How do therapists ally with adolescents in the context of family therapy? : an examination of relational control communication patterns

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How Do Therapists Ally with Adolescents in the Context of Family Therapy? An
Examination of Relational Control Communication Patterns

by

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Abstract

The creation and maintenance of a strong therapeutic alliance is one of the most robust predictors of successful treatment for adult (Horvath & Bedi, 2002) and adolescent (Karver, Handelsman, Fields, & Bickman, 2006) clients across diverse therapy formats and presenting problems. However, research on the alliance with adolescents lags far behind research with adults, particularly in the context of family therapy. Because of the supported efficacy of family therapy for diverse adolescent problems (Shelef et al., 2005), the present study examined the association between observed therapist-adolescent alliances and relational control communication in the context of conjoint family therapy. Relational control refers to how people use language in order to influence others, reflecting the implicit hierarchical and relational structure of messages people exchange with one another (Rogers & Escudero, 2004).

Specifically, two interpersonal control patterns (competitive symmetry and complementarity) were compared, in sessions where the adolescent’s alliance was positive (“good”) to sessions where the alliance was negative (“bad”). Competitive symmetry reflects a struggle for control, whereas complementarity reflects a mutual understanding of the relationship. Additionally, the likelihood of competitive symmetry and complementarity were compared in cases in which the adolescent’s observed alliance with the therapist deteriorated over time to cases in which the alliance remained stable and positive.

Ten family cases seen at a university family therapy clinic in Spain were selected based on adolescent alliance scores observed using the SOFTA (Friedlander, Escudero, & Heatherington, 2006). Sequential lag analyses were used to obtain contingency tables for therapist-adolescent relational control interactions, which were coded using the Family Relational Communication Control Coding System.
(FRCCCS; Friedlander & Heatherington, 1989). Results provided some support for the hypothesized differences in that there was relatively more competitive symmetry and relatively less complementarity in the bad alliance sessions. Moreover, in the deteriorating alliance cases, competitive symmetry increased and complementarity decreased from session 1 to 3, whereas in the stable-positive alliance cases, complementarity remained relatively unchanged and competitive symmetry decreased. Results highlight the importance of promoting cooperation and avoiding competition with the adolescent in order to develop and maintain a strong alliance in conjoint therapy.
Chapter 1

Statement of the Problem and Review of Literature

The creation and maintenance of a strong therapeutic alliance with clients has long been considered a crucial component of successful treatment (Horvath & Bedi, 2002; Shirk & Karver, 2003). Developing a therapeutic alliance from the early stages of therapy has repeatedly been shown to be one of the most robust predictors of successful clinical outcomes (Assay & Lambert, 1999; Horvath & Bedi, 2002). Indeed, research provides evidence of the important role played by the therapeutic alliance for both adults and adolescents in diverse therapy formats (Horvath & Symonds, 2001; Shelef, Diamond, Diamond & Liddle, 2005).

Because children and adolescents tend not to be self-referred and often enter into treatment unaware of their problems, in conflict with their parents, and/or resistant to change, authors suggest that the therapeutic alliance may be equally, if not more, critical in treatments for youth (Karver, Handelsman, Fields, & Bickman, 2006; Shirk & Karver, 2003). Moreover, creating and maintaining a positive working alliance with adolescents is especially challenging due to their developmental characteristics, which often pose a considerable challenge for therapists (Diamond, Diamond & Liddle, 2000; Liddle, 1995). Specifically, the striving for control and autonomy that is typical of adolescence can contribute to power struggles between adolescents and adults whom they perceive as authoritative figures (Diamond et al., 2000). These struggles for control are particularly likely in the context of family therapy, where therapists are called on to negotiate family members’ differing attitudes and often conflicting goals for treatment (Friedlander, Heatherington & Escudero, 2006).

The general goal of the present study was to explore interpersonal dynamics
between therapist and client that characterize the adolescent’s positive experiences in brief conjoint treatment. Specifically, the first objective of the study was to compare the transactional control patterns of an early session 3 in which an adolescent's observed alliance with the therapist was either highly positive or highly negative. The second objective was to examine whether specific relational control indices (competitive symmetry and complementarity) reflect differences (from session 1 to session 3) in adolescents' alliance with the therapist in cases where the alliance remained stable or deteriorated.

**The Therapeutic Alliance**

The therapeutic or working alliance, as described by Bordin (1979), refers to the degree to which the client and therapist care about one another and agree on the goals and tasks of therapy. Since Bordin (1979) defined this notion, the therapeutic alliance has been cited as the most frequently identified common factor across modalities of therapy (Norcross, 2002). A positive alliance has been found to predict treatment outcome modestly yet robustly across a wide range of therapeutic approaches, clinical populations, and outcome parameters (Castonguay, Constantino, & Holtforth, 2006; Diamond et al., 2000; Horvath, Del Re, Flückiger, & Symonds, in press; Horvath & Symonds, 1991; Shelef et al., 2005). Moreover, the strength of the alliance appears to predict outcome better than type of therapy approach, length of the treatment, or any single aspect of the therapy process (Shelef et al., 2005). Several meta-analyses reported effect sizes for the alliance-outcome association ranging from .22 to .26 (Friedlander, Escudero, Heatherington, & Diamond, in press; Horvath et al., in press; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Although modest, these effect sizes are arguably substantial for a process variable assessed within the complexity of psychotherapy (Horvath & Bedi, 2002).
In contrast to the ample empirical work examining the alliance-outcome interplay in individual therapy with adults, research on the alliance with adolescents has been relatively sparse (Shirk & Karver, 2003; Shelef et al., 2005). However, some studies in the past decade reported findings with adolescents that resemble those with adults. For example, in a meta-analytic review of the therapy process literature with children and youth, Karver et al. (2006) found a modest to strong association between therapeutic alliance and outcome. Between 1973 and 2006, results from 49 published studies that investigated the association between therapeutic relationship and outcome among children and adolescents revealed a mean effect size of .24, similar to those found with adult samples (Karver et al., 2006). In fact, the alliance-outcome relationship appears to be highly generalizable, as it has been reported across a wide variety of treatment settings (inpatient, outpatient, residential treatment centers, group homes, and in-home treatment) and treatment orientations (psychodynamic, behavioral, family systems, and treatment-as-usual in the community) (Karver et al., 2006). In a recent study, Karver, Shirk, Handelsman, and Fields (2008) found that alliance formation with adolescents during the early phase of treatment, when measured across sessions, using different methods (i.e., self-reports and observed alliance-related behaviors), and across therapeutic approaches (i.e., cognitive-behavioral and non-directive) was associated with adolescent level of involvement in therapy.

**Family Therapy with Adolescents**

Despite the challenges commonly encountered with adolescents in family therapy, this treatment format has shown considerable promise for a wide range of adolescent problems. Meta-analytic reviews suggest that family therapy is an effective form of treatment for adolescent problems, including drug use (Cormack & Carr,
2000; Rowe & Liddle, 2003; Shelef et al., 2005), behavior problems (Brosnan & Carr, 2000; Shelef et al., 2005), anxiety disorders, depression and bereavement (Moore & Carr, 2000), eating disorders (Mitchell & Carr, 2000) and adjustment to divorce (O’Halloran & Carr, 2000).

The success of family interventions seems to result from the therapist's ability to engage and retain adolescents, parents, and other family members in treatment (Stanton & Shadish, 1997). The experience of an environment where the parents feel safe and the family shares a sense of purpose about the therapy has been shown to contribute to parents’ rating of improvement (Friedlander, Lambert, & Muñiz de la Peña, 2008). The lack of any of these components may threaten the family’s therapeutic alliance as a whole and cause one or more individuals to feel disengaged, unmotivated, or threatened (Friedlander et al., 2006).

When working with families, therapists are challenged to develop a therapeutic alliance with more than one individual simultaneously (Pinsof & Catherall, 1986). Failure to form a therapeutic alliance, according to Diamond et al. (2000), can occur as a result of a family member's resistance or because the therapist provided insufficient support for the family. The therapist's flexibility and capacity to meet the needs and goals of multiple family members, particularly parents and adolescents, may be a critical factor in whether a given therapy experience is positive (Diamond et al., 2000; Friedlander et al., 2006). Differing levels of individual alliances between family members and the therapist, what Pinsof and Catherall (1986) called split alliances, are relatively frequent and may interfere profoundly with the therapeutic process (Heatherington & Friedlander, 1990; Muñiz de la Peña, Friedlander, & Escudero, 2008). Research has shown that these discrepancies between and among participants’ alliances with the therapist can interfere with the therapeutic process
more so than each individual’s alliance considered alone (Robbins, Liddle, Turner, Dakof, Alexander, & Kogan, 2006; Robbins, Turner, Alexander, & Perez, 2003, Symonds & Horvath, 2004).

Additionally, the strength of each person’s alliance with the therapist can influence one or more aspects of treatment outcome. Systems theory suggests an interaction between and among alliances, with each person's alliance acting as a moderator of other family members’ alliances with the therapist (Shelef et al., 2005). It is not uncommon for adolescents to be on the low side of the imbalance, i.e., with a relatively weaker connection to the therapist than the parent (Diamond et al., 2000; Friedlander et al., 2006), although this is not always the case. In a recent study (Muñiz de la Peña et al., 2008), split alliances in both a U.S. and a Spanish sample showed that it was also common for the adolescent’s bond with the therapist to be stronger than the bond between the therapist and the parent(s).

**Communication with Adolescents**

Communication is said to lie “at the heart of our relationships” because “we do not relate and then talk, but we relate in talk” (Rogers & Escudero, 2004, p 3.). By extension, communication “lies at the heart of” the therapeutic relationship, where therapist and client relate “in talk.” This view implies that, while relationships contextualize and shape the way people communicate, relationships are also constructed and influenced by communication processes (Rogers & Escudero, 2004). Therefore, in studying the therapeutic alliance, it is important to consider how therapist and clients communicate with one another.

Engaging adolescents in beneficial communication is often difficult because of the circumstances under which they attend therapy sessions. Adolescents are considered “therapy hostages” (Friedlander et al., 2006) when they tend not to be part
of the decision to seek therapy; often, adolescents tend to be referred or mandated by
the parents or another authority figure (Shelef et al., 2005; Rubenstein, 2003). In Berg
and Miller's (1992) words, adolescents tend to be “visitors” to the therapeutic process
because of their low motivational level and because they tend to be criticized by other
family members, who blame them for the family's problems (Friedlander et al., 2006;
Sharry, 2004).

Therapists may engage in cajoling and haranguing therapy “visitors” to
participate, which can only worsen the situation (Sharry, 2004). However, it seems
more useful to assume that everyone who attends the session is motivated to achieve
something in therapy, although a client’s personal goals may differ from and conflict
with the goals agreed upon at the onset of therapy (Sharry, 2004).

Indeed, adolescents often have goals that differ from those of their parents,
which makes alliance formation with this population more challenging but, ironically,
more critical to treatment outcome (Liddle, 1995). For this reason, some authors
recommend that, for treatment to be successful, therapists should incorporate the
adolescent’s concerns and desires into the treatment process, providing them with a
sense of control (Diamond, Hogue, Liddle, & Dakof, 1999; Sharry, 2004). According
to Liddle (1995), it is only when adolescents trust the therapist and feel connected that
treatment can be successful. Communication with adolescents must, therefore, be
handled in a way that helps adolescents feel included, respected, and cared for.

In developing a positive relationship with adolescents, particularly in the
context of family therapy, one must consider the barriers to productive communication
that have to do with the typical characteristics of adolescence (Diamond et al., 2000;
Sharry, 2004). That is, developmental differences can make it difficult for therapists
to communicate simultaneously with adolescents and parents (Diamond et al., 2000).
Along with less ability to think abstractly than parents and communicate verbally, adolescents struggle with issues like independence from parents, identity, sexuality, and so forth (Sharry, 2004). As they begin to seek more autonomy, adolescents become more apt to confront their parents and, by extension, any adult in an authoritative role, including therapists (Diamond et al., 2000). Adolescents also tend to be more private, self-conscious, and awkward, which challenges the therapist’s desire to get close to them and elicit their worldviews (Sharry, 2004). In general, adolescents often strive for control in an environment where they tend to have little say, posing roadblocks for building positive therapeutic relationships.

When considering the developmental characteristics of adolescents, particularly in the arduous context of family therapy, the therapist may tailor interventions to facilitate emotional safety, which is necessary for adolescents to open up in session and become involved. There are a number of studies that suggest that therapist effective interventions focus on the adolescent and aim at including his or her voice in the therapy process. For example, Diamond et al. (1999) explored therapist behaviors associated with improving initially poor therapist-adolescent alliances in the context of Multidimensional Family Therapy (MDFT). A list of therapist behaviors was generated from the MDFT model and other research in the area and was refined with the help of experts. Once the list was refined, five improved and five unimproved alliance cases of primarily African-American, male, adolescent substance abusers and their families were observed in their first three sessions. Observations showed that, by session 3, therapists were attending to the adolescent’s experience, formulating personally meaningful goals, and acting as the adolescent’s ally more extensively in the improved alliance cases than in the unimproved alliance cases (Diamond et al., 1999). These results suggest that an initially poor alliance can improve by listening
carefully to adolescents, giving them a voice and promoting autonomy, (Diamond et al., 1999).

In a similar study, Hogue, Dauber, Samuolis, and Liddle (2006) found that adolescent-centered interventions were effective. These interactions included meeting alone with the adolescent on a regular basis, working to establish and maintain a strong alliance, focusing on the adolescent’s problems, building individual social skills, and addressing other developmental tasks. Notably, interventions of this sort uniquely predicted improvement in some cases and moderated the impact of family interventions on others.

In a review of the clinical and empirical literature on therapy with adolescents, Bolton Oetzel and Scherer (2003) suggested that adolescent autonomy development has important implications for alliance formation. Theoretically, healthy autonomy is facilitated when parents and therapist grant adolescents increasing psychological freedom, remain emotionally available, and expect and enforce responsible behavior (Bolton Oetzel & Scherer, 2003). Research suggests that adolescents who experience the enhancement of personal autonomy in therapy show greater satisfaction with treatment at termination (Bolton Oetzel & Scherer, 2003). Indeed, Bolton Oetzel and Scherer’s results showed that adolescents tended to talk more about the therapy or the therapeutic relationship and asked the therapist for advice more frequently when the therapists made certain kinds of interventions. These interventions included presenting themselves as an ally, encouraging the adolescent to find his or her own solutions, facilitating the discussion of possible negative feelings about the therapy and the therapeutic relationship, taking responsibility for confidentiality, and providing reasonable structure for the session (Bolton Oetzel & Scherer, 2003). Along with these findings, it is reasonable to suggest that therapists may develop better alliances with
reluctant adolescents to the extent that they can join with them and engage them cooperatively early on in the therapy process.

**Relational Control Communication**

The present study examined how therapists communicate with adolescent clients in the context of family therapy and whether specific communication patterns reflect strong and weak therapeutic alliances. The communication variable of interest was relational control. Initially introduced in the 1960s, relational (or interpersonal) control has been studied in the context of individual as well as couple and family therapy (Ericson & Rogers, 1973; Friedlander, Wildman & Heatherington, 1992; Friedlander & Heatherington, 1989; Heatherington & Friedlander, 1990; Lichtenberg, Wettersten, Mull, Moberly, Merkley, & Corey, 1998; Raymond, Friedlander, Heatherington, Ellis, & Sargent, 1993; Rogers & Escudero, 2004). Relational control is based on Bateson’s (1935) theory of culture contact and schismogenesis which addresses cultural group interactional patterns which reflect differentiation or reciprocity. Applied to social relationships, relational control refers to how people use verbal and nonverbal language in order to influence others, reflecting the implicit hierarchical and relational structure of messages people exchange with one another (Rogers & Escudero, 2004). The assumption is that relationships and communication are interconnected, appearing simultaneously and influencing each other reciprocally, and that communication or relationship patterns lie between individuals rather than within individuals (Rogers & Escudero, 2004). According to Ericson and Rogers (1973), relational control is contextual and has more to do with the process of communication than with the content of messages.

The focus of attention in relational control communication is the contiguity of individual messages rather than the individual messages themselves (Rogers &
Escudero, 2004). More specifically, the unit of analysis is the communication interchange, the speech turn at the dyadic level or “reactions of individuals to the reactions of other individuals” (Rogers & Escudero, 2004, p. 12). Based on Bateson's (1935) original classification, three interactional patterns can be identified: complementary, symmetrical, and transitory (Rogers & Escudero, 2004). In complementary interactions, the definition of the relationship offered by one participant is accepted by the other and is reflected in communication exchanges such as closed question-answer or command-compliance (Friedlander et al., 1991). In contrast, competitive-symmetrical exchanges show participants' discrepant views of who is in control in a social relationship, evidenced by sequences of challenges and counterchallenges, such as when one person changes the topic of conversation and the other person does not follow along, or when one person asks a question and there is no response (Ericson & Rogers, 1973). Transitory exchanges, the third transactional style, are neutral, non-control-defining communication patterns where, for example, a speaker responds by extending the previous speaker’s topic.

A number of psychotherapy studies using these concepts have found that, overall, the predominant relational control pattern shown by therapists in individual and family therapy tends to be complementarity (Friedlander et al., 1991; Friedlander & Heatherington, 1989; Raymond et al., 1993). In other words, therapists tend to take a dominant (“one-up” or ↑) position with clients who, in turn, tend to assume a submissive (“one-down” or ↓) position (Friedlander & Heatherington, 1990). In contrast, relational control patterns characterized by question-answer and symmetrical exchanges (i.e., interruptions, nonsupportive responses, etc.) are more frequently observed in the initial sessions of clients who subsequently drop out of treatment (Beyebach & Escudero, 1997; Heatherington & Friedlander, 2004). Beyebach and
Escudero (1997), for example, compared the relational communication patterns of 16 dropout versus 16 continuation cases of solution-focused therapy. More conflictive therapeutic interactions and more domineering behaviors were observed in the dropout group than in the continuation group. Moreover, clients in the dropout group were more likely to adopt a one-up position and their therapists were less likely to respond with a one-down complementary message. However, clients in this study were largely adults seen in individual therapy, not adolescents in family therapy.

There is some evidence that relational control patterns reflect differences in therapeutic orientations. Friedlander et al. (1991) compared six family therapy interviews by expert therapists, three from the structural approach and three from the Milan systemic approach. Results supported theoretically predictable differences in relational control patterns between the two approaches consistent with the therapist distinct styles. Specifically, the structural sessions were characterized by more overt controllingness and competition whereas the systemic sessions evidenced greater complementarity (Friedlander et al., 1991). Relatedly, Heatherington (1990) compared a number of family and individual therapies with respect to four different indicators of domineeringness. Results revealed substantive differences between family therapy approaches themselves and illustrated that, in contrast with popular beliefs, some individual therapy approaches are more controlling than some family approaches. It was argued that differences in therapist controllingness arise from the theory of change rather than from the nature of the client system (i.e., family versus individual) (Heatherington, 1990).

Few studies have examined relational control patterns in the context of family therapy, and even fewer when the focus is families with adolescents. A review of the sparse literature reveals that patterns of relational control in successful family therapy
do not seem to be ubiquitous or constant (Lichtenberg et al., 1998; Raymond et al., 1993). Rather, relational control seems to evolve and change over the course of the therapy process (Heatherington & Friedlander, 2004; Raymond et al., 1993). In one notable single-case study, Raymond et al. (1993) examined the relational control dynamics in a family with an adolescent daughter who suffered from anorexia. The family was seen on an inpatient for 15 sessions. John Sargent, a prominent family therapist who is well known for his work with families of this sort, worked intensively with the family over a period of three weeks. Sessions were examined separately in terms of their relational control patterns, and changes in these patterns were explored over time by comparing the beginning, middle, and final phases of treatment. Consistent with the aim of structural therapy to alter patterns of dysfunctional interactions (e.g., enmeshment and rigidity), it was expected that changes in relational control would reflect processes consistent with the theory.

Raymond et al.’s (1993) findings provided some evidence consistent with previous research. First, therapist ↑/client ↓ complementarity predominated throughout the treatment. Higher complementarity during the early and late phases of treatment was more prominent between the therapist and the adolescent daughter, and increased symmetry was more prominent between the therapist and the father. These relational patterns seemed to reflect the therapist’s attempts to join with the adolescent early in therapy (Raymond et al., 1993). The authors also noted that the lower occurrence of complementary interactions in the middle sessions of therapy may have been due to the greater depth of work during this time, when therapist and clients were most likely to challenge each other and take risks (Raymond et al., 1993).

Only one other study was located that involved examination of relational communication in the context of family therapy with adolescent clients. Cabero
(2004) examined relational control patterns in a single therapist’s 38 initial sessions with adolescents and one or both parents. Results showed that more frequent competitive symmetry was associated with less adolescent engagement. In other words, less relational conflict occurred between adolescent and therapist when the former was more involved in the therapeutic process. In addition, results suggested that complementarity (with the therapist in a submissive position) occurred significantly more often when the adolescents demonstrated greater engagement, emotional connection, and safety.

Cabero’s (2004) findings support the widely held conclusion in the literature about the importance of joining with the adolescent in a cooperative rather than a competitive manner. However, the lack of studies examining specific relational communication patterns between adolescent clients and their therapists makes it difficult to develop strong conclusions about the nature of effective therapist-client interaction in the context of conjoint treatment.

**Summary and Hypotheses**

The present study examined two relational control communication patterns between adolescent clients and their therapists in selected early sessions from 10 cases of brief family therapy. Specifically, cases were selected from an archival data set based on the adolescent’s observed alliance with the therapist. First, five positive alliance sessions (called *good alliance sessions*) were compared to five negative alliance sessions (called *bad alliance sessions*) in order to examine theorized differences in the likelihood of competitive symmetry and complementarity. Second, two groups were contrasted, one group in which the adolescents’ alliances with their therapists remained positive and stable from session 1 to session 3, and another in which the adolescents’ alliances deteriorated during this same time period.
Competitive symmetry and complementarity were compared over time (session 1 to session 3) in the cases characterized by a deteriorating alliance versus cases characterized by a non-deteriorating, or stable/positive alliance.

Specifically, it was hypothesized that, compared to the bad alliance sessions, in the good alliance sessions there would be significantly more verbal exchanges between therapist and adolescent. It was reasoned that adolescents who feel safe and engaged in the therapy process (i.e., strong therapeutic alliance) would communicate more with the therapist. Regarding specific relational control patterns, because competitive symmetry (↑↑) reflects a nonreciprocal view of the relationship whereas complementarity (↑↓) reflects a reciprocal view, it was predicted that therapists and adolescents would be significantly more likely to respond one another’s domineering messages (↑) with domineering responses and less likely to respond with complementary responses (↓) in the bad than in the good alliance sessions. With regard to changes over time, relational control patterns were compared in (a) cases in which the adolescent’s observed alliance with the therapist deteriorated, and (b) in cases in which the adolescent’s alliance did not deteriorate (i.e., remained stable and positive) from session 1 to session 3. It was hypothesized that, in contrast to the stable alliance cases, in the deteriorated alliance cases, the adolescents and therapists would be more likely to engage in competitive symmetry and complementarity in the third session than in the first session.

**Significance of the Study**

Engaging adolescents in therapy and forming a strong bond with them is often challenging, particularly in the context of family therapy. Despite the extensive literature on therapeutic alliance with adult clients, little is known about how therapists form strong alliances with adolescents. Although relatively more is known
about the general role of the therapeutic alliance in family therapy, there is little research specific to the alliance between the therapist and adolescent clients when other family members are present in treatment.

The focus of the present study on adolescents’ alliance-related observed behaviors was expected to contribute to our understanding of the role that the therapist-adolescent communication plays in family therapy. Moreover, the observational interaction analysis, based on sequential lag analysis, provided fine-grained detail regarding adolescents’ alliance communicational manifestations.

Relational control has been broadly studied in contexts other than conjoint therapy with adolescents. A number of studies in the context of consultation, individual therapy, and couple therapy provided the groundwork for understanding how participants interact relationally in social circumstances. However, only a handful of studies have focused on relational control patterns in the context of family therapy, particularly with adolescents. The developmental characteristics of adolescents, exemplified by identity development and an increased desire for autonomy and independence, contribute to the challenging task of forming a strong alliance with teens. This challenge increases considerably when parents or other family members are present in the consulting room.

Moreover, no prior study has examined how changes in relational control communication patterns over time reflect changes in observed and perceived therapeutic alliance. The design of the present study allowed for a comparative examination of relational control in deteriorating alliance and stable alliance families. It was reasoned that significant results would advance our understanding of how therapists adapt their approach to adolescents in order to build and maintain a solid therapeutic relationship.
Chapter II

Method

The present study compared therapist-adolescent relational control patterns in sessions where the adolescent clients’ alliance was highly positive (“good”) to sessions where the alliance was highly negative (“bad”). In addition, changes over time were examined by comparing these patterns in cases in which adolescent’s alliance deteriorated from the first to the third session to cases in which the alliance remained stable and positive.

Participants

Setting and case selection. Family sessions and cases were selected from the data set of an ongoing research project in Spain, called Conecta. The Conecta Project is an intervention and research program focused on adolescents and their families; it is a collaborative effort between a university clinic in northwestern Spain and the Meniños Foundation, a non-profit organization serving children and their families across Spain.

Data from over 30 families were reviewed for inclusion in the study. The sample size was determined by the number of sessions and cases that met the inclusion criteria. Specifically, sessions were selected only if they were attended by at least one parent and one adolescent client, aged 13 to 18.

Ten families met the criteria for “good” or “bad” alliances (as described below): five families with sessions in which the self-reported adolescent alliance ratings in session 3 were negative, and five families in which the alliance ratings in either session 1 or session 3 were positive. Four families met the criteria for “deteriorating alliance cases,” and four families met the criteria for “stable alliance cases.”
It should be noted that the original plan was to compare five stable alliance to five deteriorating alliance cases. However, one of the stable alliance families differed from the other four in that the adolescent’s alliance in session 1 was negative rather positive, whereas in the other four cases, the alliance was positive and stable in both sessions. In order to have two homogeneous groups of equal size, the “improving” case was eliminated from the analysis along with one randomly selected deteriorating case.

In all cases, the same family members attended both session 1 and session 3. Of the 20 sessions analyzed for this study, 15 (75%) were attended by the mothers only, 3 (20%) by both parents, and 2 (5%) by the foster uncle and his brother. In two families, one session was attended by a sibling (i.e., in addition to the adolescent whose behavior was observed). In the other eight families, the adolescent was the only child attending the session.

Therapy in the Conecta Project tends to be time unlimited, although family progress is reviewed after 10 sessions, and a second 10-session period is considered if mutually agreed upon. The families selected for the present analysis attended an average of 9 sessions \((SD = 5.5)\); seven of the 10 families completed treatment \((M = 9.29\) sessions, \(SD = 6.65)\), whereas 3 families dropped out prematurely after sessions 5, 8, and 10.

**Family characteristics.** Table 1 provides a summary of the major demographic characteristics of the 10 families and their presenting concerns. All 10 families were low-to-middle income, White Spaniards. Family composition varied: Four were two-parent families, five families had divorced or separated parents (only the mothers participated in treatment), and one family had a foster uncle and grandmother. The ages of the adolescent clients ranged from 13 to 17 \((M = 15.4, SD =\)
### Table 1

**Descriptive Characteristics of the Participating Families**

<table>
<thead>
<tr>
<th>Family</th>
<th>Family member (age)</th>
<th>Sessions attended</th>
<th>Presenting problem at intake</th>
<th>Total # of sessions</th>
<th>Completer/Dropout</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>mother (45)</td>
<td>1, 3</td>
<td>son's behavioral difficulties</td>
<td>9</td>
<td>completer</td>
</tr>
<tr>
<td></td>
<td>son (13)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1, 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>daughter (11)</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>mother (36)</td>
<td>1, 3</td>
<td>adolescent son’s behavioral difficulties</td>
<td>7</td>
<td>completer</td>
</tr>
<tr>
<td></td>
<td>father (40)</td>
<td>1, 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>son (13)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1, 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>son (6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>uncle (72)</td>
<td>1, 3</td>
<td>adolescent's behavioral difficulties</td>
<td>8</td>
<td>dropout</td>
</tr>
<tr>
<td></td>
<td>uncle (55)</td>
<td>1, 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>grandmother (93)</td>
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<td></td>
<td>adolescent (14)&lt;sup&gt;a&lt;/sup&gt;</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>mother (52)</td>
<td>1, 3</td>
<td>relational difficulties between mother and daughter</td>
<td>23</td>
<td>completer</td>
</tr>
<tr>
<td></td>
<td>daughter (14)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1, 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>mother (-)</td>
<td>1, 3</td>
<td>relational difficulties and daughter’s behavioral problems</td>
<td>10</td>
<td>dropout</td>
</tr>
<tr>
<td></td>
<td>daughter (17)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1, 3</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>daughter (12)</td>
<td>1, 3</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Denotes additional family member.
<table>
<thead>
<tr>
<th>Family</th>
<th>Family member (age)</th>
<th>Sessions attended</th>
<th>Presenting problem at intake</th>
<th>Total # of sessions</th>
<th>Completer/Dropout</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>divorced mother (-) son (16)$^a$</td>
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<td>relational difficulties between mother and son</td>
<td>5</td>
<td>completer</td>
</tr>
<tr>
<td>7</td>
<td>mother (45) father (48) son (17)$^a$ son (20) daughter (14)</td>
<td>1, 3, 3, 1, 3</td>
<td>adolescent’s son behavioral difficulties</td>
<td>5</td>
<td>dropout</td>
</tr>
<tr>
<td>8</td>
<td>mother (38) father (42) daughter (17)$^a$</td>
<td>1, 3, 1, 3</td>
<td>relational difficulties and behavioral problems of the daughter</td>
<td>12</td>
<td>completer</td>
</tr>
<tr>
<td>9</td>
<td>mother (46) son (16)$^a$</td>
<td>1, 3, 1, 3</td>
<td>relational difficulties between mother and son</td>
<td>7</td>
<td>completer</td>
</tr>
<tr>
<td>10</td>
<td>mother (52) father (-) daughter (-) son (17)$^a$</td>
<td>1, 3, 1, 3</td>
<td>relational and behavioral difficulties of the adolescent</td>
<td>4</td>
<td>completer</td>
</tr>
</tbody>
</table>

*Note.* Ages that were unknown are indicated by a dash. $^a$ Adolescent whose behavior was studied
presenting problems included relational difficulties with parents, antisocial or other conduct problems, e.g., poor discipline, truancy. Few of the adolescents attended therapy voluntarily, several were mandated by social services or the judicial office, and most were pressured by their parents to participate.

**Therapists.** The six therapists whose cases were selected included two men and four White, Spanish women, \( M \) age = 37.3 years (\( SD = 7.5 \)), all of whom had at least a master’s degree in family or mental health counseling. The therapists’ experience levels ranged from 2 to 23 years (\( M = 8.7, SD = 7.4 \)), and their predominant orientation was an integrative approach to brief systemic therapy, which included structural, strategic, and solution-focused interventions. Continuous supervision was provided via closed-circuit television or through a one-way mirror by at least one licensed supervisor and one to five team members. Of the 6 therapists, 3 worked with only 1 family, 2 worked with 2 families (1 with 2 deteriorating and the other with 1 deteriorating and 1 stable alliance family), and 1 saw 3 families (2 of whom were deteriorating alliance cases and 1 was a stable alliance case).

**Design**

The present field study was an ex post facto, observational interaction analysis. Sequential lag analysis was used to examine relational control patterns in sessions and cases that met specific alliance criteria.

The alliance measure was the System for Observing Family Therapy Alliance (SOFTA; Friedlander, Escudero, & Heatherington, 2006a), observer (SOFTA-o) version (Friedlander, Escudero, Horvath, Heatherington, Cabero, & Martens, 2006b), which is explained in detail below. In this rating system, family members receive a global rating from -3 (extremely problematic) to +3 (extremely strong) on four alliance-related dimensions, three of which are individual and one of which refers to
the entire family unit’s alliance.

Bad alliance sessions were defined as those in which one adolescent in the family had a problematic global observer rating (-1, -2, -3) on at least two of the three individual SOFTA-o dimensions (i.e., Engagement in the Therapeutic Process, ENG; Emotional Connection with the Therapist, EC; and Safety within the Therapeutic System, SAF). Good alliance sessions were defined as those in which at least one adolescent had a positive global SOFTA-o rating (+1, +2, +3) on at least two of the three SOFTA dimensions. All sessions selected for this comparison were session 3s.

Deteriorating alliance cases were defined as those in which at least two of the adolescent’s ENG, EC, or SAF negative ratings changed from 0, +1, +2, +3 to a negative rating, i.e., -1, -2, or -3) from session 1 to 3. Stable alliance cases were those in which two or more of the global ratings either remained positive (as defined above) or improved (moved from negative -3, -2, -1 to zero or above).

**Instruments**

**SOFTA-o.** Created simultaneously in English and Spanish (Sistema de Observación de Alianza Terapéutica en Intervención Familiar; SOATIF; Escudero & Friedlander, 2003), the System for Observing Family Therapy Alliances (SOFTA-o; Friedlander et al., 2006b) is a set of observational rating scales that assess the strength of the therapeutic alliance in the context of conjoint couple and family therapy. The SOFTA-o has two versions, one for clients and one for therapists. Only the client version was used in the present study.

Behaviors in the SOFTA-o are nonspecific (e.g., “Therapist acknowledges that therapy involves taking risks or discussing private matters”) and transtheoretical. In other words, the SOFTA-o behaviors reflect a wide range of theoretical orientations, including emotion-focused (e.g., “Therapist reassures or normalizes a client’s
emotional vulnerability”), structural (e.g., “Client complies with the therapist’s request for an enactment”), and solution focused (e.g., “Client expresses optimism or indicates that a positive change has taken place”).

Trained judges observe videotaped sessions, marking the frequency and intensity of specific positive and negative alliance-related behaviors in each dimension. After viewing the session, the judges assign each client a global rating based on the valence (positive or negative), frequency, intensity, and clinical meaningfulness of the observed behaviors. Judges refer to the training manual for operational definitions of each behavior and dimension as well as for specific scoring guidelines (Friedlander et al., 2004). For example, the guidelines state that a rating of 0 (unremarkable or neutral) should be assigned when no alliance-related behaviors are observed. Ratings between +1 and +3 are assigned when only positive alliance-related behaviors are observed (e.g., “Client agrees to do homework assignments”). When only negative behaviors are observed (e.g., “Client shows indifference about the tasks and process of therapy”), ratings must remain in the -1 to -3 range. Ratings between -1 and +1 reflect the co-occurrence of both positive and negative behaviors.

The client version of the SOFTA-o has demonstrated predictive and concurrent validity with various samples of outpatient couples and families (Friedlander et al., 2006). The two SOFTA-o versions showed average intraclass correlations ranging from .72 to .95 (Friedlander et al., 2006b).

**Family Relational Communication Control Coding System.** Relational control was assessed using the Family Relational Communication Control Coding System (FRCCCS; Heatherington & Friedlander, 1989), a coding system for discourse that is based on Bateson’s (1935) theory of schismogenesis and its associated concepts of complementarity and symmetry (Erchul, 1999). The FRCCCS is an extension of the
Rogers and Farace’s (1975) dyadic Relational Communication Coding System (RCCCS), which has been used in research on conjoint behavioral consultation (Erchul, 1999; Martens, Erchul, & Witt, 1992) and individual psychotherapy (Heatherington & Friedlander, 2004).

The theoretical basis of this measure is that conversational moves toward dominance or submission reflect speakers’ understandings of their social relationship. Complementary interchanges for example, reflect mutual reciprocity and cooperation, whereas competitive symmetrical interchanges reflect conflict and a struggle for control.

Verbatim interactions from therapy sessions are coded using trained judges. The message is the basic unit of analysis, defined within speaking turns. First, each speaking turn is marked, and messages are located within the turn (Heatherington & Friedlander, 1989). Next, trained judges assign codes to each message along three dimensions. Participant refers to the speaker and the direct and indirect target(s) of the message. (The indirect target is an individual to whom the speaker alludes but is not directly addressed). Format refers to the grammatical or structural form of message (e.g. open or closed question). Finally, response mode refers to the pragmatic or meta-communicational function the message serves in relation to the preceding speaker’s message, e.g., answer, or topic shift (Heatherington & Friedlander, 1989).

After all messages in a session are coded, one of three control codes (one-up ↑, one-down ↓, or one-across →) is assigned to each message according to rules specified in the FRCCCS manual (Heatherington & Friedlander, 1989). (See Appendix A for a list of control codes and message codes). A one-up (↑) code indicates an attempt to control the relationship and conveys a move toward dominance. One-up messages include interruptions, instructions, orders, and topic
changes. A *one-down* (↓) code conveys the acceptance of another participant’s definition of the relationship and reflects a move toward submission. One-down messages include those that offer support or agreement. A *one-across* (→) code corresponds to messages that do not attempt to take or relinquish control; these are messages that neutralize the control dynamics. A typical one-across message is a continuation of the previous speaker’s topic.

Transactions refer to the control codes that are assigned to contiguous speaking turns. That is, one message is simultaneously the response to a prior message and a stimulus for the next speaker’s message, so that each message is part of two transactions. Nine possible transactional patterns can occur: complementarity (↑↓ and ↓↑ transactions); symmetry (↑↑ competitive symmetry, ↓↓ submissive symmetry, and →→ neutralized symmetry); transitory (↑→ and →↑ transactions). (See Friedlander and Heatherington (1989) for an example of control coding and transactions.)

The FRCCCS was developed to allow for the analysis of interactions that are unique to groups. In extending the RCCCS (Rogers & Farace, 1975) to families, Heatherington and Friedlander (1989) included three major changes: the use of indirect targets as recipients of messages, the use of intercepts (i.e., the interruption of a two-person exchange), and the use of disconfirmation (i.e., when a speaker fails to respond to a previous speaker and instead addresses a third party). That is, a speaker’s message may target only one other person (direct target) or two or more people (direct and indirect targets). Triadic interactions, e.g., intercepts and disconfirmations, are communication patterns by which the speaker is defining his or her social relationship with two targets simultaneously (Heatherington & Friedlander, 2004). Triadic moves are important in the context of family therapy because they reflect triangulation, a process first defined by Bowen, (1976) which occurs when two people draw in a third
person in order to defuse or avoid emotional conflict (Heatherington & Friedlander, 2004).

There is ample support for the psychometric properties of the FRCCCS. In a study of the family communication using the FRCCCS, Heatherington and Friedlander (1989) reported relatively adequate inter-judge reliability (Cohen's kappas ranging from .52 to .97; mean $k = .82$). In a recent examination of relational control in initial family therapy sessions with adolescents, Cabero (2004) also reported adequate inter-judge reliability coefficients (Cohen’s kappas ranging from .74 to .99). The known-groups validity of the FRCCCS triadic codes was supported in a study (Gaul, Simon, Friedlander, Cutler, & Heatherington, 1991) that reported a significant correspondence between the perceptions of family therapists and triadic FRCCCS control code assignments.

**Procedure**

As part of the ongoing Conecta research project, all families requesting treatment are asked by a research assistant to participate in a naturalistic study about the process of family therapy. All family members must agree to participate and sign a written consent form (see Appendix B) in the presence of the therapist, who also provides informed consent. The client’s consent form specifies that participation is voluntary and confidential. No incentive is offered for participation aside from receiving the therapy free of charge.

Trained raters ($N = 3$, one man and two women, graduate students in family therapy) coded the third session of each case on the SOFTA-o as part of the ongoing Conecta project’s protocol. Mean intraclass correlations were .72 (Engagement), .74 (Emotional Connection), and .85 (Safety).
The Conecta data set was examined in order to select sessions and cases. First, 39 session 3s that had either negative or positive adolescent alliance ratings (as defined above) were identified, and the first sessions from these 39 cases were given to the raters to code on the SOFTA-o. From these 39 cases, the final 10 cases were chosen (i.e., 26%). Table 2 shows the SOFTA-o scores for sessions 1 and 3 for each family. Families 1, 2, 3, 4, 7, 8, 9, and 10 were selected to examine differences between deteriorating and stable alliance families (see Table 3). Videos of the 20 sessions were transcribed by the investigator. Prior to the FRCCCS coding, the transcriptions were reviewed by the coders for accuracy, and corrections were made accordingly.

**FRCCCS coding.** Three different graduate students (3 women, graduate students in family therapy), who were unaware of the study hypotheses, were trained to use the Spanish version of the FRCCCS (Systema de Codificación del Control de la Comunicación Relacional Familiar, SCCCRF; Escudero, Presedo, Revuelta, & Wardle, 1998) by the author of the SCCCRF, who is a highly experienced relational control researcher. Practice videotapes of family therapy sessions (different from those included in the study) were used, and ongoing discussion clarified the judges’ coding dilemmas.

Although the judges coded the indirect as well as the direct exchanges between therapists and adolescents, only the direct exchanges were included in the analysis. That is, exchanges in which the adolescent or the therapist was the indirect target were excluded. The adolescents’ and therapists’ transactions with other family members were not coded.
### Table 2

*Adolescent Alliance Scores for all Families*

<table>
<thead>
<tr>
<th>Family</th>
<th>Session 1</th>
<th></th>
<th>Session 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ENG</td>
<td>EC</td>
<td>SAF</td>
<td>ENG</td>
</tr>
<tr>
<td>1&lt;sup&gt;a&lt;/sup&gt;</td>
<td>+1</td>
<td>+1</td>
<td>+1</td>
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<tr>
<td>2&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>+1</td>
<td>+1</td>
<td>+1</td>
<td>-1</td>
</tr>
<tr>
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<td>+1</td>
<td>+1</td>
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<td>(0)</td>
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<td>0</td>
</tr>
<tr>
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<td>-2</td>
<td>+1</td>
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<td>+1</td>
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</tr>
<tr>
<td>10&lt;sup&gt;b&lt;/sup&gt;</td>
<td>+3</td>
<td>+1</td>
<td>+1</td>
<td>+1</td>
</tr>
</tbody>
</table>

*Note.* ENG = Engagement in the Therapeutic Process; EC = Emotional Connection with the Therapist; SAF = Safety within the Therapeutic System. Session 1 from Families 5 and 6 were not included in the analyses. <sup>a</sup> Deteriorating alliance case. <sup>b</sup> Stable alliance case.
Table 3

*Adolescent SOFTA-o Scores: Good versus Bad Alliance Sessions*

<table>
<thead>
<tr>
<th>Family</th>
<th>ENG</th>
<th>EC</th>
<th>SAF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad alliance sessions</td>
<td></td>
<td></td>
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<tr>
<td>1</td>
<td>-1</td>
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<td>5</td>
<td>-1</td>
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<td>Good alliance sessions</td>
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</tr>
<tr>
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<td>+1</td>
</tr>
<tr>
<td>10</td>
<td>+1</td>
<td>+1</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note.* SOFTA-o = System for Observing Family Therapeutic Alliances (Friedlander et al., 2006b). ENG = Engagement in the Therapeutic Process; EC = Emotional Connection with the Therapist; SAF = Safety within the Therapeutic System. All sessions were session 3.
After approximately 30 hours of training, the coders were given two practice tapes. The adolescent-therapist relational patterns were coded, and interjudge reliabilities were assessed using Cohen’s kappa coefficient. After satisfactory reliability was achieved (at least $k = .75$ in each coding dimension), the sessions used in the present analysis were randomly assigned to coders. Approximately a third of the sample (i.e., 5 sessions) was coded independently by at least two of the judges, and the remaining sessions by one person. Discrepancies were negotiated as the coding progressed.

To assess reliability in all phases of the coding period, all three judges coded a third of the videos, which were distributed at the beginning, middle and end of the coding process. Interjudge reliabilities ranged from $k = .64$ to $.98$; the average kappas for message codes were $.98$ (participant), $.87$ (message format), and $.67$ (response mode).

Because the SOFTA-o was simultaneously developed in English and Spanish (Friedlander et al., 2006), there was no need to translate the measures from English to Spanish. The FRCCCS (Heatherington & Friedlander, 1989) was developed in English and translated into Spanish by Escudero et al. (1998; SCCCRF). The Spanish versions of both measures have been extensively used in previous research.

**Hypotheses**

Comparing good and bad alliance sessions, the following three hypotheses were tested:

**Hypothesis 1.** The frequency of direct exchanges (and the ratio of exchanges per session duration) between therapist and adolescent were expected to be significantly greater in the good than in the bad alliance sessions.

**Hypothesis 2.** Compared to the good alliance sessions, in the bad alliance sessions, the conditional probabilities of (a) therapist (A↑-T↑) and (b) adolescent (T↑-
A↑) competitive symmetry (i.e., the likelihood of responding to a ↑ message with a ↑ response) were expected to be significantly greater.

**Hypothesis 3.** Compared to the bad alliance sessions, in the good alliance sessions, the conditional probabilities of complementarity, i.e., the likelihood of responding to a ↑ message with a ↓ response, for both (a) therapist (A↑-T↓) and (b) adolescent (T↑-A↓), were expected to be significantly greater.

Analyzing changes in relational control from session 1 to 3 in families with deteriorating and stable-positive alliances, the two following hypotheses were tested:

**Hypothesis 4.** In the deteriorating alliance cases, the conditional probabilities of competitive symmetry, both (a) therapist (A↑-T↑) and (b) adolescent (T↑-A↑), were expected to be significantly greater in the third session than in the first; (c) this difference was not expected in the stable alliance families.

**Hypothesis 5.** In the deteriorating alliance cases, the conditional probabilities of complementarity, (a) therapist A↑-T↓ and (b) adolescent T↑-A↓, were expected to be significantly lower in the third session than in the first; (c) this difference was not expected in the stable alliance cases.

**Analyses**

The Sequential Data Interchange Standard (SDIS; Bakeman & Quera, 1992) was used to test the hypotheses. The SDIS is a standardized system that, with the aid of the Generalized Sequential Querier (GSEQ; Bakeman & Quera, 1995) software program, provides the representation and analysis of sequential data.

The test of Hypothesis 1 involved first calculating the frequency of direct exchanges between adolescent clients and their therapists in each session. Because of the small sample of sessions, the nonparametric Mann-Whitney U test was used to examine the difference between the mean number of exchanges in good alliance
sessions versus bad alliance sessions. The Mann-Whitney U test is a distribution-free, nonparametric comparison test that is recommended with small sample sizes or when the distribution data are clearly non-normal (Neuhäuser & Ruxton, 2009). Despite low statistical power, nonparametric tests are commonly used in the behavioral sciences to perform conservative reliable sample comparisons.

Because the duration of a session may largely determine the frequency of exchanges in that session, differences in the ratio of exchanges by duration were also examined. In other words, to adjust for session duration, each session’s frequency of exchanges was adjusted by the session duration in minutes, and differences were examined in the resulting values.

In order to test the remaining four hypotheses, more complex transactional interchanges were analyzed. First, the control codes of therapists and their adolescent clients were organized in contingency tables, or matrices, by taking into consideration the order of the contiguous messages in terms of antecedents and consequents. Contingency tables allow an examination of the unconditional and the conditional probability of, for example, the therapist’s consequent ↓ response to the adolescent client’s antecedent ↑ message. Therefore, for each session, two 3 x 3 contingency matrices were created, one with the adolescent’s ↑, ↓, and → messages as antecedent and the therapist’s ↑, ↓, and → messages as consequent, and a second matrix with the therapist’s ↑, ↓, and → messages as antecedent and the adolescent’s ↑, ↓, and → messages as consequent (Escudero & Rogers, 2004; Heatherington & Friedlander, 1990). Sets of matrices were created separately for the set of good alliance sessions and for the set of bad alliance sessions; each cell contained the accumulated frequency and conditional probability for the entire subsample, i.e., the good sessions as a set and the bad sessions as a set.
Prior to testing the hypotheses, two preliminary analyses were conducted, as recommended by Rogers and Escudero (2004): (a) the overall sequential association within each contingency matrix and (b) the activating/inhibiting effects of the antecedent on the consequent for each interaction type (competitive symmetry and complementarity). A nonsignificant overall association would suggest that there is no relational structure between antecedent and consequent. Therefore, if the overall association between antecedent and consequent in a given matrix is not significant, further examination of specific interaction patterns within this matrix must be done with caution. Likewise, if the activating/inhibiting effect of the antecedent on the consequent is not significant, this result means that there is no significant influence of the antecedent on the consequent in that specific interaction, suggesting that further examination of this relational contingency should also be done with caution.

According to Escudero and Rogers (2004) Pearson’s chi-square is the appropriate statistical method for testing the overall association of antecedent and consequent in the contingency matrix, although interpretations require consideration of the influence of sample size. Chi-square values were examined for each session separately as well as for the accumulated frequencies per group (i.e., the good versus the bad alliance sessions, and the deteriorating versus the stable alliance cases). The resulting p values for each contingency table provide information about the dependency of consequent responses on the antecedent messages.

If the chi-square value were to indicate a significant overall association (i.e., p < .05) for a given contingency table, the next step would be to examine the activating/inhibiting effect of specific transaction patterns (e.g., complementary adolescent ↑/ therapist ↓, and competitive symmetrical adolescent ↑/therapist ↑) using adjusted residual indexes (Escudero & Rogers, 2004). Adjusted residuals are either
positive or negative, depending on the activating versus inhibiting influence of the antecedent on the consequent. With $p \leq .05$, values $\geq +1.96$ indicate that a consequent is activated by an antecedent; values $\leq -1.96$ indicate that a consequent is inhibited by an antecedent (Escudero & Rogers, 2004).

In this way, the adjusted residual index indicates whether there is an activating influence of adolescent message on therapist response and vice versa. For example, if the adjusted residuals for competitive $T\uparrow \cdot A\uparrow$ interactions were positive and significant, this result would signify that the antecedent therapist $\uparrow$ messages significantly activated the consequent adolescent $\uparrow$ responses. Attention was paid to the appropriateness of the data for the conditions required in this analysis. The GSEQ program allows for identification of which adjusted residuals, if any, do not meet specific criteria (Escudero & Rogers, 2004).

In order to examine the hypothesized differences in the probability of competitive symmetry and complementarity between good and bad alliance sessions, Yule’s $Q$ values were computed for each conditional probability, as recommended by Escudero and Rogers (2004). This statistic is derived from the odds ratio, which (in contrast to conditional probabilities) is not dependent on the number of observations (i.e., sample size). Yule’s $Q$ provides an index ranging from $-1$, representing the maximum inhibitory effect of sequential association, to $+1$, representing the greatest activation effect of sequential association (Escudero & Rogers, 2004).

Yule’s $Q$ values, tested using the nonparametric Mann-Whitney $U$, were used to investigate Hypotheses 2 and 3, i.e., the expected differences between the bad and good alliance sessions. The graphical distribution of the conditional probabilities of each interaction type was also examined per session and per group to gain a visual understanding of the observed differences.
Prior to testing Hypotheses 4 and 5, i.e., changes in competitive symmetry and complementarity over time for the deteriorating and stable alliance subsamples, preliminary analyses involved examining the contingency tables for their overall association (i.e., chi squares) and activating/inhibiting effects (i.e., adjusted residuals). Then, to test these last two hypotheses, Four 2 x 2 (session x family subsample) chi-square tests, i.e., T↑-A↑, A↑-T↑, T↑-A↓, and A↑-T↓, were performed to analyze differences between sessions 1 and 3, and between the two subsamples.

Results from these chi squares revealed whether the observed frequencies of each type of interaction differed significantly by session and by family subsample. For example, a significant chi square for T↑-A↑ would signify that the probability of the adolescent responding with ↑ to the therapist ↑ messages in session 1 and 3 varied depending on family subsample (i.e., deteriorating or stable alliance). In addition, to test the hypotheses more conservatively, Yule's Q values were computed for the conditional probabilities of each interaction type and then compared statistically using the Mann-Whitney U test. Graphical representations of the conditional probabilities for each interaction type were obtained for a better understanding of the observed differences between family subsamples and sessions.

Effect sizes for the significant Mann-Whitney U tests and chi square values were examined. Effect sizes for the chi square tests were obtained using phi, which ranges from 0 (no effect) to 1 (greatest effect size), so that a phi value of .10 is small, .30 is medium, and .50 is a large effect size. Regarding the Mann-Whitney U tests, the phi probability index (θ) is specifically recommended for nonparametric statistics (Acion, Peterson, Temple, & Arndt, 2006; Newcombe, 2006). It ranges from 0 to 1 and indicates the probability that the value of a certain condition is larger than that of another condition. A probability of .50, for example, indicates a 50% chance that one
condition is larger than the other condition and, thus, is the lowest possible effect size. The more a value moves from .50 in either direction (i.e., toward 0 or 1.0), the greater the effect size. As a guideline, Acion et al. (2006) provided correspondence between Cohen’s $d$ values and the $\theta$; $d = .20$ (small effect size) corresponds to a $\theta = .56$ or $\theta = .44$; $d = .50$ (medium effect size) corresponds to a $\theta = .64$ or $\theta = .36$; and a $d = .80$ (large effect size) corresponds to a $\theta = .70$ or $\theta = .30$. Comparing any given two subsamples, $a$ and $b$, values above .50 indicate that observations in $a$ are greater than those in $b$, whereas values below .50 indicate that observations are lower in subsample.

Only results that were clear in the graphical representations and that had effect sizes at or above the “medium” range were interpreted as providing support for the hypotheses.
Chapter III

Results

This chapter presents the preliminary and major analyses for the comparison of relational control patterns in (a) sessions with highly positive and negative alliances as well as in (b) families in which the alliance deteriorated or remained stable/positive from the first to the third session. A summary of the major results is provided at the end of the chapter.

Good versus Bad Alliance Sessions

Hypothesis 1: Frequency of exchanges. Due to the limited sample size, an independent-samples Mann-Whitney U nonparametric test was used to compare the raw number of exchanges in the 5 good and the 5 bad alliance sessions. Table 4 provides the number of exchanges, duration (in minutes), and ratio of exchanges by duration for each good and bad session.

Results indicated no significant differences between good and bad alliance sessions in either the total number of exchanges ($U = 7.00, Z = -1.15; p = .25$) or in the ratio of exchanges by session duration ($U = 10.00, Z = -.52; p = .60$). The standard deviation for the bad alliance sessions suggested greater variability within this group ($SD = 113.41$ for total exchanges; $SD = 2.17$ for exchanges adjusted by duration), than within the good alliance sessions ($SD = 52.58$ for total exchanges; $SD = 1.13$ for exchanges adjusted by duration).

Hypotheses 2 and 3: Competitive (↑↓) and complementary (↑↑) interactions. To analyze the predicted differences in relational control patterns in good and bad alliance sessions, two contingency tables for each session were created, (a) with the therapist as the antecedent and the adolescent as consequent, and (b) with
Table 4

*Number of Exchanges, Session Duration, and Ratio of Exchanges by Duration*

<table>
<thead>
<tr>
<th>Family</th>
<th>Number of exchanges</th>
<th>Session Duration</th>
<th># of exchanges by duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good alliance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>129</td>
<td>69</td>
<td>3.43</td>
</tr>
<tr>
<td>2</td>
<td>82</td>
<td>55</td>
<td>2.40</td>
</tr>
<tr>
<td>3</td>
<td>81</td>
<td>55</td>
<td>6.24</td>
</tr>
<tr>
<td>4</td>
<td>186</td>
<td>57</td>
<td>4.40</td>
</tr>
<tr>
<td>5</td>
<td>63</td>
<td>77</td>
<td>1.77</td>
</tr>
<tr>
<td>M</td>
<td>112.00</td>
<td>63.60</td>
<td>2.20</td>
</tr>
<tr>
<td>SD</td>
<td>52.58</td>
<td>9.04</td>
<td>1.13</td>
</tr>
<tr>
<td>Bad alliance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>54</td>
<td>49</td>
<td>2.63</td>
</tr>
<tr>
<td>7</td>
<td>132</td>
<td>75</td>
<td>1.09</td>
</tr>
<tr>
<td>8</td>
<td>343</td>
<td>38</td>
<td>2.13</td>
</tr>
<tr>
<td>9</td>
<td>250</td>
<td>51</td>
<td>3.65</td>
</tr>
<tr>
<td>10</td>
<td>136</td>
<td>55</td>
<td>1.15</td>
</tr>
<tr>
<td>M</td>
<td>184.20</td>
<td>53.60</td>
<td>3.15</td>
</tr>
<tr>
<td>SD</td>
<td>113.41</td>
<td>13.52</td>
<td>2.17</td>
</tr>
</tbody>
</table>

*Note.* All sessions are session 3s. Session duration was measured in minutes. There were no significant differences between good and bad alliance sessions on any variable.
the adolescent as the antecedent and the therapist as consequent.

**Preliminary analyses.** In order to examine the overall sequential association within each contingency matrix, chi-square tests were used. Tables 5 and 6 provide the chi-square values for each contingency table per session, separately for T-A and A-T. Results revealed that, in all the good alliance sessions, the adolescent responses (consequents) were associated with the therapist messages (antecedents), whereas the therapist responses were not associated with the adolescent messages. However, in the bad alliance sessions, the adolescent responses were associated with the therapist messages, in all but one case, Family 1 $\chi^2(4) = 3.99, p > .05$, and the therapist responses were associated with the adolescent responses in two cases, Family 3 $\chi^2(4) = 11.88, p > .05$, and Family 5 $\chi^2(4) = 9.31, p > .05$.

These results suggest that, on the one hand, communication was structured by the therapist and not by the adolescent in all of the good alliance sessions, whereas the communication was structured differently in three of the five bad alliance sessions. Due to the lack of A-T relational structure in the good alliance sessions, interpretation of these contingencies was done with caution.

Next, the adjusted residuals were used to examine the statistical degree of influence of the antecedent on the consequent in each type of interaction. In other words, adjusted residuals were used to examine the activating/inhibiting effect of the antecedent ↑ messages on the consequent ↑ or ↓ messages. Tables 5 and 6 summarize the frequencies, conditional probabilities, and adjusted residuals for the ↑↑ and ↑↓ contingencies in the good and bad alliance sessions.

Regarding competitive (↑↑) interactions, the adjusted residuals revealed no significance influence of adolescent ↑ messages on therapist ↑ responses in either the good or the bad alliance sessions. There was a significant inhibiting effect of therapist
Table 5

*Conditional Probabilities, Chi-square values, Adjusted Residuals and Yule's Q Values* for Interactions with the Therapist as Antecedent

<table>
<thead>
<tr>
<th>Family</th>
<th>( \chi^2(4) )</th>
<th>T↑-A↑</th>
<th>Z</th>
<th>Yule's Q</th>
<th>T↑-A↓</th>
<th>Z</th>
<th>Yule's Q</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>Good Alliance Sessions</td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>71.67***</td>
<td>4 (.06)</td>
<td>-2.68&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.18</td>
<td>55 (.80)</td>
<td>7.45</td>
<td>0.92</td>
</tr>
<tr>
<td>7</td>
<td>13.39***</td>
<td>8 (.31)</td>
<td>1.07&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.14</td>
<td>14 (.54)</td>
<td>2.39</td>
<td>0.52</td>
</tr>
<tr>
<td>8</td>
<td>24.83***</td>
<td>5 (.11)</td>
<td>-0.29</td>
<td>-0.08</td>
<td>47 (.69)</td>
<td>1.51</td>
<td>0.23</td>
</tr>
<tr>
<td>9</td>
<td>13.14**</td>
<td>4 (.13)</td>
<td>-0.29&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.08</td>
<td>18 (.56)</td>
<td>2.55</td>
<td>0.58</td>
</tr>
<tr>
<td>10</td>
<td>25.68***</td>
<td>2 (.06)</td>
<td>-2.70</td>
<td>-0.75</td>
<td>30 (.88)</td>
<td>4.26</td>
<td>0.82</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Bad Alliance Sessions</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>3.99</td>
<td>7 (.37)</td>
<td>0.54&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.16</td>
<td>3 (.16)</td>
<td>-1.33&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.44</td>
</tr>
<tr>
<td>2</td>
<td>14.26***</td>
<td>6 (.10)</td>
<td>-3.05</td>
<td>-0.62</td>
<td>31 (.53)</td>
<td>4.48</td>
<td>0.68</td>
</tr>
<tr>
<td>3</td>
<td>53.55***</td>
<td>18 (.11)</td>
<td>-2.93</td>
<td>-0.41</td>
<td>120 (.71)</td>
<td>6.64</td>
<td>0.64</td>
</tr>
<tr>
<td>4</td>
<td>50.59***</td>
<td>36 (.27)</td>
<td>0.79</td>
<td>0.12</td>
<td>70 (.53)</td>
<td>5.36</td>
<td>0.63</td>
</tr>
<tr>
<td>5</td>
<td>35.84***</td>
<td>11 (.23)</td>
<td>-0.74</td>
<td>-0.15</td>
<td>33 (.63)</td>
<td>4.55</td>
<td>0.69</td>
</tr>
</tbody>
</table>

*Note.* Chi-square values refer to the entire contingency matrix for each session.

Frequencies of T↑-A↑ and T↑-A↓ are provided, with the conditional probabilities in parentheses. **\( p < .01 \). ***\( p < .001 \).
Table 6

*Conditional Probabilities, Chi-square values, Adjusted Residuals and Yule’s Q Values*

*for Interactions with the Adolescent as Antecedent*

<table>
<thead>
<tr>
<th>Family</th>
<th>$\chi^2(4)$</th>
<th>$A\uparrow-T\uparrow$</th>
<th>$Z$</th>
<th>Yule’s $Q$</th>
<th>$A\uparrow-T\downarrow$</th>
<th>$Z$</th>
<th>Yule’s $Q$</th>
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<tbody>
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<td></td>
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<tr>
<td><strong>Good Alliance Sessions</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1.40</td>
<td>2 (.25)</td>
<td>-1.07$^a$</td>
<td>-0.41</td>
<td>2 (.25)</td>
<td>0.39$^a$</td>
<td>0.16</td>
</tr>
<tr>
<td>7</td>
<td>3.5</td>
<td>7 (.35)</td>
<td>0.91$^a$</td>
<td>0.05</td>
<td>7 (.35)</td>
<td>-1.74$^a$</td>
<td>-0.43</td>
</tr>
<tr>
<td>8</td>
<td>0.70</td>
<td>4 (24)</td>
<td>-0.71$^a$</td>
<td>-0.21</td>
<td>10 (.59)</td>
<td>0.41$^a$</td>
<td>0.11</td>
</tr>
<tr>
<td>9</td>
<td>4.42</td>
<td>1 (.20)</td>
<td>-0.90$^a$</td>
<td>-0.46</td>
<td>3 (.60)</td>
<td>1.53$^a$</td>
<td>0.60</td>
</tr>
<tr>
<td>10</td>
<td>2.91</td>
<td>5 (.31)</td>
<td>-0.84</td>
<td>-0.24</td>
<td>8 (.50)</td>
<td>0.43$^a$</td>
<td>0.12</td>
</tr>
<tr>
<td><strong>Bad Alliance Sessions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>0.78</td>
<td>6 (.38)</td>
<td>0.48$^a$</td>
<td>0.15</td>
<td>8 (.50)</td>
<td>-0.26$^a$</td>
<td>-0.08</td>
</tr>
<tr>
<td>2</td>
<td>0.35</td>
<td>13 (.47)</td>
<td>0.35</td>
<td>0.07</td>
<td>14 (.43)</td>
<td>-0.18</td>
<td>-0.04</td>
</tr>
<tr>
<td>3</td>
<td>11.88*</td>
<td>26 (.46)</td>
<td>-0.20</td>
<td>-0.03</td>
<td>29 (.51)</td>
<td>2.13</td>
<td>0.30</td>
</tr>
<tr>
<td>4</td>
<td>3.29</td>
<td>39 (.63)</td>
<td>1.73</td>
<td>0.25</td>
<td>12 (.19)</td>
<td>-0.64</td>
<td>-0.12</td>
</tr>
<tr>
<td>5</td>
<td>9.31*</td>
<td>14 (.41)</td>
<td>0.69</td>
<td>0.14</td>
<td>13 (.38)</td>
<td>1.49</td>
<td>0.30</td>
</tr>
</tbody>
</table>

*Note.* Chi-square values refer to the entire contingency matrix for that session. Frequencies of $A\uparrow-T\uparrow$ and $A\uparrow-T\downarrow$ are provided with the conditional probabilities in parentheses. $^a$ Normal approximation for the adjusted residual was not met. *$p < .05.$
↑ on adolescent ↑ in two of the five bad alliance sessions ($Z = -3.05$ and $Z = -2.93$); with respect to competitive (↑↑) interactions, adolescent ↑ neither activated nor inhibited therapist ↑, whereas therapist ↑ activated adolescent ↑ in two of the bad and in two of the good alliance sessions.

Regarding complementary (↑↓) interactions, the adjusted residuals revealed that therapist ↑ activated adolescent ↓ in four of the five good and, likewise, in four of the five bad alliance sessions. The adjusted residuals revealed a significant activating effect of adolescent ↑ on therapist ↓ in one of the five bad alliance sessions ($Z = 2.13$, $p < .01$) and in none of the good alliance sessions. Therefore, in both the good and bad alliance sessions, therapist ↑ tended to activate adolescent ↓, whereas adolescent ↑ tended to neither activate nor inhibit therapist ↓.

It is worth noting that several of the adjusted residuals did not meet the normal approximation condition. However, this situation occurred mostly with values that were nonsignificant. Only one of the significant values did not meet a normal approximation, i.e., one $Z$ value for $T↑-A↑$ in Family 6 ($Z = -2.68$) from the good alliance subsample. Therefore, interpretations based on the significant adjusted residuals were considered reliable.

**Hypothesis tests.** Because conditional probabilities and adjusted residuals may be affected by sample size, group comparisons based on these values may be unreliable. Consequently, the conservative Yule's $Q$ index was used to examine group differences. Yule's $Q$ values were obtained for each interaction type (i.e., $A↑-T↑$, $A↑-T↓$, $T↑-A↑$, and $T↑-A↓$) for each session (shown in Tables 5 and 6). The Mann-Whitney U test of these $Q$ values showed a significant difference in the $A↑-T↑$ pattern ($U = 3.00$, $p < .05$), indicating a significantly greater inhibitory effect of the adolescent ↑ messages on the therapist ↑ responses in the good alliance sessions, i.e, a
lower likelihood of A↑-T↑ in good alliance sessions (consistent with Hypothesis 2a). The probability index estimated a large (θ = .13) effect size for this difference.

No significant difference was found between the good and bad alliance sessions in the T↑-A↑ pattern (U = 8.00, p = .35), however. Thus, Hypothesis 2b was not supported, i.e., the greater likelihood of the adolescent responding with competitive symmetry in the bad alliance sessions.

Figures 1 and 2 are the graphical representations of Hypotheses 2a and 2b. These spatial distributions of the conditional probabilities suggest a greater likelihood of the ↑↑ pattern in the bad alliance sessions than in the alliance good sessions, regardless of whether the therapist or adolescent message was the antecedent. Thus, taken together with the effect size, results supported only Hypothesis 2a, i.e., relatively less likelihood of the therapist responding in a competitive symmetrical pattern in the good than in the bad sessions.

Regarding complementary interaction patterns (Hypothesis 3), results from the Mann-Whitney U tests revealed no significant differences in either A↑-T↓ (U = 11.00, p = .75, θ = .44) or T↑-A↓ (U = 8.00, p = .35, θ = .32). However, the graphical representations of the adjusted residuals (in Figures 3 and 4) suggest a slightly greater complementarity (both A↑-T↓, and T↑-A↓) in the good than in the bad alliance sessions. Whereas these figures suggest a lower likelihood of T↑-A↓ in the bad alliance sessions (consistent with Hypothesis 3a), the difference between bad and good alliance sessions in terms of A↑-T↓, was not altogether clear. Thus, Hypotheses 3a and 3b were not supported.
Figure 1. Conditional Probabilities of Adolescent ↑-Therapist ↑ in Good and Bad Alliance Sessions

Figure 2. Conditional Probabilities of Therapist ↑-Adolescent ↑ in Good and Bad Alliance Sessions

Figure 3. Conditional Probabilities of Adolescent ↑-Therapist ↓ in Good and Bad Alliance Sessions

Figure 4 Conditional Probabilities of Therapist ↑-Adolescent ↓ in Good and Bad Alliance Sessions
Deteriorating Versus Stable Alliance Families

**Hypothesis 4 and 5: Changes in Competitive symmetry (↑↑) and complementary (↑↓) interactions.** Contingency matrices were created to examine relational control patterns in cases in which the observed therapist-adolescent alliance deteriorated or remained positive (i.e., stable). Specifically, two contingency tables (i.e., T-A and A-T) were obtained for each case separately for sessions 1 and 3.

**Preliminary analyses.** Preliminary analyses were used to examine the overall sequential association within each contingency matrix as well as the degree of influence of the antecedent on the consequent for each type of interaction. Tables 7 and 8 provide the chi-square values for each contingency matrix for each session per subsample, separately for T-A and A-T. Examination of the Table 7 shows that the association of T-A was nonsignificant for only one session 3 in the deteriorating alliance subsample. In contrast, the association of A-T (Table 8) was significant in only one deteriorating alliance family in both sessions (Family 3, session 1 $\chi^2(4) = 18.78, \ p < .001$, and session 3, $\chi^2(4) = 11.37, \ p < .05$), and in two of the session 3s from the stable alliance subsample, Family 9 $\chi^2(4) = 10.12, \ p < .05$, and Family 10 $\chi^2(4) = 18.74, \ p < .001$. Taken together, these results indicated that the relational communication tended to be structured by the therapists more so than by the adolescents, regardless of the group (deteriorating versus stable) or session number.

In order to examine the activating/inhibiting effect of each interaction pattern, the adjusted residuals were examined. Tables 7 and 8 also show the adjusted residuals for each interaction (i.e., T↑-A↑, and T↑-A↓ and A↑-T↑, A↑-T↓,) per session by family subsample. Regarding the T-A interactions, results showed a significant activating effect of T↑ on A↓ in most sessions, with the exception of one session 3 in the deteriorating alliance group, Family 1 Z = -1.33, $p > .05$, and two session 3s in the
stable alliance group, Family 9 $Z = 1.51$, and Family 10 $Z = 1.80$, both $ps > .05$. In addition, the adjusted residuals indicated a significant inhibiting effect of $T \uparrow$ on $A \uparrow$ in two of the sessions 1 (Family 3 $Z = -2.68$ and Family 5 $Z = -3.37$) and in one session 3 (Family 3 $Z = -2.92, p < .01$) in the deteriorating subsample as well as in two of the session 1s (Family 8 $Z = -2.36$ and Family 9 $Z = -2.04$, both $ps < .01$) and in one session 3 (Family 7 $Z = -2.68, p < .01$) from the stable alliance group. Therapist $\uparrow$ appeared to activate $A \uparrow$ significantly in only one session 3 in the deteriorating subsample (Family 2 $Z = 4.05, p < .001$). Taken together, the adjusted residuals for $T$-$A$ interactions suggested that $T \uparrow$ tended to activate $A \downarrow$ and to inhibit $A \uparrow$ regardless of the family subsample or the session number.

Regarding the $A$-$T$ interactions, the adjusted residuals (shown in Table 8) indicated a significant activating effect of $A \uparrow$ on $T \downarrow$ in only one session 1 and in one session 3 in the deteriorating subsample, there was no significant influence of $A \uparrow$ on $T \uparrow$ in any session in either subsample ($Zs$ ranged from -1.71 to 1.73, all $ps > .05$). Taken together, these results suggested no significant influence of $A \uparrow$ on either $T \uparrow$ or $T \downarrow$ in either family subsample or session number.

It is worth noting that several of the adjusted residuals did not meet the normal approximation condition. However, this situation occurred mostly with values that were nonsignificant. Only two of the significant values did not meet a normal approximation, i.e., one $Z$ value for $T \uparrow$-$A \uparrow$ in one session 3 (Family 7 $Z = -2.68$), and one $Z$ value for $T \uparrow$-$A \downarrow$ in one session 3 (Family 8 $Z = 3.24$) in the stable alliance subsample. Therefore, interpretations based on the significant adjusted residuals were considered reliable.
Table 7

*Conditional Probabilities, Chi-squares, and Adjusted Residuals for T-A Interactions*

<table>
<thead>
<tr>
<th>Family</th>
<th>$\chi^2(4)$</th>
<th>T↑-A↑</th>
<th>Z</th>
<th>T↑-A↓</th>
<th>Z</th>
</tr>
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<tbody>
<tr>
<td><strong>Deteriorating Alliance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>22.37***</td>
<td>11 (.11)</td>
<td>-0.52</td>
<td>72 (.73)</td>
<td>3.90</td>
</tr>
<tr>
<td>2</td>
<td>44.48***</td>
<td>4 (.08)</td>
<td>-0.58 $^a$</td>
<td>43 (.84)</td>
<td>3.30</td>
</tr>
<tr>
<td>3</td>
<td>46.59***</td>
<td>13 (.11)</td>
<td>-2.68</td>
<td>65 (.77)</td>
<td>5.54</td>
</tr>
<tr>
<td>4</td>
<td>67.52***</td>
<td>2 (.04)</td>
<td>-3.37</td>
<td>48 (.92)</td>
<td>6.97</td>
</tr>
<tr>
<td>Session 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>3.99</td>
<td>7 (.38)</td>
<td>0.54 $^a$</td>
<td>3 (.16)</td>
<td>-1.33 $^a$</td>
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<tr>
<td>2</td>
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<td>4.05</td>
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<td>2.80</td>
</tr>
<tr>
<td>3</td>
<td>35.55***</td>
<td>18 (.26)</td>
<td>-2.92</td>
<td>106 (.62)</td>
<td>5.22</td>
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<tr>
<td>4</td>
<td>50.59***</td>
<td>36 (.23)</td>
<td>0.79</td>
<td>70 (.53)</td>
<td>5.36</td>
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<tr>
<td><strong>Stable Alliance</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Session 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>23.26***</td>
<td>8 (.20)</td>
<td>-1.01</td>
<td>29 (.73)</td>
<td>4.01</td>
</tr>
<tr>
<td>8</td>
<td>18.22**</td>
<td>3 (.06)</td>
<td>-2.36</td>
<td>33 (.69)</td>
<td>3.36</td>
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<tr>
<td>9</td>
<td>28.60***</td>
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<td>-2.04</td>
<td>53 (.83)</td>
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</tr>
<tr>
<td>10</td>
<td>39.77***</td>
<td>3 (.06)</td>
<td>-1.29 $^a$</td>
<td>43 (.81)</td>
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*Table continues*
Table 7, continued

<table>
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<tr>
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<th>T↑-A↓</th>
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<td></td>
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<td></td>
</tr>
<tr>
<td>7</td>
<td>89.53***</td>
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<td>-2.68 $^a$</td>
<td>56 (.86)</td>
<td>8.18</td>
</tr>
<tr>
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<td>14.26**</td>
<td>4 (.31)</td>
<td>-1.07 $^a$</td>
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<td>24.83***</td>
<td>5 (.11)</td>
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<td>10</td>
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<td>11 (.10)</td>
<td>-0.074</td>
<td>18 (.58)</td>
<td>1.80</td>
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</table>

*Note.* Chi-square values refer to the entire contingency matrix for the session. For T↑-A↑ and T↑-A↓, interaction frequencies are provided, with the conditional probabilities in parentheses. $^a$ Normal approximation for the adjusted residual was not met.

**$p < .01$. ***$p < .001$.**
Table 8

*Conditional Probabilities, Chi-squares, and Adjusted Residuals for A-T Interactions*

<table>
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<tr>
<th>Family</th>
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<th>Z</th>
<th>A↑-T↓</th>
<th>Z</th>
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</tr>
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<td></td>
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</tr>
<tr>
<td>1</td>
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<td>-1.38a</td>
<td></td>
<td>14 (.47)</td>
<td>0.32</td>
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<tr>
<td>2</td>
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<td>5 (.42)</td>
<td>0.35a</td>
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<td>0.41a</td>
</tr>
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<td>-0.38</td>
<td>27 (.66)</td>
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<td>2.64</td>
</tr>
<tr>
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<td>9 (.39)</td>
<td>0.03a</td>
<td>9 (.39)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>0.78</td>
<td>6 (.38)</td>
<td>0.48a</td>
<td>8 (.50)</td>
<td></td>
<td>-0.26a</td>
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<td>2.13</td>
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<td>4</td>
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<td>12 (.19)</td>
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<td>-0.64</td>
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<td></td>
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<td></td>
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<td></td>
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<td>0.86a</td>
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<td>6 (.55)</td>
<td>0.81a</td>
<td>0 (.00)</td>
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<td>-1.87a</td>
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*Table continues*
Table 8, continued

<table>
<thead>
<tr>
<th>Family</th>
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<th>A↑-T↓</th>
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</tr>
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<tr>
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</tr>
<tr>
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<td>2 (.25)</td>
<td>0.39a</td>
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<tr>
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<td>7 (.35)</td>
<td>0.91a</td>
<td>7 (.35)</td>
<td>-1.74a</td>
</tr>
<tr>
<td>9</td>
<td>0.70</td>
<td>4 (.24)</td>
<td>-0.71a</td>
<td>10 (.59)</td>
<td>0.41a</td>
</tr>
<tr>
<td>10</td>
<td>4.42</td>
<td>1 (.20)</td>
<td>-0.90a</td>
<td>3 (.60)</td>
<td>1.53a</td>
</tr>
</tbody>
</table>

*Note.* Chi-square values refer to the entire contingency matrix for the session. For T↑-A↑ and T↑-A↓, interaction frequencies are provided, with the conditional probabilities in parentheses. a Normal approximation for the adjusted residual was not met.

*p < .05. ***p < .001.
**Hypothesis tests.** Four two-way chi-square analyses were performed, one for each interaction type (i.e., T↑-A↑, A↑-T↑, T↑-A↓, and A↑-T↓) to examine differences between session 1 and 3 with each family subsample. Tables 9-12 show the results of the four chi-squares per interaction type (i.e., competitive and complementary) and per antecedent message (i.e., adolescent versus therapist).

Regarding Hypothesis 4, results for competitive symmetry indicated statistically significant differences between alliance groups with both the adolescent, $\chi^2 (1) = 14.00, p < .001$, and the therapist $\chi^2 (1) = 10.9, p < .01$, as antecedent. Specifically, competitive symmetry in sessions 1 and 3 was found to vary significantly depending on the family subsample in that, in session 3, it was more likely to occur in the deteriorating than in the stable alliance families regardless of the antecedent. Therefore, results indicated an opposite trend in competitive symmetry from session 1 to 3, i.e., decreasing in stable families and increasing in deteriorating families. To determine the strength of this effect, phi was examined and indicated a medium effect size for both chi-square values ($\Phi s = .30$). These results support both Hypotheses 4a and 4b.

Regarding Hypothesis 5, results for complementarity revealed no significant differences from session 1 to 3 in the stable and deteriorating alliance families for either speaker as antecedent, A↑-T↓ $\chi^2 (1) = 2.2, p = .14$; T↑-A↓ $\chi^2 (1) = .25, p = .62$.

The more conservative Yule's $Q$ indexes were also used to examine changes in both relational control patterns. Results from the Mann-Whitney $U$ nonparametric tests of the Yule’s $Q$ values revealed no significant differences between session 1 and 3 in either competitive or complementary interactions in the deteriorating alliance families, providing no support for Hypotheses 5a, 5b, and 5c. It is worth noting,
Table 9

*Frequencies of T↑-A↑ Interactions Aggregated by Session and Family Type*

<table>
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<tr>
<th></th>
<th>Stable</th>
<th>Deteriorating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>18 (10.6)</td>
<td>25 (32.4)</td>
</tr>
<tr>
<td>Session 3</td>
<td>11 (18.4)</td>
<td>64 (56.6)</td>
</tr>
</tbody>
</table>

*Note:* Expected frequencies are in parentheses.

$\chi^2 (1) = 10.90$, $n = 118$, $p = .001$, $\Phi = .30$

Table 10

*Frequencies of A↑-T↑ Interactions Aggregated by Session and Family Type*

<table>
<thead>
<tr>
<th></th>
<th>Stable</th>
<th>Deteriorating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>24 (14.3)</td>
<td>35 (44.7)</td>
</tr>
<tr>
<td>Session 3</td>
<td>14 (23.7)</td>
<td>84 (74.3)</td>
</tr>
</tbody>
</table>

*Note:* Expected frequencies are in parentheses.

$\chi^2 (1) = 14.00$, $n = 157$, $p = .0001$, $\Phi = .30$.

Table 11

*Frequencies of T↑-A↓ Interactions Aggregated by Session and Family Type*

<table>
<thead>
<tr>
<th></th>
<th>Stable</th>
<th>Deteriorating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>158 (155)</td>
<td>228 (231)</td>
</tr>
<tr>
<td>Session 3</td>
<td>135 (138)</td>
<td>210 (207)</td>
</tr>
</tbody>
</table>

*Note:* Expected frequencies are in parentheses.

$\chi^2 (1) = .25$, $n = 731$, $p = .62$. 

51
Table 12

*Frequencies of $A \uparrow - T \downarrow$ Interactions Aggregated by Session and Family Type*

<table>
<thead>
<tr>
<th></th>
<th>Stable</th>
<th>Deteriorating</th>
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</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>32 (27.5)</td>
<td>56 (60.5)</td>
</tr>
<tr>
<td>Session 3</td>
<td>22 (26.5)</td>
<td>63 (58.5)</td>
</tr>
</tbody>
</table>

*Note:* Expected frequencies are in parentheses.

$\chi^2 (1) = 2.2, n = 163, p = .14.$
however, that for the stable alliance families, $U$ approached significance, suggesting
an increase in the inhibiting effect of therapist ↑ on adolescent ↑ ($U = 2.00$, $p = .08$).
This suggests that in the stable alliance families therapist ↑ messages inhibited
adolescent ↑ responses more so in session 3 than in session 1.

The graphs in Figures 5 to 8 provide a visual representation of the conditional
probabilities in sessions 1 and 3 by family group. Examination of the spatial
distributions of these conditional probabilities indicates changes from sessions 1 to 3
in ↑↑ (both T↑-A↑ and A↑-T↑) in the stable and in the deteriorating alliance families.
Specifically, the Figures show that competitive interactions tended to increase from
session 1 to session 3 in the deteriorating alliance families but decreased slightly in the
stable alliance families (when either the therapist or adolescent was the antecedent).
The graphical representations of the complementary (↑↓) interactions (Figures 11 and
12) show a decrease in both the stable and deteriorating alliance families from session 1 to 3 regardless of the antecedent, i.e., T↑-A↓ or A↑-T↓. However, this decrease
appeared to be greater in the deteriorating alliance families than in the stable alliance ones. In other words, the likelihood of either participant responding with ↓ to ↑
messages from the other decreased over time in both groups, but more so for the
deteriorating than for the stable alliance families, where complementarity remained
relatively unchanged.

Taken together, the graphical representations were consistent with Hypotheses
4a (T↑-A↑ competitive symmetry), 4b (A↑-T↑ competitive symmetry), and 4c (no
differences in ↑↑ in stable alliance cases), as well as 5a (T↑-A↓ complementarity) and
5b (A↑-T↓ complementarity), but not Hypothesis 5c (no differences in ↑↓ in stable
alliance cases).
**Figure 5.** Conditional Probabilities for $T \uparrow - A \uparrow$ in Session 1 and 3 of Stable and Deteriorating Families

**Figure 6.** Conditional Probabilities for $A \uparrow - T \uparrow$ in Session 1 and 3 of Stable and Deteriorating Families

**Figure 7.** Probabilities for $T \uparrow - A \downarrow$ in Session 1 and 3 in Stable and Deteriorating Families

**Figure 8.** Probabilities for $A \uparrow - T \downarrow$ in Session 1 and 3 in Stable and Deteriorating Families
Summary

Comparing five sessions characterized by a weak and five sessions characterized by a strong therapist-adolescent alliance, no significant differences were found in the number of exchanges or in the ratio of exchanges by session duration (Hypothesis 1). This finding suggests that there was a comparable amount of communication activity between therapist and adolescent regardless of the quality of the alliance.

Regarding relational control patterns, the nonparametric tests indicated that only A↑-T↑ differed significantly (with a large effect size), suggesting relatively less likelihood of the therapist responding with a domineering message in the good than in the bad alliance sessions. Graphical representation of the conditional probabilities of ↑↑ and ↑↓ interactions suggested relatively more competitive symmetry and relatively less complementarity in the bad than in the good alliance sessions, consistent with Hypotheses 2 and 3. However, the preliminary analyses showed that communication in both the good and the bad alliance sessions tended to be structured by the therapists, not by the adolescents. Therefore, interpretations of interactions with the adolescent as the antecedent must be done with caution.

Preliminary analyses of the same two relational control patterns in the deteriorating versus the stable alliance cases revealed a relational structure consistent with the one described above, i.e., the relational communication tended to be structured by the therapists, not the adolescents. Specifically, therapist ↑ tended to activate adolescent ↓ and partially inhibit adolescent ↑. The expected greater frequency of competitive symmetry by the third session in deteriorating cases was supported by the chi-square analysis, with a medium effect size, but not by the nonparametric tests of Hypotheses 4 and 5. Although the nonparametric tests were
nonsignificant, there was an apparent decrease in competitive responding by the adolescent from sessions 1 to 3 in the stable alliance cases, which was indicated by the nonparametric test. Graphical representation of the conditional probabilities also showed a considerable increase in competitive symmetry in the deteriorating alliance families and a relative decrease in stable alliance cases. On the other hand, graphical representation of the complementary interactions suggested a considerable decrease in the deteriorating alliance cases, whereas complementarity remained relatively unchanged for the stable alliance cases. Taken together, these results supported Hypotheses 4a, 4b, 5a, 5b, and 5c, but not 4c.
Chapter IV

Discussion

The goal of the present study was twofold. The first objective was to examine differences in relational control patterns in conjoint family therapy sessions in which either a positive (“good”) or a negative (“bad”) working alliance with the adolescent was observed. The specific hypotheses were that, in the bad alliance sessions, there would be relatively fewer direct exchanges between therapist and adolescent, relatively more competitive symmetry, and relatively less complementarity than in the good alliance sessions. Conversely, in the good alliance sessions, there would be relatively more direct exchanges, relatively less competitive symmetry, and relatively more complementarity. The second objective was to investigate whether relational control patterns reflect changes in the quality of the observed alliance between therapist and adolescent over time. It was hypothesized that only in the deteriorating alliance families, competitive symmetry would increase and complementarity would decrease from session 1 to session 3. In the stable-positive alliance families, no changes in these relational control patterns were predicted.

Overall, the results provided some support for these hypotheses. This chapter reviews the supportive and disconfirming evidence in relation to theoretical and practical implications. These limitations are discussed as well as ideas for future research.

Theoretical and Practical Implications

It was reasoned that compared to the poor alliance sessions, in the better sessions therapist and adolescent would be speaking more directly to one another. Contrary to expectation, however, sessions with good versus bad therapist-adolescent alliances did not differ in the frequency of direct interactions, either in the total
number of direct exchanges or in the ratio of exchanges to session duration. In other words, the strength of the working alliance was not related to the amount of direct communication between therapists and adolescents.

These findings suggest that the strength of the alliance may be more related to the quality than on the quantity of therapist-adolescent interactions. However reasonable it may seem to expect less direct therapist-adolescent communication with adolescents who do not feel safe, engaged or emotionally connected to their therapist, the present finding may be explained by the presence of a frequent interrogatory, i.e., question/answer, pattern in sessions with poor alliances. Beyebach, de la Cueva, Ramos, and Rodríguez-Arias (1990) compared interviews of clients who dropped out and with those of clients who completed treatment and found a greater occurrence of this “question/answer” pattern in the dropout than in the completer group.

Examination of the videos supported this conjecture, in that an interrogatory pattern was frequent in the bad alliance sessions more so than in the good alliance sessions, as illustrated in the following excerpt (Family 4):

T – Why do you think you don't behave that way [not paying attention, not turning homework in] with those teachers?

A – Dunno.

T – Maybe because of the subject, or is it because of them?

A – Dunno.

T – What about languages? Your mom says you are not so good at them.

A – No, I'm not.

T – Why?

A – Because they're hard.

T – Or is it because you don't like them?
A – No.

T – So, why don't you like them?

A – Because they're hard.

T – They are?

A – Yes.

This kind of question-answer sequence can result in a large frequency of exchanges in a short period of time. Observation of sessions like these suggested that when the adolescents were resistant to or uninterested in the therapy, they tended to answer questions from the therapist with short and uncommitted responses (i.e., “don't know”, “yes”, “no”, etc.). Likewise, when the therapists did not adapt their style to the adolescent’s noncommittal attitude and thus failed to help the adolescent feel safe, motivated and engaged in the therapy process, they seemed to fall into a pattern of asking frequent, closed-ended questions, most likely in an attempt to get the adolescent to talk. Although this pattern may explain the result of a comparable, poorer in quality, amount of communication in the bad than in the good alliance sessions, the present explanation is solely based on conjecture and requires further research.

Preliminary analyses provided information about the overall sequential structure in the 20 sessions chosen for this study. In this sample, regardless of the quality of the alliance, the relational communication patterns appeared to be structured by the therapists, not by the adolescents. This finding is congruent with prior literature, in that relational control in therapy tends to reflect the hierarchical nature of the therapeutic relationship, with the therapist demonstrating greater control (Friedlander et al., 1991; Raymond et al., 1993; Haley, 1963; Lichtenberg et al., 1998; Tracey, 1987). This finding is not universal, however. Heatherington (1990), for
example, compared a range of individual and family therapies with regard to the therapist’s controllingness and found substantive differences, with therapists exerting less control in some family approaches than in some individual approaches.

As shown in the above example, and consistent with previous relational control research (Friedlander et al., 1991; Heatherington & Friedlander, 1990; Raymond et al., 1993; Cabero, 2004), the present therapists’ domineering (one up) messages tended to activate the adolescents’ complementary (one-down) responses and inhibit the adolescents’ domineering responses, regardless of the quality of the working alliance. This finding indicates that even in cases in which the alliance with the therapist is weak, the adolescent seems to implicitly conform to a submissive position. It may be that adolescents learn the socially expected one-down role to be played with adults, particularly with adults in a position of power (i.e., professionals) in which there is a greater relational hierarchy. Interestingly, the only sessions in which the communication was structured by the adolescent were those with a poor therapeutic alliance. These results suggest that poor alliances are characterized by a hierarchical structure in which either the adolescent has more interpersonal power or that power is shared by therapist and adolescent.

**Comparison of relational control in good and bad alliance sessions.** With respect to Hypotheses 2 and 3, some support was found for the predicted greater presence of competitive symmetry and lower presence of complementarity in the good alliance sessions. The graphical results indicated differences in these two relational control patterns in the expected direction, but statistical differences emerged only for one of these patterns, i.e., a significantly greater presence of competitive (or domineering) responses by the therapist in the bad alliance sessions (Hypothesis 2a). In other words, these results signify that the therapists in this study were less likely to
respond in a competitive manner in sessions in which the alliance with the adolescent was strong.

Overall, relational control patterns seemed to reflect the quality of the alliance in that there seems to be greater degree of relational conflict in sessions characterized by weak therapist-adolescent alliances. Due to the finding that it was the therapists who tended to structure the communication and to influence the adolescents’ responses, it is reasonable to suggest that therapists are more responsible for the relational style that unfolds during the session. These results highlight the role of the therapist in shaping communication to promote cooperation and avoid competitive responding.

The present findings are congruent with previous research indicating that interventions characterized by a greater focus on the adolescent’s experience and goals and the therapist presenting himself as the adolescent’ ally are associated with improved alliances (Jackson-Gilford, Liddle, Tejeda, & Dakof, 2001; Diamond et al., 1999). Diamond et al., for example, found that in cases in which the alliance improved from session 1 to session 3, the therapists demonstrated a willingness to advocate for the adolescents and to help them meet their personal goals. Similarly, Jackson-Gilford et al.’s (2001) results indicated that discussing culturally salient and meaningful content themes, i.e., anger/rage, alienation, respect, and journey from adolescence to adulthood, encouraged the therapeutic engagement of Black adolescents.

Because from a relational control perspective, these kinds of interventions are more complementary in nature than competitive, the present findings suggest that therapists may contribute to the alliance by responding to the adolescent in a complementary fashion, particularly when the adolescent uses domineering messages. This interpretation is consistent with Cabero’s (2004) results, which indicated that
therapist complementarity with the adolescent was associated with greater adolescent emotional connection with the therapist.

**Comparison of relational control in deteriorating and stable alliance cases.**

Studies that examined changes over time have provided evidence of the dynamic and fluid nature of communicative patterns reflective of different tasks involved in each stage of therapy (Raymond et al., 1993; Tracey, 1985). Previous research suggests that successful treatment involves a greater degree of complementarity during the early stages in which the primary task is building rapport, followed by a greater degree of conflict in the middle stage, in which more difficult work takes place; the final “resolution” stage tends to be characterized by a return to complementarity (Raymond et al., 1993; Tracey, 1985).

Just as relational control seems to reflect changes in the tasks of therapy, it was expected that relational control patterns would also reflect changes in the quality of the therapeutic alliance. In the present analysis, results partially supported the hypothesized increase over time (i.e., from session 1 to 3) in competitive symmetry (Hypothesis 4) and decrease in complementarity (Hypothesis 5) in the deteriorating alliance cases. Specifically, the likelihood of either speaker responding in a competitive (↑) manner was significantly greater by session 3 in families in which the alliance deteriorated. Below is an example of competitive interactions between the therapist and the adolescent (in session 3 from Family 3); these interactions tend to be characterized by closed questions by the therapist and disconfirming responses by the adolescent:

T - Why do you think you got a bad grade?

(closed question/change of topic - one-up)

A - Dunno.
(assertion/extension – one across)

T - You studied less.

(assertion/extension – one across)

A - I didn’t do well on the exam.

(assertion/extension – one across)

T - What do you think about what your mom says?

(open question/change of topic – one up)

A – Nothing.

(assertion/disconfirmation – one up)

T - Is she right? Tell me.

(closed question/instruction – one up)

A - Ask her.

(assertion/disconfirmation – one up)

Although the more conservative analyses (i.e., Mann-Whitney U tests) did not provide support for the expected changes, results suggested a decrease (medium effect size) in adolescent competitive responses from session 1 to 3 only in the stable alliance families. The graphical results illustrated the expected increase in competitive symmetry and decrease in complementarity from session 1 to 3 in the deteriorating alliance families.

Taken together, these results suggest that, from session 1 to 3, in cases in which the alliance deteriorated over time, communication between the adolescent and the therapist tended to move toward greater conflict, characterized by more direct competition and less complementarity. This finding is consistent with Diamond et al.’s (1999) comparison of cases in which the adolescent-therapist alliance improved with cases in which the alliance remained poor from session 1 to 3. Results from Diamond
et al.’s study indicated that, while in the improved-alliance cases therapists increased their use of alliance-building interventions (i.e., focus on adolescent goals, presenting as an ally, etc.) from session 2 to 3, therapists in the unimproved-alliance cases decreased their use of these interventions over the same time period. In other words, in the improved cases, the therapists persevered in their effort to build a collaborative relationship, whereas in the unimproved cases, the therapists appeared to have “given up” (Diamond et al., 1999; p. 365).

A more recent study provides findings consistent with this view. Higham, Friedlander, Escudero, and Diamond’s (2010) exploratory task analysis provided evidence that certain therapist elements were associated to positive shifts in adolescent engagement in the therapeutic process. These specific elements were rolling with resistance, fostering autonomy, and understanding the adolescent’s subjective experience, all of which are more characteristic of a collaborative rather than a competitive therapeutic style.

**Summary.** Integration of the results from both types of comparisons, i.e., bad versus good alliance sessions and stable versus deteriorating alliance cases, suggests that, as expected, relational control communication patterns between therapists and adolescents mirror the quality of their alliance. That is, when the observed alliance was weak, the communication between therapists and adolescents tended to be reflected in relatively more competitive-symmetrical interactions and relatively less complementarity. Moreover, a detriment in the quality of the observed alliance was accompanied by an increase in relational conflict and a decrease in complementarity. Taken together, these findings shed some light on what may characterize successful and unsuccessful ways of communicating with adolescents.

Haley (1963) suggested that individuals maneuver communication with one
another so as to define their social relationship. Not only what an individual says, but also how the message is phrased indicates to the other party, “This is the sort of relationship I want to have with you” (Lichtenberg et al., 1998; p. 334). Thus it is not surprising to find a greater striving for control on the part of the adolescent when the bond with the therapist is weak or when his or her feelings of safety in the consulting room are problematic. Like in any social interaction, therapists attempt to define their relationships with clients through conversation. With adolescents, just as with adults, therapists verbally communicate the kinds of behavior that are to take place in the therapeutic relationship and who is to control what happens in the therapy session. Therefore, although it is not surprising, it is nonetheless clinically interesting to find that in sessions characterized by a weak alliance, therapists are more likely to interact competitively with adolescent clients. The clinical implication may be that therapists may benefit more from using their greater relational power to avoid competition, simply by not responding symmetrically to adolescents’ domineering messages.

Researchers have argued that therapists must consider the particular developmental characteristics of adolescents along with the contextual circumstances under which they come to therapy in order to adapt interventions sensitively and effectively (Cabero, 2004; Diamond, 2000; Sharry, 2004). Recommended and empirically-supported interventions with adolescents are those that incorporate the adolescent's concerns and desires and provide the adolescent with a voice in the therapeutic process, alongside a secure environment in which therapist and client work cooperatively towards common goals (Diamond, et al., 1999; Liddle, 1995; Sharry, 2004). Cabero’s (2004) examination of relational control patterns associated with positive and negative therapist-adolescent alliances in initial sessions indicated the importance of promoting complementarity and avoiding competition. Results from the
present study are consistent with Cabero’s results, in that therapists in sessions characterized by a weak alliance tended to respond competitively to adolescents’ domineering behaviors, which, ironically, may have given the adolescents greater control of the relationship.

Limitations

There are a number of conceptual and methodological limitations to be taken into consideration when interpreting the results of the present study. The ex post facto design precludes conclusions about causality. Does the way the therapist talks to the adolescent contribute to the quality of the alliance, or does the quality of the alliance contribute to the way the therapist talks to the adolescent? Regarding Rogers and Escudero (2004)’s argument, “We do not relate and then talk, we relate in talk” (p. 3); it may be just as important to determine how certain ways of communicating contribute to a strong therapeutic relationship with adolescents so as to identify relationship factors that contribute to more productive communication.

The present study was based on the assumption that the process of alliance creation and development parallels the process of communication between therapist and adolescent. However linked these two processes might be there are numerous other factors that may have contributed to the adolescent’s more or less positive experience of the therapeutic alliance. These factors include the adolescent’s stable (i.e., gender, sexual orientation, ethnic background, personality, etc.) or dynamic (i.e., gender socialization, cognitive styles, values, etc.) attributes as well as contextual circumstances (i.e., family conflicts outside of therapy, legal issues, medical difficulties, etc.). These variables may underlie the considerable within-group variability among families and sessions, but were not focus of the present study.

Regarding internal validity, attempts were made to minimize family and
therapist variables by selecting cases that were similar in terms of socio-economic background, presenting problems, age and gender of adolescents. Steps were also taken to ensure the reliability of the measures, including the use of empirically-supported instruments as well as coders whose ratings were reliable. However, any association found between relational control patterns and adolescent observed alliance behaviors should be considered in light of the specific characteristics of the participants and setting, including those of the clients, the therapist, and the clinic. Moreover, the small sample size may be contributing to Type II error, i.e., low sensitivity to differences which might in fact be present in the population.

Regarding external validity, one of the major limitations in the present study is the limited sample size and specific sample characteristics that hinder generalizability. Little research has focused on the influence of cultural variables in the process of family therapy. However, considering multicultural considerations in family therapy, authors suggest that this therapy format works differently for families from different backgrounds (Flicker, Turner, Waldron, Brody, & Ozechowski, 2008; Sue & Sue, 1990). For example, there is some evidence to suggest that the experience of an imbalanced therapeutic alliance in the context of family therapy has a greater impact for Hispanic than for Anglo families (Flicker et al., 2008). Sue and Sue (1990) argued that the different impact and experience of the therapeutic relationship in families from the different cultures (i.e., Hispanic and Anglo) is a result of different family values, such as familismo, respeto, and hierarchy. The fact that all clients in the present study were White Spaniards from low-to-middle income backgrounds, seen by White-Spaniard therapists, limits the generalizability of the results to any other racial and socio-economic group.

Gelso and Fretz (2001)'s “bubble hypothesis” points out the challenge that
researchers always confront when designing a study: The greater the control, the more rigorous the research design and the less relevant the results are for practice. Although the present study was characterized by a focus on clinical relevance, steps were taken to maximize the soundness of the analyses and results. In this sense, it is important to consider methodological limitations specific to sequential analysis. For example, arguments based on conditional probabilities are tempered by the fact that these values are influenced by sample size (i.e., the number of exchanges in each case). For this reason, more conservative statistical analyses were also included based on an index that is unaffected by sample size, i.e., Yule's Q. Due to their more conservative character, results based on these values were less sensitive and, thus, differ somewhat from the results based on graphs and probabilities. The inclusion of both types of analyses was based on a decision to balance rigor with clinical relevance.

The present examination of changes from the first to the third session sheds light on how communication patterns evolve along with shifts in the therapeutic alliance. However, as mentioned earlier, due to the design of the study, no causal interpretations may be formulated. Moreover, because the study only examined session 1 and 3, there is no information about what occurred in session 2, which may help explain the observed differences.

Moreover, results pertain to only the specific family therapy approach followed in the clinic. It is questionable if similar processes would unfold in a similar way with therapists who use other theoretical orientations. For example, systemic models encourage the therapist to be neutral and blend with the family, whereas structural family therapists encourage confrontation and shifting (Friedlander et al., 1991). Therefore, the present results should be interpreted as a source of suggestions for
future research on the relationship between relational control and therapist/adolescent alliances. In other words, as Raymond et al. (1993) indicated, data in a study of this sort should not be taken as conclusions but as findings awaiting replication with other populations, in different settings.

**Recommendations for Future Research**

Given the sparse research on therapeutic alliance with adolescents, particularly in the context of family therapy, knowledge is limited with respect to how therapists develop and maintain strong alliances. Extant literature highlights the importance of tailoring interventions to the specific developmental characteristics and needs of this age (Bolton Oetzel & Scherer, 2003). Some studies support the efficacy of certain kinds of interventions for promoting a strong alliance with adolescents in the context of family therapy (Hogue et al., 2006; Liddle, 2010). However, more research is needed that builds upon the still limited literature on the therapist-adolescent alliance.

The goal of the present study was to shed some light on what style of relational control communication accompanies strong and weak alliances. Further, the present study aimed at examining changes in communication parallel to changes in the quality of the alliance. Results provide interesting findings about what relational control pattern distinguish sessions characterized by a weak alliance and sessions characterized by a strong alliance. However, these findings should be improved upon by replicating the study with other samples with different characteristics and in different settings.

Two future lines of inquiry would contribute in different ways to our understanding of the therapist-adolescent alliance and communication. On the one hand, studies with larger, more diverse, samples and pursuing more controlled procedures would improve on the present methodological limitations by allowing for
stronger, more rigorous group comparisons. On the other hand, single-case studies focusing on more fine-grained aspects of the therapy process may help decipher more accurately the sequence of events underlying relational control patterns as they relate to specific alliance-related indicators. For example, it would be interesting to examine if a given sequence of observed alliance behaviors is associated with a sequence of specific relational control interactions.

There are a number of specific variables not examined in this study that could be considered in future research. For example, the present study only focused on observed measures of the therapist-adolescent alliance. Past research indicates the value of assessing adolescents’ subjective experiences of the alliance (Karver et al., 2008). Therefore, future research may include self-report measures of the alliance. In addition, there is some evidence of the role played by the parent-therapist alliance in successful family therapy with adolescents (Diamond et al., 2000). Moreover, research indicates the influence of certain parent contributions (i.e., support) for shifting adolescent engagement in the therapeutic process (Higham et al., 2010). Studies that include parents in the design would improve our understanding of the relational dynamics that take place in family therapy. By including the parent-therapist alliance, it would be possible to assess relational control interactions among parents, therapists, and adolescents. Despite the methodological difficulties of such an extensive endeavor, assessing all possible interactions among all possible interactants would help understand more complex relational dynamics (i.e., triangulation, indirect messages, etc.).

As stated above, future studies should consider multicultural variables in order to meet the needs of an increasingly diverse society. For example, there is some, although limited, evidence of the role gender plays in the therapist-adolescent alliance
as well as in relational control communication patterns. Cabero (2004)'s findings suggested that both the therapist's and the adolescent's gender play a role in how they communicate and relate to one another. Future studies should include gender in the design in order to explore its role in relational control patterns as well as in the development of the alliance with adolescents.

In addition, the present sample included only low-to-middle class, White Spaniards. Given evidence about the different experiences of diverse families in family therapy (Flicker et al., 2006), future research should explore therapist-adolescent alliances and relational control communication in diverse populations.
References


Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the


## Appendix A

Family Relational Communication Control Coding System (FRCCCS) Message Code Categories and Control Code Assignment

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<th>Format</th>
<th>Support</th>
<th>Nonsupport</th>
<th>Extension</th>
<th>open question</th>
<th>closed question</th>
<th>Instruction</th>
<th>Order</th>
<th>Disconfirmation</th>
<th>Topic Shift</th>
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*Note. From Family Relational Communication Control Coding Manual (FRCCCS) by L. Heatherington and M. L. Friedlander, 1987.*

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Appendix B

INFORMED CONSENT


Art. 8 from the Law 41/2002 of November 14th, basic regulation for patient autonomy and for rights and obligations with regards to clinical information and documentation.

I, Mr/Ms. ................................................. of legal age, with I.D number................, resident of.....................street.................................. phone number..........................

manifest:
That I have been verbally informed by……………………………………………………………
…………………..…………………………….., date.........../.........../200........, and that I have been provided with written information about the characteristics of the services offered at the Unit for Research and Family Intervention (Unidad de Investigación y Cuidado Familiar) as well as about the possible risks and benefits associated with my participation in this center.

I understand all the information that has been provided to me, having been clarified all my questions satisfactorily and that my participation is free and voluntary. I understand that consent is a requirement for all people participating in this service.

Therefore:

I KNOW AND CONSENT:

• To participating in sessions with one of the professionals at the Unit and his/her team according to the hereby pre-established conditions and what has been explained to me verbally and in print.
• To filling out and answering all questionnaires that are utilized for research developed at the Unit.
• To the recording of sessions carried out with the therapist and the team for a better recollection of the information and to allow for team work and supervision.
• To the use of the recorded material for research and training purposes, always granting confidentiality and professional secrecy.
• To the presence of the team as well as other professionals and trainers, graduate students or students from nursing, psychopedagogy,
psychology, and social work school.
- To the fact that the Unit does not provide assessment or report services to users, nor to other people, centers, or institutions.
- To my right to revoke my consent at any time.

I clarify that have read and understood each paragraph in this document, and for it to be in record:

I sign two copies in................... , date...................., 200..

Signature

Therapist signature

Today, .............................. of 200..... I have decided to REVOKE my consent to the realization of the procedures described in the present document.

Signature

Witness signature

Therapist signature
(or authorized person)