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A CASE STUDY OF ONLINE FAMILY THERAPY: HOW CLIENTS AND THERAPISTS PERCEIVE THE THERAPEUTIC ALLIANCE?

Dissertação no âmbito do Mestrado Integrado em Psicologia Clínica e da Saúde, Subárea de Especialização em Psicoterapia Sistémica e Familiar orientada pela Professora Doutora Luciana Sotero e apresentada à Faculdade de Psicologia e de Ciências da Educação.

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Estudo de caso de terapia familiar *online*: Como é que os clientes e os terapeutas percecionam a aliança terapêutica?

Resumo: Embora persistam na literatura dúvidas relativas à eficácia da terapia *online*, a COVID-19 implicou um incremento na prestação de serviços de saúde mental de forma não presencial. Em particular na terapia familiar e de casal, os terapeutas têm geralmente uma postura de reserva quanto à adequação da terapia *online*, sobretudo no que se refere ao estabelecimento da aliança terapêutica à distância. O objetivo deste estudo de caso de uma terapia familiar *online* é avaliar a aliança terapêutica, com base nas perspetivas de clientes e terapeutas, nas primeiras quatro sessões *online* do processo. Trata-se de uma família composta pela mãe (36 anos), pelo pai (38 anos) e pelos dois filhos (filho com 12 anos; filha com 10 anos), acompanhados por uma equipa constituída por duas coterapeutas e uma terapeuta observadora, todas mulheres, com idades entre os 22 e os 43 anos. A aliança terapêutica foi avaliada no final das primeiras quatro sessões através da aplicação *online* de um *self-report*, o *System for Observing Family Therapy Alliances- Revised* (SOFTA-sR), versão clientes e versão terapeutas. Os dados foram analisados ao nível: a) da comparação entre clientes e terapeutas sobre as dimensões da aliança terapêutica (envolvimento, conexão emocional, segurança e sentimento de partilha de objetivos); b) da evolução das pontuações globais da aliança terapêutica de acordo com a perceção de clientes e terapeutas. Os resultados revelaram que é possível o estabelecimento da aliança terapêutica na terapia familiar *online* e também que esta é percebida tendencialmente de forma mais favorável pelos terapeutas. Assim, com o presente estudo foi possível verificar no contexto de uma terapia familiar *online* que a aliança terapêutica pode ser estabelecida, tanto na perspetiva de clientes como de terapeutas, embora se detetem diferenças entre ambos já verificadas nas terapias conjuntas presenciais.

Palavras-chave: terapia familiar *online*; aliança terapêutica; estudo de caso; SOFTA-sR; clientes; terapeutas

A case study of online family therapy: How clients and therapists perceive the therapeutic alliance?

Abstract: Although doubts persist in the literature regarding the effectiveness of online therapy, COVID-19 has meant an increase in the provision of mental health services in a non-face-to-face manner. In family and couple therapy in particular, therapists generally have reservations about the appropriateness of online therapy, particularly with regard to establishing the therapeutic alliance at a distance. The purpose of this case study of online family therapy is to evaluate the therapeutic alliance, based on the perspectives of clients and therapists, in the first four online sessions of the process. This is a family consisting of the mother (36 years old), the father (38 years old) and two children (son 12 years old; daughter 10 years old), accompanied by a team consisting of two co-therapists and an observing therapist, all women, aged between 22 and 43 years old. The therapeutic alliance was evaluated at the end of the first four sessions through the online application of a self-report, the System for Observing Family Therapy Alliances- Revised (SOFTA-sR), client version and therapist version. Data were analyzed in terms of: a) the comparison between clients and therapists on the dimensions of the therapeutic alliance (involvement, emotional connection, safety and feeling of shared goals); b) the evolution of the global scores of the therapeutic alliance according to the perception of clients and therapists. The results revealed that it is possible to establish the therapeutic alliance in online family therapy and also that this is perceived more favorably by therapists. Thus, with the present study, it was possible to verify that, in the context of online family therapy, the therapeutic alliance can be established, both from the clients' and therapists' perspectives, although differences between them were already observed in face-to-face therapy.

Keywords: online family therapy; therapeutic alliance; case study; SOFTA-sR; clients; therapists

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Introduction

The Covid-19 pandemic caused an impact all over the world, and Portugal was no exception. In March 2020, the Portuguese government decreed the first state of emergency, which imposed the exercise of professional functions at home and implemented restrictions on movement on public roads (Diário da República Electrónico [DRE], 2020). The emergence of Covid -19 has caused drastic changes in the way we live and work worldwide. Our routines have changed, the home has become our workplace, and most social connections have been disrupted, which has increased stress in families (Danker et al., 2020; Primer et al., 2020; Usher et al., 2020).

The psychotherapy practice also has been severely affected, leading mental health professionals to adapt to this new reality. With the impossibility of continuing with face-to-face consultations, there was an increase in online consultations, which is already considered by many authors the new way of working in mental health (e.g., Levy et al., 2021; Mc Kenny et al., 2021). Over the years, technologies have been changing the way we communicate, facilitating contact between people in the same geographical space. The same is true in online psychotherapy, as contact can be established between therapists and clients without being in the same physical space (Hertlein et al., 2014). During the actual pandemic crisis, online therapy was a way to realize psychotherapy, allowing the therapist-client relationship to be not too broken (Humer et al., 2020; Shadbolt, 2020). Although the online practice was already used in individual therapies, where the results in terms of effectiveness are mainly positive, the same cannot yet be inferred about conjoint therapies, where the research is so far done is very scarce and not conclusive (De Boer et al., 2021)

Several studies have currently been developed to understand if it is possible to build a therapeutic alliance in online therapies, similar to face-to-face therapies (Kysely et al., 2020). So far, these studies have been developed in individual therapy and revealed contradictory results. Some report differences between the alliance that is built-in online and face-to-face therapies, reporting a decrease in patients' perception of the therapeutic alliance in the context of online psychotherapy (Farabee et al., 2016). Others show no differences between these two types of therapy concerning the alliance, with results showing that the therapeutic alliance between clients and

therapists was the same in both technology-mediated and non-technology-mediated therapy sessions (Wrzesien et al., 2013).

According to Bordin (1979), the alliance defines the strength and quality of the relationship between client and therapist. From his perspective, the concept encompasses three dimensions: (1) agreement on the goals of therapy between client and therapist; (2) agreement on the tasks necessary to achieve them; and (3) positive affective bonding between therapist and client. According to Escudero and Friedlander (2018), the therapeutic alliance is an essential variable for successful psychotherapy across all intervention modalities. In family and couple therapy, Pinsof and Catheral (1986) added to the therapeutic alliance dimensions pointed by Bordin (1979) the intra-system alliance, which refers to the alliances within the family itself, between the various elements and subsystems, as well as alliances within the therapeutic team. Although the therapeutic alliance is a central variable that should be worked on throughout the therapeutic process to obtain good results in therapy (Kramer et al., 2009), little is known about the online co-construction of the therapeutic alliance. So, the present study aims to explore the establishment of the therapeutic alliance in a case of online family therapy considering the clients' and therapists' perspectives.

I – Theoretical framework

1.1. Online therapy: Advantages and limitations

As stated, Covid 19 affected the practice of psychotherapy and prompted changes such as professionals opting for online consultations, thus ensuring case follow-up, which allowed them to maintain contact with their clients during social distancing and confinement (Humer et al., 2020; Shadbolt et al., 2020)

Online practices are divided into asynchronous and synchronous, with the latter encompassing videoconferencing, a technique that most closely resembles face-to-face psychotherapy (Shah, 2016). According to Shah (2016), videoconferencing is the best way to conduct online therapy. It allows both the psychotherapist and the client to share visual and auditory cues, enabling a two-way conversation accompanied by a video.

One of the advantages of online consultations concerns the accessibility of these services, as all that is required is access to a computer with a wi-fi

connection (Baker & Ray, 2011; Bischoff et al., 2016). Thus, access to psychological treatments has become more homogenous. It has allowed individuals in rural areas to enjoy these same services (Alleman, 2002; Baker & Ray, 2011). In addition to ease of access, providing services through technology has a lower cost (Stoll et al., 2020).

However, some studies emphasize that the therapeutic alliance created in online therapies is inferior to the therapeutic alliance formed in face-to-face therapies (Farabee et al., 2016). In addition to this drawback, there are other limitations associated with online psychotherapy, namely security and confidentiality issues (Stoll et al., 2020). Clients are often in their homes at the time of therapy, so it can be challenging to find a place where the client perceives it as a safe space to participate in psychotherapy sessions quietly. According to some authors, this is the main barrier to implementing this type of intervention (e.g., Boldrini et al., 2020). Also, the lack of physical interaction between therapists and clients is one of the significant difficulties associated with the online intervention, which can have negative consequences on the therapeutic process (Kysely et al., 2020).

Moreover, given the impossibility of sharing the same physical space, it is challenging to detect non-verbal cues in this context, leading to miscommunication and misunderstandings between both parties (Bender & Dykeman, 2016). Technical issues such as delays and distorted speech due to internet instability make communication ineffective (Hellman & Rolnick, 2019). However, Bouchard et al. (2007) show that in addition to empathy, warmth, understanding, and technique, clients can have a sense of presence that transcends distance that helps them forget that they are not physically with their therapist. Furthermore, it can be challenging to assess clients in crisis and high-risk situations (Stoll et al., 2020).

Regarding online psychotherapy, it is also essential to emphasize the training of therapists, who must have clinical skills and knowledge to enable digital devices to ensure the quality of sessions in a therapeutic process (Tullio et al., 2020). Thus, these professionals must develop therapeutic skills, adapt their practice to the online context, be creative, express interest, involvement, and interact with clients through the webcam (Mc Kenny et al., 2021).

Despite the rapid evolution and growth in online therapy, further research into this "new way" of delivering mental health services is needed in light of

the pandemic context. Based on the literature review, it was possible to list some advantages and limitations of online therapy, which leaves some unanswered questions.

1.2. Online family therapy: What we know and what we don't?

In recent years online therapy has made great strides and is considered adequate, particularly in the individual modality (Pomini, 2021). Regarding family therapy, it is scarce the studies on the effectiveness of online treatment (Borcsa & Pomini, 2017). Many family therapists are very reluctant to use technologies as a way to contact families, as they believe it will harm the therapeutic relationship (Hertlein et al., 2014). According to the literature, many challenges have been suggested for online practice with families (Wrape and McGinn, 2018; Levy et al., 2021) since this modality of therapy presents multiple people, multiple relationships, which requires more excellent articulation, which forces therapists to be more straightforward and more precise

Conjoint therapies (family, couple or group therapies) are a complex system of shared manifestations (Pinsof, 1994), which have some associated risks (Escudero, 2009). In online family therapy managing, multiple patients can be a considerable challenge, as special attention must be paid to each individual's lighting, sound, and eye contact (Wrape & McGinn, 2018). In fact, within online therapy, it is essential to emphasize the importance of adapting and making intervention practices more flexible, such as eye contact and directing specific questions to each of the individuals (circular questioning), providing the participation of all family members (Borcsa & Pomini, 2018; Springer et al., 2020).

Another well-known challenge in family therapy is the difficulty of (re)conciling the different schedules of each family member so that all family members are present in the session. Thus, online family therapy emerges as a viable option to this adversity that allows a better use and management of time (Hertlein et al., 2019).

In summing, it is important to stress that as far as it was possible to verify, there is a lack of research on alliance in online family therapy, so it becomes increasingly imperative to study the therapeutic alliance in this context,

seeking to evaluate the relationship between clients and therapists, analyzing both the clients' and therapists' perspectives.

1.3. Therapeutic alliance in family therapy: What distinguishes it? And how can it be measure?

The alliance is the essential foundation for any therapy (Hovarth & Bedi, 2002). Without a collaborative relationship between clients and therapists in an empathic connection, motivating the family to change their beliefs and behaviours, the therapeutic process becomes very challenging (Moran & Diamond, 2008). In conjoint therapies, some risks are associated with establishing the therapeutic alliance (Friedlander et al., 2012, 2018; Escudero, 2009).

Several authors highlight the particularities of establishing and maintaining the therapeutic alliance with families, stating that the challenges include (1) the development of multiple alliances with different family members, (2) the feelings that family members have about the therapy and the therapist, (3) the family as a group working together in therapy, (4) the safety felt by each member to openly express their feelings (Escudero & Friedlander, 2018; Friedlander et al., 2006, 2012). In family therapy, it is essential to note the concept of intra-system alliance developed by Pinsof (1994) and the Shared Sense of Purpose developed by Friedlander et al. (2006). According to Pinsof (1994), the first author to describe the reciprocal causality of alliance in family intervention, the intra-system alliance is more than the result of the sum of individual alliances. In family therapy, all clients observe the interaction of others with the therapist. This means that the therapist's alliance with each individual affects and is affected by the alliance they establish with everyone else in the family (Pinsof, 1994). During the session, each client closely observes how the other family members talk and interact with the therapist, determining the success or failure of working together. In this regard, several studies have shown that the family is the most influential unit in terms of motivation for change (Pinsof, 1994). Friedlander et al. (2006) posit that the Shared Sense of Purpose is associated with the fact that family members see themselves working together in therapy to improve family relationships and achieve common family goals, resulting in the sense of solidarity towards therapy ("we are in this together"), an appreciation of the

time invested with each other in therapy, which creates a felt unity within the family towards therapy. Another particularity concerning the therapeutic alliance in family therapy relates to various reasons and motivations for therapy (Friedlander et al., 2018). Each element's perspective about the need to be in family therapy or not makes establishing the alliance in this therapeutic modality a unique challenge for family therapists (Escudero, 2009). Although safety is considered essential in all therapeutic modalities, family therapy requires clients to feel safe when exploring painful issues, negotiating conflicts, and taking risks with other family members and is considered by Friedlander et al. (2006a) to be a significant predictor of whether interventions with families were successful. A series of case studies with four families (Beck et al., 2006) found that the safety ratings observed by some clients changed dramatically, depending on which family members were present in the session. A study developed by Friedlander et al. (2012) also highlights the complexity in establishing alliances in family therapy, referring to the need to promote a balance when conducting family therapy with adolescents. These authors refer to the presence of a pattern of results regarding the perspective of parents and adolescent children regarding the alliance, inferring that when adolescents envision a more substantial alliance, parents tend to obtain lower levels of the alliance and vice-versa (Friedlander et al., 2012). Therefore, it is pertinent to highlight the challenging role that therapists play in establishing "good" therapeutic alliances in family therapy, namely the ability to: 1) create and maintain multiple alliances with the family and with each family member; 2) know how to manage different perspectives, opinions, and motivations towards therapy, which are often diverse; 3) ensure safety within the therapeutic system, without compromising therapy or family relationships (Escudero, 2009; Friedlander et al., 2006; Sotero et al., 2018).

The evaluation of conjoint therapy has added difficulties due to the number of people involved in the therapeutic process and the need to create several therapeutic alliances (Escudero, 2009). Thus, most empirical work has focused on the context of individual therapy. In addition, the instruments designed to evaluate the therapeutic alliance are mainly self-report measures (Beck et al., 2006). Friedlander et al. (2006b) then developed an instrument capable of assessing the strength of the therapeutic alliance during therapy sessions, the System for Observing Family Therapy Alliances (SOFTA;

Friedlander et al., 2006b). The SOFTA construct is based on a literature review, which identifies a set of client behavioural descriptors that reflect positive and negative alliances (Friedlander et al., 2006b).

In the context of conjoint therapies, SOFTA emerged based on a transtheoretical and multidimensional model of the alliance, allowing it to be assessed along four dimensions: (1) "Engagement in the therapeutic process" (E), (2) "Emotional connection with the therapist" (C), (3) "Safety within the therapeutic system" (S), and (4) "Shared Sense of Purpose" (SSP) (Friedlander et al., 2006b). The first dimension portrays collaboration in defining the goals and objectives of therapy between therapists and clients. The client feels that therapy makes sense to him or her and collaborates with the therapist. The second dimension describes the bonds established between the therapists and each client, the way each client views the therapist. The other two dimensions (S and SSP) are specific to conjoint therapy. The third dimension reflects behaviours regarding the safety felt by clients in the therapeutic system. This safety is critical for the emotional openness of each family member to occur (Beck et al., 2006). Finally, the fourth dimension refers to intra-alliance, the alliance within the family system itself. It concerns the feeling of unity in problem-solving and the collaboration of each member to improve the family relationship (Friedlander et al., 2006b). The SOFTA is a system composed of a set of tools, including the SOFTA-o (observational version), the SOFTA-s (self-response version), and also a computer software (e-SOFTA). This alliance assessment system has several potentialities: (1) the improvement of clinical practice since it constitutes a valuable tool for the training of family therapists (Friedlander et al., 2006b), (2) the assessment of the alliance during the whole therapeutic process, thus being possible to perform the comparison of the alliance at different moments of the therapeutic process, (3) it allows monitoring the possible oscillations in the construction of the alliance and relating them to the interventions of both therapists and clients (Friedlander et al., 2006b).

1.3.1. Clients' and therapists' perspectives on the therapeutic alliance: Face-to-face *versus* online therapy

Some studies have been developed in face-to-face family therapy settings to understand clients' and therapists' perspectives on the alliance throughout

the therapeutic process. A study by Escudero et al. (2008), based on assessing clients' perspectives on the therapeutic alliance in the third and sixth sessions, revealed that clients who reflected greater comfort in the third session and a strong connection with the therapist viewed the alliance more favourably in the sixth session. Friedlander et al. (2012) highlighted the complexity in establishing alliances in family therapy, referring to the need to promote a balance when conducting family therapy with adolescents. These authors mentioned the existence of a pattern of results regarding the perspective of parents and adolescent children regarding the alliance, since, in this study, it was concluded that when adolescent's perspective a more substantial alliance, parents tend to obtain lower levels of the alliance, being a same verified in a study developed by Friedlander et al. (2018). In this study, Friedlander et al. (2018) concluded that families with a strong shared sense of purpose seem to have a better chance of achieving good outcomes, as the intra-family aspect of the alliance is strengthened over time, which is also concluded in another study by Sotero et al. (2018).

Regarding the therapists' perspective on the alliance, Azevedo (2013) developed a study based on therapists' perceptions of the alliance considering the first, fourth, and seventh sessions. The results revealed that in the four dimensions that constitute the alliance, there was no evolution throughout the therapeutic process, although there was, nevertheless, a non-significant increase regarding the emotional connection and the shared sense of purpose. Another study developed by Sotero et al. (2016) aimed to compare therapists' observable behaviours for fostering the therapeutic alliance with voluntary and involuntary clients based on the first four sessions. In the first session, therapists displayed more behaviours to promote engagement and a shared sense of purpose within the family with involuntary clients than with voluntary clients. With involuntary clients, therapists used interventions for alliance-building to create a sense of unity within the family, thus helping clients identify their problems. By the fourth session, therapists tended to contribute to a shared sense of purpose equally in both groups. The results also did not reveal any differences regarding therapists' behaviours to foster safety, as they were almost non-existent in both groups. The results further reported that there was no effort on the part of the therapists to create strong connections with the clients. Finally, it should be noted that along with

engagement, the emotional connection was another dimension that scored higher on therapists during the first and fourth sessions. Finally, a study carried out by Bedi (2006) aimed to help better understand the construction of the therapeutic alliance as perceived by clients. The results showed: 1) that clients do not attach importance to collaborative efforts and do not consider them an essential aspect of alliance building. Instead, they choose to attribute most of the responsibility to the therapist. This is because clients may be so vulnerable or distressed that they sometimes see themselves, in the words of one of the study participants, as "unable to handle much responsibility; 2) the techniques and tasks used by therapists may be mostly inseparable from the therapist's alliance, as the participants saw methods in this study as being something that strongly contributes to the building of the therapist's alliance; 3) the key factors that clients perceive to be essential for alliance building may be simple and reflect therapist skills such as non-verbal gestures and empathic listening; 4) that validation, politeness, non-verbal gestures, presentation, and body language were rated as the most important categories in this study playing a central role in any model development of the client's perspective of the alliance. Thus, this study states that clients and therapists interpret the quality and strength of the alliance in different ways, with clients tending to have more positive results regarding the alliance than therapists (Horvath & Bedi, 2002; Escudero et al., 2008)

Online therapy was met with significant opposition from those who rejected the idea that people could establish a natural, computer-mediated relationship (Skinner & Zack, 2004). Research suggests that clients, in a one-to-one modality, can benefit from online therapy and develop a positive therapeutic alliance (Cook & Doyle, 2002; Reynolds et al., 2006). Despite this research, therapists tend to negatively view online therapy and the possibility of developing a positive online alliance (Rees & Stone, 2005). What the literature has shown us is that family therapists feel poorly prepared to conduct online therapy. In a study conducted in the United States with therapists, supervisors, and students of family and couple therapy, most participants felt very uncomfortable dealing with their clients exclusively online (Hertlein et al., 2014). This discomfort was explained by the perception of these professionals, who felt that online appointments interfered with the therapeutic alliance, impairing expressions of empathy and sensitivity, with

many therapists believing that online therapies are less effective when compared to face-to-face therapy (Békés & Doorn, 2020; Hennigan & Goss, 2016). Although, some studies in individual therapy suggest that the therapeutic alliance developed in an online context is similar to the alliance created in a face-to-face context (De Bitencourt Machado et al., 2016). The same could not yet be found for family therapy.

Thus, the current literature suggests little or no differences between online and face-to-face therapy regarding the therapeutic alliance in individual modalities. According to Knaevelsrud and Maercker (2006), even though the therapeutic alliance developed in online therapy may be even more substantial than the alliance formed in face-to-face therapy, this has not yet been found to be the case in online family therapy since the few studies that have been developed on this subject are not yet conclusive (Hellman & Rolnick, 2019).

II – Objectives

Considering that the therapeutic alliance is an essential component of the therapeutic process, and little is known about it in online family therapy, the present study aims to analyze the therapeutic alliance in a case of online family therapy, considering the perspective of the clients and therapists.

Thus, this case study has the following specific objectives:

i) To compare the therapeutic alliance dimensions (engagement, emotional connection, safety, and a shared sense of purpose) from the perspective of clients and therapists in the first four online therapeutic sessions (microanalysis);
ii) To analyze the evolution of therapeutic alliance global score from the perspective of clients and therapists from the first to the fourth online therapy sessions (macro analysis).

III – Methodology

In this research, which aimed to evaluate the therapeutic alliance through a case of online family therapy, a case study was conducted, a method that seeks to understand complex social phenomena (Yin, 2015). This form of qualitative methodology is used when 1) there is a small sample size; 2) during

the research, the questions asked are of the "how" and "why" type; 3) there is little control over events 4) the focus is on contemporary phenomena that are set in a real-life context (Yin, 2015).

So, this section will present the sample's characterization, the instruments included in the research protocol, and finally, a brief clarification of the research procedures.

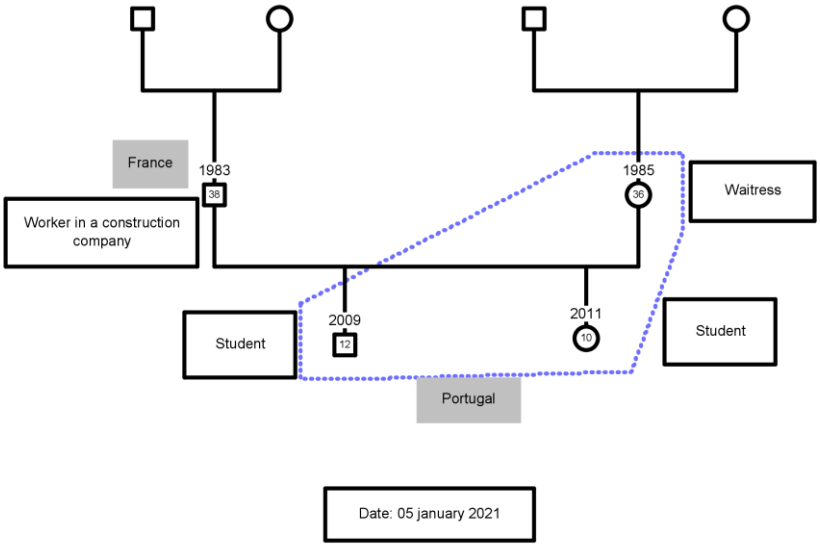
3.1. Characterization of the sample

3.1.1. Characterization of the family

The family is composed of four elements: the mother (36 years old), the son (12 years old), the daughter (10 years old), and the father (38 years old). The mother lives in a consensual union with the father and works in a coffee place as a waitress. The son is in 6th grade, and the daughter is in 4th grade. The father is an emigrant in France who comes home monthly. This family lives in a rural environment in the center of Portugal (cf., Figure 1).

Figure 1

Family genogram



3.1.2. Characterization of therapists

This case had the participation of two co-therapists and an observer therapist. Therapist1 (T1) is 22 years old, a master student in Psychology, with a specialization in Systemic Psychotherapy. Therapist2 (T2) is 43 years old, with 20 years of clinical experience, thirteen of them in family therapy, which is her area of formation. The therapist observer (OT) is 41 years old, with 18 years of clinical experience, 13 of which in family therapy. Her training area was Cognitive-Behavioral and Training in Systemic Therapy by the Portuguese Society for Family Therapy (SPTF).

3.2. Therapeutic process conditions

This case date from January 2021, after a referral from the *Gabinete de Apoio ao Aluno* (GAA), from the oldest son's school, to the *Espaço Mudança* (EM). In a preliminary contact, the family's difficulties were identified by the GAA technician, which referred to 1) the relationship between the siblings; 2) the imposition of rules by the mother. At this previous phase, before the beginning of family therapy, also the family was asked to identify which problems currently existed from the perspective of each member, as well as how this problem affected them, regarding a scale of 0 to 10, where 0 corresponds to "*It does not affect us very much*" and 10 "*It harms our life a lot*". For the mother, the problem lies in the "bad relationship between the children" rating it with 5, regarding its severity. The son noticed that her sister's "tantrums" are the problem, and she rated it also with 5 regarding its severity. Finally, the daughter mentioned that "she does not get along with her brother" and rated this problem with 6 regarding its severity. It is important to say that the father was only present in the third session since when this first contact was made, he was still in France working. Therefore, the father didn’t reply to the research protocol at this phase.

The therapeutic process followed an integrative model of brief therapy (Relvas, 2000). A therapeutic contract of five sessions was established in the first session (cf., Table 1). The consultations took place online through the Zoom platform, lasting two hours, with a break in each session, and the end of the session culminated with a debriefing by the two co-therapists. It is essential to mention that the family members attended the session from the

same device, while each therapist participated in the session from her private computer.

Table 1

Therapeutic Process

1st Session	27.01.2021 (mother, son and daughter)
2nd Session	03.02.2021 (mother)
3rd Session	05.02.2021 (mother and father)
4th Session	03.03.2021 (mother, son and daughter)
Problem identification and severity	Mother: "Bad relationship between the children" (5) Son: "My sister's tantrums" (5) Daughter: "I don't get along with my brother" (6)
Therapy goals	1) Improve sibling relationships 2) Helping parents to set limits/rules

3.3. Mesures

The research protocol of the present study integrates a self-report scale and a sociodemographic questionnaire that will be described below.

3.3.1 System for Observing Family Therapy Alliances - self-report - Revised (SOFTA-sR; Alvarez et al., 2020; Portuguese version of Sotero et al. 2021)

The SOFTA-sR (Alvarez et al., 2020) is the revised version of the SOFTA-s (Friedlander et al., 2006) that allows assessing the strength of the therapeutic alliance in three different modalities: individual, family and group therapy. This tool can be applied to clients (clients' version; Cl) and therapists (therapists' version; T) to assess the perspective on the therapeutic alliance. The only difference between clients' and therapists' versions is the wording

of the items: "*What we do in therapy can solve our problems*" (Cl); "*What we do in this therapy can solve family problems"* (T).

The instrument applied to conjoint therapies is composed of 12 items, since four items were excluded from the original version. This self-report instrument assesses the strength of the therapeutic alliance (global score) and each of the four dimensions:

1) Engagement in the Therapeutic Process (E): a high score indicates that both clients and therapists see the treatment as meaningful to them and have a sense of involvement in therapy.

2) Emotional Connection (C): a high score is associated with a good emotional bond between clients and therapists and a sense of trust that the family has in the therapy.

3) Safety within the Therapeutic System (S): a high score reveals that both therapist and family members view therapy as a context in which risks can be taken without adopting a defensive stance.

4) Shared Sense of Purpose (SSP): a high score is associated with the view (from therapists and clients) that the family is working together to improve family relationships, thus achieving shared family goals.

The SOFTA-sR is applied to family members aged 12 and over, and the SSP dimension is only assessed when more than one family member is present at the session.

The items on the SOFTA-sR are rated according to a Likert scale ranging from 1 (*Not at all*) to 5 (*Very much*) and it is possible to calculate the global score of the alliance and each dimension scores; higher scores translate into more stronger alliances.

In the original study, the SOFTA-sR presents good indicators of internal consistency (Alvarez et al., 2020): 1) client version for the global scale (α = .90) and as for each dimensions E (α = .78), C (α = .81), S (α = .61) and SSP (α = .83); 2) therapist version for global scale (α = .91) and as for each dimensions E (α = .75.), C (α = .64), S (α = .79) and SSP (α = .88). Since the Portuguese version of this instrument is still under study, a preliminary version of the scale was used in this study (Sotero et al., 2021).

3.3.2. Sociodemographic Questionnaire

The sociodemographic questionnaire was constructed for this study to collect data from the participants. Two versions were developed, one for clients and the other for therapists. The client version included questions regarding age, gender, district of residence, area of residence, level of education, profession, relational status, family-household. The therapists' version included questions on age, sex, academic background, academic training, area of specialization, and years of clinical and family therapy experience.

3.4. Procedure

In a preparatory phase, the measure to assess the study variables was selected and, after the authorization from the authors of the scales, the research protocol was built using the LimeSurvey software. The administration was exclusively online, as each participant was given a link to access the survey. Before data collection, a pilot study was also conducted to assess the comprehensibility of the protocols, which was attended by nine subjects. Three subjects answered the pre-session questionnaire, and another three answered the post-session version, and the remaining participants answered the therapists' protocol. The therapeutic process selected for this study was chosen from a sample composed of three therapeutic cases, considering the following inclusion criteria: a) follow-up in systemic family therapy; b) consultations held online; c) systematic completion of the protocol in the first four sessions.

The study's objective was made known to the family members through a phone call when scheduling the first session, where they were asked about their availability to participate in it. Following the ethical and deontological principles associated with scientific research, all participants read the study description and gave their informed consent. They were also given the possibility to withdraw at any time, with no need to justify it, and this decision did not interfere with the therapeutic process. Also, the therapists were invited to collaborate in the study and given their informed consent.

In order to study the therapeutic process, a protocol for clients and therapists was developed. The protocol for clients was applied at five different

moments in the therapeutic process, pre-session, and at the end of the 1st, 2nd, 3rd, and 4th sessions. We chose to analyse the first four sessions to obtain data from the initial and middle phase of therapy, since the third session is considered, by many authors, the session where a change in the therapeutic process occurs in family therapies (Sotero et al., 2018; Stratton et al.,2014; Vilaça, 2015). The pre-session version protocol, which was provided to them one day before starting therapy. This protocol included an instrument to assess expectations about therapy, a self-answer questionnaire about family functioning, a question about identifying the family's problem, a Visual Analog Scale (VAS) type questionnaire about the severity of the problem (Vilaça, 2015), and a sociodemographic questionnaire was also included. The post-session version, which was applied at the end of the first four sessions, right after the end of the consultation, included the SOFTA-sR (Alvarez et al., 2020), which allowed assessing the strength of the alliance, both by overall score and by dimension, a self-report questionnaire on family functioning, and a Visual Analog Scale (VAS) type question on the usefulness of the session (Vilaça, 2014).

Regarding therapists, the protocols were applied at four different moments of the therapeutic process, namely at the end of the first four sessions. These protocols included a questionnaire on goal co-construction (ECCO, Rebelo et al., 2019); and the SOFTA-sR (Alvarez et al., 2020), which allowed assessing the strength of the therapeutic alliance, both by dimension and overall score. Two questions were also included to understand the therapists' perception of the usefulness of the sessions and the family's perspective of improvement. A sociodemographic questionnaire was also applied, which was only present in the protocol at the end of the first session. In the present study, just the therapeutic alliance scores were analysed from clients and therapists' perspectives. Because the daughter is less than 12 years old (the minimum age for complete the SOFTA-sR), only the scores from the mother and the son were considered. In the 2nd session, where only the mother was present, just the dimensions E, C, and S can be analyzed since SSP implies the presence of more than one family member.

Each participant was assigned a code (for example, EM01TFF11), which allowed the research team to monitor the responses, taking into account the place where the family was being followed (EM), the associated case number

(01), the therapeutic modality (TF), the corresponding family member (M - mother; P - father; F1 - eldest child; T1 - youngest therapist; T2 - oldest therapist; TO - observer therapist) and finally the number of the session in which they were participating (1-1st session). The access code to the protocol was sent by e-mail at the end of each session, which allowed each element to access the protocol and match responses to the family members and therapists who participated in the study**.**

IV – Results

The results presentation begins with a micro-analysis of the therapeutic alliance, based on the four alliance dimensions, analyzing them in the first four online sessions. Afterwards, a macro analysis of the global score of the therapeutic alliance is carried out on the four sessions, always considering the perspective of the clients and therapists.

4.1. Micro-analysis: Therapeutic alliance dimensions session by session

4.1.1. Comparing engagement, emotional connection, safety and shared purpose from clients and therapists' perspectives (1st, 2nd, 3rd, 4th sessions)

1st Session

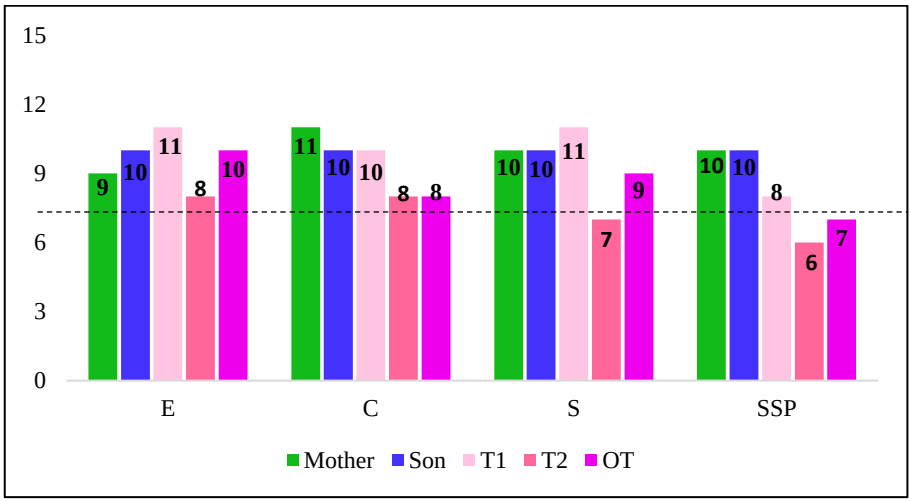
Analyzing figure 2 about therapeutic alliance dimensions in the first session, it's possible to observed that only three scores are below the mean (7.5), namely T2 in dimensions S (7) and SSP (6 and 7). The remaining therapeutic alliance scores was always above the average value for both clients and therapists, ranging from 8 to 11. The lowest score (6) reflected T2's answers to the SSP dimension. On the contrary, the three highest scores (11) corresponded to T1's responses to E and S dimensions and to the mother's perception about C.

In the first session, it is also possible to verified that the clients' perspectives about the therapeutic alliance dimensions were equal in S and SSP and very similar in E and C (differing only in one point) (cf., Figure 2). Concerning therapists, there was a greater diversity of perceptions, with only

equality scores between T2 and OT in C. T1 systematically presented higher values in evaluating the therapeutic alliance than the other therapists. In general, clients evaluated the therapeutic alliance more positively at C, S and SSP, compared to therapists.

Figure 2

Therapeutic Alliance Dimensions (1st session)



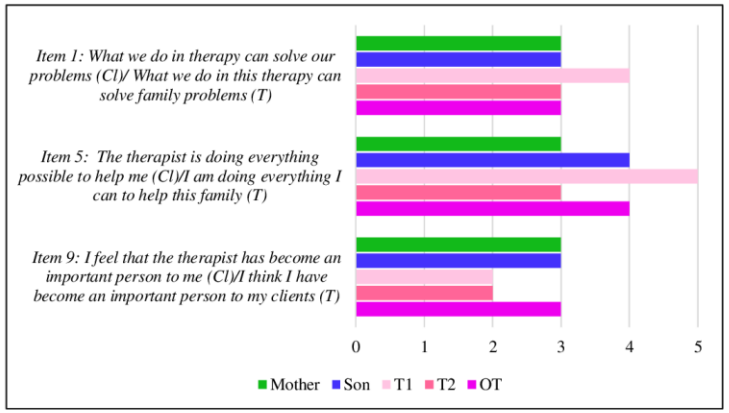
Note. E = Engagement in The Therapeutic Process; C = Emotional Connection to the Therapist; S = Safety Within the Therapeutic System; SSP = Shared Sense of Purpose

The analysis of the items (cf., Figures 3, 4, 5 and 6) allowed us to verify that item 5 in dimension E (*I am doing everything I can to help this family*) and item 11 in dimension S (*Clients understand the meaning of what is being done here*) obtained the highest score (5 - *Very much*) from T1. In turn, item 12 in dimension SSP (*Each member of the family tries to help the others get what they need in therapy*) was the only one equally rated by the three therapists (2 - *A little*). Regarding the mother and son, it was possible to verify more concordant perceptions in dimension E, namely in two of the three items: item 1 (*What we do in therapy can solve our problems*) and item 9 (*I feel that the therapist has become an important person to me)*.

1st Session – Items Response to the Therapeutic Alliance Dimensions (Clients and Therapists)

Figure 3

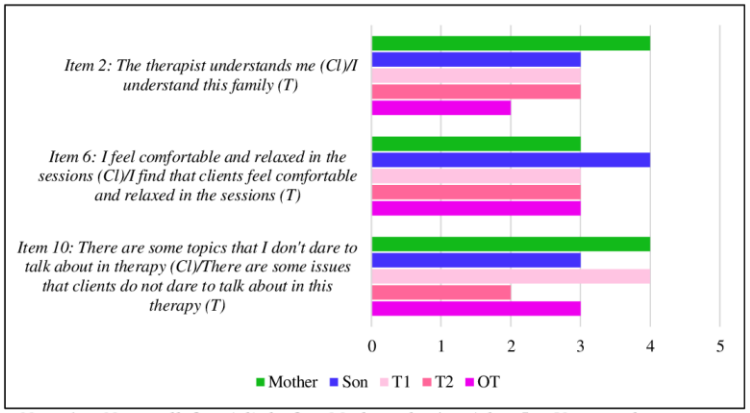
Engagement in the Therapeutic Process (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 4

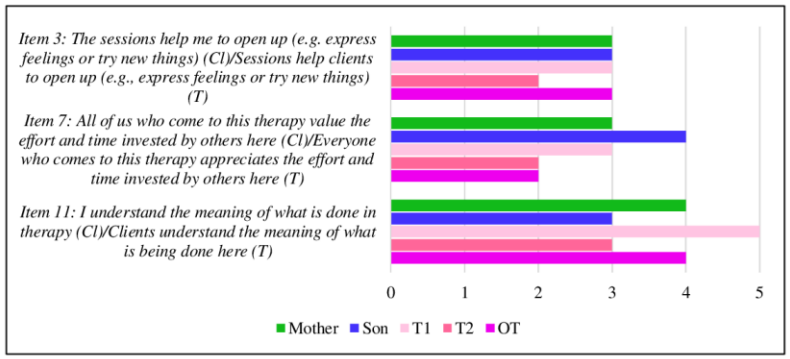
Emotional Connection to the Terapist (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 5

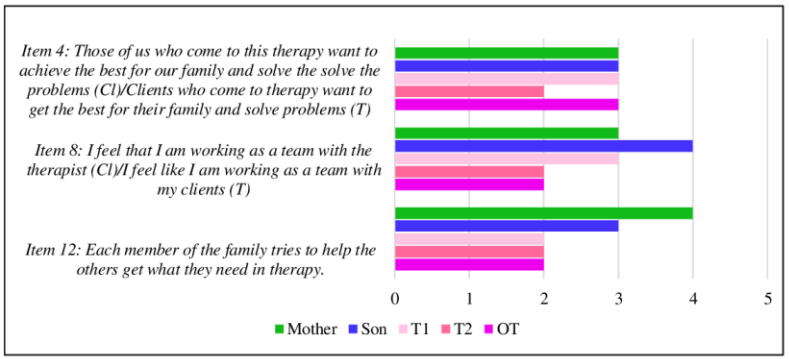
Safety Within the Terapeutic System (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 6

Share Sense of Purpose (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

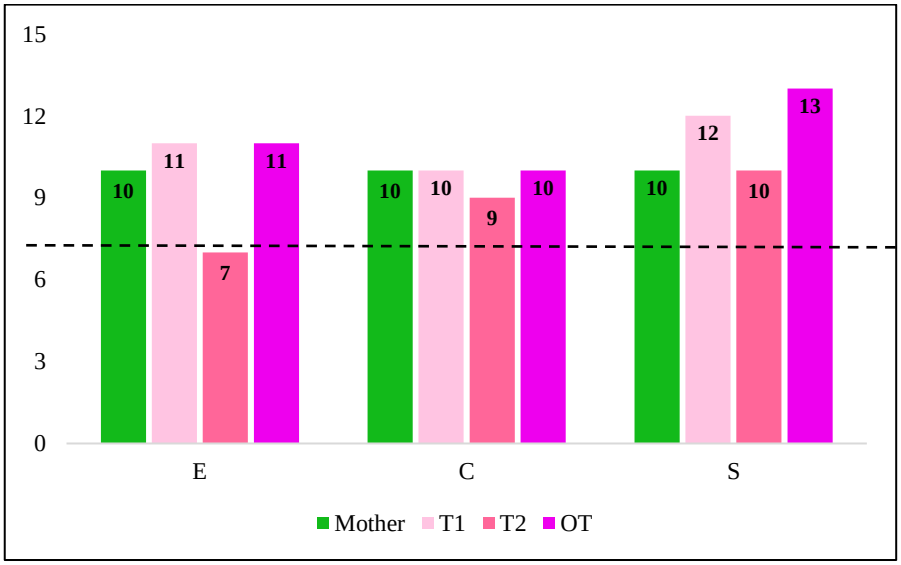
2nd Session

In the second session, all scores on the therapeutic alliance dimensions were above average (cf., Figure 7), except a score report by T2 in the E dimension. The OT reported the highest score in S, scoring 13. The mother has the same score (10) in all the evaluated dimensions (E, C and S). Its' also observed that T2 always perceive de alliance dimensions with the lower scores in the three dimensions E, C and S, when compared with T1 and OT.

The items responses' microanalysis showed that OT marks with the maximum option of the Likert scale (5 - *Very much*) two items from S, items 3 [*Sessions help clients to open up (e.g., express feelings or try new things*)] and 11 (*Clients understand the meaning of what is being done here*) and one item from C dimension, item 2 (*I understand this family*) (cf., Figures 10 and 9). Figure 9 also shows more similarities between mother and therapists' perspectives regarding the emotional connection [item 6 - *I feel comfortable and relaxed in the sessions (Cl)/I find that clients feel comfortable and relaxed in the sessions (T)*].

Figure 7

Therapeutic Alliance Dimensions (2nd session)

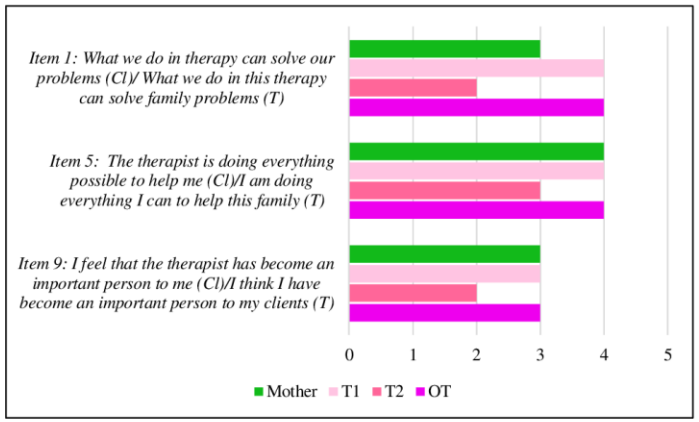


Note. E = Engagement in The Therapeutic Process; C = Emotional Connection to the Therapist; S = Safety Within the Therapeutic System

2nd Session – Items Response to the Therapeutic Alliance Dimensions (Clients and Therapists)

Figure 8

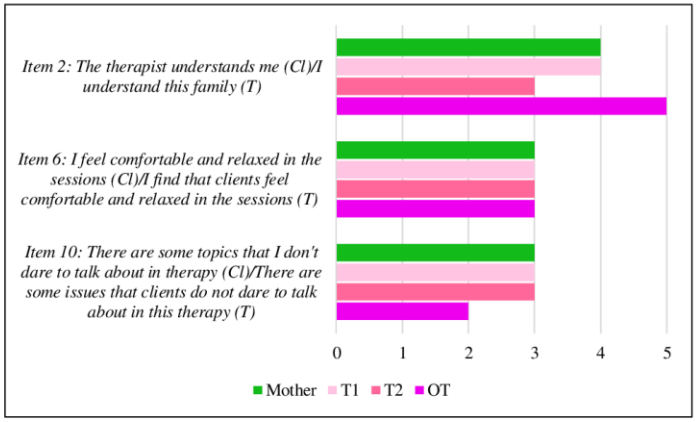
Engagement in Therapeutic Process (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 9

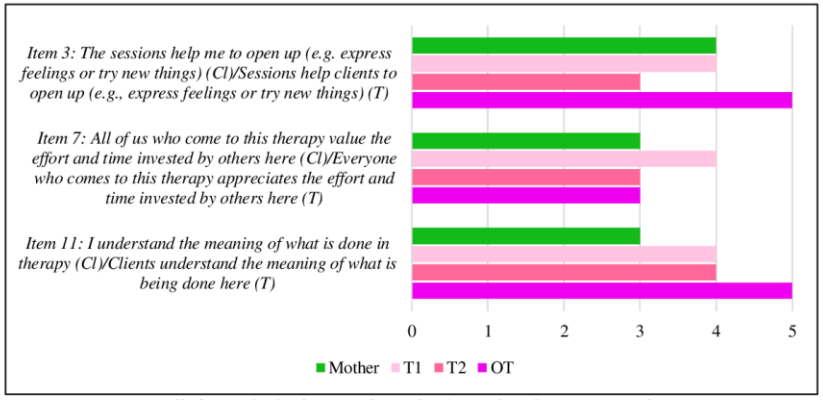
Emotional Connection to the Therapist (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 10

Safety Within Therapeutic System (items)



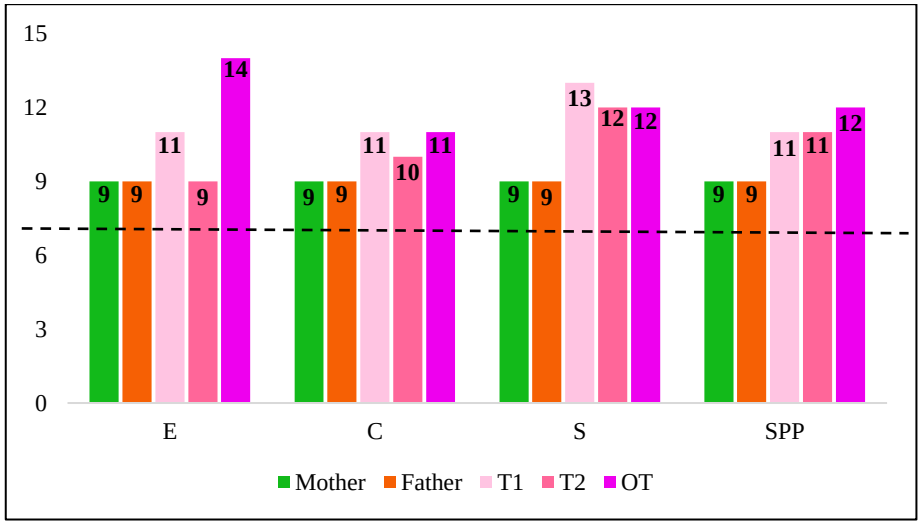
Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

3rd Session

In the third online session the father was present for the first time. As observed in figure 11, the mother and the father showed equal scores in the four alliance dimensions obtaining a score of 9. It is also possible to observed that the mother reported a decrease of one value in all dimensions, comparing with the previous session (cf., Figure 7). As showed in figure 11, all the therapeutic alliance dimensions scores were above the average, with the highest score being 14. Again, the OT perceived a better alliance score at the client's engagement level (E). In E dimension of the alliance, the three therapists also showed the highest level of disagreement (responses vary between 9 and 14) (cf., Figure 11). In the remaining dimensions, C, S and SSP the therapists' perceptions were more similar to each other.

Figure 11

Therapeutic Alliance Dimensions (3rd session)



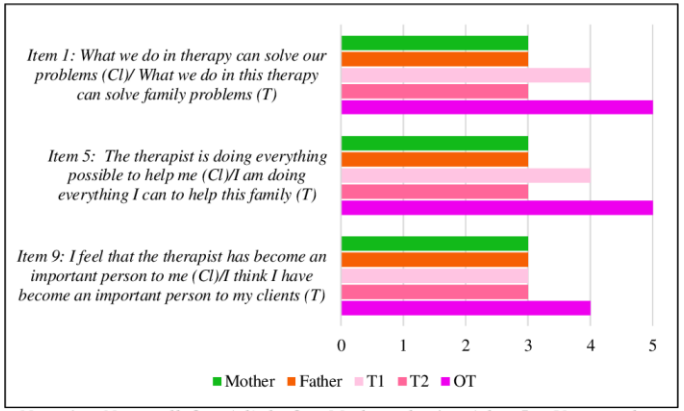
Note. E = Engagement in The Therapeutic Process; C = Emotional Connection to the Therapist; S = Safety Within the Therapeutic System; SPP = Shared Sense of Purpose

Figure 12 shows the items responses in E dimension, where it is possible to observed that OT reply with 5 in two of the three items that composed the E dimension: item 1 (*What we do in this therapy can solve family problems*) and item 5 (*I am doing everything I can to help this family*). It should also be noted that the father and mother responded moderately to all items of the scale.

3rd Session – Items Response to the Therapeutic Alliance Dimensions (Clients and Therapists)

Figure 12

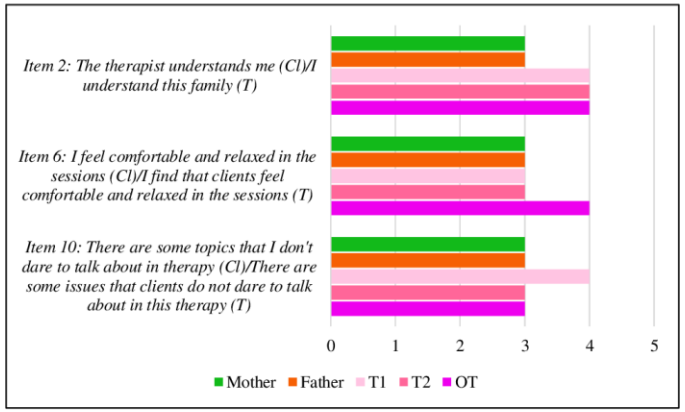
Engagement in Terapeutic Process (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 13

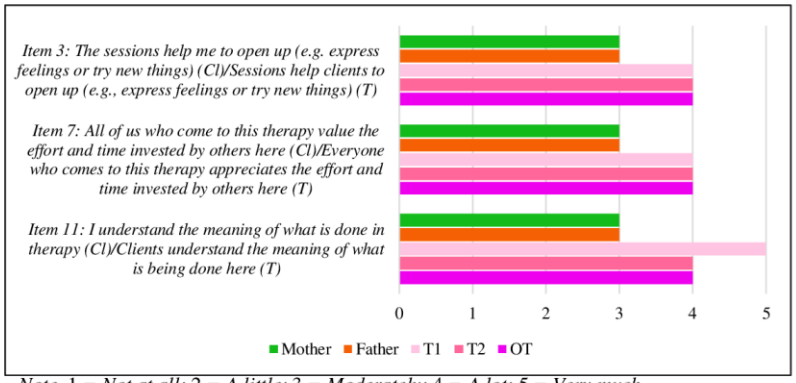
Emotional Connection to the Therapist (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 14

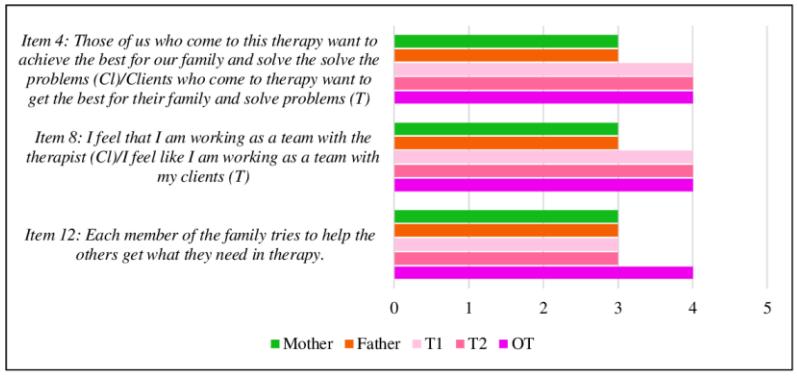
Safety within Therapeutic System (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 15

Shared Sense of Purpose (items)



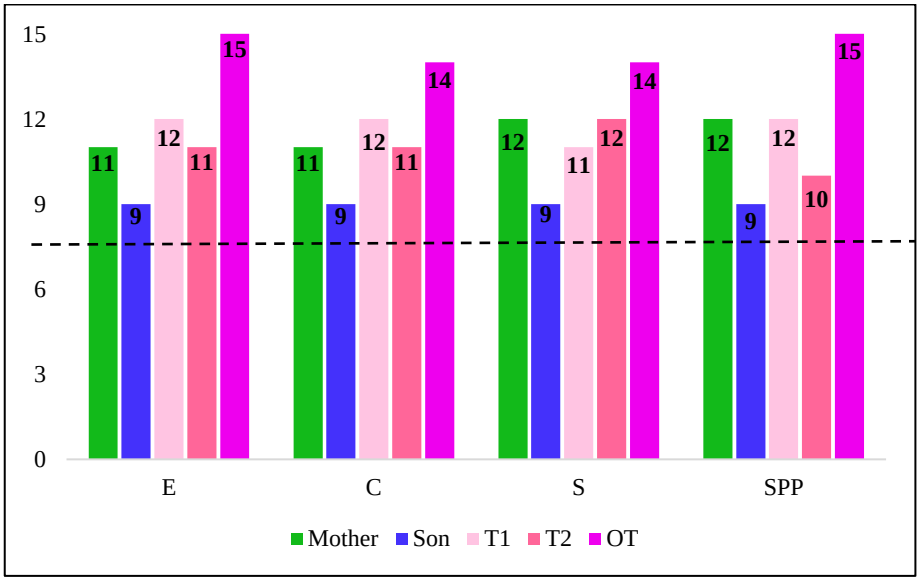
Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

4th Session

In figure 16 it's possible to verify that, once again, all the values on the therapeutic alliance dimensions were above the average, with two maximum results (15). These two scores of 15 correspond to the perspective of OT in the E and SSP dimensions. Again, the observing therapist scores more positively on all dimensions of the therapeutic alliance than the other therapists. It's also noticed that the son presents an equal score (9) in the four alliance dimensions. Regarding the mother, it's verified that in E and C dimensions her scores are the same (11), as in S and SSP dimensions (12), reflecting these systemic dimensions one more point, comparing with E and C. In this session, except for the son, who was not present from the first session, mother and some therapists tended to perceive the therapeutic alliance equally, specifically mother and T2 (E, C and S) and mother and T1 (SSP).

Figure 16

Therapeutic Alliance Dimensions (4th session)

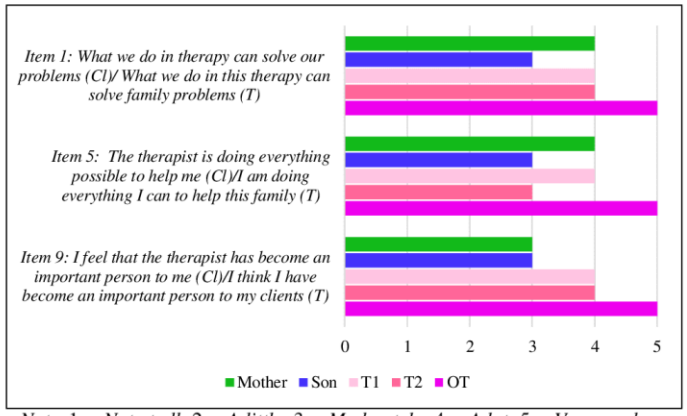


Note. E = Engagement in The Therapeutic Process; C = Emotional Connection *to the Therapist*; S = Safety Within the Therapeutic System; SPP = Shared Sense of Purpose

4th Session – Items Response to the Therapeutic Alliance Dimensions (Clients and Therapists)

Figure 17

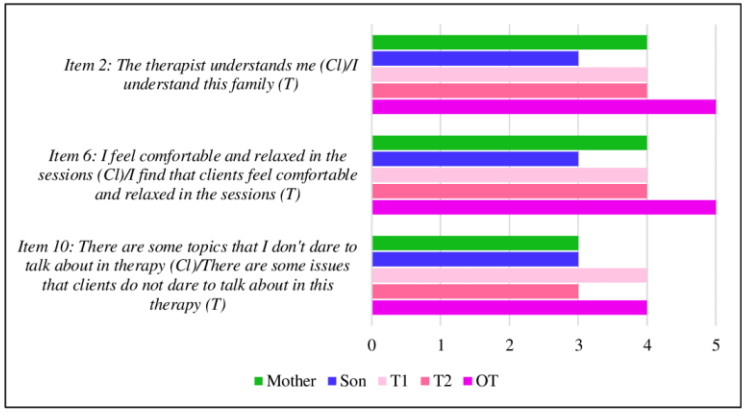
Engagement in the Therapeutic Process (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 18

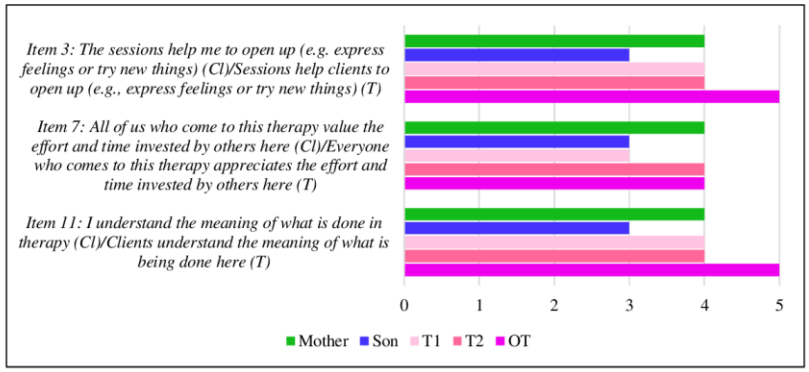
Emotional Connection to the Terapist (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 19

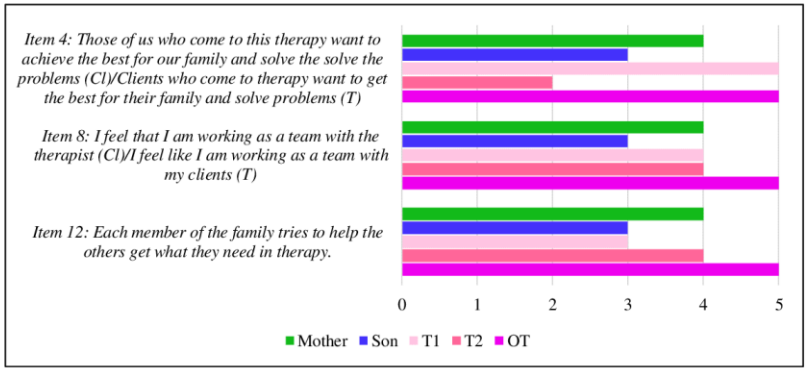
Safety within Therapeutic System (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 20

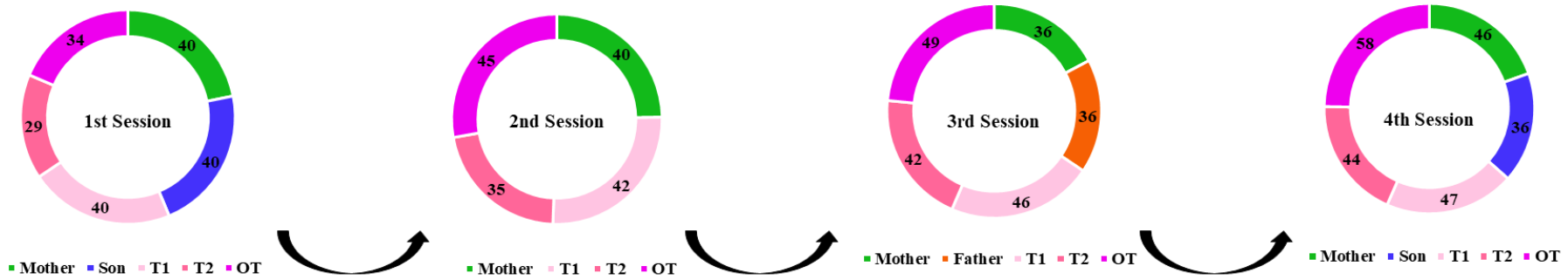
Shared Sense of Purpose (items)



Note. 1 = *Not at all;* 2 = *A little;* 3 = *Moderately;* 4 = *A lot;* 5 = *Very much*
Cl= clients; T= therapists

Figure 21

Therapeutic Alliance_ Global



In this fourth session, in the item analysis, it was also observed that the OT answered all items of dimensions E and SSP with the maximum score (5 - *Very much*). Comparing the perspective of clients and therapists, the mother and the co-therapists responded equally, in at least one item, in all dimensions (4 – *A lot*): E item 1 [*What we do in therapy can solve our problems (Cl)/ What we do in this therapy can solve family problems (T)];* C item 2 [*The therapist understands me (Cl)/I understand this family (T)]*, item 6 [*I feel comfortable and relaxed in the sessions (Cl)/I find that clients feel comfortable and relaxed in the sessions (T)*]; S item 3 [*The sessions help me to open up (e.g. express feelings or try new things) (Cl)/Sessions help clients to open up (e.g., express feelings or try new things) (T)*], item 11 [*I understand the meaning of what is done in therapy (Cl)/Clients understand the meaning of what is being done here (T)*]; SSP item 8 [*I feel that I am working as a team with the therapist (Cl)/I feel like I am working as a team with my clients (T)*].

4.2. Macro-analysis: Therapeutic alliance global score throughout sessions

4.2.1. Analyzing the evolution of the therapeutic alliance from clients' and therapists' perspectives (from session 1 to session 4)

Figure 21 shows the evolution of the alliance global score session by session. As observed, from the first to the fourth session, the therapists' perspectives increased. Attending the first session, OT obtained a global score of 34, T2 29 and T1 40. In turn, at the fourth session its's noticed that the OT obtained a global score of 58, T2 of 44, and T1 of 47. This means that from the first to the fourth session, the therapists' perspective of OT, T2 and T1, towards the alliance increased 24, 15 and 7, respectively.

Regarding the mother, who was the only family member present in all of the online sessions, it's noticed an increase of global alliance score, obtained in the first session 40 and 46 in the fourth session. However, the mother decreased from the second to the third session (from 40 to 36). It was also found a decreased in therapeutic alliance global score by the son, who was only present in the first and fourth online sessions, scoring 40 and 36, respectively. In summary, it is possible to observe that the three therapists progressively increased the global score of the alliance from session to

session, but the same did not happen with the clients. Namely, the mother maintained her score from the first to the second session, decreased from the second to the third, and increased from the third to the fourth; the son, in turn, as mentioned above, decreased from the first to the fourth session.

V. Discussion

The therapeutic alliance plays an essential role in successful therapy (Escudero et al., 2008; Hovarth & Bedi, 2002; Friedlander et al., 2018), being a mutual relationship that depends on the contributions of therapists and clients (Corbella & Botella, 2003). Given the scarce literature on how the therapeutic alliance is established in online family therapy, it seems pertinent to study the perspective of clients and therapists regarding the therapeutic alliance, including between the co-therapists and the observer therapist. Thus, the primary objective of this case study was to compare the clients' and therapists' perspectives on therapeutic alliance in an online family therapy.

Concerning the first specific goal of the present study, which was based on microanalysis of the therapeutic alliance at the end of the 1st, 2nd, 3rd and 4th online sessions, it is possible to conclude that clients and therapists have different perspectives about the therapeutic alliances. None of the sessions did clients show a therapeutic alliance score below the average, although one of the therapists involved in the process (T2) recorded lower than average scores in 1st session and 2nd session for involvement, safety and sharing of goals in the family. This result can be explained by the studies already developed (e.g., Rees & Stone, 2005), which show that therapists have some reticence towards the possibility of establishing a therapeutic alliance online. In addition, other studies show that clients and therapists do not perceive the therapeutic alliance equally, with clients tending to have a more positive score (Bedi, 2006; Horvath & Bedi, 2002). However, the present study, despite having identified differences between the perceptions of clients and therapists, revealed a different trend. That is, therapists perceived in most of the sessions analyzed a more positive alliance compared to clients. This study also showed that clients' perceptions of the alliance are more similar to each other than therapists' perceptions of each other. However, it was found that over time these discrepancies tended to decrease. It is noteworthy that in the fourth

session the mother and co-therapists tended to perceive the therapeutic alliance in the same way, specifically mother and T2 on engagement, emotional connection, and security, and mother and T1 on shared sense of purpose.

In session 1 it was also possible to observe a greater discrepancy in the perception of the therapeutic alliance in the therapists' team, with T1 scoring higher in involvement and safety. This result may be due not only to T1 being the most inexperienced therapist since he was still in training but also because it was the first case in which T1 participated as a therapist. Thus, the fact that this element is still in an early stage of the learning process and development of clinical skills and competencies that the other therapists already demonstrate makes it more "positive" or with the will that everything goes well. This result is not in line with what has been found in other studies where more inexperienced therapists feel uncomfortable during sessions (Saccuzzo, 1976) and feel insecure about their effectiveness as therapists (Thériault & Richardson, 2009; Wittenborn, 2012). Regarding clients, it is important to emphasize that in the first session mother and son are very congruent in the way they feel safe in the therapy and shared sense of purpose. This result is interesting because both dimensions (S and SSP) represents the intrasystem alliance. Inversely, in the fourth session the alliance it was seen differently between the son and the mother. It was noticed that when the mother perceives an alliance better, the child showed a worse alliance. This pattern has been verified in some studies in family therapy with adolescents, which indicate that when parents have a strong therapeutic alliance, adolescent children tend to have weaker results regarding the therapeutic alliance (Friedlander et al., 2012; Friedlander et al., 2018). Interestingly, this pattern of outcomes found in face-to-face family therapy was similar to that found in this online case study, which could point to the existence of some similarities between the two types of processes.

Another curious finding was the mother's perception of a lower score of the therapeutic alliance from the 2nd to the 3rd session. These decreased in the alliance may be related to the therapeutic context itself, i.e., in family therapy alliances can be strengthened or broken when other members come to the session for the first time (Beck et al., 2006). Maybe this is the case because in the third session the father is present for the first time. Another possibility

to understand the alliance decrease in mother perception may also due to the "way" the session took place. In the third online session the couple was at the mother's workplace, and thus there was no safe and appropriate environment for the session to take place.

It is also pertinent to highlight the results obtained by OT throughout the four online sessions since it was the therapist who exhibits maximum scores in the engagement and shared sense of purpose, in the fourth session. This result may be due to her clinical experience, as this therapist has 18 years of clinical experience and 13 years of experience in family therapy. These maximum OT values could possibly be explained by the online context of the therapy session. Being an observant therapist, it is her job to be more attentive to non-verbal cues that clients and/or other therapists may "miss" in the session. Being a difficult task to accomplish due to the context itself, the therapist is more attentive and more involved in picking up "cues" to help her formulate strategies, along with the therapy team, to help the family achieve their goals in therapy. Thus, OT sees online family therapy as something that makes sense to her, feels involved and believes that it is possible to work together with clients, and she perceives that family members work together to improve family relationships and achieve common family goals.

Regarding the second specific objective, to assess the strength of the alliance across the four online sessions from the perspective of the clients and therapists, we noticed that both therapists and the mother, the only client who was present in all online sessions, registered an increase in the alliance score from the 1st to the 4th session. Although there are some intermediate fluctuations in the mother's alliance score from the first to the fourth session, namely the mother maintained her score from the first to the second session, and decreased from the second to the third session. About the son, it is observed that his alliance score decreased from the first to the fourth online session, contrasting with the mother's alliance score, which increased. This pattern may be due to his absence in the intervening sessions, but also to the specifics of family therapy with adolescents, as previous mentioned.

Thus, overall, the results of this study reveal that it is possible to establish a good online therapeutic alliance, corroborating studies on individual therapy (Cook & Doyle, 2002; Reynolds et al., 2006; Wrzesien et al., 2013).

5.1. Limitations and suggestions for future studies

This research includes some limitations that should be considered in future studies. We only have data from the first four sessions of the therapeutic process, which is a significant limitation since it is impossible to analyze the entire therapeutic process. Thus, it would be essential to deepen the study of the therapeutic alliance in all sessions of the process to conduct a complete analysis. We also believe that it would have been important to evaluate the daughter's alliance since the problem that brought this family to therapy was the relationship between the two children. The importance of cross-referencing the data with the content of the sessions is another aspect that can be considered in future research by conducting mixed research, integrating quantitative and qualitative data to provide a broader range of information, while also adding observational data (SOFTA-o; Friedlander et al., 2006). Thus, it would also be pertinent to compare online and face-to-face therapy processes that include families with similar sociodemographic characteristics to understand what aspects would be similar and different in these two intervention contexts. Finally, another limitation relates to the fact that the research protocol included a preliminary version of the SOFTA-sR which is still under development, and studies to assess the psychometric properties of the scale should be developed in the future. However, it is essential to emphasize the pertinence of the results obtained in this research, which leads us to believe that it is possible to conduct a family therapy process in an online context and to established good therapeutic alliances. Although these findings are relevant, it is essential to reinforce that this research is a case study and therefore it is not possible to generalise the data and also the need for further studies that complement these data and helps to understand the applicability of online therapy with families.

VI. Conclusion

The therapeutic alliance has proven to be a significant predictor of success in the therapeutic process (Escudero et al., 2008; Friedlander et al., 2018; Horvath & Bedi, 2002). Within the framework of conjoint therapies, the present research contributed to the study of a case of online family therapy focusing on the establishment of the therapeutic alliance along with the first four sessions, considering the perceptions of clients and therapists. In general,

the results obtained allow us to conclude that (1) it was possible to establish a therapeutic alliance in the first four online sessions, (2) the therapeutic alliance fluctuates between online sessions, increasing or decreasing; (3) therapists tend to reveal better alliance scores comparing with clients. So, the present study contributes to the research of the online therapeutic process, based on the analysis of case study.

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