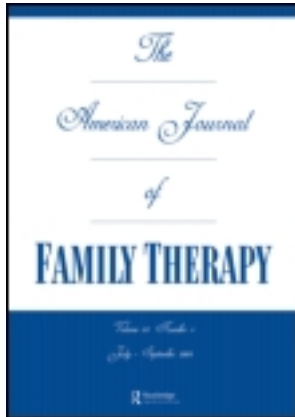


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Attachment and the Therapeutic Alliance in Family Therapy

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The therapeutic alliance has consistently predicted client outcomes in psychotherapy. This study uses attachment theory as a resource in understanding the therapeutic alliance. Participants in this study were 27 mothers, 15 fathers, and 23 adolescents that participated in family therapy. Results indicate that mothers' reports of trust in their oldest child predicted the alliance, and adolescent ratings of trust in mothers and fathers moderated the relationship between therapy alliance and symptom distress. Implications for family therapy research and practice are discussed.

INTRODUCTION

Research findings have consistently demonstrated that the therapeutic alliance predicts client outcome in psychotherapy. Two meta-analyses covering 103 total studies revealed consistent, moderate effect sizes between the working (therapeutic) alliance and clinical outcome (Horvath & Symonds,

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1991; Martin, Garske, & Davis, 2000). A third meta-analysis of 27 studies attributed treatment effectiveness to general factors such as the therapeutic alliance (Ahn & Wampold, 2001). Researchers investigating the alliance in family therapy settings also show that the relationship between alliance and outcome is consistent (Diamond, Diamond, & Liddle, 2000; Diamond, Liddle, Hogue, & Dakof, 1999; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Hampson & Beavers, 1996; Heatherington & Friedlander, 1990; Johnson, Wright, & Ketring, 2002; Rait, 2000; Robbins, Turner, Alexander, & Perez, 2003). Whereas these studies provide information on the predictive power of the alliance, there has been little advancement of alliance theory in family therapy since Pinsof and Catherall (1986) adapted Bordin's model (1979) to family therapy. To study seeks to further understand alliance theory in family therapy by using attachment theory.

According to attachment theory, early relationships with primary caregivers strongly influence humans' perception of their ability to receive love and competence as well as the dependability and trustworthiness of others (Bartholomew & Horowitz, 1991; Bowlby, 1988; Bowlby, 1980). Attachment theorists postulate that people with secure attachment tend to more easily engage in intimate relationships than people with anxious or fearful attachment. The pattern of attachment influencing relationships can also be applied to the formation of therapy alliances in that client's attachments influence the type of alliance they develop with their therapist. Regrettably, there is no research that seeks to establish a connection between attachment and the therapeutic alliance in family therapy. However, there is research from an individual therapy setting that shows this line of research would be helpful in family therapy.

A number of researchers have found clients' and therapists' ability to form beneficial alliances in individual therapy to be partly determined by attachment. Satterfield and Lyddon (1998) found a relationship between secure attachment and higher therapeutic alliance. Additionally, Mallinckrodt, Coble, and Gantt (1995) found that memories of emotional responsiveness, warmth, and intrusive parent behavior accounted for 23% of the variance in therapy alliance ratings. There is also evidence that attachment can influence the course of alliance development (Sauer, Lopez, & Gormley, 2003).

Currently, the effect of attachment on the therapeutic alliance in family therapy is not known. It is expected that the attachment is related to alliance development. However, there are some key differences between family and individual therapy, one of which is multiple family members simultaneously participating in therapy. This aspect of family therapy makes this research even more important. If family member's attachment is determined by prior relationships then in a family therapy setting the individuals who help contribute to their attachment style are in the room with them, which could exacerbate the influence of attachment on alliance development. This study seeks to discover the relationship between attachment and alliance in a

family therapy setting by answering the following questions: (1) Are mothers,' fathers,' and adolescents' report of pre-treatment parent-child attachment related to their report of therapeutic alliance in family therapy? (2) Are mothers,' fathers,' and adolescents' report of attachment predictive of therapeutic alliance in family therapy? and (3) Are mothers,' fathers,' and adolescents' perception of pre-treatment attachment a moderator of the relationship between alliance and post-treatment symptom distress?

METHOD

Participants

Participants for this study included mothers ($n = 27$), fathers ($n = 15$), and adolescents ($n = 23$) representing 32 families referred by the state social service agency for home-based family therapy. Families were recruited from 1999 to 2000 and lived primarily in rural communities in a Midwestern state. The average age of mothers was ($M = 34.3$), fathers was ($M = 37.1$), and adolescents had just entered their teenage years ($M = 14.3$). More than half of the parents were married (61%). Seventy-two percent of participants were Caucasian, and about 67% reported incomes of less than \$30,000 per year. Participation in family therapy was not mandatory and while many of the families had been reported to the state social service agency for child abuse and neglect issues, many of the reports were not substantiated and presenting problems were similar to many families participating in family therapy. Clients and the referring agency reported a wide variety of presenting problems including physical abuse and neglect, parenting problems, truancy, and other problems.

Participating therapists were from three different agencies. Two agencies were community social service agencies. Therapists from these two agencies were licensed mental health professionals. The other agency was a university training clinic where participating therapists were students in marriage and family therapy. Therapists from the university-based agency worked together in cotherapy teams with one therapist acting as primary therapist and the other performing case-manager duties (i.e., coordinating community services). All primary therapists were doctoral students who had previously completed master's degrees in mental health-related fields. When cotherapy teams were used, alliance scores from the primary therapist were used in data analysis.

Measures

The Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986) is a self-report questionnaire to assess client's perceptions of the therapeutic relationship. The FTAS has three subscales (tasks, goals, and bonds), which can be summed to create a total score. The FTAS has 29 items, rated on a

7-point *Likert*-type scale with responses ranging from completely agree to completely disagree with higher scores indicating better alliances. Fifteen items are reverse scored. The authors report test-retest reliability for the total alliance ($r = .83$), and Heatherington and Friedlander (1990) report internal consistencies for the bonds $\alpha = .81$, goals $\alpha = .80$, and tasks $\alpha = .90$ subscales. Others have found the FTAS to demonstrate predictive validity (Heatherington & Friedlander, 1990; Johnson et al., 2002). In the current study, internal consistency coefficients were $\alpha = .93$ for tasks, $\alpha = .86$ for goals, and $\alpha = .86$ for bonds.

The Outcome Questionnaire 45.2 (OQ-45.2); (Lambert et al., 1996) is a 45-item, self-report questionnaire scored on a 5-point *Likert*-type scale with responses ranging from “never” to “almost always” and higher scores indicated greater distress. Nine of the items are reverse scored. The OQ-45.2 has three subscales: symptom distress (anxiety and depression symptoms); interpersonal relations (conflict and feelings of inadequacy in relationships); and social role (dissatisfaction in roles at work, home, and leisure). Strong test-retest reliability has been demonstrated for the subscales ($r = .78$ for symptom distress, $r = .80$ for interpersonal relations, and $r = .82$ for social role), and internal consistency coefficients range from adequate ($\alpha = .70$ for social role, $\alpha = .74$ for interpersonal relationships) to high ($\alpha = .92$ for symptom distress). The authors also report moderate to strong convergent validity with related scales. For this study, only the SD subscale was used. This choice was based on previous research demonstrating that the other two subscales are highly correlated with the SD subscale and account for a large portion of the variance. Additionally, the SD subscale is the only subscale that has demonstrated construct validity (Umphress, Lambert, Smart, Barlow, & Clouse, 1997). Internal consistency for the symptom distress sub-scale for this sample was $\alpha = .92$.

The Inventory of Parent and Peer Attachment (IPPA) (Armsden & Greenberg, 1987) is a 25-item questionnaire that measures adolescent’s cognitive and affective attachment to their parents. Items are rated on a 5-point *Likert* type scale, with responses ranging from “almost never or never true” to “almost always or always true.” IPPA items were originally organized into the three subscales: trust (mutual understanding and respect), communication (extent and quality of communication), and alienation (feelings of isolation and alienation). Armsden and Greenberg (1987) reported high internal consistencies for the three subscales (with coefficients ranging from .86 to .91), an average test/re-test reliability of .93, and moderate to high convergent validity with related scales.

A confirmatory factor analysis by Johnson, Ketring, and Abshire (2003) demonstrated that adolescents from lower income families responded differently to the IPPA than the author’s original sample (Armsden & Greenberg, 1987). An exploratory factor analysis found evidence for two factors that corresponded closely to the constructs of trust and alienation (Johnson et al.,

2003). Reliability coefficients for these two factors were as follows: trust in mother $\alpha = .95$, alienation from mother $\alpha = .81$, trust in father $\alpha = .95$, and alienation from father $\alpha = .89$ (Johnson et al., 2003). In light of these findings and due to the similarity of participants in this study, the trust and alienation subscales were used. For the current study, IPPA reliability coefficients for trust and alienation factors were: trust in mother $\alpha = .94$, alienation from mother $\alpha = .73$, trust in father $\alpha = .96$, and alienation from father $\alpha = .81$.

The Revised Inventory of Parent Attachment (R-IPA) (Johnson, Ketring, & Abshire, 2003) is a revised version of the IPPA (Armsden & Greenberg, 1987). With permission from IPPA authors, Johnson and colleagues re-worded questions from the IPPA so that parents could rate the quality of their attachment relationship to their children. Like the IPPA, the R-IPA uses *Likert*-type scales. However, the R-IPA contains five items not found in the IPPA, leading to a total of 30 items. Johnson et al. added these five items to the R-IPA to address issues salient to parents as well as to increase face-validity.

Using an exploratory factor analysis, Johnson and colleagues (2003) discovered a two-factor attachment structure for the R-IPA where one factor closely corresponded to trust/avoidance and the other factor corresponded to communication. Johnson and colleagues found moderate to high internal consistency coefficients for these two factors (trust/avoidance $\alpha = .91$ and communication $\alpha = .72$). Additionally, convergent validity analyses revealed that trust/avoidance subscale correlated significantly with outside measures related to attachment, whereas the communication factor did not. Reliability coefficients found in the present sample were trust/avoidance $\alpha = .76$ and communication $\alpha = .84$.

Procedures

The state social service agency referred families to one of three agencies based on the geographical location of the family. Therapists at these agencies were required to initiate services within 36 hours. Consent forms were explained by the therapists and family members over the age of 12 signed the form. Participants completed the R-IPA (for parents), IPPA (for adolescents), and OQ-45.2 (for both parents and adolescents). Treatment followed an ecosystemic approach (Johnson & Ketring, 2000), designed to facilitate individual development, improve family patterns, and increase the family's interaction with community resources. No attempts were made to assess treatment compliance. The frequency of sessions was determined by the family's needs. In most cases, families participated in two sessions per week for 6 to 8 weeks and decreased to once a week as they improved. At the conclusion of therapy, participants completed the R-IPA or IPPA, the OQ45.2, and the FTAS.

Since this study was conducted with participation from community agencies there were no specific inclusion criteria, other than referral for family

therapy. This partially accounts for the discrepancy in the number of mothers, fathers, and adolescents participating. For example, some of the families were headed by single mothers with no adolescent children, thus in this situation only the mother was above the age of 12 and she was the only person who would have completed questionnaires.

Analyses

As in all clinical studies, attrition was an issue in this study. Fifty five percent of mothers dropped out of the study, while 58% of fathers and 39% of adolescents dropped out of the study. Based on Miller and Wright's (1995) recommendation, an attrition analyses showed that mothers who remained in the study and those who dropped out differed significantly by pre-treatment symptom distress scores ($t(65.82) = 2.15, p < .05$ —equal variances were not assumed); but not by age, communication or trust. Additional analyses show that fathers and adolescents who remained in the study do not significantly differ in age, level of symptom distress, or level of respective attachment variables. Results further show that there was not a significant association between dropping out of the study and family-income ($\chi^2(7) = 9.25, ns$) or race ($\chi^2(5) = 5.47, ns$).

This study used the definition that a moderator is “a variable that alters the direction or strength of the relation between a predictor and an outcome” (Frazier, Barron, & Tix, 2004, p. 116). To determine whether attachment acted as a moderator on alliance and outcome, this study used hierarchical regression and followed the approach recommended by Holmbeck (2003) and Baron and Kenny (1986). This also allowed controlling for the level of symptom distress at intake.

RESULTS

Question 1: Are Mothers,' Fathers' and Adolescents' Report of Pre-Treatment Parent-Child Attachment Related to Their Report of Therapeutic Alliance in Family Therapy?

Correlation analysis showed that mothers' report of attachment to their oldest child was related to mother's therapeutic alliance (see Table 1 for parents, and Table 2 for adolescents). All three FTAS subscales (tasks, goals, and bonds) demonstrated moderate, significant correlations with the R-IPA trust subscale. The only nonsignificant correlation for mothers was mother's reports of communication related to tasks. In contrast, the relationship between attachment and alliance for fathers and adolescents failed to demonstrate significance. Despite the nonsignificance all correlations were in the expected direction. Also, father's reports of communication with their oldest child were moderately correlated with the alliance subscales and adolescents' reports

TABLE 1 Correlation Matrix of Mother-and Father-Reported Attachment and Family Therapy Alliance Subscales

Subscale	1	2	3	4	5
(Mothers rating adolescents; $n = 26$)					
1. Mother-Communication	—	.43*	.38	.39*	.40*
2. Mother-Trust		—	.47*	.55**	.52**
3. Tasks			—	.84**	.92**
4. Goals				—	.83**
5. Bonds					—
(fathers rating adolescents; $n = 14$)					
1. Father-Communication	—	.82**	.28	.30	.32
2. Father-Trust		—	.04	.07	.10
3. Tasks			—	.95**	.95**
4. Goals				—	.97**
5. Bonds					—

* $p < .05$; ** $p < .01$.

of trust with their parents moderately correlated with the bonds subscale. These correlations would likely be significant with a larger sample. Similar to other studies, the subscales of the alliance were highly correlated for all participants.

Question 2: Are Mothers', Fathers' and Adolescents' Report of Attachment Predictive of Therapeutic Alliance in Family Therapy?

Regression analyses were used to determine if mothers' ratings of attachment with their oldest child, fathers' ratings of attachment with their oldest child, and adolescents' rating of attachment with their parents are predictive of their therapy alliance scores. Results showed that aspects of mothers' attachment

TABLE 2 Correlation Matrix of Adolescent-Reported Attachment and Family Therapy Alliance Subscales

Subscale	1	2	3	4	5
(Adolescents rating mothers; $n = 21$)					
1. Mother-Trust	—	-.54*	.03	.05	.36
2. Mother-Alienation		—	-.06	-.14	-.37
3. Tasks			—	.86**	.76**
4. Goals				—	.80**
5. Bonds					—
(Adolescents rating fathers; $n = 21$)					
1. Father-Trust	—	-.63**	.05	.06	.37
2. Father-Alienation		—	-.10	-.17	-.40
3. Tasks			—	.86**	.76**
4. Goals				—	.80**
5. Bonds					—

* $p < .05$; ** $p < .01$.

were predictive of their reports of alliance. Mothers' ratings of *trust* with their oldest child predicted mothers' therapy alliance tasks ($F(1, 25) = 6.89$; $p = .015$; Adj. $R^2 = .19$), goals ($F(1, 25) = 10.17$; $p < .01$; Adj. $R^2 = .27$), and bonds ($F(1, 25) = 8.91$; $p < .01$; Adj. $R^2 = .24$). Moreover, mother's ratings of *communication* also predicted their alliance scores on tasks ($F(1, 25) = 4.09$; $p = .054$; Adj. $R^2 = .11$), goals ($F(1, 25) = 4.29$; $p < .05$; Adj. $R^2 = .12$), and bonds ($F(1, 25) = 4.56$; $p < .05$; Adj. $R^2 = .13$). No evidence was found for attachment as predictor of alliance score for fathers or adolescents.

Question 3: Are Mothers,' Fathers' and Adolescents' Perception of Pre-Treatment Attachment a Moderator of the Relationship between Alliance and Post-Treatment Symptom Distress?

Findings indicated that adolescents' trust in their mothers and fathers moderated the relationship between tasks and post-treatment symptom distress (see Table 3). Both moderator models that included that interaction term, were significant (adolescent trust in mothers and tasks: $F(4, 19) = 8.13$; $p = .001$; Adj. $R^2 = .60$; adolescent trust in fathers and tasks: $F(4, 19) = 7.61$; $p = .001$; Adj. $R^2 = .58$) explained significantly more variance than

TABLE 3 Moderation Effects of Attachment and Family Therapy Alliance Subscales on Post-Treatment Symptom Distress

Model	Variable	t	B	SEB	β	R^2	R^2 change	F
						.55		
ATM & Tasks Model without interaction	ATM	-.66	-.10	.15	-.12			
	Tasks	-1.60	-.27	.17	-.28			
	Symptom Distress	3.28**	.63	.19	.59	.68	.13	6.35*
Model with interaction	ATM	-2.63*	-1.46	.55	-1.72			
	Tasks	-2.98**	-1.38	.46	-1.38			
	Symptom Distress	4.37**	.76	.18	.71			
	ATM \times Tasks	2.52*	.02	.01	2.07			
						.55		
ATF & Tasks Model without interaction	ATF	-.57	-.08	.14	-.10			
	Tasks	-1.59	-.27	.17	-.27			
	Symptom Distress	3.28*	.64	.19	.59	.67	.12	5.55*
Model with interaction	ATF	-2.44*	-1.30	.53	-1.63			
	Tasks	-2.84*	-1.23	.43	-1.23			
	Symptom Distress	4.24**	.76	.18	.71			
	ATF \times Tasks	2.36*	.02	.01	1.93			

* $p < .05$; ** $p < .01$. ATM = adolescent's trust in mother; ATF = adolescent's trust in father.

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their corresponding models without the interaction terms (trust in mothers/tasks: $F\text{-Change}(15) = 6.35$; $p < .05$; Adjusted $R^2\text{-change} = .13$; trust in fathers/tasks: $F\text{-Change}(15) = 5.55$; $p < .05$; Adjusted $R^2\text{-change} = .12$), suggesting the inclusion of the parent-trust \times tasks interactions made a significant contribution to the models that did not include the interaction terms. No other significant moderator models were found.

DISCUSSION

This study shows that mothers who presented with higher levels of trust in their oldest child were more likely to report a stronger alliance with family therapists than mothers with lower levels of attachment. It was also interesting that all correlations were in the predicted direction, suggesting that a similar relationship may exist for fathers and adolescents, but was not found because of the small sample size. Another nonsignificant finding that was possibly due to sample size is the moderate correlations between adolescent reported trust and alienation and the bonds subscale with their parents. These correlations show a trend that with a larger sample size would possibly be significant. Furthermore, evidence indicated that mothers' perception of trust and communication with their oldest child predicted their therapy alliance. Finally, adolescent ratings of trust in their mothers and fathers were found to moderate the relationship between tasks and symptom distress while controlling for level of symptom distress at intake. Thus, the degree to which adolescents trusted their mothers and fathers enhanced the strength of the tasks aspect of the therapeutic alliance. These findings indicate that attachment is a potentially important variable in the development of the therapeutic alliance in family therapy and merits further study.

Clinical Implications

The importance of the therapeutic relationship in client changes creates a paradox for families participating in family therapy. If a therapeutic alliance is a key to change, what happens to family members, who due to their attachment style have difficulty forming alliances and thus may be less likely to benefit from therapy? This research confirms this paradox. Findings show that mothers' and adolescents' attachment has an influence on their therapeutic alliance.

The paradox is greater for adolescents, where findings show a moderation effect where their attachment and alliance interact to impact their therapy outcome. This may be due to their place in the family. Adolescents with less trust in their parents are not as likely to feel they can freely discuss their concerns. This may be further exacerbated by the fact that they have tried expressing their concerns, and their expressions produced retaliation from their parents.

These findings also can be explained within the ideas of split alliances within families (Pinsof, 1995). Family members with lower level of communication and trust and higher levels of alienation are in a position to be less supportive and have less agreement about the therapy process, thus contributing to a split alliance. Research has determined that split alliances are related to therapy continuation (Robbins, Turner, Alexander, & Perez, 2003). Additional literature on the therapeutic alliance in family therapy hypothesizes that the within family alliance (the level of agreement and support among family members about the therapy) is a key component in family alliance research (Pinsof, 1995). The within family alliance can be easily influenced by family members' attachment. Family members who report less trust and more alienation are more likely to have different levels of agreement and support about family therapy.

Addressing these issues in family therapy can be challenging, especially when parents and adolescents seem to have incompatible interests. Frustrated parents are often eager to list the ways their children have behaved distrustfully. At the same time, adolescents frequently enter therapy expecting to be criticized and are skeptical that therapy will work to their advantage. Focusing too quickly on the children's untrustworthy behaviors may confirm their expectations and lead to a lack of engagement in therapy. Although families want to improve the level of perceived trust, it is a lack of trust that can inhibit successful treatment. Supporting this view, Diamond and Liddle (1996) found that the more parents focused on controlling adolescent behavior, the less cooperative adolescents were in treatment. Effectively engaging both parents and adolescents in resolving family-trust issues are necessary for a productive therapy alliance.

Family therapists presenting themselves as the adolescent's advocate who is working to help them gain a voice in therapy have demonstrated effectiveness in increasing adolescent engagement in therapy (Diamond, Liddle, Hogue, & Dakof, 1999). This intervention can teach parents to show compassion for the adolescent's side of the story. Such research further highlights the importance of other interventions which can improve adolescent trust in their parents by helping the adolescent see that the parent has his/her interests in mind. As the adolescent's trust in his/her parents increases, the therapy alliance will also be strengthened.

Limitations of Study

While the results of this study provide valuable information, there are several limitations to consider when interpreting the results. First, the sample size is relatively small thus contributing to low statistic power and important findings not being discovered. This is especially true for fathers. Another issue related to sample size is attrition. A number of participants dropped out of the study after beginning treatment, and mothers who dropped out

were significantly more distressed than those who completed the study. As mentioned previously, the difference between the two groups was negligible but less distressed participants are over-represented in this study.

Another limitation is the potential constraints on the generalizability of the findings. Participants were primarily lower income, rural families experiencing many problems including issues related to child abuse and neglect. The issues of multiple family stressors and child abuse and neglect are directly related to issues of attachment and being able to trust helping professionals. Thus, family trust issues may have demonstrated stronger correlations with outcome and alliance in this sample due to the particular relevance of trust with this population. In addition the home-based therapy services can potentially limit the generalizability of these findings to office based settings.

Finally, the results from this research are based on measurements at two points in time. And while they provide information that this is area of research worth pursuit, this study does not provide information on how the constructs of attachment and alliance interact over the course of therapy. This question the must be answered by future research.

Future Recommendations for Research

Future research needs to further explore the relationship of attachment and alliance over time in a session by session manner. By so doing, researchers could see how various attachment-related factors (e.g., client/therapist attachment, therapy-induced changes in attachment styles) influence, or are influenced by, the alliance across time. These studies are necessary because previous research has demonstrated that attachment can have different effects on the therapeutic alliance at different stages of therapy (Sauer et al., 2003).

Another area that may be related is the area of split alliances. Splits in family alliances occur when some family members have strong, positive alliances while other family members have poor or distrustful alliances (Pinsof, 1994, 1995; Pinsof & Catherall, 1986). It is possible that differing parent-child relationships in which one parent trusts the adolescent and one does not could be a contributing factor in the creation of split alliances. This could also be the case in poor or weak within-systems alliances (Pinsof, 1995). Studying the differences between individual and whole family alliances with in the context of attachment and the therapy alliance would be a promising area of research.

Due to the small size and relative specificity of this treatment sample, it is recommended that this study be replicated with a larger pool of participants. Increasing the sample sizes can improve statistical power and test the reliability of these findings. Future studies should use samples that are more demographically-diverse (e.g., different ethnicities, income-levels, and geographic locations) to increase the generalizability of the results.

Many additional topics need to be addressed by research on the relationship between attachment and the alliance. Family therapy researchers would do well to look at some of the following questions: How do various therapist attachment styles interact with different family member attachment styles in family therapy, and how does the interaction influence outcome? What are efficacious techniques for creating beneficial alliances with clients who have less secure attachment? Finally, how can family therapists adapt therapeutic interventions to families in which family members present with different individual attachment styles?

CONCLUSION

This study provides support for the salient role of mothers' and adolescents' perceptions of attachment in their therapeutic alliances. Results suggest that mothers' trust in their oldest child predicts their therapeutic alliance, and that adolescents' trust in their parents before therapy and their therapy alliance moderates outcome. This study provides a foundational step in understanding the connection between attachment and therapeutic alliances in family.

REFERENCES

- Ahn, H., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology, 48*, 251–257.
- Armsden, G. C., & Greenberg, M. T. (1987). The inventory of parent and peer attachment: Individual differences and their relationship to psychological well-being in adolescence. *Journal of Youth and Adolescence, 16*, 427–454.
- Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 52*(6), 1173–1182.
- Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226–224.
- Bowlby, J. (1980). *Attachment and loss: Sadness and depression* (Vol. III). New York: Basic Books.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.
- Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2000). The therapist-parent alliance in family-based therapy for adolescents. *Journal of Clinical Psychology, 56*, 1037–1050.
- Diamond, G., & Liddle, H. A. (1996). Resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy. *Journal of Consulting & Clinical Psychology, 64*, 481–488.

- Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (1999). Alliance-building interventions with adolescents in family therapy: A process study. *Psychotherapy: Theory, Research, Practice, Training*, 36, 355–368.
- Diamond, G. S., Reis, B. F., Diamond, G. M., Siqueland, L., & Isaacs, L. (2002). Attachment-based family therapy for depressed adolescents: A treatment development study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 1190–1196.
- Frazier, P. A., Barron, K. E., & Tix, A. P. (2004). Testing moderator and mediator effects in counseling psychology research. *Journal of Counseling Psychology*, 51(1), 115–134.
- Hampson, R. B., & Beavers, W. R., (1996). Family therapy and outcome: Relationships between therapist and family styles. *Contemporary Family Therapy: An International Journal*, 18(3), 345–370.
- Heatherington, L. & Friedlander, M. L. (1990). Couple and family therapy alliance scales: Empirical considerations. *Journal of Marital and Family Therapy*, 16, 299–306.
- Holmbeck, G. N. (2003). Toward terminological, conceptual, and statistical clarity in the study of mediators and moderators: Examples from the child-clinical and pediatric psychology literatures. In A. E. Kazdin, *Methodological Issues and Strategies in Clinical Research (3rd Ed.)*, pp. 77–105. Washington, DC: American Psychological Association.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139–149.
- Johnson, L. N., Wright, D. W., & Ketring, S. A. (2002). The therapeutic alliance in home-based family therapy: Is it predictive of outcome? *Journal of Marriage and Family Therapy*, 28(1), 93–102.
- Johnson, L. N., & Ketring, S. A. *The prevention and treatment of child abuse*. Roundtable presented at the meeting of the American Association for Marriage and Family Therapy, Denver, Colorado. November 2000.
- Johnson, L. N., Ketring, S. A., & Abshire, C. (2003). The revised inventory of parent attachment: Measuring attachment in families. *Contemporary Family Therapy*, 25(3), 333–349.
- Koocher, G. P. (1976). A bill of rights for children in psychotherapy. In G. P. Koocher (Ed.), *Children's rights and the mental health professions* (pp. 23–32). New York: Wiley.
- Lambert, M. J., Hansen, N. B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G. M., & Reisinger, C. W. (1996). Administration and scoring manual for the OQ-45.2 (Outcome Questionnaire). American Professional Credentialing Services LLC.
- Mallinckrodt, B., Coble, H. M., & Gantt, D. L. (1995). Working alliance, attachment memories, and social competencies of women in brief therapy. *Journal of Counseling Psychology*, 42, 79–84.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68(3), 438–450.
- Miller, R. B., & Wright, D. W. (1995). Detecting and correcting attrition bias in longitudinal family research. *Journal of Marriage and the Family*, 57, 921–929.

- Pinsof, W. M. (1994). An integrative systems perspective on the therapeutic alliance: Theoretical, clinical, and research implications. In A. O. Horvath & L. S. Greenberg, *Working Alliance: Theory, Research, and Practice* (pp. 173–195). Oxford, England: John Wiley & Sons.
- Pinsof, W. M. (1995). *Integrative problem-centered therapy*. New York: Basic Books.
- Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple, and individual therapy scales. *Journal of Marital and Family Therapy*, *12*, 137–151.
- Rait, D. (2000). Therapeutic alliance in couples and family therapy. *Journal of Clinical Psychology*, *56*(2), 211–224.
- Robbins, M., Turner, C. W., Alexander, J. F., & Perez, G. A. (2003). Alliance and dropout in family therapy for adolescents with behavior problems: Individual and systemic effects. *Journal of Family Psychotherapy*, *17*(4), 534–544.
- Satterfield, W. A., & Lyddon, W. J. (1998). Client attachment and the working alliance. *Counseling Psychology Quarterly*, *11*, 407–415.
- Sauer, E. M., Lopez, F. G., & Gormley, B. (2003). Respective contributions of therapist and client adult attachment orientations to the development of the early working alliance: A preliminary growth modeling study. *Psychotherapy Research*, *13*(3), 371–382.
- Umphress, V. J., Lambert, M. J., Smart, D. W., Barlow, S. H., & Clouse, G. (1997). Concurrent and construct validity of the outcome questionnaire. *Journal of Psychoeducational Assessment*, *15*(1), 40–55.