

(brief communication)

The *System for Observing Family Therapy Alliances* (SOFTA) and the preliminary Portuguese studies

(Relvas, A. P., Escudero, V., Sotero, L., Cunha, D., Portugal, A. & Vilaça, M., 2010)

Abstract

The main goal of this paper is to explain the importance of a family therapy instrument which identifies the quality of family member's interactions with each other, as well as each individual's interactions with the therapist: the *System for Observing Family Therapy Alliances* (SOFTA). This family therapy instrument evaluates two important dimensions: observational (SOFTA-o; Escudero, Friedlander & Deihl, 2004; Friedlander, Escudero & Heatherington, 2001) and self-report (SOFTA-s; Friedlander & Escudero, 2002). The present study attends SOFTA-o, a tool that focus on therapeutic alliance as the principal subject of family therapy, specifically on four sub-dimensions: *Safety within the Therapeutic System*, *Shared Sense of Purpose within the Family*, *Engagement in Therapeutic Process* and *Emotional Connection with the Therapist*. Moreover, this paper presents the SOFTA's process validation and adaption to the Portuguese language. With this study we pretend to point out the need for more investigations about the therapeutic process with Portuguese families.

Key-words: *System for Observing Family Therapy Alliances* (SOFTA); family therapy; therapeutic alliance; validation and adaptation.

Definition of Therapeutic Alliance and its Assessment Importance

The *therapeutic alliance* cannot be considered an isolated concept. It is related with a conjoint of other variables, such as: the client's and the therapist's characteristics, as well as, the intervention methods (Saramago, 2008). As Horvath (2006) supposes, the therapeutic alliance involves two main dimensions: an intrapersonal and interpersonal. The first one can be studied through self-report methods and the second one through behavioral observation methods, although little is known about the observable behaviors that contribute to a strong alliance in family therapy (Friedlander, Escudero & Heatherington, 2006).

There is a wide range of definitions of *therapeutic alliance*; however it is possible to identify a

common base to the majority of them. Therefore, the therapeutic alliance is related to an emotional connection or an affective relation, between therapist and client (Bordin, 1979; Wampold, 2001; Horvath & Bedi, 2002), as well as therapist and client shared therapeutic goals and tasks (to achieve these goals) this is, a mutual collaboration between therapist and client (Bordin, 1979; Wampold, 2001; Horvath & Bedi, 2002).

The therapeutic alliance can be seen like the structure that will support all the therapeutic process and consequently the therapeutic improvements, being an essential element to the implementation of specific therapeutic strategies and techniques (Sousa, 2006).

Moreover, there is significant empirical evidence about the working alliance predictive value for therapeutic change, across a variety of treatment modalities (e.g., Horvath & Bedi, 2002; Horvath & Symonds, 1991, Escudero, Friedlander, Varela & Abascal, 2008; Johnson, Wright, & Ketring, 2002). So, therapists should strive to establish, monitor, maintain and repair a positive connection and collaboration with their patients. The empirical literature also indicates that the therapeutic alliance quality correlates positively with certain characteristics and behaviors of patients (eg., expectation of change) and negatively with others (eg., avoidance, interpersonal difficulties) (Bachelor & Horvath, 1999).

Given the robust and the consistent relation between the therapeutic alliance and the therapeutic outcomes (especially when measured at the beginning of the intervention), evidenced in many studies (e.g., Horvath & Symonds, 1991; Hentschel, 2005), it is urgent to expand the set of the therapeutic alliance assessment instruments. However, until now, the most empirical work about the alliance has been developed in an individual treatment context (Beck, Friedlander & Escudero, 2006) and therefore, studies concerning this reality in the systemic familiar context treatment are actually need.

Therapeutic Alliance: some differences between the systemic familiar treatment context and the individual treatment context

Currently, there is a growing interest in the therapeutic alliance along with psychotherapy study (Friedlander, Escudero & Heatherington, 2006). Indeed, little is known, for example, about family members' personal experiences of the alliance in family therapy, and how client individually distinguish affect alliance formation in this treatment modality (diff of self). This lack of knowledge about therapeutic alliance in family therapy is not casual and, in fact, is associated to an additional difficult in this therapy modality. Like Escudero, Friedlander, Varela e Abascal (2008) considered, the alliance in family treatments is complicated, basically because every client observes every other client's relationship with the therapist.

While in individual treatments the relation between therapist and client is a bidirectional one, in

couple or family therapy, the single alliance should not be considered, giving rise to a complex multidirectional relation. This means that the therapist's alliance with each family member affects and it is affected by the alliance with all other family members (Beck, Friedlander & Escudero, 2006).

Moreover, establishing and maintaining alliances with several people simultaneously can be difficult because conflicts can emerge in therapy discussions, bringing consequences to the family or to the couple life (Friedlander, Escudero & Heatherington, 2006). This results in a great challenge for the therapist, especially when family members manifest different reasons for therapy and are in conflict with each other (*idem*). In this sense, and contrary to what happens in individual therapies, the diversity of views about the therapy value (many times each family member has his own opinion) contributes to *split alliances*, in other words, it contributes to make some family member's alliance with the therapist considerably stronger than with another family member (*idem*). It can be considered that therapeutic alliance in individual treatments only depends of the reciprocal contributions between therapist and client, nevertheless, in family therapy, family member's alliances with each other are extremely important since the collaboration between the family members to the therapy is an important condition to the therapeutic alliance (Escudero, Friedlander, Varela & Abascal, 2008).

To conclude, it is important to understand that the systemic interventions risks for the clients are more considerable in family therapy than in individual interventions, where the revealed information can bring no direct consequences to the family life (Friedlander et al., 2005). Some new information (e.g., a secret), shared in therapeutic set can result in punishments of some family member(s) by other(s) or in the commitment of significant relationships, among other undesirable effects (*idem*).

The System for Observing Family Therapy Alliances - SOFTA

The importance of alliance on the therapeutic outcomes, the unique flavor of therapeutic alliances in couple and family therapy and the lack of research on this area, among other reasons, led Friedlander and colleagues (2006) to developed the *System for Observing Family Therapy Alliances* (SOFTA), a set of tools, both observational (SOFTA-o; Escudero, Friedlander & Deihl, 2004; Friedlander, Escudero & Heatherington, 2001) and self-report (SOFTA-s; Friedlander & Escudero, 2002), that can be used to evaluate the strength of the therapeutic alliance from observable behavior in the context of conjoint couple and family therapy. An important aspect of the SOFTA involves identifying the quality of family member's interactions with each other as well as each individual's interactions with the therapist.

These measures are based on a transtheoretical and multidimensional model of the therapeutic alliance, because reflects aspects of the therapeutic alliance that are not specific or unique to a

particular theory of psychotherapy and estimates different aspects of the alliance from observable behavior in the both systems, clients and therapists, into four underlying dimensions of the alliance construct. Each dimension is described by several items, positive and negative, that exemplify favorable or unfavorable contributions to the alliance. Throughout the construction of SOFTA the authors conceptualized the following dimensions: *Safety Within the Therapeutic System* and *Shared Sense of Purpose Within the Family* which reflect processes unique to therapy formats with multiple clients (Friedlander, Escudero & Heatherington, 2006), *Engagement in the Therapeutic Process* and *Emotional Connection with the Therapist* which are common features in all forms of treatment, that is, collaboration on therapy goals and tasks and a bond with the therapist (Bordin, 1994). Moreover, the dimensions reflect client-therapist relations (Engagement, Emotional Connection) and within-family relations (Safety, Shared Sense of Purpose), as well as cognitive-behavioral (Engagement, Shared Purpose) and affective (Emotional Connection, Safety) areas of functioning. It should be noted that the four SOFTA dimensions are not mutually exclusive. Indeed, because they are conceptually interdependent, they are moderately correlated. Thus, a client's sense of safety is closely related to his or her emotional connection to the therapist and feeling engaged in the process. All of these dimensions are likely to be stronger when the entire family shares a common sense of why they are in therapy and what they hope to accomplish as a result.

According to Friedlander et al. (2005) the operational definitions of the four SOFTA dimensions are the following:

Engagement in the Therapeutic 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.

Emotional Connection to the Therapist: the client viewing the therapist as an important person in his/her 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.

Safety Within the Therapeutic System: the client viewing therapy as a place to take risks, be open, vulnerable, 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.

Shared Sense of Purpose Within the Family: family members seeing themselves as working collaboratively in therapy 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.

As previously stated, the SOFTA contains a set of tools for research and practice: an observational measure (SOFTA-o; client version and therapist version) and a self-report (SOFTA-s; client version and therapist version), besides the e-SOFTA, a software application to train raters on the SOFTA and that allows users to rate the quality of the therapeutic alliance. However, this article only aims to present the work that has been developed in Portugal with the SOFTA-o, a measure of observable behavior, and in these sense we suggest the website <http://www.softa-soatif.com> and recommend the book *Therapeutic alliances in couple and family therapy. An empirically informed guide to practice* (APA Books, 2006) for a more detail knowledge about other topics.

The SOFTA-o was inductively developed, in both languages English and Spanish, surpassing five steps: item construction, qualitative clustering of items for dimension development, a sorting task to assess face validity, initial reliability tests and known-groups validity assessments. The instrument's reliability and validity were supported in four exploratory studies with diverse couples and families in three countries (Canada, U.S. and Spain) and although research on the alliance in couple and family therapy is sparse, the SOFTA-o is a practical, reliable, and valid instrument for conducting studies on important couple and family therapy process and outcomes.

The task of evaluating the therapeutic alliance with the SOFTA-o is completed by trained raters while observing a videotaped family therapy session. First, the raters record the presence of specific items in the entire session. In other words, they have to note the presence of positive vs. negative and verbal vs. non-verbal behavioral indicators that are listed under each dimension. Whenever one of the listed behaviors is observed, e.g., “Client expresses optimism or indicates that a positive change has taken place,” the rater checks it in the appropriate blank space, e.g., under “mother” or “son.” The majority of items reflect clearly observable behaviors, such as open upper body posture or crying or agreeing to do homework. However, a few items require the rater to make some inferences based on the clients’ (or therapist’s) observable behavior.

Second, raters make global ratings each SOFTA-o dimension on a -3 (extremely problematic) to +3 (extremely strong) ordinal scale, where 0 = unremarkable or neutral. Specific guidelines in the *Training Manual* help raters to determine the appropriate rating based on the valence, frequency, intensity and context of the observed behaviors. In the client version, individual family members are rated separately on Engagement, Emotional Connection, and Safety; the entire couple or family unit is rated on Shared Sense of Purpose. In the therapist version, the therapist is rated on each

dimension.

The rating guidelines for the therapist version are identical to those above. Note that while the clients' behaviors *reflect the strength of the alliance*, the therapist's behaviors *reflect contributions to the alliance*. Thus, a rating of +3 means that the therapist is contributing very strongly to the clients' Engagement, Safety, and so on, whereas a rating of -3 means that the therapist's behavior is highly detrimental to the clients' experience of each dimension of the alliance.

It is recommended that at least two judges observe and rate the same family session for purposes of assessing inter-rater reliability, i.e., intra-class correlations. At a minimum, the raters should be graduate students in a mental health specialty, but a great deal of clinical experience is not necessary.

Preliminary Portuguese Studies with SOFTA-o

- **Translation Protocol**

In Portugal, Relvas and colleagues are working on the SOFTA-o (client and therapist versions) process of validation and adaptation to make possible to use. The first step towards this objective was the translation to Portuguese of the Spanish SOFTA-o by one mental health professional with systemic training, resulting in version 1. Both versions, i.e. the original and version 1, were compared by a bilingual Portuguese mental health professional with systemic training and produced version 2. Then, version 2 was back-translated to Spanish (that is, using the inverse method) by another bilingual mental health professional¹. The back-translated version was sent to the original Spanish author, who suggested changes in some items. These suggestions were accepted, resulting in version 3.

Consensual validation was settled by five mental health professionals with systemic training, through the assessment and comparison of the different versions in terms of semantic, idiomatic and conceptual equivalent of the items contents. When no consensus could be reached on the suggestions, the highest number of agreements among the judges was preferred. This resulted in the final version. A pretest was conducted with a sample of four mental health graduate students, who did not reveal any difficulty to understand the contents of the statements.

Alongside SOFTA-o, the SOFTA Observational Training Manual is also being translated into Portuguese. This manual contains the item's descriptors to provide raters with specific guidelines about the exact meaning of the items and the contexts in which they should be marked. This work will be done by research team members and then checked and validated by the authors of the system.

¹ We wish to thank Prof. Jorge De Vega for his effort in this collaboration.

- **Reliability Tests**

The second step concerned the reliability of the instrument, corresponds to the degree of congruence by which the attribute is measured. After the team members gain a clear understanding of the SOFTA theoretical model and used e-SOFTA with the training vignettes from the website (www.softa-soatif.net), they received a presencial formation on SOFTA-o, in A Coruña, for two days, with Valentin Escudero and his research team. Following an initial training and reflection on the specificities and difficulties in using the instrument, the first reliability test was conducted under these conditions: both research teams (Portuguese and Spanish) observed and rated one family session video – this process involved repeated comparisons and negotiations of the team's ratings and discrepancies, which prompted us to clarify a few items. Although we didn't do a formal reliability test, there was a noticeable improvement in inter-rater agreement over the previous rating method.

At this moment, the Portuguese research team is working to achieve good inter-rater reliability (2nd reliability test), and to do that the researchers are preparing the materials to proceed as recommended. In the beginning they worked together with a few tapes, sharing our observations and deciding on the ratings together (10-15 hours of training). Now, to assess inter-rater reliability, they will observe the same sessions independently, and, for the entire rating process, the team must rate the same sessions and gather to compare their results and negotiate to consensus when necessary. Reliability, assessed by intra-class correlation, is assessed separately for each SOFTA-o dimension. A minimum of 5 client videos analysis is needed to achieve enough reliability; practice should continue until the raters, as a group, tend to make dimensional ratings that differ by no more than a single scale point, at least 90% of the time.

A 3rd reliability test (or precision test) will be concluded when the Portuguese and Spanish research teams rate the same videotaped family session independently and compare both solutions. As described, in order to assess the reliability of SOFTA-o we will conduct this three reliability tests and we believe that results and conclusions can be disclosed very soon.

- **Validity Studies**

The validity studies are yet being planned between the Portuguese and Spanish teams. We can think of different designs to assess this psychometric measure: 1) to select a set of family therapy processes and evaluate the correlation between the two versions of SOFTA (observational and self-report) looking for potential associations between the two scales; 2) to assess a predictive validity in order to find significant or non significant associations between SOFTA-o and several therapeutic outcomes (eg. drop out, improvement, not improvement). Despite these possible studies, the

validity can be supported in other ways that the research team is still discussing.

Conclusion

SOFTA's pioneer studies and psychometric support (reliability and validity) now begin to emerge in Portugal in a fruitful and permanent collaboration with the authors. The empirical evidence emphasizes that SOFTA, as an observational tool, is useful for research, training and practice in systemic therapy. Notably, SOFTA was developed to fill an important gap, to estimate the strength of the working alliance in conjoint family treatment. To this date, no single indicator of the therapeutic process has proved to be more powerful in predicting client outcome than the therapeutic alliance (Horvath & Symonds, 1991). This can explain the scientific community's interest on this measure, which reflects the large number of languages that SOFTA has been translated to (English, French, Swedish, Hebrew and Italian).

The main goal of these preliminary studies is, on one hand, to make SOFTA available and possible to use in Portugal and, on the other hand, to promote process and outcome related research in systemic family therapy.

References

- Bachelor, A. & Horvath, A. O. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds), *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.
- Beck, M., Friedlander, M. L., & Escudero, V. (2006). Three perspectives on clients' experiences of the therapeutic alliance: A discovery-oriented investigation. *Journal of Marital and Family Therapy*, 32, 355-368.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy*, 16, 252-269.
- Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13-37). New York: Wiley.
- Escudero, V., Friedlander, M. L. & Deihl, L. (2004). SOATIF-o for therapists. Unpublished

instrument. Available from SOFTA Web site, <http://www.softa-soatif.net>

Escudero, V., Friedlander, M. L., Varela, N. & Abascal, A. (2008). Observing the therapeutic alliance in family therapy: associations with participants' perceptions and therapeutic outcomes. *Journal of Family Therapy*, 30, 194-214.

Friedlander, M. L., Escudero, V. & Heatherington, L. (2001). SOFTA-o for clients. Unpublished instrument. Available from SOFTA Web site, <http://www.softa-soatif.net>

Friedlander, M. L. & Escudero, V. (2002). SOFTA-s. Unpublished instrument. Available from SOFTA Web site, <http://www.softa-soatif.net>

Friedlander, M. L., Escudero, V., Heatherington, L. Deihl, N., Lehman, P., McKee, M. & Cutting, M. (2005). System for Observing Family Therapy Alliances (SOFTA-o) training manual-revised. Retrieved September 12, 2009, from http://www.softa-soatif.com/docusofta/softa20%instruments/manuales/Softa_CodingManual.pdf

Friedlander, M. L., Escudero, V. & Heatherington, L. (2006). *Therapeutic alliances in couple and family: An empirically informed guide to practice*. Washington, DC: American Psychological Association.

Hentschel, U. (2005). Therapeutic alliance: The best synthesizer of social influences on the therapeutic situation? On links to other constructs, determinants of its effectiveness, and its role for research in psychotherapy in general. *Psychotherapy Research*, 15, 9-23.

Horvath, A. O. (2006). The alliance in context: Accomplishments, challenges, and future directions. *Psychotherapy: Theory, Research, Practice, Training*, 43, 258-263.

Horvath, A. O. & Symonds, B. D. (1991). Relation between the working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139-149.

Horvath, A. O. & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). New York: Oxford University Press.

Johnson, L. N., Wright, D. W. & Ketring, S. A. (2002). The therapeutic alliance in home-based family therapy: Is it predictive of outcome? *Journal of Marital and Family Therapy*, 28, 93-102.

Saramago, P. (2008). *O sentir e o agir do psicoterapeuta: impactos da regulação emocional na atitude terapêutica*. Dissertação de Mestrado em Psicologia Clínica e da Saúde. Faculdade de Psicologia e de Ciências da Educação da Universidade de Lisboa, Lisboa.

Sousa, D. (2006). Investigação em psicoterapia: contexto, questões e controvérsias. *Análise Psicológica*, 3, 373-382.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.