Carla Filomena César Dias da Costa

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Tese apresentada à Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra, sob orientação da Professora Doutora Madalena Alarcão, no âmbito do Programa Interuniversitário de Doutoramento em Psicologia, área de especialização em Psicologia Clínica(área temática: Psicologia da Família e Intervenção Familiar), da Universidade de Coimbra e da Universidade de Lisboa, tendo em vista a obtenção do grau.

Coimbra, Setembro de 2013

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Universidade de Coimbra

UNIVERSIDADE DE COIMBRA

FACULDADE DE PSICOLOGIA E DE CIÊNCIAS DA EDUCAÇÃO

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THERAPEUTIC ALLIANCE AND CLIENT FEEDBACK IN FAMILY THERAPY PROCESSES

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RESUMO

As variáveis que contribuem para o sucesso dos processos terapêuticos, nas suas diferentes abordagens, têm vindo a ser investigadas por vários autores. Da teoria dos fatores comuns são destacados dois elementos importantes para os resultados positivos das terapias. Por um lado, a aliança terapêutica estabelecida entre cliente e terapeuta; por outro lado, o cliente e o seu *feedback*.

A aliança terapêutica tem vindo a ser estudada por autores da terapia familiar e de casal, visto este modelo terapêutico ter características únicas de intervenção, principalmente por estarmos perante uma família com vários elementos e não apenas com um cliente só.

O cliente e a sua perspetiva do processo terapêutico e da aliança terapêutica, por seu lado, aparece destacado no quadro das análises dos processos terapêuticos, independentemente dos modelos teóricos, sendo a sua investigação ainda escassa.

O destaque dado a estas duas variáveis levou à necessidade de estudar e compreender como é que estas duas variáveis – aliança e *feedback* do cliente – se manifestam em processos de terapia familiar, assim como de procurar explorar diferentes visões de um mesmo sistema terapêutico, isto é, de terapeuta e clientes.

A investigação, que ocorreu entre 2011 e 2013, permitiu incluir nesta tese: a) a revisão teórica acerca dos alicerces da mudança terapêutica; b) um estudo quantitativo acerca da perceção que os terapeutas têm da aliança terapêutica, contribuindo ainda para a validação da versão terapeuta do instrumento SOFTA-S; c) um estudo qualitativo que visa perceber a perceção que os clientes têm da relação terapêutica e qual o *feedback*

dado ao longo da terapia; d) um outro estudo qualitativo referente ao *feedback* dos clientes acerca do processo terapêutico; e) e, por fim, um novo estudo quantitativo com o intuito de avaliar a perceção que os clientes têm do funcionamento familiar e a forma como a evolução ao longo do processo terapêutico afeta esta perceção. Este estudo constitui ainda um contributo para a validação do instrumento SCORE-15.

Os resultados permitiram concluir que a aliança terapêutica e o *feedback* do cliente se destacam como variáveis centrais no decorrer das terapias, na medida em que são as perspetivas que os clientes têm acerca dos seus problemas, da forma como podem resolvê-los e da confiança que têm no terapeuta e no sistema que permite o fluir dos processos terapêuticos.

A possibilidade de ter acesso a diferentes perspetivas (de clientes e terapeutas) acerca do mesmo sistema (família) permitiu encontrar diferenças na avaliação feita acerca da relação terapêutica. Os clientes avaliam, geralmente, de forma mais positiva a relação terapêutica estabelecida e a importância que os terapeutas têm nas suas vidas. Por seu lado, os terapeutas, avaliam a percepção dos clientes de forma menos positiva, considerando, na sua generalidade, que têm menos importância e menos competências do que as necessárias, para ajudar as diferentes famílias.

Outra conclusão importante diz respeito à perceção que os clientes têm acerca do funcionamento familiar. Foi perceptível que a sua visão de competência e funcionamento familiar aumenta à medida que encontram recursos para lidar com as dificuldades que vão surgindo. Neste sentido, não importa tanto saber se as dificuldades e problemas vão aumentando, ao longo da terapia ou da vida; o fundamental, na terapia, é ajudá-los a desenvolver competências que lhes permitam ultrapassar essas barreiras.

Therapeutic alliance and client feedback in family therapy processes

ABSTRACT

The variables that contribute to the success of therapeutic processes, in each distinct approach, have been studied by several authors. In the common factor theory, two elements are highlighted as important for a positive outcome of the therapy. On one hand, the therapeutic alliance established between the client and the therapist and, on the other hand, the client and its feedback.

The therapeutic alliance has been studied by couples and family therapy authors, since this therapeutic model has unique intervention characteristics, especially because we are dealing with a family with several elements instead of a single client.

The client and its perspective of the therapeutic process and, on its turn, the therapeutic alliance, are highlighted during the analysis of the therapeutic processes, regardless of the theoretic models in place, being scarcely researched variables.

The focus given to these variables – alliance and feedback - lead to the need to study and understand the way they both manifest in the couples and family therapy processes, as well as to explore different views of a same therapeutic system: therapist and clients.

This investigation, which occurred in the last two years, allowed the enclosure, in this thesis, of: a) theoretical review of the bases of therapeutic alliance; b) a quantitative study about the therapist perception of therapeutic alliance, enabling the validation of the therapist version of SOFTA-S instrument; c) a qualitative study about the client perception of therapeutic alliance and the feedback they gave during the therapy process; d) another qualitative study regarding the client feedback about the therapy; e) and, lastly, a new quantitative study with the aim of assess the client perception about the way they function as family, and the relation between the therapeutic process and

their perception. This study is also a contribute to the validation of the SCORE-15 instrument.

The results allowed the conclusion that the therapeutic alliance and the client feedback stand out as central variables during therapies, since the perspectives that clients have regarding their problems, the way they can solve them, and the trust given to the therapist and the system, allow the therapeutic processes to flow.

Besides, the possibility to have different perspectives of the same system work as a basis enabled us to find differences in the evaluation made upon the therapeutic relationship. Generally, the client assessment about the therapeutic relationship and about the role of the therapist in their lives is very positive. On the other hand, the therapist evaluation about the client perception of the therapeutic relationship is less positive, feeling that his role in their lives is quite small, and don't have all the abilities to help that family.

Another important conclusion relates to the perception that the clients have about their family functioning. It was visible that, to the clients, their vision of competence and family functioning increases as resources to deal with difficulties that arise are found. In this sense, it doesn't matter much if the difficulties and problems grow. On the contrary, the most important thing is to develop strengths which allow them to overcome those barriers.

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Therapeutic alliance and client feedback in family therapy processes

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ÍNDICE

INTRODUCTION

Aims for the research

The aim of systemic therapy, either in family or couples therapy, is to allow clients to feel better and solve the problems that disturb and difficult their functioning.

The idea of change and efficacy has increasingly been the subject of investigation. Initially, the goal of the research was to evaluate the efficiency of the intervention (Nichols & Schwartz, 2004). However, studies nowadays seek to understand how change occurs during the therapeutic process (Blow et al., 2009). Couple and Familiar Therapy (CFT) research has seen some increase in the last few years but it still has a long way to go, thus this work seeks to contribute in that sense.

Multiple authors (Escudero, Friedlander, Varelac, & Abascal, 2008) have pinpointed the crucial importance of therapeutic alliance in the overall therapeutic process. In other words, a genuine therapeutic relationship that can validate clients' perceptions and experiences (Duncan, 1992), allowing the integration and modification of the contents brought to therapy.

In CFT, the client undertaking therapy consists in a group of people, not an individual element, which brought forward the concept of expanded therapeutic alliance (Sprenkle & Blow, 2004). Friedlander (2009) stressed the importance of studying this type of therapeutic alliance by considering five principles: (1) be based on a theory of systemic process of change, i.e. consider the different elements of the system individually, in subsystems and as a whole; (2) focus on the identified patient's behavior, not forgetting that this happens in the interaction and presence of the whole system; (3) pay attention to the concealed experience, since everything that happens during therapy is positively and negatively influenced by the different members of the family; (4) develop strategies to analyze multiple clients' results, considering the

different individual voices interacting; (5) be able to analyze several matters simultaneously.

According to a slightly different perspective, the Common Factors Theory, whose aim is to determine the main elements that different therapeutic models share and that guarantees parsimony and efficacy of such treatments (Blow & Sprenkle, 2001), indicates four essential factors for the therapeutic success.

Miller, Duncan and Hubble (1997), in light of this model and based on Michael Lambert's study (1992), refer to the four factors responsible for successful outcomes in therapeutic processes as: a) client/extra therapy factors (factors related to the client and its surroundings, in other words, aspects which cannot be controlled during therapy); b) relationship factors (relationship established between the therapist and the clients throughout the therapy); c) techniques and models (specific aspects of the intervention and each theoretical model); d) expectations, hope and placebo (client's hopes and expectations towards how it will feel and the result of the therapeutic process).

Bearing in mind the specific context of couple and family intervention, Sprenkle and Blow (2004) consider as CFT's unique factors: a) the relational conceptualization (description of the problems in relational terms and analysis of the systems that influence the client's life, as if they were present in the therapy room); b) the expansion of the direct treatment system (most therapists prefers to work with a highest possible number of elements of the system and so tries to bring as many people into treatment as possible); c) the expansion of the therapeutic alliance (therapists' tendency to form alliances with each element of the system, with the system as a whole, and with every subsystem within the system, in order to reach the therapeutic aims).

In this model, emphasis was given to the client's vision of the world as a crucial aspect in a successful change that stood out (Fischer, Jone, & Atkinson, 1998; Frank &

Frank, 1993; Miller, Hubble, & Duncan, 1995), to the extent that it focused the importance of being able to access its own perspective in order to reinforce the therapeutic alliance, stimulate hope and expectation, offer an acceptable and understandable rational, and implement believable interventions for the clients (Rodriguez, 2007).

Recent studies conclude that clients' feedback, at each session and stage of the therapeutic process, consists in a valuable contribute to the therapist's growth and training (Duncan, Miller, & Sparks, 2004), as well as to the psychotherapy's outcome (Miller et al., 1997). Muniz de la Peña, Friedlander and Escudero (2009) refer in a recent study that the evaluation that clients made regarding the therapeutic alliance and the process, appeared to be the most predictive factor for the success of the therapy. Escudero et al. (2008) also observed a continuous positive notion from the clients, about the usefulness of therapy, which was associated to positive outcomes at the end of the therapeutic process. So, client's feedback and the therapeutic alliance arise as primordial factors in the success of a CFT therapeutic process.

Considering these results, we studied these two dimensions, client's feedback and therapeutic alliance in family therapy processes, aiming to explore how they change throughout the process and contribute to the therapeutic outcome.

The conducted study is a longitudinal one and is based in a mixed method (two studies with qualitative methods and two studies with quantitative methods).

In order to study the therapeutic processes, we choose a sample of clients and therapists from couple or family therapy processes based on a systemic intervention model, in a classical setting, with teams of two co-therapists (specialized in family therapy) adopting a brief therapy model (with an average of 7 sessions), with an

unidirectional mirror, and a recording of the sessions. The chosen interventional model was narrative therapy.

Being a clinical sample, several difficulties were experienced during the gathering of the sample. On one hand, although confidentiality was guaranteed and the benefit of the participation in this investigation was explained, since many of these families were referred by the Court or Commissions, their adherence to this study was somewhat complicated. On the other hand, guaranteeing a never changing setting and securing therapists with the same type of intervention, also raised some difficulties in the choice of places for collecting the sample. Thus, and despite the collection occurring throughout Portugal, in the services of the University of Coimbra, in Hospital de São João (Oporto), and other clinical services open to non-governmental organizations (in Portugal mainland and islands), there were several refusals and dropouts from the therapeutic processes.

Despite these difficulties, and in order to assure the randomness of the sample, whenever a service was chosen and the therapists agreed to participate in the investigation, it was settled that from that point on every request and early processes would be sequentially accounted for with a code indicating the institution where they came from. After the attribution of such codes, clients were invited to participate in the investigation, and the entire process was carefully explained, guaranteeing confidentiality. Every process was accounted for, even refusals.

Another sample characteristic which somehow hampered the investigation process was related to the heterogeneity of the family structures that turned up in the therapeutic process. Since it was often changed during therapy or was absent in the sessions marked for data collection. Thus, there were frequent gaps regarding the gathered information.

Regarding the conceptual table, and as mentioned above, we intended to maintain the systemic basis within a classic setting, equal in every service. It is well known that in Couples and Family Therapy different dynamics are established, not only due to the attending subsystems that are distinct (family, parental, filial and fraternal subsystems in the 1st case and conjugal in the 2nd case), but also to the exposed problems not being the same. So, for this research only family therapy processes were included.

Being a process study, it was decided to assess three stages, since it is considered that throughout the process the initial, the middle and the final phases are crucial phases for the evolution and conclusion of the therapeutic process. Therefore, being a brief therapy model, the 1st, 4th and 7th sessions were fixed as the evaluation stages. This study's sample was collected as part of a larger project, where a battery of tests was administered to different elements of each family and therapist in the three stages of the therapeutic process defined.

Although some studies have been made regarding the therapeutic alliance and the feedback in the couples and family therapy context, this type of research has proved to be quite sparse rendering this investigation a more challenging objective, particularly considering the difficulties and challenges that occurred throughout the sample gathering process and during the reflection upon each of the cases.

Concerning the therapeutic alliance, there is a whole set of investigation and assessment instruments. However, regarding the characteristics of the couples and family therapy setting, the instrument which demonstrated to be more thorough and specific in assessing this variable was System for Observing Family Therapy Alliances (SOFTA) (Sotero, Relvas, Portugal, Cunha, & Vilaça, 2010). Apart from its specificity, this instrument contains another advantage which relates to the fact that it possesses two versions: a self-response and an observational version. The possibility to conjugate

formal data, gathered through self-responses (SOFTA-s) given by clients and therapists, and observational data (SOFTA-O) gathered by a team of experienced investigators in this therapeutic setting and in the application of this instrument, enabled us to increase the information and complement the analysis, relating the way the therapeutic alliance components behaviourally manifest throughout the interactions during therapy, and the way they are felt and expressed by the clients/therapists. Therefore, due to the richness of the information, I thank the investigation team responsible for the application of SOFTA-O, Dr. Paulo Marques, Dra. Luciana Sotero, Dra. Carolina Sá, Dra. Alda Portugal, Dra. Patrícia Fernandes, collaborators from the University of Coimbra.

Concerning feedback, despite its importance there is still little research made in this area. Given the exploratory character, a qualitative study was chosen, which made possible to define the concepts in light of categories related to the revised literature (content feedback – problem, causes, maintenance, impact and change; relationship feedback – engagement in the therapeutic process, safety in the therapeutic system, shared sense of purpose within the family, emotional connection and therapy usefulness) and after the transcription of the therapy sessions, analyze and integrate the verbalizations and behaviors from each element of the therapist-client system, considering these dimensions.

In terms of change, the chosen instrument allowed the assessment of the way clients perceive their family functioning (difficulties, strengths and family communication), in order to understand the existence of changes during the therapeutic process. In order to do so, SCORE-15, an instrument devised specifically for a clinical population, was used. It is important to clarify that, in terms of the protocol of investigation, the instrument that was used was SCORE-29, since this research is part of

a bigger sample collection project – Pro-Civ – and this instrument enables us to remove the data from SCORE-15.

Work organization

In the first phase of this study, and since research about CFT therapeutic processes is so important and so scarce, we decided to conduct a literature review (*O cliente e a relação terapêutica: alicerces da mudança terapêutica*), in order to understand which are the fundamental aspects that constitute the basis of successful processes. The results indicated two important variables: therapeutic alliance and client feedback.

So, we started by the first important characteristic - the therapeutic alliance – and, in a second study (*The therapeutic alliance perceived by therapists: safety, engagement and share sense of purpose factors*), we tried to understand how therapists perceive this alliance and the way the different alliance factors, pinpointed by literature, relate throughout the therapeutic process. In this stage, we were able to explore the psychometric qualities of SOFTA-S, which doesn't present the same factorial organization for this sample.

Through the reviewed literature we realized, besides the therapist, the importance of the client's feedback regarding the therapeutic alliance, and after understanding the way therapists formally perceive this alliance, in a third study (*The therapeutic relationship: the role of therapists in the clients' safety and involvement behavior*) we analyzed the way this alliance is informally perceived, seeking to comprehend the role of the client and the role of the therapist in building this relationship.

Focusing on the client and its fundamental role in therapeutic change, and after understanding how it gives feedback about the therapeutic alliance, we sought to explore the way the client manifests regarding the actual therapeutic process. Thus, in a fourth study (*Client's feedback and therapeutic process: informal and formal feedback*), we assessed the client's formal and informal feedback regarding the therapeutic process.

Finally, and after exploring the relations between formal and informal feedback, and the way this feedback places during sessions and throughout the therapy, it has become relevant to evaluate the perception that clients have about themselves, their family functioning, their problems and the therapy usefulness, in order to understand how these perception evolve along the several therapeutic sessions (*Client feedback regarding their family functioning (SCORE-15): Family strengths and difficulties*).

With this study we intend to answer some questions:

- Which are the important factors to the therapeutic process?
- In what way do therapists perceive the therapeutic alliance throughout the process and how do the alliance characteristics relate to one another and each other?
- How does feedback about therapeutic alliance occur during therapy?
- What is feedback? How does it operate in the therapeutic sessions?
- How do clients perceive family functioning, particularly the change and the usefulness of therapy, throughout the therapeutic process?

So, and viewing the results that will arise from the different studies, it will be possible to understand how these two variables, therapeutic alliance and client feedback regarding itself and its problems, evolve throughout therapy.

Besides, the therapist's role in gathering this client feedback will be noticeable, as well as its perception regarding the therapeutic alliance. With these results, we can contribute with some aspects that may aid therapists in leading their therapeutic processes, improving the therapeutic relationship and move on to more successful processes.

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CAPÍTULO I

O CLIENTE E A RELAÇÃO TERAPÊUTICA: ALICERCES DA MUDANÇA TERAPÊUTICA?

Resumo

Neste artigo faz-se uma revisão da investigação sobre processo terapêutico em terapia familiar e conjugal, com destaque para a temática dos Fatores Comuns (i.é,variáveis transversais responsáveis pela mudança terapêutica). Destaca-se o papel da aliança terapêutica (forte e securizante) e do *feedback* do cliente como aspetos fulcrais da mudança. A pesquisa foi realizada em bases de dados (e.g., *EBSCO Host*) e livros de referência.

Palavras-chave: Terapia; mudança; cliente; aliança terapêutica; fatores comuns.

Abstract

This paper makes a review of research on the therapeutic process in marital and family therapy, highlighting the theme of Common Factors (ie, transverse variables responsible for therapeutic change). We highlight the role of therapeutic alliance (strong and reassuring) and client feedback as key aspects of change. The survey was conducted in databases (eg, EBSCO Host) and reference books.

Keywords: Therapy, change, client, therapeutic alliance, common factors.

Note: Dias da Costa, C. & Alarcão, M. (2012). O cliente e a relação terapêutica: Alicerces da mudança terapêutica? Mosaico, 53, 23-33

Introdução

A investigação sobre terapia familiar e conjugal sistémica (TFC) tem procurado responder à questão de saber se esta modalidade terapêutica funciona e porquê. Numa meta-análise realizada, em 2002, por Shadish e Baldwin, foi possível comparar a eficácia entre diferentes abordagens da TFC verificando-se que os participantes em tratamento apresentavam resultados significativos de maior bem-estar do que os da amostra sem tratamento. Embora a efetividade e eficácia da TFC tenham sido referidas por muitos estudos (Blow & Sprenkle, 2001; Miller, Hubble, & Duncan, 1995; Nichols & Schwartz, 2004; White, Edwards, & Russell, 1997, citados por Rodriguez, 2007; Shadish & Baldwin, 2002; Sexton, Ridley, & Kleiner, 2004), não se conhece, com clareza, o que torna a terapia familiar e conjugal efetiva (Sexton et al., 2004; Sprenkle & Blow, 2004a).

Sprenkle, Davis e Lebow (2009) referem-se aos clientes como o fator comum mais importante para o resultado final da terapia (sucesso ou insucesso), pois são eles que vão escolhendo, ao longo do processo terapêutico, aquilo a que devem dar atenção, o que devem fazer e como é que as coisas devem funcionar. Os terapeutas apenas facilitam a dissolução do problema, ajudando os clientes a encontrar a "cura" (Tallman & Bohart, 1999).

Neste artigo pretende fazer-se uma revisão da investigação sobre processo terapêutico em terapia familiar e conjugal, refletindo sobre a evolução do modelo dos fatores comuns, nomeadamente na sua aplicação à sistémica, sistematizando os resultados encontrados e explicitando os temas ou questões sobre as quais se afigura ser relevante continuar a investigar para uma melhor compreensão da mudança terapêutica.

1. Investigação sobre Processo Terapêutico em Terapia Familiar e Conjugal

A investigação sobre terapia familiar e conjugal sistémica (TFC) tem vindo a modificar-se, tanto ao nível do foco da investigação como das metodologias utilizadas. Inicialmente os investigadores procuraram perceber se este tipo de intervenção era eficaz, nomeadamente se era mais eficaz do que a psicoterapia individual (Nichols & Schwartz, 2004). Para isso, o importante era relacionar as abordagens sistémicas, mais holísticas, e as perspetivas intra-individuais, mais lineares, com as problemáticas da saúde mental e perceber o que funcionava (Davis, 2005). Embora a investigação em psicoterapia individual apontasse para semelhanças entre os diferentes modelos, a TFC tem sido historicamente resistente a focar-se nas semelhanças entre modelos, tentando encontrar o mais eficaz (Sprenkle & Blow, 2004a), apesar da maioria das meta-análises realizadas não permitir concluir que um modelo é melhor do que outro (Shadish, Ragsdale, Glaser, & Montgomery, 1995, citados por Blow & Sprenkle, 2001).

Se inicialmente as investigações em TFC se centravam nos resultados da terapia, mais recentemente os investigadores têm tentado compreender como ocorre a mudança. Blow et al. (2009) afirmam que o processo de mudança é complexo e depende da interação de diferentes variáveis. Coady (1992), não tendo encontrado diferenças entre as abordagens ao nível dos resultados (*outcomes*), concluiu que a aliança terapêutica era um fator com peso na mudança. Pinsof e Catherall (1986), tidos como pioneiros dos estudos sobre aliança terapêutica no campo da terapia familiar, consideram que, para estudá-la, é necessário olhar para a interação terapeuta-cliente como um sistema que se desenvolve pela interação dinâmica e influente de ambas as partes.

Tendo em conta os aspetos cruciais da aliança terapêutica, Duncan (1992) refere a importância de uma abordagem eclética e flexível para facilitar, por um lado, a

acomodação à variedade de estilos interpessoais dos clientes e, por outro lado, a aceitação individual do sistema em cada cliente. Horvath e Greenberg (1989) também afirmam a necessidade de partir para a terapia numa posição de "não saber", de forma a descobrir, com o cliente, qual o problema e quais as mudanças necessárias. Duncan (1992) sublinha a necessidade de desenvolver uma relação terapêutica genuína, através de validação das perceções e experiências dos clientes, mais do que enfatizar os conteúdos teóricos ou valores pessoais do terapeuta. De modo análogo, Morrissette (1990) aponta a importância da cooperação terapeuta-cliente e o respeito pelo cliente como aspetos determinantes da aliança terapêutica. São, no entanto, ainda poucos os estudos que avaliam a relação entre aliança e mudança terapêutica na terapia familiar e conjugal sistémica, apesar de diversas investigações demonstrarem a centralidade desta variável para o sucesso da terapia (Escudero, Friedlander, Varelac, & Abascal, 2008).

Na terapia familiar e conjugal sistémica, como o cliente é um grupo, e não apenas um indivíduo, a aliança terapêutica expandida (Sprenkle & Blow, 2004a) surge como fator comum específico desta terapia conjunta. Tendo em conta esta especificidade, Friedlander (2009) considera que a investigação deve: (1) ter por base uma teoria sobre o processo sistémico de mudança, ou seja, ter em conta os diferentes elementos do sistema, considerados de forma individual, em subsistemas e no seu todo; (2) fazer uma focalização no comportamento do paciente identificado, não esquecendo que este ocorre em interação e na presença de todo o sistema; (3) dar atenção à experiência encoberta visto que tudo o que acontece durante a terapia está a ser influenciado positiva e negativamente pelos diferentes elementos da família; (4) desenvolver estratégias para analisar resultados de múltiplos clientes, tendo em

consideração as diferentes vozes individuais em interação; (5) conseguir fazer uma análise de diversas questões em simultâneo.

Assim, a investigação em TFC tem feito um esforço para diferenciar-se da investigação sobre a terapia individual, tentando ajustar as medidas de avaliação e as metodologias à conceptualização sistémica da mudança e aos aspetos únicos da terapia conjunta (Friedlander, 2009).

2. Teoria dos Fatores Comuns

Segundo Blow e Sprenkle (2001), o objetivo da teoria dos fatores comuns é determinar os elementos principais que as diferentes terapias partilham, de modo a garantir parcimónia e eficácia nos tratamentos. Em si mesmos, não definem um plano de intervenção para a promoção da mudança terapêutica (Sexton et al., 2004), mas permitem uma orientação base, comum a todos os terapeutas, independentemente do modelo teórico adoptado.

A ideia da existência de fatores comuns a todas as terapias, responsáveis pela eficácia terapêutica, foi apresentada pela primeira vez por Saul Rosenweig, em 1936 (Miller, Duncan, & Hubble, 2004; Sexton et al, 2004; Sprenkle & Blow, 2004a), e investigada por Jerome Frank a partir de 1961 (Frank & Frank, 1993). Por esta altura, Frank e Frank (1993) identificaram quatro aspetos comuns a todas as terapias eficazes: a) relação emocional e de confidência com uma pessoa que pode ajudar o cliente; b) contexto terapêutico onde o cliente acredita que o terapeuta é de confiança para providenciar os aspetos necessários para o ajudar; c) terapeuta capaz de fornecer um racional credível ou um esquema teórico plausível para a compreensão dos sintomas do

paciente; d) terapeuta que oferece rituais e procedimentos credíveis para o alívio dos sintomas.

Anos depois, Michael Lambert (1992) publicou um artigo onde propõe quatro fatores teóricos como responsáveis por toda a variância de resultados em psicoterapia: mudança extra-terapia (40%) (fatores relacionados com o cliente e com o ambiente); relação terapêutica (30%) (ligação entre terapeuta e cliente); expectativa ou efeito placebo (15%) (expectativas do cliente acerca da forma como irá melhorar como resultado da terapia); técnicas específicas do modelo (15%) (intervenções específicas de cada modelo). Miller, Duncan e Hubble (1997), partindo destas quatro categorias, modificaram-nas e apresentaram as seguintes dimensões: a) fatores cliente / extra terapia; b) fatores de relação; c) técnicas e modelos; d) expectativas, esperança e placebo. Mais tarde, em 2001, Wampold usou as quatro dimensões definidas por Frank e Frank (1993) e demonstrou que elas podem explicar cerca de 70% da variância dos resultados em terapia, sendo que apenas 8% da variância diria respeito ao modelo teórico.

A partir de 1980 começaram a surgir diversos trabalhos relativos à abordagem dos fatores comuns. Os estudos de Sexton et al. (2004) levaram a uma lista de mais de 30 fatores comuns, embora os mais influentes sejam consensualmente os seguintes: fatores dos clientes, da relação terapêutica, das expectativas e da intervenção terapêutica. É importante referir que, embora estes fatores desempenhem um papel fundamental na mudança, as terapias não são eficazes se não tiverem um modelo conceptual base que guie o terapeuta na compreensão do cliente e nas decisões que vai tomando ao longo da terapia (Sexton et al, 2004).

Detalhando um pouco mais estes quatro fatores, importa referir que:

- Os *fatores do cliente* (cerca de 40%) são todos os elementos da vida do cliente (contexto individual e familiar) que têm impacto na terapia. Incluem-se as forças interiores, a fé religiosa, os objetivos e agendas pessoais, a motivação e consciência da situação, o envolvimento e o compromisso com a terapia, os recursos pessoais ou de personalidade. É fundamental a capacidade do cliente olhar para si e ver-se como competente, capaz de confiar nos outros, ser criativo e empático. O facto de a família ser um sistema obriga à inclusão de aspetos como coesão, expressão emocional da família, vontade de participar e cooperar com os trabalhos de casa, tipo e severidade do problema. Finalmente, devem acrescentar-se os fatores extra-terapia, onde se incluem acontecimentos inesperados, suporte social, envolvimento comunitário e eventos stressantes (Rodriguez, 2007).

- Os *fatores da relação terapêutica* dizem respeito a todas as interacções que ocorrem entre o terapeuta e os membros da família e que podem contribuir para a mudança positiva (Sexton et al. 2004). Para que se obtenha uma relação de sucesso, esta necessita de ser emocionalmente carregada, positiva e curativa. Deve haver confiança entre o cliente e o terapeuta, acordo mútuo nas tarefas e objetivos, respeito partilhado, comunicação efetiva, vontade de trabalhar em conjunto, capacidade conjunta de resolver os problemas, afirmação mútua, aliança ou ligação forte, limites claros na relação, envolvimento balanceado e partilha do compromisso na terapia (Rodriguez, 2007). Apesar de, por vezes, as características do terapeuta serem consideradas à parte, na teoria dos fatores comuns são agrupadas nos fatores da relação pois aparecem como parte integrante da relação terapêutica (Fischer, Jone, & Atkinson, 1998). Qualidades essas que são: respeito, genuinidade, empatia, cuidado, consideração positiva pelos

pacientes, maturidade, respeitabilidade, ética, saúde emocional, valorização do outro, compromisso consigo próprio e com o seu desenvolvimento pessoal. Estes aspetos estão ligados à eficácia da terapia na medida em que incluem uma capacidade de criar formas comuns de ver o mundo e uma sensibilidade cultural que facilita a escuta ativa e o desenvolvimento da relação. Segundo Miller et al. (1995) este fator corresponde a 30% dos resultados da terapia.

- Os *fatores de expectativa* ou esperança são os elementos da terapia que levam o cliente a acreditar que a mudança positiva irá ocorrer. Esses fatores são: partilhar a visão do mundo, perceber uma atitude positiva e de esperança por parte do terapeuta, acreditar na sua reputação e treino. O fator placebo é também aqui incluído (Rodriguez, 2007). Lambert estimava para este fator 15% de influência na melhoria em psicoterapia (Sprenkle & Blow, 2004a)

- Os *fatores da intervenção terapêutica* consistem nos racionais conceptuais que são dados como explicações do problema familiar e nas técnicas e rituais que são utilizadas e que têm impacto no resultado da terapia. O que importa não é tanto a teoria específica, mas o quanto a família acredita e encontra sentido nas explicações dadas de forma a utilizá-las para as mudanças terapêuticas (Fischer et al, 1998). O fator que mais contribui para a aceitação do racional é a partilha da visão do mundo e as intervenções que ajudam na mudança são: a oportunidade de catarse (confrontar a fonte das dificuldades), a regulação comportamental (fazer a mudança), a mestria cognitiva (mudança da forma como se vêem as coisas / reenquadramento) e a experienciação afectiva (experiência e regulação emocional) (Rodriguez, 2007). Lambert estima que este fator contribui 15% para a mudança terapêutica (Miller et al. 1995).

Blow et al. (2009), no seu estudo sobre fatores comuns, verificaram que o cliente (motivação) e os eventos extra terapia surgem em primeiro lugar, embora a aliança terapêutica se tenha salientado como a chave para a mudança (acordo de objetivos, tarefas e laços entre terapeuta e cliente). A esperança e expectativa, principalmente durante as primeiras sessões, surgem com algum significado na mudança, assim como o papel do terapeuta, no modo de reagir, responder e motivar os clientes. Com efeito, a qualidade da relação terapêutica é apreciada de forma significativa e frequentemente vista como um preditor dos resultados (Horvath & Greenberg, 1989; Luborsky, 1994, citado por Davis, 2005). Também a variável cliente como um fator comum recebeu suporte por parte da literatura (Davis, 2005).

Em síntese, a teoria dos fatores comuns permite um olhar diferente sobre a análise do processo terapêutico, obrigando os terapeutas a debruçarem-se sobre as particularidades de cada cliente e da relação, mais do que sobre a especificidade das técnicas.

3. Teoria dos Fatores Comuns em TFC

Sprenkle e Blow (2004a; 2004b) e Sprenkle, Blow e Dickey (1999) foram os primeiros a abordar a teoria dos fatores comuns únicos em TFC. Num primeiro artigo, Sprenkle et al. (1999), fazem uma revisão de literatura relativa às quatro categorias de Lambert (1992) e adicionam mais cinco categorias de fatores comuns que acreditam ser únicas da TFC: conceptualização relacional; expansão do sistema direto de tratamento; expansão da aliança terapêutica; fatores comuns comportamentais, cognitivos e afectivos; e experiência privilegiada do cliente. Posteriormente, Sprenkle e Blow (2004a) substituem a categoria "técnicas específicas do modelo", de Lambert (1992),

pela categoria "variáveis de tratamento não específicas", incluindo a regulação comportamental (mudança da ação), o reenquadramento (mudança do pensamento) e a experienciação emocional (regulação/experiência emocional) como subcategorias. Mais tarde, fazem uma nova revisão, considerando como fatores únicos da TFC: a) a conceptualização relacional (descrição dos problemas em termos relacionais e análise dos sistemas que influenciam a vida do cliente, como se estivem presentes na sala de terapia); b) a expansão do sistema direto de tratamento (a maioria dos terapeutas prefere trabalhar com o maior número de elementos do sistema que for possível e para isso tenta trazer o maior número de pessoas possíveis para o tratamento); c) a expansão da aliança terapêutica (tendência para os terapeutas formarem alianças com cada elemento do sistema, com o sistema como um todo e com os subsistemas dentro do sistema, de forma a alcançarem os objetivos terapêuticos).

Sexton et al. (2004), refletindo sobre o modelo dos fatores comuns, referem que esta abordagem terá um papel fundamental na união de diferentes escolas sistémicas, e na própria investigação, embora sublinhem que a mesma não foi ainda sujeita a debate rigoroso, investigação e discussão necessária para que possa ser declarada como um avanço na determinação dos fundamentos conceptuais da TFC. Uma das críticas que os autores apontam prende-se com o facto de olhar em demasia para a diversidade de clientes, de contextos e para a complexidade da mudança mas de falhar na definição de um guia necessário à exploração do trabalho clínico bem sucedido.

Sprenkle e Blow (2004b) respondem à crítica defendendo que este não pretende ser um modelo único de compreensão da terapia, mas que deve ser visto como uma parte importante no futuro da mesma, na medida em que há evidências de que parte da variância de sucesso da psicoterapia é devida aos fatores que não são específicos de

nenhum modelo. Não deve ser vista como uma abordagem contra os modelos terapêuticos, mas sim como uma forma de enfatizar os aspetos necessários a uma terapia bem sucedida. O terapeuta terá o papel fundamental de maximizar estes fatores tendo por base um modelo validado empiricamente para conduzir a terapia (Sprenkle & Blow, 2004b).

A abordagem dos fatores comuns, quando combinada com um conhecimento sobre o contexto cultural dos clientes, pode guiar os terapeutas no aconselhamento multicultural, permitindo criar uma visão do mundo partilhada de forma a ajudar os clientes a dar sentido ao problema e a encontrar o caminho para a "cura". O realce dado à visão do mundo dos clientes é enfatizado como um aspecto crucial da mudança bem sucedida (Fischer et al., 1998a; Frank & Frank, 1993; Miller et al., 1995; Arredondo, 1998 citado por Rodriguez, 2007), na medida em que foca a importância de conseguir aceder à sua perspetiva para reforçar a aliança terapêutica, estimular a esperança e expectativa, oferecer um racional aceitável e compreensível e implementar intervenções credíveis para os clientes (Rodriguez, 2007).

Apesar dos esforços de adequação da teoria dos fatores comuns à TFC, é necessário um cuidado especial com a supra-simplificação do complexo processo de mudança dada particularidade da relação sistémica terapeuta-clientes. A mudança individual tem impacto direto e imediato no sistema, sendo que o contrário também é verdadeiro, e a aliança deve ser estabelecida com os diferentes subsistemas para garantir que se caminha para um objetivo comum.

4. O Estudo da Aliança Terapêutica na Terapia Sistémica

De modo a estudar o papel da aliança terapêutica em terapia sistémica, Pinsof (1995) focou-se em duas dimensões: os conteúdos da aliança (e.g., ligações, objetivos e tarefas) e a dimensão interpessoal (i.e., a relação que o terapeuta tem com cada um dos elementos do sistema cliente, com os subgrupos familiares e com o sistema total).

Na avaliação da aliança terapêutica são frequentemente utilizadas escalas de auto-resposta, como as "*Couple and Family Therapy Alliance Scales" (CTAS – Couple Therapy Alliance Scale e FTAS – Family Therapy Alliance Scale)* (Pinsof & Catherall, 1986). Os estudos revelam, porém, que a relação entre os auto-relatos dos clientes, relativos à aliança terapêutica, e os resultados terapêuticos obtidos não são lineares, na medida em que, frequentemente, o modo como os elementos da família percebem o processo terapêutico é diferente entre eles. Esta perceção dos clientes é, contudo, um preditor importante para o sucesso da terapia (Muniz de la Peña, Friedlander, & Escudero, 2009). Nesse sentido, e percebendo a importância de comparar as diferentes perceções acerca da aliança terapêutica, tornou-se imprescindível desenvolver um instrumento de avaliação que permita comparar o auto-relato com a avaliação observacional.

O *System for Observing Family Therapy Alliances – SOFTA*, desenvolvido por Friedlander e colaboradores (2006), é um instrumento que faz uma avaliação da aliança terapêutica a partir de dois modelos: um observacional e outro de auto-relato. Avalia 4 dimensões da aliança terapêutica no contexto da terapia familiar e de casal. Duas das dimensões – envolvimento no processo terapêutico e ligação emocional ao terapeuta – refletem a teoria de Bordin de 1979 (Friedlander, Escudero. & Heatherington, 2006). As outras duas dimensões – segurança dentro do sistema terapêutico e partilha do sentido

da terapia com a família – refletem aspetos da aliança que são específicos da terapia sistémica.

Os estudos com o SOFTA demonstraram, mais uma vez, a existência de diferenças entre os auto-relatos e o que é observado (Muniz de la Peña et. al, 2009), permitindo avaliar com maior clareza tais diferenças e dar pistas aos terapeutas sobre como promover uma aliança terapêutica mais fortalecida.

5. O Papel do Cliente na Mudança Terapêutica

A investigação sobre o processo terapêutico tem enfatizado, como foi referido, o papel fulcral das variáveis do cliente, tanto ao nível da motivação para a terapia como da sua perceção sobre o processo terapêutico.

No estudo de Duncan, Miller e Sparks (2004) foi possível concluir que o *feedback* dos clientes, em cada sessão e em cada momento do processo terapêutico, é um contributo valioso para o desenvolvimento e treino do terapeuta, bem como para o resultado da psicoterapia (Miller et al., 1997).

Muniz de la Peña et al. (2009), num artigo recente, referem o acordo que existe entre investigadores relativamente ao facto da avaliação que os clientes fazem sobre a aliança terapêutica e sobre o processo ser o fator mais preditivo do sucesso da terapia. Também Escudero et al. (2008) observaram que um parecer positivo contínuo, por parte dos clientes, sobre a utilidade da terapia, está associado a resultados positivos no final do processo terapêutico.

Outros estudos têm demonstrado melhorias significativas no tratamento quando os terapeutas têm acesso, em tempo real, ao *feedback* dos clientes acerca do processo e do resultado da terapia (Duncan et al., 2004). A experiência subjetiva do cliente acerca do significado da mudança, nas primeiras sessões, tem também um valor preditivo na

forma como o sistema terapeuta-cliente terá um resultado final bem sucedido (Garfield, 1994; Haas, Hill, Lambert, & Morrell, 2002; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001, citados por Miller et al., 2004).

A avaliação que o cliente faz sobre a relação terapêutica e sobre a evolução do processo parecem, pois, ter um papel fundamental na evolução da relação e da mudança em si mesmo (Duncan & Miller, 2002, citado por Miller et al., 2004). De acordo com Beutler, Bongar e Shurkin (1998), não é o terapeuta nem o tipo de tratamento que são a chave da mudança, mas sim todas as variáveis do cliente, tais como a motivação para a terapia, o conhecimento que tem acerca do processo, as expectativas que coloca no terapeuta e na sua mestria, a preparação interna do cliente para um processo de mudança e o trabalho árduo com que se dedica e entrega ao processo.

Também Hubble, Duncan e Miller (2006) referem que as características do cliente, mais do que os fatores extra-terapia, são fundamentais na ocorrência da mudança uma vez que correspondem a 40% de influência no sucesso terapêutico. Se lhe for associado o peso da relação terapêutica, este valor sobe aos 70%. Desta forma, e embora não possa esquecer-se, tal como foi referido ao longo do artigo, que o processo é um todo determinado por diferentes variáveis em interação, as características do cliente, a relação que estabelece com o terapeuta e o olhar que tem sobre a terapia desempenham um papel determinante na mudança terapêutica.

Embora a motivação do cliente seja considerada uma das variáveis mais importantes em terapia, Sprenkle et al. (2009) relembram o papel do terapeuta na motivação do cliente, para o melhor e para o pior, visto que cabe ao terapeuta o papel de ir ao encontro das visões do mundo do cliente e de conseguir encontrar uma mesma linguagem que faça sentido e dê significado ao que vai ocorrer no espaço terapêutico.

Tallman e Bohart (1999) verificaram, contudo, que o nível de experiência do terapeuta não tem uma relação significativa com o resultado da terapia.

Conclusão

A investigação em terapia familiar e do casal, embora tenha começado mais tarde do que a investigação em terapia individual, tem recentemente sido alvo de muita atenção, por parte de clínicos e investigadores. Constituindo uma tendência recente, o estudo dos fatores comuns no contexto das intervenções sistémicas está ainda a dar os primeiros passos pelo que é necessária mais investigação e debate que permita não só consolidar alguns dos resultados conhecidos como amplificar o conhecimento e melhorar as metodologias de investigação (Rodriguez, 2007).

A investigação aponta o cliente e a aliança terapêutica como elementos fundamentais na gestão da mudança. O cliente é um elemento crucial pela compreensão que faz do problema e pelo sentido que dá às estratégias propostas pelo terapeuta para aprender a lidar com as dificuldades. Também o seu *feedback* parece ser fundamental para o ajuste das técnicas e *timings* da terapia. A aliança terapêutica é apontada como um fator importante na medida em que é esta relação de confiança que permite a aproximação entre cliente e terapeuta .

Sprenkle et al. (2009) sublinham, contudo, que, embora deva enfatizar-se o papel do cliente na mudança terapêutica, é necessário ter cuidado para que o terapeuta não se sinta desencorajado e desligado, como se nada do que fizesse tivesse impacto no processo. É necessária, então, uma visão balanceada do papel do terapeuta e do papel do cliente, bem como da própria relação.

Estando a investigação sobre TFC numa fase de grande desenvolvimento, será importante reavaliar metodologias e instrumentos de avaliação de forma a especificar e garantir o respeito pelas particularidades da TFC. São ainda poucos os investigadores que se dedicam ao estudo da aliança terapêutica com base em conceitos sistémicos e, ainda menos, os que se focam no estudo da mudança terapêutica à luz destes mesmos pressupostos. O cruzamento de diferentes variáveis, tais como as diferentes perceções, ao longo do processo, tanto do terapeuta como dos clientes, as características dos clientes e do terapeuta, a aliança terapêutica, o acordo entre os objetivos, tarefas e visões do mundo, as expectativas e a motivação constituiu-se como um importante foco de estudo.

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CAPÍTULO II

THE THERAPEUTIC ALLIANCE PERCEIVED BY THERAPISTS: SAFETY, ENGAGEMENT AND SHARE SENSE OF PURPOSE FACTORS

Abstract

The essential variables for the success of therapy, according to literature, are the therapeutic alliance and clients' feedback. However, it is up to the therapist to be the moderator and the engine of the process, engaging the family in the therapy, transforming individual problems in common questions, in a safety space with great emotional connection. In this study we tried to analyse the way therapists evaluate the therapeutic alliance they establish with their clients in family therapy. Aspects such as safety, engagement and share sense of purpose play a bigger role since they are always positively related with the alliance factor.

Keywords: Family Therapy, Therapeutic Alliance, Therapists, Safety, Engagement.

Note: Submitted to Psychotherapy Research

Therapeutic alliance and client feedback in family therapy processes

Introduction

Studies regarding the therapeutic process in couple and family therapy (CFT) point to the importance of two factors – therapeutic alliance and clients' feedback – for the success of the therapy (Dias da Costa & Alarcão, 2012).

Studies concerning the therapeutic alliance indicate that this is the basis where the entire therapeutic process develops, there are a relationship of trust, safety, engagement, and commitment sharing, which will act as a background to clients and therapists, allowing them to work their difficulties and problems that led them to therapy (Rodriguez, 2007). Clients' feedback has been considered essential in guiding the therapist during the therapeutic process, contributing to the outcome of the therapy (Miller, Duncan, & Hubble, 2004).

Thus, and since the clients' perception about the therapy is so relevant, it is important to understand the role of the therapist throughout the therapy, considering that this is a key element in the establishment of the therapeutic relationship and the conduction of the process. Some authors point to the main role of the therapist in CFT as helping the family engage in the change process, in order to help the clients find different meanings for the presented problems and, by doing so, reach the desired outcomes when searching for therapy (Blow, Morrison, Tamaren, Wright, Schaafsma, & Nadaud, 2009).

Although the client's role, as well as their motivation for therapy, is considered an important aspect in therapy, it is up to the therapist to support the client's motivation and engagement, as well as meeting the problem and change theories presented by the client, in order to give more meaning to the therapeutic process (Sprenkle, Davis, &

Lebow, 2009). When the therapist is able to adapt to the clients' language and culture, in order to fit in that unique relational context, it creates the conditions to work with the family in a validating and securing way (Blow et al., 2009).

In the therapeutic process the unique characteristics of the therapist and the clients, as well as their idiosyncratic ways, determine the unrolling of the therapy because the therapist will adjust its approach considering the direct feedback from the clients. Therapy is in constant change being oriented by the movements in response to the clients' feedback (Pinsof & Wynne, 2000). The therapeutic process is thus a fluid structure where therapists will establish balance between structured sessions and more fluid sessions, in order to explore the problems following the client's rhythm and theory. The way clients emotionally react seems to be a guide to the therapist throughout the sessions. Therapists must remain neutral, respecting and maintaining the equality between every member of the family, repeating the more relevant aspects in order to emphasize and give them space in the therapeutic process, allowing clients to pay more attention to them and to its consequent internalization. Therapists provide a context of collaboration, accommodation and safety, enabling the clients to feel at ease and easily expose themselves, take chances and show vulnerability, trusting the therapist and its ability to help them (Davis & Piercy, 2007).

The therapist and the therapeutic alliance

Studies regarding the therapeutic processes show that change is more related to the relationship or the alliance established with the therapist than with the models or theories used by the therapist (Johnson, Wright, & Ketring, 2002).

Since the therapeutic alliance has a great impact in the clients' lives change, the therapists' focus on this matter must necessarily be bigger. Thus, a lesser focus on

theories and models, and giving more time and space to the therapist-client relationship is fundamental. It is important to remind that the characteristics of this relationship go beyond the basic notions of therapist-client relationship about active listening or the demonstration of genuine care. It is necessary to favour a process where the family members and the therapist build, in a collaborative manner, an agreement between what has to be done and how it should be done (Johnson et al., 2002), as well as establishing an alliance considering some of its specific characteristics.

Friedlander, Escudero and Heatherington (2006b), influenced by several investigations about the concept of therapeutic alliance, developed a multidimensional alliance model that reflects the unique quality of the systemic work with families and couples, stressing the importance of the client cooperation and affective ties between the client and the therapist, i.e., Bordin's classical conceptualization of the alliance (1979). Their concept of alliance was developed based on four essential aspects: the engagement in the therapeutic process, the emotional connection with the therapist, the safety within the therapeutic system, and the sense of purpose sharing with the family. These four dimensions exist both the intra-system (of each client with the therapist) and the intra-family alliances and have a role in four decisive therapeutic processes: establishing the relationships, negotiating the goals, completing the tasks for change, and releasing the family from the therapeutic process (Friedlander et al., 2006b).

With this definition of alliance, and following three aspects they considered as essential to support this concept – the transtheoretical applicability of the alliance; the importance of the client's behaviors, especially in the intra-family alliances; and the conceptual and empirical superposition between goals and tasks in the therapy (Pinsof, 1995), Friedlander et al. (2006b) developed an instrument for the assessment of the

therapeutic alliance, SOFTA – System for Observing family Therapy alliance, with a version for therapists and another for clients.

Reflecting about the therapist's role in this important dimension, the therapeutic alliance, we realize that the therapist must simultaneously pay attention to the needs of the system, binding them in a way that makes sense to everyone, whether through focusing and refocusing the problem in different manners, highlighting the good intentions of every family member (Pittman, 1987), or through emphasizing common values and joint forces (Coulehan, Friedlander, & Heatherington, 1998). When this process is effective, the therapist creates hope and clients who feel they're "in trouble" know they have an ally in the therapist's figure; in other words, it is up to the therapist to manoeuvre the alliances between family members, transforming individual goals into group goals, and nurturing in the family the sense of purpose sharing regarding therapy (Friedlander et al., 2006b).

The relationship that is established between therapist and clients gives a sense of safety to clients, which allows them to privilege that space as a protected and trustful sharing place. The need to feel safe in the therapeutic context is a very important characteristic when working with families and couples (Friedlander, Lehman, McKee, Field, & Cutting, 2000, as cited in Friedlander et al., 2006b).

In this study we intend to evaluate the way therapists perceive the alliance, trying to understand which factors stand out as more important throughout the therapeutic process. Therefore, it can be possible to reflect upon some essential aspects that must be considered during therapy, in order to potentiate in each session the relationship established with the clients, its openness and the change process.

Method

This work is based on a quantitative methodology. For this study, the application of the System for Observing Family Therapy Alliances – Self Report (SOFTA-S) (Sotero, Relvas, Portugal, Cunha, & Vilaça, 2010) questionnaire to therapists of a clinical population, during the therapeutic process (in three stages: 1st session, in the middle of the process, and at the end of it, usually the 7th session), was considered.

In terms of research, after the therapists accepted to participate in this investigation, all the families that requested a first appointment were invited as well. The procedures and aims of the research were explained to all family members – an invitation was made and an informed consent was signed. In this investigation there were no incentives for participating in the research.

Participants

The therapeutic processes occurred in different family support services: connected to the university, to a central hospital and different clinical services from non-governmental organizations (NGO's). The data was collected in Portugal.

These services are known as reference to the community, having a couple and family therapy approach, in a systemic perspective. The processes were developed in a narrative theoretical perspective, usually brief (with seven sessions), with the establishment of a contract generally in the first session, and it runs with sessions every three weeks.

In terms of this study, the families fitting in a medium low socioeconomic level and in its majority low, having in average two children.

Being therapeutic processes, the number of families that accepted to participate in the study was not the same that concluded it, since there were several dropouts and not all families concluded all the sessions, thus, the number of therapists filling the questionnaire also decreased throughout the therapeutic process. The data were treated considering the three stages of collection (1st, 4th, and 7th session), resulting in limitations from the reduction of the therapist sample participating in the study.

At the first stage (1st session) we gathered 134 clients (from 57 families), in the second stage (4th session) the sample was reduced to 57 clients (24 families) and in the last stage (7th session) we collect just 35 clients (15 families)..

The therapists that participated in this study were 104 (in the first evaluation session, being reduced to 40 in the middle of the process), with mean ages of 32 years, an average time of formation of 5 years, and a mean of 6 years of clinical practice in family therapy. For the first stage we obtained answers from 96 therapists, in the second stage from 40, and at the end only 25 therapists answered to this instrument. The therapists, in its majority with a psychology-training basis, worked in a co-therapy scheme, in a classic setting with a unidirectional mirror and a recording of the sessions. Most of them were women, existing only 20 men in the therapist group.

Instrument

In this study, the Portuguese translation of the therapist version of SOFTA-S was used (Sotero et al., 2010).

SOFTA (System for Observing Family Therapy Alliances) aims to assess the perception that therapists have regarding the evaluation made by clients about the therapeutic alliance. This instrument was designed in two versions: an observational one

and a self-report one, in order to assess the four dimensions of the alliance referred above: engagement in the therapeutic process; emotional connection to the therapist; safety within the therapeutic system and sharing the meaning of therapy with the family (Friedlander et al., 2006b). With this study, our attention was in the results of the therapist version of SOFTA-S in order to explore the perceptions that therapists generally have about the evaluation made by clients throughout the therapy, and the way this perception changes during the entire process.

SOFTA-S is a 16-item scale (five of them have inverted scoring), with a likert scale ranging from 1 (nothing) to 5 (very much). The items refer to the way therapists perceive the family's engagement in the therapy and their contribution to the therapeutic process: for example, item 6 "I am doing all I can to help this family"; item 9 "The family and I are working together as a family; or item 16 "Each person in the family helps the others achieve what they desire from the therapy". The higher the attained result, the stronger the therapeutic alliance is considered, in terms of the four global alliance components (obtained through the total value of the scale). Data from self-report SOFTA-S questionnaire was collected from each of the therapists involved in the process in the three assessed stages.

Data processing

The data from each questionnaire were inserted in a Statistical Package for the Social Sciences (SPSS, 2009; version 19.0) database and we proceeded to the following statistical analysis:

a) Descriptive statistics of the socio-demographic variables and the items of the Therapist version of SOFTA-S (e.g., mean, standard-deviation);

b) Exploratory factor analysis studies of SOFTA-S's Therapist version, for the first assessing stage (since it has a larger sample);

c) Internal consistency analysis (Cronbach's alpha), for each of the factors found and for the scale as a total;

d) Bivariate correlations between the resulting factors from the factor analysis and the scale's total SCORE, in the three assessed stages (1st, 4th and 7th session);

e) Mean comparisons (ANOVA), with repeated measures, of the factors found for the first and second assessing stages.

Results

Construct Validity Studies – Factor analysis of Therapist SOFTA-S

In order to determine the factor structure of the therapist version of SOFTA-s version, an exploratory analysis of the main components of the 16 items was performed for the first stage, since it is the stage with a broader sample. Significant results (close to 1) were obtained in the Kaiser-Meyer-Olkin measure of sampling adequacy (.814) and in Bartlett's test of sphericity ($X2 = 545.978{,}210$; $gl = 120$, $p < .05$). These values are favourable to the prosecution of the factor analysis and indicate that the data come from multivariate normal population (Pestana & Gageiro, 1998). The acquired solution also indicated the existence of four factors by the Kaiser criteria, indicated as well through the observation of the scree plot, with four factors existing to the left of the inflection (Kline, 1994, 1998; Pereira, 2004). In order to maximize the high correlations and minimize the weak ones, the Varimax rotation method was applied (Poeschl, 2006). Saturations inferior to .30 were excluded and the retaining criterion for an item in a

determined factor was established by the magnitude of its saturation. This rotated solution allows the explanation of 60.411% of the variance, in which a first factor with four items contributes with 34.814% of the variance, with saturations between .596 and .844, a second factor contributes with 10.293% of the variance, presenting four items with saturations between .614 and .812, a third factor which explains 9.044% of the variance, containing six items with saturations that vary between .491 and .681, and a fourth factor with two items with saturations between .613 and .731, which contributes with 6.261% of the variance.

Considering the literature (Friedlander et al., 2006a), only the second factor was close to the so-called safety factor, having three corresponding items (15, 11 and 7). For the first factor, it was possible to find two immediate items (8, 4) plus one, the item 16, which saturated simultaneously in two factors, which would associate this factor to the Shared sense of purpose, referred in the revised literature. The third factor would include two of the factors in the literature, with three items each – Emotional Connection and the Engagement in the Therapeutic Process. Finally, the fourth factor had no basis of relation to the literature and was comprised by only two items, one of which also saturated in factor one, which makes more sense.

With these results, several analyses were made, removing some items (the ones that did not fit in the factors predicted by the revised literature) and conjugating them in different ways. All the exploratory factor analyses conducted, regardless of the item that was removed, always emerged the factor that matches safety (items 15, 11 and 7) and mostly the engagement factor (items 1, 13 and 5). The two other factors, shared sense of purpose and connection, appeared in the other two factors, but always with only two of the items and did not seem to emerge regularly.

Considering these results, an exploratory factor analyses was conducted removing the items matching the shared sense of purpose and emotional connection factors, and results indicate that, when shared sense of purpose items are removed, the emotional connection factor does not emerge, and when the emotional connection items are removed (items 2, 6, 10 and 14), the three alliance factors – safety, engagement and shared sense of purpose – emerge, clearly divided in three factors. In this sense, and in line with the literature (Friedlander et al., 2006a), we decided to drop the emotional connection factor, realizing that in the cases where these items emerged, they were always associated with the engagement factor.

Consequently, and considering our results (see table 1) and the revised literature, the shared sense of purpose factor (factor 1 which explains 42.067% of the variance) emerges with the items 8, 4 and 16, as referred in the literature (Friedlander et al., 2006a). However, two items are added: items 9 "The family and I are working together as a team" and 3 "Sessions have helped family members opening up (express feeling or try new things…)", which in terms of interpretation of the Portuguese language, may be associated with the ability of sharing with the therapist and between the clients.

The safety factor always emerges with items 15, 11 and 7, just like Friedlander et al. (2006a) observed, but the item 12 is added, since in all factor analyses it emerges in this factor. Reading item 12 "Some family members don't agree with the others regarding the goals of the therapy", we can assume that when there is discordance about goals, family members do not feel safe to be and to discuss during the sessions. Factor 2 explains 11.774% of the variance. Lastly, the engagement factor through items 1, 13 and 5 explains 8,650% of the variance.

Table 1

Rotated component matrix

	Component		
	1	2	3
TS1_SOFTAS_8	,843	,251	,133
TS1_SOFTAS_4	,803	,113	,062
TS1_SOFTAS_9	,691	,134	,333
TS1_SOFTAS_3	,599	,147	,221
TS1_SOFTAS_16	,535	,079	,326
TS1_SOFTAS_15_Inv	,307	,827	,025
TS1_SOFTAS_11_Inv	-,089	,778	,230
TS1_SOFTAS_12_Inv	,221	,712	,330
TS1_SOFTAS_7	,468	,611	,082
TS1_SOFTAS_1	,142	,125	,805
TS1_SOFTAS_13	,292	,160	,701
TS1_SOFTAS_5_Inv	,274	,424	,603

Alpha Cronbach studies

The total scale and the factors' scales of the SOFTA-S questionnaire (see table 2), specifically safety in therapy and shared sense of purpose, during the first evaluation stage, show an adequate internal consistency, with Cronbach's alpha varying between .70 and .86 (Cortina, 1993; Schmitt, 1996).

Due to the conducted analyses it is possible to consider the instrument as valid but only for the assessment of the therapeutic alliance, based on the three factors whose precision is also high: safety in the therapeutic process (α=.799), engagement in the

therapeutic process (α=.701), and shared sense of purpose (α=.799) in the process (See table 2).

Table 2

Reliability Statistics

	Cronbach's Alpha	N of Items
Safety	,799	4
Share sense of purpose	,799	5
Engagement	,701	3
Total Scale	.864	16

Descriptive statistics regarding SOFTA-S

For the first stage (n= 96 therapists), the values of the SOFTA-S scale (see table 3) varied between 2.44 and 4.50, with a mean of 3.57 (SD = .44): for the safety in the therapy dimension the mean was 3.28 (SD = .71), with values ranging from 1.25 to 4.75; for the engagement in the therapeutic process dimension, the results stand between 2.33 and 5, with a mean of 3.87 (SD = .59); the shared sense of the purpose of therapy dimension obtained a mean of 3.58 (SD = .55), with values between 2 and 4.60.

Regarding the second evaluation stage, the sample was reduced to 40 therapists. The global values of the SOFTA-S scale varied between 2.44 and 4.38, with a mean of 3.49 (SD = .47). In regards to the dimensions, the safety in the therapy obtains a mean of 3.108 (SD = .73), with values ranging between 1.50 and 4.25; for the engagement in the therapeutic process, the results range from 2.33 to 4.67, with a mean of 3.76 (SD = .52); the shared sense of the purpose obtained a mean 3.50 (SD = .61), with values comprised between 2 and 4.60.

Table 3

Descriptive statistics of the therapeutic alliance factors and the global alliance

	Therapeutic Alliance S1	Safety S1	Engagement S1	Share Sense of Purpose S1	Therapeutic Alliance S4	Safety S4	Engagement S4	Share Sense of Purpose S4	Therapeutic Alliance S7	Safety S7	Engagement S7	Share Sense of Purpose S7
N Valid	96		96	96	40	40	40	40	25	25	25	25
Missing	8		8	8	64	64	64	64	79	79	79	79
Mean	3,5727	3,2839	3,5727	3,5802	3,4859	3,1063	3,7583	3,5000	3,7275	3,4800	3,9200	3,7600
Std. Deviation	,44035	,70861	,44035	,55224	,46674	,72917	,52291	,60933	,62393	,91833	,69575	,71414
Minimum	2,44	1,25	2,44	2,00	2,44	1,50	2,33	2,00	2,19	1,25	2,33	2,20
Maximum	4,50		4,50	4,60	4,38	4,25	4,67	4,60	4,69	5,00	5,00	4,80

Finally, the 7th session of the therapeutic process, the third evaluation stage, consisted in the filling of the questionnaire by a sample of only 25 therapists. As for the global values of the SOFTA-S, we acquired a mean of 3.73 (SD = .62), with values ranging from 2.19 to 4.69. Regarding the dimensions, we obtained a mean of 3.48 (SD = .92) for the safety in therapy and values between 1.25 and 5; the engagement in the therapy got values ranging from 2.33 to 5, with a mean of 3.92 (SD = .70); and the shared sense of purpose obtained a mean of 3.76 (SD = .71) with values between 2.20 and 4.80.

Relations' study

After keeping three factors in each of the three stages, the relations between the acquired results in the factors and SOFTA-S's total SCOREs in the 1st, 4th and 7th session were calculated.

Due to the characteristics of the sample, and its drastic reduction throughout the process, it is only possible to compare means between the two first assessing stages. Hence, only bivariate correlations were conducted between the three factors – safety in the therapeutic process, engagement in the therapeutic process and shared sense of purpose in the therapeutic process – in each of the three stages and the total SCOREs of the scale in the three stages, in order to understand if there were any relations between these elements (see table 4).

The engagement factor is positively related with the safety factor and with the shared sense of purpose factor in stage 1, with the shared sense of purpose and with the engagement factors in stage 2, and with the global alliance in stages 1 and 2.

Table 4

Relations between the different alliance factors and the global alliance in the three stages

		Therapeutic Alliance T1	Engagement S1	Safety S1	Shared Sense of Purpose S1	Therapeutic Alliance T4	Engagement S4	Safety S4	Shared Sense of Purpose S4	Therapeutic Alliance T7	Engagement S7	Safety S7	Shared Sense of Purpose S7
Engagement S1	Pearson Correlation		1										
Safety S1	Pearson Correlation		,555**	1									
Shared Sens Purspos S1	Pearson Correlation		,555**	,499****	1								
Shared Sens Purspos S4	Pearson Correlation		,371*	,654**	,548**				1				
Safety S4	Pearson Correlation		0,297	,545**	,532**			1	,740**				
Engagement S4	Pearson Correlation		,501**	,533**	,404**		1	,646**	,711**				
Therapeutic Alliance T1	Pearson Correlation	1	,814**	,810**	,819**		,556**	,500**	,600**				
Therapeutic Alliance T4	Pearson Correlation	,626****	,431****	,644**	,551**	1	,852**	,884**	,897**				
Therapeutic Alliance T7	Pearson Correlation	,527**	0,304	,498*	,443*	,750**	,549**	,589**	,752**	1			
Engagement S7	Pearson Correlation	,431*	0,243	0,389	0,377	,615**	,457*	,457*	,630**	,942**	1		
Safety S7	Pearson Correlation	,484*	0,201	,552**	0,343	,710**	,504*	,572**	,671**	,903**	,823**	1	
Sharing Meaning S7	Pearson Correlation	,549**	0,308	,464*	,573**	,697**	,453*	,556**	,837**	,919****	,826**	,733**	1

**. Correlation is significant at the 0.01 level (2-tailed). / *. Correlation is significant at the 0.05 level (2-tailed).

The safety factor in stage 1 is positively related with shared sense of purpose factor in stage 1, with the shared sense of purpose, the safety and the engagement factors in stage 2, with the safety and the shared sense of purpose factors in stage 3, and with the global alliance in the three stages (1, 2 and 3).

The shared sense of purpose factor in stage 1 is positively related with the shared sense of purpose, with the safety and the engagement factors in stage 2, with the shared sense of purpose factor in stage 3, and with the global alliance in the three stages (1, 2 and 3).

The engagement factor in stage 2 is positively related with the engagement, the safety and with shared sense of purpose factors in stage 3, and with the global alliance in the three stages (1, 2 and 3).

The safety factor in stage 2 is positively related with the engagement factor in stage 2, with the engagement, the safety and the shared sense of purpose factors in stage 3, and with the global alliance in the three stages (1, 2 and 3).

The shared sense of purpose factor in stage 2 is positively related with the safety factor and the engagement factor in stage 2, with the engagement, the safety and the shared sense of purpose factors in stage 3, and with the global alliance in the three stages (1, 2 and 3).

The engagement factor in stage 3 is positively related with the safety and the shared sense of purpose factors in stage 3, and with the global alliance in the three stages (1, 2 and 3).

The safety factor in stage 3 is positively related with the shared sense of purpose factor in stage 3, as well as with the evaluation of the global alliance of the three stages (1, 2 and 3).

The shared sense of purpose factor in stage 3 is positively related with the global alliance in the three stages.

In terms of the alliance values in its global, we observed that, there is a positive relation throughout all the process.

Mean comparison (ANOVA)

Despite the reduction of 104 to 40 therapists, making the sample weaker, it is possible to guarantee that the sample of therapists is the same in both assessing stages. Thus, we conducted mean comparisons between the three therapeutic alliance factors considering the time factor.

We conducted ANOVA repeated measures (Coolican, 2009) since the sample is the same in both stages.

Thus, for the shared sense of purpose, the results of the F-statistic from a repeated measures Anova was: F (1, 39) = 0,415, p = .523, which means that we have to accept a null hypothesis, in other words, there are no significant differences between both assessed stages.

For the safety in the therapeutic process, the results of the F-statistic from a repeated measures Anova was: F (1, 39) = 0,709, p = .405, which once more means that we must accept the null hypothesis, i.e., there are no significant differences between both assessed stages.

Finally, for the engagement factor, the results of the F-statistic from a repeated measures Anova was: F (1, 39) = 0,786, p = .381, which means that we have to accept a null hypothesis, in other words, there are no significant differences between both assessed stages.

Thus, and despite the previously conducted correlations point to positive influences between factors and between these and the alliance (global), when we analyse these factors during the therapeutic process, we realize that more than four sessions are needed in order to observe significant changes in the perception therapists have regarding the therapeutic alliance established with clients.

Discussion

The exploratory factor analyses does not allow the emergence of the four therapeutic alliance dimensions referred in the literature (Friedlander et al., 2006a). However, it was possible to consider the instrument as valid for the evaluation of the therapeutic alliance perception regarding therapists, based on three factors: safety, engagement, and shared sense of purpose (when items related to emotional connection are dropped).

The fact that the items referring to emotional connection were dropped does not mean that this factor isn't important. However, the way the therapists seem to have positioned themselves regards an expert's posture, where they felt confident in the way they understood the family and felt secure that they made everything they could to help them. Nonetheless, this aspect contradicts the theoretical model (systemic model) they share and with the adopted therapeutic guidance (narrative therapy). By using the instrument's observational version, emotional connection is evaluated on the bases of

nonverbal behaviors, which leads to the assumption that translating this dimension into a self-response questionnaire is a harder task.

In this line of thought, it would be interesting to undertake a new research perspective, where it would be possible to discuss with therapists: a) is this dimension relevant to the therapeutic alliance?; b) how can this dimension be translated?; c) which questions can be made in order to understand if there is emotional connection?

Looking at the results in a more detailed way, it is visible that: the engagement in the 1st session does not correlate with the safety in the 4th session and it neither does with any of the therapeutic alliance factors, or with it as a global measure in the last session; the safety in the 1st session does not correlate with the engagement in the 7th session; the shared sense of purpose in the 1st session does not correlate with the engagement and neither does with the safety in the 7th session. On the contrary, the perception of the alliance in the 4th and 7th sessions is positively correlated in the several dimensions and with the global values of the alliance.

This may lead to think that what occurs in the 1st session is highly centred in the initial contact and probably in the more immediate difficulties that bring the family to therapy, and these relations may be less related to the perception of the alliance in the end of the process.

However, in terms of the global results found, we highlight two general conclusions: the relation between the three alliance factors, studied in each moment, is positive amongst itself for each stage; and the relation regarding the global evaluation of the alliance is positive among itself when longitudinally looking at the process.

Thus, we observe that the values of the relations are all positive, and although there were no significant differences between the three stages, a slight decrease is visible in the therapy's 4th session.

Since the 4th session represents the middle of the therapeutic process, it is around this time that some upturns at the symptomatic and behavioural level occur, which apparently the family members would have abandoned during the initial sessions, and it is also a stage where there is a regress to a more linear vision of the family, which may portray an image of regression or stagnation of the process, both to the therapist and the family.

The relations between the fourth and the seventh session are all positive relations, both among the individual factors of one session with another session, as among the individual factors of the last stage and the whole alliance throughout the therapeutic process. These higher correlating results can be perceived as a bigger articulation between the different alliance dimensions as the therapy progresses in time.

Apparently, the shared sense of purpose factor, in couple and family therapy, seems to be a factor that is transversal to the whole therapy, relating with every factor of the therapeutic alliance, regardless of the stage of the therapy.

Considering the importance that is currently given to a higher autonomy of clients and its role in building change and the therapeutic process *per se*, the aspects of the shared sense of purpose and the safety thus seem to be more relevant throughout the entire process.

So we realize that, in general, the shared sense of purpose by the family (the system as a whole), as well as safety, is important to the perception of the alliance, in order for therapy to become a space of openness for clients.

For the therapist, the way it perceives the therapeutic alliance seems to be firmly associated to the way it perceives the existence of a shared sense of purpose and safety by the clients during the entire process. This way, it is important that the family may explain this shared sense of purpose and lower their defence levels, being available for therapy, and for this to happen it is up to the therapist to support these aspects of the therapeutic process. The engagement in the therapeutic process is associated to the perception that the therapist has about joint work and the therapy's efficacy, being also positively and significantly associated with the therapy.

In terms of non-significant mean comparisons between the first and the fourth session, it suggests that significant differences will not be perceived during the process and, since these evaluations are highly positive, we can not only consider that there aren't many fluctuations, but also that a good therapeutic alliance is established. Let us just point out that, although there are no significant differences, the evaluation increases during the therapeutic process, existing in the first session a bigger emphasis in the engagement, and safety is the less perceived factor. From there on there is a strong evolution regarding the shared sense of purpose and safety. So, it is important to understand if a bigger safety leads to a greater engagement, or if a lesser engagement implies less safety in the therapeutic process.

Also, in future studies, it is important to be able to relate variables beyond the first and middle sessions, in order to understand if the outcomes in the end of the process appear to be significant, and how do they evolve.

Limitations and Conclusions

This study presents some limitations especially concerning the collected sample, considering that the number of collected processes was scarce, since the number of therapists is quite low and, at the same time, the high number of dropout's and non-concluded processes throughout the investigation, decreased this number even more during the three considered stages. The reduction of the sample is drastic which leaves us with some care regarding the interpretation of the results found, as well as leaving an open door to further studies.

However, and in terms of therapeutic relationship, it is clear that the therapist's evaluation about the therapeutic alliance established with the clients is of great interest, since the way it is perceived will determine the way therapists will act during the process, in order to promote the different characteristics associated with this component, with the aim of increasing the clients' sense of shared sense of purpose, safety and engagement.

Still in the beginning of the relation of the therapists' perception with the clients' perception, and trying to understand if the results are similar, or if there are any discrepancies, reflecting about the underlying causes to those differences.

The fact that the alliance components are quite clear but, at the same time, very linked indicates the necessity of equipping therapists with tools that allow them to understand such an important variable in the therapeutic processes, in order to be able to act considering families' characteristics, increasing the chance of a therapeutic relationship and of success.

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The Pro-CIV Project is a research project that aims to assess the family therapy processes, at three different stages (first session, in the middle, and in the end of the process), through an application protocol for clients and therapists. In this protocol several dimensions are assessed: family functioning, therapeutic alliance, family communication, and coping strategies used by the families. The sample of family therapy cases has changed through time, i.e., the cases sent by court and commissions are increasingly recurrent, ending up transforming clients that are in therapy in a non-voluntary population. This project collected data from two types of population: voluntary and non-voluntary, so it is possible to compare the differences and similarities between both types of the process, in order to improve and enhance successful therapeutic interventions.

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CAPÍTULO III

THE THERAPEUTIC RELATIONSHIP: THE ROLE OF THERAPISTS IN THE CLIENTS' SAFETY AND INVOLVEMENT BEHAVIOR

Abstract

The therapeutic relationship is one of the most important variables for therapeutic success. Safety, trust and feedback have been proved to be key aspects in the therapeutic process to achieve a good therapeutic alliance between therapist and patient. However, the role of the therapist in enhancing and nurturing the safety and emotional connection throughout the therapeutic process appears at times to be quite passive. Thus, the assessment and meta-communication about the therapeutic alliance presents itself as a way to make the therapist's role more active which can lead to an increase to the therapeutic alliance and a more successful therapy overall.

Keywords: Therapeutic relationship, alliance, safety, involvement, couple and family therapy

Note: Submitted to Journal of Family Therapy

Therapeutic alliance and client feedback in family therapy processes

Introduction

Therapeutic alliance is essential for a good successful therapy. In common factors and principles of change studies, the strength of the therapeutic alliance will predict the success or the failure of the therapy (Friedlander, Escudero, & Heatherington, 2006). Studies concerning therapeutic alliance go back to the 1930's. Until the beginning of 1970 a great number of proposals were made regarding the elements that comprised this variable, such as: i) the client's ability to connect to the therapist, ii) the therapist's personal traits, iii) the client's commitment to the tasks of the treatment, iv) the emotional bond between therapist and client, to name a few (Friedlander et al., 2006). Bordin (1979), one of the most prominent authors to define this variable, proposed that three components were necessary: agreement between therapist and client regarding the goal of the treatment, agreement on both parts about the tasks necessary to achieve said goals, and an emotional bond between both therapist and client in order to sustain the hard work involved in therapeutic change.

A recent theoretical review concerning the key variables for change in Couple and Family Therapy (CFT) pointed to a common factor model in which the therapeutic alliance and the clients' feedback stood out as crucial elements to the therapeutic process (Dias da Costa & Alarcão, 2012). The CFT model revealed some interesting properties that influenced the therapeutic alliance variable, namely the number of elements in therapy which is higher than in individual therapy, the impact of what is said by one element about another family member and the interactions during therapy that had immediate repercussions within the family. Considering what the model revealed and the researches that showed the centrality of this variable in terms of the success of the therapy (Escudero, Friedlander, Varelac, & Abascal, 2008), it is

important to look at this variable in a 'client as a group perspective'. Specifically so it can be properly assessed and defined.

Therapeutic alliance in CFT has unique characteristics (Pinsof, 1995; Rait 1998 as cited in Friedlander et al., 2006): a safe environment must be provided for all the family members, boundaries for negative exchanges must be created, and the limits of confidentiality, goals, treatment and the role of each participant have to be clearly defined (Snyder, 1999).

Friedlander (2009) has suggested that research approaches the therapeutic alliance must consider five crucial aspects: (1) have a theory concerning the systemic process of change as basis, meaning that all the different elements of the system must be considered either individually, as subsystems or as a whole; (2) must focus on the identified patient's behavior, bearing in mind that it occurs by interaction with and in the presence of the whole system; (3) needs to pay attention to the covered up experience since everything that happens during therapy is being positively and negatively influenced by each and every member of the family; (4) must develop strategies to analyze the results from multiple clients, considering the multiple individual voices that interact; (5) be able to analyze several questions simultaneously.

Authors such as Duncan (1992) stressed the necessity to develop a genuine therapeutic relationship through the validation of clients' perceptions and experiences, rather than by the therapist's theoretical contents or personal values. Similarly, Morrissette (1990) pointed out the importance of the therapist-client cooperation and respect for the client as key aspects of the therapeutic alliance.

Studies revealed that, according to many clients, the most important element for the success of the therapy is a good relationship with the therapist and the evaluation made by the clients' concerning it. Interestingly, these results also showed that the

clients' and therapists' perception of the therapeutic alliance do not always coincide (Friendlander et al., 2006).

The studies referred above, point to the need to conduct further studies regarding these two variables, therapeutic alliance and feedback, within Couple and Family Therapy. This paper aims to add to the study of these dimensions by trying to understand how these variables influence the course of the therapeutic process.

Safety, trust and feedback

Therapeutic alliance includes several components that are fundamental for the therapeutic process to be elapsed, guaranteeing both the clients' involvement and the success of the therapy, of which such as safety is one of the most important. The need to feel safe in the therapeutic context is a necessity in family and couple treatment (Friedlander, Lehman, McKee, Field & Cutting, 2000 quoted by Friedlander et al., 2006). In general, when family members have reasons to seek help, they have been in conflict among themselves for some time and in most cases family members are at different developmental stages. Thus creating a safe environment for all may be hard achieve, particularly when from the start some are perceived as the winners and others as the losers. The therapist must evaluate the difficulty and anxiety level that therapy causes in the participants, in order to achieve an appropriate balance in promoting support, acceptance and mutual understanding within the family (Friedlander et al., 2006).

The first session is one of the most delicate in the extent that clients will expose themselves to the therapist for the first time, and the way he perceives their worries and guides them will have a direct impact in the motivation with which every member of the family commits to the treatment (Shapiro, 1974). Moreover, the purpose of creating a

safe environment that promotes everyone's involvement will mostly depend on the trust in the therapist, more so than on the intellectual understanding of the therapeutic process, since it is by feeling trust and safety within that space and in the therapist itself that will allow clients to take interpersonal risks, face harsh realities and chart a new path for himself (Friedlander et al., 2006).

Furthermore, the sense of a shared purpose in the family is the imperative basis to maintain the joint treatment format and systemic focus, so it can be a mediator of its own results (Heatherington, Friedlander & Greenberg, 2005). Since without this sense of shared goals, values and therapeutic needs it is not possible to create a viable therapeutic setting for the family. In addition to these two dimensions, an emotional connection with the therapist must still be leveraged so solid therapeutic relationships can be established and maintained throughout the treatment, especially when family conflicts arise or difficulties in the change process are experienced. Lastly, the involvement in the therapeutic process, regardless of the theoretical model and practical techniques, reveals itself as essential due it being a pre-requisite to the acceptance and cooperation in the therapy by the clients (Friedlander et al., 2006). The therapist must be able to make the goals and theoretical techniques have significance to the client, so he may integrate them himself and become active in the therapeutic process (Wampold, 2001).

An important aspect that enhances the emotional connection and the establishment of the relationship between therapists and clients is the use of humor. In a study carried out by Sequeira (2012), it was observed that throughout the therapeutic process, existing memories regarding life situations were connected with the emotional significance and the mood state experienced at the time. Thus, in order to create new memories and new meanings, it is necessary to activate these memories during therapy,

and discuss them in a way that provides a new integration and significance to them different from the initial one. Being humor one of the elements that defines the way we integrate these moments, it is crucial that the therapist focuses on the positive aspects, using humor to promote these aspects and decentralize from the symptoms and its negative load.

Also, Pittman (1987) states the importance of the usage of humor by therapists, in order to lighten the mood and simultaneously put to the test the reality that is on debate. Carrol and Wyatt (1990) also showed that humor can reduce tension, increase motivation, facilitate the release of emotions, reveal incongruences, expose irrational thoughts, and help clients develop a more realistic evaluation of the magnitude of their problems.

In the same way, Reynes and Allen (1987) in a thinking about humor showed that it can be used both as an assessment technique and as a therapeutic technique. When used as a therapeutic technique, it effectively allowed to break the resistance, lead to new interpretations, break the tension caused by the therapeutic process, help the clients consider new alternatives, ease the corrective emotional experience and implicitly established the bases to a healthier identification with the therapist.

As we have seen, and due to the impact the therapeutic alliance has in the therapy continuity and result in CFT, it is of utmost importance to study, comprehend and integrate each client's perception of the alliance between himself and the therapist (Johnson, Wright, & Ketring, 2002). Several studies were conducted using the System for Observing Family Therapy Alliances - SOFTA, leading to different conclusions (Friedlander et al., 2006). One point that must be made is that there are discrepancies between the results of self-report and what is indeed observed (Muniz de la Peña, Friedlander, & Escudero, 2009).

Friedlander et al. (2006) developed SOFTA as an assessment tool which aims to evaluate the therapeutic alliance through the clients', therapists' and researchers' perspective. The making of this tool aims to organize and synthesize the richness of the self-response and behavioral information, to which therapists should pay attention, so they may establish, nurture and maintain the therapeutic alliances with every single family member that may be experiencing conflict or that have very distinct motivations regarding therapy. This instrument was designed in two versions: an observational one and a self-report one, in order to assess the four dimensions of the alliance: involvement in the therapeutic process; emotional connection to the therapist; safety within the therapeutic system and sharing the meaning of therapy with the family (Friedlander et al., 2006).

Quantitative studies highlight central aspects to the clients, two of them being impartiality and safety (Christensen, Russel, Miller, & Peterson, 1998). Furthermore, the results are consistent in highlighting the importance of safety, emotional connection, involvement and sense of sharing among family members (Friedlander et al., 2006).

The multiple factors that may affect the therapist's relationship with the family and the intra-family alliances respond to a fluid and complex dynamic that must be closely monitored in order to understand how the evolution of these four variables occurs throughout the process. Literature has shown that these aspects of the therapeutic relationship, as the involvement, trust, safety, and the sense of sharing the process, are even more crucial in the non-voluntary populations (Friedlander et al., 2006).

As we have been exposing, the therapeutic alliance is an essential part of therapeutic change. Furthermore, studies have shown that clients' perception is also an important predictor for a successful therapy (Muniz de la Peña et al., 2009).

Therefore, it is possible to assess the therapeutic alliance in light of the several therapy participants. Furthermore, try to evaluate how the therapeutic process promote the different features of the alliance. And also, understand which are the key aspects in promoting therapeutic success. This study intends to qualitatively assess family therapy processes in three specific moments. Formally using SOFTA (observational and self-report) (Sotero, Relvas, Portugal, Cunha, & Vilaça, 2010) and in an informal way, through the session content analysis of the feedback from clients regarding the therapeutic relationship and the usefulness of therapy.

The feedback variable is analyzed qualitatively, through observation, gathering and transcription of the information from the sessions, following SOFTA-O criteria regarding the four categories plus references to the usefulness of therapy. The usefulness aspect refers to a 2008 study, carried out by Escudero et al., where results pointed out to a continuous positive opinion from the clients, about the usefulness of the therapy, and it is linked to positive results in the end of the therapeutic process.

With this study it will also be possible to understand discrepancies or incongruences between the several elements involved in the process, and try to understand which the behavioral tendencies of the therapists are so it may be possible to draw implications to improve therapeutic processes.

Method

This work was based on a qualitative methodology through an exploratory data analysis. Five therapeutic processes from non-voluntary clients were analyzed, collected as part of a bigger research project, where a battery of tests was administered to different elements of each family in three stages of the therapeutic process: at the beginning, the middle and at the last session, usually the 1st, 4th, and 7th session

respectively. This study considered the application of the SOFTA-S and the SCORE-29 questionnaire, as well as the collected data from SOFTA-O and the content analysis of feedback (CAF). Four of these cases were evaluated and analyzed in three stages of the process: 1st, 4th, and 7th session; while a fifth case was analyzed and evaluated only at the first and the last session.

Regarding the research, after the therapists accepted to participate in the investigation, all the families that required first time appointments were invited join in as well. The procedures and aims of the research process were explained and clarified to all family members, a formal invitation was made, and an informed consent was signed. No incentives for participation were provided for in this research.

Participants

The therapeutic processes were conducted in three family care services, one of which was associated with an university and the other two connected to the social sector. These services are known in the community as sites where couple and family therapy is performed in a systemic approach. The procedures were developed based on a theoretical perspective of the narrative approach on family therapy, usually brief therapy (seven sessions). Sessions were held every three weeks, and a therapeutic contract was carried out, generally after the first session. The therapeutic setting consisted of the classic setting, with a unidirectional mirror, a team behind the mirror, and a recording of the sessions with the families' consent.

The families in this study were all composed by Caucasian members. Two of them were from a medium socioeconomic level, and three from a lower socioeconomic level (see Table 1). Two family subsystems were involved in the therapeutic process: parental and filial with an average two children. Concerning therapy referral, the

Table 1

Characterization of participants

Cases	1st Case	2nd Case	3rd Case	4th Case	5th Case
Family members age:	**Parental Subsystem:** mother (44) and father (49); **Filial Subsystem:** son (15) and daughter (13)	**Parental Subsystem:** mother (37); **Filial Subsystem:** son (15) and son (9)	**Parental Subsystem:** mother (38); **Filial Subsystem:** daughter (14) and daughter (10)	**Parental Subsystem:** mother (45) and father (50); **Filial Subsystem:** son (14) and daughter (11)	**Parental Subsystem:** mother (32) and father (44); **Filial Subsystem:** son (18), son (12) and daughter (5)
Occupation:	Mother - waitress Father - shopkeeper	Mother – operating assistant	Mother - unemployed	Mother – primary school teacher; Father – college professor	Mother – waitress; Father - salesman
Socioeconomic level:	Medium Socioeconomic Level	Low Socioeconomic Level	Low Socioeconomic Level	Medium Socioeconomic Level	Low Socioeconomic Level
Referral:	Submitted	Submitted	Mandated	Submitted	Submitted

families were referred due to problems such as parental separation, children behavioral problems and domestic violence, whilst some of the children were already being followed through individual psychotherapy. It is also important to refer that four of the families were referred by other therapists or services, and one family was sent by court within a promotion and protection program.

Seven therapists were involved in this research (five women and two men), with mean age of 30 years, having had at least the basic training in psychology, with an average training time of 5 years and mean duration of clinical practice for 8 years.

Measurements

Data from self-report SOFTA-S (Sotero, Relvas, Portugal, Cunha, & Vilaça, 2010) questionnaire was collected from each of the clients and therapists involved in the process at the three assessed stages, as well as from SOFTA-O collected from the same sessions (Sotero, Relvas, Portugal, Cunha, & Vilaça, 2011). The results that were used correspond to the values of the four dimensions, and also the specific SOFTA item regarding the usefulness of therapy ("1. What happens in therapy can solve our problems").

SCORE-29 (Stratton, Bland, Janes, & Lask, 2010) an instrument conceived to assess family functioning as well as the perception that clients have regarding the problem that leads them to therapy, its impact, the associated change, and therapy usefulness was also used. For this research only the item regarding therapy usefulness was considered: "On a scale of 0 to 10, where 0 refers to 'Very useful' and 10 refers 'Not useful', do you consider therapy will be/has been useful?". We should point out that the data collected through this instrument raised some issues, specifically to the extent that this item was listed on a reverse scale to previous items (whereas 0 would be

the most negative value, and 10 the most positive one), leaving some doubts regarding the family's attention and understanding about this difference when filling the questionnaire.

With these instruments and the content analyses, besides being able to understand what kind of information was verbalized regarding the therapeutic alliance, the manifested non-verbal behaviors, it was possible to compare data collected through the clients, therapists and researchers assessments, concerning these five dimensions.

The content analysis of feedback (CAF) intended to classify the verbalizations and non-verbal behavior of family members through the five feedback categories (Engagement in the process, Emotional connection with the therapist, Shared sense of purpose within the family, Safety within the therapeutic system, and Therapy usefulness) (see Table 2*). At the same time, also linked a therapist's verbalization or behavior to each of these quotations, in order to understand if they were a fruit of requests made by the therapist, or given spontaneously by family members In other words, attempted to understand if the verbalizations and the behaviors were occurring spontaneously or as a response to the therapist's questioning. Thus, we intended to clarify the therapist's role in gathering this type of information regarding the therapeutic alliance.

It was possible to register and quantify the number of verbalizations and behaviors that each family member had throughout the process, as well as in which feedback category they belong, analyzing the transcripts of therapy sessions. Besides, it was possible to compare the number of answers marked by the researchers while the SOFTA-O instrument was being filled out, as well as taking into account the number of identified verbalizations for each category, by comparing it to the assessment made by

Note: * See table 1 in the appendix with more detailed

Table 2

Feedback Categories regarding Therapeutic Alliance

Category	Description of the Category	Examples
Engagement in the Process	The client viewing treatment as meaningful; a sense of being involved in therapy and working together with the therapist, that therapeutic goals and tasks in therapy can be discussed and negotiated with the therapist, that taking the process seriously is important, that change is possible.	SOFTA-O item: indicate agreement with the therapist's goals. CAF: "...I think there is a problem on her part...", Father, Case 5
Emotional Connection with the therapist	The client viewing the therapist as an important person in her/his life, almost like a family member; a sense that the relationship is based on affiliation, trust, caring, and concern; that the therapist genuinely cares and "is there" for the client, that he/she is on the same wavelength with the therapist (e.g., similar life perspectives, values), that the therapist's wisdom and expertise are valuable.	SOFTA-O item: share a lighthearted moment or joke with the therapist. CAF: Daughter 1 embraces the therapist crying, Case 3
Shared Sense of Purpose within The Family	Family members seeing themselves as working collaboratively to improve family relations and achieve common family goals; a sense of solidarity in relation to the therapy ("we're in this together"); that they value their time with each other in therapy; essentially, a felt unity within the family in relation to therapy.	SOFTA-O item: ask each other for their perspective. CAF: "we all agreed", Mother, Case 4
Safety Within the Therapeutic System	The client viewing therapy as a place to take risks, be open, flexible; a sense of comfort and an expectation that new experiences and learning will take place, that good can come from being in therapy, that conflict within the family can be handled without harm, that one need not be defensive.	SOFTA-O item: vary his/her emotional tone during the session. CAF: "this is a privileged space that we have...it forces some refrain in the others and the dialogue..." Father, Case 4
Therapy usefulness	The client views the therapy as useful; the client is able to achieve his/her goals; The client is able to perceive changes; there is an increased well-being in the family's life.	SOFTA-S item 1. What happens in therapy can solve our problems. CAF: "good thing it is as a family because that way we all speak…and everything is better…" Father, Case 5

Note: Examples of SOFTA-O – one of the corresponding items; Example of the Content Analysis of Feedback (CAF) – an example of the session's transcription; Definition of the categories based on the SOFTA-O definitions (Friedlander et al., 2006).

the members of the family in a more formal assessment of the therapy, by completing the SOFTA-S and answering the item regarding therapy usefulness (from SCORE-29).

For example, in case 1 the mother was the only one that verbalized or manifested behaviors that demonstrated engagement in the therapeutic process. However, all of the elements positively evaluated the attained therapeutic engagement, formally, through SOFTA-S. In that way, it's possible to draw some hypothesis regarding the relationship between to which each client manifest and feel the therapeutic alliance and the therapy usefulness, with the evaluation they made from the same variable, and how it manifests throughout the therapeutic process.

Procedures

The data analysis was conducted through several steps. The first one enveloped the visualization and the transcription of the therapy sessions, followed by an analysis of those sessions by the first author in order to identify all the behaviors (of both therapist and family) associated with feedback about the therapeutic alliance. The specific analysis of the sessions consisted on a first read through of the transcript, selecting and organizing all parts of the sessions for each of the categories, and then with the second author, reading the sessions and identifying those same categories in each part of the session for confirmation (see table 2).

Thus, the contents of fourteen therapeutic sessions' videos were transcribed and analyzed in light of the proposed categories for the definition of feedback (Involvement in the therapeutic process, Emotional connection with the therapist, Safety within the therapeutic system, Sense of goal sharing in the family, Therapy usefulness).

SOFTA-O data from each session were rated according to the listing rules and provided by the research team. The SOFTA-S and SCORE-29 results (self-report

instruments) were collected by the research team after the completion of the instruments by family members.

In terms of the method for the results analysis, a comparison method was used. The data collected from the content analysis of feedback (CAF), were compared to the data assessed by the research team (SOFTA-O) and to the data gathered by the self-report instruments regarding the clients' and therapists' perception [SOFTA-S and the item regarding therapy usefulness (from SCORE-29)]. This comparison will allow to understand if the assessment make by the observers of the therapeutic alliance goes the same way that the assessment made by the family. It also allows analyze how the family members manifest the established alliance with the therapist. And in addition, it is possible to compare the assessment that clients formally do about the alliance and its manifestation during the sessions.

Results

During the sessions, feedback about the relationship was mostly verbal and very scarce. The moments where family members referred to the therapeutic process were few, and to be able to assess the relationship between verbal and non-verbal feedback were even more complicated, since the non-verbal feedback are sometimes difficult to detect. Examples of a non-verbal feedback: for the emotional connection variable are behaviors like refuses or is reluctance to answer the therapist (e.g., Case 1, the daughter remained in silence through several direct questions from the therapist); for safety within the therapeutic system variable happens when the client express anxiety non verbally (e.g. taps or shakes – in Case 1, the daughter who, when questioned, started sweating a lot from her hands).

The non-verbal behaviors that were most frequently detected were defense behaviors, where family members crossed their arms or closed their posture in order to create a barrier between themselves and the therapists. For instance in Case 4, daughter 1 said several time "…but I don't like that question!" followed by crossing her arms and refusing to answer, while in Case 3, daughter 1 remained in silence when directly questioned by the therapist These behaviors were usually shown by the adolescents, especially when they were viewed as the problematic focus, and were less involved in the process. Thus, these elements of the family ended up choosing a posture of refusal or hesitation in answering, or non-verbal behaviors of closing up and defending themselves.

The engagement in therapy supposes that the client view the treatment as meaningful and feel to be involved in therapy, working together with the therapist. For example, in Case 1, the mother said "Yes, yes." when directly questioned by the therapist about the goals of the therapy, and adherence to tasks (see table 2); the whole family acceded to a task proposed by the therapists. However, when sessions were less directed, this component ended up having less expression (see table 3). This raised the question regarding which aspects therapists' capture as therapy involvement markers and consequent involvement in the therapeutic process.

In terms of emotional connection, two aspects stood out: a more negative one which related to the refusal to answer (through verbal and non-verbal defensive posture) and a more positive one related to the humor during the session, like we saw in Case 1, the father told a joke that involved the whole family, during a suggested exercise (see table 2). It was possible to observe that the usage of humor by the therapist, or even among family members, promoted syntonic moments, a greater proximity and sense of

sharing. Therefore, with the intention of breaking the tension and the negative connotation of the problems, humor was a very important "weapon" in the therapeutic process. However, we recognized that in the cases studied, this resource was rarely employed by therapists and the records for the emotional connection was very low (see table 3).

In regards to safety, the most identified items were related to: a) intimacy openness, encouraging others to speak, as we saw in Case 4, when the mother asked "Well, who wants to start? Girls come on..."; b) the variation of the emotional tone, for example when the father in Case 5 said "…enough! Enough Miguel!" yelling at his son; c) the expression of anxiety, like in Case 5, the son 2, when someone talked about him, he got very agitated in his chair, nervously moving and laughing; or d) the non-verbal protection, as in Case 3, the daughter 1 facing her mother's accusations, buttoned her coat and crossed her arms. This category was seldom informally identified, and assessed in a less positive manner regarding the formal instruments, especially when the therapists' perception was considered (see table 4 and 5).

In general, in the self-report questionnaires (table 4), the family members pointed out the therapist and the setting as very positive items which confirmed the aspect of safety. However, being a crucial point for the course of the process, and allowing a greater involvement, greater exposure and connection, the little expression by the therapists in seeking the clients' feedback, alerted us to this variable and its possible consequences.

In terms of sharing the meaning, the items that stood out the most were those related to the way elements interacted among themselves: validated each other's point of view (e.g. Case 1, mother and father when talking about the problems), shared a

funny moment (e.g. Case 1, parents and children told a funny situation that happened in family), blamed themselves, or made sarcastic comments (e.g. Case 3, mother and daughter 1 attacked each other, making sarcastic comments, and blaming each other for the problems that occurred) (see table 3).

Tables 3

Relationship between quantitative data from the Feedback's Qualitative Analysis (CAF) and SCORE-29

Families		Quantity of Content Feedback					SCORE-29: Therapy usefulness
		Engagement in the Process (1st / 4th / 7th Sessions)	Emotional Connection with the therapist (1st / 4th / 7th Sessions)	Safety Within the Therapeutic System (1st / 4th/7th Sessions)	Shared Sense of Purpose within The Family (1st / 4th / 7th Sessions)	Therapy usefulness (1st / 4th / 7th Sessions)	
Case 1	Father	0 / 1 / 2	0 / 0 / 0	1 / 0 / 1	2 / 1 / 0	0 / 0 / 2	/ 4 / 2
	Mother	4 / 1 / 1	0 / 0 / 0	4 / 0 / 2	1 / 1 / 0	0 / 0 / 0	2 / 3 / 5
	Son	0 / 1 / 0	3 / 0 / 1	2 / 0 / 0	0 / 0 / 0	0 / 0 / 0	3 / 4 / 2
	Daughter	0 / 1 / 0	1 / 2 / 2	2 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 1 / 2
	Total:	**4 / 4 / 3**	**4 / 2 / 3**	**9 / 0 / 3**	**3 / 2 / 0**	**0 / 0 / 2**	
Case 2	Mother	3 / 1 / 0	1 / 0 / 0	2 / 1 / 1	0 / 0 / 0	0 / 0 / 0	1 / 1 / 1
	Son 1	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	5 / 2 / 3
	Son 2	0 / 0 / 0	1 / 0 / 0	4 / 0 / 0	0 / 0 / 0	0 / 0 / 0	1
	Total:	**3 / 1 / 0**	**2 / 0 / 0**	**6 / 1 / 1**	**0 / 0 / 0**	**0 / 0 / 0**	
Case 3	Mother	0 / 2 / 1	0 / 0 / 0	2 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 2 / 10
	Daughter 1	0 / 0 / 1	0 / 2 / 0	9 / 7 / 0	0 / 4 / 0	0 / 0 / 0	4 / 2 / 5
	Daughter 2	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	2
	Total:	**0 / 2 / 2**	**0 / 2 / 0**	**11 / 7 / 0**	**0 / 4 / 0**	**0 / 0 / 0**	
Case 4	Mother	1 / / 0	0 / / 0	1 / / 3	1 / / 0	0 / / 0	0
	Father	0 / / 0	0 / / 0	0 / / 2	1 / / 0	0 / / 0	2
	Daughter 1	0 / / 0	0 / / 2	0 / / 0	1 / / 0	0 / / 0	5
	Daughter 2	0 / / 0	0 / / 0	0 / / 0	0 / / 0	0 / / 0	
	Total:	**1 / / 0**	**0 / / 2**	**1 / / 5**	**3 / / 0**	**0 / / 0**	
Case 5	Mother	0 / 1 / 0	1 / 0 / 0	1 / 5 / 0	0 / 0 / 0	0 / 0 / 1	5 / 3 / 4
	Father	1 / 0 / 0	0 / 0 / 0	0 / 8 / 2	0 / 0 / 0	0 / 0 / 1	/ 1 / 0
	Son 1	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	5 / 7 / 1
	Son 2	0 / 0 / 0	0 / 0 / 0	0 / 0 / 2	0 / 0 / 0	0 / 0 / 0	
	Daughter 3	0 / 0 / 2	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	
	Total:	**1 / 1 / 2**	**1 / 0 / 0**	**1 / 13 / 4**	**0 / 0 / 0**	**0 / 0 / 2**	

The usefulness of the therapeutic process was in itself difficult to assess, since it was, on one hand, associated with achieving goals, but on the other hand it may have

been related to little improvements and the increase of the family's well being. In this research we attempted to assess the clients' perception regarding therapy's usefulness in solving their problems. The family became able to find more competences in their structure, and because of that, felt more confortable fighting all difficulties. When this happened, the family say the therapy uselful.

Tables 4

Family perception of therapeutic relationship: SOFTA-S scale

Families		SOFTA-S				
		Engagement in the Process (1st / 4th / 7th Sessions)	Emotional Connection with the therapist (1st / 4th / 7th Sessions)	Safety Within the Therapeutic System (1st / 4th/7th Sessions)	Shared Sense of Purpose within The Family (1st / 4th / 7th Sessions)	SOFTA-S: Item 1 Therapy usefulness (1st / 4th / 7th Sessions)
Case 1	Father	17 / 15 / 15	16 / 17 / 19	18 / 16 / 18	14 / 14 / 15	4 / 4 / 4
	Mother	13 / 15 / 17	10 / 16 / 16	15 / 16 / 17	17 / 17 / 18	0 / 3 / 4
	Son	14 / 18 / 16	15 / 18 / 18	14 / 18 / 17	18 / 17 / 18	3 / 5 / 5
	Daughter	13 / 17 / 15	13 / 18 / 16	12 / 11 / 12	12 / 13 / 16	4 / 4 / 4
Case 2	Mother	19 / 17 / 15	19 / 20 / 19	17 / 18/ 15	18 / 13 / 16	5 / 5 / 4
	Son 1	19 / 16 / 12	18 / 17 / 14	19 / 17 / 16	20 / 15 / 12	4 / 4 / 3
	Son 2	15	17	11	19	4
Case 3	Mother	18 / 16 / 20	20 / 19 / 20	15 / 15 / 15	18 / 16 / 17	5 / 4 / 5
	Daughter 1	13 / 13 / 15	18 / 17 / 14	11 / 13 / 13	15 / 15 / 14	3 / 3 / 3
	Daughter 2	16	18	15	14	5
Case 4	Mother	17	17	15	19	4
	Father	19	9	16	16	5
	Daughter 1	16	15	12	17	4
	Daughter 2	14	18	13	17	4
Case 5	Mother	17 / 18 / 19	17 / 18 / 19	19 / 20 / 19	18 / 18 / 19	4 / 4 / 5
	Father	17 / 18 / 20	18 / 18 / 18	17 / 19 / 19	16 / 16 / 16	4 / 5 / 5
	Son 1	19 / 16 / 18	19 / 18 / 18	19 / 19 / 18	20 / 18 / 17	4 / 3 / 4
	Son 2					
	Daughter 3					

Note: The blank results refer to the non-completion of the questionnaires.

Looking at the different assessments and different perspectives, there was a difference that stood out in the assessment of two items: the importance of the therapist

in the clients' life, and the skills required to help in the process. This assessment was made by the therapists in a less positive manner (see table 4). These findings pointed to two directions: a more defensive assessment from the therapists or a lower assessment when compared to an inflated assessment by the family because of social desirability or self-defense aspects (recognize that it is worth it).

Tables 5

Therapis assessment of clients' perception of therapeutic relationship: SOFTA-S scale

Families	SOFTA-S					
	Engagement in the Process (1st / 4th / 7th Sessions)	Emotional Connection with the therapist (1st / 4th / 7th Sessions)	Safety Within the Therapeutic System (1st / 4th/7th Sessions)	Shared Sense of Purpose within The Family (1st / 4th / 7th Sessions)	SOFTA-S: Item 10 Importance of therapist (1st / 4th / 7th Sessions)	SOFTA-S: Item 14 Competences for therapy (1st / 4th / 7th Sessions)
Case 1	16,5 / 15 / 14,5	13,5 / 12,5 / 13	11 / 10,5 / 10	16,5 / 15 / 16,5	2,5 / 3 / 3	3 / 3 / 3
Case 2	11,5 / 14 / 14	13,5 / 13 / 13	12,5 / 12,5/ 12	15,5 / 13,5 / 13	2,5 / 2,5 / 3	3 / 2,5 / 3
Case 3	14 / 13,5 / 16	15,5 / 16 / 14	12,5 / 9,5 / 16	12 / 13,5 / 13	3,5 / 4 / 4	2,5 / 2 / 2
Case 4	18 / / 18	16,5 / / 17,5	11,5 / / 14	16 / / 17,5	3 / / 4	1,5 / / 2
Case 5	16 / 16 / 16	13 / 14 / 15	15 / 17 / 14	15 / 16 / 17	3 / 3 / 3	3 / 3 / 2

Note: The values are the mean assessment of the both therapist, in each case

Discussion

The chance to gather informal data regarding the therapeutic alliance and being able to cross them with more formal data (assessment from clients, therapists, and researchers) allows a reflection about this variable's importance, and the way it can be used by therapists so it improves and guides therapeutic processes, through the chance of reflecting with the families.

It seems to be a lack of harmony between the formal and informal data, namely concerning the clients' formal assessment. As the informal results for alliance are scarce and highly defensive or aggressive we would expect to have less positive results in the clients' formal assessment. However, this assessment appears to be quite high and positive. Regarding the therapists the formal assessments show lower results, considering that they feel that clients are not very involved and safe in the therapy. This discrepancy between the therapists' and clients' results can be understood in light of the clients' involuntariness, in that they, not being there by choice, are expected to show less involvement and commitment to the process.

Client cooperation is essential in psychotherapy. So that it may be an active part of the treatment, the clients must first be involved in the therapeutic process. Many of the difficulties that therapists encounter when trying to involve multiproblematic families relate to the lack of safety (Friedlander et al., 2006) in the system.

When a family feels threatened, inside or outside their system, the first thing to do is attend to safety before thinking about making progress in therapy. Guaranteeing safety must be the therapist's priority goal in the beginning of the treatment. To increase the feeling of safety and the sense of purpose sharing by the family, the therapist must focus on promoting the involvement and the emotional connection (Friedlander et al., 2006). Although reaching an optimum level of safety doesn't necessarily guarantee therapeutic success, when safety is highly threatened, failure probability increases. Safety is essential when working with couples and families that live each day with intense conflict and drama (Beck, Friedlander, & Escudero, 2006).

On the other hand, when the meaning sharing in therapy is deficient, it is up to the therapist to use the safety and emotional connection gained so far, in order to boost

the clients' involvement. The stronger the involvement, the greater the sense of safety (Friedlander et al., 2006).

Considering these literary aspects and the results found, we propose some reflections and warnings that appear relev1ant.

Regarding the alliance categories and what concerns the involvement in the therapeutic process, the fact that there were few identified elements from this category leads us to speculate about the perception or the reading that therapists make about therapy when the situations do not present a direct expression of involvement, beside bringing new subjects to the process. These findings concern us, to the extent that therapists who are not as aware about the alliance categories, may have greater difficulty in interpreting less explicit behaviors from the clients, such as involvement, even when they may actually be involved.

In terms of emotional connection, the fact that only two aspects stand out – refusal in participating, and humor – also makes us wonder how therapists feel and perceive the clients' connection, especially when families scantly manifest how they feel. Thus, and realizing that in the analyzed cases therapists seldom use this technique, it is of utmost importance to alert to the potential of humor in the increasing the sense of connection, in the way that it makes it more positive, and in increasing the sense of sharing and union between family members, especially in session full of problems and negative emotions.

The perception therapists hold regarding the safety clients feel in therapy is low. Thus, and knowing through literature that this variable is essential to the clients' openness and sharing, as well as to the creation of an environment where changes may

occur, the question of how can therapists act in order to enhance this variable in the therapeutic process arises.

The sharing of meaning is on its turn scarcely identified in the informal assessment, in that only when processes evolve, do the interactions between family members increase, making this component more visible.

In terms of conclusion, we point out some aspects, including the importance of the way the therapist views, and works out the manner in which clients assess and perceive the different components of the therapeutic alliance. Besides, introducing and frequently recurring to humor in therapy, especially when it is full of negative emotions, may provide a greater well being, and greater emotional connection within the therapeutic system. Another aspect that needs to be considered is the safety in the therapeutic system, essential in order to develop a good process and, in some way, very neglected by the technicians.

The chance to use data from the assessment of these variables, and meta-communicate about them during sessions, becomes an asset in the achievement of richer therapeutic processes, as well as greater therapeutic success.

Limitations and conclusions

Throughout this study we came across several limitations regarding the collection of the sample, especially concerning the quality of the sessions' videos. Such issues as camera placement, sound quality, and the visibility of the different family members (non-verbal behaviors) increased the difficulty of the transcription and analysis of the sessions.

The results found through the different information sources (clients' perception, therapists, and researchers) allowed to explore the different perspectives about the therapeutic alliance, the way it is experienced and perceived by each element. Since the therapeutic alliance is a key factor in a successful therapy, the possibility for therapists and clients to meta-communicate about different views on the alliance's variables, as well as the success of the therapy, gave to the therapeutic system the opportunity to find the best way to achieve the family objectives . Thus, more studies are needed in order to further our understanding of the different categories, and explore ways therapists may increase the impact of each one of these categories (especially safety and involvement in the therapeutic process) in terms of the therapy.

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between both types of the process, in order to improve and enhance successful therapeutic interventions.

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CAPÍTULO IV

CLIENT'S FEEDBACK AND THERAPEUTIC PROCESS: INFORMAL AND FORMAL FEEDBACK

Abstract

Client's feedback regarding their own theory about problems and its change is a key element for therapeutic change. We conducted a qualitative study, with a content analysis of 14 sessions of family therapy process from non-voluntary families, in order to explore five categories of feedback - Problem, Causes, Impact, Maintenance, and Change – and to understand the way clients verbalize this kind of information and how therapists use it for therapeutic success. The therapist's active role in requesting this information and creating a favourable environment for spontaneous sharing is critical to a successful treatment.

Keywords: Family therapy; Feedback; Formal and Informal Feedback; Client; Therapist

Note: Submitted to Counselling Psychology Quarterly

Therapeutic alliance and client feedback in family therapy processes

Introduction

In family and couple therapy (CFT), research about the therapeutic process that has been developed is still scarce, although the interest and dedication by therapists and researchers have been growing over time (Rodriguez, 2007). The question that has been placed through CFT is related to the change that takes place in this process and the variables that contribute to these results. Thus, some authors analyse this process' complexity and the importance of the interaction between various variables (Blow et al., 2009) as common factors of therapy. Regarding the importance of this issue, a theoretical review study has been made, focusing on the importance of common factors for success of CFT, to find what are the variables that most contribute to therapeutic change (Dias da Costa & Alarcão, 2012).

Of studies already carried out, the client feedback throughout the therapeutic process has proved to be a valuable and important contribution to the development and therapeutic outcome (Duncan, Miller, & Sparks, 2004). In addition, the possibility of therapists to access this client feedback about the process and outcome of therapy (Duncan et al., 2004), as well as the subjective experience of clients about the meaning of change, especially at the beginning of the process, has a predictive value of therapeutic outcome (Garfield, 1994; Haas, Hill, Lambert, & Morrell, 2002; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001, as cited in Miller, Duncan & Hubble, 2004). The way client evaluates the process and the therapeutic relationship, seems to have a role in changing and therapeutic results, being this one of the most predictive of therapeutic success (Duncan & Miller, 2002 quoted by Miller et al., 2004; Muniz de la Peña, Friedlander, & Escudero, 2009).

Taking into account these results it became relevant to explore studies that already exist about client's feedback, realizing how it is defined, evaluated and what are

the results that this entails. So, in spite of a small from the specific research on CFT, authors as Pinsof and Wynne (2000) point to a different kind of research that takes into account the unique qualities of the therapist and clients and the idiosyncratic ways in which therapy takes place. These therapies assume that therapists deal with each case based on its way to proceed and then change their approach based on direct client feedback sessions. In this way, it is a therapy that is constantly changing, guided by responses/reactions of clients, guided by the movements of the therapist and the therapist's subsequent replies to client feedback.

Some studies have shown significant improvements both in the process as in the result of the treatment, when the therapists have formal access (evaluation utilizing questionnaires), and a real-time client feedback about the process and outcome of therapy (Duncan et al., 2004; Miller, Duncan, Brown, Sorrell, & Chalk, 2006). Having this important role as the engine of the therapeutic process and giving possibility for the therapists to go working along with the clients' perception of everything that is taking place in therapy, the evaluation of this component becomes a very important aspect to be taken into account and in the therapeutic relationship as in the change itself (Duncan et. al, 2004). Other studies suggest that giving feedback to therapists about the subjective experience of the process has a positive effect and at the cases where the therapist had access to information about the alliance and the process led to a lower likelihood of clients destroying the relationship, staying longer in the therapeutic process (Miller et al., 2004).

Conceptualization of feedback

Although several studies show the importance of this feedback, when we investigate on this subject, there is a lack of an operations concept to ensure uniformity. Authors like Miller, Duncan and Hubble (2004), discuss the feedback as to

opinion/perception that clients give to their experience in relation to the therapeutic process and the therapeutic alliance. These authors believe that the subjective experience of change contributes to the result of therapy (Miller et al., 2004). This feedback is evaluated either formal and/or continuously and informal way, being sought the perception that clients have about the nature of the therapeutic progress through issues that are being placed along the therapy, such as: How does the treatment fit with the client's vision on the problem and on the process of change? How does is fit with the goals, expectations and wishes of the client to the treatment? How does the client experiment the therapist in terms of respect, empathy, affirmation and collaboration? How does the treatment enhances what the client can do? Does the client believes they are being used all available resources to lead to change? How does the treatment leads to increased sense of hope and client self-control? How does the treatment contribute to the growth of self-esteem, self-efficacy and auto-mastery? Does the client believe the treatment is working? (Miller et al., 2004).

These authors believe that the higher the congruence between the clients' beliefs about the causes of the problem and the treatment approach, the better will be the results of change as well as the creation of a strong alliance, which in itself will increase and enhance the results. This way, the therapist has to go against the theory of change of the client to ensure that the topics covered and material worked on session makes sense and are integrated by clients in its context in order to exists that change (Miller et al., 2004).

In the book "the heroic client" (Duncan et al., 2004), the authors, leading an investigation on the subject, address the theory of client change, where through their examples and explanations is possible to reach the perception the client has about the problem, what the solutions already in use and their results, as well as to create new solutions based on different ideas and methods (success or failure). Sharing similar

beliefs with clients about causes and treatment is a prerequisite for the therapy's success (Duncan et al., 2004). Other authors such as Duncan and Moynihan (1994) focus on the role of the theory of client change as a therapeutic relationship facilitator in order to increase the client's participation in this process and provide more positive results.

Duncan, Hubble and Miller (1997) consider the theory of client change as the key to success, regardless of the model that is used by the therapist, and Frank (1995) states that the success of the therapy depends on the way the therapist adjusts his methods in order to meet clients' expectations. Thus, we can say that is according to several authors that the perception the client has about the problem's origin and its resolution affects the process and its outcome (Duncan et al., 2004).

Thus, and considering the definition proposal by Duncan et al. (2004), that suggest that the client's feedback should be considered as the information clients give about the therapeutic process and the therapeutic alliance, and after verifying the positive results that accrue from these studies, when you consider this variable, we tried to systematize the way these authors operationalize this assessment. Therefore, the information about the process is gathered when therapists are able to question and study the theory of the problem and the theory of client's change, and it will be modified and used, with the different types of devolutions being made, with the purpose of integrating new meanings and solutions. In order for this to happen, it is necessary to gather information related to the theory of the problem (ideas that clients hold about the problem, its causes, its maintenance and impact) and to the theory of change (or theory of the cure focused on the ideas clients have about what must be different so that change may occur and lead to problem solving), throughout the process, as well as changes that occur and their impact.

Considering the research, we can say that it is important to seek feedback from clients regarding their theories about the problem and about change, and try to meet their view of the therapy, in order to ensure that the work being developed in therapy makes sense to the members of the family, and they will be able to include it in their theories so they may achieve the goals set for the therapy.

So, and based on this definition of feedback, we divide this variable in two categories: content feedback and relationship feedback. From the first category derived five sub-categories: Problem, Causes, Impact, Maintenance and Change. The second category was divided in: Therapeutic involvement, Emotional connection, Safety within the therapeutic system, Sharing the meaning and usefulness of therapy using the categories of the therapeutic alliance proposed by Friedlander, Escudero, and Heatherington (2006).

In this study, we manage to evaluate the importance of the clients' feedback regarding the content of therapy during the therapeutic process; to compare formal (assessed by instruments) and informal (assessed by verbal and nonverbal behaviors during sessions) feedback information in order to assess congruencies and discrepancies of clients; and relate different perspectives of the therapeutic process, in the light of the clients' eyes, therapists and researchers.

Formal and informal feedback

During the therapy, the therapist may access two types of information about the clients' perception and ideas: the formal theory, where he has a privileged position on the client's visions and the definition of the problem's structures; and the informal theory which involves the client's specific notions about the causes of his situations and the way change may occur (Duncan et al., 2004). The therapist, rather than make the

client fit his formal theory, must balance his own theory in order to integrate the client's beliefs, so they may build new solutions together. It is of utmost importance to remember that it is the link between the content of the therapy and the theory of change held by the client which leads to the potential of change (Duncan et al., 2004). According to these authors, research should be directed towards finding more effective ways to use the client's ideas and his feedback about the results and therapeutic process in order to improve success.

Formally, in these authors' study, the treatment progress and therapeutic alliance feedback was assessed by two scales, ORS (Outcome Rating Scale – therapeutic process) and SRS (Session Rating Scale – therapeutic alliance), with specific moments in therapy, and an immediate analysis with the clients, about the results found. The results indicate that this analysis and the chance to understand the client's perception and feelings regarding therapy, are the basis for promoting the necessary changes so that the processes may lead to the sought outcomes (Miller et al., 2004).

The Systemic Clinical Outcome and Routine Evaluation (SCORE; Stratton, Bland, Janes, & Lask., 2010) was an instrument created to assess therapeutic processes in CFT, monitoring clients' feedback and their evolution throughout the therapeutic process. It is a formal way to assess this kind of information, leading the family members to make a thought about their competences and difficulties.

Clients' perception and the information accessed by therapists may occur throughout the therapeutic process, through information (verbal and nonverbal) that clients bring into the sessions, which translates to informal feedback; or it can be collected through by applying instruments about the clients' perception regarding therapy, this being formal feedback. The combination of these two types of feedback

allows the therapist to understand if there is any coherence between the clients' self-reports, and the therapist's perception about the clients' behaviour throughout therapy.

Method

This work is based on a qualitative methodology through an exploratory data analysis. Five therapeutic processes from non-voluntary clients were analysed (collected as part of a bigger research project, where a battery of tests was administered to different elements of each family in three stages of the therapeutic process: in the beginning, in the middle and in the last session, usually the 1st, 4th, and 7th session). This study will consider the application of the SCORE-29 questionnaire: four families submitted to therapy and a family mandated by court. Four of these cases were evaluated and analysed in three stages of the process: 1st, 4th, and 7th session; while the fifth was analysed and evaluated in the 1st and last session.

In terms of research, after the therapists accepted to participate in this investigation, all the families that requested a first appointment were invited as well. The procedures and aims of the research were explained to all family members – an invitation was made and an informed consent was signed. In this investigation there were no incentives for participating in the research.

Participants

The therapeutic processes were performed in three family care services, one attached to a university and the other two connected to social care. These services are known in the community as places where family and couple therapy is conducted in a systemic perspective. The procedures are developed based on a theoretical perspective of the narrative approach on family therapy, usually brief (7 sessions), and sessions are

spaced every three weeks. A therapeutic contract is carried out, generally after the first session. The processes were always conducted with two co-therapists in a setting with a unidirectional mirror, a team behind the mirror and a recording of the session (with the family's consent).

Regarding the families in this study, they are Caucasian families, two of them are from a medium socioeconomic level, and three are from a low socioeconomic level. They have on average two children, and parental and filial subsystems are involved in the therapeutic process. Regarding therapy referral, four of the families were referred by other therapists or services, and one family was sent by court within a promotion and protection program. The reasons that lead to the referral of these families were: parental separation, children's behavioural problems, family conflicts, and domestic violence. Regarding the therapeutic history, in three of the cases the children were already being followed in individual therapy.

Seven therapists were involved in this research (five women and two men), all psychologists, with mean ages of 30 years, with an average training time of 5 years and mean duration of clinical practice of 8 years.

Measurements

The possibility to analyse the therapy's effect on the family has become a crucial aspect in allowing the analysis of the therapeutic process in the family and couple therapy model, as well as its efficacy. Stratton, Blando, Janes and Lask (2010) developed an assessment instrument, with this purpose – the SCORE. The first version included 40 items, and the version used in this study (instrument used in the established protocol) results from some modifications, having only 29 items.

The SCORE-29 is an instrument conceived to assess family functioning (strengths, difficulties and communication) as well as the perception that clients have regarding the problem that leads them to therapy, its impact, the associated change, and therapy usefulness.

In order to evaluate this perception, clients answered to questions like: "What is the main problem/difficulty that made you resort to therapy"; "What is the main problem/difficulty for your family right now". The answers to these questions are quite diverse, however clients tend to specify their preoccupations and difficulties, as we can see in the following examples: "the main problem is the lack of understanding and dialogue"; "little confidence in each other"; "the main problem is children dealing with their parents' quarrelsome separation".

Besides these items, this instrument has four questions in a 0 to 10 likert scale, which allows the evaluation of the clients' perception about their problem, its impact and the role of therapy. In this study, we shall consider two of the questions that gather: Information given on the problem: "On a scale of 0 to 10, where 0 corresponds to 'Absence of problem' and 10 corresponds to 'Very Serious', what is the severity of the problem?"; Information given on the Impact: "On a scale of 0 to 10, where 0 refers to 'It doesn't affect us much' and 10 refers to 'Greatly undermines our life', what is the severity of the problem?"),

The content analysis of feedback (CAF) intended to classify the verbalizations and non-verbal behaviour of family members through the five feedback categories (Problem, Causes, Impact, Maintenance, and Change) (see Table 1). It was possible to link a therapist's verbalization or behaviour to each of these quotations, in order to understand if they were a fruit of requests made by the therapist, or given spontaneously by family members. For instance, in case 4 the Therapist tries to better understand what

specifically is considered a problem by the family by questioning "can you give any examples of things that go wrong around the house?", to which the eldest daughter answers "we frequently argue about meaningless things…stupid stuff…". In this particular case we are before a verbal description regarding the problem, in response to a direct verbalization from the therapist.

Thus, in addition to being able to understand what sort of information is collected and focused on the therapeutic processes, it is possible to evaluate the role of therapists in the collection of this information. In other words, the way therapists seek to know more information, give more feedback to clients' verbalizations and behaviors, engage each member of the family during the session, varies from therapist to therapist and these differences can be evaluated in order to understand which strategies promote a higher engagement and enhance the advance of the therapeutic process.

Through this qualitative analysis it was possible to register and quantify the number of verbalizations and behaviors that each family member had throughout the process, as well as in which feedback category they belong.

Therefore, later, and taking into account the number of identified verbalizations for each category, it could be compared to the assessment made by the members of the family in a more formal assessment of therapy, given by the clients by completing a SCORE-29. For example, in case 1, the father verbalized aspects related to the problem twelve times and attributed it a value of 7 in his formal evaluation, which represents a high severity of the problem. On the other hand, and considering the impact, in this same case we notice that the daughter only twice verbalized aspects related to the impact of the problem in their lives but classifies it, formally, with the value of 10.

We also intent to draw some hypothesis regarding the relationship between to which each client evaluates the problem and its severity and how it manifests throughout the therapeutic process - for instance, considering the case depicted above, we can say that, regarding the problem, there was coherence between the severity attributed to it and the number of times this topic is referred to throughout the session. However, when it comes to the impact, we observe that despite it being seldom pointed by the daughter, it is felt as something with great impact on her life.

Procedures

The data analysis was made throughout several steps. The first step consisted of viewing and transcribing the sessions, followed by an analysis of those sessions carried out by the first author, in order to identify all the behaviors (therapist and family) related to the feedback about the content of the sessions. The specific analysis of the sessions consisted of a first reading of the transcript, a selection and arrangement of the sessions' parts by each one of the feedback categories, and in the test, with the second author, consisted in reading the sessions and identifying the parts where each of the considered feedback dimensions appeared (see Table 1*).

Thus, the content of fourteen therapeutic sessions' videos were transcribed and analysed (five from the 1st session, four from the 4th session, five from the last session) in light of the proposed categories for the definition of feedback.

The SCORE-29 data (self-report instrument) were collected by the research team, through the completion of the instruments by the family members.

Note: * See table 2 in the appendix with more detailed

Table 1

Categories regarding the Content Analysis of Feedback (CAF) of the sessions

Category's Name	Description of the Category	Examples
Problem	Client verbalizes about what are the problems	CAF: "...Always had that tendency to go mess…evolve to more complicated cases", Mother, Case 1
Causes	Client explains what are the causes that are in the basis of the problems	CAF: "...you can clearly tell that she's not capable...", Mother, Case 1
Impact	Client materializes what are the impacts, consequences that the problems have had in the family and its several elements	CAF: "...full of fear, terrified..", Mother, Case 2 CAF: "we are all very upset with these arguments..." Father, Case 4
Maintenance	Client verbalizes what are the aspects that lead to the fact that the problem remains and persists over time	CAF: "...so tires that sometimes I don't even have patience to listen to them...", Mother, Case 5
Change	Client clarifies what are the changes he/she wants to achieve, what wants to be different, and what must happen in order to be different	CAF: "...we settled some things, I think that there has been opening...", Mother, Case 4

In terms of the method for results analysis, a comparison method was used. The data gathered from the qualitative feedback analysis (CAF) was compared to the data collected through the clients' perception self-report instruments (SCORE-29).

Results

A content analysis of the fourteen sessions allowed to say that the two categories that stand out the most, in terms of data collection, are: Problem (e.g. "…she was very aggressive…called me names, wanted to leave the house on hours I wouldn't let her…", Mother, Case 3) (with 385 references) and Change (e.g. "...we already talked about one or two themes…we talked about family communication…", Father, Case 4) (with 244 references) (see Table 2).

The information collected regarding Causes (e.g. "...because they came here as well because…of the problems of the mother and the father…", Mother, Case 2), Impact (e.g. "…even confessed to me that it affected his studies…", Father, Case 5), and Maintenance (e.g. "…yes, he has more need for affection…", Mother, Case 5) are, in the majority of the cases, very reduced and mostly a result of more direct questions made by the therapist (e.g. Case 1) "…do you also notice that your family is a bit concerned with these things that happen at school?".

Throughout the therapeutic process the answers that are being given start to be more spontaneous rather than a product of the therapist's questioning, both at the level of the problem and the change (e.g. Case 4)"…I think that there was also change on our part…" said the father, reflecting upon change without the therapist's solicitation. In some cases, when sessions are more focused on the problem, the spontaneous verbalizations regarding change are rarer (e.g. in some sessions from Case 3).

Spontaneity during therapy, although it occurs and, in the majority of the cases, in adults (parental subsystem), is something that is highly dependent on the characteristics of each individual and the way they feel the therapy, i.e., when parents perceive the setting as safe and as the place where they can openly discuss their problems (e.g. "…this is privileged space that we have to say it…because we even have the generals commanding…", Father, Case 4), the number of spontaneous verbalizations increases (e.g. case 5, where the parents bring the conflicts into the therapy and use that space to be able to talk about them). As such, we realize that parents elect that setting as the place to deal with delicate or conflicting matters (e.g. Case 5) "…lack of affection, lack of attention…we are here talking…the thing is, this was something that happened yesterday (…) the daughter came up to the mother telling her that it hurt, it was hurting…the mother didn't pay her the attention she needed, she even told her that if it was a piece of something else it would be even worse…she should fend for herself…". When it comes to the children or adolescents, their participation appears to be more complicated, considering their maturity (in other words, the way they are capable of speaking about what they feel, of exposing themselves before adults and strangers). And also a place to engage and feel safe in a family process, since in many cases the problem is related to parent-adolescent relationships (e.g. relationship mother – son 1, in case 2; relationship mother – daughter 1, in case 3), or in the parents' perspective, to adolescents themselves.

Table 2

Relationship between quantitative data from the Content Analysis of Feedback (CAF) and SCORE-29

Families		Quantity of Content Feedback					SCORE-29: Problem	SCORE-29: Impact
		Problem (1st / 4th / 7th Sessions)	Causes (1st / 4th / 7th Sessions)	Maintenance (1st / 4th/7th Sessions)	Impact (1st / 4th / 7th Sessions)	Change (1st / 4th / 7th Sessions)		
Case 1	Father	12 / 6 / 8	2 / 0 / 1	1 / 0 / 2	7 / 2 / 3	7 / 13 / 10	7 / 4 / 7	7 / 6 / 6
	Mother	15 / 13 / 14	6 / 2 / 3	5 / 1 / 8	11 / 5 / 7	9 / 16 / 15	5 / 5 / 5	5 / 3 / 6
	Son	3 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	4 / 3 / 0	8 / 4 / 4	8 / 8 / 6
	Daughter	2 / 1 / 0	0 / 0 / 0	0 / 0 / 0	2 / 0 / 0	2 / 0 / 0	10 / 9 / 6	10 / 2 / 5
	Total:	**32 / 20 / 22**	**8 / 2 / 4**	**6 / 1 / 10**	**20 / 7 / 10**	**22 / 32 / 25**		
Case 2	Mother	28 / 13 / 14	1 / 5 / 3	4 / 0 / 0	5 / 3 / 3	7 / 7 / 3	7 / 8 / 9	9 / 9 / 9
	Son 1	9 / 2 / 9	1 / 0 / 3	0 / 0 / 4	0 / 0 / 2	4 / 3 / 4	5 / 8 / 7	6 / 6 / 7
	Son 2	2 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0	7	6
	Total:	**39 / 15 / 23**	**2 / 5 / 6**	**4 / 0 / 4**	**5 / 3 / 5**	**11 / 10 / 7**		
Case 3	Mother	18 / 1 / 12	5 / 0 / 0	3 / 0 / 4	0 / 0 / 0	5 / 10 / 7	10 / 5 / 7	10 / 7 / 10
	Daughter 1	17 / 14 / 3	7 / 2 / 1	5 / 4 / 3	3 / 5 / 0	7 / 5 / 8	6 / 3 / 7	10 / 3 / 8
	Daughter 2	3 / 0 / 0	0 / 0 / 0	0 / 0 / 0	1 / 0 / 0	2 / 0 / 0	3	5
	Total:	**38 / 15 / 15**	**12 / 2 / 1**	**8 / 4 / 7**	**4 / 5 / 0**	**14 / 15 / 15**		
Case 4	Mother	9 / / 3	3 / / 0	0 / / 0	0 / / 0	2 / / 9	5	8
	Father	4 / / 7	1 / / 1	0 / / 0	1 / / 0	1 / / 11	8	9
	Daughter 1	6 / / 0	3 / / 0	0 / / 0	0 / / 0	0 / / 9	7	6
	Daughter 2	1 / / 1	1 / / 0	0 / / 0	0 / / 0	1 / / 1	0	0
	Total:	**20 / / 11**	**8 / / 1**	**0 / / 0**	**1 / / 0**	**4 / / 21**		
Case 5	Mother	19 / 23 / 23	4 / 2 / 1	0 / 3 / 1	0 / 7 / 1	5 / 7 / 6	4 / 7 / 5	5 / 8 / 7
	Father	12 / 21 / 18	5 / 5 / 2	1 / 0 / 1	3 / 12 / 7	7 / 21 / 9	8 / 8 / 5	7 / 7 / 5
	Son 1	5 / 1 / 1	0 / 0 / 0	0 / 0 / 0	4 / 1 / 1	2 / 1 / 1	8 / 8 /3	9 / 10 / 8
	Son 2	3 / 1 / 5	0 / 0 / 0	0 / 0 / 0	4 / 1 / 1	2 / 1 / 4		
	Daughter 3	1 / 0 / 2	0 / 0 / 0	0 / 0 / 0	1 / 0 / 0	2 / 0 / 0		
	Total:	**40 / 46 / 49**	**9 / 7 / 3**	**1 / 3 / 2**	**12 / 21 / 10**	**18 / 30 / 20**		
	Sum:	**169 / 96 / 120 = 385**	**39 / 16 / 15 = 70**	**19 / 8 / 23 = 50**	**42 / 36 / 25 = 103**	**69 / 87 / 88 = 244**		

Note: The blank results refer to the non-completion of the questionnaires.

Therefore, we can say that parents verbalize different aspects by answering the therapist's questions and spontaneously, while the children usually give more answers when asked by the therapist (e.g. Case 4, the therapist asks the eldest son directly "What do you see? What do you think about it?", and son answered "often discussed by things that do not make sense…"). Thus we see that children, regardless of age, and considering their personal traits, are more dependent on the therapist to be more involved and participative and in a more spontaneous way in the therapeutic process.

The age factor and the role they play in the problem that leads to therapy are key factors in the involvement of adolescents in therapy.

However, and taking into account the existence of these two subsystems, syntonic and sharing behaviors between parents, and between brothers are visible in certain moments of the therapy – humor (e.g. Case 1, during the role inversion task and facing the difficulty of putting themselves in another person's shoes, they joke as they help each other) and, safety, complicity (e.g. in case 2, the son 2 sits closer to son 1 when the mother begins to attack the father; in case 4, daughter 2 makes complicit comments to daughter 1; case 1, the parents have a complementary speech) – although its highlights through the process may differ.

Throughout the therapeutic process, the feedback that is being requested is different. Initially, the focus is more on the problem and its characterization, although aspects that promote change are immediately sought. As sessions progress, the focus on change tends to increase, although it is visible that problem situations, even though they change, always occupy a great space in the therapy (e.g. Case 5: the number of verbalizations about the problem has a large demonstration throughout the entire

process, although the verbalizations regarding change are also increasing through the sessions) (see Table 2).

In terms of feedback requests, often there is a greater focus on the problem and its characterization and description through examples, than in exploring the causes with the family, and its maintenance processes. Regarding impact, this emerges when clients talk about the inherent consequences of the problem, not as something to which they give much emphasis, but rather something that is a direct condition of the situation they are experiencing (e.g. Case 5: "…she talked to me later…I felt that she was affected by the situation…"). Change being the final goal it is often brought in to try decentering from the focus of the problem (e.g. Case 1: "…they are more visible…his side shows…he's more open, more relaxed…").

The way therapists give voice to the different elements of a family stands out as an important aspect, being careful regarding which questions to ask, so different opinions may be expressed, rather than conditioning the information based on the problems described by adults.

There are striking differences between therapists, not only in their behavioral pattern while questioning different members (by which order they give voice, what kind of questions they ask, the way they explore information, etc.), as well as in terms of the space they create in order for the more reserved be able to speak and get involved in the process. It is important to go beyond confirming and refuting problems, and allowing the exploration of different opinions and points of view (e.g. Case 5: after the parents have spoken and explained their perspective of the problem, the therapist focuses on the son and questions "would you care to explain to me a little more about what is happening in the house and why do you feel it is important for all of us to be gathered

here today, talking?", giving him a voice without directing him to what has already been said and allowing him to give his opinion).

Throughout the process and as the problems are explored, new aspects arise, especially concerning family relations and dynamics. Such situations are often more problems that weren't yet considered or were on a second plane (e.g. Case 2: when the problem becomes the behaviour of the eldest son and the mother-son relationship, instead of focusing on the way the children manage the separation of their parents). The clients' urgent search concerning the resolution of the questions that arise, is noticeable, often ending up forgetting the achievements they already made. It is important that the therapist not only fits and returns the information in a structured and interrelated manner, but gives the clients a vision of the global and the impact little changes have, so that these strategies may be generalized and integrated in a more constructive and productive way, in every member of the family (e.g. Case 3: when the therapist reformulates what was said, integrating the change occurring in the daughter's behaviour "…she thinks that she's different in some ways, or at least, regardless of being different or not, she carries out a number of things that she didn't used to").

Comparing formal (given by SCORE-29 items) and informal feedback data (feedback content analysis) (see table 3) we can state that, even though there's not a total correspondence, the information retrieved from informal feedback has a much higher number of references to Problems, even when the assessment in the SCORE isn't as high, in terms of severity (e.g. Case 1: Mother formally evaluates the problem with a 5, a medium value, but then makes frequent verbalizations regarding the problem). In the case of Impact, we realized that, in most cases, there are few references although it is assessed with a very high level (e.g. Case 1: Daughter almost doesn't informally refer

to impact but formally evaluates it with a value of 10, giving the highest SCORE to how she feels the problem has an impact on her life). We also observed that, in terms of the children that are less requested and intervene less during the process, the assessment they make, both of the problem as of the impact, is generally quite high although they have few verbalizations throughout the process (e.g. Case 1: the two children have very few informal verbalizations or manifestations about the problem, its impact, or change; however, formally, they always evaluate as having a severe problem whose impact greatly affects their lives).

Discussion

Authors such as Horvath and Greenberg (1989) stated the importance of starting the therapeutic process from a "not knowing" position, in order to give voice to the clients and together understand what problem brought them to therapy, and what changes are sought.

As the results of this research show, the entire therapeutic process is a discovery made with clients about their problems and the way in which changes may occur in order to overcome these problems.

Feedback given by clients mostly occurs through the therapist's questioning, ending up being more spontaneous as the therapeutic alliance is strengthened. This aspect is crucial since the therapist's interventions, through questioning or returns, must add an acceptable and comprehensible rationale, so it may be integrated by clients thus promoting change (Fischer et al., 1998a; Frank & Frank, 1993; Miller et al., 1995; Arredondo, 1998 as cited in Rodriguez, 2007). Through this perspective we may understand that, although the client plays a fundamental role, it is up to the therapist (Sprenkle, Davis, & Lebow, 2009) to leverage the involvement in therapy, as well as to

balance and restructure the, frequently unorganized, contents that are brought to therapy by family members.

When intervening with families therapists must conciliate several subsystems, and the parental system often takes a more active and present role in therapy. Thus, it is necessary to enhance the importance of the role of therapists when conducting sessions, seeking to involve all family members, giving voice to the filial subsystem which is often taken hostage by the problems, or just passive and uninvolved in the therapeutic process.

The definition of the problem, centred in an element or relationship, is also noticeable since when looking at the relationship, change is dependent on several elements, as opposing what happens when change depends solely on one person. Furthermore, looking at the problem as the person themselves, instead of their behaviors, makes it difficult to make changes and setting goals. Considering this knowledge, the search for every vision regarding the same problem should be safeguarded, as well as trying to understand the vision each family member has about the impact that the entire problematic situation has for the rest of the family, and searching for examples in order to limit the problem to behaviors in specific contexts, to the detriment of a comprehensive and restrictive manner, as being one person itself.

When clients begin a therapeutic process, they usually bring a set of information to share, being visible the high number of verbalizations about the problem in the first session. However, the way this feedback is collected by the therapist and the family, the way the therapist returns and adds information will allow clients, who are the most knowledgeable people about themselves, to go beyond the problematic vision, framing the situation in the family resources and a more integrative vision of the process. For

this, it is important to further explore the other problem situation elements: causes, impact, and maintenance, in a way that it may bring diversified information to the family and to the therapist, facilitating the integration of the information and promoting a bigger change.

Focusing exclusively on problems, brings nothing new to the family, since this information is already known and is somewhat crystalized in each of them. To renew this information, and in the wake of what has been said, it is the therapists' responsibility to try and request this information from the more silent members in a clearer way, and promote a safe environment that is conducive to the emergence of spontaneous feedback from different family members.

Feedback can be assessed in therapy in a formal manner through questionnaires. With the results we realized that the family members that manifest less, in this case the filial subsystem, show a highly negative assessment of the problem and its impact. Thus, we realized that silence during therapy can indicate uneasiness or lesser involvement in the process, so it ends up not being useful to that element.

The use of this type of instrument to assess formal feedback may provide the therapist rich information regarding the therapeutic process, the concerns of each family member and the way each one experiences it, allowing the therapist to metacommunicate about all of this throughout therapy.

Thus, we conclude that the collection of feedback is of utmost importance for therapists in conducing therapeutic processes, both in terms of its effectiveness, and as a way for a successful therapy.

Limitations and conclusions

Throughout this study we came across some limitations in regards to the sample collection, especially regarding the quality of the videos from the sessions. Aspects such as camera placement, sound quality and visibility of the family members (nonverbal behaviour) led to an increased difficulty in the transcription and analysis of the sessions.

The chance to analyse the family therapy sessions and reflect upon the way therapists conduct the sessions, in order to gather clients' feedback regarding their problems, causes, impact, maintenance and change, concluded that the sessions are often heavy and very focused on the problems, eventually giving little room to explore change. In addition, the active voice that is given to each family member is different, being mostly the adults who are able to talk more and expose their considerations towards the family.

Although in a therapeutic process the focus on change is essential, the conscience and understanding of the causes and their maintenance seem to be aspects to emphasize throughout the therapy. However, in this study, the results point to strategies focused on the solutions, where the gathered information ends up being quite dichotomous between the problems and the changes to achieve. Considering these results, new studies are important in order deepen the way different types of feedback may enhance therapy results.

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The Pro-CIV Project is a research project that aims to assess the family therapy processes at three different times (first session, the middle, and the end of the process), through an application protocol for clients and therapists. In this protocol several dimensions are assessed: family functioning, therapeutic alliance, family communication, and coping strategies used by the families. The sample of family therapy cases has changed through time, i.e. increasingly, the cases sent by court and commissions are recurrent, eventually making clients a non-voluntary population. This project intends to collect data from two types of population: voluntary and non-voluntary, in order to compare differences and similarities between both kinds of processes, so it may improve and enhance successful therapeutic interventions.

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CAPÍTULO V

CLIENT FEEDBACK REGARDING THEIR FAMILY FUNCTIONING (SCORE-15): FAMILY STRENGTHS AND DIFFICULTIES

Abstract

The SCORE-15 is a self-report questionnaire that allows the understanding of the patient' perception regarding family functioning (strengths, difficulties and communication). This study explores the psychometric properties for a sample of 57 families (134 participants) referred to a family therapy process. The findings allow us to conclude that the instrument enables assessing, with reliability, the family strengths and difficulties. The results point to, on one hand, pretty strong perceptions about the family functioning, as well as the problems and the usefulness of therapy, and on the other hand, to positive relations between different family functioning components: family strengths and difficulties, and the global perception of the functioning throughout the therapeutic process. Besides, the comparison of the answers given in the first to the fourth therapy session indicates a significant increase of the perception that clients have about their family strengths.

Keywords: SCORE-15, family functioning, family strengths, family difficulties, family therapy.

Note: Submitted to Clinical Psychology and Psychotherapy

Introduction

Couple and Family Therapy (CFT), at a research level, did not possess the means to measure the therapeutic effects and, consequently quantify therapy results. To address this issue, authors such as Stratton, Bland, Janes and Lask (2010) developed Systemic Clinical Outcome and Routine Evaluation (SCORE**)**, an instrument easy to employ in clinical context to assess the perception that clients have about their own strengths, difficulties and family communication. As well as providing an understanding to their view of the problem, its impact and therapy usefulness.

Originally, the SCORE was constructed in the United Kingdom and Ireland and has been adapted all throughout Europe, including Portugal. This instrument appeared due to the need to assess therapeutic processes in CFT, monitoring clients' feedback and their evolution throughout the therapeutic process (Stratton et al., 2010). In order to fit to clinical practice, it was assembled following two main prerequisites: i) allow each member of the family to answer, so it can give a broader view of the family functioning; ii) be sensitive to family change through time. In this sense, SCORE can provide information regarding the aspects that therapists consider more relevant during intervention: aspects of family life that cause more challenges or problems to different family members; and aspects of family functioning for which improvement is sought and expected during the therapeutic process (Stratton et al., 2010). Pilot studies were conducted and a first version with 40 items was constructed. Although it presented the appropriate psychometric properties, the SCORE-40 revealed itself to be quite extensive in terms of items and time needed for its completion, hence not viable in a clinical practice context.

Thus, more studies were conducted and it was possible to reduce the instrument to only 15 items (Stratton et al., 2010). In Portugal, a preliminary study with the SCORE-15 version was conducted with a nonclinical convenience sample composed by 21 participants, which allowed the verification of the accessibility, brevity, and clarity of this instrument (Portugal, et al., 2010).

On the other hand, a theoretical review regarding the key aspects of therapeutic change pointed to the importance of clients' feedback about the therapeutic process and alliance, in family therapy, to the success of the therapy (Dias da Costa & Alarcão, 2012).

Although recent studies have demonstrated the effectiveness of systemic therapies for different problems (Carr, 2009a; 2009b), some studies pointed out the difficulty therapists have in identifying the worsening of symptoms in the clients, causing therapists to not be able to identify nor predict those situations (Hannan et al., 2005; Hatfield, McCullough, Frantz, & Krieger, 2009; Hatfield & Ogles, 2006). In order to answer this difficulty, Lambert (2007), as other authors (Hatfield et al., 2009), conducted studies where a feedback system regarding worsening of symptoms was employed by therapists which results indicated a considerable improvement in therapeutic outcomes.

Considering these two ideas, we aimed to conduct an exploratory analysis regarding the perception that clients appear to have about their family functioning, the problem that leads them to therapy, and the therapy usefulness, in order to contribute to the validation of the SCORE-15. Additionally we tried to provide some understanding for the changes that occur in the clients' perception during the therapeutic process.

Method

For this study the application of the SCORE-15 to a clinical population during the therapeutic process to be applied in three stages (first session, in the middle of the process, and at the end of the process, generally the 7th session) was employed (quantitative method).

At the beginning of our research, several therapists were approached and invited to participate. After the therapists accepted to participate in this investigation all the families that requested a first appointment were invited join as well. The procedures and aims of the study were explained to all family members, an invitation was made and informed consent was signed. No incentives for participation were provided during the course of this investigation.

This study was divided in two phases, the first one consisted in the validation of the instrument through an exploratory factor analysis, the second phase consisted in a comparison of means between the first and the second stage of evaluation. The third stage did not have a valid sample for these type of analyses.

Participants

The families that participated in this study were referred to family therapy by experts from several departments, such as Health Centers, Commissions for the Protection of Children and Youth at Risk, Social Security, Juvenile and Family Court, and the Holy House of Mercy. The families were referred due to problems linked to divorce/parental separation, children behavioral problems, family violence, depression, conjugal conflicts, and other problems affecting normal family functioning.

The therapeutic processes occurred in three different family support services, one connected to the University of Coimbra, another one to the Hospital of S. João (Oporto) and the others to three different clinical services from non-governmental organizations (NGO's). Data was collected from mainland Portugal and the Funchal and Azores Islands. The therapeutic processes were developed in a narrative theoretical approach, with two therapists and in a traditional family therapy setting. The therapies were usually brief, with no more than seven sessions, following the establishment of a contract in the first session sessions, and ran every three weeks.

The families all came from a medium-low or from a low socioeconomic level and had on average two children. From the first stage (1st session) a sample of 134 clients, from 57 families was gathered however at the second stage (4th session) the sample was reduced to 57 clients, from 24 families, and at the last stage (7th session) to the samples was further reduced down to 35 clients, from15 families.

A total of 104 therapists participated in this study, comprising 52 pairs of co-therapists. Therapist mean age averaged 32 years, with most having completed their academic formation in psychology or social services after 5 years, and having mean of 6 years' experience of clinical practice in family therapy. From the 104 therapists, only 20 were male, thus resulting in a majority of female co-therapist pairs.

Measurements

The SCORE-29 (Fay et al., 2013) is a self-reported questionnaire concerning the perception of familiar functioning. The SCORE-29 contains items from both the SCORE-28 and the SCORE-15, allowing for a faster application.

A more recent factor analysis of SCORE-40 confirmed the structure of three factors – Strengths, Difficulties, and Communication – however the items with lower saturation were removed which lead to the creation of a more reduced version with 28 items, the SCORE-28 (Cahill, O'Reilly, Carr, Dooley, & Stratton, 2010). Considering that there were two shortened versions of the same instrument and in order to be able to conduct studies with both versions simultaneously, a third version was created by Fay et al. (2013), the SCORE-29. Each of the 29 items was quoted according to a five-point Likert scale, ranging from 1 "Describes us very well" to 5 "Describes us very badly". The total result of the SCORE was obtained by inverting the items 4, 6, 7, 9, 10, 11, 15, 16, 20, 21, 22, 25, 27 and 28, so that the highest result corresponded to the bigger difficulties in the family.

SCORE-15 being more directed to the clinical population was the questionnaire chosen for this study. It still assessed the same three factors: Strengths (items 4, 7, 10, 25, 29), Difficulties (items 9, 19, 21, 22, 28), and Communication (items 12, 17, 23, 24, 26) (Fay et al., 2013).

Additionally, the SCORE-15 also contained three more open questions regarding the problem that led the family to therapy, the problem that still affected it at the present time, and the descriptive characteristics of the family. To finalize the questionnaire four more questions were added: a) "On a scale of 0 to 10, where 0 corresponds to 'Absence of the problem' and 10 corresponds to 'Very serious', what is the severity of the problem?"; b) "On a scale of 0 to 10, where 0 corresponds to 'Very well' and 10 corresponds to 'Very badly', how are you organizing as a family?"; c) "On a scale of 0 to 10, where 0 corresponds to 'Doesn't affect us much' and 10 corresponds to 'Greatly affects our life', what is the severity of the problem?"; and d) "On a scale of 0 to 10,

where 0 corresponds to 'Very useful' and 10 corresponds to 'Not useful at all', how useful do you consider therapy to be?".

Procedures

For this study, samples were collected between September of 2011 and April of 2013.

The number of families that accepted to participate in the study at the start was not the same that at its end due to several dropouts and to not all families having concluded all the sessions. Consequently not all instruments could be correctly filled out. Initially, data from 57 families (134 participants) was gathered, midway through the process only 24 families (57 participants) remained, and at the final assessing stage data from only 15 families (35 participants) could be collected.

Collected data was treated considering the three stages of collection (1st, 4th, and 7th sessions), which caused limitations due to the reduction of the sample size and the heterogeneity of families and its elements. In other words, when families presented themselves for therapy, they presented different configurations, either parents and children, mother and daughter, mother and children, etc.. Furthermore the very disparate ages between members of different families made comparative studies between families not possible.

The data from each questionnaire was introduced into the Statistical Package for the Social Sciences (SPSS, 2009; version 19.0) software and processed according to the following statistical analysis:

a) Exploratory factor analysis studies of SCORE's version 15, for the first evaluated stage of the process (1st session);

b) Internal consistency analysis (Cronbach's alpha), for each of the factors found and for the scale as a total;

c) Bivariate correlations between the resulting factors from the factor analysis and the scale's total SCORE, in the three assessed stages (1st, 4th and 7th session);

d) Descriptive statistics of the socio-demographic variables, of the SCORE-15 factors, and the last four questions about the problem and therapy usefulness;

e) Mean comparisons (ANOVA), with repeated measures, of the factors found for the first and second assessing stages.

Results

Construct Validity Studies – SCORE-15 factor analysis

In order to determine the factor structure of the SCORE-15, an exploratory analysis of the main components for this 15 items version was performed for the first stage, since it was the stage with a broader sample. Significant results (close to 1) were obtained by the Kaiser-Meyer-Olkin measure of sampling adequacy (0.823) and Bartlett's test of sphericity ($X2 = 778.210$; $gl = 105$; $p < 0.05$). These values were favourable to conduct factor analyses and indicative that the data came from a multivariate normal population (Pestana & Gageiro, 1998). The acquired solution also indicated the existence of three factors by the Kaiser criteria, as well as through the observation of the scree plot. To maximize the high correlations and minimize the weak ones, the Varimax rotation method was applied (Poeschl, 2006). Saturations with values

below 0.30 were excluded, the retaining criterion for an item in a determined factor was established by the magnitude of its saturation. This rotated solution (table 1) explained the 60.300% in variance, for which a first factor with seven items contributed with 35.553% to the variance. With saturation values between 0.589 and 0.811, a second factor contributed with 17.646% to the variance. The presence of five items with saturations between 0.765 and 0.8315, a third factor which accounted for 7.101% of the variance, containing two items with saturations that vary between 0.557 and 0.742.

Table 1

Rotated component matrix

	Component		
	1	2	3
CS1_SCORE_21_Inv	0,811	0,240	0,110
CS1_SCORE_25_Inv	0,781	0,086	0,010
CS1_SCORE_10_Inv	0,734	-0,059	-0,110
CS1_SCORE_22_Inv	0,677	0,109	0,249
CS1_SCORE_7_Inv	0,614	0,114	0,414
CS1_SCORE_28_Inv	0,600	0,228	0,380
CS1_SCORE_19_Inv	0,593	0,259	0,338
CS1_SCORE_29_Inv	0,589	0,277	0,378
CS1_SCORE_17	0,193	0,831	-0,083
CS1_SCORE_12	0,179	0,816	-0,094
CS1_SCORE_23	0,181	0,811	-0,233
CS1_SCORE_24	0,099	0,788	0,043
CS1_SCORE_26	0,015	0,765	0,282
CS1_SCORE_9_Inv	0,159	-0,089	0,742
SCORE inverted item 4	0,119	-0,080	0,557

Looking at the results found and starting by the second factor because it is the most directly linked with the literature, this factor is comprised by five items (items 12,

17, 23, 24, 26) that compose the Family Strengths in Fay and collaborators' study (2013).

In the first factor, seven items corresponding to Family Difficulty dimension were included (items 21, 25, 10, 22, 28, 29, 19), which shared some similarities with the aforementioned study that had four items in common (items 19, 21, 22 e 28). Items 10, 25 and 29 were included in this factor since they exhibited a higher saturation in the Difficulties dimension, contrary to Fay and collaborators' study (in press), where it was saturated in the Communication factor.

The third factor, Family Communication, was made up by three items (items 9, 7 and 4). Regarding item 7, "In my family we often do not tell the truth to each other", although it showed a slightly higher saturation on the first factor when compared to the according to the literature (Fay et al., 2013; Stratton et al., 2010) it belonged to the Family Communication dimension. Since the saturation of the item in factors 1 and 3 was deemed approximate, it was decided to include it in the third factor as well.

According to the literature, item 9 "We feel it is difficult to face everyday problems" should have been in Factor 1 (Family Difficulties), and item 10 "In my family, when people get angry, they intentionally ignore each other" in Factor 3 (Family Communication). However, in this study, they were SCORE in reverse. After analyzing these items we realized they could have been a bit ambiguous to be understood, since 75.5% of our sample had only secondary education. Item 9, in particular may have been interpreted as a communication problem, while item 10 could have been perceived as a difficulty in the relationship among family members.

Precision Studies

The global scales and the SCORE-15 questionnaire factor scales, for the first evaluated session specifically for Family Strengths and Family Difficulties, showed an adequate internal consistency, with Cronbach's alpha values (table 2) varying between 0.85 and 0.88.

Regarding the Family Communication factor, a significant alpha was not obtained, being lower than the 0.70 criterion (Cortina, 1993; Schmitt, 1996). This demonstrated the reduced precision of the scale and thus was excluded and not considered for further analysis.

Table 2
Reliability statistics

	Cronbach's Alpha	N of Items
Family Strengths	0,884	5
Family Difficulties	0,851	7
Family Communication	0,441	3
Global SCORE-15	0,862	15

From the results found, both from the exploratory factor analysis and from the Cronbach's Alpha, it was possible to assess that the instrument was indeed valid. However only for the evaluation of the perception of the family functioning, based on the two factors whose precision was high: family strengths and family difficulties.

Descriptive statistics regarding SCORE-15

At the first stage (N=134 participants) the overall SCORE-15 punctuation varied between 0.00 and 4.47, with a mean of 2.58 (SD = 0.79) (table 3). While the Family Strengths dimension had a mean of 2.29 (SD = 0.97) with values between 0.00 and

5.00, and the mean for the Family Difficulties dimension was 2.69 (SD = 0.86), varying between 1.00 and 4.57.

For the second stage (N=57 participants) we calculated an overall SCORE-15 mean of 2.52 (SD = 0.60), varying between 0.00 and 3.33. With Family Strengths scoring a mean of 2.26 (SD = 0.73), with values between 0.00 and 4.60,and Family Difficulties which values ranging from 1.00 to 4.29, a mean of 2.59 (SD = .76).

Finally, at the seventh session, we found values ranging from 1.67 to 3.40 for the global values of the scale, with a mean of 2.67 (SD = 0.45). For the Family Strengths a mean of 2.36 (SD = .73) with values between 1.20 and 4.00 was observed and the Family Difficulties dimension the values ranging from 1.14 to 4.29, with a mean of 2.62 (SD = .81).

Table 3

Descriptive statistics of SCORE-15 factors and of SCORE-15 in its global

	General CS1	Family Strengths S1	Family Difficulties S1	General CS4	Family Strengths S4	Family Difficulties S4	General CS7	Family Strengths S7	Family Difficulties S7
N Valid	135	134	129	57	57	56	35	35	35
Missing	8	9	14	86	86	87	108	108	108
Mean	2,5811	2,2914	2,6881	2,5263	2,2561	2,5901	2,6739	2,3600	2,6197
Std. Deviation	,78828	,97318	,86493	,60086	,73071	,75799	,44586	,72728	,80565
Minimum	,00	,00	1,00	,00	,00	1,00	1,67	1,20	1,14
Maximum	4,47	5,00	4,57	3,33	4,60	4,29	3,40	4,00	4,29

Relations' Study

With two factors remaining, in each of the three stages, the relationships between the results obtained in the factors and the total SCOREs of SCORE-15 were

calculated. Bivariate correlations were performed between Family Difficulties and Family Strengths which demonstrated that there was a positive relationship between some of the variables (table 4).

We observed that the perception that clients had about family strengths at the first stage was positively correlated with the overall evaluation both in at first and second stage. Additionally the perception that clients had regarding family difficulties at each of the three stages, was positively related with the global evaluation throughout the process as well. The perception clients had about family strengths in the middle of the process was also positively related with the overall evaluation of at the first and second stages. Furthermore the perception that clients had regarding strengths at the seventh session were the only ones that were positively related to the global evaluation at the third stage, maintaining the positive relation at the other two stages.

The relationships found with the global evaluation in sessions 1, 4 and 7 were all strong. Nevertheless, it was only possible to compare the means from the first and the fourth session, since these were the only ones whose sample size was still large enough to allow this type of analyses.

Concerning the final four questions of the questionnaire, we conducted a descriptive analysis (table 5) in order to analyze how the answers to these questions were distributed.

In terms of means, we observed that the severity of the problems was distributed with 5.83, 5.82 and 5.26 during the three assessing stages respectively. As to the organization of the family, the means were 4.40, 4.64, 4.37. Regarding the impact of the problem and how it affected the family we obtained means of 6.24, 5.62 and 5.74

Table 4

Relations between the General SCORE and its components in the three stages

		CS1General	Family Strengths S1	Family Difficulties S1	CS4General	Family Strengths S4	Family Difficulties S4	CS7General	Family Strengths S7	Family Difficulties S7
Family Strengths S1	Pearson Correl.		1							
	Sig.									
	N		134							
Family Difficulties S1	Pearson Correl.		0,346**	1						
	Sig.		0							
	N		128	129						
Family Strengths S4	Pearson Correl.		0,775**	0,227		1				
	Sig.		0	0,096						
	N		56	55		57				
Family Difficulties S4	Pearson Correl.		-0,006	,645**		0,123	1			
	Sig.		0,966	0		0,367				
	N		55	55		56	56			
Family Difficulties S7	Pearson Correl.		-0,114	0,664**		0,017	0,661**			1
	Sig.		0,515	0		0,922	0			
	N		35	35		34	34			35
Family Strengths S7	Pearson Correl.		0,340*	0,388*		0,349*	0,296		1	0,258
	Sig.		0,046	0,021		0,043	0,09			0,134
	N		35	35		34	34		35	35
CS1General	Pearson Correl.	1	0,742**	0,894**		0,557**	0,590**		0,545**	0,606**
	Sig.		0	0		0	0		0,001	0
	N	135	134	129		56	55		35	35
CS4General	Pearson Correl.	0,792**	0,448**	0,671**	1	0,632**	0,870**		0,448**	0,633**
	Sig.	0	0,001	0		0	0		0,008	0
	N	56	56	55	57	57	56		34	34
CS7General	Pearson Correl.	0,741**	0,035	0,697**	0,741**	0,107	0,732**	1	0,552**	0,900**
	Sig.	0	0,841	0	0	0,547	0		0,001	0
	N	35	35	35	34	34	34	35	35	35

**. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).

throughout the process. Finally, in relation to the usefulness of the therapy means of 3.46, 3.62 and 3.86.

Table 5

Descriptive Statistics of SCORE's four individual questions SCORE

	N	Minimum	Maximum	Mean	Std. Deviation
CS1_SCORE_Problem Severity	128	0	10	5,83	2,482
CS1_SCORE_Family Organization	129	0	9	4,40	2,548
CS1_SCORE_Impact	130	0	10	6,24	2,658
CS1_SCORE_Therapy Usefulness	120	0	10	3,46	2,741
CS4_SCORE_Problem Severity	57	0	10	5,82	2,414
CS4_SCORE_Family Organization	56	0	10	4,64	2,489
CS4_SCORE_Impact	56	0	10	5,62	2,625
CS4_SCORE_Therapy Usefulness	55	0	10	3,62	2,642
CS7_SCORE_Problem Severity	35	0	10	5,26	2,477
CS7_SCORE_Family Organization	35	0	10	4,37	2,414
CS7_SCORE_Impact	35	0	10	5,74	2,43
CS7_SCORE_Therapy Usefulness	35	0	10	3,86	2,881
Valid N (listwise)	29				

It is important to mention that despite the values being homogenous throughout the process, except in regards to the problem impact which appeared to decrease a bit through time, the number of clients answering the questionnaire during the process was drastically decreased. This made it not possible for us to understand the significance of the relationship between the different results throughout the process.

Mean comparison (ANOVA)

Despite the reduction in sample size throughout the therapeutic process, and since families were the same, it was possible to conduct mean comparisons for the two factors through the ANOVA statistical method for repeated measures (Coolican, 2009).

Considering the Family Difficulties factor the results of the F-statistic from a repeated measures ANOVA were 1,089 (p = 0.301), which led us to accept the null hypothesis, in other words, there were no significant differences between the perception of family difficulties at the beginning of the therapeutic process and the perception of the difficulties after four therapy sessions.

Regarding Family Strengths the results of the F-statistic from a repeated measures ANOVA were 5.653 (p = 0.021), which showed that there were significant differences between the two assessed stages of therapy. After adjusting for multiple testing with the Bonferroni correction there was still a significant difference of -0.167 (p = 0.070) between both stages' means. This negative effect showed that the value of the mean found for the family strengths in the middle of the process was higher than the mean of the perceptions at the beginning of the process. Thus, we concluded that there was an increase in the perception that clients had about family strengths during the first four sessions.

These results pointed to an important role of therapy in the way clients perceived themselves. However, it must be stress that it would have been benefitial to continue with the evaluation throughout the process, so an understanding could be reached regarding whether the improvement in the perception of strengths was something that

was maintained, as well as understanding what happened to the perception of the family difficulties as these changes occurred.

Discussion

With this study we have demonstrated a relationship between the family strengths and family difficulties factors and the global perception of family functioning. Furthermore we provided an understanding to the kind of relationships established both between components as well as at the process level, by mean comparison analyses regarding the two first assessing stages.

From the relationship found between the components and the instrument in its overall performance, we concluded that the family difficulties were a component that throughout the process was positively correlated with all the stages of therapy. In turn family strengths, at the beginning and middle of the process, was only related with the global evaluation at these two stages (beginning and middle), while at the end of the therapy that the perception of family strengths was positively related with the whole therapeutic process.

Thus, we conclude that throughout the therapeutic process the perception that the clients have regarding their own strengths increases, with these strengths gradually connected with the perception of a better family functioning, regardless of the fact that this positive relation was only significant in the last session, probably during a final balance of the therapy where clients communicate a better functioning with increased strength. At the same time, the perception of the difficulties increased during the process. However, these were always positively related with the global functioning, in other words, these results indicate that the more problems a family notices, the better it

functions. Associated with the positive relation with family strengths, since it is not family difficulties that decrease the perception of the family functioning but, instead, the perception of having the strengths to deal with these difficulties, this positive relationship seems to be an indicator of a better family functioning.

Regarding the Family Communication dimension, despite emerging with the difficulties in the exploratory analysis, it eventually did not emerge in a factor with significant precision, which would allow a more concrete analysis. This relationship between both dimensions, and the fact that the communication items emerge in the family difficulties may point to the fact that, in our sample, the problems brought to therapy were bound to the relationships between family members and, consequently, the communication between them.

In terms of the final four questions of the questionnaire, we must point out that the perception of the existence of the problem on average through the three stages SCORE a value of 5 tending to 6, although at the end of finishing the process achieved a more concrete mean of SCORE of 5. In respect to the family organization, it maintained the mean of 4 throughout the whole process. The impact of the problem on the life of different family members was evaluated during the process with a 6, an indication that it was present and real. A slightly lower value of 5,74 at the final stage of the process may point to a decrease in the perception of the negative impact that the problem had in their families. As for the usefulness of therapy, the values were consistently 3, which are close to great usefulness throughout the three assessing stages.

Concerning the mean comparison conducted between the first and the second assessing stages, we recognize that during the first four therapeutic sessions the

improvement of their perception about their family strengths was clear, although there were no significant differences in the perception that clients had about their family difficulties. So, we can accept that the therapeutic process contributes to the improvement of family strengths.

Thus, we can conclude that clients throughout the process notice they have a better functioning. While the clients may experience an increase in difficulties, the existence and severity of their problems, they feel more capable to deal with them, leading to a perception of therapy as useful.

These results raise many interesting questions that need to be investigated before we understand what happens in the rest of the therapeutic process. Specially, in what concerns the family difficulties component and the way it is influenced or not by the improvement of the strengths during therapy.

Limitations and conclusions

This study contains certain limitations, specifically concerning the collected samples, which were affected by a high number of dropouts and non-concluded processes throughout the investigation. Thus, the reduction of the sample was drastic, which precluded us from conducting a more thorough study.

It is also relevant to point out that the clinical sample was gathered from a population with a significantly low level of education, which may have an effect on d the understanding and interpretation of the items by the clients and compromised the answer to the questionnaire. The fact that, in Portugal, this instrument has only been

submitted to selected preliminary studies and with a non-clinical population, leads us to the thought of this aspect is possibly an important element to take into account in further revisions of this instrument.

To conclude, it must be highlighted that the results of this study point to a strong perception by the clients, regarding their family functioning throughout the entire therapeutic process. As well as noticing the changes in the terms of the evaluation made about the severity and the impact that the problem has in their lives and regarding the usefulness of the therapy. Thus, and clients' feedback being a crucial information in the assessment of the therapeutic process, is important to perform more studies with this instrument in the future, so it may be validated for Portugal. Comparisons may be made between the different factors obtained: strengths, difficulties and communication, and the global evaluation of the functioning perceived by the family, in order to give significance to the strong relations found in this study.

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The Pro-CIV Project is a research project that aims to assess the family therapy processes at three different stages (first session, in the middle, and at the end of the process), through an application protocol for both clients and therapists. In this protocol several dimensions are assessed: family functioning, therapeutic alliance, family communication, and coping strategies used by the families. The sample of family

therapy cases has changed through time, i.e., the cases sent by court and commissions are increasingly recurrent, ending up transforming clients that are in therapy in a non-voluntary population. This project collected data from two types of population: voluntary and non-voluntary, so it is possible to compare the differences and similarities between both types of the process, in order to improve and enhance successful therapeutic interventions.

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CONCLUSION / DISCUSSION

After the conducted studies it is possible to highlight some aspects and view the client-therapist relationship and the actual therapeutic process with a more integrative look. Thus, and considering the two crucial elements for the therapeutic process – therapeutic alliance and client feedback –, we will look at the results and their implications in regards to therapy.

Starting with the therapeutic alliance in light of the therapists' perception, we realize that they perceive the therapeutic alliance globally as positive, and that the factors pointed out in the literature as important to the perception of the alliance, engagement, safety and shared purpose, are all intertwined. The results show that relations are found between the alliance factors and the alliance in its global, practically in all stages of the therapy. Reflecting upon the average evaluation made by therapists, it should be noted that throughout the therapeutic process there is a clear evolution of the factors safety and shared purpose. In its turn the engagement, although it also evolves during the therapeutic process, does not show such a visible evolution; and its higher evaluation is found precisely in the first stage of the therapeutic process. In other words, therapists perceive a high engagement by the clients in the first session of the therapy and, during the process, the shared purpose between the several elements and the safety increases greatly.

These results highlight the importance of the way the client may feel in therapy, in regards to safety, in order to feel the will to share, to open up, to be in a relationship with the family, in order to work the problems presented during the whole process. Not only safety but the notion of family as a client in this process is highlighted in the therapists' perception.

These results meet the cares Friedlander (2009) referred when defining the extended therapeutic alliance in a couple and family therapy model, where the client isn't only an individual, where interactions between therapist and client, between each client, and between the family and the therapist are important. It also seems to show that, although we are facing a whole with several parties, when in therapy this whole stands out more than the individual parties.

Thus, the therapeutic process seems to intend to create a safe place that promotes the engagement of everyone, since it is the trust and safety in that place and in the therapist who will allow clients to take interpersonal chances, face harsh realities and draw a new path (Friedlander, Escudero, & Heatherington, 2006).

By obtaining the therapists' perception about the therapeutic alliance and considering the importance of the client's feedback regarding the alliance in order for the therapist to improve and boost the therapy's conditions, we looked at the informal feedback, verbalizations, and non-verbal behaviors form clients and therapists during the assessed therapeutic sessions.

Despite being a qualitative study and therefore more limited in terms of the sample, we realized that the positive evaluations of the therapists are inferior to the clients', and even though clients positively evaluate the therapeutic alliance, the way they manifest said alliance is quite shy.

The client's cooperation in psychotherapy is essential, with the client being an active part of treatment, and for that it must first engage in the therapeutic process (Friedlander et al., 2006). Through the gathered data, in informal terms, we conclude that few engagement characterizing elements are identified, with the main one being the introduction of problems during the session. This finding, and despite observing that

therapists make a positive evaluation of the engagement, allows us to ponder about which are the indicators of engagement for the therapist, assuming that the shared sense of purpose displays a role in indicating the engagement in the therapeutic process.

Despite not being possible to evaluate the emotional connection at a quantitative level, we cannot help but reflect upon two aspects which stand out in informal terms: the refusal to participate in the process, and the humor as pointers for emotional connection. Humor is a very important instrument in therapy, since it allows easing and putting to the test the reality that is brought up during the therapeutic process (Pittman, 1987). Through the analyzed cases, and despite the utility of this tool, therapists seldom use it, even when faced with complex situations and great emotional load.

In regard to safety, and even though the therapists' perception about safety is positive and strong throughout the process, the informal results leave us with not enough bases to support this result inasmuch as the manifestations of behaviors and verbalizations regarding this factor are quite scarce, leaving an apparent idea that therapists would not be very committed to fomenting safety during sessions. In other words, the fact that very few behaviors and interactions that may potentiate safety in the therapeutic system were identified makes us question the way therapists dedicate themselves to feeding this dimension, essential for change and evolution of the therapeutic processes. Anyhow, it seems important that a safe and trustworthy space is increasingly promoted by the therapists, in a more explicit way, allowing clients to feel more available to share their privacy both with the family members and with the therapist, in order to learn how to better address the problems.

The shared purpose, just as we observed regarding safety, in informal terms is seldom identified. However, it is evaluated as central and important throughout the entire process, as well as the therapists' perception regarding its existence is quite clear.

These apparent discrepancies between formal perceptions and verbal and non-verbal behaviors (informal aspects) regarding the alliance, points to the possibility of evaluating the perception throughout the process, and returning it to the clients during the therapeutic process, in order to clarify the inconsistencies, understand the differences and, most importantly, be able to improve the safety context, promoting a higher engagement, connection, and shared purpose between family members.

If the clients' feedback regarding the therapeutic alliance is so important and, seemingly, so sparse, it is essential to understand how does the feedback materializes in relation to the therapeutic process.

The results in this study, where clients' feedback is formally and informally assessed, reveal that the focus of therapy varies between the clients' perception of their own problems and the way their perceive changes.

The therapist's role becomes even clearer, since in its majority the clients' feedback arises from the direct therapist questioning, in a first stage of the therapy. As the trust is established and the therapeutic alliance formed, clients tend to be more spontaneous in their verbalizations.

If, on one hand, it is the clients' feedback that becomes a crucial part in understanding and following the family throughout the sessions, it is the way therapists question and return the rationale, so it increases the range of responses, creating a more flexible thought which allows the integration of the information in different and more

adaptive manner (Fischer, Jone, & Atkinson, 1998; Frank & Frank, 1993; Miller, Hubble & Duncan, 1995; Sprenkle, Davis & Lebow, 2009).

Just as we previously observed, the fact that the family is composed by several elements turns the role of the therapist an even more sensitive one, since it needs to arrange several subsystems, giving them an active voice and maintaining the balance between every part, regarding the participation and engagement in the therapy. The results indicate some difficulty in keeping this balance, sometimes being more complicated for the therapist to give voice to the filial subsystem. Especially when it is considered by the parents as the focus of the problem that led to therapy is their sons and daughters.

In terms of leading the therapeutic process, we concluded that therapists follow an intervention model that is more centered in the solution, since the work that is done points to a search of the clients' *feedback* regarding the problems brought and the changes that may be associated. Aspects such as causes, impact, and the maintenance of the problem are, apparently, in its majority less worked.

Although this model makes sense, considering the theory focused on solutions, it seems important to integrate the information in a broader spectrum, so it may increase the understanding of the function and the maintenance of the problem, in order to raise consciousness of the circular causality inherent to these processes, thus allowing more consistent changes through time. This way, it is fundamental to reflect with family members about the mechanisms that maintain that problem and which interactions are more complex, so that all elements may find more effective solutions together, as well as more structural changes, regarding relationships and family functioning. Besides, and always considering the basis of the therapeutic alliance and the feedback given,

promoting a reassuring environment will allow a bigger openness of all family members, as well as a more spontaneous family feedback.

Comparing the formal and informal feedback about the problems, their severity and therapy usefulness, it must be stressed that there is enough agreement between the verbalizations about the problem and the evaluation made about its existence. However, the more silent elements of the process – usually adolescents – make a more negative formal evaluation of the situation than that which they imply during sessions. Through this perspective, it is considered that if therapists have access to the formal feedback data given by children and adolescents, they could seek to explore and engage, in different manners, the clients' perspectives, thus increasing the client's contribution to the family therapy process. Nevertheless, and despite there always existing problems and being serious, clients consider therapy useful, which indicates that a well-established therapeutic alliance allows clients to feel safe and confident in a space that gives them the possibility to approach their problems and acquire strengths. This makes therapy quite useful, despite problems apparently keep arising.

It seems also relevant to formally and informally evaluate the clients' feedback regarding the therapeutic process, inasmuch as therapists collect valuable information which allows them to lead their intervention and render the clients, turning these differences in aspects to work in the therapy, which may increase the family's strengths, as well as ease the solution of the problems.

Finally, and already having a clear view of clients' feedback, the role of the therapist and the therapeutic alliance throughout the sessions, the only thing left is to assess the perception that clients have regarding their family functioning - family

strengths and difficulties, throughout therapy, i.e., understanding how therapy promotes strengths and decreases difficulties.

A first interesting result to discuss is related to the type of answers that emerge from the difficulties factor, which unlike what happens in the revised literature regarding the SCORE-29 instrument (Fay et al., 2013), in this study the family difficulties and communication appear together. This leads us to think that in relation to our sample, the difficulties felt by the family members are related to the communication ability between the elements, in other words, they are, apparently, relationship based.

Furthermore, the results indicated other interesting conclusions. Throughout the process, the perception that clients have regarding their strengths increases, and this perception relates to the perception of a better family functioning. On the other hand, the family difficulties perception also increases, which may be related to a higher family and problem awareness.

Curiously, family difficulties positively relate to the increase of the strengths' perception and with the increase of a better family functioning's perception. This aspect may at first sight seem incoherent since difficulties aren't supposed to be a sign of a better family functioning, but when looking at the relation between the three components we observe that, as the family perceives itself as having strengths to deal with the difficulties, even if they keep increasing, the family sees itself with a better family functioning.

On the other hand, the results regarding the evaluation made about the existence and the severity of the problems are high, as well as the evaluation regarding therapy usefulness. This relation indicates that clients, throughout therapy, view themselves as functioning better since, even though they experience an increase of their difficulties

and they perceive the presence of problems and their severity, they feel more able to manage and deal with them, leading to a perception of the therapy as useful.

Thus, we conclude that in order for therapy to be seen as useful to the clients, it is up to the therapists to promote safe and trustworthy contexts, where good therapeutic alliances are established with clients. This therapeutic context with a safe and strong alliance, allows clients to perceive the therapy as the primordial space where they can expose their difficulties and problems, without fear or insecurities, and where, along with the therapist, they may explore their theories regarding problems and change, in order to improve their strengths as a family, gaining more strategies to deal with their difficulties, and thus experiencing a better functioning as a family.

These results also lead to a reflection upon the training of family therapists, to the extent that, on one hand, having a higher conscience of the therapeutic alliance dimensions, of the way they engage with each other, and of the importance that clients give to safety and shared sense of purpose, gives the therapists the chance to prepare for these components in a more careful way and to enhance them. On the other hand, by being aware of the differences between formal and informal feedback, and the richness of the information, allows new therapists to be aware of other indicators and regularly promote this type of information gathering, regarding the therapeutic process.

LIMITATIONS

This study presents some limitations, especially regarding the collected sample, since the gathered number of processes was low, and the number of therapists is quite sparse and, at the same time, the high number of dropouts and unconcluded processes throughout the research reduced these numbers even further, during the three considered

stages. The reduction of the sample is drastic which leads to some care when interpreting the results found, as well as it leaves an open door to future studies.

The cutback in the sample throughout the sessions makes it impossible to conduct a longitudinal evaluation, being only possible to comprehend, in terms of significant relations, the evolution of the processes from the first to the fourth session.

Another important aspect is the validation of the scales for a clinical sample. Being validated still and since this study is another contribute for its validation, we realize that in terms of the clients, the scale did not allow the emersion of the expected factors, considering the revised literature, which precluded the use of this data. Comparisons and relations between the results of the perception of the therapeutic alliance, in a formal level, between clients and therapists, would have been a very important data for our results. This way, more studies with this instrument are needed: try to understand the relationship, differences and similarities, between therapists' and the clients' perception of the process and the therapeutic alliance; a longitudinal view of the therapeutic processes in light of the evaluation carried out by therapists and clients appears to be a surplus in comprehending relations and processes that occur during therapy; and promote studies where in one of the samples the feedback is given to therapists and they may use this information during sessions, and try to compare with processes where this does not happen, which may allow to see if there are any difference in the evolution of therapy. These studies will enable the growth of the range of knowledge regarding the therapeutic alliance in light of both perspectives (clients and therapists), so it may improve therapeutic relationships and enhance the therapists' success.

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APPENDIX

Table 1

Examples form Feedback Categories regarding Therapeutic Alliance

Category	Type of response	Examples: SOFTA-O / CAF
Engagement in the Process	ADQ	SOFTA-O item: indicate agreement with the therapist's goals. CAF: "...I think there is a problem on her part...", Father, Case 5
	SR	SOFTA-O item: introduces a problem to be discussed. CAF: "because when I'm not there ...", Mother, Case 1
	SR	SOFTA-O item: expressed optimism or indicates that there was a positive change. CAF: "Very.. yes .. All the will of him .. He's very happy ... "
	ADQ	SOFTA-O item: mentions the treatment. CAF: ".. And evaluating your help .. in the case of Peter in the positive direction .. ..", Father, Case 1
	ADQ	SOFTA-O item: introduces a problem to be discussed CAF: "I think there is a willingness to communicate but sometimes, there are things that stumbled on our way and prevent us ..", Mother, Case 4
Emotional Connection with the therapist	SR	SOFTA-O item: share a lighthearted moment or joke with the therapist. CAF: Daughter 1 embraces the therapist crying, Case 3
	SR	SOFTA-O item: share between them a joke or a funny moment CAF: "Looking back gives us will, some laugh ..", Father and Son 1, Case 4
	ADQ	SOFTA-O item: is reluctant or refuses to respond to the therapist CAF: ".. My face says what I'm feeling .. then do not say anything ...", Daughter 1, Case 4
	ADQ	SOFTA-O item: interacts with hostile or sarcastic therapist CAF: ".. If he threatened to kill me three times ... what do you think might happen?" – in an aggressive way, Mother, Case 2
	ADQ	SOFTA-O item: avoids eye contact with the therapist CAF: lower face and stays in silent, Son, Case 1
Shared Sense of Purpose within The Family	SR	SOFTA-O item: ask each other for their perspective. CAF: "we all agreed", Mother, Case 4
	SR	SOFTA-O item: validate each other's points of view CAF: ".. So always been so ...", Mother and Father, Case 1
	ADQ	SOFTA-O item: Reflected in the mirror of each body postures CAF: Have precisely the same body position, arms crossed, Son and Daughter, Case 1

Safety Within the Therapeutic System	ADQ	SOFTA-O item: vary his/her emotional tone during the session. CAF: “this is a privileged space that we have...it forces some refrain in the others and the dialogue...” Father, Case 4
	ADQ	SOFTA-O item: "open" their intimacy CAF: ".. Ready agent walks constantly and always gets to a point that also discourages ..", Mother, Case 1
	SR	SOFTA-O item: encourage other family members to open up and tell the truth CAF: ".. So tell the truth", Mother, Case 2
	ADQ	SOFTA-O item: states or indicates that therapy is a safe place, a place where he trusts CAF: ".. This is a privileged space that we have to say so .. because space requires some restraint in others and in dialogue ..”, Father, Case 4
	ADQ	SOFTA-O item: encourage other family members to open up and tell the truth CAF: "Does it have to be the mother to talk?" "I think it was interesting each give their perspective", Mother Case 4
Therapy usefulness	ADQ	SOFTA-S item 1. What happens in therapy can solve our problems. CAF: “good thing it is as a family because that way we all speak…and everything is better…” Father, Case 5
	SR	SOFTA-S item 1. What happens in therapy can solve our problems. CAF: "is the father .. is less controlled than when it was time sessions...", Mother, Case 5

Note: Examples of SOFTA-O – one of the corresponding items; Example of the Content Analysis of Feedback (CAF) – an example of the session’s transcription.

Type of response refers to the way that the quotes happened: ADQ – Answer a direct question from therapist; SR – Spontaneous reflection

Table 2

Examples from categories regarding the Content Analysis of Feedback (CAF) of the sessions

Category	Response	Examples - CAF
Problem	ADQ	"...Always had that tendency to go mess…evolve to more complicated cases", Mother, Case 1
	ADQ	"... I realize that this aggression was the conversation that his father had with me ..", Mother, Case 2
	SR	"..I'm tired of being in a place where she enjoys with my face, I try to talk and she's always interrupts..", Daughter 1, Case 3
	SR	"… begin to compare myself to other people and I do not like it, because I'm different ..", Daughter 1, Case 4
	ADQ	".. I think the difficulty the greater the level of communication is with Michel ..", Mother, Case 5
Causes	ADQ	"...you can clearly tell that she's not capable...", Mother, Case 1
	ADQ	".. I feel he has that anger because he wanted and I perhaps for me alone, let up, but I can't ever forget ...", Mother, Case 2
	ADQ	"Sometimes I can also come from school upset .. the day did not go so well, or be a bad day .. and ready .. this conditions ..", Daughter 1, Case 4
	SR	".. It's what I always say .. you sometimes have conflicts because of it .. sometimes towards kids ..", Mother, Case 5
	ADQ	".. Because she thinks these crises and this lack of interest may come from ... I spend too much time out ..", Father, Case 5
Impact	SR	"...full of fear, terrified..", Mother, Case 2
	ADQ	"we are all very upset with these arguments..." Father, Case 4
	SR	".. And when I'm going to blow me away from home .. and that's what happened this week-end, I took the kids and left home ..", Mother, Case 5
	SR	".. Sometimes I just want to be alone .. shut me .. or else go somewhere where there is no one (starts to cry) ..", Daughter 1, Case 3
	ADQ	".. I go for the head and be filled with me crying.. I can't eat because I do not know if they are eating .. even if you are sleeping well ..", Mother, Case 2
Maintenance	ADQ	"...so tires that sometimes I don't even have patience to listen to them...", Mother, Case 5
	ADQ	".. No .. because I am very proud and ...", Son 1, Case 2
	SR	".. The more we forbid is the worst thing you can do", Daughter 1, Case 3
	ADQ	".. So tired that I sometimes do not have patience to listen to them .." Mother, Case 5
	ADQ	".. From the moment she can't hear me when I need to vent over ..", Daughter 1, Case 3
Change	ADQ	"...we settled some things, I think that there has been opening...", Mother, Case 4
	SR	".. Look he was okay .. not too much trust in people and I understand more I understand it too ..", Daughter 1, Case 3
	SR	".. The situation is a little better ..", Mother, Case 2
	ADQ	" .. Yes yes .. He has given the negative influences ", Mother, Case 1
	ADQ	".. Yes .. what one finds is that has fallen .. it's true ..", Son 1, Case 4

Note: Example of the Content Analysis of Feedback (CAF) – an example of the session's transcription;

Response – types of response refers to the way that the quotes happened: ADQ – Answer a direct question from therapist; SR – Spontaneous reflection