose on treatment outcome consistently support that higher levels of SSP positively impact family treatment outcome. This finding emerged from several small samples receiving brief family therapy (Escudero et al., 2008; Friedlander et al., 2008), family therapy with involuntary clients (Sotero et al., 2018), and family-based treatment for adolescent Anorexia Nervosa (Isserlin, & Couturier, 2012). However, the current body of evidence on the association between the within-family alliance and outcome in family treatment for youth problems is relatively small (Welmers – van de Poll et al., 2018), and to our knowledge no studies have yet been published on the effect of the family's shared purpose in home-based family treatment.

Present Study

The present explorative study investigated the association between family members' unbalanced alliances and the family's *shared sense of purpose*, and youth behavior problems after home-based family treatment. We hypothesized that a greater imbalance between family members' alliances with the therapist would be negatively associated and higher levels of *shared sense of purpose within the family* would be positively associated with a decrease of youth behavior problems after treatment.

Methods

Participants and Treatment Setting

Participants were 49 parents ($n = 30$ (step)mothers, $n = 19$ (step)fathers) and 21 children from 29 families. The mean age of the child for whom the treatment was indicated was 9.2 years ($SD = 4.3$; range 1 – 16). The mean age of the children participating in the study was 11.1 years ($SD = 2.7$; range 5-16), and the mean age of parents was 38.3 years ($SD = 8.5$; range 25-55). In one family, one parent was born in a foreign western country, and in three families one or both parents were born in a non-western country. Participating families received home-based family treatment for youth problems, called *Intensieve Pedagogische Thuishulp* (IPT, Van der Steege, 2007). They were seen by 22 IPT-workers (male: $n = 2$, M age 41; $SD = 8.5$), with an average of 8.4 ($SD = 4.9$) years of experience as IPT-worker. All had a social work related (post-) bachelor's degree.

Intensieve Pedagogische Thuishulp (IPT, Van der Steege, 2007) is a home based family treatment in the Netherlands, for families dealing with complex child behavior and parenting problems. Most families experience problems in other domains as well, such

as financial problems, parental psychopathology or lack of a supporting social network. The treatment has an empowering, solution-focused and systemic approach, focusing on improving parenting skills and enhancing social support (Van der Steege, 2007). During treatment, an IPT-worker visits the family once or twice a week or once every two weeks, depending on the families' needs and stage of treatment. Families in this study received IPT for an average period of 47 weeks ($SD = 25.3$; range 12-109).

Procedures

Participating families were drawn from four teams specialized in IPT of two Dutch providers of specialized youth care. When a family started treatment with an IPT-worker of a participating team, they were informed about the research project by the IPT-worker or institution and received a letter with information. In one team, all IPT-workers directly asked their clients to participate. In the remaining three teams a member of the research team called the family to ask them to participate. Children aged 8 years or older were asked to complete the Working Alliance Inventory (WAI) and were included in coding observations using the System for Observing Family Therapy Alliances (SOFTA). Therapists were asked to reflect on alliances with all family members involved in treatment, regardless of age. Participating family members between 12 and 16 years gave assent, and older participants gave informed consent. The project was approved by the ethical board of the Faculty of Social and Behavioral Science of the University of Amsterdam. All participating families received a €10,- gift card and by draw, two families received a voucher for visiting a zoo or fun park of their own choice.

As a standard treatment procedure in all participating teams, parents filled out the Child Behavior Checklist (CBCL) at the start and end of treatment. Because the response rate at the end of treatment was very low, the research team carried out a follow-up telephone interview to gather CBCL data 18 months after the family had ended the treatment. Thirty-two participating families were excluded from the present study sample, because they had missing CBCL data on either the start of treatment or at follow-up. We compared family members of included and excluded families for therapist-, self- and observer reported alliances at T1 and T2, families' SSP scores and CBCL measures at T1 and T2 and CBCL at baseline and follow-up by performing an independent samples t-test. Results indicated that families included in the present study sample had slightly higher self-reports of the alliance at T1 ($t(88) = -.884, p = .020$) and slightly lower self-reports of alliance at T2 ($t(67) = .013, p = .028$). Furthermore, total youth problems at baseline were lower for included families as compared to excluded families ($t(43) = .541, p = .015$). There were no significant differences between included and excluded families for any other measures.

When a family participated, two sessions with an IPT-worker at the family's home were videotaped, and all family members involved in the videotaped session as well as the therapist were asked to independently complete the WAI-s right after the session. For T1—in the early treatment phase—the third session (and by exception the fourth or fifth) was filmed. We chose the third session because families were informed about the research and asked to consider participation in the first session. By choosing the third session they had some time to consider participation, but treatment was still in its starting phase, which lasts about six weeks (Van der Steege, 2007).

Measurements

Working Alliance Inventory – Short Form (WAI-s) To assess the alliance as perceived by therapists and family members, we used the Working Alliance Inventory, Short Form (WAI-s; Horvath & Greenberg, 1989; Killian, Forrester, Westlake, & Antonopoulou, 2017). The questionnaire consists of 12 items (e.g. "My family counselor and I agree upon what I should do in order to improve the way things are going in my family" for the client version or "This client agrees upon what family members should do in order to improve the way things are going in the family" for the therapist version) and measures task-, goal- and bond-elements of the alliance on a 5 point Likert scale ranging from 1 (*never*) to 5 (*always*). In the current sample, Cronbach's alpha for the therapists' version was .86 at T1 and .87 at T2, and for the clients' version .84 at T1 and .92 at T2.

System for Observing Family Therapy Alliances (SOFTA-o). The SOFTA-o (Friedlander, Escudero, & Heatherington, 2006b) was developed to assess four dimensions of alliance-related behavior from videotaped family or couple therapy sessions. Two dimensions reflect the individual alliance between a family member and the professional based on Bordin's (1979) classical definition of the alliance, i.e., Engagement in the Therapeutic Process, representing task and goal elements of the alliance, and Emotional Connection. The two other dimensions, Safety within the Therapeutic System, and Shared Sense of Purpose within the Family, reflect aspects of the alliance that are unique to conjoint family treatment. For the purpose of this study, we used the Shared Sense of Purpose scale, and an average of Engagement and Emotional Connection to reflect the individual alliance between a family member and the therapist. Scores of these two subscales were significantly correlated (T1: $r = .292, p = .034$, T2: $r = .422, p = .007$).

When using the SOFTA-o, a trained coder observes a session and notes the frequency of specific positive and negative alliance-related behaviors along the four dimensions. After observing the session, based on the frequency, intensity and clinical meaningfulness of the marked behaviors, coders assign global ratings on

each dimension on a 7 point Likert scale ranging from -3 (*extremely problematic*) to +3 (*extremely strong*). For the purpose of this study, the SOFTA-o was translated from English to Dutch, following guidelines as prescribed by Van Widenfelt, et al. (2005).

For coding the videotaped IPT-sessions with the SOFTA-o, we used the training manual by Friedlander et al. (2005) as a guideline. The first author received training from prof. dr. Escudero, one of the developers of the instrument. After training and translation of the manual, first author coded 12 videotapes with at least two family members in the session to use as a golden standard. Coding dilemmas were discussed with prof. dr. Escudero. Next, 3 master students in Educational Sciences were trained, receiving 15 hours of coder training over five weeks. They were introduced to the theoretical framework of the SOFTA, coding guidelines, practice material from the developers and Dutch practice material taken from the Dutch dramaserie *In Therapie (In Therapy)*. Trained coders independently coded at least 10 videotapes to increase their reliability as coders compared to the golden standard codings by first author and received feedback on each coding. As advised by Friedlander et al. (2005), training continued until coders differed no more than one point in their scale scores in 90% of the cases.

After their training, each coder rated a random selection of the videotapes. Coding dilemmas were discussed and difficult parts were consensus coded during meetings with the coding team every two weeks. In total, 90 sessions were independently coded after training. Of these sessions, 15 random selected sessions (16,7%) were double coded by the first author, coders were blind to these double coded sessions. To assess interrater reliability, we calculated intra-class coefficients for the 15 double coded sessions using the single measures of a two-way mixed effect model based on absolute agreement (Koo & Li, 2016). ICC for the combined Engagement and Emotional Connection scale was .44, ICC for the Shared Sense of Purpose scale was .59. According to Cicchetti (1994), ICC's are fair when $>.4$, good $>.6$ and excellent $>.8$.

CBCL The Child Behavior Checklist (CBCL; Achenbach, & Rescorla, 2000; 2001; Van der Hulst, & Van der Ende, 2013) is a parent questionnaire for assessing problems in 1,5 to 18-year-old children and adolescents. The CBCL version contains 120 items (100 items in the version for 1,5 – 5-year-olds) on behavioral or emotional problems during the past 6 months, scored on 0-2 point Likert scale ('*not true*', '*somewhat true*' or '*very or often true*'). For the purpose of this study we used the internalizing, externalizing and total problems scale. Internalizing problems refer to problems that are present inside the child, such as feeling anxious or depressed. Externalizing problems refer to problems that become manifest in conflict with others and with expectations that others have of the child. The total problem scale includes both the internalizing and externalizing

problem scale items, as well as items referring to other problems such as thought and attention problems. Because the number of items per scale (32 for internalizing and 35 for externalizing problems) outrated the number of participating families, we reasoned that a proper estimate of reliability was not viable and thus we did not calculate Cronbach's alpha for the current study sample. The manual of the Dutch CBCL version reports good reliability and validity (Van der Hulst, & Van der Ende, 2013).

Statistical Analyses

To investigate unbalanced alliances within the family, we calculated difference scores for alliances of two family members. When there were three family members with alliance scores within the same family ($n = 7$ for therapist reports, $n = 2$ for self- and observer reports) we used scores of the two family members that were most discrepant. To investigate the effect of unbalanced alliances within the family, and the family's *shared sense of purpose* on youth internalizing, externalizing, and total behavior problems at follow-up, we first calculated zero order correlations (pearson's r) between the included alliance measures (alliance difference scores and SSP) and follow-up CBCL scores. Because of the small sample size, we also performed post hoc non-parametric tests (Spearman's ρ) for all significant effects we found. Next, to control for youth internalizing, externalizing, and total problems at the start of treatment, we calculated partial correlations for all alliance measures and follow up CBCL scores, controlling for CBCL scores at the start of treatment.

Because of the explorative nature of the study and the small sample size with limited statistical power, we also reported trend-significant and substantial non-significant correlations that might be of theoretical importance.

Results

Preliminary Analyses

First, we performed a paired t-test with baseline and follow-up CBCL scores (Table 1), to test whether youth problems improved from intake to 18 months post-treatment. We found that externalizing youth problems ($t = 5.322, p < .001$) and total youth problems ($t = 4.212, p < .001$) improved significantly from the start of treatment to 18 months after ending treatment. For internalizing problems, the t-test was not significant, but indicated a trend ($t = 1.797, p = .083$).

Table 1

Descriptives for CBCL scores

	Baseline (Mean, SD)	Follow-up ¹ (Mean, SD)	<i>T</i>	<i>p</i>
Internalizing Problems	16.172 (9.385)	13.240 (8.339)	1.797	.083
Externalizing Problems	23.621 (8.809)	14.550 (8.153)	5.322	<.001
Total Problems	70.517 (21.827)	49.000 (22.123)	4.212	<.001

Note. ¹Follow-up was measured 18 months post-treatment

Next, we calculated means and standard deviations of all alliances of individual family members, alliance differences, and shared sense of purpose within the family (Table 2). Therapist-, self- and observer reports all showed strongest alliances for mothers as compared to fathers, and subsequently youth, although differences were relatively small, especially between fathers and mothers. All alliances became somewhat stronger from T1 to T2, except for fathers' observed alliances. Differences between family members' alliances with the therapist were largest for observer reports. Interestingly, although differences between family members' therapist- and observer-reported alliances slightly increased from T1 to T2, differences in self-reported alliances decreased. Finally, there was a small increase of shared sense of purpose from T1 to T2.

We also calculated zero order and partial correlations for each family member's individual alliance with the therapist and CBCL scores at follow-up. The results are reported in Tables 3 and Table 4. Most correlations between mothers' and fathers' alliances and follow up CBCL scores were small to moderate and not significant. The partial correlation between mothers' self-reported alliance at T2 and youth externalizing behavior problems at follow up was trend-significant ($r = .277, p = .090$), indicating that stronger alliances with mothers at mid-treatment were associated with more externalizing behavior problems of the child after controlling for baseline externalizing behavior problems.

Table 2

Descriptives for alliance scores

<i>Informant</i>	<i>T1</i>		
	Therapist ¹ Mean (SD, n)	Self ¹ Mean (SD, n)	Observer ² Mean (SD, n)
<i>Family Member</i>			
Mother	4.078 (.429, 29)	4.300 (.360, 30)	1.733 (.504, 30)
Father	3.745 (.518, 14)	4.190 (.268, 12)	1.308 (.435, 13)
Youth	3.555 (.449, 14)	3.845 (.742, 8)	1.222 (.618, 9)
<i>Difference</i>	.288 (.365, 22)	.476 (.485, 19)	.595 (.539, 21)
SSP	-	-	.86 (1.108, 21)

Note. Difference = alliance difference scores, SSP = Shared Sense of Purpose within the family, T1: alliance measured early treatment, T2: alliance measured mid-treatment (2 months after T1).

Table 3

Pearson's *r* zero order correlations between individual alliances and youth behavior problems at follow-up

	<i>T1: n</i>	Internalizing Problems	Externalizing Problems	Total Problems
Mother (t)	29	.109	.092	.143
Mother (s)	30	.063	.031	-.061
Mother (o)	30	.077	.072	.066
Father (t)	15	.076	-.283	-.081
Father (s)	14	.111	-.031	-.043
Father (o)	15	.588* ¹	.283	.490* ²
Youth (t)	13	.155	-.109	.142
Youth (s)	8	-.207	-.609	-.455
Youth (o)	9	.512 ⁺	.603* ³	.626* ⁴

Note. t = therapist-report, s = self-report, o = observer-report, Diff = alliance difference scores, SSP = Shared Sense of Purpose within the Family, T1: alliance measured early treatment, T2: alliance measured mid-treatment (2 months after T1). ¹In a post-hoc non-parametric test the correlation remained significant: $r = .502, p = .040$

Therapist ¹ Mean (SD, n)	T2	
	Self ¹ Mean (SD, n)	Observer ² Mean (SD, n)
4.145 (.326, 27)	4.340 (.431, 26)	1.404 (.469, 26)
4.017 (.426, 16)	4.292 (.290, 9)	1.100 (.394, 10)
3.635 (.600, 16)	4.000 (.709, 5)	1.500 (1.354, 4)
.367 (.419, 24)	.391 (.414, 12)	.615 (.712, 13)
-	-	1.150 (1.214, 13)

¹Clients' selfreports, and therapist-reports are measured on a 5 point Likert scale (1-5). ²Observer reports are measured on a 7 point Likert scale (-3 - +3)

T2: n	Internalizing Problems	Externalizing Problems	Total Problems
27	.028	.015	.032
26	.099	.121	.053
26	.218	.208	.243
16	.373*	.148	.250
9	.550*	.119	.394
10	.113	-.053	-.044
16	.217	-.080	.098
5	-.483	-.738*	-.894* ⁵
4	-.580	-.336	-.669

² In post-hoc non-parametric test the correlation remained significant: $r = .590, p = .017$. ³ In a post-hoc non-parametric test the correlation was not significant: $r = .386, p = .152$ ⁴ In a post-hoc non-parametric test the correlation was trend significant: $r = .580, p = .051$ ⁵ In a post-hoc non-parametric test the correlation remained significant: $r = -.379, p = .045$ ⁵ In a post-hoc non-parametric test the correlation remained significant ($r = -.900, p = .019$)

For alliances with youth we found that observer rated alliances at T1 were strongly and (trend-) significantly associated with youth internalizing ($r = .578, p = .067$), externalizing ($r = .647, p = .042$), and total behavior problems ($r = .689, p = .029$) after controlling for baseline CBCL scores, indicating that stronger early treatment observed alliances were associated with less improvement of youth behavior problems from baseline to 18 months follow up. At T2, this association was in the opposite direction and large yet not significant for internalizing ($r = -.932, p = .118$) and total problems ($r = -.733, p = .238$). Associations of self-reported youth alliances at T1 with CBCL scores were small and not significant, except for the partial correlation with youth externalizing behavior problems ($r = -.613, p = .072$), indicating a trend towards more improvement of externalizing youth behavior problems 18 months after treatment when children and adolescents perceived their early alliances with the therapist as stronger. At T2, youth self-reports of the alliance were largely associated with improvement of youth behavior problems. Here, only the association with youth total behavior problems was significant ($r = -.945, p = .027$). It should be noted, however, that the number of youth self-reports on alliance at T2 was extremely small ($n = 5$).

Unbalanced Alliances

Results from zero order and partial correlation tests between unbalanced alliances, shared sense of purpose, and youth behavior problems at follow up are reported in Table 5 and Table 6 respectively. At T1, both tests showed that unbalanced observed alliances were significantly associated with youth problems at follow up. In contrast to our hypothesis, results indicated that larger differences at the starting phase of treatment were associated with less youth externalizing problems ($r = -.411, p = .032$) and total problems ($r = -.415, p = .031$), also when controlling for baseline youth externalizing problems ($r = -.564, p = .005$). The association between unbalanced therapist reported alliances and youth total behavior problems at follow up was moderate and significant, after controlling for baseline CBCL scores it was trend-significant ($r = -.369, p = .055$). These findings indicate that when differences between family members in their observed early treatment alliances with the therapist were larger, there was more improvement of youth externalizing and total behavior problems at 18 months post-treatment. At T2, associations between unbalanced observed alliances and youth behavior problems at follow up after controlling for baseline were in the expected direction, indicating that smaller differences between family members in their observed mid-treatment alliances with the therapist were associated with more improvement of youth behavior problems. However, these correlations at T2 were rather small and failed to reach significance.

For therapist-reported alliances at T1, the zero order correlation test showed small and non-significant results. After controlling for baseline differences, we found a trend indicating that larger alliance differences between family members were associated with less youth internalizing behavior problems at follow up after controlling for baseline scores ($r = -.292, p = .099$), which was inconsistent with our hypothesis. At T2, all correlations between alliances differences as reported by therapists and youth behavior problems at follow up were very small and not significant, which was also inconsistent with our hypothesis.

Finally, associations between differences in family members' self-reported T1 and T2 alliance and youth behavior problems at follow up were small and not significant.

Shared Sense of Purpose

Inconsistent with our hypotheses, results of both the zero order and partial correlation tests between the family's observed shared sense of purpose at T1 and youth behavior problems at follow up indicated that higher levels of early treatment shared sense of purpose were associated with less improvement of youth behavior problems. However, all correlations were rather small and not significant. At T2, there was a moderate association between the family's shared sense of purpose and youth internalizing behavior problems after controlling for baseline scores, indicating that – as expected – higher levels of mid-treatment SSP were associated with more improvement of youth internalizing behavior problems 18 months after treatment ($r = -.382, p = .110$). However, the association was not significant. Correlations between mid-treatment SSP and improvement of youth externalizing behavior and total problems were also in the expected direction, yet small and not significant.

Table 4

Pearson's *r* partial correlations between individual alliances and youth behavior problems at follow-up, controlled for youth problems start of treatment

	<i>T1: n</i>	Internalizing Problems	Externalizing Problems	Total Problems
Mother (t)	29	.021	.065	.145
Mother (s)	30	-.099	-.002	-.042
Mother (o)	30	.128	.051	.090
Father (t)	15	.115	-.073	-.032
Father (s)	14	-.081	-.134	-.052
Father (o)	15	.398	.278	.458
Youth (t)	13	.390*	-.093	.274
Youth (s)	8	.052	-.613*	-.257
Youth (o)	9	.578*	.647*	.689*

Note. t = therapist-report, s = self-report, o = observer-report, Diff = alliance difference scores, SSP = Shared Sense of Purpose within the Family,

Table 5

Pearson's *r* zero order correlations between alliance differences, SSP and youth behavior problems at follow-up

	<i>T1: n</i>	Internalizing Problems	Externalizing Problems	Total Problems
Diff (t)	22	-.149	.089	-.016
Diff (s)	19	.243	-.065	.106
Diff (o)	21	-.241	-.411* ¹	-.415* ²
SSP	21	.034	.251	.118

Note. t = therapist-report, s = self-report, o = observer-report, Diff = alliance difference scores, SSP = Shared Sense of Purpose within the Family, T1: alliance measured early treatment, T2: alliance measured mid-treatment (2 months after T1).

Table 6

Pearson's *r* partial correlations between alliance differences, SSP and youth behavior problems at follow-up, controlled for youth problems start of treatment

	<i>T1: n</i>	Internalizing Problems	Externalizing Problems	Total Problems
Diff (t)	22	-.292*	.026	-.084
Diff (s)	19	.160	-.094	.054
Diff (o)	21	-.193	-.564**	-.369*
SSP	21	.118	.296	.110

Note. t = therapist-report, s = self-report, o = observer-report, Diff = alliance difference scores, SSP = Shared Sense of Purpose within the Family,

T2: n	Internalizing Problems	Externalizing Problems	Total Problems
27	.008	.099	.046
26	.061	.277 ⁺	.113
26	.107	.212	.238
16	.384 ⁺	.219	.251
9	.497	.405	.468
10	.110	.099	-.044
16	.160	-.027	.098
5	-.732	-.681	-.945 [*]
4	-.932	-.166	-.733

T1: alliance measured early treatment, T2: alliance measured mid-treatment (2 months after T1)

⁺ $p \leq .10$. ^{*} $p \leq .05$. ^{**} $p \leq .01$. ^{***} $p \leq .001$ (one-tailed)

T2: n	Internalizing Problems	Externalizing Problems	Total Problems
24	-.252	.101	-.016
12	-.079	-.254	-.013
13	.131	-.040	.113
13	-.201	.126	-.120

¹In a post-hoc non-parametric test the correlation remained significant: $r = -.379$ $p = .045$. ²In a post-hoc non-parametric test the correlation remained significant: $r = -.403$ $p = .035$.

⁺ $p \leq .10$. ^{*} $p \leq .05$. ^{**} $p \leq .01$. ^{***} $p \leq .001$ (one-tailed)

T2: n	Internalizing Problems	Externalizing Problems	Total Problems
23	-.096	.005	-.017
11	.162	-.267	-.024
12	.197	.280	.278
13	-.382	-.037	-.146

T1: alliance measured early treatment, T2: alliance measured mid-treatment (2 months after T1)

⁺ $p \leq .10$. ^{*} $p \leq .05$. ^{**} $p \leq .01$. ^{***} $p \leq .001$ (one-tailed)

Discussion

In the present study we investigated the association between (a) family members' unbalanced alliances and the family's *shared sense of purpose*, and (b) youth behavior problems 18 months after ending home-based family treatment. Contrasting our hypotheses, our findings indicate that unbalanced observed early-treatment alliances lead to more favorable treatment outcome in terms of externalizing and – to some extent – total youth behavior problems at follow up. This is a remarkable finding that contrasts the scarce body of previous research on alliance differences and family treatment outcome showing no effect of unbalanced alliances (Forsberg et al., 2014; Glebova et al., 2018) or a negative effect (Escudero et al., 2021). However, across treatment the association changed to the opposite direction: at mid-treatment a greater imbalance was related to more externalizing and total youth problems at follow-up, although this association was small and not significant. Thus, a plausible explanation seems that larger early treatment alliance differences offer more room for balancing alliances during treatment, which may in turn enhance treatment outcome. This hypothesis is supported by a study of Bartle-Haring et al. (2012), who found that in their sample of couples receiving therapy, an increase in congruence between partners in their alliance with the therapist predicted treatment success. In another study, Escudero et al. (2021) found that a larger number of sessions with split alliances was predictive of less favorable treatment outcome in a sample of families receiving therapy because of serious child maltreatment. Both studies underline the relevance of further research on the effect of trajectories in unbalanced alliances over the course of treatment.

Differences in observer-rated alliances were more strongly associated with improvement of youth behavior problems as compared to differences in therapist- or self-reported alliances. This suggests that the observer's perception of the alliance may be a more important perspective to signal alliance differences as compared to the perception of family members and therapists. Perhaps the lack of personal involvement in the treatment process helps observers to gain a more objective perspective on the therapist's alliances with family members. On the other hand, it could also be argued that the observer's perspective reflects a different rather than a more objective perspective on the alliance. Horvath (2006) distinguishes between the intrapersonal and the interpersonal construction of the alliance. Observers' measures of the alliance operationalize the interpersonal dimension of the alliance, reflected in tangible behavior in the interpersonal exchange. Therapists' and family members' self-reports operationalize the intra-personal dimension of the alliance, which encompasses the individual thoughts, feelings and opinions in relation to the other person and to the relationship with the other person. Following this line of reasoning, our study findings indicate that a disbalance in the interpersonal behavioral dimension of family members' alliances with the therapist seems most essential in marking clinical significance.

When comparing our study findings with previous studies on unbalanced alliances, it should be noted that studies differ largely in how the concept of unbalanced or split alliances is operationalized. Like in our study, several studies used a continuous measure, such as a difference score (e.g., Forsberg et al., 2014; Robbins et al., 2003) or a similarity index (Glebova et al., 2018) to reflect the degree of unbalance in alliance between two family members. Other studies compare groups by defining the concept of split alliances in terms of standard deviations. In these studies, alliances are referred to as 'split' when the strength of two alliances differ at least one standard deviation (e.g., Muñiz de la Peña et al., 2009). The commonality among these studies is that they all adopt a quantitative approach to examine unbalanced or split alliances. Considering the fact that results of these studies are ambiguous, and that some studies specifically indicate that differences between family members in their alliances with the therapist are the rule rather than the exception (e.g., Welmers – van de Poll et al., 2020), a valid question seems: when do unbalanced alliances become problematic in achieving favorable outcome? Perhaps this distinction is qualitative rather than quantitative, and thus, future research could benefit from a more qualitative observational investigation of how problematic differences between family members' alliances differ from non-problematic differences.

Our findings regarding the family's *shared sense of purpose* showed that the family's *shared sense of purpose* was moderately but not significantly associated with the decrease of youth internalizing behavior problems 18 months after treatment. The fact that the correlation in our sample failed to reach significance, could indicate that the importance of the family's shared sense of purpose is negligible. However, we should consider that the small sample size resulted in limited statistical power, and that the direction of the association was in line with meta-analytic findings of Friedlander et al. (2018), indicating that in couple and family therapy the family's shared purpose is predictive of outcome. Taken together, our finding suggests that a stronger shared purpose within the family at mid-treatment may have a clinical significance in reducing internalizing child behavior problems that warrants further exploration.

Although not a focus of this study, it was interesting to find that youths' self-reported mid-treatment alliances with the therapist were strongly associated with positive treatment outcome in terms of total behavior problems. This indicates that building strong alliances with children and adolescents seems vital for family treatment success in terms of youth behavior problems. However, strong alliances with children and adolescents in the context of conjoint family treatment is complex, as was illustrated in a previous study on alliance discrepancies between family members in home-based family treatment. In this study, alliances with children and adolescents were significantly weaker as compared to alliances with parents (Welmers - van de Poll et al., 2020). Furthermore, therapists were

more congruent in their perspective on the alliance with parents, and did lack a shared perspective on the alliance with youth. However, as in our present study, the number of included youth with self-reports on the alliance in this previous study was very small. Consequently, further research on the effect of alliances with children and adolescents in the context of conjoint family treatment is warranted.

Limitations of this study include the small sample size and the relatively weak interrater reliability of observer rated alliance. The use of a small sample may have limited the ability to identify associations at the 0.05 level significance. Insufficient statistical power also hindered the ability to apply multivariate analyses to study unique effects of SSP and unbalanced alliances. Several authors have pointed to the statistical disadvantages of using difference scores and have recommended other methods requiring larger samples, such as polynomial regression or the use of latent group models (Laird & De Los Reyes, 2013; Kivlighan, 2007). Another limitation is that changes in youth behavior problems from baseline to follow up measures were rather small (yet significant), with one standard deviation or less improvement. It has been reasoned before that change should be interpreted as clinically significant if it is at least two standard deviations from baseline (e.g. Bachler et al., 2016, following Jacobson et al., 1984). Perhaps treatment effects might have been stronger when measured end-of-treatment, and thus the lack of end-of-treatment measures in our study may have hindered the investigation of larger treatment effects. On the other hand, the use of follow-up measures enabled the investigation of sustainable change in youth problems after ending treatment.

An important strength of our study is the use of observations in a clinical representative research context of home-based family treatment. Although observational methods are time-consuming and therefore often result in smaller sample sizes, they also enable the investigation of family members' actual behaviors and interactions with each other and with the therapist. As Oka and Whiting (2013) point out, observing behaviors and interactions in a representative context may help in bridging the gap between research and everyday clinical practice of systemic family treatment. Our additional use of therapist- and self-reports of the alliance enabled a comprehensive multi-informant perspective on the occurrence of unbalanced alliances. Furthermore, our study was the first to examine a disbalance in family members' alliances regardless of family role, whereas previous studies only investigated alliance differences specifically between or within subsystems (parent – adolescent or father-mother respectively).

Future research on unbalanced alliances and the family's shared sense of purpose may benefit from several approaches. First, studying larger and more diverse samples could improve generalizability of the results. Studying larger samples also enables

more effective methods to investigate the effect of unbalanced alliance on treatment outcome (e.g., polynomial regression, or the use of a latent group model; Bartle-Haring et al., 2012; Kivlighan, 2007). Our study findings suggest that it may be particularly interesting to investigate the effect of processes in the family's shared sense of purpose and alliance differences over the course of treatment (e.g., improving versus impairing shared purpose). Second, a more qualitative observational investigation on unbalanced alliances may improve our understanding of how and when differences between family members' alliances with the therapist become problematic. Furthermore, investigating predictors of the family's shared purpose and alliance differences may increase our understanding of how these systemic aspects of the alliance can be affected in order to enhance treatment outcome. Finally, future research on the effect of shared purpose and unbalanced alliances may benefit from investigating a broader range of treatment outcomes, including end-of-treatment measures and measures of improvement on therapeutic goals and of youth and family functioning.

Conclusions

Establishing the degree to which systemic aspects of the alliance matter for positive outcomes of home-based family treatment seems important; this study was – to our knowledge – the first to examine the alliance from a systemic perspective in the context of home-based family treatment, and has thus taken a first step toward that goal. Our findings suggest clinical significance of unbalanced alliances and of the within-family alliance or shared sense of purpose that warrant further exploration. Ongoing research should examine the effect of the interaction between multiple family members' alliances and of the family's shared sense of purpose, their courses over treatment, and their predictors, to allow for further understanding of the complex role of alliance in (home-based) family treatment. This may help providers of HBFT in establishing strong therapeutic alliances both with and within the family system to facilitate meaningful changes for families dealing with a variety of youth and family problems.



General Discussion

General Discussion

Home-based family treatment (HBFT) is the most provided service in youth care, serving a heterogeneous group of families with complex child- and parenting problems. Given the fact that empirical evidence indicates varying outcomes of HBFT, it is important to examine factors that may contribute to desirable outcomes. The current dissertation aimed at investigating such an important factor: the working alliance. The central aim was to investigate alliance processes in (home-based) family treatment and their relation to treatment outcome, paying particular attention to the therapists' role and to the systemic complexity of building multiple interacting alliances with and within the family. To meet the central research aim, we performed a meta-analytic review of previous studies on the alliance-outcome association in family-involved treatment for youth problems, and collected longitudinal multi-informant questionnaire and observational data on alliances and treatment outcome in a Dutch home-based family treatment for youth problems (*Intensieve Pedagogische Thuishulp, IPT*; Van der Steege, 2007). In this concluding chapter I provide a summary of and reflection on the main findings presented in this dissertation. Building on the presented findings, I discuss the dissertation's strengths and limitations, and provide suggestions for future research. The chapter concludes with implications for clinical practice, education, and policy making.

Summary of Main Findings

To gain a better understanding of the importance of the alliance in family-involved treatment, in **Chapter 2** I meta-analytically reviewed results of 28 studies reporting on the alliance-outcome association in 21 independent study samples of families receiving family-involved treatment for youth problems ($N = 2126$ families). The quality of the alliance was significantly associated with more positive treatment outcomes in terms of youth symptom severity or functioning, parental or family functioning, retention, goal attainment or therapeutic progress ($r = .183, p < .001$). Correlations were significantly stronger when alliance scores of different measurement moments were averaged or added, when families were help-seeking rather than receiving mandated care, and when studies included younger children. The association between alliance improvement and treatment outcome just failed to reach significance ($r = .281, p = .067$), and there was no significant association between family members' unbalanced or *split* alliances and treatment outcome ($r = .106, p = .343$). However, it should be noted that there was only a relatively small number of included studies reporting on alliance change scores or split alliances. Findings in this chapter demonstrate that alliance plays a significant role in the effectiveness of family-involved treatment, especially in non-mandated care and with

families of younger adolescent children. Findings also underscore the importance of a process-oriented approach when investigating alliances, with multiple measurement moments over the course of treatment. Future research should focus on investigating the more complex systemic aspects of alliance to gain fuller understanding of the dynamic role of alliance in working with families.

Given the therapists' vital role in building strong alliances, in **Chapter 3** I investigated the predictive value of therapists' personality, years of clinical experience and observed alliance building behaviors for mid-treatment alliance as reported by therapists and family members. Participants were 77 parents and 21 youth from 57 families receiving HBFT from 33 therapists. Therapist *openness to experience* and *agreeableness* as well as therapists' in-session *engagement* and *emotional connection* behaviors predicted more positive therapist and family member reports of the alliance. Therapist *neuroticism*, *extraversion* and *conscientiousness* predicted more negative alliance-reports. In-session *safety* behaviors also predicted more negative alliance-reports, but this finding was only significant for therapists' and not family members' reports of the alliance. Therapists' clinical experience did not predict the quality of alliances.

Chapter 4 focused on the occurrence and development of discrepancies between alliances of different family members, and the therapists' evaluation of multiple alliances and discrepancies. Participants were 92 parents and 61 youths from 61 families receiving HBFT. Family members, therapists, and observers reported early and mid-treatment alliance. There were significant discrepancies, with strongest alliances for mothers, followed by fathers, and then youths. These alliance discrepancies became smaller during treatment. Therapist-reports yielded similar discrepancies as compared to client self-reports and observer-reports. In the starting phase of treatment, the correlation between therapist- and client self-reports was moderate and significant for alliances with mothers, but non-significant for alliances with fathers and youths. Two months later, these correlations were large for alliances with mothers and fathers, but not for youths.

Chapter 5 presented results of an explorative study on the association between (a) family members' unbalanced alliances (alliance differences) and the within-family alliance or *shared sense of purpose* (SSP), and (b) youth behavior problems 18 months after ending HBFT. For this study, families were included in the sample if they provided data on a measure of the alliance with the therapist for at least two family members, or if they provided data on a measure of the within-family alliance. In addition, families had to report data on the measures of youth behavior problems at the start as well as 18 months post-treatment. This resulted in a sample of 29 families. Considering the small sample size and limited statistical power, we also reported trend-significant and substantial non-significant

correlations that might be of theoretical importance. We found that a greater imbalance in observed early-treatment alliances was associated with less externalizing and total youth behavior problems at follow up. Over the course of treatment this association changed to the opposite direction: at mid-treatment a greater imbalance was associated with more externalizing and total youth problems, although the association was small and not significant. One conclusion was that perhaps the process of balancing family members' differing alliances during treatment, rather than the lack of difference in alliances itself, may contribute to improvement of children's behavior problems and deserves further investigation. Furthermore, higher levels of mid-treatment shared sense of purpose were moderately, but not significantly, associated with the decrease of youth internalizing behavior problems 18 months post-treatment. This indicates that a stronger shared sense of purpose within the family at mid-treatment may have a clinical significance in reducing internalizing child behavior problems that warrants further exploration.

Reflection on Main Findings

Working alliance as predictor of better treatment outcomes

A key finding, resulting from the meta-analytic review in Chapter 2, is that building strong working alliances with families in treatment for a variety of youth problems contributes to positive treatment outcome. This finding is consistent with other recent meta-analytic findings, indicating that the alliance is a predictor of positive outcomes in child and adolescent psychotherapy (Karver et al., 2018; Roest et al., 2021b), adult psychotherapy (Flückiger et al., 2018), and couple and family therapy (Friedlander et al., 2018). The finding is also consistent with two recent studies on the alliance – outcome association in home-based family interventions (Bachler et al., 2016; De Greef et al., 2018b). The overall effect size of $r = .18$ in our meta-analysis was smaller as compared to results of recent meta-analyses on the alliance-outcome association in adult psychotherapy ($r = .28$; Flückiger et al., 2018), couple and family therapy ($r = .30$; Friedlander et al., 2018), and adolescent mental health treatment ($r = .29$; Murphy & Hutton, 2018), but comparable with two other recent meta-analyses in youth psychotherapy ($r = .20$; Karver et al., 2018; $r = .16$; Roest et al., 2021b). Taken together, these findings to some extent imply a smaller contribution of the alliance for treatment focused on youth problems as compared to adult and family problems, although findings regarding the magnitude of the effect size in treatment addressing youth problems remain equivocal. Nevertheless, these findings do suggest a significant contribution of the alliance to family treatment for youth problems, and underline the importance of building strong alliances with families when providing (home-based) family treatment.

Alliance Complexity: The Matter of Perspective

Another key finding that emerges from the studies included in this dissertation is that – especially in family treatment – the working alliance is not a simple, unilateral, objective construct, but rather a matter of perspective: establishing a judgement on the strength of the alliance depends on whose perspective is measured.

A first matter of perspective regards different informants (therapists, observers, and family members) reporting on the alliance. In line with prior research in individual youth and adult psychotherapy (for meta-analytic reviews see Roest et al., 2021b; Tryon et al., 2007), this dissertation (Chapter 3) showed that therapists generally reported weaker alliances as compared to family members and observers. These different ratings may reflect different frames of reference: therapists probably compare relationships with clients to those with previous clients or to a theoretical ideal of the therapeutic relationship, whereas clients may rather compare the therapeutic relationship to their interaction with friends, family members, teachers, etc. (Hartmann et al., 2015; Roest et al., 2021b; Tryon et al., 2007). Although these different (interpretation) frameworks may be a given, prior research in individual therapy indicates the importance of a more or less shared perspective on the strength of the alliance to promote treatment effectiveness (Bachelor, 2013; Fjermestad et al., 2016; Kivlighan, 2007; Rozmarin et al., 2008; Zilcha-Mano et al., 2017). Moreover, a recent family therapy study found that a shared alliance perception between the therapist and all family members in treatment was a predictor of improvement in child functioning and achieving family goals (Escudero et al., 2021).

It was interesting to find in the meta-analysis (Chapter 2) that alliance informant did not moderate the alliance-outcome association, indicating that the effect of alliance on outcome is independent of whose perspective (i.e., therapist, observer, client) on the alliance is measured. However, the study presented in Chapter 5 did indicate an informant-effect: family members' unbalanced observed early treatment alliances were positively associated with treatment outcome, whereas unbalanced therapist- or self-reported alliances were not. This finding implies that alliance discrepancies between family members as observed during an early treatment session (the *interpersonal* aspect of alliance) may be a marker of potential treatment success – as will be discussed further on in this chapter – whereas discrepancies in their inner perceptions of the alliance (the *intrapersonal* aspect) are not. Apparently, different reports, reflecting different aspects of the alliance, in turn may have different effects on outcome.

The second important 'matter of perspective' in this dissertation is unique to systemic family treatment, namely: multiple alliances with different family members, each with their own perspective on the alliance. In Chapter 4, we found that the strength of the

alliance may differ notably from one family member to another, especially during the starting phase of treatment. More specifically, similar to results of some prior studies (Robbins et al., 2003; 2008), we found that therapists had stronger alliances with parents as compared to youth. This study was – to my knowledge – the first to show a significant difference between mothers and fathers: therapists had stronger alliances with mothers in the early treatment phase. However, these differences between fathers and mothers faded over the course of treatment, whereas differences in alliance between parents and youth remained. These findings indicate that building alliances with youth in the context of family treatment presents a specific challenge, deserving some further reflection.

Engaging ‘Treatment Hostages’: Alliances with Children and Adolescents

Several authors have vividly described challenges specific to building alliances with youth regardless of treatment context, related for instance to children’s and adolescents’ developmental stages (e.g., Cirasola et al., 2021; Karver et al., 2018; Shirk et al., 2011; Thompson et al., 2007). In family treatment, various factors add to this complexity. First, for children and adolescents, family treatment belongs to the world of adults (Escudero & Friedlander, 2017), because it can usually only be initiated by adults, and is always provided by an adult. Consequently, children and adolescents are less powerful interaction partners than adults, which makes it hard for them to ‘take the floor’ and actively participate during a conjoint session (O’Reilly, 2008). Second, treatment is oftentimes initiated as a solution to the child’s “problematic behavior”, resulting in the child feeling accused and punished by being dragged into treatment alongside their parents. Thus, children and adolescents often expect treatment to be a correcting and coercive environment, resulting in defensive and mistrusting behavior (Escudero & Friedlander, 2017). The presence of parents in sessions, even though of crucial importance, may add to this mistrusting attitude in children and adolescents, since it may cause feelings of shame or fear of negative consequences after the treatment session (Escudero & Friedlander, 2017; Strickland-Clark et al., 2000).

Adding to the complexity of building alliances with youth in family treatment, Chapter 4 indicated that the therapist’s perspective on the alliance with a child or adolescent in treatment may differ largely from this child’s or adolescent’s own perspective. This finding indicates that treatment effectiveness may benefit from asking children’s and adolescents’ feedback on the alliance: asking alliance feedback was found to be effective in adult psychotherapy too (e.g., Mihalo & Valenti, 2018; Van Hennik, 2020; Zilcha-Mano & Errazuriz, 2015). However, it is important to note that ‘what works’ in building alliances with adults can be counterproductive when forming an alliance with an adolescent (Creed & Kendall, 2005). For example, addressing clients’ negative feelings towards the therapist in order to repair an alliance rupture appeared to be effective in adults (Safran et al., 1994),

but was found to negatively impact alliances with adolescents (DiGiuseppe et al., 1996). Ultimately, playing an active role in a conjoint treatment process with adults, for example by providing feedback, is important as well as challenging for children and adolescents. It should therefore be carefully guided by the therapist both verbally and non-verbally (Escudero & Friedlander, 2017; Moore & Bruna-Sue, 2011; O'Reilly, 2008; Strickland-Clark et al., 2000).

The importance of understanding and attending to children's and adolescents' experiences of the alliance is underlined by results of analyses in Chapter 5, indicating that youth's self-reports of the alliance were strongly associated with more positive treatment outcomes in terms of youth problems, in contrast with parents' self-reports of the alliance. Although the number of included youth with self-reports on the alliance was too small to draw reliable conclusions, this finding is in line with some previous family treatment studies (Friedlander et al., 2012; Johnson et al., 2002; Keeley et al., 2011; Rienecke et al., 2016) and with meta-analytic research in adolescent treatment (Murphy & Hutton, 2018; Roest et al., 2021b), both underlining the importance of youth's self-reported alliance in predicting treatment outcome. In the meta-analysis (Chapter 2) there was no significant difference in the effect on treatment outcome between alliances with parents and alliances with youth (therapist-, self- and, observer-reports collapsed). We did, however, find a substantial difference between parents and youth with regard to changes in the alliance over time, indicating that improvement of alliances with youth over the course of treatment affected outcomes more strongly than improvement of alliances with parents. This underlines the importance of a process-oriented approach both for practice and scientific research: building alliances with youth in family treatment, likely because of the specific challenges outlined before, may take considerable time.

Balancing Alliance Differences: Associations with Outcome

Moving beyond the observation that alliances differ notably between family members, the present dissertation also aimed at studying the presumed effect of these alliance differences – referred to as unbalanced or split alliances – with two prominent findings. First, the meta-analysis (Chapter 2) indicated no effect of unbalanced or split alliances on treatment outcome. However, only five studies reported on the effect of unbalanced or split alliances, and these studies were highly heterogeneous in their definitions and measures of split alliances and treatment outcomes. A more recent meta-analysis in couple and family therapy identified seven studies on unbalanced or split alliances and outcome, and found a significant moderate effect size ($r = .316$), indicating that a greater imbalance in family members' alliances leads to less favorable treatment outcome (Friedlander et al., 2018).

The second finding regarding unbalanced alliances contrasts findings of both meta-analyses: the explorative study in Chapter 5 indicated that a greater imbalance in family members' early treatment observed alliances was associated with more positive treatment outcome in terms of youth behavior problems 18 months after treatment. However, when alliances were measured two months later the association was negative (yet small and not significant), giving rise for the premise that it may be the process of balancing family members' differing alliances during treatment – rather than the difference in alliances itself – that is key in enhancing treatment outcomes. Another explanation for this unexpected finding could be that larger alliance differences between family members during the starting phase of treatment may be a marker of problematic family functioning and interaction. To illustrate, previous research has shown that larger informant discrepancies in reporting on parenting and child disruptive behavior were associated with problem severity (De los Reyes & Kazdin, 2006; Moens et al., 2018). In the present study sample, problematic family functioning and interaction may be reflected in family members' divergent attitudes towards treatment and the therapist. Following this line of reasoning, especially these families with problematic family functioning may benefit most from treatment (see for example also Van Aar et al., 2019). As the treatment progresses, the family's functioning is likely to improve, which in turn may result in smaller alliance discrepancies, as was the case in the present study sample. Nevertheless, an important conclusion is that the body of research on the process and effect of unbalanced alliances in family treatment is still small and yields equivocal results, underlining the importance of further research.

Within-family Alliance: The Importance of a Shared Sense of Purpose

An important strength of the current dissertation is that it was – to my knowledge – the first to examine the within-family alliance in the context of home-based family treatment. Following Friedlander et al. (2006), this systemic alliance concept was referred to as *shared sense of purpose within the family (SSP)*, reflecting family members' alignment and collaboration on shared family goals. Several findings indicate that enhancing the family's shared sense of purpose is likely to promote positive treatment outcome of systemic family treatment, including home-based family treatment. In the meta-analysis (Chapter 2), the overall effect size for systemic alliance including SSP was significant ($r = .21$), and it was slightly, but not significantly, higher than the overall effect size of individual parent or youth alliance. However, the number of included studies with a systemic measure of alliance was small. A more recent meta-analysis on the alliance-outcome association in couple and family therapy indicated that systemic alliance aspects, such as the family's SSP, were a significantly stronger predictor of positive outcome than individual alliances, even if multiple family members' alliances were averaged or added to measure a family unit of alliance (Friedlander et al., 2018).

In Chapter 5, the explorative study showed a moderate association between mid-treatment SSP and more positive treatment outcomes at follow-up in terms of youth internalizing problems, although this association failed to reach significance. However, based on the small sample size resulting in limited statistical power, one conclusion in this study was that promoting the family's shared purpose may have a clinical significance in reducing child internalizing problems that warrants further research with larger study samples. It is important to note here that only observed SSP was included in line with previous studies (Escudero et al., 2008; Friedlander et al., 2008; Isserlin & Couturier, 2012; Sotero et al., 2018). Although observations do shed light on the behavioral indicators of family members' agreement and active collaboration during a treatment session, they do not capture family members' personal experience of being aligned as a family in relation to treatment. This process of alignment and collaboration on shared goals within the family may par excellence be a process that takes place between rather than within treatment sessions. Thus, self-report questionnaires on SSP for all family members, preferably with repeated measures over the course of treatment, may help increase our understanding of this understudied concept and its relation to treatment outcome.

Building Strong Alliances: The Key Role of the Therapist

Following previous studies indicating the key role of the therapist in building alliances (Baldwin et al. 2007; Dinger et al., 2008; Nissen-Lie et al., 2010), a specific aim of this dissertation was to shed more light on therapists' contributions to alliances in systemic family treatment, with several prominent findings. First, the study in Chapter 3 showed that therapists' observed alliance building behaviors significantly affected family members' and therapists' perceptions of the alliance, underlining the importance of actively engaging family members in the therapeutic process as well as connecting with them at an emotional level. This finding adds to the scarce body of knowledge on therapist contributions to the alliance in family treatment (Escudero et al., 2012; Friedlander et al., 2014), although one particular finding in Chapter 3 contrasts these previous studies: when therapists were observed to invest more in family members' sense of safety in the therapeutic context, they rated alliances as less strong immediately after the session. As reasoned in Chapter 3, perhaps when therapists perceive their alliance with family members as less favorable, they increase their investment in family members' sense of safety.

Furthermore, the current dissertation was – to my knowledge – the first to show an association between therapist personality and family members' and therapists' evaluations of alliance. Findings indicate that alliances are relatively stronger when therapists report themselves to be more agreeable, open to new experiences, and emotionally stable, whereas therapists with high levels of extraversion or conscientiousness had relatively

weaker alliances. These findings imply that some therapists by nature may be more successful in building strong alliances with family members than others. However, it is important to note here that specific preferred behaviors associated with personality traits are not necessarily unchangeable: the extent to which personality traits are activated can vary across situations (Hoekstra & De Fruyt, 2014). An important next step to shed more light on the effect of therapist personality is to investigate what (behavioral) mechanisms explain the association between therapist personality and alliance. Nevertheless, training therapists to become more aware of typical conscientious or extravert behaviors and to apply alternative behaviors more beneficial to the alliance, may support highly extraverted and conscientious therapists in being more attuned in their communication with family members.

Finally, observational measures of therapists' behavioral contributions to the alliance (Chapter 3) indicated that therapists were mainly observed to show engagement and emotional connection behaviors, promoting alliances with individual family members. Their investment in family members' safety and the family's shared sense of purpose, specific systemic aspects of the alliance, were scarce. This may be due to the complexity of building systemic alliances: multiple family members with different behaviors are simultaneously involved, requiring more meta-reflection on the therapeutic process and careful guidance of within-family interactions during a treatment session (Escudero & Friedlander, 2017; Rober, 2017). However, the finding that therapists reported similar differences in family members' alliances as compared to observer- and family members' self-reports (Chapter 4), indicate therapists' abilities to detect discrepancies between their alliances with different family members. This is an important starting point for another systemic aspect of alliances in family treatment: balancing different family members' alliances over the course of treatment.

Directions for Future Research

Is It Really the Alliance? Causality Considerations

Although several methodological features strengthen the interpretability of the research findings of this dissertation (e.g., the use of multi-level models, multiple informants, and multiple time points), it is important to note that the study design does not provide evidence for a causal relation between the alliance and treatment outcome. One reason for this is that the presented studies only provided data on end-of-treatment (meta-analysis in Chapter 2) or follow up (Chapters 2 and 5) measures of outcome. This raises the question whether a strong alliance predicts more problem improvement, or rather, a stronger alliance is an effect of problem improvement during treatment (Crits-

Christoph et al., 2006; Kazdin & Nock, 2003; Zilcha-Mano et al., 2016). Addressing this issue of reversed causality requires the use of early treatment improvement measures and specific methodologies to investigate the reciprocal effect between alliance and problem improvement (e.g., by means of autoregressive cross lagged modeling; Glebova et al., 2011; Zilcha-Mano et al., 2014). Findings of a recent meta-analysis on this emerging body of research on individual adult psychotherapy indicates that alliance and symptom change indeed affect one another over the course of treatment (Flückiger et al., 2020). The review furthermore indicates the temporal precedence of a stronger alliance on symptom improvement, providing stronger indications for a possible causal effect of alliance on treatment gain (Flückiger et al., 2020). However, in family treatment, systemic alliance aspects particularly raise questions on reversed causality: congruence in family members' attitudes toward treatment and the therapist (reflected in balanced alliances) and a within-family collaboration on shared goals may par excellence be early family treatment gains rather than predictors of eventual treatment outcome. Further research investigating this premise is warranted to disentangle the alliance-improvement cycle in systemic family treatment.

Another limitation concerning causality is that alliance was examined as an isolated process factor. In reality, a successful therapeutic process of course entails many factors likely to mutually affect one another and to reciprocally affect treatment outcome (Liber, 2020). Examples include expectancies of treatment (Sprenkle & Blow, 2004), therapists' theoretic orientation or adherence to a specific model (Karver et al., 2008; Lange et al., 2017), family empowerment (Hoagwood, 2005), and the use of specific therapeutic techniques (Chen et al., 2020; Liber, 2020; Weinberger, 2014). The relatively small effect size of the meta-analysis in Chapter 2 underscores the importance of a more integrative approach in future research, investigating the reciprocal effect of alliance and other factors over the course of treatment. This kind of research helps answering the important question of what causes desirable family treatment outcomes, and adds to our knowledge on key factors that should be addressed to improve effectiveness of (home-based) family treatment.

What Works for Whom? Diversity Considerations

An important strength of this dissertation is that the research was conducted in a naturalistic clinically representative context. The use of observations as well as the focus on therapists' contributions enhances the translation of research findings into recommendations for clinical practice. Nevertheless, this dissertation does not answer the question *when* and *for whom specifically* alliance building behaviors contribute to better alliances, and ultimately to better treatment outcomes. To answer this question, future research could benefit from studying interaction effects between client and

therapist behaviors and characteristics on outcome (e.g., Friedlander et al., 2008a; Muñiz de la Peña et al., 2012), in order to guide providers of family treatment in how to effectively attune their behaviors to family members' unique behaviors and characteristics.

It is also important to note several sample limitations that may hinder the generalizability of results. These limitations indicate the importance of further research on several client characteristics in relation to the alliance in order to well serve the diverse population of families receiving HBFT. First, data on therapists' cultural background was lacking, and the study sample included only 4 families with parents from a non-western foreign country (5%), whereas approximately 15% of families receiving home-based family treatment in the Netherlands have a non-western cultural background (CBS, 2021). Although the meta-analysis in Chapter 2 did not indicate that the association between alliance and treatment outcome differs between different cultural groups, the body of reviewed studies reveals that cultural background is an under-researched topic in studies on alliance. Notably, a handful of prior qualitative studies in adult psychotherapy does indicate that cultural background may indeed be a relevant factor that affects the process of building alliances during treatment (Asnaani & Hofmann, 2012; Lee et al., 2019; Schonfeld-Ringel, 2001; Vasquez, 2007).

A second limitation of the sample is the underrepresentation of families receiving mandated care ($n = 3$). In the meta-analysis in Chapter 2, the effect of alliance on treatment outcome was significantly stronger for families receiving voluntary treatment than for mandated families, but only few included studies actually identified referral status of the sample. In a recent study on predictors of alliance in home-based family treatment in the Netherlands, 17% of the families included in the sample received court-mandated treatment, and referral status was not related to both therapist- and parent-reported strength of the alliance (De Greef et al., 2018b). However, a series of studies investigating a Spanish sample of families receiving family therapy showed that alliances with mandated families at the start of treatment were more problematic and did require specific alliance building behaviors of the therapist, but a larger evidence base is still lacking (Sotero et al., 2016; 2017; 2018).

A final sample limitation is that a rather small number of fathers and male therapists was included. The underrepresentation of fathers and male therapists is a common phenomenon in family treatment studies (e.g., De Greef et al., 2018a/b; Escudero et al., 2021; Friedlander et al., 2019), and seems rather representative of clinical practice. However, this given is in striking contrast with findings of several studies convincingly indicating the importance of father involvement on child development and well-being (Flouri & Buchanan, 2003; Lundahl et al., 2008; Wilson & Prior, 2011). Additionally, findings of this dissertation – in line with other studies – indicate a significant effect of gender

both on the process of alliance over the course of treatment (Chapter 4; Bhati, 2014), as well as its relation to treatment outcome (meta-analysis on alliance change and outcome in Chapter 2; Friedlander et al., 2019; Johnson et al., 2002). Given the fact that in many cases ideally both genders are present in systemic family treatment, more knowledge on gender-specific aspects of the alliance is warranted.

Working on Multiple Alliances: Systemic Considerations

Another important strength of this dissertation, is that it was – to my knowledge – the first to investigate systemic aspects of the alliance in the field of HBFT, providing more knowledge on the complexity of building multiple interacting alliances both with and within the family system. These findings add to a relatively small, but emerging body of research on systemic aspects of the alliance in family treatment, and warrant further research for several reasons. First, the sample of families providing sufficient data to investigate the association between systemic aspects of the alliance and treatment outcome was small (Chapter 5), resulting in limited statistical power and hindering the use of preferred methods to investigate the effect of unbalanced alliances (e.g., polynomial regression; Bartle-Haring et al., 2012; Laird & De Los Reyes, 2013). Building on this explorative study, further investigation of the effect of unbalanced alliances and the family's shared sense of purpose on family treatment outcome is important, and may benefit from studying larger samples with a multi-informant perspective on the family's shared sense of purpose.

Second, in the study on therapist contributions to the alliance (Chapter 3), therapists' contributions to the family's shared sense of purpose were excluded from the analyses: therapists' scarce observed investment in SSP complicated the establishment of sufficient interrater reliability for this measure. Given previous studies' indications of the importance of systemic alliance aspects, such as family members' sense of safety and their shared sense purpose (Friedlander et al., 2018), the finding that therapists scarcely invest in these systemic aspects of the alliance raises the question for future research on how therapists can be trained and supervised effectively in using skills to enhance alliances in systemic treatment. Third, although the current dissertation did measure therapists' safety contributions, it lacks a reliable measure of family members' sense of safety within the treatment context. The importance of family members experiencing the conjoint treatment context as a safe environment is indicated by two previous studies (Friedlander et al., 2008b; Sotero et al., 2018), and may perhaps be of extra importance in home-based family treatment, as the therapist 'invades' the family's home environment. However, no studies on alliance including family members' sense of safety in the context of home-based family treatment – to my knowledge – have been carried out so far, indicating an important direction for future research.

Finally, a very small number of youth with self- and observer-reports on the alliance was included. A promising direction to further investigate children's and adolescent's perspectives on their alliance with the therapist in the context of systemic family treatment, is the use of video-stimulated recall interviews (SRI's; e.g. Morgan, 2007; Van Mourik et al., 2018). SRI's allow children and adolescents to watch their actual, video-taped interaction with the therapist and other family members during a session. Based on their own specific observations, they then may answer questions, for example, on what helps and hinders their active involvement and bonding in treatment. Therapists' and parents' perspectives on effectively building alliances with youth in family treatment can be investigated using the same strategy. Moreover, the use of SRI's may be highly beneficial to research on the broader process of building alliances in systemic family treatment, for example, when investigating the occurrence of problematic unbalanced alliances and therapist behaviors either contributing to or impairing this unbalance.

Practical Implications

Findings presented in this dissertation translate into several recommendations to enhance (home-based) treatment of families with complex child and parenting problems. First, on the level of clinical practice, it should be noted that findings in this dissertation indicate that providers of home-based family treatment do a fairly good job in building strong alliances with individual family members (especially parents), by actively engaging them in the treatment process and connecting with them on an emotional level. This is important, as it increases the odds of positive treatment outcome, regardless of the treatment model. However, it is also important to realize that building multiple interacting alliances with the family is complex: the strength of the alliance is likely to differ between family members, building strong alliances with youth in family treatment seems particularly challenging, and promoting a shared sense of purpose within the family seems important but is often overlooked. Monitoring alliances both with and within the family may prove helpful in detecting and repairing problematic alliances as well as in balancing different family members' alliances over the course of treatment, for example by using video-observations and asking family members' feedback. Asking feedback on the alliance has shown to be effective in several settings (e.g., Mihalo & Valenti, 2018; Van Hennik, 2020; Zilcha-Mano & Errazuriz, 2015), and good examples of using a feedback form that is accommodated both to the systemic context of family treatment and the specific needs of youth are emerging (e.g., Rober et al., 2020; Rober, 2017).

Second, in training and supervision of (future) providers of family treatment, knowledge on the importance of the alliance and a focus on alliance building skills should be a standard element. Findings of this dissertation indicate that training and supervision may be more effective when it attends to trainees' personality profiles. That is, increasing self-awareness and monitoring of the way therapists' neurotic, extraverted, or conscientious tendencies become too manifest in in-session interactions, is likely to benefit their abilities to build strong alliances with family members. Another important recommendation to promote training effectiveness, is the use of video-feedback (Eubanks et al., 2015), preferably accompanied by a structured evaluation form to help participants focus on specific behaviors that promote strong alliances (Fukkink et al., 2011). More specifically, using the System for Observing Family Therapy Alliances (SOFTA-o; Friedlander et al., 2006), also used in this dissertation, is likely to increase trainees' conceptual, observational, and executive skills related to the alliance (Carpenter et al., 2008; Escudero et al., 2011). An important benefit of the SOFTA-o is its design, specifically for the context of systemic family treatment, providing the ability of training participants to promote systemic aspects of the alliance (i.e., family members' sense of safety and shared purpose in treatment). The finding that providers of family treatment were observed to barely invest in these systemic alliance aspects (Chapter 3), underlines the need for a systemic focus on the alliance in training and supervision.

Third, for policy makers and youth care organizations with a strong preference for home-based family treatment as a service for families dealing with a variety of problems, it is important to realize that building strong alliances with families in care is important as well as complex. Organizational and policy making effort to promote a context in which strong alliances with families are highly valued, and monitoring and reflecting on alliances is both facilitated and part of 'practice as usual' can guide providers of family treatment in enhancing treatment outcomes by actively addressing the alliance (Jensen-Doss et al. 2018; Miller et al., 2005; Miller et al., 2018).

Finally, for families receiving treatment to overcome child and parenting problems, it is important to know that experiencing a positive working relationship with the therapist helps to benefit from treatment. Although being in treatment together as a family may at times cause feelings of discomfort and tension, investing in a strong bond and collaboration on shared family goals may prove helpful in reducing child problems. A constructive way to influence the working relationship is to provide feedback on how the therapist engages different family members in the treatment process, connects with them on an emotional level and promotes the family's collaboration on shared goals. Additionally, participating in video-observations of treatment sessions helps the therapist in reflecting and receiving direct feedback on her skills in building strong working alliances with the family.

Final Conclusions

The current dissertation underlines both the importance and complexity of building strong working alliances with families receiving (home-based) treatment for complex child and parenting problems. It indicates that clinical practice as well as education and training of providers of (home-based) family treatment may benefit from a focus on actively engaging family members in the treatment process and investing in strong emotional bonds. The findings of this dissertation underscore the importance of a more systemic perspective on the working alliance to do justice to the complexity of systemic (home-based) family treatment. This includes addressing the process of building multiple interacting alliances with different family members, engaging children and adolescents in a conjoint treatment process with parents, and promoting the family's collaboration on shared goals. Future research on the process and effect of these systemic alliance aspects is warranted to build a stronger evidence base. Ultimately, a systemic research perspective on working alliances in family treatment may guide family treatment providers in their efforts to well serve a variety of families striving to overcome complex child and parenting problems.



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Summary

Background

Home-based family treatment (HBFT) is the most provided service in youth care, serving a heterogeneous group of families with complex child and parenting problems. Given the fact that empirical evidence indicates varying outcomes of HBFT, it is important to examine factors that may contribute to desirable outcomes. The current dissertation aimed at investigating such an important factor: the working alliance. The central dissertation aim was to investigate alliance processes in (home-based) family treatment and their relation to treatment outcome, paying particular attention to the therapists' role and to the systemic complexity of building multiple interacting alliances with as well as within the family by system. To meet the central research aim, I performed a meta-analytic review of previous studies on the alliance-outcome association in family-involved treatment for youth problems, and collected longitudinal multi-informant questionnaire and observational data on alliances and treatment outcome in a Dutch HBFT for youth problems (*Intensieve Pedagogische Thuis hulp, IPT*).

Results

To gain a better understanding of the importance of the alliance in family-involved treatment, **Chapter 2** presents a meta-analytical review of 28 studies reporting on the alliance-outcome association ($N = 2126$ families). The quality of the alliance was significantly associated with more positive treatment outcomes in terms of youth symptom severity or functioning, parental or family functioning, retention, goal attainment or therapeutic progress. Correlations were significantly stronger when alliance scores of different measurement moments were averaged or added, when families were help-seeking rather than receiving mandated care, and when studies included younger children. The association between alliance improvement and treatment outcome was somewhat larger but just failed to reach significance, and there was no significant association between family members' unbalanced or *split* alliances and treatment outcome. However, this may be due to the relatively small number of included studies reporting on alliance change scores or split alliances. Findings demonstrate that alliance plays a significant role in the effectiveness of family-involved treatment, especially in non-mandated care and with families of younger adolescent children. It also underlines the importance of a process-oriented approach to the alliance with multiple measurement moments during treatment. Future research should focus on investigating the more complex systemic aspects of alliance to gain fuller understanding of the dynamic role of alliance in working with families.

Given the therapists' vital role in building strong alliances, the next step in **Chapter 3** was to investigate the predictive value of therapists' personality, years of clinical experience and observed alliance building behaviors for mid-treatment alliance as reported by therapists and family members ($N = 57$ families). Therapist *openness to experience* and *agreeableness* as well as therapists' in-session *engagement* and *emotional connection* behaviors predicted more positive therapist and family member reports of the alliance. Therapist *neuroticism*, *extraversion* and *conscientiousness* predicted more negative alliance-reports. In-session *safety* behaviors also predicted more negative alliance-reports, but this finding was only significant for therapists' and not family members' reports of the alliance. Therapists' clinical experience did not predict the quality of alliances.

Chapter 4 focused on the occurrence and development of discrepancies between alliances of different family members, and the therapists' evaluation of multiple alliances and discrepancies. Family members, therapists, and observers reported early and mid-treatment alliance ($N = 61$ families). The study showed significant discrepancies, with strongest alliances for mothers, followed by fathers, and then youths. These alliance discrepancies became smaller during treatment. Therapist-reports yielded similar discrepancies as compared to client self-reports and observer-reports. In the starting phase of treatment, the correlation between therapist- and client self-reports was moderate and significant for alliances with mothers, but non-significant for alliances with fathers and youths. Two months later, these correlations were large for alliances with mothers and fathers, but not for youths.

Chapter 5 presented results of an explorative study on the association between (a₁) family members' unbalanced alliances (alliance differences), (a₂) the within-family alliance or *shared sense of purpose* (SSP), and (b) youth behavior problems 18 months after ending HBFT. Considering the small sample size ($N = 29$ families) and limited statistical power, the study also reported trend-significant and substantial non-significant correlations that might be of theoretical importance. A greater imbalance in observed early-treatment alliances was associated with less externalizing and total youth behavior problems at follow up. Over the course of treatment this association changed to the opposite direction: at mid-treatment a greater imbalance was associated with more externalizing and total youth problems, although the association was small and not significant. One conclusion was that perhaps the process of balancing family members' differing alliances during treatment, rather than the lack of difference in alliances itself, may contribute to improvement of children's behavior problems. Furthermore, higher levels of mid-treatment shared sense of purpose were moderately, but not significantly associated with the decrease of youth internalizing behavior problems 18 months post-treatment. This indicates that a stronger shared sense of purpose within the family at mid-treatment may have a clinical significance in reducing internalizing child behavior problems that warrants further exploration.


Conclusions

Study findings presented in this dissertation underline both the importance and complexity of building strong working alliances with families receiving (home-based) treatment for complex child and parenting problems. Taken together, findings also underscore the relevance of a systemic perspective on the working alliance in (home-based) family treatment both in research and clinical practice. This systemic perspective includes addressing the process of building multiple interacting alliances with different family members, engaging children and adolescents in a conjoint treatment process with parents, and promoting the family's collaboration on shared goals.

Important next steps in research on alliance in family treatment include studying larger and more diverse samples to provide a stronger evidence base, enhance generalizability, and enable more sophisticated methods to study the effect of systemic alliance aspects on treatment outcome. Furthermore, research on the process of alliance aspects typical of systemic family treatment could benefit from a qualitative multi-informant approach (e.g. the use of Stimulated Recall Interviews), for example to investigate therapists' contributions to alliances with youth in conjoint treatment sessions and the occurrence and repair of problematic disbalances in family members' alliances. Finally, applying a more integrative research approach including multiple process factors as well as early treatment gain measures may enhance our understanding of how and when which key factors in the treatment process should be addressed to promote positive outcomes of home-based family treatment.

Clinical practice as well as training and education of (future) providers of family treatment may benefit from addressing the working alliance by focusing on therapists' alliance building behaviors, for example by the use of video feedback, and from attending to the influence of personality traits on building alliances with the family. Findings in this dissertation indicate that in every-day practice, the importance of systemic alliance aspects such as promoting family members' collaboration on shared goals is often overlooked. However, systemic awareness and skills in building multiple interacting alliances both with and within the family is likely to increase effectiveness of (home-based) family treatment, serving the interests of families who rely on this key service to overcome complex child and parenting problems.





Samenvatting

(Summary in Dutch)

Achtergrond

Ambulante gezinsbehandeling is de meest ingezette vorm van jeugdhulp en richt zich op de ondersteuning van een diverse groep gezinnen met complexe gedrags- en opvoedingsproblemen. Eerder onderzoek laat zien dat de resultaten van ambulante gezinsbehandeling sterk variëren, daarom is het belangrijk om te onderzoeken welke factoren bijdragen aan positieve behandeluitkomsten. Dit proefschrift richt zich op zo'n belangrijke factor: de alliantie of werkrelatie tussen de gezinsbehandelaar en het gezin. Het centrale doel was om alliantie-processen binnen (ambulante) gezinsbehandeling en hun samenhang met uitkomsten van de hulp te onderzoeken. Daarbij was het doel ook om specifieke aandacht te hebben voor de bijdrage van de gezinsbehandelaar en voor de complexiteit van het werken aan meerdere allianties met verschillende gezinsleden, die eigen is aan behandelvormen gericht op het gezinssysteem. Om dat doel te bereiken is (1) een meta-analyse uitgevoerd van eerdere studies naar de samenhang tussen de alliantie en uitkomsten van gezinsgerichte jeugdhulp en (2) data verzameld over de alliantie en resultaten van de hulp bij gezinnen die een vorm van Intensieve Pedagogische Thuishulp (IPT) ontvingen, met behulp van vragenlijsten en video-observaties van hulpverleningsgesprekken.

Bevindingen

Om een beter beeld te krijgen van bestaande kennis over het belang van de alliantie in gezinsbehandeling opent dit proefschrift (**Hoofdstuk 2**) met een meta-analyse van 28 studies die rapporteren over de samenhang tussen alliantie en uitkomsten van gezinsgerichte hulp voor kinderen en jongeren met psychosociale problemen en hun ouders ($N = 2126$ gezinnen). De kwaliteit van de alliantie bleek significant samen te hangen met een positiever behandelresultaat. Deze samenhang was sterker als er een gemiddelde van verschillende meetmomenten van de alliantie werd gebruikt, wanneer gezinnen hulp ontvingen in een vrijwillig in plaats van gedwongen kader, en wanneer kinderen relatief jonger waren. De samenhang tussen verbetering van de alliantie gedurende het behandeltraject en uitkomsten van de hulp was groter, maar net niet significant. Verder was er geen significante samenhang tussen alliantie-verschillen binnen het gezin (d.w.z. verschillen tussen gezinsleden in de sterkte van de alliantie met de gezinsbehandelaar) en behandelresultaten. Er waren echter maar weinig studies beschikbaar die resultaten rapporteerden over verbetering van de alliantie tijdens het behandeltraject of over alliantie-verschillen tussen gezinsleden en de samenhang met uitkomsten van de behandeling. Uitkomsten van deze studie laten zien dat de alliantie een significante rol speelt in de effectiviteit van gezinsgerichte vormen van jeugdhulp,

met name binnen vrijwillig geboden hulp en in de hulp aan gezinnen met relatief jongere kinderen. De resultaten onderstrepen het belang van een procesmatige benadering van de alliantie met meerdere meetmomenten tijdens het behandeltraject. Vervolgonderzoek is nodig om meer zicht te krijgen op de complexe systemische aspecten van de alliantie in het werken met meerdere gezinsleden.

Vanwege de belangrijke rol van de gezinsbehandelaar in het werken aan een sterke alliantie, stond in **Hoofdstuk 3** de bijdrage van de gezinsbehandelaar centraal. Ik onderzocht de samenhang tussen persoonlijkheid, aantal jaren werkervaring en geobserveerd gedrag van de gezinsbehandelaar enerzijds en de alliantie zoals ervaren door gezinsleden anderzijds ($N = 57$ gezinnen). Wat betreft persoonlijkheid liet deze studie zien dat de mate van openheid voor nieuwe ervaringen en altruïsme van de gezinsbehandelaar een sterkere alliantie voorspelden zoals ervaren door gezinsleden en de gezinsbehandelaar zelf. De mate van neuroticisme, consciëntieusheid en extraversie van de gezinsbehandelaar voorspelden minder sterke allianties. Wanneer de gezinsbehandelaar in de geobserveerde sessie gezinsleden actief betrok in het behandelproces en werkte aan een emotionele band met de gezinsleden, beoordeelden zowel gezinsleden als gezinsbehandelaar de alliantie als positiever. Wanneer de gezinsbehandelaar in de geobserveerde sessie werkte aan de ervaren veiligheid in de behandelcontext, beoordeelde zij zelf na afloop allianties met gezinsleden als minder sterk. Het aantal jaren werkervaring van de gezinsbehandelaar bleek niet van invloed te zijn op de alliantie.

In **Hoofdstuk 4** onderzocht ik de sterkte en ontwikkeling van alliantie-verschillen tussen gezinsleden, en de beoordeling van de gezinsbehandelaar van die verschillende allianties met gezinsleden ($N = 61$ gezinnen). De resultaten uit deze studie lieten zien dat er significante verschillen waren tussen gezinsleden in de sterkte van de alliantie: gezinsbehandelaren hadden de sterkste alliantie met moeders, gevolgd door vaders en de minst sterke allianties met kinderen en jongeren. Deze verschillen werden kleiner gedurende het behandeltraject. Verschillende informanten (gezinsbehandelaren, gezinsleden en observatoren) rapporteerden over het geheel genomen vergelijkbare alliantie-verschillen tussen gezinsleden. De afzonderlijke beoordelingen door gezinsbehandelaren en moeders van hun werkrelatie hadden in de beginfase van de hulp een matige overeenkomst en 2 maanden later een sterke overeenkomst. Bij vaders ontbrak deze overeenstemming over de werkrelatie in de beginfase van de hulp, maar 2 maanden later kwamen de beoordelingen van gezinsbehandelaren en vaders wel sterk overeen. De afzonderlijke beoordelingen van gezinsbehandelaren en jeugdigen over hun werkrelatie kwamen op beide meetmomenten niet overeen, hierbij moet wel genoemd worden dat er maar weinig zelfrapportages van de alliantie door jeugdigen beschikbaar waren.

In **Hoofdstuk 5** presenteerde ik de resultaten van een exploratieve studie naar het verband tussen (a_1) verschillen tussen gezinsleden in hun afzonderlijke alliantie met de gezinsbehandelaar, (a_2) de alliantie *tussen* gezinsleden, ook wel *gezamenlijke doelperceptie* genoemd, en (b) gedragsproblemen van het geïndiceerde kind 18 maanden na afsluiten van de hulp. De steekproef bestond uit 29 gezinnen, vanwege de kleine steekproef met onvoldoende statistische power werden ook substantiële niet-significante correlaties die van theoretisch belang zouden kunnen zijn gerapporteerd. In deze studie hing een groter verschil tussen gezinsleden in de sterkte van hun geobserveerde alliantie met de gezinsbehandelaar in de beginfase van de hulp samen met minder gedragsproblemen na afloop van de hulp. Gedurende het traject veranderde deze samenhang: 2 maanden later gemeten hingen grotere alliantie-verschillen tussen gezinsleden juist samen met méér gedragsproblemen na afloop van de hulp, al ging het slechts om een klein en niet significant verband. Hier was de conclusie dat wellicht vooral het proces van balanceren van de verschillende werkrelaties tijdens het behandeltraject bijdraagt aan succesvolle hulp, meer dan de aanwezigheid van die verschillen zelf. Verder liet deze studie een matige, maar niet significante samenhang zien tussen een sterkere gezamenlijke doelperceptie binnen het gezin (de alliantie *tussen* gezinsleden) in de actieve veranderfase van de hulp en afname van internaliserende gedragsproblemen bij de jeugdige 18 maanden na afloop van de hulp. Hier was de conclusie dat een sterke gezamenlijke doelperceptie binnen het gezin mogelijk effect heeft op het verminderen van internaliserende gedragsproblemen, wat vraagt om verder onderzoek.

Conclusies

De bevindingen uit dit proefschrift laten zowel het belang als de complexiteit zien van het werken aan sterke allianties met gezinnen die (ambulante) gezinsbehandeling ontvangen vanwege complexe opgroei- en opvoedproblemen. De onderzoeksresultaten onderstrepen ook de relevantie van een systemische benadering van de alliantie in de (ambulante) gezinsbehandeling, zowel voor onderzoek als voor de praktijk. Deze systemische benadering omvat het proces van werken aan meerdere allianties met verschillende gezinsleden tegelijkertijd, het betrekken van kinderen en jongeren in een gezamenlijk behandelproces met ouders en het stimuleren van de samenwerking tussen gezinsleden aan gezamenlijke doelen.

Een belangrijke vervolgstap voor onderzoek naar de alliantie in de context van ambulante gezinsbehandeling is het gebruik van grotere, meer diverse steekproeven van gezinnen om de generaliseerbaarheid van resultaten te versterken. Dit biedt ook de mogelijkheid tot meer geavanceerde data-analyses van systemische aspecten van de alliantie, zoals

het effect van de werkrelatie *tussen* gezinsleden en alliantie-verschillen binnen het gezin. Verder kan een meer kwalitatieve benadering vanuit verschillende perspectieven (bijvoorbeeld met Stimulated Recall Interviews) bijdragen aan beter begrip van alliantie-processen in de context van systemische gezinsbehandeling. Belangrijke thema's voor zulk onderzoek zijn de bijdrage van de gezinsbehandelaar aan werkrelaties met jongeren in een gezamenlijke behandelcontext met ouders en het ontstaan en verhelpen van problematische alliantie-verschillen tussen gezinsleden. Tot slot kan onderzoek met een meer integratieve benadering van verschillende werkzame factoren en de interactie met behandel-effect al tijdens het traject bijdragen aan kennis over welke factoren op welke momenten in het behandelproces belangrijk zijn in het realiseren van effectieve ambulante gezinsbehandeling.

In de hulpverleningspraktijk en in opleiding en training van (toekomstig) gezinshulpverleners is het belangrijk om aandacht te hebben voor het werken aan sterke allianties door te focussen op concreet gedrag van gezinshulpverleners, bijvoorbeeld met behulp van video-feedback. Daarbij kan het helpend zijn om aandacht te hebben voor de invloed van persoonlijkheid van de gezinshulpverlener op de alliantie. Verder laten bevindingen in dit proefschrift zien dat het belang van systemische aspecten van de alliantie, zoals het werken aan een sterke werkrelatie *tussen* gezinsleden, in de dagelijkse praktijk vaak over het hoofd wordt gezien. Meer bewustwording van dit belang en meer aandacht voor vaardigheden in het werken aan meervoudige allianties met en tussen gezinsleden kan een belangrijke bijdrage leveren aan effectievere hulp voor gezinnen die afhankelijk zijn van (ambulante) gezinsbehandeling vanwege complexe opgroei- en opvoedproblemen.



About the author

About the author



Marianne Welmers – van de Poll was born on February 23 1985 in Hoogeveen, the Netherlands. After completing her secondary education (Gymnasium, Carolus Clusius College Zwolle) she spent a gap year as a resident volunteer attending to young adults with cerebral palsy at Beit Tamar (Ilan Foundation) in Jerusalem, Israel. In 2004 she started her studies in Pedagogical and Educational Sciences at Rijksuniversiteit Groningen. After obtaining her bachelor's degree in 2007, she started the clinical master program in Educational Sciences (*Orthopedagogiek*). During her master program she participated as a research assistant in a longitudinal research project on successful treatment for adolescents in secure residential care.

Based on these research activities, she wrote her masters' thesis on involving families in secure residential care of adolescents. She finished her clinical internship at *De Reeve* (later: *Vitree*), a specialized youth care organization for children and adolescents with Mild Intellectual Disabilities (MID). After graduating in 2009, she was employed as a remedial youth psychologist in residential care at *De Reeve*. In 2011 she became lecturer Social Work at Windesheim University of Applied Sciences, with teaching activities involving i.e. courses on the care for people with MID and multi-stressed families, training students and care workers in Motivational Interviewing, and supervising students' internships and research projects. In 2013, she joined the newly formed research group Control in Youth Care (later: research group Youth), and participated in several research projects on process and outcome of youth and family care. She started her PhD research on alliances in home-based family treatment in 2014 and was rewarded with a grant for teachers from the Dutch Research Council (NWO). Over the next years, her research activities resulted in several national and international publications and presentations and provided material for education and training of (future) social work professionals in the field of (home-based) youth and family treatment. Currently, Marianne continues her teaching in social work and research in the area of youth and family care at Windesheim University of Applied Sciences.



Publications

Publications

Publications in this dissertation

Welmers-van de Poll, M.J., Roest, J.J., Van der Stouwe, T.S., Van den Akker, A.L., Stams, G.J.J.S., Escudero, V., Overbeek, G.J. & De Swart, J.J.W. (2018) Alliance and Treatment Outcome in Family-Involved Treatment for Youth Problems: A Three-level Meta-Analysis. *Clinical Child and Family Psychology Review*, 21(2), 146-170. <https://doi.org/10.1007/s10567-017-0249-y>

Welmers-van de Poll, M.J., Stams, G.J.J.M., Van den Akker, A.L., & Overbeek, G. (2020). Alliance Discrepancies in Home-Based Family Treatment: Occurrence, Development, and the Therapist's Perspective. *Journal of Family Therapy*. <https://doi.org/10.1111/1467-6427.12309>

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Baecke, J., Welmers-van de Poll, M.J., & De Swart, J.J.W. (2015). Werken in trajecten bij jeugdhulp. *Jeugdbeleid*, 9, 1-8. <https://doi.org/10.1007/s12451-014-0067-x>

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