ABSTRACT

Title of Thesis: THERAPIST COMMON FACTORS' INFLUENCE ON CLIENT CONSTRUCTIVE COMMUNICATION AND CONFLICT RESOLUTION IN COUPLE THERAPY

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This study investigated the relationship between therapist common factors behaviors and changes in client constructive communication during couple therapy. Research suggests that common factors are associated with client improvement, but research on these factors in couple therapy is lacking. This study was a secondary data analysis of 41 couples presenting with mild to moderate psychological and physical partner aggression who received ten sessions of couple therapy at a university family therapy clinic. The study examined the relationship between therapist collaborative behavior and use of systemically based techniques coded from the fourth couple therapy session, and changes in client constructive communication, measured by client cognitions during conflict, client and partner behavior during conflict, and video coding of couple communication. Minimal significant links were found, but unexpectedly, therapist use of systemic techniques was negatively associated with change in female constructive problem solving cognitions. Implications of these findings are discussed.

THERAPIST COMMON FACTORS' INFLUENCE ON CLIENT CONSTRUCTIVE COMMUNICATION AND CONFLICT RESOLUTION IN COUPLE THERAPY

By

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Chapter 1: Introduction

Statement of the Problem

In the field of individual psychotherapy, and more recently in the field of marital and family therapy, the development and implementation of therapy models with interventions based on core model constructs has been considered the primary means of effecting positive change in clients. However, this conceptualization has been called into question in the last few decades, largely as a result of the pioneering work of Smith, Glass, and Miller (1980) and Wampold (2001), as well as a growing number of other therapy researchers. Several studies have shown that while therapy commonly creates demonstrable benefits for clients, there is little difference in the degree of efficacy among the models (e.g., Luborsky, Singer & Luborsky, 1975; Shadish, Ragsdale, Glaser, & Montgomery, 1995). In light of this surprising finding, more attention has been paid recently to the question of *how* therapy models facilitate change. One conceptualization is that improvements made in therapy are partly a result of "common factors" that are delivered through many of the models. These factors are not associated with the concepts and specific methods that are the hallmark of a particular model, and they are generally understood to include four categories: 1) client factors, such as motivation to change; 2) therapist factors, such as empathy; 3) therapist-client relationship factors, such as the quality of the therapist-client collaborative alliance; and 4) universal technique factors associated with good therapy rather than a particular model, such as pacing of interventions to match client readiness for change (Sprenkle & Blow, 2004).

As a relatively new concept, for which it is difficult for researchers to attract external funding, common factors have remained relatively untested empirically. In order to gain traction in the field and be useful in practice, the impact of common factors must be fully understood and

the individual components assessed for impact (Blow, Sprenkle, & Davis, 2007). Only then can practitioners have a well-rounded understanding of what contributes to good therapy and, just as important, good therapists.

Couple and family therapy (CFT) provides even more complexity to the study of common factors with its systemic conceptualization of relationships and presenting problems. Multiple clients in a session change the conceptualization of common factors, including what it means to have a strong therapeutic alliance and how technique factors play out. Collaboration, for example, is about working *with* the client in individual therapy. It looks very different with families and couples, and perhaps has greater importance in this context in which active participation is needed from all members of the group. Therapists working with relational cases can collaborate with the clients as individuals and as a group, showing the family or couple how to collaborate amongst themselves and work together better as a unit.

Overall, technique common factors in CFT look quite different from those used in individual therapy, largely because of the importance of understanding and intervening in the context of systems theory. With multiple clients in the room, such factors focus more on the therapist's ability to identify behavioral interaction patterns occurring among family members and increase the members' awareness of those patterns, using non-blaming language. Common factors in this context have largely remained unexplored in research, and the systemic context is different enough that findings from individual psychotherapy research cannot be generalized to CFT. Because of the importance of understanding common factors in CFT, there is a great need for more research in this area.

Given that the core goal of research on common factors is to identify ways in which those factors influence outcomes of treatment, their effects on couples' abilities to communicate

constructively and resolve relationship conflicts would be a high priority, but little research on that topic has been conducted to date. It has been established that the way couples interact to resolve conflict is associated with their level of marital satisfaction (Christensen & Shenk, 1991; Greeff & de Bruyne, 2000). Members of distressed relationships have been shown to exhibit high levels of negative and low levels of positive affective expressions (e.g., high contempt and low validation) when they communicate about areas of conflict (Karney & Bradbury, 1995). If couples are unable to resolve the inevitable conflicts that arise in committed relationships, they are unlikely to have long-term satisfaction in their relationships. Thus, increases in positive communication styles such as problem solving, validation, and collaboration that facilitate conflict resolution are important goals in couple therapies (e.g., Epstein & Baucom, 2002). Although model-specific interventions such as communication skills training are designed to produce those positive changes in couple interaction, cross-model common factors may contribute to those changes as well.

Studies that have been conducted on common factors in psychotherapy, like many studies in the field, have explored variables that create a reduction in negative aspects of client functioning. While such decreases are important parts of goal attainment in therapy, a thorough exploration of what makes therapy work also must include factors that result in increases in positive outcomes. Research has indicated the great importance of positive interactions in influencing couples' relationship satisfaction. For example, Gottman (1994) found that it takes a high frequency of positive acts to balance the deleterious effects of negative acts on marital satisfaction. A satisfying relationship involves not just of a lack of negative behaviors, thoughts and emotions, but also the presence of positive responses, such as mutually constructive communication (Christensen & Shenk, 1991). It is important to identify therapeutic factors,

whether model-specific or common factors, that contribute to increases in such positive partner responses.

Each theoretical model of CFT has its own unique model-specific ways of intervening to improve couples' positive interactions. What is unknown is how common factors across the models might contribute to such positive outcomes. It is possible that common factors are the answer as much as or more than interventions such as skills training in cognitive-behavioral therapy (Epstein & Baucom, 2002), facilitation of partners' vulnerable primary emotions and empathy for each other's unmet attachment needs in emotion-focused therapy (Johnson, 2008), and shifting partners' rigid and narrow focus from chronic problems to potential new solutions in solution-focused therapy (Hoyt, 2015). One possible process through which common factors may operate is by facilitating clients' openness to therapist interventions, regardless of the therapy model. Another possible process involves common factors themselves directly influencing client functioning; for example, when positive therapist behaviors such as collaborative actions serve as a model for improved client behavior. As therapists implement specific interventions and models, it is helpful to know if their way of being as a therapist will help or hinder client progress. The field of CFT in particular recognizes the influence of systemic factors on a relationship, and the impact of the therapist's characteristics on the couple relationship should not be overlooked. Therapists who are skilled at providing positive therapeutic common factors might be modeling good behaviors for couples, such as collaborative language and a systemic understanding of arguments rather than one based on blame. To date, minimal research has examined such therapist effects on couple functioning in CFT (Blow et al., 2009; Davis & Piercy, 2007).

In summary, common factors have been shown to influence therapeutic outcomes, with most studies focused on individual psychotherapy (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016). In particular, the existing common factors research has not addressed effects of common factors in couple therapy on achievement of the goal of increasing members' positive responses to each other. The present study was intended to fill a portion of this gap in knowledge by investigating the degrees to which therapist collaboration with clients and systemic technique factors in couple therapy are associated with increases in partners' constructive communication over the course of treatment.

Purpose

The purpose of this study was to explore the relationships between common factors in couple therapy involving therapists' in-session behaviors and changes in couples' conflict resolution skills over the course of therapy. In particular, this study investigated whether therapist collaborative behavior and use of systemically based technique factors during sessions are associated with improvements in partners' positive communication with each other, through the therapists' modeling of such constructive behavior for the clients. This study involved a secondary analysis of data that were collected previously for a study, the Couples Abuse Prevention Program, that investigated the effects of a manualized form of Cognitive Behavioral Couple Therapy (CBCT) versus other couple therapy models for treating couples who were experiencing psychological and mild to moderate physical partner aggression (Epstein, Werlinich & LaTaillade, 2015).

Researchers and practitioners developing new interventions need to understand specifically how therapy common factors influence the functioning of couples who are

experiencing relationship distress to create the most effective treatments. Therapists working with couples can benefit greatly from a clearer understanding of the value that specific therapist actions can provide in fostering constructive behavior between partners, rather than simply believing themselves to be a vessel for the delivery of their preferred theoretical model. In turn, this understanding may improve the quality of the therapy and thus the therapeutic outcomes for clients.

There is a large body of empirical literature demonstrating how common factors qualities of therapist behavior in individual therapy influence improvement in client functioning. With multiple clients in the room, as is the case with couple and family therapy, the complexity of the potential impacts of common factors can increase immensely. At present there is limited information about possible effects of therapist common factors behaviors that occur during sessions on improvement in couples' positive communication skills over the course of therapy. Consequently, there is a need for research to determine the extent to which therapists should attend to specific aspects of their actions during sessions as closely as they do to delivering standard interventions within their therapy theoretical models. The findings of such research will have implications for understanding the processes involved in effective therapy, for clinical practice, and for graduate-level training.

As previously noted, relatively little research has been done on common factors in CFT, and particularly on therapist common factors (Blow et al., 2007). However, knowledge of therapist common factors can have an immediate impact on the field, providing guidelines for clinical training programs and for practicing clinicians on how therapists can intentionally behave during sessions to create more positive outcomes for clients.

This study also can contribute to the body of knowledge regarding strength-based approaches to treatment. Rather than the more common deficit-reducing outcomes that have been the foci of many studies in the fields of psychology and psychotherapy, this study focused on therapists' abilities to enhance clients' *positive* communication styles to create more positive subjective experiences in their couple relationships and more satisfying resolution of conflicts. Therapists who are encouraged to consider increasing couples' positive rather than only reducing negative styles of communication can gain a new perspective on their clients' abilities and create a more well-rounded treatment plan. This research was based on a longstanding tradition of utilizing positive qualities of therapists' behaviors toward clients to facilitate client growth in individual therapy, but applying it to therapist common factors influences in couple therapy.

Literature Review

Brief Summary of Empirical Evidence for the Effectiveness of Couple Therapy

Empirical support for the effectiveness of couple therapy has been a focus of much of the literature in the field in the past few decades. Initially, Gurman and Kniskern's (1981) review of the early treatment studies showed that conjoint marital therapy was more effective than individual therapy for reducing marital distress. As the number of outcome studies increased, meta-analyses were conducted to identify overall findings. Shadish et al. (1993) is the most extensive and rigorous meta-analysis to date, reviewing 163 published and unpublished controlled studies of marital and family therapy with randomly assigned, distressed patients. Shadish and his coauthors conclude that clients who received marital therapy saw improvement over untreated control clients, with an effect size of .6, which means that the difference between the means for the measure of relationship quality between the treatment group and control group was .6 standard deviation (the pooled standard deviation for the two groups), where an effect size

of .5 is considered moderate. Couple therapy was shown to be as effective in treating relationship problems as individual psychotherapy was for improving problems in individual functioning such as depression. Shadish and colleagues (Shadish, Ragsdale, Glaser, & Montgomery, 1995; Shadish & Baldwin, 2003) also found such positive results, the latter study with a large effect size of .84. Reviews by Baucom, Shoham, Mueser, Daiuto, and Stickle (1998), Snyder, Castellani, and Whisman (2006), and Fischer, Baucom, and Cohen (2016) also provided strong evidence that couple therapy is effecive for treating a variety of individual and relationdship problems. Subsequent studies have indicated the efficacy of couple interventions for specific individual problems such as depression, anxiety disorders, eating disorders, and substance abuse (e.g., Barbato & D'Avanzo, 2008; Belus, Baucom, & Abramowitz, 2014; Bulik, Baucom, & Kirby, 2012; Kirby, Runfola, Fischer, Baucom, & Bulik, 2015; McCrady, Epstein, Cook, Jensen, & Hildebrandt, 2009; Schumm, Fredman, Monson, & Chard, 2013). In addition, studies have shown significant positive effects with couple interventions for a variety of physical health problems such as cardiovascular disease, arthritis, chronic pain, diabetes, and cancer (Fischer, Baucom, & Cohen, 2016). Thus, there is a substantial body of empirical evidence that couple therapies are effective in treating problems in both relationship and individual functioning.

History of Empirical Research to Test Efficacy of Specific Therapy Models

The most common conceptualization of the process of change in therapy includes a core assumption that theoretical models and techniques are responsible for clients' improvement. Many therapists with diverse theoretical emphases believe that it is the characteristics of their specific preferred model that are primarily responsible for change, and couple therapists are no different. For example, a therapist with an emotionally focused orientation would explain that couples improve when the members access their primary emotions and unmet attachment needs, creating new and healthier dyadic cycles in and out of sessions (Johnson, 2008). A therapist following Gottman's (2015) model would describe strengthening the "sound relationship house"

through interventions designed to improve partners' closeness, conflict management to build trust, commitment, and shared meanings. Each alternative theoretical model includes interventions intended to alter processes within and between members of a couple that are assumed to produce a more constructive and satisfying relationship.

It is clinically valuable that many clinicians have such an allegiance to a particular model of individual, couple, or family therapy. However, this allegiance can create bias in therapeutic research, where researchers often have personal and financial investments in the success of the models being studied. Most psychotherapy efficacy research has been conducted by a creator or supporter of a particular model in an attempt to prove its superiority over other models (Sprenkle, Davis, & Lebow, 2009). In fact, many psychotherapy studies have compared a model to a basic "nonspecific" treatment (i.e., paying attention to clients and engaging them in discussions that lack the "active ingredient" interventions of the model) that can barely be considered therapy, not to another model that has been demonstrated to be effective (Wampold (2001). Luborsky and his colleagues found in one meta-analysis that therapist allegiance to a model is actually the most important factor in the outcome of a treatment study (Luborsky et al., 1999). It follows logically that therapists who are involved in an experiment on the efficacy of their preferred model will be more motivated and better able to successfully carry out treatment with that model than if they were in a "treatment as usual" condition in which they were asked to conduct a standard intervention other than their own model. In an early explanation of their "common factors" paradigm, Sprenkle and Blow (2004) stated that they were unaware of a single study in the field of couple therapy that was conducted by unbiased researchers and that compared two effective treatments. In studies intended to demonstrate a particular model's efficacy, therapist common factors that are independent of each model's specific therapeutic

interventions are considered to be "noise" to be removed from the study by having therapists closely follow standard treatment manuals meant to minimize individual differences among therapists (Sprenkle et al., 2009). The assumption in this model-driven paradigm is that all therapists would be equally able to deliver treatment based on a manual. This trend, following the medical model (a standard medical treatment should be delivered the same by various physicians), assumes that it is the treatment models themselves that create change rather than the therapists who deliver the treatment.

Common Factors Influencing Therapy Outcomes (versus Therapy Model-Specific Effects)

Definition of common factors. In 1936, psychologist Saul Rosenzweig stated that all models could be equally successful because of the impact of factors that are common to all psychotherapies and that are present at different levels in all therapists. Rosenzweig referenced Lewis Carroll's (1865) *Alice in Wonderland* in stating his conclusion; in the book, a dodo bird says, "Everybody has won, and all must have prizes." This began the conversation among psychotherapy writers regarding common factors. When Luborsky, Singer, and Luborsky (1975) revisited the idea with a review of psychotherapy outcome literature and found that psychotherapy models were generally equivalent in their outcomes, the "dodo bird verdict" was born. A variety of other rigorous studies on model efficacy found the same result (Elkin et al., 1989; Luborsky et al., 2002; Shadish & Baldwin, 2003). Perhaps the most influential of these studies, Elkin et al.'s (1989) National Institute of Mental Health Collaborative Depression Study, reviewed psychotherapy effectiveness with no particular model allegiance in mind. The researchers found that, in spite of efforts to control for therapist factors, differences in outcomes between models were minimal, while major differences were found for therapist effectiveness. Although this extreme view of models as being irrelevant to therapeutic outcomes is rarely

espoused, the findings did allow researchers to explore alternatives to the model-driven change paradigm. The obvious next question was, "If specific models are not responsible for the positive outcomes that therapy produces, what is?"

According to Michael Lambert's (1992) therapeutic outcome model based on his interpretation of a review of psychotherapy outcome studies, 15 percent of the outcome of therapy can be attributed to the therapeutic model, 15 percent to hope and the placebo effect, 40 percent to client factors, and 30 percent to therapist factors. Similarly, Wampold (2001) conducted a meta-analysis of studies comparing two or more therapy models and found that eight percent of the outcome of therapy could be attributed to the therapeutic model, 22 percent to unknown factors, and 70 percent to general factors present in all psychotherapy such as the therapeutic alliance between clinician and clients and the degree to which clients held hope for improvement. These general factors, including therapist characteristics factors (e.g., warmth, empathy), client factors (e.g., commitment to the relationship), model/technique factors (that are common to all models, e.g., reframing), and factors that involve the interaction between therapist and client (e.g., shared goals), are now frequently called "common factors." The term is in contrast to "specific factors" that are unique to a particular model.

Sprenkle and Blow (2004) define common factors as treatment variables that are not specific to any particular psychotherapeutic model but that are responsible for a large part of the outcome of therapy. This is considered the *broad view* of common factors. Lambert (1992) conceptualizes common factors with a *narrow view*, including only techniques that are commonly found in many models (such as reframing and finding exceptions to problematic relationship patterns). A broad view of common factors includes other aspects of treatment that affect the experience and outcomes, including client, therapist, and therapist-client relationship

characteristics (Hubble et al., 1999). For the purposes of this thesis study, the broad view of common factors was adopted. Sprenkle and Blow (2004) also embraced a moderate position on the importance of common factors, in contrast to some early extreme interpretations by Wampold (2001) and others. Sprenkle and his colleagues consider theoretically based treatment models to be important aspects of therapy but also see a place for common factors. As they state it, common factors may be the car that gets a client to their destination, but an effective model is the roadmap (Sprenkle et al., 2009).

The therapeutic alliance. Sprenkle and Blow (2004) theorize that models are the vehicles through which common factors create change in therapy, rather than models being the change agents themselves. Once common factors had been defined and the various components identified, researchers began questioning not just what they were but how they worked and in what circumstances. In the study of common factors, the therapeutic alliance between the therapist and client(s) is perhaps the most researched and understood as a crucial contributor to positive therapeutic outcomes (Blow et al., 2007; Martin, Garske, & Davis, 2000). The term refers to the strength of the bond between therapist and client, and it has long been seen as an important factor in the therapeutic process. Horvath and Symonds (1991) conducted a meta-analysis of 24 studies relating the quality of the alliance to therapy outcomes and found a moderate but reliable association. The alliance between therapist and client can be measured in many different ways. The most common measure of alliance is the Working Alliance Inventory (Horvath & Greenberg, 1989), a self-report assessment that can be filled out by the therapist, the client, or a clinical observer, with different versions for each perspective. The therapeutic alliance has been shown to influence the likelihood that therapy will even be able to continue,

with a stronger alliance lowering the chances that clients will drop out of therapy before goals are achieved (Horvath, 2006).

An interest in the concept of a therapeutic or "working alliance" has long been part of the field of individual psychotherapy. Freud (1958) saw the client's attachment to the therapist as valuable information for understanding the client's early personality development but did not seek a strong bond between therapist and client. Carl Rogers (1957) was perhaps the first therapist to look at the therapeutic alliance from the perspective of the therapist's ability to engage empathically with the client and create an atmosphere of unconditional positive regard. The therapeutic alliance is commonly assumed to be influenced by characteristics of the therapist, but it truly is a variable in which therapist factors and client factors interact.

Therapist common factors. "It is rather surprising, indeed shocking, that relatively little attention is paid to therapist variables as contributors to outcome," according to Blow et al., (2007, p. 298). While the therapeutic alliance has been the subject of much research, less is known about therapist factors per se that contribute to a positive alliance and positive therapy outcomes. Therapists have a large role to play in creating a strong therapeutic alliance, and prior literature has identified therapist qualities that allow this to occur behaviors such as warmth, presence, and collaboration.

Findings from studies that investigated effects of therapist factors have been promising. The National Institute of Mental Health Collaborative Depression Study tested two forms of psychotherapy — cognitive behavioral and interpersonal — in the treatment of 250 depressed outpatient clients for 16 weeks across three sites (Elkin et al., 1989). Psychotherapy was performed by 28 therapists (10 psychologists and 18 psychiatrists), and patients were assigned to therapists within treatments according to the availability of the therapist. The findings were

unexpected: both treatments showed evidence of effectiveness, but there was no evidence that one treatment produced better outcomes than the other. Furthermore, despite controlling for therapist factors such as training, experience level, and allegiance to the model, major differences were found across therapists. That is, reduction in depression in clients was more strongly associated with the particular therapist than with the treatment model. The authors of this study were not intending to study therapist factors, however, so no specific therapist characteristics were identified.

Although client characteristics are certainly also crucial to the success of therapy, clinicians must be aware of their own impact on the process in order to be as effective as possible. Baldwin, Wampold, and Imel (2007) conducted a study on the importance of therapist and patient variability in predicting therapeutic outcome for individual therapy. They defined therapist variability in the alliance as "the ability to engage patients in collaborative, purposive work" (p. 843) and patient variability in the alliance as a client's ability to form a collaborative relationship, as measured by the distance from the mean for each therapist or client's mean score on the Working Alliance Inventory (WAI) as rated by each client. They found that therapist variability in the alliance was related to outcome on the self-report Outcome Questionnaire-45 (Lambert et al., 2004) but did not find a similar result for patient variability in ability to form an alliance. Therapist common factors that have been empirically demonstrated to influence the effectiveness of individual therapy include but are not limited to empathy and collaboration (Norcross, 2002; Tryon & Winograd, 2001).

Client common factors. While paying appropriate attention to the person of the therapist in therapeutic research is an important component of the common factors paradigm, the influence of the client on his/her own improvements in therapy cannot be understated. In fact,

Duncan and Miller (2000) suggest that the client, not the model *or* the therapist, is the true change-maker or "hero" in the process. Identified client factors include motivation for change, inner strength, and quality of the client's social support system (Prochaska, DiClemente, & Norcross, 1992; Sprenkle et al., 2009). Some of those characteristics are fully in the client's control, whereas others, such as motivation for change, can be influenced by the therapist. One of the most important client factors, which Lambert referred to as the "placebo" effect, is in reality the effect of hope or expectancy, improvement resulting from the client's awareness that they are receiving treatment and their expectancy that it has the potential to produce change (Sprenkle et al., 2009).

Common factors and CFT. As is the case in psychotherapy research in general, most couple therapy treatment studies have compared two models or techniques of couple therapy, or compared one model to treatment as usual or a waitlist control condition (Davis, Lebow, & Sprenkle, 2012). In the studies that compare treatments, therapist qualities and skill level are matched (controlled) across treatments, to attempt to compare the methods themselves, free of therapist influences. The ways in which the therapists themselves differ are rarely systematically analyzed in relation to outcomes within or across treatments. Such couple therapy outcome studies commonly investigate general outcomes such as partners' overall relationship satisfaction, rather than exploring changes in specific outcomes in individual and relational functioning to better understand the process of change.

Thus far, little attention has been paid to how common factors influence the process and outcome of couple and family therapy and how they compare to common factors that have been found to be influential in individual therapy (Davis & Piercy, 2007). As noted earlier, meta-analyses have shown that, while couple and family therapies are effective, there are almost no

differences among models in terms of their effectiveness on the overall outcome measures (Shadish et al., 1993). Similar to studies of individual psychotherapy, Pinsof (1978) studied models of family therapy and found significant overlap in what therapists did in sessions across models, in spite of theoretical differences in the emphases of the models. Consequently, little is known about how therapist common factors interact with models and client presenting problems (Davis & Piercy, 2007). Sprenkle et al. (2009) note anecdotally that there appears to be more resistance to the common factors paradigm among relational therapists compared to clinicians who conduct individual therapy. More research clearly is needed to determine whether there are differences in common factors operating in relational versus individual therapy.

For example, how a couple and family therapist creates an effective therapeutic alliance with more than one client in the room may involve quite different actions than in individual therapy, particularly when the clients are at odds with each other. The alliance in couple therapy consists of several distinct components: the alliance between each partner and the therapist, the alliance between the couple as a unit and the therapist, and the alliance between the members of the couple about the therapy (Pinsof, 1994). The therapist must bring both partners into the alliance and balance the relationships so that he/she does not have a stronger alliance with one partner, thus alienating the other. An unbalanced alliance has been shown to have a negative effect on the therapeutic process (Pinsoff, 1995). While the strategic therapy model calls for therapists limiting the strength of the therapeutic alliance, (Haley, 1987; Watzlawick, Weakland & Fisch, 1974), most family therapy models prioritize building an alliance. For example, structural family therapy gives much attention to how to "join" with a family (Minuchin, 1974).

Therapist systemic technique factors. While some therapist common factors behaviors initially identified in individual therapy (e.g., empathic responses) exist in modified forms in the

context of couple and family therapy, others are distinctive to the CFT field. Sprenkle et al. (2009) define four therapist common factors (how the therapist thinks and behaves) that are unique to couple and family therapy: 1) a relational conceptualization of the presenting problem, 2) disruption of dysfunctional relational cycles, 3) expansion of the direct treatment system, or the members of the group who are present in therapy, and 4) expansion of the therapeutic alliance. Conceptualization of presenting problems in relational terms, including symptoms of an individual family member such as depression, is seen in all marriage and family therapy models, even though the explanation of the relational processes influencing the problem differs from one model to another. The demonstrated effectiveness of these systemic models lends support to the significance of this relational conceptualization factor (Shadish & Baldwin, 2003). Similarly, the therapist's disruption of relational interaction cycles is seen in all models, although how the therapist intervenes in the cycle differs by model. Generally, goals in this area include reducing members' blaming of each other for the problem, increasing each family member's identification of his or her own contribution to the negative relational cycle, and finding ways in which each member can behave differently at each step in the negative cycle to avoid perpetuating it. With each of these systemic therapy technique factors, different models use different language and specific techniques, such as intervening primarily via behaviors, cognitions, or emotions. However, the overall systemic nature of the intervention factors themselves remains fundamentally the same and is responsible for improvement in couple and family therapy.

Summary. In summary, couple therapy has been shown to be effective for a variety of couple and individual issues. Historically, therapy research has compared two models or one model to a control condition. When therapy models are compared, very little difference is found between models. Thus, effectiveness of therapy must be attributed to other factors that are

common to all empirically supported models. These common factors include therapist factors, client factors, and therapist-client relational factors. Some common factors are specific to relational therapy, such as disruption of dysfunctional relational patterns. Research on common factors is in its infancy, but each category has been shown to influence therapeutic effectiveness, including in couple therapy.

Theoretical Foundations for Study

Social Learning Theory as a Base for Understanding Effects of Therapist Behavior on Client Functioning

Social learning theory is a model of human behavior that states that an individual's actions are a result of an interaction between the person and the environment (Bandura, 1976). According to the theory, rewards and punishments from the environment increase or decrease, respectively, the likelihood of the behavior in the future; a process of operant conditioning notably demonstrated by Skinner (1953). Positive reinforcement increases the probability of an individual's behavior by following it with a pleasing consequence, negative reinforcement increases the probability of an individual's behavior by following it with the termination of an aversive condition, and punishment decreases a behavior by following it with an aversive consequence. Bandura's early work, such as studies on children's learning of aggressive behavior (Bandura & Walters, 1963), expanded on simple operant principles to show that the learning can occur through direct experience (receiving of consequences for one's actions) *or* through observation of behaviors and consequences modeled by others. Children as well as adults commonly learn complex behavioral responses by observing other people enact them and

then imitating them. Imitating a model may also be likely when the model is attractive to the observer (e.g., holds a high status).

Research findings by Bandura (1965) and further analysis by Deguchi (1984) suggest that exposure to modeling influences behavior in three separate ways. The first way involves an observer acquiring new behavior patterns that did not exist previously. The second way is when an observer self-imposes inhibition or disinhibition of his/her own behavior based on the model's actions and their consequences. Positive consequences for the modeled behavior would increase the observer's use of the behavior, while negative consequences would have the opposite effect. Finally, social prompts of a behavior that has already been learned can provide social facilitation and strengthen existing behaviors (Bandura, 1969).

A social learning framework can be applied to understanding ways in which therapists influence their clients' behavior. Applying basic operant conditioning principles, therapists can encourage clients to practice new behaviors in and outside therapy session and provide positive feedback and praise, thereby positively reinforcing the specific actions. However, modeling can also occur in the therapy room. Therapists have the power to encourage positive changes in client behavior by exhibiting the types of constructive behaviors consistent with the client's therapy goals, such as more positive couple communication. This observational learning process with the therapist providing a model of constructive interpersonal behavior that clients can imitate theoretically can weaken negative client response patterns, strengthen existing positive responses in the client's repertoire, or teach new behaviors. There is some prior evidence that behaviors modeled by therapists during couple sessions can influence behaviors of client couples. For example, Epstein, Jayne-Lazarus and DeGiovanni (1979) had members of female-male cotherapist teams intentionally model either the female or the male therapist taking the lead and

being the verbally dominant member of the team. They found changes in heterosexual couples' verbal dominance patterns, in coded samples of communication during couple discussions of relationship issues, over the course of behaviorally oriented therapy that mirrored the pattern modeled by the therapists. However, research on effects of such modeling by therapists of positive common factors behaviors on couple therapy outcomes has been very limited. Given the growing evidence that therapist common factors behaviors influence couple therapy outcomes, it is important to determine how much specific types of therapist modeling leads to more constructive couple interactions.

Constructive communication skills. Communication skills are a common topic in couple therapy literature and are known to be essential for relationship success. Research has shown that distressed couples exhibit not only more negative communication behaviors but also fewer positive communication behaviors (Revenstorf et al., 1984, Gottman, 1979). Epstein et al. (2013) defined couple communication skills as knowing how to listen, sharing one's thoughts and feelings honestly, and refraining from criticizing. Comparing communication skills to six other skillsets including knowledge of partner and life skills, communication was found to be the most predictive of relationship satisfaction (Epstein et al., 2013).

In their pioneering book *Marital Therapy: Strategies Based on Social Learning and Behavior Change Principles,* Jacobson and Margolin (1979) define specific targets of couple communication training, including empathy and listening skills, validating, feeling talk, negative feeling expression, and positive expressions. Empathy and listening skills are seen as focusing one's attention on the partner's messages and demonstrating to the partner through reflective feedback that his/her remarks were heard and understood. Validation is defined as conveying to the other person that his or her thoughts and feelings are legitimate and understandable in the

circumstances, with or without agreeing with their choices. Feeling talk is simply talking to one's partner about one's feelings. Negative feeling expression involves productive communication about negative thoughts and emotions. Finally, positive feeling expressions are statements of gratitude, caring, and affection, which are important in a relationship but often decrease over time and in times of distress. Jacobson and Margolin (1979) suggest that successful communication and conflict resolution rely on collaborative attitudes and behavior, and in couple therapy this requires "a perspective which attributes their current difficulties to *mutual* behavioral deficits and excesses, and that both accept a prescription requiring that they *both change* together" (p. 134). They go on to say that the therapist must elicit this collaborative perspective in distressed couples, as it will rarely be the attitude that couples bring to therapy on their own.

In Gottman, Notarius, Gonso, and Markman's (1976) *A Couple's Guide to Communication*, couples are taught to listen and validate first and foremost as the beginning of positive communication. The authors also teach couples to "level," or be transparent in stating feelings and thoughts in specific, constructive ways. They encourage couples to use leveling when needed, but also to communicate in a way that more closely resembles the respect and politeness one shows a stranger, rather than letting criticism and interruptions overtake the interactions. In this book and in others, (e.g., Gottman, 1994), Gottman showcases his research-based belief that *positive* interactions and expressions are just as important for relationship satisfaction as a lack of negative interactions.

The process of social learning in couple therapy to foster conflict resolution and constructive communication. The most common complaint of clients seeking couple therapy is communication issues (Geiss & O'Leary, 1981; Whisman, Dixon, & Johnson, 1997). According to social learning theory, "a critical skill in determining a successful marriage is skill in conflict

resolution" (Jacobson, 1981, pp. 559-560). Koerner and Jacobson (1994, p. 208) state that, "distress results from couples' aversive and ineffectual responses to conflict." Thus, communication skills are crucial for improving relationship satisfaction, and evidence that interventions have contributed to better communication and conflict resolution are keys to considering couple therapy to be successful. Shadish and Baldwin (2005) found that communication and problem-solving strategies led to most of the treatment effects seen in their study of Behavioral Marital Therapy.

There are many specific skills involved in successful conflict resolution that can be improved in therapy. For example, the ability to hear one's partner's perspective without responding defensively is predictive of marital satisfaction (Gottman, 1994). Gottman also found that a "harsh startup" or an initiation of conflict involving a display of strong negative emotions is associated with subsequent divorce. Across couple therapy theoretical models, therapy is intended to improve the partners' abilities to recognize their own role in conflict and to respond more constructively and respectfully. Therefore, therapist interventions that contribute to more constructive couple communication and conflict resolution should be identified and used extensively.

Importance of improvement in communication and conflict resolution in treatment of couples experiencing partner aggression. Couples who engage in physical and psychological aggression to resolve conflict are in even greater need of effective couple therapy than the average clinical couple. Intimate partner physical and psychological aggression have been shown to be associated with a wide range of psychological issues, including depression and low self-esteem (Sackett & Saunders, 1999), chronic pain (Haber, 1985), alcoholism (Bergman, Larsson, Brismar, & Klang, 1987), anxiety and insomnia (Ratner, 1993), and PTSD (West,

Fernandez, Hillard, Schoof, & Parks, 1990). However, the effects of physical and psychological aggression are not limited to individual distress. Partner aggression poses a risk to relationship quality as well as to the psychological and physical well-being of its victims (Jose & O'Leary, 2009). Stith, Green, Smith, and Ward (2008) conducted a meta-analysis of 32 studies and found a small to moderate effect size between partner aggression and relationship dissatisfaction. This association is not limited to physical aggression; it also can be found for victims of psychological aggression (Jose & O'Leary, 2009).

In contrast to battering cases in which one member of a couple (more often a male) uses severe forms of physical and psychological aggression to control and punish a partner (more often a female), couples who experience what has been labeled "common couple violence" exhibit psychological aggression and mild-to-moderate physical aggression (e.g., pushing, slapping), which tends to be bidirectional (Epstein et al., 2015). Treatment programs that have been developed to reduce such common couple violence (e.g., Epstein et al., 2015; Stith, McCollum, & Rosen, 2011) focus on increasing couples' awareness of their ingrained aggressive cycles, including their thoughts and emotions during an argument that may lead to negative behavioral escalation, and substituting constructive communication behavior for aggression (Horwitz, Santiago, Pearson, & LaRussa-Trott, 2009). Using data from the same program as the current study, Hrapczynski et al. (2012) found that conjoint couple therapy can be effective in reducing partners' negative attributions about each other, their negative communication, and their aggressive behavior in couples experiencing psychological and mild-to-moderate physical partner aggression. Interestingly, those positive effects occurred across cognitive-behavioral and other couple therapy models (e.g., emotion-focused, solution focused, narrative). Thus, there is a need for further research to determine the extent to which common factors account for success of

couple therapies in improving relationships marked by partner aggression. The present study is designed to reduce the gap in knowledge about therapist common factors that may contribute to gains in positive behavioral interactions among couples who entered therapy exhibiting psychological and mild-to-moderate physical partner aggression.

Social learning processes in therapist influences on the improvement of couple conflict resolution. Social learning theory has been applied to couple therapy primarily in the context of behavioral marital/couple therapy, a model that emphasizes how partners regularly shape each other's actions through operant and observational learning processes, and that therapists also can shape partners' behaviors through instructions and feedback. Relationship quality would thus improve when positive behaviors are prompted and reinforced, and dysfunctional behaviors are ignored or punished. Social learning theory, however, can also be understood to account for changes during couple therapy in another way. That is, therapists have opportunities during sessions to model the types of behavior that they see as healthy communication, with the goal that members of the couple will begin to mirror this behavior as they view it to be desirable and effective. For example, a therapist looking to reduce partners' use of blaming language with each other can model a non-blaming stance through his/her own language in session, in addition to rewarding non-blaming language from the client through attention and continued conversation, and discouraging or blocking blaming language through inattention or redirecting the conversation.

While traditionally and for the purposes of this study behavioral and/or cognitive behavioral couple therapy models have been used to explicitly teach problem-solving skills to improve conflict resolution, therapeutic modeling of positive behaviors in sessions can be a powerful tool across models. Davis and Piercy (2007) refer to this as "isomorphism," or the

therapist modeling attributes that clients need in order to change, such as validating and showing respect. Couple therapy creates a unique opportunity for therapeutic modeling compared to individual therapy. If a couple is stuck in a negative conflictual cycle and unable to move toward constructive conversations, the therapist's modeling of relevant expresser-listener and problem-solving skills toward one or both partners, in addition to providing each partner with reinforcement (e.g., praise) for his or her constructive efforts, can allow them to feel how they hope to be treated by their partner and see how to treat their partner the same way. In a broader sense, the therapeutic alliance that the clinician develops with each partner can similarly provide a model for a positive couple alliance. Blow et al. (2009) described an intensive case study in which a couple's scores regarding the quality of their marital relationship each week mirrored their ratings of the therapeutic alliance. Thus, the relationship qualities exhibited by a couple's therapist can model a powerful constructive bond that can teach partners how to relate to each other positively.

Variables in the Present Study

Based on the literature regarding therapist common factors in couple therapy and guided by social learning concepts, this study tested the relations between specific therapist common factors (the independent variables) and outcomes of couple therapy (the dependent variables). The therapist common factors behaviors that were examined are collaboration and systemically based technique factors. Based on prior research, therapist *collaboration* was defined as behavioral expression of willingness to work cooperatively with the client to meet the client's goals. Therapist *systemically based technique* factors were defined as behaviors that intervene in the couple's interaction cycles to facilitate systemic change. The dependent variable for this study was the level of constructive conflict resolution communication skills exhibited by the

members of a couple, which was defined as the presence of constructive problem solving cognitions and behavior. Figure 1 depicts the study's variables and their relationships.

Hypotheses

H1: The higher the level of collaboration exhibited by the couple therapist, the more the clients will improve in their problem solving, validation, and facilitation behaviors from the beginning to the end of therapy.

H2: The higher the level of collaboration exhibited by the couple therapist, the more the clients will improve in their mutual constructive communication behaviors from the beginning to the end of therapy.

H3: The higher the level of collaboration exhibited by the couple therapist, the more the clients will improve in their constructive problem solving cognitions from the beginning to the end of therapy.

H4: The higher the level of therapist systemic technique factors exhibited by the couple therapist, the more the clients will improve in their problem solving, validation, and facilitation behaviors from the beginning to the end of therapy.

H5: The higher the level of therapist systemic technique factors exhibited by the couple therapist, the more the clients will improve in their mutual constructive communication behaviors from the beginning to the end of therapy.

H6: The higher the level of therapist systemic technique factors exhibited by the couple therapist, the more the clients will improve in their constructive problem solving cognitions from the beginning to the end of therapy.

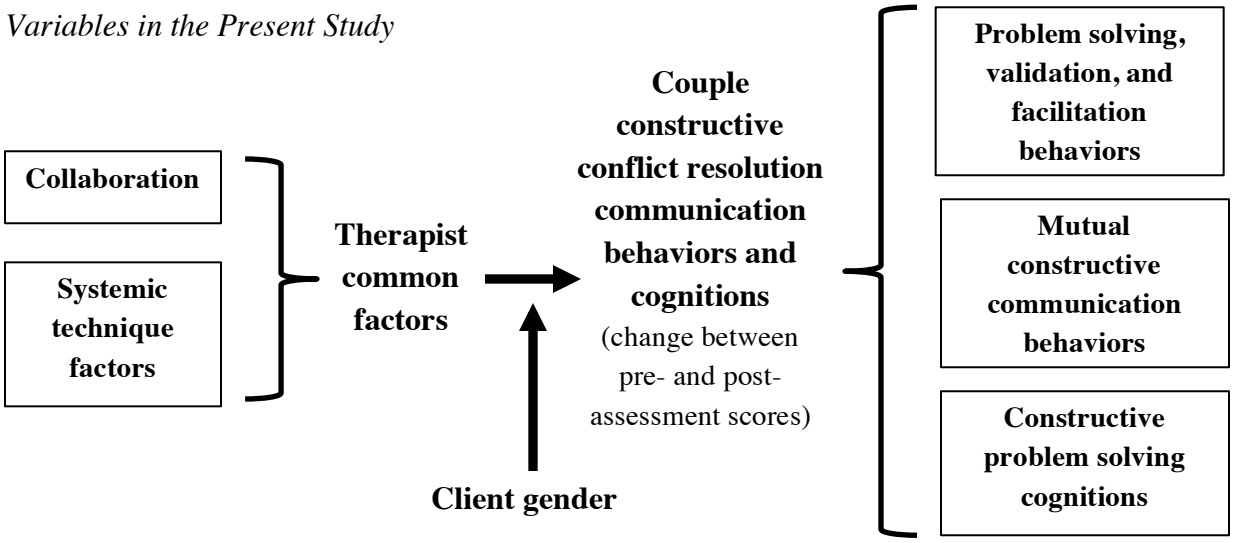
Research Question

Although the existing literature does not suggest any systematic client gender differences in effects of therapist behavior, this study explored the possibility that therapist in-session collaborative behavior and use of systemic interventions might have different effects on female and male partners. Thus, the following research question was posed:

Does client gender influence (moderate) the relationship between therapist common factors (collaborative behavior and use of systemic interventions) and change in client constructive communication?

Figure 1

Variables in the Present Study



CHAPTER 2: METHOD

Sample

This study was a secondary analysis of data collected as part of a previously conducted study, the Couples Abuse Prevention Program (CAPP; Epstein et al., 2015; LaTaillade, Epstein, & Werlinich, 2006), at the University of Maryland's Center for Healthy Families (CHF). Thus, the present study only used previously collected data, and it involved no interaction between the investigator and human subjects. The client sample for the present study was 41 heterosexual couples that attended ten 90-minute sessions of couple therapy at the CHF within the Department of Family Science between 2000 and 2009. To be part of the initial study from which the present study's data was obtained, couples had to be 18 years or older, in a relationship for at least six months, and experiencing psychological aggression and/or mild to moderate physical aggression in the past four months (based on self-report assessment instruments). Both members of the couple had to voluntarily agree to be part of the CAPP study. CHF therapists conducted individual interviews with the members of a couple to ensure that both partners felt safe participating in the treatment.

Couples were excluded from the study if they had experienced severe physical violence resulting in injury during the previous four months, if the partner aggression involved any weapons, if either member currently had untreated drug or alcohol abuse, if either member individually expressed fear of living with or participating in couple therapy with their partner, or if they were currently participating in other couple therapy treatment. Although this sample was selected for the present study based on the availability of data regarding their conflict-resolution behavior, highly relevant for the purpose of the study, the potential generalizability of the findings must be viewed in the context of the likelihood that couples experiencing intimate

partner violence may have an even greater need for improved conflict resolution than the average couple to avoid dangerous escalation of arguments.

Participants included in the present study were between 20 and 51 years old, with a mean female age of 31 (SD = 8.03) and a mean male age of 33 (SD = 8.25). The mean couple relationship length was six years (SD = 4.25). Ninety-three percent of the couples were married or cohabiting. See Table 1 for descriptive statistics on relationship status. Table 2 presents the racial composition of the sample for females, and Table 3 for males. Overall the sample was diverse, with the largest percentages being white and African American. Education ranged from some high school education to a doctoral degree for both females and males. Eighty-eight percent of females and 73 percent of males had at least some college education, making this a highly educated sample. Table 4 presents the highest level of education achieved by female participants, and Table 5 by male participants. Income levels varied from $0 to $130,000, indicating a wide variation in incomes, which is representative of the Center for Healthy Families clinical population. Despite higher education levels by female participants, the mean income for female participants was $27,577 (SD = $25,796) and the mean income for male participants was $49,838 (SD = $24,061). Therapists who provided treatment to the couples during the CAPP study were graduate students in the nationally accredited Couple and Family Therapy master's degree program at the University of Maryland, College Park, who worked in co-therapy teams with individual couples. Eighty-four percent of the therapists were female and 16 percent were male. The majority of the co-therapy teams were composed of two female therapists (68 percent), with the remaining co-therapy teams composed of one female and one male therapist.

Table 1

Descriptive Statistics for Couple Relationship Status

Relationship Status	**Frequency**	**Percent**
Currently married, living together	26	63.4
Currently married, separated	1	2.4
Living together, engaged	7	17.1
Dating, living together	5	12.2
Dating, not living together	2	4.9

Table 2

Descriptive Statistics for Race of Female Partners

Race	**Frequency**	**Percent**
African American	9	22.0
Asian/Pacific Islander	1	2.4
Hispanic	4	9.8
White	24	58.5
Other	2	4.9
[Missing]	1	2.4

Table 3

Descriptive Statistics for Race of Male Partners

Race	**Frequency**	**Percent**
African American	6	14.6
Native American	1	2.4
Hispanic	1	2.4
White	30	73.2
Other	2	4.9
[Missing]	1	2.4

Table 4

Descriptive Statistics for Highest Level of Education Achieved for Female Partners

Education	**Frequency**	**Percent**
Some high school	2	4.9
High school diploma	3	7.3
Some college	13	31.7
Associate degree	5	12.2
Bachelor's degree	9	22
Some graduate education	3	7.3
Master's degree	4	9.8
Doctoral degree	2	4.9

Table 5

Descriptive Statistics for Highest Level of Education Achieved for Male Partners

Education	**Frequency**	**Percent**
Some high school	1	2.4
High school diploma	10	24.4
Some college	7	17.1
Trade school	1	2.4
Associate degree	7	17.1
Bachelor's degree	5	12.2
Some graduate education	4	9.8
Master's degree	3	7.3
Doctoral degree	3	7.3

Participating clients were required to complete standard assessments before and after the course of therapy. These self-report assessments gathered information on individual concerns such as depression and a variety of relationship factors such as overall relationship satisfaction,

couple communication patterns, and trust in one's partner. Assessment of each couple also included a ten-minute communication sample in which the partners were asked to discuss an area of their relationship (e.g., finances, relationships with friends) that was a topic of conflict in their relationship, without the therapists present. These discussions were video-recorded with the couples' permission and subsequently coded for forms of positive and negative communication by trained raters.

In addition, with the couple's permission, therapy sessions were recorded for use in the therapists' supervision by their clinical faculty supervisor, and recordings of sessions 1, 4, 8, and 10 were kept for further research. In 2011, then-Family Science Ph.D. candidate Laura Evans used recordings of therapy session 4 in her doctoral dissertation research, to assess a set of therapist qualities in their interactions with couples, to investigate the associations between such therapist behaviors and couple therapy outcomes. Evans (2011) developed and used a new measure to rate those therapist in-session behaviors toward client couples — the Therapists' General Clinical Skills/Qualities Scale (TGCSQ; Evans, Epstein & McDowell, 2009), which is described in detail in the Measures section. The present study used some of the data on client outcomes from the CAPP study, as well as and ratings of the couples' therapists that were derived from the TGCSQ. The data exist in a password-protected data file in the CHF that includes no client names or other identifying information. The data used in this study are from the 41 couples that Evans (2011) used in her study, whose fourth therapy session was coded using the TGCSQ. More information on the use of the pre-existing data is provided in the Procedures section.

Measures

Therapist Collaborative Behavior

The independent variable for the present study, therapist collaborative behavior toward client couples, was measured via the previously coded video recordings of the fourth session with the couples, using the TGCSQ (see Appendix A). The TGCSQ was designed for coding therapist behaviors during couple therapy sessions and was used initially in Evans' (2011) study using the 90-minute sessions of the CAPP project. The TGCSQ was applied in the Evans (2011) study by extensively trained undergraduate raters. Two raters independently rated therapist behavior during a couple's session, and the scores for the individual TGCSQ therapist behavior rating scales was the average of the two raters' scores. The TGCSQ includes separate rating scales for five types of therapist behaviors involving quality of the clinicians' therapeutic relationship with the clients: warmth, empathy, validation, therapist presence, and collaboration. For this study, only the degree of therapist collaboration with the client couple was examined, as it is the focus of the study as a potential model for partners' behavior toward each other. Therapist collaboration is measured with the TGCSQ by the number of times the therapist is seen "asking clients for their opinions and preferences regarding interventions, tasks, and goals" as well as using "collaborative language" such as "we" and "us" (Evans et al., 2009).

Therapist Use of Systemically Based Techniques

The TGCSQ also includes scales for rating degrees to which therapists use intervention techniques consistent with a systemic model of couple therapy and that impose structure and control over negative couple behavioral interactions during sessions. The TGCSQ "technique" factors comprise two subscales: systemically based techniques and session structure. This study only examined therapists' use of systemically based techniques, which is measured by a "balance

in attention to partners," "noting cyclical patterns in couple interaction," "circular questioning," and "seeking information and/or creating interventions based on multiple environmental levels" (Evans et al., 2009).

The TGCSQ behavioral cues for each rating scale are each given a rating ranging from 0 (meaning the therapist did not exhibit this behavior at all) to 4 (meaning the therapist exhibited this behavior very much). Two raters viewed each 90-minute session, rated the session on each of the cues, and calculated an average score for each of the subscales. An average of the two raters' scores was obtained for each subscale item. In terms of achieving inter-rater reliability, the two raters' scores had to be within one point of each other, so the rater pair had to discuss any larger discrepancies and reach consensus. Coding was done for the co-therapy team rather than for each individual therapist, because of the limitations placed on coding by the angle of the camera in some videos, as well as the CHF procedure of having one therapist generally take the lead in session while the other was mostly quiet. In the initial study using this scale with CAPP data, therapist collaboration was found to be correlated with technique factors more than relationship factors (Evans, 2011).

Client Constructive Problem Solving Cognitions

Individual partners' positive, collaborative thoughts during conflict with their partner were measured in the original CAPP study (Epstein et al., 2015; LaTaillade, Epstein, & Werlinich, 2006) by a cognitions scale of the Styles of Conflict Inventory (SCI; Metz, 1993; see Appendix B). This self-assessment asks clients to rate on a five-point Likert scale how often they have specific cognitions during arguments with their partner. The SCI lists no time frame for clients to consider, simply asking "in general" how they think during conflict. The 30-item SCI cognitions scale has subscales for aggressive, assertive, submissive, avoidant, and constructive

problem solving cognitions, with the latter being the only positive style assessed. This constructive problem solving cognitions subscale was used in the present study because of its focus on positive, collaborative interaction with one's partner, the focus of this study. The subscale includes seven items, such as, "Let's work this out together" and, "I want to respect your thoughts and feelings." In the present sample, the Cronbach alpha for the constructive problem solving cognitions subscale was .83 for females and .68 for males. Original concurrent validity analyses of the SCI were conducted with general personality measures, global relationship measures, and specific measures of similar constructs and garnered mostly positive results (Metz, 1993). Discriminant validity was found between satisfied versus dissatisfied couples, adjusted versus distressed couples, normative versus clinical couples, and newly married versus longer married couples (Metz, 1993). Clients in the original CAPP study at the CHF completed the SCI at the beginning and the end of therapy, and in the present study change in SCI constructive problem solving cognitions was examined via difference scores from pre- to post-therapy.

Observed Client Constructive Communication Behavior

Constructive behaviors during actual couple communication were measured in the CAPP study via coded video recordings of couple communication samples, using the Marital Interaction Coding Scale-Global (MICS-G; Weiss & Tolman, 1990; see Appendix C). The MICS-G is designed to assess couple communication based on observation by trained raters and includes six subscales: conflict, problem solving, validation, invalidation, facilitation, and withdrawal. Each member of each couple is rated on each subscale using a mix of content cues, which focus on at *what* is said, and affect cues, which look at *how* things are said. For this study, the three positive communication subscales will be used: problem solving, validation, and

facilitation. Problem solving is defined for the MICS-G as willingness to "discuss or commit to make a change in [the] relationship" (Weiss & Tolman, 1990, p. 6). The content cues for problem solving are a description of the problem, proposing a positive solution, proposing a negative solution (something the couple will stop doing that will improve the problem), and compromise. The affect cues for problem solving are calmness and reasonableness. Validation measures how one person responds to their partner's speaking behaviors. The content cues for validation are agreement, approval of the partner, and accepting responsibility for the self or the couple. The affect cues for validation are assent, receptivity, and encouragement to the speaker. Finally, facilitation measures how spouses "serve to facilitate the progress of the interaction" (Weiss & Tolman, 1990, p. 9). Facilitation content cues are positive mindreading, paraphrasing, and humor. Affect cues for facilitation are positive physical contact, smiling or laughter that is friendly, openness of body posture, and warm or affectionate tone of voice. This study combined these three subscales, creating one total score for observed constructive behavior.

As described previously, each couple completed a 10-minute problem-solving discussion about a conflict topic in their relationship without the presence of the therapists at the beginning and again at the end of treatment, to serve as a sample of their communication styles. For each recorded communication sample, two undergraduate raters used the MICS-G to independently rate the six types of behavior in each two-minute interval of the ten-minute discussion. Ratings were given for each partner, with a score of 0 meaning the partner did not exhibit that behavior at all to 5 meaning the partner exhibited that behavior for most or all of the interaction. An average score was calculated for each rating cue, and then a total score for each subscale. Similar to the TGCSQ, a composite score for each rater team was obtained by taking the average of the raters' scores, which had to be within one point of each other.

Client Self-Reports of Couple Mutual Constructive Communication

Couples' constructive behaviors during communication also were measured in this study via self-report, through the partners' scores on the Communication Patterns Questionnaire (CPQ; Christensen & Sullaway, 1984; see Appendix D) that also was administered pre- and post-therapy in the original CAPP study. While coded video of communication samples may give a more objective measure of constructive communication, it is also important to assess the couples' subjective experience of communication in their relationship and whether *they* see changes in pre- and post-assessments. The CPQ asks each partner to rate on a nine-point Likert scale how likely they and/or their partner are to exhibit particular behaviors when a problem arises in their couple relationship, during a discussion of a relationship problem, and after a discussion of a relationship problem. This instrument does not list a time frame for clients to consider in answering the questions. For the purpose of this study, analyses were run only on the CPQ mutual constructive communication subscale. The subscale includes five items, including "Both members express their feelings to each other" during a discussion of a relationship problem and, "Both feel that the problem has been solved" after a discussion of a relationship problem. This subscale was found to be positively associated with marital adjustment in Christensen's initial research (Christensen, 1988). It was also found to differentiate nondistressed married couples, married couples beginning treatment for marital distress, and separated/divorcing couples, while the mutual avoidance and demand/withdraw subscales did not successfully differentiate the three groups (Christensen & Shenk, 1991).

This study used multiple outcome measures of couple communication to create a more complete picture of effects of therapist behavior on client communication. Self-report assessments are important to gain an understanding of the client's subjective experience of

communication in the relationship, but a variety of biases may affect the results. While behavioral observations do not explore the inner experience of each member of the couple, they are able to assess what the couple is actually doing when they communicate, rather than relying on what they say they do or think. Furthermore, the inclusion of a measure of client cognitions about communicating with the partner during conflict allows for assessment of a change in attitude alongside the change in behavior. According to social learning theory, observing a model conveys concepts as well as specific behaviors to imitate. The therapists are modeling an attitude or concept of collaboration/cooperation as well as actual ways to behave collaboratively, and assessing client cognitions in the moment of couple conflict examines whether the attitudinal aspect is being internalized.

Procedure

The data for this study were from the data set collected for the CAPP study (LaTaillade et al., 2006) as well as Evans' (2011) dissertation project. For that study, all couples attending sessions at the Center for Healthy Families between 2000 and 2009 filled out a set of pre-therapy assessments. These assessments determined whether couples qualified according to age, relationship length, presence of psychological and/or mild to moderate physical aggression absence of alcohol or drug abuse, and both members reporting feeling safe participating in therapy. Aggression was assessed using the Revised Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, Sugarman, 1996) and the Multidimensional Measure of Emotional Abuse scale (MMEA; Murphy & Hoover, 2001). The CTS2 measures frequencies of forms of partner aggression, as well as constructive responses, that members of a couple report using when they are in conflict. The CTS2 includes 78 items that comprise five subscales: negotiation, psychological aggression, physical assault, injury, and sexual coercion. For each item, the

respondent is asked to report the frequency with which he or she engaged in the specific type of behavior during the last four months, as well as the frequency with which his or her partner engaged in that behavior, using a six-point scale ranging from "not in the past 4 months, but it did happen before" to "more than 20 times in the past 4 months," with another option for "this has never happened." It has been shown to have high internal consistency, with one study finding alphas ranging from .79 for psychological aggression to .95 for injury (Strauss et al., 1996). Another study of the CTS2 with incarcerated females also found high internal consistency reliability, with alphas ranging from .62 for sexual coercion to .91 for negotiation (Jones, Ji, Beck, & Beck, 2002). Discriminant validity was established in a study of Italian women comparing victims versus non-abused women, with *t*-scores ranging from -10.40 for extreme violence to -18.52 for psychological and physical aggression (Signorelli, Arcidiacono, Musumeci, Di Nuovo, & Aguglia, 2014).

The MMEA contains 56 items that comprise four subscales that assess degrees to which members of a couple engage in forms of psychological aggression: restrictive engulfment (which measures coercive behaviors that isolate one's partner, restrict one's partner's activity, or show intense jealousy); dominance/intimidation (which measures attempts to produce fear or submission through threats, property violence, and intense verbal aggression); denigration (which measures attacks at the partner's self-esteem through humiliating and degrading behaviors); and hostile withdrawal (which measures punishment to increase the partner's insecurity through a withholding of emotional contact and withdrawal in a hostile manner). Similar to the CTS2, for each item the respondent is asked to report the frequency with which he or she engaged in the specific type of behavior during the last four months, as well as the frequency with which his or her partner engaged in that behavior, using a six-point scale ranging

from “not in the past 4 months, but it did happen before” to “more than 20 times in the past 4 months,” with another option for “this has never happened.” One study of internal consistency for the MMEA found a Cronbach’s alpha of .94 at both pretreatment and 6-month follow-up (Taft, Murphy, King, Musser, & DeDeyn, 2003).

Couples who qualified and agreed to participate filled out more self-report assessments and participated in the 10-minute communication sample in which they were instructed to discuss a topic that was a source of moderate disagreement in the relationship. Couples were then randomly assigned to receive ten 90-minute sessions of either 1) Cognitive Behavioral Therapy (CBT) designed for couples experiencing mild to moderate partner aggression or 2) treatment as usual at the clinic, with the two therapists choosing any CFT model except CBT (including but not limited to solution focused, narrative, and emotionally focused couple therapy). Couples completed a variety of post-therapy assessments after the 10 sessions, as well as at a four-month follow-up appointment to explore the longevity of effects. Four-month follow-up assessments were not used in the present study.

As noted previously, there was no interaction with human subjects for the purposes of this study. Statistical analyses were computed on couples’ scores from the existing CAPP database and ratings of therapist behaviors from the Evans (2011) study. These procedures involved accessing data from these data sets, which do not include any identifying information regarding the participants.

CHAPTER 3: RESULTS

Overview of Data Analysis

Each of the hypotheses was tested with a Pearson correlation computed between a therapist common factor variable and change in couple positive communication over the course of therapy. The tests were one-tailed because the hypotheses were directional. Therapist common factors collaboration and use of systemic techniques were used as separate variables in the analyses. Composite scores were calculated separately for male and female pre-therapy and post-therapy scores on the mutual constructive communication subscale of the CPQ (five items), the constructive problem solving cognitions subscale of the SCI (seven items), and the positive communication subscales of the MICS-G (three items). Pre-therapy scores for each assessment were subtracted from post-therapy scores for males and females, respectively, to derive the change scores for each measure.

Tests for Potential Control Variables

Before hypotheses were tested, tests were conducted to determine whether any of the demographic variables should be used as control variables. Pearson correlations were computed between the participant age and number of years in the relationship variables and each outcome variable involving pre-to-post change. Years in the relationship was found to be significantly correlated with difference scores in men's constructive problem solving cognitions, with a Pearson correlation of -.36 (p = .03). This suggests that men who have been in relationships longer are more likely to have *fewer* constructive problem solving cognitions in the post-assessment than in the pre-assessment. This was the only significant correlation to consider controlling for.

Tests of the Hypotheses

The first hypothesis stated that the higher the level of collaboration exhibited by the couple therapists, the more the clients would improve in their problem solving, validation, and facilitation behaviors from the beginning to the end of therapy. A Pearson correlation was computed on the 34 cases that included complete data for this hypothesis, so the results are based on 34 women and 34 men. No significant correlation was found for either gender, with a Pearson correlation of .06 (p = .37) for women and a Pearson correlation of .17 (p = .17) for men.

The second hypothesis stated that the higher the level of collaboration exhibited by the couple therapist, the more the clients would improve in their mutual constructive communication behaviors from the beginning to the end of therapy. A correlation was run on the 39 cases that included complete data for this hypothesis, so the results are based on 39 women and 39 men. No significant correlation was found for either gender, with a Pearson correlation of -.17 (p = .15) for women and a Pearson correlation of -.09 for men (p = .30).

The third hypothesis stated that the higher the level of collaboration exhibited by the couple therapist, the more the clients would improve in their constructive problem solving cognitions from the beginning to the end of therapy. A correlation was run for the 39 female participants that included complete data for this hypothesis. No significant correlation was found, with a Pearson correlation of -.14 (p = .20). Because it was necessary to control for years in the relationship in the test of this hypothesis for men, a stepwise multiple regression analysis was computed predicting change in men's constructive problem solving cognitions scores. In step one of the analysis, the number of years in the relationship was entered. The multiple correlation (R) was .36, R^2 = .13, p = .03. In the second step, therapist collaboration was entered. The multiple correlation (R) was .36, R^2 = .13, and the change in R^2 was not significant (p = .95).

Therefore, after controlling for years in the relationship, there was no significant relationship between therapist use of collaborative behavior and change in men's constructive problem solving cognitions.

The fourth hypothesis stated that the higher the level of therapist systemic technique factors exhibited by the couple therapist, the more the clients would improve in their problem solving, validation, and facilitation behaviors from the beginning to the end of therapy. A correlation was run on the 34 cases that included complete data for this hypothesis, so the results are based on 34 women and 34 men. No significant correlation was found for either gender, with a Pearson correlation of -.29 for women (p = .14) and a Pearson correlation of .14 for men (p = .22).

The fifth hypothesis stated that the higher the level of therapist systemic technique factors exhibited by the couple therapist, the more the clients would improve in their mutual constructive communication behaviors from the beginning to the end of therapy. A Pearson correlation was run on the 39 cases that included complete data for this hypothesis, so the results are based on 39 women and 39 men. A significant correlation was found for women, with a Pearson correlation of -.28 (p = .04), in the opposite direction of the hypothesis. The more the therapists used systemic technique factors, the more female participants' perceptions of couple mutual constructive communication behaviors *decreased*. No significant correlation was found for men, with a Pearson correlation of .01 for men (p = .48).

Finally, the sixth hypothesis stated that the higher the level of therapist systemic technique factors exhibited by the couple therapist, the more the clients would improve in their constructive problem solving cognitions from the beginning to the end of therapy. A correlation was run for the 39 female participants that included complete data for this hypothesis. No

significant correlation was found, with a Pearson correlation of -.14 (p = .20). Because it was necessary to control for years in the relationship in the test of this hypothesis for men, a stepwise multiple regression analysis was computed predicting change in men's constructive problem solving cognitions scores. In step one of the analysis, years in the relationship was entered. The multiple correlation (R) was .36, R^2 = .13, p = .03. In the second step, therapist systemically based technique was entered. The multiple correlation (R) was .36, R^2 = .13, and the change in R^2 was not significant (p = .86). Therefore, after controlling for years in the relationship, there was no significant relationship between therapist use of systemically based techniques and change in men's constructive problem solving cognitions.

Test of Research Question

The research question posed was: Does client gender influence (moderate) the relationship between therapist common factors (collaborative behavior and use of systemic interventions) and change in client constructive communication? For all but one of the hypotheses, no significant relationship was found for either gender, and thus there was no gender difference to be tested. For the fifth hypothesis, results indicated a significant negative correlation between therapist systemic technique factors and female constructive problem solving cognitions but no significant correlation for male participants. This apparent gender difference was tested with the z-test for the difference between two Pearson correlations. The result was z = -1.25, p = .21 (two-tailed), indicating that there was no significant gender difference.

Post-Hoc Analyses

In order to more fully understand the results of the present study, a number of further analyses were run on the data, in a post-hoc manner. These analyses examined patterns in the

data associated with the three time points when the study's measures had been administered: (1) *pre-therapy assessment* of clients' SCI cognitions, CPQ reports of couple mutual constructive communication, and coded observations of couple positive communication with the MICS-G, (2) coded observations of therapists' collaborative behavior and use of systemic techniques *"mid-therapy" during the fourth session*, and (3) *post-therapy assessment* of clients' SCI cognitions, CPQ reports of couple mutual constructive communication, and coded observations of couple positive communication with the MICS-G. Although the sequential data do not necessarily demonstrate causal influences from one time point to another, they may help with understanding whether therapist behaviors might have been influenced by client characteristics, or vice versa.

Mean pre-therapy and post-therapy outcome scores were calculated, and they showed overall improvement for both males and females on all assessment instruments. Participants did see gains in their positive communication behavior and cognitions over the course of therapy, as indicated by statistically significant prior findings from the original outcome study (e.g., Epstein et al., 2015; Hrapczynski, Epstein, Werlinich, & LaTaillade, 2012). Table 6 presents pre-therapy and post-therapy means on assessment instruments for females, and Table 7 for males. Thus, the lack of positive results in the present study is specific to the relationship between client change and therapist factors rather than due to a lack of client improvement.

Table 6

Mean Scores on Pre- and Post-Therapy Assessments for Female Partners

	Pre-Therapy	**Post-Therapy**
Mutual Constructive Communication (CPQ)	25.83	30.88
Constructive Problem Solving Cognitions (SCI)	25.20	26.95
Video Coded Positive Communication (MICS-G)	3.17	3.60

Table 7

Mean Scores on Pre- and Post-Therapy Assessments for Male Partners

	Pre-Therapy	**Post-Therapy**
Mutual Constructive Communication (CPQ)	25.45	28.50
Constructive Problem Solving Cognitions (SCI)	26.25	27.30
Video Coded Positive Communication (MICS-G)	3.32	3.64

Pearson correlations were computed between scores on therapist collaboration and technique factors scores and scores on the clients' pre-therapy measures. This analysis revealed no significant correlations between pre-therapy positive couple communication cognitions or behavior and therapist in-session behavior. This suggests that therapists' session four behaviors were not influenced by clients' behaviors upon entering therapy, such as for example therapists behaving less collaboratively after seeing higher levels of couple conflict during initial sessions and on the pre-therapy assessments. However, there were several significant correlations between therapist in-session behavior and clients' post-therapy cognition and behavior scores,

further suggesting that therapist behavior during session four influenced later client behavior/perceptions. Female post-therapy reports of couple mutual constructive communication were found to be negatively correlated with both therapist collaboration and therapist use of systemically based techniques. The Pearson correlation for collaboration was -.26, with a one-tailed significance level of .05. The Pearson correlation for use of systemic techniques was -.26, with a one-tailed significance level of .05. Similar results were found for female participants' SCI constructive problem solving cognitions. The Pearson correlation between use of systemic techniques and the females' constructive problem solving cognitions was -.38, with a one-tailed significance of .01. The Pearson correlation for therapist collaborative behavior and constructive problem solving cognitions was -.31, with a one-tailed significance level of .03. Given the timing and sequence of the three assessment points (pre-therapy client assessment, mid-therapy therapist behavior, and post-therapy client assessment), these results indicate that therapist behaviors were not predicted based on the couple communication characteristics at the beginning of therapy. However, therapist behaviors did predict the females' cognitions and perceptions about couple communication at the end of therapy.

Significant correlations were found between therapist in-session behavior and clients' post-therapy cognition and behavior scores. However, the true nature of this relationship remained unknown without an understanding of the influence of couple communication before therapy, measured by pre-therapy scores. Thus, partial correlations were run between therapist behaviors and change in the three client communication outcome measures, controlling for pre-therapy scores on each of the outcome measures. Change in female reports of couple mutual constructive communication were found to be negatively correlated with therapist use of systemic techniques when controlling for female pre-therapy mutual constructive

communication, with a correlation of -.29 (p = .04). There was no significant relationship between therapist use of systemic techniques and change in male mutual constructive communication scores, controlling for pre-therapy male mutual constructive communication scores, with a correlation of .06 (p = .35). Change in female reports of their positive problem-solving cognitions were found to be negatively correlated with therapist use of systemic techniques when controlling for female pre-score problem solving cognitions, with a correlation of -.32 (p = .03). There was no significant relationship between therapist use of systemic techniques and change in male scores regarding their positive problem solving cognitions, controlling for pre-therapy positive problem solving cognitions, with a correlation of -.01 (p = .47). No correlation was found between therapist use of systemic techniques and change in video coded constructive communication behaviors for either gender, controlling for pre-therapy behaviors, with a correlation for females of -.14 (p = .21) and a correlation for males of .13 (p = .23).

The partial correlation between therapist collaborative behavior and change in female reports of mutual constructive communication when controlling for female pre-therapy scores on mutual constructive communication revealed a trend toward significance, with a correlation of -.24 (p = .08). No significant relationship was found between therapist collaborative behavior and change in reports of mutual constructive communication by men when controlling for pre-therapy scores on mutual constructive communication, with a correlation of -.14 (p = .21). The partial correlation analyses revealed no significant relationship between therapist collaboration and change in problem solving cognitions in females or males, controlling for pre-therapy problem solving cognitions, with a correlation of -.21 (p = .11) for females and a correlation of .09 (p = .31) for males. Finally, no significant relationship was found between therapist

collaboration and change in video coded communication behaviors for females or males when controlling for pre-therapy communication behavior scores. The correlation for females was .06 (p = .38) and for males was .15 (p = .20).

These results are consistent with the findings previously reported regarding the associations between therapist behaviors and measures of client communication variables when not controlling for pre-therapy scores, and is further evidence that there is a negative relationship between some therapist in-session behaviors and couple communication cognitions and behaviors.

CHAPTER 4: DISCUSSION

The aim of the present study was to investigate the impact of therapist collaborative behavior and use of systemic techniques during therapy sessions on changes in couples' positive communication over the course of therapy. The results indicated that while couples did improve in their positive communication behaviors and cognitions over the course of therapy (as documented in prior studies with the data set), these improvements could not be attributed to the therapist factors examined. No evidence was found for the six hypotheses, and some evidence was found that contradicted hypothesis 5, that therapist use of systemic techniques would be positively associated with change in couples' mutual constructive communication behaviors from the beginning to the end of therapy. Therapists' degree of use of systemic techniques was associated with female participants exhibiting a *decrease* in their perceptions of mutual constructive communication behavior occurring between them and their male partners over the course of therapy. This is a surprising result, given the importance given to systemic technique factors in various couple therapy models and previous studies showing a positive relationship between therapist common factors and positive therapeutic outcomes.

Post-hoc analyses provided a little information about the causal process in effect, but raised more questions about how therapists and clients influence each other. Therapist behaviors that were coded from the fourth session had no relationship to couples' pre-therapy communication. However, those mid-therapy therapist behaviors were found to be correlated with some post-therapy scores for female partners' cognitions regarding couple communication. This suggests that therapist collaborative behavior and use of systemically based technique may have negatively influenced problem solving cognitions and perceptions of mutually constructive communication behavior, specifically in females.

It is possible that instead of the therapists serving as models of constructive, collaborative communication for the partners to learn from, those who used systemic language and behaved collaboratively gave female participants a comparison point for their male partner's communication. Without a dramatic change from the male partner toward using this type of communication and expressing understanding of his role in couple dynamics, this comparison may have led females to see their partners (and the couple's own communication during conflict) in a more negative light. Female post-therapy scores on the CPQ and SCI were negatively associated with both therapist mid-therapy use of systemic techniques and collaborative behavior during session four.

It is important to note that the two self-report measures reflect only participants' *perceptions* of constructive communication, and there were no significant findings showing an association between therapist behavior and change in couples' actual coded communication behaviors. Change in perception can be interpreted in a number of ways, including increased awareness on the part of the female participants of the negative patterns in the relationship. Participants in this study were couples who were experiencing physical and/or psychological aggression; thus, negative patterns of conflict were certainly present. It is possible that therapists' naming of the harmful patterns allowed female participants to become more aware of them. While couple therapy literature generally presents improvements in communication and marital satisfaction as the primary outcome, coming to terms with a relationship's destructive issues is highly valuable, particularly for couples experiencing abuse. These relationships have many negative patterns to notice and work toward changing, and whether the outcome is eventually change or dissolution of the relationship, awareness of the negative patterns is an important first step. Relatedly, female participants may have felt safer and more comfortable to report negative

aspects of the relationship after hearing them from a third party and establishing a relationship with the therapists.

Female participants were more highly educated on average than their male partners. It is possible that this influenced how they interpreted what was happening in the therapy room and in their relationship. Higher education teaches critical thinking skills, and the women in this study may have employed these skills in interpreting the therapists' noting of cyclical patterns in the ways discussed above.

A final potential influence on female participants was therapist gender. The vast majority of the therapists in the present study were female, as is the case in the field in general. Most couples in this study, had two female therapists. It is impossible to know exactly how this influenced the therapeutic process, but there are some likely possibilities. Male clients may have felt "outnumbered" and "ganged up on" by the three females in the room. Females may have expected the therapists, particularly female therapists, to validate their positions during couple conflicts and to convey that to the male partner. When the therapists pointed out the couple's cyclical patterns, females may have interpreted it as further proof that the male partner was communicating poorly.

The lack of other significant results can be interpreted in a few ways. This may be in part due to flaws in the data collection and measures used in the study, discussed later in this chapter. Or perhaps systemic technique factors such as therapists asking clients for their preferences and opinions, showing balance in attention to two partners, and employing circular questioning are simply not crucial to success in couple therapy, even though systemically oriented therapy texts commonly emphasize their importance. It is possible that other types of therapist interventions with couples that were not assessed in this study contributed to positive outcomes for the

couples. Most studies on therapist common factors have shown differences in client outcomes based on therapist factors, but have not identified individual factors (e.g., Baldwin et al., 2007). Any further information narrowing down the effect of specific factors is valuable to this area of research, even if the finding is a lack of improvement.

The overall improvement in constructive communication exhibited by the couples in the present study leaves unanswered questions about what factors were responsible for change. As previously noted, it is possible that other therapist factors not accounted for in this study are responsible for the change in communication. Perhaps other items on the TGCSQ would have proven more responsible for improvements, such as use of validation or session structure techniques such as control of conflict. Client common factors most likely also played a role in client improvement, as such factors as motivation to change and expectation that therapy will improve the presenting problem have been shown to be associated with improvement (Sprenkle et al., 2009). While the present study did not find a positive relationship between therapist collaborative behavior or use of systemically based techniques and couple constructive communication, common factor research is still in its infancy and worth continuing to explore for the benefits it can bring to the field.

Limitations of the Current Study

An important limitation to consider when interpreting these findings is the small, non-representative clinical sample from whom the data were gathered. These were couples in distress who had experienced partner aggression, and thus the results cannot be assumed to apply to all couples. Although they were distressed couples, they also were motivated enough to try to improve their relationships that they took the time and effort to engage in couple therapy and participate in a clinical trial.

The low Cronbach alpha for males for the constructive problem solving subscale of the SCI suggests low internal consistency for those items. It is possible that this is partly responsible for the lack of significant findings with this assessment for males, as it was not a highly consistent measure of this concept.

While couple communication and the partners' cognitions about communication regarding conflict were assessed before therapy and at the end of therapy, therapist common factors behaviors were coded only in the fourth session of therapy. This was a small portion of client-therapist interaction, and session four may not be representative of therapist common factors behavior in all sessions. Future studies would benefit from tracking therapist factors over the course of therapy, similar to how couple characteristics were assessed. This may become possible as raters continue to rate videos of therapy using the TGCSQ and move on to other sessions.

Similarly, the use of the TGCSQ is complicated by the presence of two therapists in the room. Coding was done collectively, with scores being given for co-therapy teams rather than individual therapists. Rating therapist common factors is difficult when two therapists are exhibiting different levels of each factor, particularly in relation to two different clients in the room. Co-therapy teams could receive similar scores for very different in-session behaviors. For example, two therapists both exhibiting moderate levels of systemically based techniques such as balance in attention to partners may receive a similar score to a co-therapy team in which one therapist employs such techniques often and well while the other therapist fails to do so. Observer ratings of such sessions may produce similar scores, but the experience for the clients could be quite different. Results may look very different using data on only one therapist, which would also more closely resemble the average couple therapy context in various clinical settings.

It is important to keep in mind that the therapists in the present study were graduate student therapist interns with less than two years of experience in couple therapy. It is possible that even when rated highly on collaboration and use of systemic techniques, the therapists were not able to implement these common factors as constructively as more experienced therapists. TGCSQ raters were trained on videos of similar therapist interns, and thus were comparing each therapist's common factors behaviors to the common factors behaviors of other new therapists. A high score on the TGCSQ for either of the subscales used in the present study may not have warranted the score if compared to the behaviors of more experienced therapists.

Objective measures of therapist behavior and demeanor in session are understandably complex. Attempting to categorize a particular factor as positive or negative in all situations may have partially contributed to the lack of significant results. While the factors measured by the TGCSQ have all been found to be generally associated with positive outcomes in therapy (primarily in individual therapy), suggesting that more of any one factor is inevitably a benefit to therapy is an oversimplification. Collaboration, for example, may have a curvilinear relationship with effectiveness in therapy, particularly for couple therapy. Collaborating with a client suggests a willingness to work together and respect for a client's ability to come up with solutions to his/her own problems. However, too much collaborative language may suggest an inability or unwillingness to facilitate change. For an individual in therapy, this may lead to more leeway for him/her to explore and direct the session with the therapist. High levels of collaborative behavior may be more detrimental in couple therapy, where active direction of sessions may be needed to pull the clients out of the negative cycles they are stuck in. Collaboration can be a useful model for couples looking to communicate better, but can have a

negative effect if the therapist is so collaborative that he/she fails to disrupt the dysfunctional relational patterns.

Finally, the use of undergraduate students as raters rating therapist common factors can be seen as a limitation of the study. While inter-rater *reliability* was achieved and rater training was conducted by couple therapists, undergraduate raters may have difficulty understanding the nuances of therapy and therapist factors necessary for *valid* rating. Clinically experienced couple therapists working as raters would likely have the ability to pick up on subtle skills exhibited by the therapists in the recorded sessions. For example, therapist use of systemically based techniques is measured in part through balance in attention to partners, and a clinician trained in working with couples may be more able to track the needs and responses of each partner in coding this type of therapist response. Similarly, the personal experience that a rater has who has a personal background as a therapist in using techniques such as "circular questioning" may allow the individual to understand and identify such therapist interventions more accurately.

Directions for Future Research

The present study began to shed light on how specific therapist factors may influence specific therapeutic outcomes. This is an area of research that should continue in order to give therapists the information they need to be the most effective with clients. This study raises questions for further research based on its results and limitations. Future researchers could gather more longitudinal information on the therapist common factors behaviors as they relate to client outcomes, allowing researchers and clinicians to better understand the working relationship over the course of therapy. This will be possible with the data set used for the present study when video recordings from session 1, 8, and 10 have also been coded using the TGCSQ. These data could elucidate the relationship between these variables over time. Given the differences

between individual and couple therapy, it is particularly important that this work continues to be done in couple therapy rather than allowing for assumptions to be made based on research from individual therapy settings. The relationship between other therapist common factors such as warmth and interventions to reduce aversive couple interactions during sessions and couple outcomes is a related area worth exploring further.

It is possible that therapist collaboration has a complicated relationship with client outcome, particularly couple outcomes, as previously discussed. Future researchers may consider examining therapist collaborative behavior's full range of association with couple therapy outcomes to test the idea that a mid-level of collaborative behavior is ideal, rather than running a linear correlation.

The couple outcomes evaluated in this study were specific to positive communication behaviors and cognitions. Future research on therapist common factors, and specifically collaboration and use of systemic techniques, should include analysis of more general outcomes such as couple satisfaction with their relationship. This would improve understanding of the more general influence of these common factors in couple functioning and improvement.

Future researchers in this area should be conscious of the potential effect of gathering data from a co-therapy model, as well as the potential for therapist gender influences, which were not explored here. Future studies examining the relationship between therapist common factors and couple therapy outcomes using only one therapist would be helpful to better understand the influence of the therapist.

The findings of the present study, particularly those that showed negative relationships between therapist common factors and couple communication, introduce questions about client perceptions of therapist behaviors. Female participants in particular may have had reactions to

therapist collaborative behavior and use of systemic techniques that were not expected or intended by the therapists. While the negative relationships found may not be the result of conscious responses from clients to therapist behavior, this is certainly an area deserving of more research. Therapist common factors' influence on client outcomes are an important line of research, but there is also much to be gained from a better understanding of client perceptions of therapists' use of common factors behaviors, given research on the importance of the therapeutic alliance (e.g., Pinsoff, 1995). Future research on therapist common factors should explore multiple measures of common factors, including therapist self-reports and client self-reports along with observer ratings of therapist behavior with scales such as the TGCSQ.

Finally, the tradition of strengths-based research should continue as a valuable addition to the field. Therapists and clients need to know what it looks like to improve on positive behavior and cognitions as well as decrease negative perceptions and dynamics. Positive interactions have been shown to be important for marital satisfaction, and improvement in positive interactions is a valuable goal of couple therapy (e.g., Christensen & Shenk, 1991; Gottman, 1994). A clearer understanding of therapist influence on increases in positive interactions is valuable for couple therapists and training programs.

Common factors research is a valuable paradigm shift from an understanding of specific therapy models as the primary and even only source of change. Continued research into common factors supports the power of the therapist and the client to create meaningful change based on their abilities and the relationship they create. While common factors are hard to quantify, attempts to do so continue to legitimize the common factors paradigm. Future research on common factors in couple therapy in particular are necessary in light of the different ways

common factors play into client outcomes with more than one client in the room (e.g., Pinsoff, 1995).

Implications for Clinicians

This study has a number of implications for clinicians and clinicians-in-training. First, while therapist common factors are powerful therapeutic tools, there is still much to learn about them and how they relate to client outcomes. Therapist common factors, as well as other common factors, must be tended to with care in session. However, like all things in therapy, they should be tracked regularly and tailored to the needs of the particular client(s) in the room. It seems even something as fundamental to couple therapy as use of systemically based techniques can have a negative impact on some clients. Asking clients for feedback is a helpful way to track how the therapist is coming across and whether such techniques are being received well. Therapists should ask for such feedback with care, as the present study showed that collaboration can be received negatively, as well. However, requests for feedback about specific techniques and perceptions of therapist common factors seem likely to give the therapist valuable information about how to direct session without giving too much ownership of session to the couple. While more is known from research about how therapist variables influence individual therapy (e.g., Baldwin, Wampold, & Imel, 2007), couple therapists must rely more on their own knowledge of couple therapy and the specific couple clients when deciding how to interact and direct session.

Couple therapists attempting to integrate the common factors paradigm into their practice are faced with the complexity of multiple clients in the room, often with conflicting preferences and goals. Attempts to improve upon therapist common factors are understandably difficult, given the differing levels of conflict and antagonism present between clients. Couple clients with

a history of mild to moderate partner aggression may be particularly in need of attentiveness as the therapist decides how to present him/herself in session.

Finally, clinicians can see this study as evidence for the different effects their behaviors may have on client outcomes depending on the gender of the client. While this is only one study, it indicates the potential for male and female clients to respond differently to certain therapist behaviors in session. It is also possible that this was a result of the overrepresentation of female therapists in the present study. Thus, therapists should consider their own gender and how it interacts with client gender in planning interventions. Garfield (2004) has urged therapists to consider both therapist and client gender and how they may influence the therapeutic alliance, even suggesting addressing these gender dynamics with clients.

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
Warmth	**Use of humor to connect with clients:** Therapist jokes with clients at appropriate times			
	Smiling: Therapist smiles when greeting clients, and at appropriate times during session			
	Voice tone: Therapist uses a supportive, calm tone			
Empathy	**Reflective statements** demonstrating empathic understanding of client thoughts and emotions (as evidenced by exchange b/n therapist and client) E.g.: Client – "I just feel like he ignores me, and doesn't listen to me" Therapist: "You don't feel heard or appreciated by your partner" Client: "Yes, that's it, I just don't feel appreciated by him"			
Validation	**Agreement** E.g: Client- "I think we are just really tired all the time, and that's why we're fighting" Therapist: "Yes, that could be."			
	Affirming/legitimizing: Verbally conveying that the therapist takes the clients' thoughts and feelings seriously E.g: Client- "I think we are just really tired all the time, and that's why we're fighting" Therapist: "Yes, that could be. *It is more difficult to constructively deal with problems when we are tired.*"			
Therapist Presence	**Asking personal questions, showing interest in clients' lives:** Therapist asks questions about the clients in order to learn more about them as people			
	Staying on topic: Therapist follows a clear line of questioning, follows up on client statements, and does not jump from topic to topic			
	Eye contact: Therapist makes eye contact with the clients when he or she is speaking, and when the clients are speaking			
	Body language E.g. Posture oriented towards the clients, no physical barriers			
Therapist Collaboration	**Asking clients for their opinions & preferences regarding interventions, tasks, and goals** E.g.: Therapist - "We've discussed several ways the two of you could spend time together this week – which sounds best to you?"			
	Collaborative language use displayed by the therapist such as "we" and "us" E.g: Therapist: "I am confident that all of us are working hard and trying our best to make things a little better."			

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

Appendix B

UNIVERSITY OF MARYLAND

SCI (RESEARCH)

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code _____

YOUR THOUGHTS

In general, when you experience disagreement or conflict in your relationship, or when you experience events that might lead to a disagreement, how do you typically react? *Please circle the number that indicates how often* **YOU** *have the following thoughts:*

	Never	Rarely	Occasionally	Often	Very often
★ 1. Let's work this out together	1	2	3	4	5
2. Go away; leave me alone	1	2	3	4	5
3. I give up; you win	1	2	3	4	5
4. I'll deal with it later	1	2	3	4	5
5. You've got no right to	1	2	3	4	5
★ 6. We really get along well	1	2	3	4	5
7. I hate you	1	2	3	4	5
8. I'd better be quiet and go along	1	2	3	4	5
9. We'd better not get into this; avoid the subject	1	2	3	4	5
10. What the hell makes you think you can	1	2	3	4	5
★ 11. I want to respect your thoughts and feelings	1	2	3	4	5
12. To avoid an argument I'd better give in	1	2	3	4	5
13. I want out	1	2	3	4	5
14. I won't deal with this	1	2	3	4	5
15. I'll get you back	1	2	3	4	5
★ 16. I want to cooperate with you	1	2	3	4	5
17. I want to go away	1	2	3	4	5
18. I want to ignore this	1	2	3	4	5
★ 19. I want to resolve our disagreement	1	2	3	4	5
20. I wish I weren't here	1	2	3	4	5
21. We should not be disagreeing	1	2	3	4	5
★ 22. I want to do what I can to make this better	1	2	3	4	5
23. How can I get out of this?	1	2	3	4	5
24. I'll withdraw	1	2	3	4	5
25. You make me angry	1	2	3	4	5
26. I'll back off so it doesn't get worse	1	2	3	4	5
27. I should let you have your way	1	2	3	4	5
28. I should avoid the issue	1	2	3	4	5
★ 29. I want to stop our disagreement	1	2	3	4	5
30. I should be quiet	1	2	3	4	5

SCI.Rev.09/26/01

Appendix C

MICS-G CODE SHEET FAMILY#_____ RATER:_____ TAPE#

LOW 0 1 MODERATE 2 3 HIGH 4 5

CONFLICT
1. Complain
2. Criticize
3. Negative Mindreading
4. Put Downs/Insults
5. Negative Command
6. Hostility
7. Sarcasm
8. Angry/Bitter Voice

CATEGORY RATING

M_1	F_1	M_2	F_2	M_3	F_3	M_4	F_4	M_5	F_5

★ PROBLEM SOLVING
1. Problem Description
2. Proposing Solution
3. Compromise
4. Reasonableness

CATEGORY RATING

M_1	F_1	M_2	F_2	M_3	F_3	M_4	F_4	M_5	F_5

★ VALIDATION
1. Agreement
2. Approval
3. Accept Responsibility
4. Assent
5. Receptivity
6. Encouragement

CATEGORY RATING

M_1	F_1	M_2	F_2	M_3	F_3	M_4	F_4	M_5	F_5

INVALIDTION
1. Disagreement
2. Denial of Responsibility
3. Changing the Subject
4. Consistent Interruption
5. Turn-Off Behavior
6. Domineering Behaviors

CATEGORY RATING

M_1	F_1	M_2	F_2	M_3	F_3	M_4	F_4	M_5	F_5

★ FACILITATION
1. Positive Mindreading
2. Paraphrasing
3. Humor
4. Positive Physical Contact
5. Smile/Laugh
6. Open Posture

WITHDRAWAL
1. Negation
2. No Response
3. Turn Away from Partner
4. Increasing Distance
5. Erects Barriers
6. Noncontributive

CATEGORY RATING

M_1	F_1	M_2	F_2	M_3	F_3	M_4	F_4	M_5	F_5

Appendix D

CPQ (DAY 1)

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

Directions: We are interested in how you and your partner typically deal with problems in your relationship. Please rate each item on a scale of 1 (=very unlikely) to 9 (=very likely).

A. WHEN SOME PROBLEM IN THE RELATIONSHIP ARISES:	Very Unlikely								Very Likely
1. Both members avoid discussing the problem.	1	2	3	4	5	6	7	8	9
★ 2. Both members try to discuss the problem.	1	2	3	4	5	6	7	8	9
3. Man tries to start a discussion while Woman tries to avoid a discussion.	1	2	3	4	5	6	7	8	9
Woman tries to start a discussion while Man tries to avoid a discussion.	1	2	3	4	5	6	7	8	9

B. DURING A DISCUSSION OF A RELATIONSHIP PROBLEM:	Very Unlikely								Very Likely
1. Both members blame, accuse, and criticize each other.	1	2	3	4	5	6	7	8	9
★ 2. Both members express their feelings to each other.	1	2	3	4	5	6	7	8	9
3. Both members threaten each other with negative consequences.	1	2	3	4	5	6	7	8	9
★ 4. Both members suggest possible solutions and compromises.	1	2	3	4	5	6	7	8	9
5. Man nags and demands while Woman withdraws, becomes silent, or refuses to discuss the matter further.	1	2	3	4	5	6	7	8	9
Woman nags and demands while Man withdraws, becomes silent, or refuses to discuss the matter further.	1	2	3	4	5	6	7	8	9
6. Man criticizes while Woman defends herself.	1	2	3	4	5	6	7	8	9
Woman criticizes while Man defends himself.	1	2	3	4	5	6	7	8	9
7. Man pressures Woman to take some action or stop some action, while Woman resists.	1	2	3	4	5	6	7	8	9
Woman pressures Man to take some action or stop some action, while Man resists.	1	2	3	4	5	6	7	8	9
8. Man expresses feelings while Woman offers reasons and solutions.	1	2	3	4	5	6	7	8	9
Woman expresses feelings while Man offers reasons and solutions.	1	2	3	4	5	6	7	8	9
9. Man threatens negative consequences and Woman gives in or backs down.	1	2	3	4	5	6	7	8	9
Woman threatens negative consequences and Man gives in or backs down.	1	2	3	4	5	6	7	8	9
10. Man calls Woman names, swears at her, or attacks her character.	1	2	3	4	5	6	7	8	9
Woman calls Man names, swears at him, or attacks his character.	1	2	3	4	5	6	7	8	9
11. Man pushes, shoves, slaps, hits, or kicks Woman.	1	2	3	4	5	6	7	8	9
Woman pushes, shoves, slaps, hits, or kicks Man.	1	2	3	4	5	6	7	8	9

(Over)

C. AFTER A DISCUSSION OF A RELATIONSHIP PROBLEM:	Very Unlikely								Very Likely
★ 1. Both feel each other has understood his/her position	1	2	3	4	5	6	7	8	9

2. Both withdraw from each other after the discussion.	1	2	3	4	5	6	7	8	9
★ 3. Both feel that the problem has been solved.	1	2	3	4	5	6	7	8	9
4. Neither partner is giving to the other after the discussion.	1	2	3	4	5	6	7	8	9
5. After the discussion, both try to be especially nice to each other.	1	2	3	4	5	6	7	8	9
6. Man feels guilty for what he said or did while Woman feels hurt.	1	2	3	4	5	6	7	8	9
Woman feels guilty for what she said or did while Man feels hurt.	1	2	3	4	5	6	7	8	9
7. Man tries to be especially nice, acts as if things are back to normal, while Woman acts distant.	1	2	3	4	5	6	7	8	9
Woman tries to be especially nice, acts as if things are back to Normal while Man acts distant.	1	2	3	4	5	6	7	8	9
8. Man pressures Woman to apologize or promise to do better, while Woman resists.	1	2	3	4	5	6	7	8	9
Woman pressures Man to apologize or promise to do better, while Man resists.	1	2	3	4	5	6	7	8	9
9. Man seeks support from others (parent, friend, children).	1	2	3	4	5	6	7	8	9
Woman seeks support from others (parent, friend, children).	1	2	3	4	5	6	7	8	9

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