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Threats to the Therapeutic Alliance in First Sessions with High Conflict Couples

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Conflict Couples

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Threats to the Therapeutic Alliance in First Sessions with High

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Threats to the Therapeutic Alliance in First Sessions with High Conflict Couples

The National Center for Health Statistics (2012) estimates that women ages 15-44 years old, married between 2006-2010, have a 20% probability of divorcing within five years of marriage with the probability increasing to 48% within 20 years. Even as divorce rates plateau and slowly decline, many married couples divorce and must face dividing not only their assets but their parenting responsibilities as well. Roughly, half of all divorces involve children (Elrod, 2001) and divorced couples who have children remain co-parenting partners and must negotiate a new relationship throughout the life of their children, even during the adversarial court process.

In the short-term, members in a family during the divorce process face some negative consequences (Hetherington & Elmore, 2003), however after the first one to two years, family members in divorcing families generally look no different than members in families who did not go through divorce (Hetherington & Kelly, 2002). Generally, children in divorced families lie within the normal range on measures of functioning, symptoms, and happiness (Hetherington & Kelly, 2002). Nevertheless, some couples engage in hostile conflict regarding custody and parenting that goes beyond the typical disengagement of divorcing couples. These couples may be unable to create boundaries between their parental interactions and their personal feelings (Whiteside, 1998). High parental conflict is well established as a predictor of negative effects for children such as poor adjustment, academic decline, and an increase in behavioral problems following divorce (Amato, 2001; Boyan & Termini, 1999; Frisco, Muller, & Frank, 2007; Sun, 2001). Boyan and Termini (1999) found that the most significant factor in child adjustment following divorce is the level and intensity of conflict between his or her parents.

Though some couples are able to negotiate child custody and visitation without help from others (Emery, 1994), other divorcing couples have conflict over parenting decisions and custody arrangements that cannot be resolved even through assistance from the family court system or mediation. High conflict couples may be unresponsive to standard forms of mediation and engage in dualistic thinking between themselves and their co-parenting partner (Johnston, Walters, & Friedlander, 2001; Neff & Cooper, 2004). Two distinct attributes characterize high conflict couples. High conflict couples engage in (1

destructive communication patterns in pervasive negative exchanges within a (2) hostile, insecure emotional environment (Anderson et al., 2011). These attributes undermine the parents' ability to communicate civilly and resolve parenting or custody decisions. Rather, the parents use the separation and ensuing court case as a means of controlling and punishing the other, dragging out the legal and emotional separation process (Coates, Deutsch, Starnes, Sullivan, & Sydlik, 2004). One study estimates that family courts and related professionals spend 90% of their time on the 10% of the population labeled "high conflict" (Neff & Cooper, 2004). When high conflict court cases are unable to resolve their difference and find a mutual agreement, the court system often refers the case to therapy (Lebow & Rekart, 2007). Anecdotal evidence suggests that therapy is often difficult with this population, with many therapists reporting apprehension at working with this population and the difficulties they have in establishing a therapeutic alliance with these clients. This paper presents the results of an observational study designed to examine the therapist behaviors that may contribute to poor therapeutic alliances.

Literature Review

Though the literature on high conflict couples provides clinicians with a frame to guide assessment and treatment of this population (Anderson et al., 2011; Lebow & Rekart, 2007; Shmueli, 2012) little is written in regards to the therapeutic alliance and what therapists do to affect it with this population. The therapeutic alliance encompasses not only the relationship between client(s) and therapist, but also the collaborative and facilitative condition that occurs in session. Though we know that therapy is effective (Shadish & Baldwin, 2002), presently, there is less research on what makes good therapy, let alone good therapy with high conflict couples. Until the field of marriage and family therapy understands what makes good therapy, treatment outcomes cannot improve. Though some aspects of therapy cannot be controlled, the relationship between client and therapist is something that the therapist has considerable control over (Beutler, Consoli, & Lane, 2005; Friedlander, Escudero, & Heatherington, (2006). Furthermore, Baldwin, Wampold, and Imel (2007) found therapeutic outcome is predicted by therapists' ability to build an alliance with their clients rather than clients' ability to build a collaborative relationship with their therapists, suggesting that therapist must evaluate their contributions to the alliance

rather than the clients'. In addition, clients seem to place responsibility of alliance formation on the therapist ; Bedi, Davis, & Williams, 2005), because the clients may be emotionally vulnerable (Bedi, 2006).

In his seminal article, Bordin (1979) proposed a trans-theoretical model that conceptualized the therapeutic alliance into three distinct parts, goal, bond, and task. These components refer to agreed upon goals of therapy (goal), the relationship between client and therapist (bond), and the means of obtaining the goals (tasks). This collaborative relationship has a strong positive relationship with outcomes in individual, couple and family therapy (Friedlander et al., 2011; Horvath & Symonds, 1991; Knobloch-Fedders, Pinsof, & Mann, 2004). Researchers have found the therapeutic alliance may account for as much as five to twenty percent of the variance in outcome in therapy (Horvath & Symonds, 1991; Knobloch-Fedders, Pinsof, & Mann, 2007; Martin, Garske, & Davis, 2000) in both theoretical and empirical research. However, in high conflict couple therapy, there are multiple alliances within the room.

It is possible that within a couple seeking therapy, the partners will differ in their motivation to change (Moore, Tambling, & Anderson, 2013), their expectations on goals and tasks for therapy (Tambling, 2012), and the expectations of the outcome of therapy (Tambling, 2012; Tambling, Wong, & Anderson, 2014). It may be difficult in couple therapy to establish a mutual goal and for the therapist to maintain a therapeutic alliance with both partners, let alone in therapy with high conflict couples. Previous research on the experiences and expectations of high conflict couple clients found that clients see the initial session as tense and triggering of past conflict (Hynes et al., 2014). Furthermore, the therapist must also be aware of the alliance between the partners in therapy because the within system alliance is shown to be one of the strongest predictors of outcomes in couple therapy (Knobloch-Fedders, Pinsof, & Mann, 2007; Pinsof, Zinbarg, & Knobloch-Fedders, 2008). Without a strong within system alliance, goals for therapy may be more difficult to achieve.

Friedlander and colleagues (Friedlander, Escudero, & Heatherington, 2006; Friedlander et al., 2011) proposed an important dimension of the within system alliance, safety, that is germane to high

conflict couples. Safety reflects the experience of security members feel in discussing his or her relationship in therapy with another member. Safety may be difficult to achieve because high conflict couples may have several months if not years of antagonism built between each member, which may prevent clients from being vulnerable in therapy.

The literature on the therapeutic alliance in high conflict couple therapy is sparse. The literature that does exists, suggests that the therapeutic alliance is difficult to establish (Johnston, Walters, & Friedlander, 2001; Tohn & Oshlag, 1996). Some parents may be looking for allies in the custody battle, while others may feel isolated and therapists must be aware to engage both parents in therapy while avoiding confirming the parents' distorted beliefs. (Johnston, Walters, and Friedlander, 2001). Because of these factors, therapy should be planned and structured with an agenda to pursue. Not only is establishing a therapeutic alliance difficult because there are two opposing individuals in the therapy room, but the clients are often coming to therapy involuntarily (Johnston, 1994). The court system may refer co-parenting couples to attend high conflict couple therapy when the couples are unable to resolve differences related to parental decisions and visitation (Johnston, 1994).

Moore and colleagues (2013) proposed a unique category of clients, "soft mandated" clients. High conflict couples may fit into this group. Soft mandated clients feel pressure from a referrer to attend therapy, but are not mandated, with the threat of consequences such as jail time, to attend therapy from a powerful system (Moore, Tambling, & Anderson, 2013). Soft mandated clients report feeling high levels of pressure to attend therapy from sources that hold personal relevance, and many experience negative outcomes for failing to attend. Like soft mandated clients, high conflict clients often report feeling significant pressure from agents of the court to attend therapy, despite relatively few consequences for failing to comply. In their study of the links between motivation to change, referral sources, initial levels of distress, and pressure to attend, Moore, Tambling, and Anderson (2013) found that clients who felt the most pressure to attend therapy were most likely to be in the pre-action stages of change compared to clients who felt little to no pressure. While high conflict couples are not the same as traditionally mandated clients, the high levels of pressure to attend therapy may impact their motivation to change.

In preliminary research with a small group of high conflict co-parents, we identified several therapist behaviors that co-parents said decreased their relationship with the therapist. In the preliminary research (Hynes et al., 2014), eight co-parenting partners met with researchers before and after their first three sessions of high conflict therapy. Each partner separately met with an interviewer immediately following each session and watched a video recording of the session to describe what was helpful and unhelpful in session. The client stopped the recording and described the interaction and whether he or she believed the interaction was helpful or not helpful in session. A content analysis of interviews with these co-parents indicated several therapist behaviors that co-parents perceived to be disruptive to the alliance. The partners identified allowing talkovers (one partner tries to take control of the speaking floor from the original speaker),, not establishing ground rules (structuring therapy such as one client will talk at a time), talking about the partners' relationship before the divorce, addressing emotions, allowing conflict (allowing conflict to go beyond the baseline level of intensity for the couple), taking sides, discussing client's mental health history, and being passive as behaviors that were detrimental to the therapeutic alliance (Hynes et al., 2014)

Research Question

Some divorcing couples are seen for therapy with the goal of resolving conflict or at the very least coming an agreement on goals and communication. High conflict couples session may be seen as tense and bad (Hynes et al., 2014), however the therapist may be able dampen the conflict through the establishment of a strong therapeutic alliance. The literature on therapist behaviors and therapeutic alliance is sparse with this populartion. This study is an exploratory study on threats to the therapeutic alliance in high conflict co-parenting sessions that builds on the preliminary results of a previous study that identified eight therapist behaviors that co-parents saw as detrimental to their therapy. The purpose of this study is provide a preliminary quantitative validation of the behaviors identified in the qualitative study. The therapist behaviors identified were talkovers (defined as when one partner tries to take control of the speaking floor from the original speaker), not establishing ground rules, talking about the partners'

relationship before the divorce, addressing emotions, allowing conflict, taking sides, discussing client's

mental health history, and being passive.

We know little about therapist behaviors in sessions with high conflict couples and how these

behaviors relate to the development of the therapeutic alliance with this population. The primary research

questions for this study are: (1) How frequently do talkovers, not establishing ground rules, talking about

the partners' relationship before the divorce, addressing emotions, allowing conflict, taking sides,

discussing client's mental health history, and being passive occur during the first session of therapy? and

(2) Are these behaviors associated with decreased levels of therapeutic alliance? We hypothesized that

therapists would (1) be active in session . We also hypothesized that therapists would frequently engage

in therapist behaviors such addressing emotion, asking questions, and taking sides by reflecting clients'

statements. (2) There would be decreased levels of therapeutic alliance associated with therapist behaviors

that were viewed as detrimental.

Methods

Sample

A convenience sample of thirteen co-parenting couples was used in this study. All thirteen

couples enrolled in therapy at an on-campus marriage and family therapy training clinic in New England.

Ten cases stated they were referred to therapy by court or court support services within the court, one case

stated their attorney suggested it, one case stated their physician suggested it, and one case did not answer.

Fifty eight percent of the participants identified as White/Caucasian, nineteen percent identified as

Hispanic, and twenty-three percent declined to answer or stated they would prefer not to answer.

Eight doctoral or masters-level student therapist interns conducted the therapy sessions as

individual or co-therapy teams and were enrolled in a marriage and family therapy training program

accredited by the Commission on Accreditation for Marriage and Family Therapy Education. One

licensed marriage and family therapist and faculty supervisor participated as a co-therapist for one case.

The therapists consisted of three White males, four white females, one Asian male, and one Hispanic

female. Three faculty supervisors provided live supervision or supervision in consultation during weekly

supervision sessions with the therapists in this project. Clients were aware that their therapists were graduate students in training and that sessions were supervised.

All participants (clients and therapists) were recruited through a larger research project and were not compensated for their participation. Participants were informed that participation in the project was voluntary and their services would not be influenced by participating or not participating in the project.

Measures

Therapeutic Alliance. The Session Rating Scale (SRS; Duncan et al, 2003) is a four-item measure of the therapeutic alliance. Each item uses a visual analog scale with opposing statements about the therapeutic alliance anchoring each side of a 10 centimeter line. Example opposing items are "I did NOT feel heard, understood, and respected" and "I felt heard, understood, and respected." Clients made a mark along the line to indicate which anchor is closer to their experience. Each item is scored by then measuring the distance from the left in to one decimal point. The four items are then averaged to create a total score of the therapeutic alliance with a range of 0.0 – 10.0. Chronbach's alpha for the sample was .84. .

Couple Therapy Alliance Scale – Revised, Short Form (CTAS; Pinsof, Zinbarg, & Knobloch-Fedders, 2008). The CTAS is a 12 item measure of the therapeutic alliance. Each item is rated on a 1 (Completely Disagree) to 7 (Completely Agree) scale. Scores are reverse coded as appropriate and then summed as and averaged to create an average item score to form an overall measure of the therapeutic alliance. Since the CTAS does not have a cutoff using the item average allows us to judge the relative strength of the alliance by putting the clients' average score back on the same scale as each of the items.

Therapist Alliance Behaviors. Therapist Behavior Observational Coding Tool (TBOCT) was used to code therapist alliance behaviors. Based on preliminary research with eight co-parenting partners, the TBOCT was developed to code therapist behaviors that co-parents identified as detrimental to the therapeutic alliance. One expert rater viewed the video recordings of the first sessions of high conflict couples and coded the behaviors as they occurred in session. The behaviors included: allowing talkovers,

not establishing ground rules, talking about the partners' relationship before the divorce, addressing emotions, allowing conflict, taking sides, discussing client's mental health history, and being passive (Refer to appendix for a detailed description of the codes).

Allowing talkovers, addressing emotions, allowing conflict, addressing client's mental health history and taking sides included subcodes the rater used to code the therapist behaviors. Allowing talkovers was broken into four possible behavior subcodes: completed or incomplete talkovers with whether or not the therapist intervened. Addressing emotion was divided into solicited and unsolicited emotion addressment. Therapists were coded with addressing emotions when the client solicited emotions by talking about the his or her emotions or the therapist could address the emotion unsolicited by noticing a client's emotion in the room and asking about the emotion. Therapists behaviors with allowing conflict were divided into four subcodes. Therapists were coded if they did nothing when conflict occurred, verbally intervened to stop the conflict, raised their hand to intervene, or stoodup to intervene. Taking sides was composed of four subcodes, the therapist reflecting on clients' statements, asking a question in regards to clients' statements, agreeing with clients' statements, or agreeing and adding judgment with clients' statement. Therapists were coded for three addressing mental health history subcodes. Therapists were coded if they ignored mental health history brought forth by the clients, acknowledged the clients' statements, or acknowledged and shifted the focus to the statement.

For each occurrence, the coder noted the therapist behavior, the start and end time of the behavior, and the gender of the speaker and partner. For some codes, the therapist behavior is dependent on client behaviors. For example, the talkover code is dependent on the occurrence of a talkover by a client. If a talkover occurs, raters mark whether or not the therapist intervened and if the talkover was completed.

Procedure

All clients at the on-campus clinic complete a comprehensive assessment battery and demographic questionnaire prior to their first session of therapy. In addition, all clients are invited to allow their video recordings to be archived and matched to their questionnaire data in order to better

understand how change happens in therapy. Data for this study were derived from those who agreed to allow for recordings to be used for research. Following their first session, clients completed the SRS and CTAS. All measures including the CTAS were then administered every 4 sessions. The SRS was administered following every session.

Data Analyses

All data analyses were conducted on SPSS version 22. To answer research question one, regarding the frequency of alliance behaviors, we calculated descriptive statistics, including the mean and standard deviation of each variable. To answer research question two, regarding whether therapist behaviors are associated with decreased levels of therapeutic alliance, we used nonparametric tests after a preliminary examination of the data showed the behavior variables did not demonstrate a normal distribution. Every therapist behavior as well as CTAS at session four were skewed toward zero, while the SRS displayed a normal distribution and CTAS at session was multimodal. Spearman R one-tailed correlation analyses were carried out to investigate the relationships between different therapist behaviors and therapeutic alliance measures. CTAS at first and fourth session had missing data in ten and eleven cases, respectively. To resolve this, pairwise deletion was used to maximize the data that was available.

Results

Frequency of Therapist Alliance Behaviors.

Table 1 displays the descriptive statistics for in-session therapist behaviors split between male and female clients. Figure 1 displays the frequency of talkovers in session. As this figure indicates, talkovers happen frequently during initial sessions with high conflict coparents. Interestingly, therapists appear to hold back when talkovers occur intervening in less than one quarter of the talkovers that occur. Not surprisingly, the most frequent therapist behavior was asking questions followed by taking sides. In interviews with high conflict co-parents, they indicated that routine therapy behaviors such reflecting on clients' statements, asking questions regarding clients' statements, and agreeing the clients' statements can be detrimental to the alliance. These "taking sides" behaviors were the most frequent with therapists

conveying judgment much less frequently. Most of the other alliance-detracting behaviors, however, occurred infrequently in session with many behaviors occurring less than once per session on average. For example, while therapists are trained to address emotion in therapy, with this sample they addressed emotions less than once per session. The discussion of client's mental health history did not occur in any of the sessions. In addition, the therapists did not establish ground rules often in session. The relationship before divorce or separation was also not addressed often in therapy. Finally, while this group is referred to as "high-conflict coparents", overt conflict was rare in session, with less than three distinct episodes of conflict. When conflict did occur, therapists were about as likely to intervene as not intervene.

Table 1. Male and Female client alliance variables and therapist behaviors toward male and female client variables: Descriptive Statistics

Variables	Male			Female		
	M	*SD*	Range	M	SD	Range
SRS Session 1	5.66	3.20	.45-10	5.88	2.74	0-10
CTAS Session 1	5.34	1.35	3.61-7.00	5.49	.96	3.97-6.75
CTAS Session 4	4.73	.67	3.88-5.89	4.72	.81	3.75-6.33
Completed talkover w/ intervention	.00	.00	0	.31	.63	0-2
Completed talkover w/o intervention	.92	1.32	0-4	1.46	2.96	0-10
Incomplete talkover w/ intervention	.54	.97	0-3	.46	.66	0-2
Incomplete talkover w/o intervention	1.15	1.63	0-5	2.69	2.14	0-7
Established ground rules	.23	.60	0-2	.15	.38	0-1
Therapist asks questions	12.23	6.14	4-27	11.54	6.55	4-23
Conflict	1.15	1.68	0-5	1.54	2.37	0-7
Conflict: No intervention	.69	1.11	0-4	.62	1.19	0-4
Conflict: Therapist intervenes	.46	.88	0-3	.92	1.71	0-5
Sides	3.69	2.32	1-8	4.92	3.38	1-12
Regular Therapy Behavior	3.23	2.47	1-8	4.15	3.15	1-11
With judgment	.46	.78	0-2	.77	1.36	0-4
Relationship before divorce	.69	.95	0-3	1.08	1.98	0-6
Emotion	.38	1.39	0-5	.54	1.20	0-4
Solicited emotion	.08	.28	0-1	.15	.55	0-2
Unsolicited emotion	.31	1.11	0-4	.38	.77	0-2
Talkover: Any	2.62	3.43	0-10	4.92	4.72	0-17

Therapist Intervenes	.54	.97	9-3	.77	1.24	0-4
No Intervention	2.08	2.81	0-8	4.15	4.54	0-17
Completed	.92	.132	0-4	1.77	3.03	0-10
Incomplete	1.69	2.21	0-7	3.15	2.30	0-7
Mental Health History	.00	.00	0	.0	.0	0

Alliance Scores

Table 1 displays the descriptive statistics for alliance scores for male and female clients. Overall, the alliance scores for the SRS and CTAS were very low. Duncan et al. (2003) suggest that any scores below nine are areas that should be addressed by the therapist. Our study's SRS scores for males ($M = 5.66$, $SD = 3.20$) and females ($M = 5,88$, $SD = 2.74$) were below that cutoff. First session scores of the CTAS for male clients ($M = 5.92$, SD $= 1.35$) and female clients ($M = 5.82$, SD $= .96$) were also below the clinic mean ($M = 6.14$, SD $= 1.05$).

In addition, the CTAS scores dropped from the first session to the fourth session for both males and females [Males (1st): $M = 5.34$, SD $= 1.35$; Males (4th): $M = 4.73$, SD $= .67$; Females (1st): $M = 5.49$, SD $= .96$; (4th): $M = 4.72$, SD $= .81$]. Post hoc paired sample t-tests were conducted to examine if this decrease was statistically significant for male and female clients. While there were mean differences, these differences were not statistically significant due to the low power associated with the tests ($t_{male}(4)=1.21$, $p = 0.29$; $t_{female}(6)=1.68$, $p = 0.14$). Finally, the CTAS scores for both males and females at session one were strongly positively correlated with each other ($r = .94$, $p \leq .001$) indicating that clients agreed on the experiences at first session.

Association between therapist behaviors and alliance for male clients

Table 2 displays the significant correlations between male clients' alliance scores and aggregated therapist behaviors and therapist behaviors correlations with other behaviors. These correlations offer mixed findings regarding the hypothesized relationship between therapist behaviors and alliance. Spearman R correlation analyses showed that, as expected, the therapist establishing ground rules was significantly positively correlated with SRS at first session

(r = .58, p ≤ .05). Results also support the hypothesized relationship between lack of therapist intervention during a talkover and decreased alliance. The CTAS at fourth session was significantly and negatively correlated with completed talkovers by the partner without an intervention from the therapist (r = -.74, p = ≤ .05). Contrary to the hypothesized relationship, therapist taking the side of the client was significantly and positively correlated with CTAS at session 1 (r = .73, p ≤ .05). While this result does not support the findings of the previous qualitative study, they make intuitive sense. As predicted, therapist addressing the relationship before separation approached significance in the negative direction with SRS (r = -.43, p = .065) In addition, therapists addressing emotion in session was marginally positively correlated with both the SRS and CTAS at sessions one and four (SRS: r = .46, p = .056; CTAS1: r = .62, p = .07; CTAS4: r = .66, p = .075)

Association among therapist behaviors for male clients

Establishing ground rules and addressing emotions with male clients were significantly and positively correlated (r= .74, p ≤ .001). Talking over ones partner was significantly and positively correlated with conflict (r=.55, p ≤ .05). Therapist addressing emotions and talkovers approached a significance in the negative direction (r = -.39, p = .091).

Association between therapist behaviors and alliance for female clients

Table 2 displays the significant correlations between female clients' alliance scores and therapist behaviors. While the results support an association between therapist behaviors and alliance, for female clients, each association was opposite of the hypothesized relationship. Spearman R correlation analyses showed the therapist addressing emotion significantly and positively correlated with SRS and CTAS at first session (SRS: r = .56, p ≤ .05; CTAS1: r = .64, p ≤ .05). Further analyses found that therapist addressing emotions behaviors that were unsolicited by the client, was significantly correlated with SRS and CTAS at session one (SRS: r = .58, p ≤ .05; CTAS1: r = .62, p ≤ .05). Contrary to hypothesis, therapist taking the side of the client was significantly and positively correlated with CTAS at first session (r = .75, p ≤ .001). Contrary to our hypothesis, therapist addressing the relationship before separation was positively correlated with CTAS at session four (r = .59, p ≤ .05).

Association among therapist behaviors for female clients

Therapist addressing the relationship before separation and talkovers by the partner were significantly and negatively correlated ($r = -.48$, $p \leq .05$). In addition, therapist asking questions to the client was significantly and negatively correlated with talkovers by client's partner ($r = -.59$, $p \leq .05$). The therapist intervening after a talkover by the partner was significantly and negatively correlated with the therapist asking questions to the female client ($r = -.77$, $p \leq .01$).

Table 2

Therapist Behaviors with Male and Female Clients: Correlations and Descriptive Statistics

Male

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. SRS	_	.78*	.23	.58*	-.13	-.44	-.32	-.35	-.30	-.32	-.14	-.26	.37	.43
2. CTAS1	.16	_	.67	.62	.66	.00	-.04	-.57	.04	.06	.08	-.06	.73*	.62
3. CTAS4	-.08	.11	_	.66	.38	.40	-.46	-.49	-.24	-.65	.07	-.31	.43	.66
4. EG	.06	-.31	.52	_	.00	-.38	-.38	-.33	-.29	-.32	-.23	-.37	.43	.74**
5. TP	-.06	-..05	.47	.23	_	.16	.00	-.22	.05	-.02	.12	.04	.50*	.000
6. RBD	.06	-.16	.59*	.14	.65**	_	-.20	-.17	-.16	-.20	-.10	.26	-.35	-.26
7. Talkover	.14	-.27	-.12	-.03	-.59*	-.48*	_	.43	.96**	.85**	.87**	.55*	.09	-.39
8. TOInt	.22	-.16	-.07	-.28	-.77**	-.43	.72**	_	.25	.32	.40	.33	-.11	-.22
9. TONoInt	.09	-.35	-.11	.06	-.41	-.42	.96**	.54*	_	.74**	.87*	.56*	.13	-.39
10. TOCom	.01	-.27	-.06	-.06	-.47	-.39	.96**	.61*	.97**	_	.53*	.30	-.09	-.22
11. TOInCo	.14	-.26	-.07	-.03	-.60*	-.50*	1.00**	.75	.94**	.94**	_	.64**	.40	-.39
12. Conflict	-.01	.26	.44	.16	.33	.21	.19	-.19	.25	.22	.19	_	.03	-.25
13. Sides	.26	.75**	-.277	-.09	-.12	-.13	-.12	-.14	-.18	-.14	-.13	-.11	_	.24
14. Emotion	.57*	.639*	.18	-.23	.17	-.06	-.13	-.01	-.07	-.12	-.13	.06	.20	_

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Total	N	26	16	15	26	26	26	26	26	26	26	26	26	26	26
	M	5.77	5.43	4.73	.15	1.19	.89	3.77	.65	3.11	1.35	2.42	1.35	4.31	.46
	SD	2.92	1.11	.73	.46	2.26	1.53	4.21	1.09	3.85	2.33	2.33	2.02	2.91	1.27

Correlations for males are presented above the diagonal with correlations for females below the diagonal   *$p < .05$. **$p < .01$

Variables:

SRS: Session Rating Scale   TONoInt: Talkover without Therapist Intervention

CTAS: Couples Therapeutic Alliance Scale   TOCom: Completed Talkover

EG: Establish Ground Rules   TOInCo: Incomplete Talkover

TP: Therapists asks question   Conflict: Conflict Occurred

RBD: Relationship before Divorce   Sides: Therapist takes one client's side

Talkover: Talkover Occurred   Emotion: Client Emotion addressed

TOInt: Talkover with Therapist Intervention

Discussion

This study explored the therapist behaviors that were reported to negatively impact the therapeutic alliance in first session of high conflict couples. Research question one asked how frequently therapist behaviors occur that were previously identified as detrimental to the therapeutic alliance. As hypothesized, therapists were active in session, asking questions to both clients. Therapists also engaged in taking sides behaviors by reflecting on clients' statement and asking questions following clients' statements. Unexpectedly, therapists did not address emotions or establish ground rules often in session. Therapists were also less likely to intervene when a talkover occurred compared to not intervening. Finally, therapists rarely discussed the clients' relationship before divorce and never discussed clients' mental health history.

Overall, the alliance scores for the SRS and CTAS were low. In addition, while there was a substantial drop in CTAS scores from session one to four, these results were not significant due to the low power of the analyses. A power analyses suggests that assuming a medium effect size, a sample of 25 couples would allow for sufficient power (.7) to test hypotheses if the alpha level is set at .05. The low ratings are in line with research by Hynes et al. (2014), which suggests clients view high conflict couple sessions as tense and bad. However, the drop in alliance scores differ from Hynes and colleagues who found that clients' rating of the therapeutic process increase as their expectations of how therapists will conduct sessions. Clients expect their therapists to be directive and provide clear structure and ground rules (Hynes et al., 2014) and it is possible that these expectations were not met by therapists in this study. Despite clients' conflictual status, clients' CTAS scores at first session were strongly correlated with each other. Clients appeared to judge the therapeutic alliance and the first sessions similarly, suggesting some agreement about their experiences. Therapists may not realize how similarly their clients experience the session and may want to focus on these experiences as common ground to work from.

Research question two asked whether therapist behaviors that previous co-parents identified as detrimental to the alliance are associated with decreased level of therapeutic alliance. There was one therapist behavior that were significantly negatively correlated with alliance scores of male clients.

Talkovers that occurred to male clients with no therapist intervention were associated with decreased alliance for male clients. However, establishing ground rules was associated with improved alliance with male clients. There were no therapist behaviors that were significantly negatively correlated with female clients. Despite these results, many important findings occurred that may help inform therapists on their behaviors in relation to the clients' alliances. Preliminary research found that clients reported when therapists addressed emotion in session it was not helpful. However, for female clients in this study, addressing emotion was positively correlated with greater alliance scores at session one for the SRS and CTAS. Further, female clients alliance scores were only positively correlated when the therapist addressed emotions unsolicited, that is when the therapist saw that the client was feeling an emotion and asked about it and not when the client expressed her emotion to the therapist. In addition, male clients' alliance scores at first session and fourth approached significance in the positive direction with therapist addressing emotion. Previous research by Hynes et al. (2014) found that clients expected the first sessions to be tense with their co-parenting partner and their experiences matched these expectations. Bringing forth emotions seemed to give the clients a chance to air their emotions out, even while expressing wariness about the process. Furthermore, therapists are assumed to discuss emotions and these findings validate the process that therapists may utilize in therapy.

For male clients, the therapist establishing ground rules was positively correlated with the clients' emotions being addressed. It appeared that when ground rules were established, emotions were able to be addressed which is correlated with greater therapeutic alliance. In addition, talkovers by female partners, specifically talkovers that were not complete or when the therapist did not intervene, approached significant negative correlations with addressing emotion. When male clients' partners are able to complete their talkover and the therapist does not intervene, the male client's alliance scores may be negatively affected at session four. This may be because at session one content is relatively light compared to session four because first sessions were typically shorter due to clients completing paperwork during session time, however if the therapist hesitates to intervene at session one they may be likely to continue that behavior at session four, leading to the correlation only at that time. These findings

support Thomas, Werner-Wilson, and Murphy's (2005) findings that negative statements made by the male client's partner had a detrimental impact on the alliance and that male clients expect therapists to establish safe environment and this may be accomplished through the use of ground rules.

For female clients, talkovers by their partner were negatively correlated with the therapist asking a question to the female client. The therapist may not be specifically intervening in this case, but an active therapist who asks questions may prevent possible talkovers from happening by the male partner. However, when therapists did intervene following a talkover, it was negatively correlated with the therapist asking a question to the female client. The therapist may have indirectly refocused the conversation onto the male partner rather than continue with the female speaker's train of thought. In addition, the therapist addressing the relationship before divorce was positively correlated with CTAS at session four. This may be because female clients view this discussion as salient to the larger conversation about co-parenting while male clients do not.

Of considerable note is the effect sizes of the significant correlations found in this study. Cohen's (1992) guidelines suggest r's equal to .50 are large effect sizes. Many of the statistically significant and insignificant correlations had at least an effect size of .5 if not greater. Effect sizes suggest the magnitude of the relationship between variables (Cohen, 1992) and the effect sizes within this study suggest that the relationship between correlated variables is strong. However, due to the small sample size, the power of the analyses were limited. An increase the sample size may denudate significant correlations.

Limitations and Future Directions

Several methodological limitations should be noted for this study. Due to the nature of the sample, generalizations should be limited. Seven of the thirteen cases were conducted by one White male therapist. Another three cases were conducted by another White male therapist. In addition, there was also only one instance of an individual female therapist conducting sessions, the other female therapists were paired with a male therapist. This study may be less about what do therapists do in session with high conflict couples and more what does one therapist do in session or what do White male therapists do in session.

While clients were randomly assigned by the clinic director of the on-campus clinic, specific therapists do request to see high conflict couples as their clients in the clinic. This purposive self-selection led to a sample that was not representative of the entire therapist population of the clinic. A more representative sample of the therapist population may have resulted in a wider range of therapist behaviors.In addition, clients were seen at a university based clinic and there may be important differences between clients who seek treatment at a university based clinic and elsewhere.

This study was also reliant on preliminary research that used clients' self-report on what was not helpful in session. Clients may have had difficult recalling the exact behaviors or their thoughts about the behaviors that that occurred in session. Client reports also may suffer from responses biases due to the nature of the interview process with a separate therapist as the researcher. Furthermore, this study examined the behaviors that were seen as detrimental to the development of the therapeutic alliance. This format prevents a better understanding of the clients' full experience rather than just their negative experiences. In addition, the behaviors identified were limited to concrete and specific factors and other factors may have occurred that were more abstract, but also impact the alliance. Finally, the factors identified were seen to be unhelpful in the initial sessions of high conflict therapy which may be different than the behaviors that are unhelpful in maintaining the alliance.

An additional limitation is the sample size of this exploratory study. The sample size was small and as a result, the power of the analyses suffered. Future studies on therapist behaviors should increase the size of their client and therapist samples to create more power in the analyses and increase the sensitivity of the analyses.

Despite these limitations, this study explored a previously unknown factor in the development of the therapeutic alliance with high conflict couples. Future research on therapist behaviors in high conflict couple therapy should continue to examine therapist behaviors in different treatment settings and with a larger pool of therapists and clients. This study has provided the initial evidence of the importance of therapist behaviors in session with high conflict couples. More research is needed to explore how therapists behaviors toward one client may affect the alliance of the other client in session.

Appendix A

Allowing talkover: Allowing talkover occurs when the client who is speaking is interrupted by the partner and the partner controls the floor. The therapist may intervene to prevent the partner from completing a talkover. A talkover is considered complete if the speaker stops talking and the partner continue talking for the rest of the conversation section.

Subcodes include:

Completed talkover with therapist intervention

Completed talkover without therapist intervention

Incomplete talkover with therapist intervention

Incomplete talkover without therapist intervention

Establishing Ground rules: Occurs when the therapist talks about rules for therapy. Rules included no interrupting, no yelling, or stating to use this space to talk about parenting in an effort to make the sessions a safe place to talk and lower the tension in the room. A therapist may or may not establish ground rules by stating the rules, modeling appropriate behavior, or intervening and reminding when rules are broken.

Relation Before Divorce: A therapist may ask or address the clients' relationship or history before the divorce by questions as, "how did you first meet?" or "what was it like before you two separated?"

Addressing emotions: Addressing emotions in session consists of the therapist asking or focusing on emotions in session. This may be solicited or unsolicited.

Subcodes include:

Solicited: When the client states an emotion they are/were feeling and the therapist follows the statement with a question or statement about that emotion.

Unsolicited: When the therapist states or asks the client if they were feeling an emotion without the client previously stating he or she felt an emotion.

Allowing Conflict: Allowing conflict occurs when the therapist allows the session to rise above a baseline level emotional intensity for that couple.

Subcodes include:

The therapist does nothing

The therapist verbally tells the clients to stop or go back to a less conflictual topic

The therapist motions with a hand to stop

The therapist stands up to stop the conflict.

Taking sides: Taking occurs when the therapist says something that takes one client's side.

Subcodes include:

The therapist reflects or paraphrase a client's statement

The therapist asks for more information after a client's statement

The therapists agrees with the client's statement

The therapist agrees and makes a judgment along with the client's statement.

Addressing a client's mental health history: This is when a therapist addresses the mental health history of either client

Subcodes include:

The therapist ignores the statement mental health

The therapist acknowledges the statement,

The therapist acknowledges and directs the conversation towards mental health.

Therapist passivity: Reflects the number of questions the therapist asks during the session.

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