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Pre-therapy relationship adjustment, gender and the alliance in couple therapy

Tyler C. Halford,[a] Jesse Owen,[b] Barry L. Duncan,[c] Morten G. Anker[d] and Jacqueline A. Sparks[e]

This study examined gender differences in session one alliances and in the trajectory of the alliance over the course of couple therapy. Additionally, this study examined the association between men and women's pre-therapy relationship adjustment and alliance at session one and over the course of therapy. A total of 316 couples seeking outpatient couple therapy were given the Locke–Wallace marital adjustment test at pre-therapy to measure relationship adjustment and the session rating scale after each session to measure alliance with the therapist. The results showed that men had lower alliance ratings after session one than women. Men's pre-therapy relationship adjustment was positively associated with their own session one alliance as well as their own alliance trajectory over the course of therapy. Men's pre-therapy relationship adjustment was also positively associated with their partner's session one alliance. Women's pre-therapy relationship adjustment showed no significant relationship with their own alliance or their partners at session one or the alliance trajectory over the course of therapy. The implications for how these gender differences may impact on the process of couple therapy with heterosexual couples are discussed.

[a] Department of Educational and Counseling Psychology, University of Louisville, Louisville, KY 40292, USA. E-mail: tchalf01@louisville.edu

[b] Associate Professor, University of Louisville, USA

[c] Clinical Psychologist, Director of the Heart and Soul of Change Project, Jensen Beach, FL, USA

[d] Clinical Psychologist, Vestfold Counselling Office of Family Affairs, Tønsber, Norway

[e] Associate Professor, University of Rhode Island, Rhode Island, RI, USA

Practitioner points

- Initial alliances may differ for men and women in heterosexual couples and attending to reasons for seeking help may be instrumental.
- Partners' pre-therapy relationship distress can negatively impact on early alliance establishment; thus, more attention to the alliance may be needed for more distressed couples.
- Therapists may want to monitor the alliances in couple therapy to develop a better understanding of each partner's engagement in the process.

Keywords: couple therapy; alliance; relationship distress; gender.

Couple therapy is an effective way of helping couples alleviate relationship distress, manage conflict, and increase relationship stability (Sexton *et al*., 2004). Although various mechanisms of change have been examined in couple therapy, one common mechanism across therapeutic approaches is the working alliance. A recent meta-analysis demonstrated that the alliance in couple and family therapy accounted for 6.7 per cent of variance in therapy outcome (Friedlander *et al*., 2011), which is consistent with alliance outcome associations in individual therapy (Horvath *et al*., 2011). The alliance is typically defined as the agreement on the goals for therapy, the methods used to achieve the goals, and the emotional or relational bond between therapist and client, which is founded on trust and safety (Bordin, 1979). In couple therapy the alliance is a complex process as therapists need to form and maintain a quality alliance with both partners (Pinsof *et al*., 2008). As the connection between alliance and outcome has been well established, investigators are turning their attention to potential factors that might influence the formation and trajectory of the alliance (Horvath and Bedi, 2002; Knerr *et al*., 2011; Knobloch-Fedders *et al*., 2004; Mamodhoussen *et al*., 2005). In the current study we examine how gender and pre-therapy relationship adjustment may influence the initial alliance and the trajectory of the alliance.

Gender and the alliance

Gender socialization may help provide the context explaining why the alliance may differ for men and women in heterosexual couples. Men are typically socialized to conform to the masculine norms of

being independent and self-reliant (Kaplan, 1987; Mahalik *et al*., 2003; Ogrodniczuk, 2006); whereas women are generally socialized to conform to feminine norms, such as being relationship-focused, nurturing and emotionally expressive (Ogrodniczuk, 2006). These gender socialization processes may impact on the establishment of the alliance in couple therapy. For instance, men are generally less willing to seek help and view therapy as more stigmatizing than women do (Mansfield *et al*., 2003; Robertson and Fitzgerald, 1992; Vogel *et al*., 2006, 2009). These gender differences are evident even after controlling for distress levels (Kessler *et al*., 1981). In addition, it has been found that women are more often the initiators of couple therapy than men (Doss *et al*., 2003). Therefore, men, as compared to women, may initially feel more wary of coming to couple therapy and subsequently be less engaged in therapy, which may translate into difficulties in alliance formation.

Addressing gender differences in the formation and maintenance of the alliance can help address potential gender disparities in the treatment of men or women. For instance, Mahalik *et al*. (2012) found that therapists tend to align more with women in couple therapy and not recognize men's positive influence in the couple/family. To date, most couple therapy alliance studies have examined gender differences in the association between alliance and outcome (for example, Brown and O'Leary, 2000; Knobloch-Fedders *et al*., 2007; Quinn *et al*., 1997; Symonds and Horvath, 2004). Although these studies are important, our focus is to examine whether men and women differ on their first-session alliance ratings and whether there are differences between men and women in the rates at which their alliance scores change over the course of therapy. Initial alliances are vital to the strength of the relationship throughout the course of therapy. For instance, couple therapy session one alliances have been shown to predict the premature termination of couple therapy (Knobloch-Fedders *et al*., 2004; Raytek *et al*., 1999). Additionally, the alliance is mainly formed in the first session; however, approximately half of clients experience the alliance differently in subsequent sessions (Sexton *et al*., 2005), suggesting that the trajectory of the alliance is important to monitor (Duncan, 2010).

Few studies have directly focused on gender differences in the magnitude of the alliance. Nevertheless, some studies have shown significant differences in alliance ratings for men and women at various points in the therapy. For example, men have reported having lower alliances than women at session one ($d = .16$; Knobloch-Fedders *et al*.,

2004) and three (d = .42; Werner-Wilson, 2008). Apart from initial differences, research on gender differences in alliance changes over the course of couple therapy is scarce. For example, Knobloch-Fedders *et al*. (2007) showed that couples' alliance at session eight were not significantly different from their reported alliance at session one. Glebova *et al*. (2011) also reported that alliance ratings remained stable when measuring alliance for the first six sessions of couple therapy. In a notable exception, a recent study by Bartle-Haring *et al*. (2012) found that women's alliance scores increased from session two to session six while men's alliances remained relatively stable. Yet this study did not test whether these trajectories were significantly different for men and women. Despite studies to date that provide evidence of alliance change over time in couple therapy, none have investigated how the alliance changes over the entire course of therapy. The present study aims to address that gap by measuring the alliance at each session, intending to capture alliance differences and trajectories over the entire course of couple therapy for men and women, from session one to termination.

Pre-therapy relationship adjustment and alliance

Pre-therapy relationship adjustment may affect the formation and maintenance of the alliance in couple therapy. Couples with lower levels of relationship adjustment typically express a lack of consensus and more disagreement on foundational relationship issues and values (Locke and Wallace, 1959; Spanier, 1976). Couples with lower levels of adjustment are more likely to have negative communication patterns (Markman *et al*., 2010) and express more negative emotions (Gottman *et al*., 1998). Pre-therapy relationship adjustment has been shown to affect couples' general goals for therapy. For example, Owen *et al*. (2012) found that couples with lower levels of pre-therapy relationship adjustment were more likely to want to clarify the future of the relationship (for example, should they even stay together) versus seeking therapy as a method of improving the relationship. Furthermore, higher levels of disagreement between partners may make forming an alliance difficult due to the necessity to agree on the goals and tasks in therapy. Additionally, individuals with lower levels of relationship adjustment in couple therapy may affect their partners' ability to form a bond with the therapist.

Research examining the association between relationship adjustment and the alliance has been mixed. In some studies, pre-therapy

relationship adjustment demonstrated no significant association with alliance when the alliance was measured at the first or third session (Bourgeois *et al*., 1990; Brown and O'Leary, 2000; Johnson and Talitman, 1997). In contrast, Mamodhoussen *et al*. (2005) found that pre-therapy relationship distress was negatively associated with alliance quality at the third session for men and women. Additionally, Knerr *et al*. (2011) found that women's rating of pre-therapy relationship distress negatively impacted on their own goals and the tasks of their alliance at the second session; however, there was no significant association between men's pre-therapy relationship distress and alliance scores. In a study by Knobloch-Fedders *et al*. (2004), where alliance ratings were measured at the first and eighth sessions, men's pre-therapy relationship distress was shown to be negatively associated with their own alliance ratings at the eighth session, but for women, only one aspect of their relationship adjustment (sexual satisfaction) was shown to impact on their alliance at both sessions one and eight.

Relationship adjustment in couple therapy: actor-partner effects

Although it is becoming clear that clients' pre-therapy relationship adjustment can affect their own alliance with the therapist (Knerr *et al*., 2011; Knobloch-Fedders *et al*., 2004; Mamodhoussen *et al*., 2005), what is less well understood is the influence clients' pre-therapy relationship adjustment has on their partner's alliance with the therapist. In the present study we examine the associations between men's and women's pre-therapy relationship adjustment on their own alliance scores (that is, the actor effect) as well as their partner's alliance scores (that is, the partner effect). In this study, the term actor effects refers to the association between an individual's pre-therapy relationship adjustment and their own alliance score. For example, men's pre-therapy relationship adjustment may impact on their own alliance ratings, and in the same way, women's pre-therapy relationship adjustment may affect their own ratings. To date, this has been the most common means of analysing data in couple therapy, but it ignores possible partner effects. In this study, the term partner effects refers to the association between individuals' pre-therapy relationship adjustment and their partner's alliance score. For example, men's pre-therapy relationship adjustment may be associated with their partner's alliance ratings (or vice versa).

Hypotheses

The goals of the current study are to examine (i) whether there are gender differences in initial alliance ratings and the trajectory of the alliance over the course of therapy and (ii) whether men's and women's pre-therapy relationship adjustment is associated with alliance ratings. We predict that men's alliance scores will be significantly lower than women's scores after session one (Hypothesis 1). Given the lack of previous data regarding the trajectory of alliances in couple therapy, we did not make a formal prediction about the gender differences in the changes in alliances over the course of therapy. Next, we predict that men's and women's pre-therapy relationship adjustment will be positively associated with their own first session alliance as well as the trajectory of their own alliance over the course of therapy, respectively (Hypothesis 2a: men actor session one; Hypothesis 2b: women actor session one; Hypothesis 2c: men actor trajectory; Hypothesis 2d: women actor trajectory). We also predict that men's and women's pre-therapy relationship adjustment will be positively associated with their partner's alliance. Men's pre-therapy relationship adjustment will be positively associated with their partners' session one alliance (Hypothesis 3a). Women's pre-therapy relationship adjustment will be positively associated with their partners' session one alliance (Hypothesis 3b). Men's pre-therapy relationship adjustment will be positively associated with their partners' alliance trajectory (Hypothesis 3c). Women's pre-therapy relationship adjustment will be positively associated with their partners' alliance trajectory (Hypothesis 3d).

Method

Participants

The present study consists of 632 individuals, or 316 couples.[1] The couples were recruited from two family counselling agencies that provided free government-subsidized services in Norway. Each couple was seeking outpatient couples therapy. The initial exclusion criteria via a phone interview consisted of couples where one partner refused to attend, one or both partners reported a desire for the relationship to end, or one or both refused to give their informed consent.

[1] Note this is a reanalysis of the Anker *et al*., 2010 data set and more detailed information about the sample can be found in that article

All the couples in this study were White, Euro-Scandinavian and heterosexual, with an average age of 38.54 years (SD = 8.47; range from 22 to 72). The participants were seen by twenty therapists (thirteen women and seven men) at two family counselling agencies in Norway. The therapists included ten licensed psychologists, nine licensed social workers and one licensed psychiatric nurse. The reported theoretical orientations that the twenty therapists used with the couples ranged from solution-focused, narrative, cognitive-behavioural, humanistic and systemic, though each were professed eclectics primarily, and none professed to adhere to only one orientation always. The average age of the therapists was 44 years (SD = 12.6; range 26–61) and the average years of experience with couples work for each therapist was 6.7 years (SD = 6.98; range 0–19).

Measures

Locke–Wallace marital adjustment test (MAT). The MAT (Locke and Wallace, 1959) is a fifteen-item scale designed to assess levels of adjustment in romantic relationships. The scores obtained from the MAT range from 2 to 158, with higher scores indicating better relationship adjustment and scores below 100 indicating clinically distressed relationships. The MAT measures relationship adjustment across a variety of areas: global happiness, agreement on relationship matters such as finances, and thoughts and feelings about the relationship and the partner. The MAT has been shown to correlate highly with the often used dyadic adjustment scale (r = .93; Spanier, 1976). The alpha for the present sample was .75. The average MAT scores for the sample were 70.81 for women (SD = 24.51) and 76.85 for men (SD = 26.09).

Session rating scale (SRS). To measure the alliance in this study, the SRS (Duncan, 2012; Duncan *et al*., 2003) was administered at the end of each session. The SRS is based on Bordin's (1979) concept of the working alliance, which emphasizes relational bonding and goal agreement between therapist and client. The SRS is a four-item visual analogue scale that focuses on relationship (I felt heard, understood and respected), goals and topics (we worked on and talked about what I wanted to work on or talk about), approach and method (the therapists approach suits me) and the overall alliance (overall, today's session was right for me). Participants make a mark along a 10-cm line nearest the pole that best describes each of the four areas. Their marks are then measured by single centimetre units and given a score from 0

to 40. In terms of validity and reliability, the SRS has been shown to be comparable to other alliance rating scales (Duncan *et al*., 2003) and has been used with couples (Anker *et al*., 2009; Reese *et al*., 2010). The SRS has also been shown to correlate well with the longer and frequently used working alliance inventory (r = .63; Campbell and Hemsley, 2009). In the current sample, the internal consistency of the SRS was .89.

Procedure

This was a naturalistic study conducted in community-based outpatient centres. The clients were invited to participate in a research study about improving the benefits of therapy. All participating clients gave their informed consent and institutional review and approval was secured. Participant intake forms – which included the MAT measure – were assigned randomly and weekly to available therapist intake slots. Therapists could exchange one case for another if they felt uncomfortable with a couple's clinical presentation as depicted on the intake paperwork or had any previous nonclinical contact with a couple. Such an exchange happened twenty times over the course of the study, primarily because of previous non-therapy contact with the couple. The clients filled out the SRS at the end of each session.

Results

We utilized a three-level multilevel model to test our hypotheses. For the model, sessions for men and women (level 1) were nested within couples (level 2) who were nested within therapists (level 3). In other words, we modeled the trajectory for men's and women's SRS (alliance) scores over the course of treatment. The main predictors of the intercept (session 1) and the trajectories were men's and women's MAT scores at pre-therapy. We conducted a dual-intercept model such that each partner would have a separate intercept and slope, while accounting for the interdependencies between couples (Atkins, 2005). This method of analysis is analogous to the actor-partner interdependence model (Cook and Snyder, 2005; Kenny *et al*., 2006). Additionally, we were able to account for interdependencies between couples who were treated by the same therapist. We analysed the multilevel models using the statistical program hierarchical linear modeling, version 6 (Raudenbush *et al*., 2004).

For Hypothesis 1, we predicted men's alliance would be significantly lower than women's alliance at session one. The results demonstrated

TABLE 1 *Summary of fixed effects*

	Coefficient (SE)	95% CI	*P* value
Intercept			
Men	33.03 (0.55)	31.95, 34.11	<0.001
Actor MAT	0.04 (0.01)	0.02, 0.06	.004
Partner MAT	0.02 (0.01)	−0.001, 0.004	.12
Women	34.52 (.33)	33.87, 35.17	<0.001
Actor MAT	−0.01 (0.01)	−0.03, 0.01	0.62
Partner MAT	0.03 (.009)	0.01, 0.05	0.001
Slope			
Men	0.54 (0.12)	0.30, 0.80	<0.001
Actor MAT	−0.01 (0.002)	−0.01, −0.01	0.035
Partner MAT	−0.01 (0.002)	−0.01, 0.01	0.43
Women	0.39 (0.07)	0.25, 0.53	<0.001
Actor MAT	−0.01 (0.003)	−0.02, 0.004	0.63
Partner MAT	<0.001 (0.002)	<−0.001, 0.001	0.92

Note. SRS intercept *dfs* = 19 and for estimates with MAT *dfs* = 313.

that first session alliance ratings (intercept; see Table 1) were significantly lower for men than women, $\chi^2(1) = 18.22$, $P < 0.01$ (supporting Hypothesis 1).[2] We also examined whether there were gender differences in the trajectory of the alliance over the course of therapy. Although the results were only marginally significant, men's rate of change by session was slightly higher than women's rate of change, $\chi^2(1) = 3.08$, $P = 0.07$. Figure 1 illustrates the rate of change over the course of therapy based for men and women.

For our second hypothesis, we predicted that pre-therapy relationship adjustment would be positively associated with the alliance for both men at session 1 (Hypothesis 2a) and women at session 1 (Hypothesis 2b), as well as impact on their own alliance trajectory (Hypothesis 2c: men; Hypothesis 2d: women). We found that men's pre-therapy relationship adjustment scores were positively related to their own alliance ratings at session 1 (see men intercept actor MAT, Table 1), as well as their alliance ratings over the course of therapy (see men slope actor MAT, Table 1). This provides support for hypotheses 2a and 2c, but not hypothesis 2b and 2d.

Lastly, we also predicted that pre-therapy relationship adjustment would be positively associated with the alliance of each partner at session 1 (Hypothesis 3a: men; Hypothesis 3b: women), as well as over

[2] The χ^2 coefficients are the result of general linear hypothesis tests.

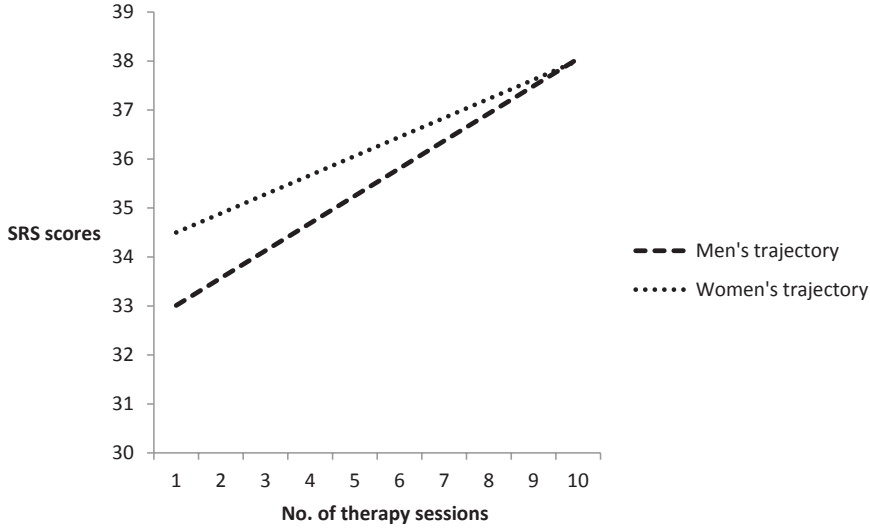

Figure 1. Men's and women's predicted alliance scores over the course of therapy.

the course of therapy (Hypothesis 3c: men; Hypothesis 3d: women). Men's pre-therapy relationship adjustment was shown to positively relate to their partners' session 1 alliance (see women intercept partner MAT, Table 1), but not to their partners' alliance trajectory. Women's pre-therapy relationship adjustment was shown to have no statistically significant association with alliance: either their own alliance or the alliance of their partner, at both session 1 and over the course of therapy. Therefore, support was found for Hypotheses 3a but not hypotheses 3b, 3c and 3d.

For an illustration of the relationship between first session alliance ratings and pre-therapy relationship adjustment, we calculated a predictive score for men who were one standard deviation above the mean on the MAT ($SD = 26.09$). Given that men's mean MAT score was 76.85, a one standard deviation increase in MAT scores reflects 102.94, which is approximately the clinical cut-off on the MAT (for example, 100) that distinguishes between couples who are distressed and those who are not. Men who were one standard deviation above the mean on the MAT had an initial SRS score of 34.07 (as compared to 33.03 at the mean), a difference of 1.04 points. This score is approximately the same as women's initial SRS scores (men = 34.07, women = 34.52).

Discussion

We examined gender differences in alliance ratings as well as the association of pre-therapy relationship adjustment with their own alliance and their partner's alliance. For gender differences in alliance, we found that men had significantly lower alliance ratings than women at session one. However, men's alliance ratings improved faster than women's and they eventually paralleled those of women as therapy progressed. Our findings support previous results wherein men had a significantly lower session one alliance rating than women (Knobloch-Fedders *et al*., 2004). In regard to trajectory differences, our findings differ from Bartle-Haring *et al*. (2012), who found that only women's alliance ratings significantly increased. Our findings further emphasizes the importance of early session alliance formation (Knobloch-Fedders *et al*., 2004; Sexton *et al*., 2005) and the maintenance of the alliance over the course of couple therapy (Duncan, 2010; Owen *et al*. 2013). At the same time, gender differences in alliance formation may suggest some disparities in the way the alliance is experienced in couple therapy.

Gender role socialization theories may offer reasons why men have a lower alliance than their partners after the first session of couple therapy. It may be reflective of men being less willing to seek professional help or having stigmas about help-seeking (Mansfield *et al*., 2003; Robertson and Fitzgerald, 199; Vogel *et al*., 2006, 2009), which could stem from traditional societal expectations for men to be more independent and autonomous (Kaplan, 1987; Mahalik *et al*., 2003; Ogrodniczuk, 2006). This lower level of interest in help-seeking may make it more difficult for therapists to engage men at the onset of couple therapy. Good *et al*. (2005) suggest that men may show more resistance to building a therapeutic bond with their therapists, and may go to such lengths as avoiding therapy or acting out in therapy to evade entering into an emotional relationship or sabotage it. Apart from focusing specifically on men and/or gender roles as the issue, perhaps the couple therapy process is contributing to lower alliances for men. For example, in addition to finding that therapists report that they align better with women in couple therapy, Mahalik *et al*. (2012) also showed that men in couple therapy tend to feel more than women that they are the centre of blame, the greater source of conflict and the 'identified patient'. Accordingly, therapists may need to adjust the way that they connect with men in couple therapy to address men's relatively lower initial ratings of alliance.

Second, we found that men's pre-therapy relationship adjustment was positively associated with both their own session one alliance and women's session one alliance. Additionally, men's pre-therapy relationship adjustment was positively associated with their own alliance trajectory. However, women's pre-therapy relationship adjustment was not statistically associated with their own alliance or that of the men. Couples who report lower relationship adjustment generally have more problems and sources of conflict, thus identifying corresponding goals and tasks for several presenting issues could result in lower alliance ratings. Interestingly, our findings indicate that men's pre-therapy relationship adjustment was shown to be more predictive of impacting on the alliance than women's pre-therapy relationship adjustment. Potentially higher levels of distress for men may suggest that they feel more disenfranchised in a relationship and could be related to negative interpersonal expressions such as anger or the need for control (Mahalik *et al*., 2012), thus leading to disruptions in the alliance for both themselves and their partner. Putting together our findings with those of Mahalik *et al*. (2012) that men entering couple therapy have lower levels of relationship adjustment could suggest that men do not feel the therapist validates their concerns, resulting in poor initial alliances. Lower levels of relationship adjustment for men, therefore, suggests a greater need for connection, support or understanding.

Limitations and future directions

Despite several interesting findings relative to the way the therapeutic alliance is associated with gender, pre-relationship distress and partner influence in couple therapy, these results should be considered in light of the limitations of this study. Firstly, the SRS only measures each individual's alliance with the therapist and not alliances between the couples. Furthermore, this study focused only on processes in therapy, not outcomes. Therefore, it is unknown how these effects might directly influence the outcome of the couple and each partner in therapy. However, previous studies with this same data set did study the outcome and found positive links between the alliance and outcome (Anker *et al*., 2010). Another limitation is that, although the population was representative of couples seeking outpatient couple therapy, its characteristics were very homogenous. All 316 couples were heterosexual, Caucasian couples from Norway, thus, the degree to which this may generalize to other countries and treatment

settings is unknown. Since the couples in the study were all heterosexual, generalizability with same-sex couples is unclear. Moreover, though our findings showed men's alliance improved at a faster rate than that of women over the course of therapy, this finding should be viewed in light of the finding that men also had a significantly lower alliance rating than women after session one. Therefore, the men's alliances were not restricted (that is, via ceiling effects) to the same degree as the women's alliance scores.

The significant effects in this study were in general small in size and such effects should be interpreted with caution. Accordingly, while our findings highlight some unique associations between men's and women's relational distress and alliance intercepts and trajectories, these effects are only one element that could influence the formation of the alliance and how it changes over the course of therapy. Lastly, this was a brief couple therapy study and the average number of sessions each couple received was four. Thus, generalizations about alliance trajectory and how it applies to different therapy modalities or therapy lengths is unknown.

The conclusions drawn from this study have highlighted several potential pathways that future couple therapy alliance research might explore. It may be beneficial for future research to continue utilizing methods of analysis that examine partner effects in couple therapy process and outcome. Given the preliminary nature of the procedures used in this study, where the alliance was measured at each session, future research should continue to add to our understanding of how the alliance forms and changes over the course of couple therapy, and how this may be impacted on by pre-existing moderating variables or mediating factors in the couple therapy process. Future studies may also wish to capture systemic alliances (Pinsof *et al*., 2008; Knobloch-Fedders *et al*., 2004) – for example, the level of accord between partners over the goals and tasks of the therapy – to gain a more in-depth understanding of the overall alliance agreement within the triad of the therapist and the two partners. Furthermore, pre-relationship adjustment is a commonly utilized pre-therapy alliance moderator in couple therapy alliance research. Future studies may want to expand our knowledge of pre-therapy relationship adjustment and how it may interplay with similar moderators. For example, the inclusion of personality constructs (such as measures of narcissism) and how these may be tied to relationship adjustment and the alliance could be useful in helping untangle other potential contributors to the association between alliance and relationship adjustment. Additionally, examining which partner initiated couple

therapy or who is more motivated in couple therapy could be another important third variable explanatory factor.

This study provides several implications for couple therapy practitioners. The most important implication is centred on an instillation of greater awareness for couple clinicians. This applies to the importance of establishing a first session alliance for heterosexual couples seeking couple therapy, particularly with regard to pre-therapy relationship distress and early alliance establishment. Couple therapists should be more cognizant of couples entering therapy wherein the male partner is reporting clinically low levels of relationship adjustment, and the bearings this could have on establishing his and his partner's alliance. This is further underlined with the emergent findings that early therapy alliance is negatively associated with premature termination in couple therapy (Knobloch-Fedders *et al*., 2004; Raytek *et al*., 1999). If the man in a heterosexual couple is reporting low levels of relationship adjustment pre-therapy, this could potentially result in lower alliance ratings for both partners, which could lead to a greater likelihood of early termination.

A better awareness of gender differences can also be deduced from our findings. Couple therapists should be more aware of how they are attending to both partners in heterosexual couple therapy. It is always helpful to ensure that biases are in check and that the identified client is the couple and/or the relationship, not one partner or the other. Furthermore, it is important to be aware of how biases and balanced attention may be impacting on alliance establishment and potential alliance change (such as alliance growth over time, ruptures and repairs and split alliances between partners). In other words, the imbalance resulting from not properly attending to each partner could potentially lead to worse alliance ratings from either partner, which in turn could result in poor outcomes. To help address this issue, it is recommended that couple therapists track alliance ratings in couple therapy via brief client self-report measures like the SRS as frequently as possible. The use of clinical judgment alone may not sufficiently disclose whether alliances are developing positively and remaining stable or whether there may be unforeseen alliance ruptures. Thus, the use of alliance measures will confirm or contradict the clinical judgment and subsequently assist therapists in their efforts to treat the partners impartially. Additionally, tracking outcome ratings alongside alliance ratings, now an evidence-based practice (Duncan, 2010), may also prove beneficial and may help to establish a greater degree of

understanding among therapists on how processes and changes are unfolding conjointly over time (Anker *et al*., 2009).

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