

## ABSTRACT

Title of Thesis: THERAPIST COMMON FACTORS AND CHANGES IN CLIENT ANGER MANAGEMENT IN THE CONTEXT OF COUPLE THERAPY

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The present study investigated the associations between therapist common factors behaviors and changes in client anger control in the context of couple therapy. Research on psychotherapy suggests that common factors are more strongly associated with therapy outcome than model-specific interventions. However, research on the effects of specific common factors on therapeutic outcomes is lacking. This study was a secondary analysis of data from 40 couples that presented with mild to moderate physical and psychological partner aggression and who received couple therapy at a university family therapy clinic. The study examined the associations between five therapist common factor behaviors (warmth, empathy, validation, systemically-based techniques, and session structuring) coded from couples' fourth couple therapy session and changes in clients' anger control, as well as the role of gender as a moderator. No main effects were found, and one significant interaction (session structure and gender) was found to be associated with improvements in anger control for males. Implications of these findings are discussed.

THERAPIST COMMON FACTORS AND CHANGES IN CLIENT ANGER  
MANAGEMENT IN THE CONTEXT OF COUPLE THERAPY

by

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## CHAPTER 1: INTRODUCTION

### Statement of the Problem

The field of Couple and Family Therapy (CFT) was originally developed as a result of emerging theories that tended to oppose established concepts and practices in psychology that were focused on the medical model and intra-psychoic causes of individuals' symptoms. The new therapy models, based on systems theory concepts that focused on interpersonal influences in family relationships, attracted a large following among clinicians even though they were not based on empirical research evidence (Dutch & Ratanasripong, 2016). Their appeal was due at least in part to their being disseminated by charismatic leaders in the field (e.g., Murray Bowen, Jay Haley, Virginia Satir, Carl Whitaker, and Salvador Minuchin), regardless of the lack of empirical support (Crane, Wampler, Sprenkle, Sandberg, & Hovestadt, 2002; Nichols, 2013, Sprenkle & Blow, 2004). However, over time practitioners and researchers in the field have increasingly recognized the importance of developing, testing, and validating treatment models based on research evidence. Rigorous research on effects of CFT models has emerged in the field, increasingly using sound research designs and methodology; e.g., random assignment of subjects to treatment groups, a no-treatment or alternative treatment control group, multiple measures of pre-post treatment change on theoretically relevant characteristics (Heatherington, Friedlander, Diamond, Escudero, & Pinsof, 2015). Studies have identified empirically supported treatments (ESTs), based on minimal criteria such as at least two high quality randomized clinical trials showing the effectiveness of a treatment for a particular disorder/problem, as well as studies conducted by at least two different investigators (Chambless & Hollon, 1998; Gehart, 2016; Sprenkle, Davis, &

Lebow, 2013). The sources of motivation for these research endeavors have been twofold: (1) for the advancement of expertise among practitioners in the field, and (2) to open the door for couple and family therapists to have access to insurance payments for empirically supported clinical services, as well as access to further research funding for clinical researchers (Gehart, 2016; Lerner, 2004).

Initially, CFT researchers followed the lead of investigators who had been studying effects of individual psychotherapies, focusing on studies of specific models of therapy. Although a variety of therapy models (family therapy models as well as individual therapy models) have been found to be effective in relation to no-treatment control groups, studies comparing models have seldom shown greater efficacy of one model over another (Sprenkle et al., 2013). While conducting research on different therapeutic models and showing their efficacy has been important, researchers have noted the need to explore *how* these models operate to generate change. The degree to which alternative therapy models have been found to have comparable effects has raised the question of whether effectiveness is due to some factors that are common across models. Some authors have suggested that the specific theoretically based interventions in therapy models are relatively less important than “common factors” shared by models in accounting for change in therapy (Sprenkle & Blow, 2004).

Consequently, more recent research has examined such “common factors” in therapy. This line of research started with individual therapy, with findings indicating that there are aspects that all (or most) therapeutic models share that account for part of the change in therapy (Sprenkle et al., 2013). Much of the research has examined common factors concerning (a) characteristics of therapists (e.g., empathy), (b) characteristics of

clients (e.g., expectancies/hope for improvement), and (c) aspects of the therapist-client relationship (e.g., degree to which they have a positive alliance) (Gehart, 2016; Sprenkle et al., 2013). Findings from the studies indicate that such common factors account for more variance in therapy effectiveness than specific interventions in various therapy models (Wampold & Imel, 2015).

Some authors have used the common factors tenets to generate a better understanding of how CFT works. Sprenkle et al. (2013) have suggested that common factors similar to those present in individual psychotherapies (e.g., empathy, warmth) also operate in CFT, but there are some additional common factors that are specific to CFT; for example, therapist relational conceptualization and interventions with clients' presenting problems, and disrupting dysfunctional relational patterns. However, in contrast to the large body of research on common factors in individual psychotherapy, relatively few studies have been conducted as yet on common factors in CFT. Researchers in this field have suggested that more studies are needed, specifically regarding the effects that common factors have on therapeutic change (Sprenkle et al., 2013). For example, Blow et al. (2007) pointed out that little attention has been paid to the role of the therapist in treatment effectiveness, and that there is a need to study the effects of therapist characteristics and behavior during therapy sessions, especially therapist common factors behaviors on treatment outcome.

The intentional use of common factors by clinicians presents unique challenges in CFT when compared to individual therapy. For example, a therapist working with a couple needs to be mindful of his or her alliance with each partner. Whereas a therapist-related common factor such as empathy expressed toward clients can be fairly

straightforward when there is one client in the room, it often is more complex with couples because as the therapist conveys empathy for one partner the other observes this and may interpret it negatively as favoritism (Epstein & Baucom, 2002). Similarly, the construct of therapeutic alliance can be challenging when working with a couple, since the therapist may experience a “split alliance” (Knobloch-Fedders, Pinosof, & Mann, 2004) in which the members of the couple have different (even opposite) perceptions of the therapeutic alliance. Thus, findings on common factors in individual therapy cannot be generalized to CFT without direct empirical tests of whether the effects found in individual therapy also occur with couples and families. Thus, there is a great need for more research on common factors in CFT.

Another notable advance in the CFT field has been the increased use of couple and family level interventions to treat problems and issues that previously were addressed only with individual therapy, such as obsessive-compulsive disorder (OCD), anorexia nervosa (AN), depression, alcohol abuse, and post-traumatic disorder (PTSD) (Baucom, Belus, Adelman, Fischer, & Paprocki, 2014; Baucom, Whisman, & Paprocki, 2012; Epstein & Zheng, 2016). In addition, whereas problems with anger management and partner aggression traditionally have been treated with individual or group therapy, conjoint couple interventions have been developed and shown to be safe and effective for couples experiencing psychological aggression and mild to moderate physical aggression (Epstein, Werlinich & LaTaillade, 2015). For example, LaTaillade, Epstein, and Werlinich (2006) developed a conjoint couple treatment for partner aggression based on cognitive-behavioral principles and interventions, in what they called the Couples Abuse Prevention Program [CAPP]. This model has been shown to reduce negative

communication, partners' negative attributions about each other and both psychological and physical partner aggression, to increase the partners' anger management and perceptions of safety within their relationship, and to increase relationship satisfaction and constructive negotiation between the partners (Epstein, Ott, & Werlinich, 2015; Hrapczynski, Epstein, Werlinich, & LaTaillade, 2011; Kahn, Epstein, & Kivlighan, 2015; LaTaillade et al., 2006).

Thus, couple therapy has been found to have positive effects on a variety of aspects of couple and individual functioning, including individuals' cognitions and emotions such as anger. However, there has been a lack of research investigating whether common factors such as therapist behaviors play roles in those therapeutic outcomes. In order to begin to address this gap in knowledge, the present study was designed to test whether therapist in-session behaviors are associated with improvements in partners' anger management.

Anger is a normal experience that should not be considered pathological (Novaco, 2010); however, higher frequency and intensity of this emotion, as well as intense outward anger expression and/or heightened suppression of the emotion (directing it "inside") have been associated with a variety of health, psychological, and relational problems. For example, both chronic internal hostility and overt anger expression have been found to be predictive of cardiovascular disease (Williams, 2010). In addition, the experience and negative expression of anger are elevated in individuals with anxiety and depression disorders, compared with healthy control individuals; the higher presence and negative expression of anger is associated with greater symptom severity and worse

treatment response (Cassello-Robbins & Barlow, 2016; Moscovitch, McCabe, Anthony, Rocca, & Swinson, 2008).

In the relational context, anger has been associated with psychological and physical partner aggression, which has led to the inclusion of increasing anger management as one of the key goals of conjoint couple therapy for partner aggression (Epstein et al., 2015; Park, 2014). Anger management is also highly relevant for couple relationships because the ability to control anger expression is positively associated with marital quality (Wachs & Cordova, 2007). Thus, it is important to address the issue of individual experiences of anger in the context of couple therapy, both to prevent aggression and to foster greater relationship quality. It is important to identify aspects of couple interventions, including therapist common factors behaviors that contribute to improvement in anger management.

Findings regarding a gender difference in anger expression have been mixed. On the one hand, some studies have not found gender differences in the experience and control of anger (e.g. Wachs & Cordova, 2007). On the other hand, Kocur and Deffernbacher (2014) have suggested that context has an impact in the experience of anger, such that the anger expression is greater in the context of a romantic relationship than in “general” relationships. In addition, they reported that in the context of partnered relationships “women reported greater outward, negative expression than men” (p. 130). Consequently, any investigation of factors in therapy that may influence anger management should examine possible gender differences. The present study tested whether therapist common factors behaviors during couple therapy sessions had different effects on improvement in anger control among female and male partners.

In summary, there is empirical evidence that suggests that common factors account for change in CFT, along with evidence that couple therapy contributes to improvement in clients' anger management, at least within their couple relationships. However, these lines of research are fairly new, and there are several gaps in knowledge. One specific area is the identification of specific elements of common factors in couple therapy, such as therapist in-session common factors behavior, that contribute to successful increases in anger management. The present study was intended to increase knowledge about such therapist behaviors associated with improvement in client anger control.

### **Purpose**

The purpose of the present study was to investigate how therapist common factors behaviors affect outcomes for individual client functioning (specifically anger control) in the context of couple therapy. In particular, the study focused on the effects of specific therapist behaviors related to two types of common factors (in contrast to model-specific behaviors): therapist behaviors that facilitate the therapist-client relationship and therapist behaviors that involve management of the structure of therapy sessions and a focus on systemic aspects of couple interactions. Based on prior findings in the literature, the study examined the associations between those therapist common factor behaviors and the degree to which partners exhibited an increase in anger management at the end of couple therapy.

The data for the present study came from the previously mentioned study by LaTaillade et al. (2006) that investigated the effects of a conjoint couple therapy approach (CAPP) for treating partner aggression. The main objectives of CAPP were to

enhance the overall quality of the relationship, reduce partner aggression, and improve aspects of individual functioning such as anger control (LaTaillade et al., 2006). Prior studies have found that the CAPP interventions successfully achieved those goals (Epstein, Ott & Werlinich, 2015; Epstein et al., 2015; Hrapczynski et al., 2011; Kahn et al., 2015; LaTaillade et al., 2006). The purpose of this present study was to investigate the degree to which client improvements in anger control were associated with therapist in-session common factors behaviors.

This study contributes to the CFT field in several ways. First, it added to the important trend toward research on common factors in CFT. The common factors approach in CFT has been criticized for being based mostly on prior research on individual psychotherapy (Sexton & Ridley, 2004), which highlights the need for studies about common factors with couples. Second, it helped strengthen the role of the CFT field in the treatment of individual as well as relational problems, in this case anger management. While the main focus of CFT has been improving the relationship between partners and among family members, the effect it can have on individual client functioning has sometimes been overlooked. In recent years researchers have shown the effects of couple therapy in addressing “individual” problems such as depression and OCD (Baucom et al., 2012; Epstein & Zheng, 2016); the present research was designed to add to those findings in relation to changes in anger management. Third, this study advances the field in its attempt to bring together two newer foci in the field of therapy: the effects of common factors in specific therapeutic outcomes (e.g., change in anger management), and the use of common factors in the specific context of couple therapy.

This study contributes to the CFT field by pointing to specific behaviors that the therapist performs in sessions that can influence how change occurs in partners and their relationship. A better understanding of how common factors work, the impact that they have on therapy outcomes, and how therapists use them in sessions could help guide the training and supervision of couple and family therapists (Davis, Lebow, & Sprenkle, 2012). This type of study can help bridge the gap between researchers and clinicians, as clinicians may find research about interactions in the therapeutic context relevant and helpful (Schade, Sandberg, Bradford, Harper, Holt-Lunstad, & Miller, 2015).

## Literature Review

### Common Factors in Couple Therapy

#### Definition of Common Factors

In psychotherapy, “common factors” refer to the variables that account for change in clients that are not a part of any specific theoretical approach or model (Sprenkle & Blow, 2004). Unlike “specific factors” that are associated with a particular conceptual therapy model or empirically supported treatment (EST) (such as Socratic questioning in cognitive-behavioral therapy or externalizing the problem in narrative therapy), common factors are shared across different approaches to therapy (Amole et al., 2016).

Sprenkle and Blow (2004) suggest that common factors have been defined in the literature from both a narrow and a broad perspective. The narrow perspective (Lambert, 1992) encompasses interventions that are found across treatment models but under different names. For example, the process of tracking sequences of the two partners’ behaviors in cognitive-behavioral therapy is similar to mapping the couple’s interactional cycle in emotionally focused therapy. On the other hand, the broad conceptualization of common factors (Hubble, Duncan, & Miller, 1999) includes various aspects of the therapeutic setting and participants, such as characteristics of the client (e.g., clients’ motivation), the therapist (e.g., empathy), and the relationship between the therapist and client (e.g., therapeutic alliance).

Although there are some differences in foci among writers who espouse a common factors perspective, which will be detailed below, there are several aspects that are shared within the common factors perspective: (1) an emphasis on common mechanisms shared by models that account for therapeutic change, (2) a belief in the

relative importance of the impact of aspects “surrounding” treatment over effects of factors that are specific to particular therapy models, (3) a belief in the relative importance of the therapist’s characteristics and behaviors toward the client (e.g., warmth) over the specific therapy protocol, and (4) a belief in the relative importance of the client’s characteristics over those of the therapist in the process of change (Sprenkle et al., 2013).

### **Brief History of Common Factors Concepts and Research**

Although relatively understudied and new in the field of couple and family therapy, common factors as a concept originated in 1936 through the work of Saul Rosenzweig, who described “unrecognized factors” in addition to the “intentionally utilized methods,” and added that the unrecognized factors could have a greater effect than the planned interventions (Sprenkle & Blow, 2004). In the 1960s, common factors became more popular through the work of Jerome Frank, who described common components of therapy in the different editions of his book *Persuasion and Healing* (Frank & Frank, 1991).

This initial observation of aspects that different therapeutic approaches had in common was corroborated by research findings, when clinical trials comparing models found that various therapies had similar effectiveness. In a rigorous meta-analysis, Wampold (2001) examined only studies that directly compared two or more bona fide treatments, and he found that type of therapeutic model accounted for a smaller percentage of the variance in psychotherapy outcomes than general aspects of therapy (8% versus 70%) (Sprenkle & Blow, 2004; Wampold & Imel, 2015).

Thus, even though the interest in common factors began almost a century ago, it is only recently that more rigorous research has been conducted, and that a greater push for examining the effects of common factors as explanations for change in psychotherapy has emerged. In addition, most of the initial work on common factors has focused on individual psychotherapy; research on common factors in CFT, and the description of common factors that are unique to the field, has only recently been emerging. For example, Hubble et al. (1999) modified common factors models that had been derived from individual psychotherapy to take into account characteristics of CFT, and Sprenkle et al. (2013) identified common factors that are present only in CFT.

### **Understanding the Processes of Change in Couple Therapy**

The degree of efficacy of couple therapy in improving the quality of intimate relationships (especially increases in partners' relationship satisfaction) has been studied through randomized controlled trials (RCTs) and meta-analyses, two methods that have provided extensive evidence that such relational treatments benefit couples (Davis et al., 2012). RCTs have usually focused on examining outcomes for specific models of therapy in comparison to no-treatment or treatment as usual in a clinical setting. In such studies, particular therapy models often are shown to be more effective than control conditions in improving certain individual level (e.g., depression) or relationship level (e.g., communication quality) outcomes (Davis et al., 2012). However, those model-specific differences do not tend to be found when meta-analyses are used to compare different specific models, or when controlling for common factor variables such as researcher allegiance to models (Davis et al., 2012; Halford & Snyder, 2012; Sprenkle & Blow, 2004).

Thus, RCTs have contributed evidence regarding the efficacy of couple therapy, but “cannot determine which elements of treatment are driving the change and whether these elements are unique to either therapy” (Benson, McGinn, & Christensen, 2012, p. 33). This finding raises the question of what it is across models that accounts for change (Davis et al., 2012), a question that has not been explored enough in research (Blow et al., 2009). The common factors perspective suggests that:

because most models can facilitate similar couple processes, it is likely that most models will find a use either throughout or at different points in the therapeutic process with most clients. This could explain why most tested couple therapy models are effective but none significantly more than another – because they all do an adequate job invoking the right change mechanisms at the right time. (Davis et al., 2012, p. 38)

### **“Extreme” Perspectives in Common Factors**

Some proponents of common factors have taken what Sprenkle et al. (2013) consider the “extreme” perspective on common factors, which is characterized by a disregard for the effects of specific therapy models and the value of RCTs. From this perspective, all models are believed to be equally good; a position characterized by the phrase “the Dodo verdict” coined by Luborsky et al. (1975), which they took from the story of *Alice in Wonderland*, in which it referred to everyone receiving prizes. From the “extreme” perspective, common factors are regarded as necessary *and sufficient* for change in therapy (Patterson, 1984), and therapy models designed to focus on common factors should replace models that focus on specific theoretically based mechanisms of change (Wampold & Imel, 2015). The extreme perspective has major implications for

modifying traditional clinical training in which therapist trainees are taught the concepts and methods of specific models.

### **Moderate Perspectives in Common Factors**

Sprenkle et al. (2013) suggest that although the specific model approach and the common factors approach are different, they are not polar opposites. Unlike the extreme perspective, a moderate approach to common factors suggests that it is possible that “some specific treatments add to the common factors that underlie all effective treatments” (Sprenkle et al., 2013, p. 67). Thus, Sprenkle et al. (2013) take a “both-and” perspective rather than an “either-or” stance, attempting to maximize benefits derived from both common factors and model-specific interventions.

A second characteristic of the moderate perspective is that while it questions the relative efficacy of treatments and models, it still values absolute efficacy (Blow et al., 2007; Sprenkle et al., 2013). Models are considered relevant, in that core constructs in a model and the clinical interventions that are based on them are considered as actively producing positive change in client functioning, even if alternative interventions in another model may produce similar effects. This view considers efficacy research to be necessary. The alternative to this idea would be that any intervention (e.g., tarot cards) beyond specific therapy models would be effective as long as it includes common factors. Thus, a third idea of the moderate approach is that clinical trials are necessary, but common factors should also be measured whenever feasible, to examine the relative degrees to which model-specific interventions and common factors influence outcomes (Sprenkle et al., 2013).

A fourth idea within this moderate approach is that models are important as vehicles to deliver common factors in psychotherapy (Sprenkle et al., 2013). As Davis et al. (2012) suggest, “models provide a critical framework for treatment, without which many of the common factors may not be potentiated” (p. 39); they are comparable to road maps in that they provide order and structure to therapy. Blow et al. (2007) suggest that in order to be effective, therapists need to understand the principles of change and the models that allow it to occur, rather than just learning about the “active components” or the models.

Lastly, the moderate view suggests that the quality of the therapeutic relationship is one of the aspects of change, but not the only one (Sprenkle et al., 2013). The therapeutic alliance between clinician and clients has been the most studied common factor in CFT research (Sprenkle & Blow, 2004), but while it is an important factor, it is not considered sufficient to account for change within this perspective.

### **Classification of Common Factors**

Sprenkle et al. (2013) suggest that there are five types of common factors that were originally studied in individual psychotherapy, and four common factors that are unique to CFT. The following are descriptions of those types of common factors.

*Client characteristics as common factors.* One of the benefits that the common factors approach has brought is a systematic examination of client characteristics that can influence the efficacy of therapy. Some authors have suggested that one of the reasons why therapy is effective is that clients view the therapist’s interventions as relevant for addressing their personal needs (Davis et al., 2012; Sprenkle & Blow, 2004). In addition, the focus has shifted from static client characteristics such as race or gender to internal

psychological qualities (e.g., level of motivation, commitment to change, inner strength, religious faith), as well as extra-therapeutic factors in clients' lives that affect change (e.g., social support, community involvement, stressful events) (Sprenkle et al., 2013).

Of the client characteristics mentioned, motivation and engagement have received the most attention, perhaps because those are factors that therapists can influence (for better or worse) (Sprenkle et al., 2013). In addition, although client motivation is a factor that was borrowed from the literature on individual therapy, it is an even more challenging factor in CFT, as the therapist needs to engage two or more people in a couple or family who have different levels of motivation, as well as potentially different goals (Davis et al., 2012).

***Therapist characteristics as common factors.*** Therapist characteristics as common factors that may influence therapy outcomes have largely gone understudied (Hollon & Sexton, 2012), possibly because in RTCs the researchers typically attempt to control for therapist differences by having them follow manualized treatments (Davis et al., 2012), so it is assumed that therapists are standardized and interchangeable. However, therapist effects still have been shown to exist, regardless of the characteristics of the clients (Wampold, 2015), the type of treatment delivered (Blow et al., 2007; Wampold, 2015), and the experience level of the clinician (Blow et al., 2007). Moreover, the variability in effectiveness across therapists has been shown to be greater than across treatments (Davis et al., 2012), and it has accounted for a greater portion of the variance in effectiveness (Blow et al., 2007; Wampold, 2015).

Some of the therapist characteristics that have been shown to have an impact on client changes are friendliness and positivity (as opposed to criticism, hostility, and

defensiveness), sensitivity to the clients' needs (e.g., providing insight-oriented interventions for clients who exhibit a tendency toward self-reflection), and an appropriate level of activity in session (i.e., active enough to interrupt destructive patterns, but not too active that it prevents clients' engagement in work during sessions) (Davis et al., 2012). In addition, effectiveness is increased when therapists are able to structure sessions properly (e.g., not allowing discussions to drift off on tangents) (Blow et al., 2007) and believe that the treatment they are working with can help the client (Blow et al., 2007; Davis et al., 2012).

Evans (2011) suggested that therapist common factor behaviors during sessions can be subdivided in two main types: those that focus on the quality of the therapist-client relationship (relationship factors) and those that involve management of interpersonal processes occurring among therapists and clients during a session (technique factors). Relationship factors include therapist behaviors that aim to enhance his or her relationships with the members of a couple and engage them in the process of therapy; such behaviors include being empathic, warm, and present, as well as validating and collaborating with the clients. Therapist behaviors such as empathy, warmth and validation can potentially provide emotional support and build client self-esteem, in addition to giving the client a sense that therapy sessions are a safe place to work on challenging personal problems. On the other hand, two major types of technique factors identified by Evans (2011) are the use of systemic interventions (e.g., drawing partners' attention to circular processes in their dyadic interaction patterns) and the structuring of sessions to make them constructive (e.g., balancing the partners' opportunities to express their thoughts and emotions during sessions) (Blow & Sprenkle, 2001).

Of the therapist common factors present in Evans' (2011) classification, empathy and warmth have received great attention in the literature. While sometimes they have been included in the concept of therapeutic alliance, some studies have attempted to study them by themselves as a quality that the therapist brings to session and that has an impact on the clients' outcomes. For example, according to Wampold (2015), meta-analyses have shown that ratings of therapist empathy have relatively large effects on outcomes.

In addition, some researchers have examined the effect of therapist warmth on the clients, both directly (therapist toward client) and indirectly (therapist effect on one partner results in that individual being warmer to the other partner). In a longitudinal study that included 11 heterosexual couples that received 12-session emotionally focused therapy (EFT), Schade et al. (2015) found statistically significant associations between therapist warmth toward husbands and husbands' warmth toward wives across time, but not the other way around regarding wives' responses toward husbands. Moreover, while the expression of warmth from husband to wife tended to decline as therapy progressed, therapist warmth was a moderating variable that shifted the trajectory toward increased husband warmth over time. According to Schade et al. (2015), this suggests that "therapists can potentially affect therapeutic outcome by facilitating the nurturing, affiliative types of responses which would be desired in couples therapy simply by increasing their own warmth behaviors towards husbands" (p. 301).

*Aspects of the therapeutic relationship as common factors.* The therapeutic relationship has been studied primarily through the concept of therapeutic alliance, which refers to "the quality and strength of the collaborative relationship between client and therapist in therapy" (Sprenkle et al., 2013, p. 88). It is a collaborative process between

clients and therapist, not simply something that the therapist provides to the client. However, the therapist can have a great influence on the alliance by, for example, being warm, congruent, and genuine (Sprenkle et al., 2013). Interestingly, Bedi, Davis, and Williams (2005) found that from the perspective of the clients the techniques that therapists used directly to improve clients' symptoms had a greater effect in fostering the therapeutic alliance than the actions (e.g., empathy) that therapists used for the purpose of developing the alliance.

Bordin (1979) suggested that the therapeutic alliance is composed of three elements: the *bond* between the client and therapist, including dimensions such as trust and care; the *agreement about the tasks* in therapy, and how credible the clients finds them; and *agreement on the goals* for therapy (Sprenkle et al., 2013). This classification could help explain the finding by Bedi et al. (2005) that the therapist's degree of effort regarding accomplishing tasks in therapy had a greater impact on increasing the affective relationship (bond) between therapist and client than the specific interventions that therapists used for the purpose of developing the alliance.

Wampold (2015) suggested that meta-analyses show that the therapist-client alliance has a medium size effect on change in therapy outcomes. Specifically in couple therapy, a study by Knobloch-Fedders et al. (2007) found an association between the level of the therapeutic alliance and the reduction of clients' marital distress. However, while there is a demonstrated correlation between degree of therapeutic alliance and client outcomes, some authors have challenged the idea that the establishment of the alliance is antecedent to the therapy outcomes (Davis et al., 2012; Webb et al., 2014),

noting the importance of demonstrating temporal sequencing through longitudinal studies.

Because of its systemic nature, the therapeutic alliance has been studied from different perspectives – as perceived by the therapist, by each member of the couple, and by external observers. Some studies have found that the client’s perception of the alliance is superior to the therapist’s perception in predicting client outcomes (Sprenkle & Blow, 2004), although other studies have found the opposite (e.g., Symonds & Horvath, 2004). In addition, researchers have tended to assume that outside observers’ perceptions of the therapist-client alliance are more accurate than the couple’s self-reports of the alliance (Kuhlman et al., 2013), although client reports of their personal experience of the therapist-client bond seem very relevant. Lastly, there are mixed results regarding the point in the therapy (early, mid-treatment, at the end) when the quality of the alliance is the best predictor of outcome (Kuhlman et al., 2013).

*Aspects of client expectancies as common factors.* Regarding client expectancies about therapy, Sprenkle et al. (2013) suggest that, “these variables refer to the portion of improvement resulting from the client’s knowledge of being in treatment, becoming hopeful, and believing that the treatment was credible” (p. 53). On the one hand, this focus on client expectancies points to the importance of including interventions beginning early in treatment that increase clients’ sense of hope (Sprenkle et al., 2013). On the other hand, it is difficult to conduct research on this aspect of common factors, as clients cannot be blind to the fact that they are participating in therapy versus a no-treatment control condition (Davis et al., 2012). Nevertheless, it is possible to conduct

studies that examine the degrees to which variation in clients' pre-therapy expectancies regarding treatment efficacy predict their responses to the therapy.

*Nonspecific mechanisms of change as common factors.* This category of common factors, the focus of the narrow view of common factors, includes the mechanisms of change that are components of different models but under different names and that are implemented with different conceptual language (Sprenkle et al., 2013). Sprenkle et al. (2013) have grouped these interventions in three broad categories according to the realm of experience that they target: behavioral regulation (changing what clients do), cognitive mastery (changing how clients think about their relationships), and emotional experiencing (affective experiencing/regulation). Research on these factors requires the use of coding systems that describe specific characteristics of the intended treatment targets (e.g., reduced forms of verbal aggression between partners).

*Conceptualizing difficulties in relational terms.* This type of common factor is unique to CFT, in contrast to the common factors that are foci in individual psychotherapy. It refers to the definition of the clients' problems in terms of reciprocal interactions between partners, in which "one person's symptoms become understandable only in the context of their partner's symptoms, and each are presumed to exacerbate and maintain the other" (Davis et al., 2012, p. 42). For example, unresolved conflict may be tied to a circular demand-withdraw pattern in which one person's demanding behavior elicits the other's withdrawal, and vice versa. This relational focus contrasts greatly with the psychiatric view presented in the DSM-5, in which mental disorders occur within a person (Sprenkle et al., 2013). This does not mean that biological or intra-psychic factors

are discounted, but the focus is on the interpersonal interactions that maintain or exacerbate the presenting problem.

***Disrupting dysfunctional relational patterns.*** In addition to conceptualizing problems in relational terms, therapists working with couples interrupt dysfunctional relational cycles, to help the dyad become “unstuck” (Sprenkle et al., 2013). This can be done both by interrupting the process of the couple’s pattern during therapy sessions and by prescribing new patterns of behavior as “homework” to do outside of therapy.

***Expanding the direct treatment system.*** Unlike individual therapy, CFT involves more clients than a single identified patient in the room, based on the idea that having couple and/or family members present in session can have a more powerful effect for change than discussing issues with one of the system’s members (Sprenkle et al., 2013). Thus, change in couple therapy could be explained by the involvement of the relevant people who have contributed to the problematic patterns and whose positive changes will contribute to improvement in the relationship, with their commitment to change making change more likely and durable (Davis et al., 2012). The presence of this common factor could explain why some CFT approaches for specific issues (e.g., conduct disorders in adolescents, depression) are preferable to individual approaches.

***Expanding the therapeutic alliance.*** The therapeutic alliance, described above, is a complex concept in individual psychotherapy and even more complex in the context of couple therapy. As Davis et al. (2012) suggest, “a couple therapist must monitor not only his or her alliance with each partner, but their alliance with each other and the overall alliance as a group working together” (p. 43). When there is split alliance (disagreement about the therapeutic alliance between the members of the couple), the therapist needs to

review the process through which he or she developed the alliance with the couple; for example, characteristics of the bond, development of collaborative tasks, and shared goals (Knobloch-Fedders et al., 2004).

### **Anger in Couple Relationships and Couple Therapy to Treat It**

#### **Anger, Aggression, Romantic Relationships, and Gender**

Anger is one of the basic emotions (Kocur & Deffenbacher, 2014), which includes peripheral physiological responses (e.g., increased blood pressure, facial warming) and subjective experiences and cognitions (Potegal & Stemmler, 2010). It is generally considered to be a negative emotion, although “it can be accompanied by positive feelings, such as increased alertness, strength, confidence, determination, and pride” (Potegal & Stemmler, 2010, p. 6). As such, although anger is often associated with aggression, both expressions *can* occur in the absence of the other (Potegal & Stemmler, 2010), and anger can lead to positive and constructive behaviors (Kocur & Deffenbacher, 2014). For example, anger “can mobilize physical and psychological resources, energize behaviors for corrective action, and facilitate perseverance” (Novaco, 2011, p. 251).

Thus, problems associated with anger “are not derivative of anger per se, but instead result from anger dysregulation” (Novaco, 2011, p. 251). Dysregulated anger can be expressed outwardly or inwardly. The outward expression of anger takes the form of verbal and nonverbal behavior, often through a range of aggressive acts. This includes physical acts toward other people or objects (e.g., assault, slamming doors) and verbal expressions (e.g., criticism, sarcasm, insults). The inward expression of anger refers to experiencing anger symptoms such as physiological arousal and negative thoughts but holding them in or suppressing them (Spielberger & Sydeman, 1994).

Anger control refers to calm, constructive expressions of anger, such as calming down and controlling one's temper (Kocur & Deffenbacher, 2011; Spielberger & Sydeman, 1994). Unlike the outward and inward expressions of anger, anger control is a desirable and non-problematic way of handling anger. Previous research has shown that anger control is negatively correlated with both outward and inward expressions of anger, suggesting that greater ability to control one's anger is associated with less experiences of outward or inward anger (Kocur & Deffenbacher, 2011; Lievaart, Franken, & Hovens, 2016).

Kocur and Deffenbacher (2011) suggest that differences in individuals' experiences of anger (among different individuals as well as across one person's experiences over time) are based on both individual differences (e.g., anger as an individual difference trait; Spielberger, 1988) and on environmental and contextual factors (e.g., an individual who generally is slow to anger becomes enraged quickly when observing someone behaving abusively to his or her child; Deffenbacher, 2011). In a study using self-report measures for trait anger and for anger expression, Kocur and Deffenbacher (2011) found that participants reported experiencing more anger in general relationships (e.g., non-romantic relationships) than in romantic partnered relationships. Even though they tend to be less frequent, when there is a dysregulated experience of anger in a romantic partnered relationship, it can be a precursor to marital dissatisfaction and relationship dissolution (Kocur & Deffenbacher, 2011; Park, 2014).

In Kocur and Deffenbacher's (2011) study, they also found few gender differences in reports of feelings of anger in general, with the only exception being that men reported more anger control than women. When looking at the type of relationship

and gender simultaneously, the authors found that women reported more experiences of outward anger expression in the context of romantic partnered relationships than men, However, Fischer and Evers (2012) found that the type of external manifestations of anger can vary by gender, with women tending to prefer more indirect displays of anger and men tending to prefer more direct expression. Regardless of individuals' preferences for modes of expressing anger, there is extensive evidence that consistent experiences of anger are detrimental to one's physical health (Haukkala, Kontinen, Laatikainen, Kawachi, & Uutela, 2010; Russell, Smith, & Smyth, 2016; Williams, 2010), and unregulated negative forms of anger expression (venting, passive aggressive acts, withdrawal) detract from couple relationship satisfaction (Epstein et al., 2015).

### **Classic Therapeutic Approach to Anger Issues and Partner Aggression**

Gender-specific group treatment has been the traditional approach to anger issues and partner aggression. These group treatments use a variety of interventions, such as cognitive, cognitive-behavioral, relaxation coping skills, and social skills training (Glancy & Saini, 2005). However, those traditional approaches have been criticized for not addressing specific dyadic processes in the context of the couple (LaTaillade et al., 2006), such that the skills that clients acquire in the individual therapy or gender-specific group therapy may not generalize to interactions with intimate partners (Epstein et al., 2015).

### **Relevance of Couple Therapy**

Halford and Snyder (2012) propose that there are four factors that highlight the relevance of couple-based interventions for a variety of problems:

(a) the high prevalence of couple relationship distress, (b) the impact of couple relationship quality on the health and well-being of adult partners and their offspring, (c) the demonstrated effectiveness of evidence-based couple therapy and relationship education in enhancing couple relationships and reducing relationship problems, and (d) the effectiveness of evidence-based couple interventions as the primary or adjunct intervention for a variety of individual psychological and physical health disorders (p. 1)

Baucom et al. (2012) suggest that couple therapy has two main benefits for couples experiencing conflict and distress, as well as individual psychological problems. First, couple therapy can change patterns of hostility or disengagement, which can then help the therapist implement more specific interventions addressing a partner's individual psychological distress (e.g., anger control). Second, it can reduce overall relationship discord, a significant chronic life stressor for each individual. As mentioned previously, couple therapy has been shown to be effective in reducing both individual problems and relationship distress (Baucom et al., 2012; Halford & Snyder, 2012).

### **Couple Therapy for the Treatment of Anger Issues and Partner Aggression**

The use of couple therapy to address issues of anger expression and aggression is relatively new, as the most common therapeutic intervention has been gender-specific treatment groups (Epstein et al., 2015). However, given that gender-specific treatment groups do not address the couple interaction patterns in which the aggression occurs, some authors have suggested using couple therapy to address it. The goal of this type of couple therapy is to “replace aggression with constructive means of trying to influence

one's partner, thus improving the quality of the couple relationship as well as protecting the partners' well-being" (Epstein et al., 2015, p. 391).

There is a wide range of severity of anger expression and aggression; thus, therapists have to assess the manifestations and degree of aggression before recommending a certain treatment. Couple therapy for the treatment of anger management and partner aggression has been suggested for couples with mild to moderate physical aggression, as more severe aggression may put couple members at risk of physical harm. In those cases, in order to protect the safety of members of couples with more severe aggression separate individual treatments are recommended (Epstein et al., 2015).

The approaches most often used in the treatment of partner aggression have been based on concepts and methods of cognitive-behavioral couple therapy (CBCT) and solution-focused couple therapy, two models that are highly structured and allow for interrupting dysfunctional patterns quickly (Epstein et al., 2015). The specific CAPP model developed by LaTaillade et al. (2006), is based on CBCT, and it includes psychoeducation, anger management training, cognitive restructuring, communication skills training, and problem solving training (Epstein et al., 2015).

### **Research Supporting the Use of Couple Therapy for Anger Issues and Partner Aggression**

The CAPP protocol has been shown to reduce partner aggression as well as other dysfunctional patterns in the couple. More specifically, research suggests that after treatment couples have reduced psychological and physical partner aggression, less negative communication, and less negative attributions about each other (Hrapczynski et

al., 2011; LaTaillade et al., 2006). In addition, couples report enhanced relationship satisfaction and constructive negotiation, increased anger management, and increased perceptions of safety within the relationship (Epstein et al., 2015; Kahn et al., 2015). Thus, the overall outcomes of couple therapy for partner aggression, including improvement of partners' anger management, have been demonstrated. However, to date there has been limited research on common factors, including therapist common factors that may contribute to those therapeutic gains. Consequently, the present study was intended to investigate therapist in-session common factors behaviors as predictors of improvements in partners' anger management.

### **Common Factors in Anger Issues**

#### **Common Factors as Guidelines for Anger Management Treatment**

Most treatments aimed at improving individuals' anger management have been focused on specific interventions to reduce the experience and manage the expression of anger (e.g., skills training). However, some authors have recognized the importance of common factors, particularly regarding the therapeutic alliance, when working with people with heightened expression or anger. Deffenbacher (2011) suggests that it is common for people with strong anger responses to externalize the sources of anger (i.e., viewing the sources as originating outside the self and blaming those sources for causing one's anger) and to have difficulties with recognizing anger as a personal problem. In this case, it is difficult to get clients to agree that anger management should be a goal of therapy. Deffenbacher's (2011) suggestion is to focus on the therapeutic alliance to validate the client's experiences (e.g., of frustration with the current quality of the couple relationship) and to start with a motivational interview focused on making personal

contributions to improving the relationship before engaging in the more structured process of anger management. Considering that two of the aspects of the therapeutic alliance are agreement between therapist and client on tasks and on goals for therapy, this initial step can have the effect of strengthening the therapeutic alliance and helping the client to be more receptive to the clinician's subsequent interventions.

Similarly, in his literature review on anger management treatment, Novaco (2011) found that therapeutic alliance, especially validation, could have a positive effect in facilitating clients' treatment engagement. However, while validation of the individual's personal experiences can facilitate the alliance, the therapist should still aim to encourage the client to take personal responsibility for change by setting anger management as a goal.

### **Research Findings Regarding Effects of Common Factors in Group Interventions for Anger Management**

In a study evaluating the effect of cognitive-behavioral based group treatment for male partners who had been violent toward their wives, Taft, Murphy, King, Musser, and DeDeyn (2003) found that higher therapist ratings of therapeutic alliance were strongly associated with decreases in levels of physical and psychological abuse. In addition, in a study evaluating an anger management treatment with military veterans with post-traumatic stress disorder, Mackintosh, Morland, Freuh, Greene, and Rosen (2014) found that the therapeutic alliance had an indirect effect on the reduction of anger symptoms, in which that association was mediated by improvements in the veterans' anger regulation skills.

## **Research Findings Regarding Common Factors in Couple Therapy for Anger Management**

Since the use of couple therapy for anger management and the research on common factors in the context of couple therapy are relatively new, there is a small number of studies examining these variables simultaneously. Using the same dataset as that used in the current study, Park (2014) examined the effect of clients' initial levels of expression of anger on the outcome of therapy for couples with mild to moderate physical aggression and/or psychological aggression. He found that greater outward expression of anger was associated with less improvement in couples' relationship satisfaction. In addition, he examined the effect of therapist common factors behaviors on the outcome of therapy, and found that higher therapist use of systemic techniques was associated with greater increases in positive satisfaction for female partners. That study did not investigate the association between therapist common factors behaviors and improvements in clients' anger management.

### **Study Variables**

#### **Independent Variables**

*Relationship factors.* Common factor behaviors by the therapist that have the potential to enhance his or her relationships with the members of a couple are comprised of verbal and nonverbal aspects of the expression of warmth, empathy, and validation.

*Warmth:* Therapist warmth is conveyed by, for example, using humor to connect with clients in an appropriate manner, smiling to greet clients and at appropriate moments during a session, and using a supportive and calm tone of voice.

*Empathy:* Based on Carl Rogers' idea of empathic understanding of the client's frame of reference (Witty, 2008), empathy is a process in which the therapist is attuned to cues of the client's subjective thoughts and emotions, adopting his or her perspective, and conveys this understanding to the client. This is displayed in session by the therapist's reflective statements that convey a sense of empathic understanding.

*Validation:* Therapist validation of the client involves legitimizing the client's right to his or her views and valuing the client's perspective. It involves verbal messages (e.g., "Yes, that could be it", "You have worked very hard to accomplish what you have in your career.") showing that the client's thoughts and feelings are taken seriously.

*Technique factors.* In addition to the therapeutic relationship-enhancing common factors behaviors examined in this study, a set of other therapist behaviors were investigated that involve behaviors focused on intervening with systemic patterns in couples' interactions and structuring sessions to maximize constructive interactions.

*Systemically-based techniques:* Therapists demonstrate working from a systemic framework by balancing their attention and involving both partners, by pointing out cyclical patterns in the couple's interactions, by asking circular questions that identify such patterns, and by including aspects of the clients' context (e.g., children, work) in the questions and interventions.

*Session structure:* Therapists establish and maintain positive structure in sessions by giving both partners opportunities to express concerns and goals, by balancing the clients' need to express themselves and the need to keep the conversation on track, by controlling overt conflict that may occur during sessions, and by reinforcing instances of positive interaction.

**Dependent Variable**

*Anger control.* When people are feeling angry, they may experience those feelings inwardly or express them outwardly, and the degree to which they express anger constructively depends on skills for emotion regulation and positive communication. Anger control refers to the investment of energy into moderating the intensity of one's inner experience of anger, as well as its constructive outward expression. Examples of anger control are self-soothing and being patient with others (Forgays, Forgays, & Spielberger, 1997; Spielberger & Sydeman, 1994).

**Moderator Variable**

*Gender.* This study explored whether links between therapist common factor behaviors and anger expression differ by the gender of the client. The interest in knowing whether particular therapist behaviors tend to have differential effects on females and males is based on past research suggesting gender differences in anger expression and a need to identify any conditions that influence the effectiveness of couple therapy for conflict and partner aggression.

As described in the literature review, previous research has shown that while the use of common factors in couple therapy has a positive impact on both partners, sometimes the magnitude of the effects and/or the paths for the desired effects are affected by gender. For example, Schade et al. (2015) found that therapist warmth had a direct positive effect on the husband, which in turn affected the wife, but not the other way around. In a similar way, anyone can experience anger, but its expression tends to vary by gender. For example, women tend to prefer more indirect anger displays when compared to men, which seems to be connected to common negative social perceptions

of women's expression of anger (Fischer & Evers, 2012). However, some research shows that the usual preference for less antagonistic anger expression in women does not apply to their relationships with their partners, where women report greater outward expression of anger than men (Kocur & Deffenbacher, 2012). Nonetheless, the difference in anger expression between genders could influence the relationship between therapists' use of common factors in couple therapy and changes in clients' experienced and expressed anger. Therefore, gender was used as a moderator variable in this study to test for possible gender differences in links between therapist behaviors and client improvements in anger control.

### **Hypotheses**

Based on the existing theoretical and empirical literature on therapist common factors in couple therapy, as well as regarding factors influencing successful treatment of anger and partner aggression in the context of couple therapy, the following hypotheses were tested in this study.

*Hypothesis 1:* Members of couples whose therapists display higher levels of warmth during session 4 will have a greater increase in their perception of their ability to control their anger.

*Hypothesis 2:* Members of couples whose therapists display higher levels of empathy during session 4 will have a greater increase in their perception of their ability to control their anger.

*Hypothesis 3:* Members of couples whose therapists display higher levels of validation during session 4 will have a greater increase in their perception of their ability to control their anger.

*Hypothesis 4:* Members of couples whose therapists display higher levels of systemically-based techniques during session 4 will have a greater increase in their perception of their ability to control their anger.

*Hypothesis 5:* Members of couples whose therapists display higher levels of session structure during session 4 will have a greater increase in their perception of their ability to control their anger.

### **Research Question**

*Question 1:* Does gender moderate the relationship between couple therapists' display of common factors behavior (warmth, empathy, validation, systemically-based techniques, and session structure) in session 4 and the clients' changes in their perception of their ability to control their anger.

## **CHAPTER 2: METHOD**

The present study was a secondary analysis of data collected during the Couples Abuse Prevention Program (CAPP) study in the Center for Healthy Families at the University of Maryland, College Park and of data generated for Evans' (2011) study of common factors in couple therapy. The main purpose of the CAPP study was to compare the effects of cognitive-behavioral and other couple therapies in treating couples experiencing psychological and mild to moderate physical partner aggression. The following sections describe the participants, measures, and procedures followed in the CAPP study, as well as the specific procedures used in the present study. Some of the measures and procedures that were used in the original study (LaTaillade et al., 2006) are omitted, as they are not pertinent to this study.

### **Participants**

This study used data that were collected from 40 heterosexual couples that voluntarily sought couple therapy at the Center for Health Families (CHF) at the University of Maryland, College Park. The CHF is a university-based training clinic where students enrolled in a CFT master's degree training program conduct clinical work with families, couples, and individuals while closely supervised by licensed and highly experienced clinicians. The couples were comprised of 40 females and 40 males, and the mean age was 31 years for females (range: 20-51) and 33 years for males (range: 22-51). Regarding race, the demographics were 62% Caucasian, 21% African American, 10% Hispanic, and 8% Other for females, and 74% Caucasian, 15% African American, 3% Hispanic, and 8% Other for males. Most males and females (88% of the males and 73% of the females) were employed outside of the home, and half of them had a college

degree or higher (50% for both groups). The majority of the males (62%) had an income greater than \$40,000, whereas only 24% of the females had that level of income.

Women's income was unevenly distributed, with 26% of women earning less than \$10,000 and 26% of women earning \$30,000 to \$39,999. Of the 40 couples, 83% were living together, either married or cohabiting, and the mean length of their relationships was six years (Evans, 2011).

*Inclusion criteria:* Couples participating in the CAPP study had to be heterosexual, with both members being 18 years old or older. They had to have sought therapy at the CHF and be willing to be assigned randomly to either mode of treatment. The study included couples who had been in their relationship for at least six months, and that had experienced psychological aggression (e.g., verbal denigration, hostile withdrawal) and/or mild to moderate physical aggression during the previous four months. In separate individual interviews, both partners had reported feeling safe participating in conjoint treatment and a desire to stay together as a couple.

*Exclusion criteria:* Couples were excluded from the original CAPP study when there was presence of severe physical violence (e.g., an injury that required or should have required medical attention) during the previous four months, reports of a history of untreated drug or alcohol abuse for either partner, and/or having concurrent couple treatment.

*Participating therapists:* Each couple was assigned a co-therapist team, as is frequently done in the CHF. Of the therapists who worked with the participating couples, 84% were females and 16% were males. One-third of the couples that participated

worked with a team composed of a male and a female therapist, but most co-therapy teams (68%) were composed of two females.

*Participant compensation:* All clients at the CHF pay a fee after each standard 45-minute weekly therapy session, based on a sliding scale (\$20, \$40, or \$60) according to the family income and number of dependents. During the screening for the CAPP study, therapists informed couples that if they were eligible and agreed to participate, the original fee would change to \$20 for each double-length (90-minute) CAPP protocol session.

## **Measures**

### **Independent Variables: Therapists Common Factors Behaviors**

Therapist common factors behaviors were measured using the *Ratings of Therapists' General Clinical Skills/Qualities Scale* (TGCSQ; Epstein, McDowell, & Evans, 2009) (See Appendix A) that was developed for Evans' (2011) initial common factors study with the CAPP data set. This measure is a set of rating scales that were designed for coding therapist behaviors from 90-minute couple therapy tapes from the CAPP project. In Evans' (2011) study, the TGCSQ was used to rate therapist behaviors from the fourth therapy session only. Scores on the TGCSQ are derived as the average ratings of therapist behavior from the independent ratings by two undergraduate students who have received extensive training in applying criteria for judging levels of each type of common factor behavior. Each type of therapist behavior is given a rating ranging from 0 ("not at all") to 4 ("very much"), depending on the degree to which each behavior was displayed for the duration of the session. Each rating is assigned for the co-therapist team, rather than separately for each therapist, as in some cases the position of the camera

does not allow raters to differentiate between therapists. The rating of a type of common factors behavior is made even if it is displayed by only one of the two therapists.

*Therapist relationship factors:* This variable was measured using the relationship factors component of the TGCSQ, which includes ratings of the therapists' warmth, empathy, validation, presence, and collaboration. Warmth is rated based on the use of humor to connect with clients, smiling, and voice tone. Empathy is rated based on the use of reflective statements. Validation is rated based on the use of agreement and of affirming/legitimizing. Table 1 includes descriptive statistics for ratings on these variables.

Therapist presence and therapist collaboration are also types of therapist relational common factors behaviors that are assessed by the TGCSQ but were not selected for use in the present study. Presence is rated based on the therapist asking personal questions to show interest in clients' lives, staying on topic, maintaining eye contact, and exhibiting body language that conveys paying close attention to the clients. Therapist collaboration is rated based on the degree to which therapists ask clients for their opinions and preferences regarding interventions and goals, as well as their use of collaborative language.

Although the five therapist behaviors that comprise the Relationship Factors scale of the TGCSQ are thought to have a positive impact on the therapist's relationship with clients, warmth, empathy, and validation were selected for this study because they have been the foci of previous research on therapeutic alliance. In addition, these three therapist behaviors are associated with a therapist displaying a disposition toward being

welcoming, non-judgmental, and inviting, a stance more clearly directed from the therapist to the client.

Evans (2011) found an unexpected effect of therapist presence, such that greater occurrence of therapist presence was associated with less relationship satisfaction for male partners. Based on that previous finding, therapist presence was not selected for this study. In Evans' study, therapist collaboration correlated more highly with therapist technique factors than with relational factors, an area of some construct ambiguity that led to the decision to not use collaboration as a variable in the present study.

*Therapist technique factors:* This variable was measured using the technique factors component of the TGCSQ, which includes two therapist behaviors. First, systemically-based techniques are rated according to the presence of four behaviors: balance in attention to partners, noting cyclical patterns in couple interactions, circular questioning, and seeking information/creating interventions based on multiple environmental levels. Second, session structure is rated based on the presence of four behaviors: therapists' control of conflict, pacing and efficient use of time, opportunity for both members of couple to express concerns and goals, and therapist reinforcement of positive change. See Table 1 for descriptive statistics on these variables.

Table 1

*Descriptive Statistics for Therapist Common Factor Behaviors*

	<i>n</i>	<i>Potential Range</i>	<i>Actual Minimum</i>	<i>Actual Maximum</i>	<i>Mean</i>	<i>SD</i>
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
Systemically- Based Techniques	40	0 – 4	2.00	3.88	2.73	.373
Session Structure	40	0 – 4	1.38	3.71	2.80	.524

**Moderator Variable: Gender**

*Gender:* Gender was included in the demographics self-report measure completed by all clients who attend the CHF, and participants were identified either as male or female.

**Dependent Variable: Anger Control**

Change in anger control from pre- to post-therapy was measured with the Spielberger Anger Inventory (SAI; Spielberger, 1988; Spielberger & Sydeman, 1994), a self-report questionnaire that includes 24 statements describing inward anger, outward anger, and control/management of anger. For each item, the respondent indicates which alternative best describes the frequency of each listed reaction when he or she is angry, from four options: almost never (1), sometimes (2), often (3), and almost always (4). Thus, total SAI scores (AX/Ex) can range from 24 to 96. In addition to the global score,

the SAI has three subscales, Anger Out or venting (AX/Out), Anger In or experienced internally (AX/In), and Anger Control or regulated anger (AX/Con). Each scale has scores that can range from 8 to 32.

This study used the Anger Control subscale, which includes statements that reflect the individual's degree of success in regulating his or her experience of anger (e.g., I control my temper, I am patient with others) (Spielberger & Sydeman, 1994). This investigator selected this SAI scale in order to assess the degree to which clients in the CAPP study became better able to regulate their anger, rather than examining decreases in unregulated external or internal expressions of anger (Anger Out and Anger In SAI scales), because the CAPP study emphasized anger management skills (Epstein et al., 2015). Descriptive statistics for the Anger Control scale are presented in Table 2.

Table 2

*Descriptive Statistics for SAI Anger Control Scores by Gender*

<i>Variable</i>	<i>n</i>	<i>Potential Range</i>	<i>Mean (SD)</i>
Pre-treatment SAI Anger Control	40	8 – 32	22.85 (4.34)
Scores - Males			
Post-treatment SAI Anger Control	40	8 – 32	24.20 (4.27)
Scores - Males			
Pre-treatment SAI Anger Control	40	8 – 32	20.70 (5.01)
Scores - Females			
Post-treatment SAI Anger Control	40	8 – 32	23.25 (4.82)
Scores - Females			

*Note.* SAI = Spielberger Anger Inventory. Standard deviations are in parentheses.

The SAI has extensive published evidence of reliability and validity, with Cronbach alpha coefficients ranging from .66 to .87 for the Anger Control subscale (Kocur & Deffenbacher, 2014; Lievaart, et al., 2016; Spielberger, 1988). In this study, the Cronbach alpha coefficients ranged from .78 to .84.

In addition, the Anger Control scale correlates negatively with the Anger Out and Anger In scales (Kocur & Deffenbacher, 2014; Lievaart et al., 2016). In the CAPP study, participants completed the SAI during a pre-therapy assessment, at the end of the tenth session (post-treatment) and four months after the end of treatment (four-month follow-up). In this study, the change score was obtained by subtracting each client's pre-therapy score from his or her post-therapy score. The complete SAI scale that participants completed and the items pertaining to each subscale can be found in Appendix B.

### **Procedures**

The data for the present study come from both the original CAPP study (LaTaillade et al., 2006) and from Evans' (2011) dissertation project. Aspects of both projects' procedures are described in this section.

### **Data Gathering**

The standard assessment protocol in the CHF involves every client completing an assessment during the first appointment at the center. For the CAPP project, information from the first assessment determined couples' eligibility to participate in the treatment study (e.g., presence of psychological and/or mild to moderate physical aggression as determined by the Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 2001) and the Conflict Tactics Scale – Revised (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996), reported absence of a history of alcohol or drug abuse, and

both couple members feeling comfortable and safe in conjoint therapy as determined by an individual interview). Couples who were eligible to participate were invited, and if they agreed they signed an informed consent form and attended a second day of assessment, during which they completed additional self-report measures of individual and relationship functioning, as well as a 10-minute video-recorded sample of their couple communication while discussing a topic that was a source of moderate conflict in their relationship.

After the assessments, couples were randomly assigned to the cognitive-behavioral (CBT) treatment condition or treatment as usual (UT) at the CHF that consisted of other systemically-focused couple therapy models such as solution focused, emotionally focused, structural, and narrative. Both conditions included ten 90-minute sessions over the course of 3 to 4 ½ months, with couples assessed again at the end of those ten sessions (post-treatment) and again at a four-month follow-up. The present study used the SAI scores for each partner from the pre-treatment and post-treatment couple assessments during their couple therapy.

### **Observational coding**

This study also used data collected for Evans' (2011) study using the *Ratings of Therapists' General Clinical Skills/Qualities Scale* (TGCSQ), which was described in the measures section. The development of this instrument included intensive literature review consultation and extensive training of the undergraduate coder team. As already noted, the TGCSQ was used to rate therapist common factors behaviors during session four of treatment of the 40 couples in the CAPP study. Two trained undergraduate students rated each session video independently; then an average of their scores for each type of

therapist behavior was computed to provide the final score for each therapist common factors behavioral dimension.

Thus, the present study did not involve any new data collection. This study was a secondary analysis of the data collected for the CAPP study (LaTaillade et al., 2006) (e.g., demographic information, SAI scores) and the data generated for Evans' (2011) study of common factors in couple therapy in which therapist behaviors during session number 4 were coded with the TGCSQ. The procedures involved accessing data from the pre-existing data sets from those studies, which do not include information that could identify the client participants.

## **CHAPTER 3: RESULTS**

### **Overview of Data Analysis**

The hypotheses for this study all involved predicted associations between levels of therapist common factors behaviors and degrees of change in anger control over the course of couple therapy. In addition, the research question regarding possible gender differences in those associations involved examining gender as a moderator variable for those relationships between therapist behaviors and changes in anger control.

Each of the hypotheses was tested with a stepwise multiple regression analysis predicting change in Anger Control (SAI scores). In order to contribute to the clarity in the interpretation of data, all predictor variables were centered before the multiple regression analysis. In the first step, ratings of one of the therapist common factors behaviors were entered. The second step involved entering gender as a predictor variable, and finally the third step involved entering an interaction effect term computed as the product of the therapist common factors behavior ratings and gender. The pattern of any significant interaction effect was explored through separate regression analyses for the therapist common factors behavior for the female partners and for the male partners.

### **Preliminary Analyses**

There were minimal missing data in the data set for this study; two out of the 1,280 data points for the SAI Anger Control subscale were missing (80 participants, with 8 item scores pre-treatment and 8 item scores post-treatment for each participant). The two missing data points were addressed with mean replacement. In order to determine the degree of internal consistency reliability of the SAI Anger Control subscale, the Cronbach alpha was calculated for it at both pre- and post-therapy. The pre-therapy and

post-therapy alphas for the total sample were .82 and .80, respectively, for the females they were .84 and .82, and for the males they were .78 and .78. These Cronbach alpha coefficients indicate a very good level of internal consistency reliability of the Anger Control subscale.

Before testing the study's hypotheses regarding therapist behaviors as predictors of change in clients' control of their experience of anger, it was necessary to review whether the clients indeed had experienced change in their reports of their ability to control their anger (i.e., was the couple therapy effective overall in achieving that goal). Table 2 shows the mean SAI Anger Control scores for males and females pre- and post-therapy, with post-therapy levels of anger control higher than those at pre-therapy. Paired-comparison  $t$  tests were computed to determine whether those differences were statistically significant (due to pre-therapy and post-therapy scores being non-independent). The results of the paired-comparison  $t$  tests for SAI Anger Control for females and males indicated that there was significant increase in SAI Anger Control scores for both females ( $t = 4.35, df = 39, p < .001$ ) and males ( $t = 2.49, df = 39, p = .017$ ). Thus, overall the ten couple therapy sessions resulted in improvement in control of anger. Given that overall finding, it was appropriate to test this study's hypotheses regarding therapist behaviors associated with degree of improvement in clients' anger control.

After testing the significance of change in the SAI dependent variable, a new variable was created to reflect the degree of *change in anger control* by subtracting participants' pre-therapy SAI Anger Control score from their post-therapy SAI Anger Control score. A higher positive change score reflected a greater increase in anger control

over the course of therapy. In addition, the predictor variables (each type of therapist common factor behavior and client gender) were centered before use in the multiple regression analyses. Centering commonly is used in multiple regression analyses that involve interaction effect variables that are products of two predictor variables, to reduce the correlation between the resulting interaction term and its two components. Because the present study tested the interaction between gender and each type of therapist behavior by creating such interaction variables, this researcher centered the predictor variables before computing the interaction terms. Thus, for client gender and each type of therapist behavior (e.g., empathy) for that couple, the mean was computed and subtracted from each case's original score. This created centered scores for each variable, with a mean of 0 for every variable.

### **Tests of Hypotheses**

#### **Hypothesis 1**

Hypothesis 1 stated that *members of couples whose therapists display higher levels of warmth during session 4 will have a greater increase in their perception of their ability to control their anger*. This hypothesis was tested by computing a stepwise multiple regression analysis in which the dependent variable was change in SAI Anger Control scores. Step 1 had degree of therapist warmth as a predictor variable, step 2 added client gender as a predictor, and step 3 added the interaction of warmth and gender. Table 3 summarizes the results of that analysis. There was a trend found for the effect of warmth on SAI Anger Control change (Model 1), and the regression coefficient was in the opposite direction of what was hypothesized ( $\beta = -.21$ ,  $t = -1.877$ ,  $p = .064$ ), such that

greater therapist warmth was associated with less increase in anger control. The gender effect and the interaction effect were not significant.

Table 3

*Stepwise Multiple Regression for Therapist Warmth and Client Change in Anger Control*

Model	<i>R</i>	<i>R</i> <sup>2</sup>	<i>F</i>	<i>p</i>	Change Statistics				
					<i>R</i> <sup>2</sup>	<i>F</i>	<i>df</i> <sub>1</sub>	<i>df</i> <sub>2</sub>	Sig. <i>F</i>
					Change	Change			Change
1	.208	.043	3.524	.064	.043	3.524	1	78	.064
2	.267	.071	2.961	.058	.028	2.337	1	77	.130
3	.302	.091	2.551	.062	.020	1.678	1	76	.199

*Note.* Model 1 predictors = warmth. Model 2 predictors = warmth, gender. Model 3 predictors = warmth, gender, warmth X gender.

## Hypothesis 2

Hypothesis 2 stated that *members of couples whose therapists display higher levels of empathy during session 4 will have a greater increase in their perception of their ability to control their anger.* This hypothesis was tested by computing a stepwise multiple regression analysis in which the dependent variable was change in SAI Anger Control scores. Step 1 had therapist empathy as a predictor, step 2 added client gender as a predictor, and step 3 added the interaction of therapist empathy and client gender. There was no main effect found for empathy (see Table 4), and thus no support for Hypothesis 2. The gender and interaction effects also were not significant.

Table 4

*Stepwise Multiple Regression for Therapist Empathy and Client Change in Anger**Control*

Model	R	R <sup>2</sup>	F	p	Change Statistics				
					R <sup>2</sup> Change	F Change	df1	df2	Sig. F Change
1	.144	.021	1.646	.203	.021	1.646	1	78	.203
2	.221	.049	1.977	.145	.028	2.282	1	77	.135
3	.223	.050	1.329	.271	.001	.079	1	76	.780

*Note.* Model 1 predictors = empathy. Model 2 predictors = empathy, gender. Model 3 predictors = empathy, gender, empathy X gender.

**Hypothesis 3**

Hypothesis 3 stated that *members of couples whose therapists display higher levels of validation during session 4 will have a greater increase in their perception of their ability to control their anger*. This hypothesis was tested by computing a stepwise multiple regression analysis in which the dependent variable was change in SAI Anger Control scores. Step 1 had therapist validation as a predictor, step 2 added client gender as a predictor, and step 3 added the interaction of therapist validation and client gender. There was no main effect found for validation (see Table 5), and thus no support for Hypothesis 3. The gender and interaction effects also were not significant.

Table 5

*Stepwise Multiple Regression for Therapist Validation and Client Change in Anger**Control*

Model	R	R <sup>2</sup>	F	p	Change Statistics				
					R <sup>2</sup> Change	F Change	df1	df2	Sig. F Change
1	.029	.001	.067	.796	.001	.067	1	78	.796
2	.170	.029	1.152	.321	.028	2.235	1	77	.139
3	.236	.056	1.494	.223	.027	2.144	1	76	.147

*Note.* Model 1 predictors = validation. Model 2 predictors = validation, gender. Model 3 predictors = validation, gender, validation X gender.

**Hypothesis 4**

Hypothesis 4 stated that *members of couples whose therapists display higher levels of systemically-based techniques during session 4 will have a greater increase in their perception of their ability to control their anger.* This hypothesis was tested by computing a stepwise multiple regression analysis in which the dependent variable was change in SAI Anger Control scores. Step 1 had therapist use of systemically-based techniques as a predictor, step 2 added client gender as a predictor, and step 3 added the interaction of therapist use of systemically-based techniques and client gender. There was no main effect found for systemically-based techniques (see Table 6), and thus no support for Hypothesis 4. The gender and interaction effects also were not significant.

Table 6

*Stepwise Multiple Regression for Therapist Use of Systemically-Based Techniques and Client Change in Anger Control*

Model	R	R <sup>2</sup>	F	p	Change Statistics				
					R <sup>2</sup> Change	F Change	df1	df2	Sig. F Change
1	.000	.000	.000	.998	.000	.000	1	78	.998
2	.168	.028	1.117	.333	.028	2.233	1	77	.139
3	.185	.034	.896	.447	.006	.471	1	76	.495

*Note.* Model 1 predictors = therapist use of systemically-based techniques. Model 2 predictors = systemically-based techniques, gender. Model 3 predictors = systemically-based techniques, gender, systemically-based techniques X gender.

### **Hypothesis 5**

Hypothesis 5 stated that *members of couples whose therapists display higher levels of session structure during session 4 will have a greater increase in their perception of their ability to control their anger.* This hypothesis was tested by computing a stepwise multiple regression analysis in which the dependent variable was change in SAI Anger Control scores. Step 1 had therapist session structure as a predictor, step 2 added client gender as a predictor, and step 3 added the interaction of therapist session structure and client gender. There were no main effects found for therapist session structure and client gender, but there was a significant effect found for the interaction of therapist session structure and client gender in Model 3 (see Table 7).

Table 7

*Stepwise Multiple Regression for Therapist Use of Session Structure and Client Change in Anger Control*

Model	<i>R</i>	<i>R</i> <sup>2</sup>	<i>F</i>	<i>p</i>	Change Statistics				
					<i>R</i> <sup>2</sup>	<i>F</i>	<i>df</i> 1	<i>df</i> 2	Sig. <i>F</i>
					Change	Change			Change
1	.151	.023	1.818	.181	.023	1.818	1	78	.181
2	.226	.051	2.068	.133	.028	2.287	1	77	.135
3	.325	.106	2.990	.036	.055	4.641	1	76	.034

*Note.* Model 1 predictors = therapist use of session structure. Model 2 predictors = therapist use of session structure, gender. Model 3 predictors = therapist use of session structure, gender, therapist use of session structure X gender.

A post hoc analysis was conducted to explore the direction of the significant interaction. Separate linear regressions for females and males were run with therapist use of session structure as a predictor of changes in SAI Anger Control scores. For females, therapist use of session structure did not predict changes in client SAI Anger Control scores;  $F(1, 38) = .250, p = .620$ ; see Table 8). For males, therapist use of session structure significantly predicted changes in client SAI Anger Control scores;  $F(1, 38) = 7.528, p = .009$ ; see Table 9). As stated above (see Table 2), males' scores for Anger Control increased from a mean of 22.85 (pre-treatment) to a mean of 24.20 (post-treatment). The positive regression coefficient ( $\beta = .407$ ) indicated that for males the more the therapist used session structure techniques the more the clients' anger control increased over the course of couple therapy (consistent with Hypothesis 5).

Table 8

*Linear Regression for Therapist Use of Session Structure and Change in Client Anger*

*Control for Females (n = 40)*

<i>R</i>	<i>R</i> <sup>2</sup>	<i>F</i>	<i>p</i>
.081	.007	.250	.620

Table 9

*Linear Regression for Therapist Use of Session Structure and Change in Client Anger*

*Control for Males (n = 40)*

<i>R</i>	<i>R</i> <sup>2</sup>	<i>F</i>	<i>p</i>
.407	.165	7.528	.009

## CHAPTER 4: DISCUSSION

The aim of the study was to examine the degrees to which the use of therapist in-session common factor behaviors was associated with improvements in anger control for clients in couple therapy for partner aggression. It was hypothesized that greater use of therapist common factor behaviors would be associated with a greater increase in clients' perception of their ability to control the amount and intensity of their anger. In addition, the study explored whether gender moderated the relationship between the therapist common factors behaviors and changes in clients' anger control; i.e., whether those associations between therapist behaviors and change in client anger control differed for females versus for males.

### **Therapist Common Factors Behaviors and Changes in Clients' Anger Control**

The results indicated that even though clients did increase their perceptions of their ability to control their anger from pre- to post-therapy, there was no support for any of the five hypotheses regarding main effect associations between particular therapist common factors behaviors and increased anger control. In fact, the direction of the trend toward an association between therapist warmth and change in client anger control was opposite to the hypothesized direction; greater therapist warmth was associated with decreased anger control.

***Session structure.*** The only support for a hypothesis occurred for therapist session-structuring behaviors, with a significant interaction effect involving degree of session structuring and gender. Specifically, the hypothesized association between greater therapist session structuring behavior and greater increase in client anger control was found for male partners but not female partners. Thus, for male clients the increase in the

ability to control anger was related to therapist behaviors involving the structuring of the session (e.g., therapist control of couples' overt conflict, pacing and efficient use of time, opportunity for both members of the couple to express concerns and goals, and verbal reinforcement of positive change).

The therapist's structuring of sessions has not been the focus of much prior research in the CFT common factors literature. Moreover, two studies that hypothesized that session structure would predict therapeutic outcomes (e.g., relationship satisfaction, psychological aggression) found no support for the hypotheses (Evans, 2011; Park, 2014). More fine-grained research following trajectories of the two variables over multiple therapy sessions would help increase understanding of their connection.

Although session structure has not received much attention in outcome research about common factors, a few studies and articles highlight the relevance of the therapist's ability to structure sessions for the clients' outcomes. For example, findings from qualitative research suggest that clients, therapists, and model developers perceive the balance between structure and flow to be an important aspect of therapy. Davis and Piercy (2007) indicate, "most of the work in therapy was done by the clients, but within the structure that the therapist set up" (p. 248) and that the clients who were interviewed appreciated that therapist role of structuring the session. The therapist's imposition of session structure could contribute to increased anger control by providing a model of constructive regulation of emotion and behavior, as well as some direct therapist coaching of clients in self-regulation via that structuring.

Similarly, Dobson and Dobson (2013) highlight the benefits of greater session structure in the context of cognitive-behavioral therapy. They suggest that in-session

structure can help reduce client anxiety and distress that typically is elicited by unregulated conflict, increase clients' confidence that they can improve their relationship through therapy, and increase client focus on specific constructive behaviors they can enact.

In addition, Davis and Piercy (2007) highlight safety as one of the aspects that clients value in therapy. According to the authors, "knowing what to expect in therapy and trusting that the therapist was competent enough to not let things get too overwhelming" (p. 450). It is possible that the use of session structure by the therapist contributed to a sense of safety for the clients that allowed them to do the therapeutic work that led to increases in their ability to control anger.

The present study examined the association between session structure during session 4 and changes in anger control between the beginning of treatment and the end of the tenth session. It is important to consider the possibility that the link between therapist structuring of sessions and client anger control may involve some bi-directionality across treatment that this study, because of its cross-sectional nature, could not capture. Previous research suggests that, in the beginning, clients' emotional reactivity or poor anger control might influence the degree to which the therapist attempts to impose structure on sessions (Davis & Piercy, 2007), such that higher emotional reactivity leads to more session structuring by the therapist, which then increases client anger control. This is related to one of the criteria for the session structure score in the TGCSQ, therapist control of conflict (Evans, 2011); i.e., therapists impose structure partly to control existing conflict.

To better understand the causal process between therapist behavior and client behavior, future research should track changes in degree of therapist session-structuring behavior from initial to later sessions, as well as changes in clients' anger control over the course of those sessions. This idea is discussed further in the next section.

Given the overall lack of research on gender effects associated with therapist common factors behavior, there is no direct evidence to explain the gender difference found in this study, in which the association between greater therapist session structuring and greater increase in client anger control existed for males but not among females. However, previous research looking at other therapist common factors behaviors suggests that the impact of those behaviors can be different depending on the gender of the client, and can be particularly important for men. For example, Schade et al. (2015) found that therapist warmth had a positive effect on the husband, which affected the wife, but not the other way around. Similarly, previous research suggests that males' degree of therapeutic alliance with the therapist tended to be more strongly associated with therapy outcome (e.g., general measures of individual, relationship, and overall wellbeing; marital satisfaction) (Anker, Owen, Duncan, & Sparks, 2010; Friedlander, Escudero, Heatherington, & Diamond, 2011; Symonds & Horvath, 2004).

Some authors have suggested that the gender difference may be related to the degree of commitment that partners show to therapy. Anket et al. (2010) suggest that most of the treatment in their study was initiated by female partners, and that the significant results for men may be a reflection of the therapist's ability to engage the less engaged partner (in this case, mostly male partners) in the treatment. This idea has led some authors to believe that the gender difference could disappear or change when

evaluating later sessions in treatment, such that there is no gender difference, or women's perceptions of common factors become increasingly important (Anker et al., 2010; Friedlander et al., 2011).

***Warmth.*** In the case of warmth, the trend results suggested an association between greater therapist warmth and less change in anger control. In other words, higher ratings of therapist warmth during session four were unexpectedly associated with smaller changes in client anger control. One possible reason for the observed finding involves methods for measuring therapists' in-session behaviors. Previous research that focused on warmth in therapeutic interactions (therapist-client and client-client) assessed three types of behaviors: nonverbal communication (e.g., loving smiles), supportiveness (e.g., offering encouragement and praise), and content (e.g., statements of affirmation, appreciation, and concern) (Schade et al., 2015). Unlike that approach, the instrument used in the present study focused on nonverbal behaviors such as smiling and voice tone, and added use of humor when appropriate.

The measure used in previous research seems to combine aspects that in the TGCSQ are separated, such as warmth, empathy, and validation. It is possible that in the attempt to capture the non-verbal aspect of warmth the instrument did not measure warmth accurately. In addition, two of the three behaviors considered in the warmth score (smiling and use of humor) are rated "when appropriate," which poses a challenge for raters, as it can be difficult for an undergraduate rater to determine the appropriateness of a behavior. Lastly, because of the way sessions were recorded, in many cases it is not possible to give a rate for smiling, as the therapists are out of the frame or the video only shows their backs.

A second aspect that may help understand the unexpected trend regarding the use of warmth is related to the “units” in the therapy setting. Previous research has measured warmth from one therapist to each partner and the warmth between partners (Schade et al., 2015). In the present study, the co-therapist team received a score that considered both therapists’ behaviors, and it did not differentiate which therapist enacted them. Thus, it was possible for a co-therapist team to receive a moderate to high score for warmth in a case in which one or both therapists behaved warmly toward only one of the partners, yet changes in anger control were assessed for both partners. More research is needed to understand how the presence of common factor behaviors in one therapist and not the other in a co-therapist team affects each member of the couple.

In addition, the measure did not differentiate which member of a couple the therapist behaviors were directed at. It is possible that the perception by one partner that the therapist is being warm toward the other partner and not them detracts from their process, possibly interfering with their ability to control anger or other therapeutic outcomes.

***Empathy.*** The use of empathy was not associated with changes in the clients’ anger control. Carl Roger’s idea that empathy is necessary has been accepted in the field of therapy and has been found in previous research to account for a significant proportion of the variance in outcome treatments (Wampold & Imel, 2015). However, the idea that empathy is sufficient for change has been challenged, especially when moving from individual therapy to systemic approaches such as couple and family therapy.

Thus, it is possible that while empathy may be an important element in the process of change it is not sufficient by itself to explain change in couple therapy clients.

For example, clients could feel understood by the therapist, but still feel angry with others who do not share their posture, and thus not showing increases in anger control. Empathy may be an important step in the therapeutic process, for example, increasing the therapeutic alliance, but more structured techniques may be required after the alliance is established to elicit change.

***Validation.*** The use of validation was not associated with changes in the clients' anger control. It is possible that this was due to different experiences that the two members of the couple had of validation, a difference that the TGCSQ cannot capture. For example, if the therapist agreed with (validated) what one partner said, the other partner may experience this as lack of empathy toward his/her own position or as invalidating.

***Systemically-based techniques.*** The use of systemically-based techniques was not associated with changes in the client's anger control. It was hypothesized that the therapist noting of cyclical patterns in couple interaction, balance in attention to partners, and circular questioning could offer partners perspectives that could help in the reduction of anger and could block their typical negative behavioral patterns. However, it is possible that even if there were changes in partners' aggressive behaviors associated with the use of systemically-based techniques, those changes may not translate into the individuals' global ability to control their experience of anger. More individually tailored focus on each person's internal experiences of anger and development of personal anger management strategies may require more intervention than the couples in this study received. Alternatively, future research may need to examine possible paths between the use of systemically-based techniques and changes in anger control. For example, it is

possible that pointing out cyclical patterns and asking circular questions may help clients understand their role in the process and take responsibility for their actions, which could later lead to an increased ability to control anger.

### **Study Limitations**

This study had several limitations that need to be considered. First, the study used a small, non-representative sample of couples (those who sought help at a family therapy clinic for a variety of relationship problems and were selected based on their partner aggression experiences). Thus, the results cannot be generalized to couples lacking partner aggression and/or to non-distressed couples.

Second, the set of therapist in-session common factor behaviors account for part of the therapeutic process, but it is possible that they are not representative of the process as a whole. The therapists enacted a wide variety of behaviors during sessions, some of which were model specific and others of which were more reasonably considered common factors although not representing the set of common factors behaviors emphasized within the TGCSQ.

Third, as mentioned in the previous subsection, the ratings of therapist common factor behaviors were assigned to the co-therapist teams instead of each therapist within the team separately. It is possible that in some co-therapist teams the therapist common factor behaviors were different for each therapist, a difference that cannot be captured by the TGCSQ. In a similar way, the couple was also seen as a “team,” as coders did not specify who was the recipient of the common factor behavior (e.g., coders may assign a high score on empathy to the therapist, but that behavior may be directed only toward one partner). Those sources of measurement error could have reduced the observed

associations between therapist behaviors and client responses to therapy (specifically increases in anger control). Another issue that should be considered is that this study focused on only one outcome variable – anger control – whereas it is possible that other aspects of individuals' personal functioning may have been influenced more by the therapist common factors behaviors.

Lastly, this study used variables that come from different information sources. Clients reported their levels of pre- and post-therapy anger control through self-report questionnaires, whereas therapist common factor behaviors were obtained through observational coding. It is possible that the perceptions that clients have of therapist behaviors could yield a higher association with changes in anger or therapy outcomes in general.

### **Implications for Future Research**

Based on the limitations presented for this study, a first implication for future research is to explore the effect of therapist common factor behaviors using longitudinal studies. Evaluating the effect of common factors through process research could enhance the findings for this field, as common factors may develop during treatment in a way that cross sectional studies cannot reflect (Snyder & Balderrama-Durbin, 2012). For example, it is possible that session-to-session changes in the studied outcome (e.g., anger control) lead to the increase or decrease in certain therapist behaviors (e.g., session structure). Understanding the trajectory of change in the outcome and the trajectory of change in the use of common factor behaviors, as well as the association between the two trajectories, could enrich both the research and practice of CFT. More specifically, within the trajectory of the use of common factor behaviors, it would be interesting to learn about

when therapists emphasize relationship factors and when they increase their use of technique factors.

Second, the number and representativeness of participants should be increased. Doing so could contribute to the generalizability of findings, provide greater statistical power to detect smaller effect sizes, and allow for more control variables such as model used, length of client relationship, etc.

Third, future studies that involve co-therapist teams should look at individual behaviors of each therapist and the experiences of the individual clients regarding the therapist common factors behaviors directed toward them. Triangulating information based on observation by trained coders and client reports could enhance the research on common factors, both regarding specific outcomes and about the best way to do research in this area. There is no consensus on the literature about the most helpful way to measure common factor constructs (e.g., observer, therapist, client), nor clear research on which source offers more information about the therapeutic process in regard to a specific outcome (Kuhlman et al., 2013; Sprenkle & Blow, 2004; Symonds & Horvath, 2004; Taft et al., 2003).

Fourth, future research could control for pre-treatment factors and client characteristics, such as pre-treatment level of anger control and other variables that may influence the therapeutic relationship. It is possible that the therapist common factor behaviors have a different effect on clients depending on those initial levels. In a similar way, the pre-treatment levels of anger, depression, anxiety or other variables could have an impact on the degree to which the therapist uses each common factor behavior.

Fifth, in a similar way, studies should control for therapist characteristics (e.g., experience, gender, and age) and for therapy characteristics (i.e., therapeutic model). Considering therapist characteristics, it is possible that the same therapist common factor behavior is perceived differently and has a different effect in the client depending on characteristics of the therapist. For example, studies from social psychology suggest that when women are perceived to be warm, they are also thought of as less competent (Fiske, Xu, Cuddy, & Glick, 1999).

Considering therapy characteristics, it is possible that while therapist common factor behaviors are present in all therapeutic models, certain behaviors are emphasized in specific models. For example, it is possible that therapist in the CBT condition may have higher use of session structure, as they were following a more specific treatment protocol and using a model that offers specific guidelines for how to structure sessions (e.g., use of check-in, assigning homework).

Sixth, the therapeutic outcomes evaluated in this type of research should be expanded from relationship distress to other aspects of relationships and measures of individual functioning. This could help increase knowledge about the degree to which common factors may have an effect on more global aspects of clients' lives even when the treatment is not explicitly designed to address those areas. The relationship and individual client functioning areas could include problem areas, but they also could be broadened to encompass the enhancement of positive aspects of couple experiences such as joy or hopefulness (Snyder & Balderrama-Durbin, 2012).

Seventh, future studies with larger samples could examine interactions between types of common factors, as it is possible that the combination of certain common factors

is what predicts change in clients. In a similar way, studies with larger samples could look at similarities and discrepancies between couple members and compare the effects that therapist common factor behaviors have in a couple, based on how similar or different the partners are in a specific outcome (e.g., control of anger).

Finally, future research could address further the gender difference that was found in the effect of common factors. While it is possible that common factors affect clients differently solely based on their genders, future research could focus on couples' gender roles, partners' openness to attend therapy, and other variables that could explain the gender differences found in previous research. In addition, future research could include a more diverse sample, including homosexual and lesbian couples.

### **Implications for Clinical Practice and Training**

Based on the findings of this study, there are three main implications for clinicians and for clinical training. First, therapist common factors should be used in clinical work with clients and in the context of training novice therapists; however, they should be addressed with caution, as there is not enough evidence yet to support their association with positive therapeutic outcomes. Thus, it may be relevant to clinicians to structure a session in a constructive and productive way, making sure to control overt conflict behaviors and to pace the session to allow flexibility without going on tangents, as well as giving both partners the opportunity to express concerns and give positive feedback. This could have a positive effect on the therapy outcome, especially regarding the male partner.

Second, therapists should also be intentional about the use of the common factor behaviors presented in the study and observe the effects that they may have on clients, as

some of these behaviors (e.g., warmth) may have an opposite effect than the one intended by the therapist. It can be beneficial for the therapeutic process to ask clients for feedback regarding the therapist's style and the therapeutic alliance, to use the feedback to tailor the therapist's use of common factors behaviors.

Lastly, clinicians should consider the different effects that interventions and behaviors may have on their clients depending on their gender. Although the research literature is not yet clear on how client gender moderates the relationship between common factor behaviors and therapeutic outcomes, there is some evidence that there is a gender effect. In addition, therapists should consider the interaction of their own gender and the client's gender when thinking about these possible differences in effects on outcomes.

## APPENDIX A

**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 Scale Score	Scale Score Average
<b>Warmth</b>	<b>Use of humor to connect with clients:</b> Therapist jokes with clients at appropriate times			
	<b>Smiling:</b> Therapist smiles when greeting clients, and at appropriate times during session			
	<b>Voice tone:</b> Therapist uses a supportive, calm tone			
<b>Empathy</b>	<b>Reflective statements</b> 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”			
	<b>Agreement</b> 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.”			
<b>Validation</b>	<b>Affirming/legitimizing: Verbally conveying that the therapist takes the clients’ thoughts and feelings seriously</b> 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 difficult to constructively deal with problems when we are tired.</i> ”			
	<b>Asking personal questions, showing interest in clients’ lives:</b> Therapist asks questions about the clients in order to learn more about them as people			
	<b>Staying on topic:</b> Therapist follows a clear line of questioning, follows up on client statements, and does not jump from topic to topic			
<b>Therapist Presence</b>	<b>Eye contact:</b> Therapist makes eye contact with the clients when he or she is speaking, and when the clients are speaking			
	<b>Body language</b> E.g. Posture oriented towards the clients, no physical barriers			
<b>Therapist Collaboration</b>	<b>Asking clients for their opinions &amp; preferences regarding interventions, tasks, and goals</b> E.g.: Therapist - “We’ve discussed several ways the two of you could spend time together this week – which sounds best to you?”			
	<b>Collaborative language use displayed by the therapist such as “we” and “us”</b> 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 Scale Score	Scale Score Average
<p><b>Systemically-Based Technique</b> Therapist demonstrates working in a systemic manner</p>	<p><b>Balance in attention to partners:</b> Therapist involves both partners in session by addressing each of them, and following up with each partner.</p> <p><b>Noting cyclical patterns in couple interaction:</b> 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 each other"</p> <p><b>Circular questioning:</b> 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?"</p> <p><b>Seeking information and/or creating interventions</b> 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 couple could use to communicate with their child's school.</p> <p><b>Control of conflict:</b> controlling overt conflict behaviors displayed by clients towards one another like partners blaming one another or making critical remarks</p> <p><b>Pacing &amp; efficient use of time:</b> allowing flexibility and facilitating client discussion of important topics without allowing clients to go off on tangents</p> <p><b>Opportunity for both members of couple to express concerns &amp; goals,</b> and therapist summarizes those</p> <p><b>Therapist reinforces positive change using positive feedback, encouragement, etc.</b> 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 times like you had on Saturday ahead."</p>			
	<p><b>Session Structure</b> Therapist structures session to make it constructive &amp; productive</p>			

## APPENDIX B



## SAI (DAY 2)

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Therapist Code: \_\_\_\_\_ Family Code: \_\_\_\_\_

Everyone feels angry or furious from time to time, but people differ in the ways that they react when they are angry. A number of statements are listed below which people use to describe their reactions when they feel **angry or furious**. Using the key below, read each statement and then circle the number which indicates **how often you generally react or behave** in the manner described when you are feeling angry or furious. Remember that there are no right or wrong answers. Do not spend too much time on any one statement.

**Circle one:**      1- Almost never      2- Sometimes      3- Often      4- Almost always

**When Angry or Furious**

- |  |   |   |   |   |
|--|---|---|---|---|
| 1. I control my temper.....  | 1 | 2 | 3 | 4 |
| 2. I express my anger.....   | 1 | 2 | 3 | 4 |
| 3. I keep things in.....   | 1 | 2 | 3 | 4 |
| 4. I am patient with others.....                                     | 1 | 2 | 3 | 4 |
| 5. I pout or sulk.....   | 1 | 2 | 3 | 4 |
| 6. I withdraw from people.....                                       | 1 | 2 | 3 | 4 |
| 7. I make sarcastic remarks to others.....                           | 1 | 2 | 3 | 4 |
| 8. I keep my cool.....   | 1 | 2 | 3 | 4 |
| 9. I do things like slam doors.....                                  | 1 | 2 | 3 | 4 |
| 10. I boil inside, but I don't show it.....                          | 1 | 2 | 3 | 4 |
| 11. I control my behavior.....                                       | 1 | 2 | 3 | 4 |
| 12. I argue with others.....   | 1 | 2 | 3 | 4 |
| 13. I tend to harbor grudges that I don't tell anyone about.....     | 1 | 2 | 3 | 4 |
| 14. I strike out at whatever infuriates me.....                      | 1 | 2 | 3 | 4 |
| 15. I can stop myself from losing my temper.....                     | 1 | 2 | 3 | 4 |
| 16. I am secretly quite critical of others.....                      | 1 | 2 | 3 | 4 |
| 17. I am angrier than I am willing to admit.....                     | 1 | 2 | 3 | 4 |
| 18. I calm down faster than most other people.....                   | 1 | 2 | 3 | 4 |
| 19. I say nasty things.....  | 1 | 2 | 3 | 4 |
| 20. I try to be tolerant and understanding.....                      | 1 | 2 | 3 | 4 |
| 21. I'm irritated a great deal more than people are aware of.....    | 1 | 2 | 3 | 4 |
| 22. I lose my temper.....  | 1 | 2 | 3 | 4 |
| 23. If someone annoys me, I'm apt to tell him or her how I feel..... | 1 | 2 | 3 | 4 |
| 24. I control my angry feelings.....                                 | 1 | 2 | 3 | 4 |

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Anger-in : 3, 5, 6, 10, 13, 16, 17, 21  
 Anger-out : 2, 7, 9, 12, 14, 19, 22, 23  
 Anger-control : 1, 4, 8, 11, 15, 18, 20, 24

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