

ABSTRACT

Title of Thesis: THE RELATIONSHIPS BETWEEN
THERAPIST COMMON FACTOR
BEHAVIORS AND CLIENT EVALUATIONS
OF COUPLE THERAPY SESSIONS

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There is an insufficient amount of research on therapist common factor behaviors during therapy sessions that contribute to the process of therapeutic change in couple and family therapy. The purpose of this study was to explore the association between therapists' common factor behaviors during a couple therapy session and clients' evaluations of that session. The sample was 40 couples presenting with mild to moderate psychological and physical partner aggression who received ten therapy sessions at a university-based clinic. A set of Pearson product-moment correlations were conducted and revealed that only the degree of therapist collaboration behavior was significantly associated with female partners' positive evaluations of the session; statistical trend for males. Overall, male and female ratings of session helpfulness were positively correlated. The possible explanations for the lack of relationships between other therapist behaviors and session evaluations are discussed.

THE RELATIONSHIPS BETWEEN THERAPIST COMMON FACTORS AND
CLIENT EVALUATIONS OF COUPLE THERAPY SESSIONS

by

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Chapter 1: Introduction

Statement of the Problem

There is a great deal of research literature confirming the efficacy of couple and family therapy models in producing positive therapeutic outcomes (Johnson, 2002; Sexton, Robbins, Hollimon, Mease, & Mayorga, 2003; Sprenkle, 2002; Wampold, 2001). Many scholars have spent years studying specific aspects of treatment models in the hopes of understanding what theoretical framework works best in facilitating therapeutic change (Wampold, 2001; Wampold & Imel, 2015). Theoretical models of both individual psychotherapy and couple and family therapy help clinicians conceptualize their clients' problems and identify appropriate treatment methods to address them, but studies comparing models (with substantially more research to date on individual therapies but an increasing body of research on couple and family therapy models) have tended to indicate that they generally lead to similar positive outcomes (Luborsky, Singer, & Luborsky, 1975; Luborsky et al., 2002; Shadish & Baldwin, 2002; Sprenkle & Blow, 2004). The lack of differences in outcomes among models has led to further investigation into what produces therapeutic change, if not the interventions that are specific to one model or another.

In order to understand the commonalities of these models that make therapy effective, Lambert (1992) conducted a meta-analysis of decades of individual psychotherapy outcome research. He found that client improvement can be attributed to four primary factors: the therapeutic relationship, extra-therapeutic factors, clients'

hope and expectancies regarding treatment effectiveness, and therapy techniques. The therapeutic relationship is commonly defined as the “emotional bond established in the therapeutic dyad and the agreement between patient and therapist concerning therapy goals and the tasks necessary to achieve them” (Mano et al., 2016, p. 485). Extra-therapeutic factors include client personality characteristics (e.g., level of motivation, commitment to change, inner strength) as well as factors in the clients’ environment (e.g., social support, religious faith, stressful events) that contribute to positive change. The third factor that Lambert (1992) discusses, clients’ hope and expectancies regarding the effectiveness of treatment, suggests that being hopeful about therapy outcomes leads to positive change (Reiter, 2010). Finally, therapy techniques refer to the specific interventions (e.g., challenging clients’ negative cognitions about their couple relationship) or methods of questioning clients (e.g., use of circular questions that focus clients’ attention on their couple interaction patterns) that clinicians use during treatment, which are consistent with the core concepts of a theoretical model.

These aspects that cut across *all* theoretical models are referred to as the “common factors” of therapy (Spemle & Blow, 2004). A common factors approach to treatment places a major focus on those shared characteristics that influence outcomes, rather than on specific model concepts and methods. Additional research on these four areas has supported Lambert’s findings (Bachelor & Horvath, 1999; Reiter, 2010), whereas other researchers have expanded on particular aspects of the four types of common factors (Howard et al., 1996; Lambert & Ogles, 2004). For example, Johnson and Talitman (1997) proposed that the strength of the therapeutic

relationship between therapist and clients is an important predictor of treatment outcome, particularly within what the authors define as the task dimension of the therapeutic relationship (the couple's perception that the therapist was helpful and that the tasks within therapy were relevant to their presenting concerns). They found that the therapist's ability to describe treatment in a way that is consistent and congruent with client expectations of therapy contributes to successful outcomes.

Because it reduces the importance of model-specific interventions in favor of more generic characteristics of treatments, the common factors approach tends to be a controversial topic among clinicians who hold strong allegiances to particular theoretical approaches with specific types of interventions associated with their favorite model's core concepts. As marital/couple and family therapy has only recently emerged as a distinct mental health profession, its proponents initially emphasized the unique value of particular theoretical models and the strategies for change within each school (Sprenkle, Davis, & Lebow, 2009). Model developers emphasized the differences in their approaches and argued for the respective advantages of the specific approaches to treatment. This comparative discourse has dominated family therapy textbooks and training curricula (Sexton & Alexander, 2002). This competitive stance led to those studies that compared relative effects of alternative therapy models, but as already noted the outcome studies generally failed to identify "winners" in the competitions.

Although findings that alternative therapy models have comparable effects could be interpreted positively as support for the value of therapies that benefit clients by modifying negative systemic patterns in their relationships, many practitioners and

researchers have been resistant to the new common factors paradigm. In this emerging paradigm, the roles of the therapist's and clients' personal characteristics and behaviors are more central to constructive change than are interventions in specific models that target aspects of client functioning that may not be addressed in other models. In the common factors approach the therapist and client characteristics are the essential catalyst in producing client change via *any* model's methods (Sprenkle et al., 2009). However, resistance to the common factors model may be inappropriate in that it still values specific therapy models and interventions as the vehicles through which change is implemented via the common factors. Nevertheless, in spite of growth in theoretical and empirical literature supporting the common factors paradigm, much of the professional training of clinicians still focuses on developing technical abilities through specific theoretical models. In contrast, adherents of the common factors paradigm argue that clinicians should focus on enhancing interpersonal characteristics (empathizing, validating, being present, etc.) before they learn specific treatment techniques (Eugster & Wampold, 1996).

Interestingly, the literature on the efficacy of specific therapeutic approaches treats effects of therapist characteristics on client outcomes as a source of error rather than a relevant source of variance (Mallinckrodt, 1993; Sprenkle et al., 2009). The focus has been on what treatment is being delivered, rather than on who delivers the treatment and *how* they deliver it. However, a study conducted by the National Institute for Mental Health (NIMH) found that, regardless of similar level of training and expertise, there were major differences among therapists in their levels of effectiveness across treatment models (Elkin et al., 1989). These findings suggest a

need for more information about how therapists use common factors characteristics throughout treatment, as well as the effects that those characteristics have on the process and outcome of therapy.

The existing literature on common factors in therapy and their impact on therapeutic outcomes have made it clear that common factors are important components of effective treatment. However, the existing studies have focused on the links between common factors and ultimate therapy outcomes (e.g., improvement in individuals' depression or in couples' relationship satisfaction) but have not assessed the process of change at the session level of treatment. We still do not know which specific therapist behaviors lead to which specific client changes within the session that ultimately produce better therapy outcomes. Data regarding such session-level processes can take the form of in-person interviews with clients, but they are generally collected via paper assessments in which clients report their subjective experiences of the therapeutic alliance or therapist interventions occurring in a session. Examples of such questionnaire measures are the Session Evaluation Questionnaire (Stiles, 1980), the Working Alliance Inventory (Horvath & Greenberg, 1989), the Session Impact Scale (Elliott & Wexler, 1994), the Integrative Psychotherapy Alliance Scales (Pinsof, Zinbarg, & Knobloch-Fedders, 2008), and others of similar nature. Session-level feedback from clients regarding various therapeutic experiences they have had during sessions can be helpful for the clinician in tailoring treatment strategies for the clients (Mallinckrodt, 1993), and it contributes to the collaborative nature of the therapeutic process as client input helps shape therapist interventions (Stiles et al., 1994). Positive session-level evaluations are

correlated with clients' positive evaluations of their therapy as a whole (Kivlighan, Angelone, & Swafford, 1991). Therefore, it would behoove clinicians to learn more about how helpful their clients perceive their actions during therapy sessions. There is a need for research to identify associations between therapist common factor behaviors and client experiences of sessions.

Therapist awareness of therapy process components, such as the presence of certain common factors associated with therapist behavior (e.g., empathy, warmth, structuring of sessions), that may predict a client's evaluation of a therapy session would give clinicians a greater understanding of what their clients find helpful. The uniqueness of each individual client's experiences requires therapists to tailor their interventions for each client based on a mutual understanding and goals for their experiences in therapy sessions. Previous research on session evaluations has found that therapists and clients often have different perceptions and evaluations of the quality of sessions (Eugster & Wampold, 1996). Studies have indicated that clinicians are likely to view particular therapy sessions positively when the client is involved and active or is demonstrating progress or learning, and when the therapist perceives him or herself as being effective or an expert in some way during the session.

Therapists rated sessions more negatively when they believed that they had been too transparent, personally involved with the clients, or overly self-disclosing (Eugster & Wampold, 1996). In contrast, clients made more positive session ratings when they had felt more invested in the session, experienced progress toward overcoming the problems that led them to seek treatment, and generally perceived themselves as learning new things in therapy (Eugster & Wampold, 1996). The research findings

suggest that clients commonly value the interpersonal interactions with their therapists more than the technical aspects of the treatment itself. Another study (Mallinckrodt, 1993) revealed that a therapist's expertise was not as significant a predictor of clients' positive session evaluations as was the strength of the therapeutic relationship between clinicians and clients.

The discrepancies between the perceptions of session quality of therapists and their clients may be disconcerting for the therapists, because it is important for therapists to grasp the quality of the therapy process and make adjustments as needed to maximize the alliance with clients and positive outcomes. Although prior research has focused primarily on therapist common factors and therapeutic outcomes, it also is important to increase knowledge about specific aspects of therapy such as therapist common factors that lead to positive client responses to single sessions. As previously noted, the presence of certain common factors such as therapist empathy and validation has been found to lead to positive client evaluations of sessions, even though therapists place more value on techniques associated with their therapy model (Stiles & Snow, 1984). In order to focus more on factors that influence clients' evaluations of sessions, ratings of therapist behaviors by trained outside observers, using systematic rating systems that capture common factors involving specific forms of therapist behavior, offer another avenue for investigating therapy process.

Process coding in couple and family therapy generally involves the use of coders, raters, or judges who have no interpersonal involvement in the system being studied (Alexander, Robert, Robbins, & Turner, 1995). Such therapy process coding provides researchers with information about specific forms of observable behaviors

that may tap relational processes between the client and the therapist (Pinsof, 1979). The existing literature on therapist behavior rating systems has focused predominantly on the experiences of clients in individual psychotherapy, with some attention to family therapy research (Barber & Critis-Christoph, 2010). In recent years, couple and family therapy researchers have used measures such as the *Family Therapist Behavior Scale* (FTBS; Pinsof, 1979) and the *Ratings of Therapists' General Clinical Skills/Qualities Scale* (TGCSQ; Evans, Epstein, & McDowell, 2009) to assess therapist actions in sessions in studies of the processes of therapeutic change. The FTBS was designed to identify and study clinically relevant verbal behaviors of short-term, problem-oriented family therapists, whereas the TGCSQ was specifically developed to measure therapist common factor behaviors toward client couples.

The insufficient amount of research on therapist behaviors during sessions leaves a significant gap in knowledge regarding therapist common factors contributing to the process of therapeutic change in couple and family therapy. There is especially little prior research on the association between therapist behaviors during sessions and clients' experiences of those sessions. The present study investigated the association between therapist behaviors assessed through behavioral coding of video-recorded sessions and client ratings of their experiences in the sessions

Purpose

The purpose of this study was to explore the association between therapists' common factor behaviors during couple therapy sessions and client evaluations of those sessions. Prior evidence regarding the difference in perspectives between

therapists and their clients on what therapist actions facilitate constructive therapy sessions suggests that clients especially value therapist common factor behaviors more than model-specific therapy techniques. Those therapist common factor behaviors may fall into two main categories: (a) *relationship factors*, the actions that facilitate a positive relationship or alliance between therapist and client, and (b) *technique factors*, the actions that create structure in sessions and contribute to constructive use of the time to improve couple interactions (Evans, 2011). Rather than relying on therapists' own perceptions of session quality, this study assessed therapists' use of common factors with the *Ratings of Therapists' General Clinical Skills/Qualities Scale* (TGCSQ; Evans et al., 2009), with which trained raters observe therapist-client interactions during sessions and rate particular therapist behaviors in those two major categories of relationship factors and technique factors. The TGCSQ observational assessment method was developed for Evans' (2011) study that explored the couple therapy process and its relation to therapy outcomes (e.g., increases in partners' relationship satisfaction) with a similar emphasis on the therapists' common factor behaviors toward clients.

By exploring what therapists do during sessions that facilitates clients' positive versus negative perceptions of the therapy sessions, we may be better able to understand what clients find helpful about treatment and how therapists can continue to refine these particular skills and/or qualities throughout their practice as clinicians. In addition, the study explored whether female and male clients are influenced differently by particular therapist behaviors, such as degree of expressed empathy or degree of session structuring.

The findings from this study have both theoretical and clinical implications for couple and family therapists and researchers. In terms of theory, the findings can add to understanding the effective components of couple therapy that are shared by various models and could be enhanced in manuals for empirically supported treatments. Pragmatically speaking, developing a greater understanding of what clients value in couple therapy seems likely to result in more effective therapy and greater client satisfaction. As the field of relational therapy continues to expand and change, it is important for clinicians to stay focused on the most important aspect of therapy, the client. The findings can increase understanding of the impacts of various common factors therapeutic behaviors so that clinicians might adapt their therapeutic style in order to provide clients with the optimal therapeutic experience, regardless of the clinician's preferred therapy theoretical model.

Chapter 2: Literature Review

Introduction

The following review covers literature regarding the exploration of clients' perceptions and experiences of therapy and the impact of common factors on positive therapeutic outcomes. Historically, clinicians and researchers have sought to understand what makes therapy effective, largely within the context of specific theoretical models (Ogles, Anderson, & Lunnen, 1999; Sexton, Ridley, & Kleiner, 2004). As outcome research has expanded, it has been suggested that the mechanisms of change in therapy include certain *shared* general characteristics of various theoretical approaches, as opposed to characteristics of specific theoretical models (Lambert, 1992; Sprenkle & Blow, 2004; Sprenkle et al., 2009). Although many researchers have explored what the common factors of therapy are, fewer have examined how they operate to facilitate positive change in therapy. Similarly, little is known about clients' perceptions of the therapeutic experience through a common factors lens. This study examined the impact of therapists' use of common factor behaviors on clients' perception of couple therapy sessions, in particular how helpful they found the sessions.

Therapy Common Factors Research

The term "common factors" refers to components common to all models of therapy that influence positive client outcomes. Interest in these factors first began

with Rosenzweig's (1936) publication in which he suggested that common factors across various schools of individual psychotherapy facilitate therapeutic change (Sexton & Alexander, 2002; Sprenkle & Blow, 2004). Researchers in the field of psychotherapy continued their exploration into common factors in individual therapy over the subsequent years. Lambert (1992) conducted a meta-analysis of 40 years of outcome studies and concluded that there are four primary factors influencing positive therapy outcome. Lambert concluded that (1) extra-therapeutic factors (e.g., the client's personality, social support, stressful events) account for 40% of positive therapy outcome, (2) the therapeutic relationship (e.g., emotional connection and agreement between therapist and client on goals and tasks for therapy) accounts for 30%, (3) client hope and expectancy factors (e.g., the client's prediction that therapy will be helpful) account for 15%, and (4) specific therapeutic models or techniques account for only 15% of positive psychotherapy outcomes such as changing behavior, altering cognitions, and experiencing emotions differently. It should be noted that these relative percentages of variation in therapy outcome have no standard statistical validity, as Lambert made an informed approximation of each factor's respective influence based on the results, such as effect sizes, in his meta-analysis.

Nevertheless, Lambert's (1992) analysis brought significant attention (surprising to many psychotherapy researchers and practitioners) to the relative importance of common factors in contrast to model-specific interventions.

The common factors framework of therapy efficacy has been controversial in both individual psychotherapy and marriage and family therapy (Sexton et al., 2004), as each field traditionally has been largely formed by model-driven change theories.

Some writers suggest that the therapeutic fields should each be more integrated, with less focus on specific theories with their unique assumptions regarding factors that produce change in clients and their problems (Lambert & Bergin, 1994). This shift would allow clinicians to focus on the factors involved in practicing effective therapy, rather than adhering to a particular clinical model or technique that in itself may have limited impact beyond its delivery of the effective common factors. Other researchers believe that the literature on the common factors model of therapy efficacy is still severely limited (Sexton et al., 2004) and suggest further studies examining effects of various common factors, especially in the field of couple and family therapy.

Many researchers have explored the influence of common factors on the process of change in individual psychotherapy (Hubble, Duncan, Miller, 1999; Lambert 1992; Luborsky et al., 1975; Sprenkle & Blow, 2004). However, findings from the individual psychotherapy studies cannot be generalized to therapies with couples and families, as they fail to account for relational dynamics (therapists' actions toward multiple clients in the same room) that might affect therapists' use of common factor behaviors or clients' perception of the therapists' actions during sessions. Thus, more research is needed on effects of therapist common factor behavior in couple and family therapy. In addition, given that client perceptions of helpfulness of various therapist behaviors differ from therapist perceptions of what is helpful, more research is needed on the clients' perceptions regarding common factors, especially in the field of couple and family therapy.

Categories of Common Factors

Extratherapeutic Factors

Lambert (1992) was among the first psychologists to draw attention to the role of the client in accounting for outcome variance in individual psychotherapy. He referred to external components of therapy, such as client characteristics and environmental influences, as “extratherapeutic factors” that influence client outcomes. He defined extratherapeutic change as, “those factors that are part of the client (such as ego strength and other homeostatic mechanisms) and part of the environment (such as fortuitous events, social support) that aid in recovery regardless of participation in therapy” (p. 97). These factors are what clients bring to therapy and what influences their life outside the therapy room. As noted earlier, according to the results of Lambert’s (1992) investigation, external factors account for approximately 40% of therapeutic change.

Although several clinicians and researchers have emphasized the client as the main determinant of the outcome of couple therapy (Asay & Lambert, 1999; Miller, Duncan, & Hubble, 1997), much of this research has focused on individual psychotherapy, with little attention paid to client factors in the field of couple and family therapy. According to Sprenkle and Blow (2004), most of the research on client factors in relational therapy has focused on static characteristics of individuals (e.g. age, gender, and sexual orientation), with virtually no research on client characteristics much more related to outcome (e.g. motivation and engagement in treatment, perseverance and cooperation in completing therapeutic tasks) (Sprenkle et al., 2009). At this point, there is minimal understanding of the influence of client

factors on therapeutic outcomes. The insufficient literature on the influence of specific client factors on therapeutic outcomes warrants further investigation of these variables and their effect on the process of therapy.

Therapeutic Relationship Factors

The concept of the therapeutic alliance was first explored in the context of individual psychotherapy, but it has played a key role in the development of the clinical practice of couple and family therapy. The therapeutic alliance (also referred to as the therapeutic relationship or working alliance) has been defined as the quality and strength of the collaborative relationship between the client and the therapist in therapy (Horvath & Bedi, 2002). More specifically it has been described as, “the degree to which the therapist is able to provide a positive bond and collaborate with a client on the goals and processes of treatment” (Muran & Jacques, 2010, p. 368).

The couple and family therapy literature describes the development of the therapeutic relationship in varying terms, including “establishing a useful rapport” (Ackerman, 1966, p. 100), “empathic attunement” (Johnson, 1996, p. 35), “setting the stage” (Haley, 1976, p. 14), and most notably “joining” (Minuchin & Fishman, 1981, p. 32). A review of decades of individual psychotherapy research on the client-therapist relationship supports the notion that a strong therapeutic alliance leads to positive client outcomes (Lambert & Barley, 2001). The exploration of the association between the therapeutic alliance and therapy outcomes specific to couple and family therapy has found results similar to those in the general psychotherapy research.

The development of the alliance in couple and family therapy differs from individual therapy in that it often involves multiple clients, producing multiple relationships per client system (couple or family). According to couple and family therapy researchers, the inclusion of two or more people in the therapeutic process introduces complexity into the relation between the therapeutic alliance and therapy outcomes. These complexities were explored in a small study (Quinn, Dotson, & Jordan, 1997) that collected data from 17 couples receiving couple or family therapy treatment at a university-based clinic. The authors examined various aspects of therapeutic alliance and their associations with treatment outcome in family therapy, using the Interpersonal Psychotherapy Alliance Scale (IPAS; Pinsof & Catherall, 1986). The IPAS explored three relational areas: the therapist and the client, the therapist and the client's family, and the therapist and the interpersonal system in which the client is a part. Treatment outcome was assessed by the clients' responses to two questions, (1) the degree to which they believed the goal of therapy to have been met and (2) the degree to which they believed changes made in therapy would last for the next 3 to 6 months. Interestingly, the authors' findings suggest that successful therapy outcomes are more highly associated with women, more so than their husbands, feeling aligned with the therapist and believing that other family members are working well with the therapist (Quinn, Dotson, & Jordan, 1997). Although the study only assessed a small sample of cases, the results corroborate prior research findings indicating an association between therapeutic alliance and outcome.

Depending on the specific population, the concept of the therapeutic alliance has been explored and defined in a variety of different ways. However, each description seems to be derived from Bordin's (1979) conceptualization of the working alliance between a client and their therapist. He defines the working alliance as collaboration between the client and the counselor based on the development of an attachment bond, as well as a shared commitment to the goals and tasks of therapy. Bordin proposed that the working alliance consists of three interdependent components: goals (e.g., increase marital satisfaction, decrease marital conflict), tasks (e.g., in-session activities, homework), and bonds (e.g., level of trust, feeling of common purpose or understanding). In order to understand how these components influence the process of therapy, more research is needed on therapists' behaviors during sessions.

Client Hope and Expectancy Factors

Miller, Duncan, and Hubble (1997) suggest that hope and positive expectancy is the third domain of the common factors paradigm that influences positive therapeutic change. According to Lambert's (1992) meta-analysis of individual psychotherapy outcome research, hope and expectancy or "placebo factors," accounted for about 15% of outcome variance. They argue that all models of therapy have ways of working with clients to facilitate hope and positive expectancy for change. A therapeutic interaction that facilitates hope also encourages the client to predict positive change, which is believed to lead to successful therapeutic outcomes (Lambert, 1992; Miller et al., 1997; Reiter, 2010).

Part of a client's hope is their expectancy of therapy outcomes; the two are mutually connected. In fact, clients' expectancies of therapy have often been thought of as the "activating energy" of hope for change (Reiter, 2010, p. 135). Hope can be understood in terms of how people think about goals (i.e., their ability to achieve and maintain desired changes). Goal pursuit thinking is the foundation of hope. When a client develops goals, it means that they expect some useful outcome for their efforts. Thus, by helping a client to generate hope, the therapist is also increasing a client's sense of positive expectancy.

Specific Therapeutic Models and Techniques

Theoretical models help clinicians to conceptualize their clients' problems and appropriate treatment methods to address them. As couple and family therapy has only recently emerged as a distinct mental health profession, its proponents initially highlighted the unique value of particular theoretical models and the strategies for change within each school (Sprenkle et al., 2009). Model developers emphasized the differences in their approaches and argued for the respective advantages of the specific approaches to treatment. This comparative discourse has dominated family therapy textbooks and training curricula (Sexton & Alexander, 2002).

In their chapter exploring the therapeutic efficacy of models and techniques, Ogles et al. (1999) define a model as, "a collection of beliefs or unifying theory about what is needed to bring about change with a particular client within a particular treatment context" (p. 202). According to this notion, models would then be comprised of techniques, defined as "actions that are local extensions of the beliefs or theory" (p. 202). This framework suggests that all therapists work from a set of

assumptions or beliefs about what facilitates positive change. As Sprenkle et al. (2009) point out, therapists' perceptions of the process of therapeutic change depend on the particular paradigm or "set of lenses" through which they view psychotherapy (p. 45.). As many clinicians subscribe to the model-driven change paradigm, they believe that only the unique and/or particular dimensions of models are the primary engines that drive change.

However, research that explores the efficacy of these models indicates that they generally lead to similar positive outcomes (Luborsky et al., 1975; Luborsky et al., 2002; Shadish & Baldwin, 2002; Sprenkle & Blow, 2004). This aspect of common factors research has been the most controversial for couple and family therapists (Sexton et al., 2004), as it suggests that one theoretical orientation has no more of an impact on client change than any other orientation. As the field has traditionally been formed by model-driven change theories, these findings directly challenge the current establishment of how therapy is learned and taught.

In Lambert and Bergin's (1994) comprehensive review of both meta-analytical research and individual comparative studies, they examined the overall effectiveness of individual psychotherapy on symptom reduction, as well as the effectiveness of different schools of therapy. As previously noted, their findings support the conclusion that psychotherapy is effective, regardless of the theoretical orientation of the therapist. Lambert and Bergin argued that there is little to no difference among therapy models when comparing outcome results, but there is not enough evidence to rule out the importance of the models in the process of therapy.

The efficacy of couple and family interventions is only further solidified by the growing amount of couple and family research literature. Sprenkle (2002) offers a summary of the qualitative reviews and meta-analyses that suggests these relational interventions are (1) efficacious for a wide range of problems, (2) produce positive results with different types of families, and (3) create positive results that endure over long periods of time. Current reviews of literature suggest that couple and family intervention programs are effective in treating a variety of issues (e.g., adult schizophrenia, alcoholism, drug abuse, adolescent conduct/oppositional defiant disorder). The lack of quantitative differences in treatment modalities on client outcome has led some scholars to suggest that there is little difference among traditional schools of therapy (Gurman & Kniskern, 1981). However, others maintain the belief that success of *certain* intervention programs with specific clinical problems suggests that differences among approaches do indeed exist and are, in fact, substantial (Sexton, Alexander, & Mease, 2004).

Although the main proponents of the common-factors change paradigm reject the notion that the unique aspects of particular theoretical models are the main contributors to therapeutic change (Blow, Sprenkle, & Davis, 2007; Sprenkle et al., 2009), they do believe that effective clinical models are an indispensable part of good therapy. Sprenkle and Blow (2004) describe theoretical models as the vehicles through which common factors operate. As such, it is the therapist that brings the “human” aspect to treatment through the use of common-factor behaviors (e.g., expressing warmth, being empathic, validating the client’s experience). Although we know that there are common factors across treatment modalities that facilitate

therapeutic change, little is known about how therapists utilize these common-factor behaviors and how they lead to specific client changes within the session that ultimately produce better therapy outcomes.

Clients' Perceptions of the Therapeutic Experience

Traditionally, the literature on the client's experience of therapy is based on the therapist's or researcher's experience or interpretation of the client's perception. The objective outcome approach of the early field of psychotherapy placed little emphasis on the process of therapy in favor of solely exploring how specific treatments facilitated successful outcomes. In Greenburg and Pinsof's (1986) discussion of process and outcome research, they suggested that the two have often been considered separate domains, with little regard for *what* about the process produces successful outcomes. Similarly, those authors stressed the importance of further investigating what it is that therapists do during the therapeutic process that facilitates positive change and how clients perceive their experience in therapy.

Understanding how therapy process translates into outcomes for clients has proven to be a difficult venture for many scholars. Only recently have researchers begun to focus on the importance of clients' evaluations of sessions (e.g., whether the session seemed good or helpful, whether they felt good afterward) and their influence on the therapeutic process. Data collection regarding these session-level processes can take the form of in-person interviews with clients, but they are generally assessed with paper assessments (or more recently with i-Pad questionnaires) in which clients report their subjective experiences of the therapeutic alliance or therapist interventions occurring during a session. Examples of such questionnaire measures

are the Session Evaluation Questionnaire (Stiles, 1980), the Working Alliance Inventory (Horvath & Greenberg, 1989), the Session Impact Scale (Elliott & Wexler, 1994), and the Integrative Psychotherapy Alliance Scales (Pinsof et al., 2008).

Although each of those assessments examines slightly different aspects of the therapeutic process, they are all meant to identify helpful and hindering aspects of therapy.

According to Elliott and Wexler's (1994) review of session-level evaluation measures, assessments such as the Session Evaluation Questionnaire (SEQ; Stiles, 1980), typically ask clients to judge individual sessions as good or bad in two distinct ways: "depth" and "smoothness." For example, in terms of depth, a session can either be deep (powerful, effective) or shallow (weak, worthless); in terms of smoothness, sessions may either be perceived as smooth (relaxed, comfortable) or rough (tense, distressing). Other measurement tools, such as the Session Impact Scale (SIS; Elliott & Wexler, 1994) focus on evaluating helpful and hindering aspects of the therapeutic process from the client's perspective. The SIS consists of three subscales, (1) Task Impacts (progress toward knowing what to do about one's problems), (2) Relationship Impacts (feeling validated by the therapist, feeling closer to the therapist), and (3) Hindering Impacts (more bothered by unpleasant thoughts, not enough direction from therapist) (Elliott & Wexler, 1994). Although the SEQ may be useful in evaluating how clients perceived sessions, the SIS may provide more insight into *what* clients found helpful or unhelpful in a session.

As noted earlier, previous research on session evaluations has found that therapists and clients often have different perceptions and evaluations of the quality

of sessions. Eugster and Wampold (1996) conducted a study exploring the systematic differences between therapists and clients in the process components that predict evaluation of psychotherapy sessions. They found that therapist session evaluations were best predicted by “therapist expertness” (competence or expertise) and client session evaluations were best predicted by the “therapist real relationship” (degree of transparency, strict role-defined behavior). The lack of congruency between therapists’ and their clients’ perceptions of “good” therapy suggests the need for further investigation of what therapist behaviors facilitate the therapeutic process that leads to successful client outcomes.

Helmeke and Sprenkle (2000) confirmed these findings in their qualitative study examining clients’ perceptions of pivotal moments in couple therapy. After analyzing session transcripts, post-session questionnaires, and two post-therapy interviews with each couple, their findings revealed that pivotal moments were highly individualized, with little overlap between spouses, and little overlap between therapist and client identification of pivotal moments. Multiple perceptions of the same therapeutic experience can make the process of therapy stressful for a clinician. Beyond having a biased opinion about their own performance, therapists face the challenge of tailoring one treatment to multiple people’s needs. Although each person is bound to have an individualized experience in couple therapy, understanding how, when, what, and whom the changes occur for will help the therapist facilitate better therapy.

Session-level feedback in couple and family therapy is particularly valuable given the complex process of relational therapy. Exploring how clients perceive the

therapeutic experience can help clinicians tailor treatment strategies to their clients' needs and contribute to the collaborative nature of the therapeutic process as client input helps shape therapist interventions (Stiles et al., 1994). Similarly, exploring how therapist behaviors influence clients' perceptions of therapy can shed light on the therapist's role in the "how" of change. For example, Couture and Sutherland's (2006) conversation analysis of family therapy sessions suggests that even a slight change in the content or timing of what a therapist says during a session can change the meaning of that interaction for the client. This suggests that there is a need for more research on how therapist behaviors influence clients' perceptions of the therapeutic process.

Developments in Research on Common Factors in Therapy Process

As the literature on the efficacy of the common-factors change paradigm continues to grow, scholars are becoming more interested in the specific change mechanisms of the therapeutic process. Some researchers are interested in how clients perceive the four major types of common factors (i.e., extratherapeutic factors, model/techniques, therapeutic alliance, and hope/expectancy) and how they contribute to change in the therapeutic process (Lambert & Barley, 2001; Thomas, 2006). Others are interested in evaluating specific interactions in therapy that clients perceive as helpful, meaningful, or pivotal (Elliott & Wexler, 1994; Helmeke & Sprenkle, 2000). The importance of the therapeutic relationship in facilitating successful therapeutic outcomes has been noted by many (e.g., Bordin, 1979; Hatcher & Barends, 2006; Lambert 2016). However, *how* therapists behave in session to facilitate this positive relationship during sessions and its subsequent influence

throughout the process of therapy remains an under investigated topic among couple and family therapy scholars. The present study was intended to advance knowledge in this area.

In the area of couple therapy in particular, recent research has investigated therapist common factor behaviors and their relation to client improvement. Evans (2011) conducted a study that examined the role of both client and therapist common factors in helping distressed couples overcome relationship negativity and improve relationship satisfaction. Evans' (2011) study examined the relationship between two types of characteristics that members of distressed couples tend to bring to therapy (their amount of negative couple communication behavior and the degree to which each person makes negative attributions about their partner) and aspects of couple therapy outcomes (levels of overall relationship satisfaction and psychological partner aggression). Additionally, Evans' study investigated how specific therapist behaviors regarding their relationship with clients and their delivery of therapeutic interventions are related to the therapy outcomes of increased relationships satisfaction and decreased psychological aggression. Therapist behaviors were examined in two categories, relationship-oriented therapist factors (warmth, empathy, presence, validation, and collaboration) and technique-oriented factors (therapist use of systemically-based technique and session structure). Evans' found that therapist factors moderated the relationships between the client pre-treatment negative characteristics and therapy outcomes but did not buffer the negative relationship between client negativity and positive therapy outcomes. Although Evans' study provided a deeper insight into how therapist behaviors influence client outcomes,

further investigation of these behaviors and their relation to client experiences of couple therapy sessions would expand the understanding of the therapeutic process.

Hypotheses and Research Questions

The common factors framework describes commonalities across treatment models that influence positive client outcomes in psychotherapeutic treatment (Sprenkle & Blow, 2004). Positive client session evaluations of therapy are correlated with a strong therapeutic relationship, feeling understood, and how relevant therapeutic tasks addressed their presenting problem (Mallinckrodt, 1993). As existing literature on therapist behavior rating systems has focused predominantly on the experiences of clients in individual psychotherapy (Barber & Critis-Christoph, 2010), couple therapy process coding provides researchers with information about specific forms of observable behaviors that may tap relational processes between the client and the therapist. Evan's (2011) research on therapist common factors in couple therapy, which assessed relationship factors (warmth, empathy, presence, validation, and collaboration) and technique factors (use of systemic techniques and session structure) provided a foundation for investigating how therapist common factor behaviors are associated with client experiences in couple therapy. The present study tested two hypotheses that involve directional predictions about the associations between therapist common factor behaviors and client perceptions of couple therapy sessions:

Hypothesis 1: Members of couples who work with therapists who exhibit higher levels of common factor behaviors involving warmth, empathy,

presence, validation, and collaboration will give higher ratings regarding the quality of the therapy session as providing them help with their problems.

Hypothesis 2: Members of couples who work with therapists who utilize higher levels of systemic techniques and session structure will give higher ratings regarding the quality of the therapy session as providing them help with their problems.

The study also explored possible gender differences in partners' perceptions of couple therapy sessions as a function of therapist relationship and technique common factor behaviors. Two research questions (as opposed to directional hypotheses) were investigated:

Research Question 1: Do the relationships between therapists' levels of warmth, empathy, presence, validation, and collaboration and client evaluations of therapy sessions as providing them help with their problems differ for female and male members of couples?

Research Question 2: Do the relationships between therapists' use systemic techniques and session structure and client evaluations of therapy sessions as providing them help with their problems differ for female and male members of couples?

Definitions of Variables

Therapist Relationship Common Factor behaviors observed in the 90-minute fourth couple therapy session within the 10-session treatment protocol (Evans, 2011):

Warmth. Therapists' use of humor to connect with clients, smiling when appropriate, and generally using a calm tone of voice.

Empathy. Therapists' use of reflective statements to demonstrate empathic understanding of clients' thoughts and emotions.

Validation. Therapists agree with clients when appropriate; take the clients' thoughts and feelings seriously and convey this through affirming and legitimizing statements.

Presence. Therapists make eye contact with client and show interest in clients' lives by asking personal questions; therapists follow up on client statements and follow a clear line of questioning.

Collaboration. Therapists use inclusive language to ask clients for their opinions and preferences regarding interventions, tasks, and goals.

Therapist Technique Common Factor behaviors observed in the 90-minute fourth couple therapy session within the 10-session treatment protocol (Evans, 2011):

Systemically-based techniques. Therapists demonstrate working in a systemic manner by involving both partners in the session and following up with each partner; therapists identify cyclical patterns in couple interaction; therapists use circular questioning to encourage clients to think about mutual influence; therapists seek information to create interventions based on multiple environmental levels.

Session structure. Therapists structure the session in a constructive and productive manner; therapists control conflict behaviors displayed by clients toward one another; therapists allow clients the opportunity to discuss important topics

without going on a tangent; therapists allow time for both members of the couple to express concerns and goals; therapists reinforce positive change using positive feedback and encouragement.

Chapter 3: Method

Introduction

The purpose of this study was to investigate the influence of therapists' common factor behaviors during couple therapy sessions on client evaluations of those sessions. In order to examine this aspect of the therapeutic process, the associations between therapist behaviors that were rated previously (Evans, 2011) and clients' evaluations of that couple therapy session were tested. The study was a secondary analysis of data from Evans' (2011) previous study testing therapist common factor behaviors toward client couples seeking therapy at a university-based training clinic, the Center for Healthy Families at the University of Maryland, College Park. The Center for Healthy Families is an outpatient facility where couple and family therapist interns, with varying levels of experience, provide services, as the clinical training component of their enrollment in an accredited Couple and Family Therapy master's degree program. The clinic offers treatment to community individuals, couples, and families with a variety of relationship problems and mental health issues. Therapist interns learn and work from a family systems framework and are supervised by licensed couple and family therapists via live observation through one-way mirrors or review of session video recordings.

Sample

The sample used in this study was comprised of 40 heterosexual couples who sought treatment between 2000 and 2009 at the Center for Healthy Families at the University of Maryland, College Park. The couples were recruited for their voluntary participation in a larger treatment outcome study (*Project Title: An Evaluation of Couple Treatments for Domestic Abuse*, also referred to as the *Couple Abuse Prevention Program (CAPP) Study*). The study examined the effectiveness of different couple therapy models for couples who were experiencing psychological and mild to moderate physical partner aggression in their relationships.

Descriptive Statistics for Participating Couples

The study used data that were collected from 40 males and 40 females who completed assessments for the larger treatment study (CAPP). The mean age for males was 33 years (range: 22-51 years), and the mean age for the females was 31 years (20-51 years). The sample's racial demographics for males are 70% Caucasian, 18% African American, 5% Hispanic, 2% Native American, and 5% Other, and for females are 63% Caucasian, 20% African American, 10% Hispanic, 2% Asian/Pacific Island, and 5% Other. Of the 40 couples, 92% were married (and living together) or cohabitating, and the mean relationship length was six years. Tables 1-4 include other demographic information including participants' education and income.

Table 1. Demographic Information for Couples

Couple Characteristics	<i>n</i>	Minimum	Maximum	Mean	Standard Deviation
Female's age	40	20.00	51.00	31.33	8.11
Male's age	40	22.00	51.00	33.10	8.32
Years together	40	1.00	29.00	6.24	5.58

Female's income	40	0	125,000	27,137	25,912
Male's income (\$)	40	18,000	130,000	48,425	24,642

Table 2. Relationship Statuses of Couples

Relationship Status	Frequency	Percent
Currently married, living together	25	62.5 %
Currently married, separated	1	2.5 %
Living together, engaged	7	17.5 %
Dating, living together	5	12.5 %
Dating, not living together	2	5 %
Total	40	100 %

Table 3. Demographic Information for Female Partners

Female's Characteristics	Frequency	Percent
Race		
African American	8	20%
Asian/Pacific Islander	1	2.5%
Hispanic	4	10%
Caucasian	25	62.5%
Other	2	5%
Total	40	100%
Education		
Some high school	2	5%
High school diploma	3	7.5%
Some college	12	30%
Associate degree	5	12.5%
Bachelor degree	9	22.5%
Some graduate education	3	7.5%
Masters degree	4	10%
Doctoral degree	2	5%
Total	40	100%

Table 4. Demographic Information for Male Partners

Male Characteristics	Frequency	Percent
Race		
Native American	1	2.5%
African American	7	17.5%
Hispanic	2	5%
Caucasian	28	70%
Other	2	5%
Total	40	100%
Education		
Some high school	1	2.5%
High school diploma	9	22.5%
Some college	8	20%
Trade school	1	2.5%
Associate degree	7	17.5%
Bachelor degree	4	10%
Some graduate education	4	10%
Masters degree	3	7.5%
Doctoral degree	3	7.5%
Total	40	100%

Sample Eligibility Criteria

In order for couples to be eligible to participate in the larger CAPP study, both members of the couple had to be at least 18 years of age, and the couple had to have been in an intimate relationship with each other for at least six months, with overtly stated desire to improve their relationship. Similarly, at least one member of the couple had to report psychological and/or physical aggression within the relationship. Lastly, each partner needed to report that they felt safe living together and participating in a couple treatment program together. Couples who reported physical

violence that resulted in injury, who reported fear of their partner, and/or reported untreated substance use by either member of the couple were excluded from the original CAPP study.

Instruments

Ratings of Therapist Common Factor Behaviors

Therapists' common factor behaviors during the fourth CAPP therapy session were observed and rated in Evans' (2011) study using the *Therapists' General Clinical Skills/Qualities* (Evans, et al., 2009). The TGCSQ was developed to assess aspects of therapists' common factor behaviors across couple therapy models. Blow and Sprenkle's (2001) description of common factors that therapists often report as influencing positive outcomes served as a guide throughout the development process of the TGCSQ. The authors developed specific criteria for rating therapist *relationship factors* (i.e., therapist warmth, empathy, presence, validation of the client, and therapist-client collaboration) and *technique factors* (i.e., therapists' ability to control the session and conceptualize clients' problems systemically) that are commonly used by couple and family therapists regardless of their treatment model. Rather than relying on therapists' perceptions of session quality, this study assessed therapists' use of common factors with the observational ratings that were made by trained raters of therapist in-session behaviors in the Evans (2011) study, using the *Therapists' General Clinical Skills/Qualities Scale* (TGCSQ; Evans et al., 2009). Therapist behavior ratings in the two major common factors categories of relationship factors and technique factors were used in the present study.

Client Rating of Couple Therapy Session Quality

Session Evaluation Questionnaire (SEQ; Stiles, 1980). The SEQ is a session-level impact measurement tool with which clients report their perceptions of a therapy session, typically immediately after the session. The Center for Healthy Families clinic where the data for this study were collected uses the section of the SEQ that consists of four Likert-scale type questions, each of which the client answers using a 4-point response scale of 0 = Not at all, 1 = A little, 2 = A moderate amount, and 3 = Very much, indicating the client's experience of a therapy session. The four SEQ items are as follows: (1) *My partner and I had an opportunity to discuss important concerns about our relationship*, and (2) *This session helped me learn new way to reduce conflict in our relationship*, (3) *During the session, my partner and I had an opportunity to practice new ways to deal with conflict and anger*, and (4) *Overall, session was helpful*. In the present study, the SEQ was used to examine the associations between therapist in-session behaviors and clients' overall experiences of the usefulness of the session. In the present sample, the internal consistency of the 4-item SEQ was calculated in terms of the Cronbach alpha, separately for female partners and male partners. The Cronbach alpha for the females was .70, and for the males it was .78, both at the traditional acceptable level of .70.

Procedures

The data used in the present study were previously collected for Evans' (2011) study, which examined the relation between client and therapist common factors and

outcomes of couple therapy. In order to measure therapist common factor behaviors, Evans developed a team of trained undergraduate coders to code the fourth 90-minute session of 40 couple cases involved in the CAPP study. The coders used the *Therapists' General Clinical Skill/Qualities Scale* (TGCSQ; Evans et al., 2009) to assess two broad components of therapist behavior: **relationship factors** and **technique factors**. Two trained undergraduate coders independently coded therapy session number four for each participating couple, and an average of the coders' scores determined the final score for each category of therapist behavior. Each behavioral cue associated with each type of therapist behavior (e.g., cues for therapist empathy) was given a code of 0 ("not at all," meaning that the therapist did not engage in the behavior) to 4 ("very much," meaning that the therapist engaged in the behavior to large extent). One score was given for each co-therapy team (e.g., if one therapist behaved in one way and the other therapist behaved in a way contradictory to this, the coded score reflected consideration of each of these behaviors). Scores for each behavior were summed to arrive at a final rated score for both the relationship and technique components of the TGCSQ. Consensus and reliability were obtained by having two undergraduate coders code each session, taking the average of their two coding scores, which must not be greater than 1 point different from each other.

In the present study, in order to assess the influence of therapists' use of common factor behavior in session on client experiences of the session, client Session Evaluation Questionnaire (SEQ) ratings were used to assess the degree to which the client found a session helpful. The SEQ had been administered at the end of every therapy session during the CAPP study in order to measure the clients' perceptions of

the treatment process. Each item of the questionnaire was given a score of 0 (“Not all”), 1 (“A little bit”), 2 (“Moderate amount”), and 3 (“Very much”). Participant responses to the four SEQ items were summed to produce an overall “session helpfulness” score for session four, for each member of a couple.

Chapter 4: Results

Data Analysis

To investigate the two hypotheses and associated research questions, Pearson product-moment correlations were computed to assess the associations between therapist common factor behaviors and clients' evaluations of the therapy session. Then, the test for the difference between two correlation coefficients, using r to z transformations, was used to test whether there were differences between the correlations for male versus female members of the couples.

The descriptive statistics for the therapist common factor behaviors can be found in Table 5. The potential range of scores for therapist common factor behaviors (warmth, empathy, validation, presence, collaboration, technique, structure) was 0 to 4. The lowest therapist behavior mean was for therapist collaboration ($M = 2.1$), and the highest was for therapist presence ($M = 3.34$).

Table 5. Descriptive Statistics for Therapist Variables

Therapist Behavior	<i>n</i>	Potential Range	Actual Minimum	Actual Maximum	Mean	Standard Deviation
Warmth	40	0-4	1.50	3.75	2.63	.654
Empathy	40	0-4	2.50	4.00	3.26	.519
Validation	40	0-4	1.25	3.50	2.44	.483
Presence	40	0-4	2.50	4.00	3.34	.369
Collaboration	40	0-4	.50	3.75	2.1	.738
Technique	40	0-4	2.00	3.88	2.73	.373
Structure	40	0-4	1.38	3.71	2.8	.524

The descriptive statistics for the clients' session evaluation questionnaires can be found in Table 6. The potential range of scores for the Session Evaluation Questionnaire was 0 to 12. The actual minimum/maximum scores for females' session evaluations were 5/12 and the actual minimum/maximum scores for males' session evaluations were 3/12. Similarly, the mean female SEQ score was 9.65 (SD = 2.12), whereas the mean male SEQ score was 8.43 (SD = 2.74).

Table 6. Descriptive Statistics for Client Session Evaluation Questionnaires

SEQ	<i>n</i>	Potential Range	Actual Minimum	Actual Maximum	Mean	Standard Deviation
Female SEQ	40	0-12	5.00	12.00	9.65	2.12
Male SEQ	40	0-12	3.00	12.00	8.43	2.74

Finally, a paired sample *t*-test was used to test for a possible gender difference between male and female partners' SEQ evaluations of the therapy session as providing them help with their problems. Overall, both members of couples rated the

session positively, with a mean female SEQ score of 9.65 (SD = 2.12) and mean male SEQ score of 8.42 (SD = 2.74) (Table 7). There was a significant difference between male and female mean SEQ scores, $t(39) = 2.972, p < .005$, with females giving higher ratings. Male and female SEQ scores were moderately and positively correlated ($r = .450, p = .004$).

Table 7. Gender Comparison of Session Evaluation Questionnaire Scores

Paired Samples Test									
		Paired Differences					<i>t</i>	<i>df</i>	Sig. (2-tailed)
		Diff. in Means	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair	FSEQ - MSEQ	1.22500	2.60657	.41214	.39138	2.05862	2.972	39	.005

Note. FSEQ = Female Session Evaluation Questionnaire scores
MSEQ = Male Session Evaluation Questionnaire scores

Tests of Hypotheses

The hypotheses regarding associations between the individual therapist common factor behaviors and client perceptions of couple therapy session helpfulness were tested with a set of Pearson product-moment correlations. The tests were one-tailed because the hypotheses were directional. The correlation coefficients computed between (a) the relationship common factor behaviors of warmth, empathy, presence, validation, and collaboration and (b) the technique common factor behaviors of use of systemic techniques and session structure and client SEQ total scores are presented in Table 7. Second, the test for the difference between female and male correlations between therapist collaboration and client SEQ scores was tested computed, using r -to- z transformations was used to determine whether the correlations between therapist

common factor behaviors and SEQ ratings of sessions were different between female and male clients.

Therapist Relationship Common Factor Behaviors and Client Session Evaluations

The first hypothesis predicted that members of couples who work with therapists who exhibit higher levels of common factor behaviors of warmth, empathy, presence, validation, and collaboration will give higher ratings regarding the quality of the therapy sessions as providing them help with their problems. However, therapist collaboration behavior was the only type of therapist relationship common factor behaviors found to be significantly (and positively) associated with female SEQ scores; $r = .311$, $n = 40$, $p = .025$ (see Table 2). Although therapists' collaboration behavior was not significantly correlated with male SEQ scores, the results indicated a trend in that direction; $r = .216$, $n = 40$, $p = .090$ (see Table 8).

Regarding the research question about possible gender differences in associations between therapist common factor behaviors and client evaluations of sessions, since only one type of therapist behavior (collaboration) was significant for either partner, tests of the gender difference in correlations were not conducted overall, but a single test using r -to- z transformations was used to compare female and male correlations between therapist collaboration and client SEQ scores. The result was not significant ($z = .44$, $p = .33$).

Therapist Technique Common Factor Behaviors and Client Session Evaluations

The second hypothesis predicted that members of couples who work with therapists who utilize higher levels of systemic techniques and session structure common factor behaviors will give higher ratings regarding the quality of the therapy session as providing them help with their problems. Neither therapist session structuring nor therapist use of systemic techniques was significantly correlated with client SEQ scores, for females or males (Table 8). Consequently, no tests comparing females' and males' correlations were conducted.

Table 7. Pearson Correlations of Therapist Common Factor Behaviors with Couple Member Session Evaluations

		Warmth	Empathy	Validation	Presence	Collaboration	Technique	Structure	FSEQ	MSEQ
Warmth	Pearson Correlation	-								
	Sig. (1-tailed)									
	N	-								
Empathy	Pearson Correlation	.133	-							
	Sig. (1-tailed)	.206								
	N	40	-							
Validation	Pearson Correlation	-.032	.361	-						
	Sig. (1-tailed)	.422	.011							
	N	40	40	-						
Presence	Pearson Correlation	.170	.378	.122	-					
	Sig. (1-tailed)	.147	.008	.227						
	N	40	40	40	-					
Collaboration	Pearson Correlation	.105	.161	.170	.080	-				
	Sig. (1-tailed)	.260	.161	.148	.312					
	N	40	40	40	40	-				
Technique	Pearson Correlation	.176	.363	.179	.521	.017	-			
	Sig. (1-tailed)	.139	.011	.134	.000	.459				
	N	40	40	40	40	40	-			
Structure	Pearson Correlation	.114	.330	.195	.385	.533**	.518	-		
	Sig. (1-tailed)	.241	.019	.114	.007	.000	.000			
	N	40	40	40	40	40	40	-		
FSEQ	Pearson Correlation	-.124	.062	-.072	.096	.311	-.191	.115	-	
	Sig. (1-tailed)	.223	.351	.329	.277	.025	.119	.240		
	N	40	40	40	40	40	40	40	-	
MSEQ	Pearson Correlation	.005	-.035	.035	-.040	.216	-.182	.161	.450	-
	Sig. (1-tailed)	.488	.414	.415	.403	.090	.131	.161	.002	
	N	40	40	40	40	40	40	40	40	-

Note. * = Correlation is significant at the .05 level (1-tailed); ** = Correlation is significant at the .01 level (1-tailed). FSEQ = female Session Evaluation Questionnaire score; MSEQ = male Session Evaluation Questionnaire score.

Post Hoc Analysis

A post hoc analysis was conducted to explore whether examining the items of the Session Evaluation Questionnaire separately revealed anything more about the impact of therapist common factor behaviors. A series of Pearson product-moment correlations were conducted with the four individual items of the SEQ to assess their associations with the types of therapist common factors behaviors. Client ratings on SEQ items 1 and 4 were not significantly correlated with any of the therapist

relationship common factor behaviors for either partner. However, ratings of therapists' use of systemic techniques were significantly correlated with higher ratings on item 2 ("This session helped me to learn new ways to reduce conflict in our relationship") among males ($r = .351, p < .013$). In addition, ratings of therapists' collaborative behavior in the session were significantly correlated with higher client endorsement of item 3 ("During the session, my partner and I had an opportunity to practice new ways to deal with conflict and anger") among both males ($r = .366, p < .01$) and females ($r = .364, p < .01$). These findings indicate that the four items of the SEQ tend to measure more than one aspect of client perceptions of therapy sessions, and that the therapist behaviors tended to influence clients' specific perceptions of opportunities for development of better conflict management rather than their perceptions of opportunities to discuss existing problems or overall session helpfulness, particularly among males.

Chapter 5: Discussion

The aim of the current research was to investigate the influence of therapist common factor behaviors during a couple therapy session on clients' evaluations of that session. It was hypothesized that members of couples who work with therapists who exhibit higher levels of common factor behaviors (e.g., warmth, collaboration, session structure) would give higher ratings regarding the quality of the therapy sessions as providing them help with their problems. Previous studies have examined the influence of common factors on the process of change in individual therapy (Lambert 1992; Hubble et al., 1999; Luborsky et al., 1975; Sprenkle & Blow, 2004), but those findings fail to account for clients' experiences in conjoint therapy (therapists' actions toward multiple clients in the room) that occur in couple therapy. Similarly, clients' experience of therapy has been traditionally based on the therapists' or researchers' experience or interpretation of the clients' perceptions, rather than how clients themselves perceive their experience in therapy. The goal of this project was to add to the increasing literature on common factors, specifically how therapists' common factor behaviors influence client perceptions of helpfulness of therapy sessions.

Therapist Behaviors and Clients' Perceptions of Session

The client-therapist relationship, also referred to as the therapeutic alliance, has been cited throughout the common factors literature as a predictor of individual psychotherapy outcomes. Often described as a therapist's ability to "bond and collaborate with the client on the goals and processes of treatment" (Muran & Jacques, 2010, p. 368), the strength of the therapeutic alliance has been suggested to be a significant predictor of positive client session evaluations. Although less is known about how client-therapist relationship factors influence couple therapy outcome, findings suggest that couples experience a session as helpful when they perceive their therapist as understanding their goals and that the tasks within therapy were relevant to their presenting problem (Johnson & Talitman, 1997).

Based on prior knowledge regarding the influence of therapist behaviors on client outcomes, it was hypothesized that therapist common factor behaviors, both relationship and technique, would influence clients' evaluations of a couple therapy session. Specifically, it was expected that clients who worked with therapists who exhibited higher levels of the theoretically constructive types of common factor behaviors would give higher ratings regarding the helpfulness of the therapy session as providing them help with their problems. However, the results of this study indicated that only the degree of therapist collaboration behavior was significantly associated with female partners' positive evaluations of the session, while being a positive statistical trend for male partners.

Therapist collaboration was coded according to two criteria: (1) therapists' ability to ask clients for their opinions and preferences regarding interventions, tasks, and goals, and (2) therapists' use of collaborative language such as "we" and "us". Although the Therapist General Clinical Skills/Qualities Scale was not designed to be a measure of the strength of the therapeutic alliance, its assessment of a therapist's collaboration with clients includes aspects of a therapist's active contributions to developing the therapeutic relationship. Thus, higher ratings of therapist collaboration behavior may indicate a stronger therapeutic alliance between the couple and their therapists, which predicts higher client experiences of session helpfulness. The significant correlation between therapist collaboration and client perceptions of session helpfulness suggests that clients value being involved in the planning of their treatment; a participant in the therapeutic journey rather than a follower.

This study also explored possible gender differences in partners' perceptions of couple therapy sessions as a function of therapist relationship and technique common factor behaviors. Literature on gender differences in the utilization of support networks in seeking therapy suggest that women are more than twice as likely than men to speak to someone regarding their problems, even after controlling for the size of their social network (Moynihan & Adams, 2007). Additional findings suggest that women have more complex relationship schemas, focus more attention on relationships, and think more about their relationships, than their male counterparts (Doss, Atkins, & Christensen, 2003). Literature on couples' perceptions of the therapeutic experience suggests that members of a couple often cite different "pivotal" moments in sessions, which suggests that two partners may have some

relatively unique experiences of therapy in addition to shared experiences (Helmeke & Sprenkle, 2000). The present study assessed clients' evaluations of a session and found that male and female partners' ratings of a session's helpfulness were positively and *moderately* correlated ($r = .45$), suggesting that there is some overlap between the partners' experiences of a session (as one would expect, given that they spent the same hour with the therapists) but that there was a notable degree of non-overlap in their perceptions. Consistent with prior research indicating that women tend to value thinking about and discussing relationship concerns more than men do, the female partners in this study rated the session as more helpful than their male partners did.

These findings provide some limited support for the current common factors literature that stresses the importance of the building a strong therapeutic alliance with clients. Couples (especially female partners, given the significant correlation) found the session helpful when the therapists were collaborative and inclusive of the clients' needs in that moment (assigning tasks, developing mutual goals). Bordin's (1979) early conceptualization of the therapeutic alliance between the therapist and the client defines the working alliance as collaboration between the client and the counselor based on the development of an attachment bond, as well as a shared commitment to the goals and tasks of therapy. Thus, therapist collaborative behaviors may predict the strength of the therapeutic alliance, which has been suggested as a common factor in how clients perceive the therapeutic experience.

On the other hand, none of the other therapist common factor behaviors that had been hypothesized to be associated with positive client evaluations of session

helpfulness were found to have that relationship. While previous literature has found these types of behavior influence the strength of the therapeutic alliance (Dunken & Friedlander, 1996), the items of the SEQ ask clients about their satisfaction with the tasks and goals of therapy, rather than the client-therapist bond. Therefore, the questionnaire may not have measured the clients' experience of session through the lens of the therapeutic relationship; an aspect of therapy that incorporates many of the relationship common factor behaviors that therapists tend to focus on in order to build a strong therapeutic alliance with their clients.

Therapist warmth was defined as the therapists' use of humor to connect with clients, smiling when appropriate, and generally using a calm tone of voice. This behavior may not have influenced SEQ ratings because clients rated the session on how much it helped them with their presenting problem, rather than how comfortable they felt with their therapist. Similarly, empathy was defined as therapists' use of reflective statements to demonstrate empathic understanding of clients' thoughts and emotions. However, clients were not asked about the degree to which they felt understood or the degree to which they felt their therapist understood their problems. Therapist validation was defined by the therapists' ability to agree with clients when appropriate, take the clients' thoughts and feelings seriously and convey this through affirming and legitimizing statements. Higher levels of validation may have been insignificantly related to SEQ ratings due to the questionnaire's focus on tasks and goals of couple therapy, rather than the therapeutic bond. Additionally, therapists' presence was defined as the therapists making eye contact with clients and showing interest in the clients' lives by asking personal questions and following up on client

statements and following a clear line of questioning. Although therapist presence may have influenced the clients' experience of therapy, the questionnaire did not address how helpful the therapists' presence was during session.

Additionally, therapist technique common factors were also not significantly associated with positive client evaluations of session helpfulness. Therapists' ability to utilize systemically-based techniques was defined as demonstrating working in a systemic manner by involving both partners in the session, following up with each partner, identifying cyclical patterns in couple interaction, using circular questioning to encourage clients to think about mutual influence, and seeking information to create interventions based on multiple environmental levels. Although working systemically in those ways can aid in the therapist's conceptualization of a couple's problem, and in systemic therapy a common goal is to induce change by increasing clients' awareness of dyadic patterns, the clients might not identify those therapist behaviors as particularly helpful because they might not understand the process of therapy. It may be significant that the data for this study were derived from the fourth session of couple therapy at the clinic, quite early in the process through which clients become "socialized" into the world of therapy. It is unknown how much prior experience this sample of couples had with therapy in general or couple therapy in particular. The questionnaire assesses clients' perceptions of session helpfulness based on what they experience in session, not their understanding of the therapeutic process. Working systemically is a part of the process of couple therapy that may lead to positive outcomes, but if the systemic techniques fail to overtly provide clients

with help with their issues, couples may not consider them during their evaluations of a session.

Lastly, session structure was defined as the therapists' ability to structure the session in a constructive and productive manner, to control conflict behaviors displayed by clients toward one another, to allow clients the opportunity to discuss important topics without going on a tangent, to allow time for both members of the couple to express concerns and goals, and to reinforce positive change using positive feedback and encouragement. Those therapist behaviors had been hypothesized to contribute to sessions being helpful to clients because they are designed to reduce aversive couple interactions and focus the partners on developing more positive ways of dealing with their conflicts. Although part of maintaining session structure involved giving partners an opportunity to express concerns and goals regarding therapy, this particular behavior was not significantly correlated with clients' perceptions of session helpfulness. One reason for this may be that enforcing session structure (ending the session on time, interrupting one partner to allow the other time to talk) may not align with the clients' expectations of therapy. For example, the first question on the SEQ asks clients to rate how much they agree with the following statement: "My partner and I had an opportunity to discuss important concerns about our relationship." If a therapist interrupts a client in order to control conflict or give both members of the couple an opportunity to speak, that individual may give that item a lower rating because they believe *they* did not get such an opportunity. Thus, the clients may rate session helpfulness from an individual perspective rather than from a relational perspective.

Study Limitations

This study was a secondary analysis of a preexisting data set. The data were collected prior to the formulation of the current study and hypotheses, which limited the selection of instruments used and information available to test the hypotheses. The study utilized a small, non-representative sample of client couples; therefore, these findings cannot be generalized to the larger population of distressed couples, or more broadly to non-distressed, non-aggressive couples. Additionally, therapist behaviors were coded at a single point in time, during session four, and only represent a snapshot of the therapist-client interaction over the course of ten sessions of therapy. Given that little is known about the therapists' behaviors in the other sessions (including the three sessions that preceded the one that was coded), it is possible that factors beyond the therapists' behaviors during session four influenced clients' evaluations of that session. If more than one session was coded, the impact of therapist common factor behaviors may be stronger.

Another limitation of the study was the coding of therapists' behaviors as a single co-therapist team, rather than separate coding of each therapist. Co-therapist teams were coded collectively, and thus the unique contributions of each therapist were not taken into account. For example, if one therapist exhibited high levels of validation while the co-therapist offered more invalidating statements, the coders had been instructed to take both therapists' behaviors into consideration and report an average of the two therapists' behaviors. Such averaging across therapists may have cancelled out actions by each therapist that the clients may have found helpful. There

was no way to capture which therapist behaviors resonated with each client and influenced his or her perception of the session.

It is also important to note the limitations that might result from the effects of the therapists in the study using a variety of specific therapeutic models in treating the couples. Differences in coded therapist common factor behaviors may have been the result of differences in therapeutic interventions and session structuring associated with the therapists' use of specific theoretical models. For example, a co-therapy team using emotion-focused therapy (EFT) might have obtained a higher score in the empathy component of the TGCSQ, because conveying empathy is a technique frequently used in EFT to help clients develop a deeper understanding of their attachment processes to one another. Thus, although the factors observed are considered to be common across all therapy models, therapists' behaviors in session may have varied considerably as a result of using a specific therapeutic model. Common factors effects and model-specific effects may have been confounded to some extent in this study.

Similarly, the findings might be an accurate reflection of a situation in which the therapists' behaviors may have actually had little impact on clients' perceptions of session helpfulness. As previously noted, clients and therapists often have different perceptions of sessions. A therapist might think that a client found a session helpful because the client learned new ways of coping, but really the client valued the session because it gave her a safe setting to express her emotions. The coders were trained by an experienced couple and family therapist who may have shared common assumptions among therapists about what types of therapist behavior are helpful to

clients, and those assumptions may differ somewhat from this client sample's perceptions.

Given the limitations of the study, a variety of alterations may improve its capacity for testing the hypotheses. First, increasing the sample size and diversity would improve the power and generalizability of the findings. Second, using assessment tools that measure the strength of the therapeutic alliance would allow for an in depth exploration of how clients perceive therapist common factor behaviors. Additionally, coding more than one session would allow for a more comprehensive analysis of how therapist common factor behaviors influence clients' perceptions of their experience in therapy. It should also be noted that co-therapist teams create difficulties for the coding process. As such, future studies should examine the influence of one therapist's behavior in couple therapy, rather than averaging two therapists' behaviors. Finally, the limitation of discerning whether therapists' behaviors were influenced by theoretical model suggests that one model at a time should be used for future research on therapist common factor behaviors.

Implications for Clinical Practice

Despite the limitations of the study, there are several potential implications for the clinical application of the results. In general, the results of this study can assist clinicians in widening their view about what works in therapy according to the clients' perceptions. The current literature on clients' perceptions of therapy suggests that feedback from clients is an important aspect of providing effective therapy. The findings of this study indicate that clients value the therapists' collaborative behavior

during the therapeutic process, which supports the literature that suggests that client outcomes improve when therapists and clients have mutual goals and agree to the tasks of therapy. Learning about clients' perceptions and experiences of the therapy that we practice as clinicians can help any program or agency provide quality services to their clients.

The results of this study suggest the importance of collaboration between a therapist and their clients. It seems to be important for the clients to be participants in the therapeutic process, actively deciding what they want out of therapy and coming to a mutual understanding and agreement of how they will achieve the goals they have established, with their therapist's guidance. Previous research on client-therapist collaboration in therapy suggests that a client's endorsement of the tasks involved in therapy is most closely associated with positive outcome (Horvath & Luborsky, 1993). Therefore, it is not only important for clients to be involved in therapy and *invested* in the therapeutic process, but for therapists to be invested in contributions from their clients.

Implications for Clinical Training

The findings of this study suggest some implications for the training of couple and family therapists. Although a large aspect of clinical training involves becoming familiar with theoretical treatment models, it seems that attention should also be paid to the therapist interns' development or refinement of interpersonal skills. The results of the study suggest that therapists' use of collaboration was correlated with clients' positive evaluations of session, which suggests that clients prefer to be involved in

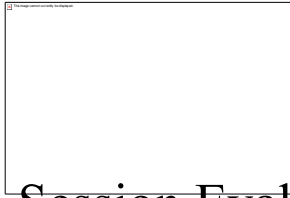
their treatment. As such, it is important for clinical training programs to ensure that their trainees not only understand the importance of involving their clients, but also know *how* to involve their clients in a constructive and therapeutic way.

Implications for Future Research

Further research on clients' perceptions of therapy is needed in order to understand the therapist behaviors that clients find most helpful in treatment. Though there is some literature on the influence of common factors on therapy outcomes, less is known about their influence on the client's experience of therapy. Future research in this area should utilize session-level feedback that assesses the client's experience of treatment more thoroughly than a limited questionnaire. Specific focus should be placed on exploring the four major categories of common factors: the therapeutic relationship, extra-therapeutic factors, clients' hope and expectancies regarding treatment effectiveness, and therapy techniques (Lambert, 1992). As previously discussed, the commonalities among treatment models are the foundation of effective therapy and should be given the attention they surely warrant.

Appendix A

Session Evaluation Questionnaire



Session Evaluation Questionnaire

FOR CLIENTS:

Gender: _____

Date of Birth: _____

FOR THERAPISTS:

Session #: _____ Family Code: _____ Therapist Code: _____

Date: _____ Therapist Code: _____

Your therapist will use your feedback to understand what you have found useful so your therapist's work with you can be more helpful. It will also be used in research to study the therapy process.

1. My partner and I had an opportunity to discuss important concerns about our relationship.

Not At All A Little A Moderate Amount Very Much

2. This session helped me learn new ways to reduce conflict in our relationship.

Not At All A Little A Moderate Amount Very Much

3. During the session, my partner and I had an opportunity to think about and address issues in our relationship.

Not At All A Little A Moderate Amount Very Much

4. Overall, this session was helpful.

Not At All A Little A Moderate Amount Very Much

Appendix B

Ratings of Therapists' General Clinical Skills/Qualities (TGCSQ)

Directions: Please rate the following items from 0-4 based on your observation of the therapists in the given videotaped session. Refer to the following value labels to record scores:

- 0 = Not at all
- 1 = A little
- 2 = Moderately
- 3 = Quite a bit
- 4 = Very much

Relationship Factors		Item Score	Total Score	Scale Score Average
Warmth	Use of humor to connect with clients: Therapist jokes with clients at appropriate times			
	Smiling: Therapist smiles when greeting clients, and at appropriate times during session			
	Voice tone: Therapist uses a supportive, calm tone			
Empathy	Reflective statements demonstrating empathic understanding of client thoughts and emotions (as evidenced by exchange b/n therapist and client) E.g.: Client – "I just feel like he ignores me, and doesn't listen to me" Therapist: "You don't feel heard or appreciated by your partner" Client: "Yes, that's it, I just don't feel appreciated by him"			

Relationship Factors		Item Scor	Tota l Scal	Scale Score Averag
Validation	Agreement E.g: Client- "I think we are just really tired all the time, and that"s why we"re fighting" Therapist: "Yes, that could be."			
	Affirming/legitimizing: Verbally conveying that the therapist takes the clients' thoughts and feelings seriously E.g: Client- "I think we are just really tired all the time, and that"s why we"re fighting" Therapist: "Yes, that could be. <i>It is more</i>			
Therapist Presence	Asking personal questions, showing interest in clients' lives: Therapist asks questions about the clients in order to learn more about them as people			
	Staying on topic: Therapist follows a clear line of questioning, follows up on client statements, and does not			
	Eye contact: Therapist makes eye contact with the clients when he or she is speaking, and when the clients are			
	Body language E.g. Posture oriented towards the clients, no physical barriers			
Therapist Collaboration	Asking clients for their opinions & preferences regarding interventions, tasks, and goals E.g.: Therapist - "We"ve discussed several ways the two of you could spend time together this week – which sounds best			
	Collaborative language use displayed by the therapist such as "we" and "us" E.g: Therapist: "I am confident that all of us are working hard and trying our best to make things a little better."			

Technique Factors		Item Score	Total Score	Scale Score Average
Systemically-Based Technique Therapist demonstrates working in a systemic manner	Balance in attention to partners: Therapist involves both partners in session by addressing each of them, and following up			
	Noting cyclical patterns in couple interaction: therapist demonstrates a non- blaming stance (does not blame either of the partners for their presenting problem) E.g: Therapist -“So it really seems like when Partner A gets scared, Partner B gets angry, and then both of you pull away from			
	Circular questioning: Questions that encourage clients to think about mutual influence between themselves, in dyadic terms E.g. “What have you noticed happens between the two of you that results in your arguments escalating?”			
	Seeking information and/or creating interventions based on multiple environmental levels including extended family, school, work, the economy E.g: If the couple mentions that their child’s behavior problems at school are causing them stress. The therapist asks about what is happening at school (environmental domain). The therapist could spend time discussing strategies the			
Session Structure Therapist structures session to make it constructive & productive	Control of conflict: controlling overt conflict behaviors displayed by clients towards one another like partners blaming one another or making critical remarks			
	Pacing & efficient use of time: allowing flexibility and facilitating client discussion of important topics without allowing clients to go			
	Opportunity for both members of couple to express concerns & goals, and therapist summarizes those			
	Therapist reinforces positive change using positive feedback, encouragement, etc. E.g: Client – “This week was rough, but we did have really nice time on Saturday when we made breakfast together” Therapist – “I think it’s really great that you can find the good in the midst of the bad, and believe that there are more good			

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