

ABSTRACT

Title of Document: COUPLE THERAPY PROCESS AND ITS
RELATION TO THERAPY OUTCOME.

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Science

Research on psychotherapy has found that characteristics of clients and therapists often are more strongly associated with treatment outcome than are specific therapeutic models or techniques. This study examined the relations between client and therapist common factors and outcomes of couple therapy. The sample was 40 couples presenting with mild to moderate psychological and physical abuse and who received ten sessions of couple therapy at a university-based clinic. The study investigated relations of client common factor characteristics (negative communication and negative attributions) and the therapist common factor characteristics (warmth, empathy, presence, validation and systemic techniques and session structuring) with couple therapy outcomes (changes in overall relationship satisfaction and in level of psychologically abusive behavior). Hierarchical linear modeling analyses testing an Actor-Partner Interdependence Model (APIM) revealed that males' negative attributions were associated with a decrease over treatment in their own use of psychological abuse, whereas females' negative attributions were

associated with increased use of psychological abuse by males. Females' negative communication was associated with increased psychological abuse by females. As expected, therapist use of technique factors was associated with decreased psychological abuse by males. Unexpectedly, therapist presence was associated with less positive change in relationship satisfaction for males, and therapist use of technique factors was associated with less positive change in relationship satisfaction and increased use of psychological abuse for females. Therapist factors moderated the relationships between the client pre-treatment negative characteristics and therapy outcome, such that in some cases higher levels of therapist factors (warmth, presence, validation) enhanced a positive relationship between pre-treatment negativity and positive therapeutic outcomes and in others higher levels of the therapist factors (technique factors, presence, validation) amplified a negative relationship between pre-treatment characteristics and poor therapeutic outcomes. Therapist factors did not buffer the negative relationship between client negativity and positive therapy outcomes as expected, although there were instances in which therapist factors enhanced a positive relationship between these variables. Actor and partner effects, as well as gender differences, are discussed. The study's implications and limitations are considered as they contribute to understanding how client and therapist common factors influence the course of couple therapy.

COUPLE THERAPY PROCESS AND ITS RELATION TO THERAPY OUTCOME

By

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Table of Contents

Acknowledgements	ii
Table of Contents	v
List of Tables	viii
List of Figures	ix
Chapter 1: Introduction	1
Statement of the Problem	1
A Brief History of Common Factors	2
Evidence that the Study of Common Factors is Important	4
Purpose of the Present Study	6
Chapter 2: Literature Review	10
The Need for Effective Couple Therapy	10
Findings on the Effectiveness of Couple Therapy	11
Outcome Studies on Couple Therapy	12
Meta-analyses of Couple Therapy Effectiveness	17
Reviews of Therapy Outcome Studies	18
Types of Common Factors Affecting Therapy Outcome	21
The Common Factors Debate	22
Common Factors as Predictors of Therapy Success	27
The Application of a Common Factors Approach to Couple Therapy	30
Identifying and Defining Common Factors in Couple Therapy	30
Unique Challenges Faced by Couple and Family Therapists when Considering Common Factors	36
Empirical Support for the Investigation of Common Factors in Couple and Family Therapy	37
Therapist and Client Common Factors that Influence the Course of Therapy	42
Client Common Factors	43
Negative Couple Communication	45
Negative Attributions	46
Therapist Common Factors	47
Therapist-Client Relationship/Therapeutic Alliance	48
Therapist Warmth	51
Therapist Empathy	52
Collaboration	53
Therapist Positive Regard	54
Systemic Technique and Session Structure	54
Indices of Couple Therapy Outcome	55
Relationship Satisfaction	56
Psychological Abuse	56
Theoretical Base for the Study	57
Gaps in the Literature on Common Factors in Couple Therapy Outcome	62
Definitions of Variables	63
Pre-Treatment Couple Common Factor Characteristics:	
Independent Variables	63
Negative Communication Behaviors	63

Negative Attributions	63
Therapist Common Factors Process Variables: Moderator Variables	63
Relationship Factors	63
Technique Factors	63
Couple Therapy Outcomes: Dependent Variables	63
Change in Relationship Satisfaction	63
Change in Levels of Psychologically Abusive Behavior	63
Research Questions and Hypotheses	64
Chapter 3: Method	68
Sample	68
Descriptive Statistics for Participating Couples	68
Descriptive Statistics for Participating Therapists	70
Inclusion Criteria	70
Exclusion Criteria	71
Participant Compensation	71
Procedures	71
Data Gathering	71
Development of Instrument for Coding Therapist Behavior	73
Observational Coding	75
Couple Communication Sample Coding	75
Coding of Therapist Behavior toward Clients during Therapy Sessions	75
Measures	76
Independent Variables: Couple Common Factors Characteristics	
Pre-Treatment	76
Moderator Variables: Therapist Common Factors Process	78
Dependent Variables: Couple Therapy Outcomes	80
Chapter 4: Results	83
Statistical Analyses	83
Test of Hypotheses	91
Summary of Findings	113
Overall Change in Symptoms	113
Negative Attributions Predicting Therapy Outcome	114
Negative Communication Predicting Therapy Outcome	114
Therapist Relationship Factors Predicting Therapy Outcome	115
Therapist Technique Factors Predicting Therapy Outcome	115
Therapist Relationship Factors Moderating the Relationship between Client	
Characteristics and Therapy Outcome	116
Expected Findings	116
Unexpected Findings	119
Therapist Technique Factors Moderating the Relationship between Client	
Characteristics and Therapy Outcome	120
Expected Findings	120
Unexpected Findings	120
Chapter 5: Discussion	121
Interpretation of Findings	121

Overall Change in Relationship Satisfaction and Psychologically Abusive Behavior.....	121
The Influence of Client Common Factors on Couple Therapy Outcome.....	122
Negative Attributions Predicting Therapy Outcome.....	122
Negative Communication Predicting Therapy Outcome.....	124
The Influence of Therapist Common Factors on Couple Therapy Outcome.....	127
Therapist Relationship Factors Predicting Therapy Outcome.....	127
Therapist Technique Factors Predicting Therapy Outcome.....	129
Therapist Common Factors Moderating the Relationship between Client Pre-Treatment Common Factors and Therapy Outcome.....	131
Warmth.....	132
Empathy.....	134
Presence.....	136
Validation.....	137
Technique Factors.....	141
General Conclusions.....	142
Theoretical Interpretations.....	147
Limitations of the Study.....	148
Study Strengths.....	151
Future Directions for Research.....	152
Clinical Implications.....	157
Conclusion.....	159
Appendices.....	160
Appendix A.....	161
Appendix B.....	162
Appendix C.....	164
Appendix D.....	167
Appendix E.....	168
Appendix F.....	170
Appendix G.....	174
References.....	178

List of Tables

Table 1: Demographic Information for Male Partners, Pre-Treatment.....	69
Table 2: Demographic Information for Female Partners, Pre-Treatment.....	69
Table 3: Descriptive Statistics for Female Variables.....	89
Table 4: Descriptive Statistics for Male Variables.....	90
Table 5: Descriptive Statistics for Therapist Variables.....	90

List of Figures

Figure 1: Conceptual Model of the Proposed Relations Among the Variables in the Study.....	8
Figure 2: Model 1 for Statistical Analysis.....	85
Figure 3: Example of the Statistical Model for Testing Interaction Effects.....	86
Figure 4: Model 2 for Statistical Analysis.....	87
Figure 5: Model 3 for Statistical Analysis.....	88
Figure 6: Model 4 for Statistical Analysis.....	88
Figure 7: Female Change in Relationship Satisfaction as Predicted by Female Negative Communication and Therapist Presence.....	97
Figure 8: Female Change in Relationship Satisfaction as Predicted by Male Negative Communication and Therapist Warmth.....	98
Figure 9: Male Change in Relationship Satisfaction as Predicted by Female Negative Communication and Therapist Presence.....	99
Figure 10: Female Change in Relationship Satisfaction as Predicted by Female Negative Communication and Therapist Validation.....	100
Figure 11: Female Change in Relationship Satisfaction as Predicted by Male Negative Communication and Therapist Presence.....	101
Figure 12: Female Change in Psychological Abuse as Predicted by Female Negative Communication and Therapist Warmth.....	102
Figure 13: Male Change in Psychological Abuse as Predicted by Female Negative Communication and Therapist Validation.....	103

Figure 14: Female Change in Relationship Satisfaction as Predicted by Female Negative Communication and Therapist Technique Factors.....	105
Figure 15: Male Change in Relationship Satisfaction as Predicted by Female Negative Communication and Therapist Technique Factors.....	106
Figure 16: Male Change in Relationship Satisfaction as Predicted by Male Negative Attributions and Therapist Validation.....	108
Figure 17: Female Change in Relationship Satisfaction as Predicted by Male Negative Attributions and Therapist Validation.....	109
Figure 18: Female Change in Relationship Satisfaction as Predicted by Female Negative Attributions and Therapist Validation.....	110
Figure 19: Male Change in Relationship Satisfaction as Predicted by Female Negative Attributions and Therapist Validation.....	111
Figure 20: Male Change in Psychological Abuse as Predicted by Male Negative Attributions and Therapist Technique Factors.....	113

Chapter 1: Introduction

Statement of the Problem

The field of Marriage and Family Therapy (MFT), now commonly referred to as Couple and Family Therapy (CFT), pays a great deal of attention to which specific therapeutic models are most effective in producing positive outcomes among clients who seek treatment.

Increasingly, there is a search for empirically supported treatments, with studies conducted that compare outcomes of alternative models. There is accumulating empirical evidence that a number of CFT models are effective, with no one model having a clear advantage over others in resolving relationship problems. However, the limited number of comparative outcome studies leaves the question unresolved as to whether some treatments may be more effective overall for specific presenting problems. In addition, relatively little is known about *how* the empirically supported models operate to produce positive outcomes. In fact, there is considerable evidence that there are commonalities among effective therapeutic models that account for a large percentage of their positive impacts. The term “common factors” is used to refer to common aspects of treatment, including characteristics of the therapist, the client, the alliance between therapist and client, and the therapy procedures that are not tied to a specific therapeutic model (Lambert & Bergin, 1994). For example, a therapist common factor would be warmth conveyed to clients, a client common factor would be openness to change, a therapist-client relationship common factor would be a collaborative alliance, and a therapy procedure common factor would be interventions that interrupt a couple’s typical negative interaction pattern.

There is a growing body of empirical evidence that individual psychotherapies are effective in large part due to common factors such as the client-therapist relationship (Wampold, 2001), but much less is known about the common factors -- both what they are and how they

operate -- that influence couple therapy outcome. In recent CFT literature, calls have been made for clinical researchers to redirect their focus to the mechanisms that make CFT work rather than simply pitting one therapeutic model against another. Identifying common factors that influence the course of therapy is necessary for increasing our understanding of how couple and family therapy produces effective outcomes, so that interventions can be designed to have the maximal positive impacts in assisting distressed couples and families.

Currently, the scant literature on common factors in CFT (Sprenkle, Blow, & Dickey, 1999) has focused on defining what the common factors are and how they compare with common factors found to operate in individual and group psychotherapies. Less attention has been given to how common factors operate in CFT, such as how therapist characteristics interact with client characteristics in influencing the outcome of treatment of distressed couples. If the field is to move beyond a competition among therapy models to an integrative approach that identifies and maximizes the use of effective treatment components, it is important that therapy researchers increase their attention to common factors and how they affect treatment outcomes. The present study is intended to take a step in that direction by investigating the effects on couple therapy outcome of a number of characteristics of therapist behavior during therapy sessions, characteristics that members of distressed couples bring to therapy, and the interaction between therapist and client characteristics. The study adds to knowledge about common factors in couple therapy by investigating these characteristics across therapy cases involving diverse theoretical therapy models.

A Brief History of Common Factors

The concept of common factors in psychotherapy was first introduced to the literature in the mid 1930s (Rosenzweig, 1936) and has received considerable attention in literature on

individual psychotherapy process since that time. Many have advocated that a common factors view is helpful in understanding the process by which psychotherapy is effective, whereas others have criticized it for being both atheoretical and too unspecific to be of use. Many contemporary theorists believe that common factors are necessary for positive therapeutic outcomes, but that they cannot stand alone in producing effective treatment (Sprenkle & Blow, 2004b). The debate regarding the importance of common factors in therapeutic processes and outcomes continues among clinicians and researchers, and those who advocate certain therapy models may place little significance on common factors in contrast to effects of specific theoretically active components of a model.

The notion that therapy can and will help anyone who presents for treatment, who is treated by any clinician operating from any model, has loomed in the therapy literature since Rosenzweig's (1936) seminal paper. In order to investigate such claims, it has been common for researchers to conduct meta-analyses investigating treatment outcomes among various types of psychotherapy. Luborsky, Singer, and Luborsky's (1975) meta-analysis of over 100 therapy treatments (including psychoanalysis, Adlerian therapy, behavioral therapy, group therapy, and management of psychological concerns with medication, among others) found that the outcomes of various therapeutic treatments, with the exception of medication management, were generally positive but similar. Some, following Rosenzweig (1936), have concluded that the findings that there are few outcome differences among therapeutic models means that psychotherapy outcomes justify a "dodo bird verdict" (Luborsky, Singer, & Luborsky, 1975), implying that "everyone has won and so all must have prizes" (Carroll, 1992, p. 34), referring to the children's book, *Alice's Adventures in Wonderland*.

More recently, a review of 17 meta-analyses that compared therapeutic treatments to each other (as opposed to comparing one treatment with a no-treatment control condition) concluded that for the most part support for the dodo bird verdict “is alive and well” (Luborsky et al., 2002), given that evidence that one approach is superior to another tends to be rare. Although such conclusions may not sit comfortably with clinicians who have an allegiance to a specific therapy model, they do strongly suggest that there are common processes that cut across therapeutic approaches, which influence the outcome of therapy. Although these processes may vary in form from one therapeutic model to another, or among clinicians and clients, these findings of common factors must be taken into consideration by those who are not simply interested in whether or not therapy works, but rather in *how* therapy works.

Evidence that the Study of Common Factors is Important

Given the debate surrounding the use and study of common factors in psychotherapy, it is important to discuss the merits of investigating common factors as mechanisms through which therapy can have positive outcomes on client well-being. The most convincing rationale for further investigation of common factors in psychotherapy practice lies in the fact that studies have found that large amounts of variance in treatment outcome are attributable to factors other than specific techniques associated with particular therapy models. Lambert (1992) found that, across types of therapy, 40% of the positive change in psychotherapy was attributable to “extratherapeutic” factors occurring in clients’ lives (e.g., illness). This means that 60% of the positive outcome in therapy was attributable to clients’ experiences within the context of therapy. Of this 60%, 30% was due to client-therapist relationship factors (e.g., the quality of their alliance or positive working relationship), 15% was due to specific model or technique factors (e.g., exposure), and 15% of variance in the outcome of therapy was due to placebo, hope, or

expectancy factors. Lambert's study did not examine possible differences in effects of particular interventions for particular types of client presenting problems but rather focused on overall effectiveness of therapy.

Lambert's study highlights two important points. First, a considerable percentage of variance in the outcome of therapy has little to do with the actual therapy procedures or characteristics of the therapist, and a significant portion results from the client's own life outside of the therapy room or the beliefs that they hold about the value and effectiveness of therapy in general. Second, the client-therapist relationship determines a considerable portion of the outcome of therapy. The client-therapist relationship, or alliance, is frequently studied, and its importance to positive therapeutic outcome is well documented (Blow, Sprenkle, & Davis, 2007; Bordin, 1979; Martin, Garske, & Davis, 2000). However, less is known about what influences the formation of a positive alliance in terms of client factors, therapist factors, or other contributing factors (Knobloch-Fedders, Pinsof, & Mann, 2004).

The client-therapist relationship has received a great deal of attention in the literature, with some authors arguing that the client is the most important ingredient for therapeutic change (Tallman & Bohart, 1999), others proclaiming that the therapist is the most important contributor to therapeutic change and outcome (Blow, Sprenkle, & Davis, 2007), and others focusing on the relationship between the client and the therapist as the crucial factor in change (Knobloch-Fedders, Pinsof, & Mann, 2004; Martin, Garske, & Davis, 2000). Each of these perspectives, despite their differences, is grounded in the notion that there are common factors, not specific to any one therapy model or technique, that influence the course and outcome of treatment.

Luborsky, McLellan, Diguier, Woody, and Seligman (1997) found significant differences in degrees of improvement for clients of various therapists, and therapists who were successful in

their treatment of one sample of clients were also successful with other samples of clients, regardless of the client's presenting concerns or characteristics. A study using data from the first National Institute of Mental Health multisite psychotherapy study, the Treatment of Depression Collaborative Research Program (Elkin et al., 1989) also revealed significant variability in therapy outcome based on therapist factors (Blatt, Sanislow, Zuroff, & Pilkonis, 1996). These studies highlight the importance of understanding more than specific treatment models or techniques when investigating therapy outcome, and they have paved the way for further investigation of common factors related to treatment outcomes for individuals, couples, and families. On the one hand, it may appear that these studies support the "dodo bird" verdict suggesting that all therapy approaches are equal as long as therapists with positive qualities are conducting them. On the other hand, the findings suggest that use of potentially superior interventions for particular presenting problems may be compromised if they are delivered by therapists who lack positive therapeutic qualities and fail to establish positive alliances with their clients. The latter possibility suggests that studies comparing specific therapy models and interventions should include assessments of therapist and client common factors that otherwise would contribute to error variance masking differences in treatment outcomes. The common factors literature indicates that both the general stylistic aspects and the model-specific aspects of what a therapist does in session with clients influence outcome.

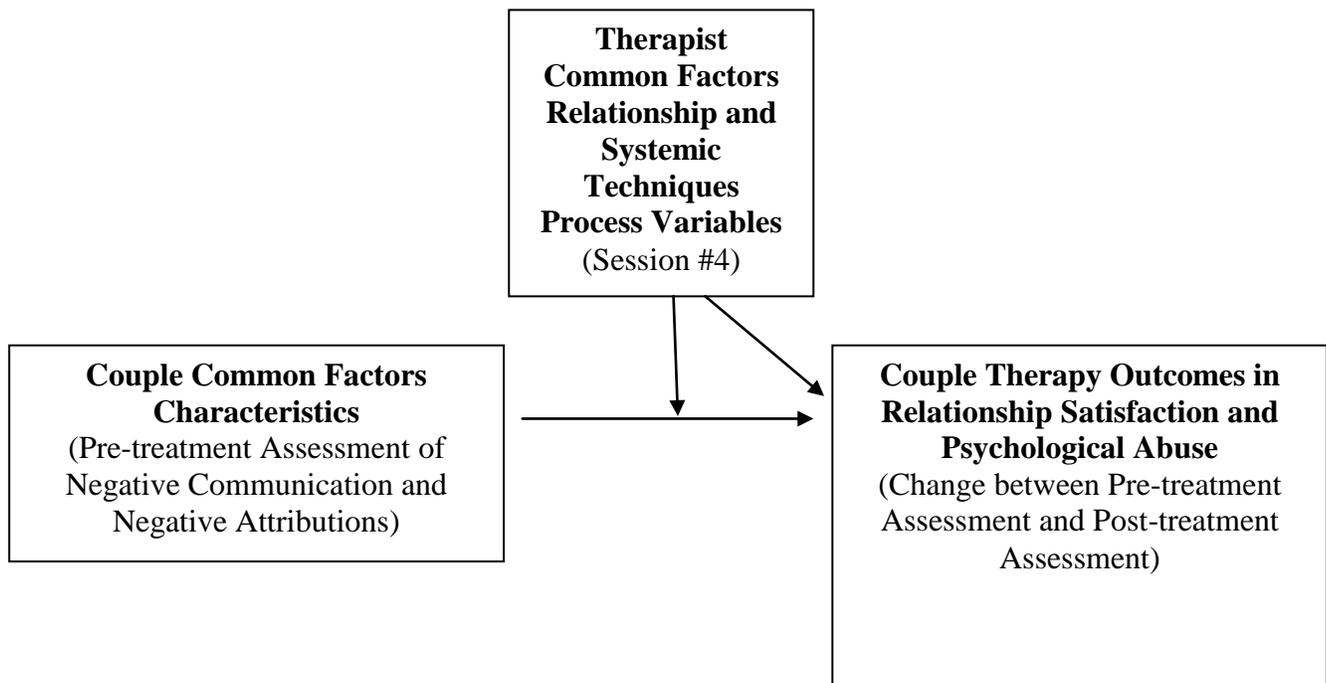
Purpose of the Present Study

The purpose of the current study was to examine how couple therapists intervene to help distressed couples overcome relationship negativity by investigating both client and therapist common factors. Because Holmes (2006) states that little is known about what contributes to the success of couple and family therapists, this study was intended to illuminate some processes

through which couple therapists can intervene effectively. Given the likely importance of therapist factors, including the therapist-client relationship, and client factors, this study examined each of these. Increasingly, there has been a call within the CFT field for researchers to conduct studies that will provide insight into the processes through which therapy works (Eisler, 2006). Specifically, leading clinical researchers in the field believe that it is time to identify how therapist factors, therapy models, and client factors interact with each other to produce optimal therapeutic results (Davis & Piercy, 2007a, 2007b; Simon, 2006).

The present study examined the relations between two types of characteristics that members of distressed couples tend to bring to therapy (their amount of negative couple communication behaviors and the degree to which each person makes negative attributions about their partner) and aspects of couple therapy outcomes (levels of overall relationship satisfaction and psychological abuse). Negative couple communication behaviors and negative attributions that members of couples make about each other may serve as risk factors for poor couple therapy outcome (Johnson & Talitman, 1997; Snyder, Mangrum, & Wills, 1993). In addition, the present study investigated how specific therapist behaviors regarding their relationship with the clients and their delivery of therapeutic interventions are related to the therapy outcomes of increased relationship satisfaction and decreased psychological abuse. The relationship-oriented therapist factors examined include warmth, empathy, presence, validation, and collaboration, whereas the technique factors included therapist use of techniques that are systemically-based and that provide structure for sessions and for couple interactions. Finally, the degrees to which the positive therapist relational and technique behaviors buffer the risk that couple negative communication and negative attributions lead to poor therapy outcome were tested. See Figure 1 for a conceptual model of the study.

Figure 1. Conceptual model of the proposed relations among the variables in the study.



This study extends the current literature on common factors in CFT in several ways. First, it begins to correct for the historical neglect of common factors research in CFT literature (Sprenkle & Blow, 2004a). Second, it is a clinical study that was not aimed at comparing the effectiveness of specific treatment models but rather examined common factors across diverse couple therapy approaches. Furthermore, this study of common factors was not a meta-analysis of effects from multiple studies, but rather an individual study that specifically investigated particular common factors (Sprenkle, Davis, & Lebow, 2009). Fourth, this study addressed the prior minimal attention given to the influence of therapist factors on treatment outcome for couples (Blow, Sprenkle, & Davis, 2007). Finally, this study used observational coding of therapist behaviors during therapy sessions to assess therapist common factor behaviors and tested how these moderate the relations between pre-treatment couple characteristics and therapy outcomes.

Although this study primarily investigated the interaction of therapist and client common factors, it in no way was intended to discount the use of specific therapy model-based techniques when treating distressed couples. In fact, the author strongly agrees with Sprenkle and Blow (2004b) that CFT models are the vehicles through which common factors can operate effectively. The study was aimed at facilitating a deeper understanding of how therapy can be administered in the most beneficial ways, regardless of therapeutic model, in hopes that the findings will be of utility to clinicians who work with distressed couples.

Chapter 2: Literature Review

The Need for Effective Couple Therapy

Effective couple therapists and therapies are in high demand given the number of distressed couples in the United States. The divorce rate in the U.S. rose from the mid-1800s through the 1970s, stabilized at approximately 50% during the 1980s, and has declined somewhat since (Teachman, Tedrow, & Hall, 2006). Although couple distress is often discussed in terms of divorce, these statistics do not include the distress experienced by non-married partners.

The number of couples who struggle with unhappiness in their relationships who ultimately end their marriages with divorce is reason enough for research to be focused on effective strategies that couple therapists can use to facilitate positive relationship change in couples. Perhaps a more compelling reason for the investigation of effective couple therapy and therapists is the fact that within ongoing relationships, many of which do not end in divorce, relationship distress commonly has serious negative effects on members of the couple as well as on any children they may have. Although this project does not investigate the negative impact of couple distress on adults and children, it is important to briefly discuss these impacts in order to demonstrate how important it is for researchers to understand aspects of couple therapy that can produce positive outcomes for couples whose relationships are functioning poorly.

In terms of individual functioning, it is well documented that relationship distress can lead to serious difficulties in personal adjustment. A study by Swindle, Heller, Pescosolido, and Kikuzawa (2000) revealed that the most commonly cited reasons triggering “nervous breakdowns” involved relationship difficulties including divorce, marital separation, and marital distress. Similarly, there is substantial evidence that relationship distress plays a causal role in

the development of depression, and couple therapy can be an effective treatment for depression that has a relational component (Beach, Dreifuss, Franklin, Kamen, & Gabriel, 2008). Clearly, the difficulties associated with relationship distress have implications for each partner's individual well-being.

Relationship distress and divorce also have consequences for children who observe and live with their parents' relationship conflict. Correlations between marital conflict and child emotional and behavior problems have been well documented in the literature (Fincham, 1994), and studies of clinical (Cummings, Davies, & Campbell, 2000; Fincham, 1994) and non-clinical (Gartland & Day, 1992) populations have documented the associations between marital conflict and poor child outcomes. Although much of the literature on the impact of relationship distress on children examines the effect that divorce has on children, several studies have found that high levels of conflict between parents, more so than family structure (intact versus divorced), are associated with child emotional and behavior problems (Amato, Loomis, & Booth, 1995; Morrison & Coiro, 1999; Vandewater & Lansford, 1998).

Given the widespread occurrence of relationship distress, and its critical impacts on individual and family functioning, it is important for studies to examine how couple therapists can be most effective in the work that they do with distressed couples. The effectiveness of couple therapy is well documented in the literature, but less is known about therapist and client factors that contribute to treatment effectiveness. This project examined just this – the direct and interactive influences of couple therapist behaviors and client factors on couple therapy outcome.

Findings on the Effectiveness of Couple Therapy

In the past several decades, there has been an increased emphasis on evaluating the effectiveness of individual, couple, family, and group therapy and the importance of using

empirically supported treatments in clinical work (Sprenkle, 2002). A rapidly expanding number of controlled treatment outcome studies have been conducted, including studies evaluating the effectiveness of couple therapies. There are three major ways in which current knowledge regarding the effectiveness of couple therapy can be evaluated: (1) examination of findings from outcome studies that are exemplary in the rigor of their designs, use of commonly employed outcome measures, and applicability to clinical practice; (2) identification of major trends found in meta-analyses that pool effects found across multiple outcome studies, and (3) consideration of review articles in which authors summarize results across sets of outcome studies and meta-analyses. The following are summaries of what is known about the efficacy of couple therapy from these three perspectives.

Outcome Studies of Couple Therapy

Most couple therapy treatment outcome studies have compared two types of couple therapy or compare a specific type of couple therapy to treatment as usual that may not involve any direct intervention with the couple. The outcomes that most studies investigate are changes in global relationship distress versus satisfaction, although some studies have examined the specific influence of a treatment on levels of partners' negative behavior (including aggression). Most studies have examined forms of conjoint treatment for couples (both partners participating in treatment together), but several studies compared outcomes of conjoint couple therapy with those of group couple therapy. The following is a description of representative major couple therapy treatment outcome studies. This overview is not meant to be comprehensive coverage of the many studies that have been conducted, but rather a sampling of studies to demonstrate the range of models that have been evaluated, the types of outcome measures used, and the overall findings.

Several models of couple therapy have been demonstrated to produce successful outcomes for couples in terms of increased overall relationship satisfaction. A study by Snyder and Wills (1989) compared the effects of behavioral marital therapy (BMT) and insight-oriented marital therapy (IOMT) with effects of a no-treatment waitlist control group among 79 distressed couples. They found that 55% of those couples who received BMT, 40% of those couples who received IOMT, and 5% of those couples put on a treatment waitlist were no longer distressed post-treatment. These results were sustained at the six-month follow-up in which 50% of those who received BMT, and 43% of those who received IOMT were no longer distressed.

Another study that examined the effectiveness of couple therapy compared the effects of traditional behavioral couple therapy (TBCT) and integrative behavioral couple therapy (IBCT) among 134 chronically distressed couples. Each treatment was deemed effective given that 71% of those in the IBCT group and 59% of those in the TBCT group reported improvement in *Dyadic Adjustment Scale* (DAS, Spanier, 1976) scores, or had reached non-distressed levels on the DAS, meaning that overall relationship satisfaction had improved for the majority of participating couples (Christensen et al., 2004).

Further examination of the effectiveness of TBCT and IBCT among a study of 134 couples randomly assigned to one of these forms of treatment found that both TBCT and IBCT led to positive outcomes for the couples. There were, however, differences in how the outcome was obtained and when it occurred throughout the course of therapy. Both groups increased in their levels of acceptance and positive communication; however, those couples who received TBCT increased in positive communication more than the IBCT group, and the IBCT group had greater increases in level of acceptance. Early in treatment the TBCT led to increases in the frequency with which members of the couple exchanged positive behaviors, and this was

associated with increases in relationship satisfaction. In the latter part of treatment, those who received IBCT had increased levels of emotional acceptance of each other, and this was associated with even higher levels of relationship satisfaction post-treatment (Doss, Thum, Sevier, Atkins, & Christensen, 2005). These findings highlight the effectiveness of each of these forms of couple treatment, as well as the varying processes by which change occurs during treatment.

In keeping with Gurman and Kniskern (1981) who stated that approximately two thirds of couples benefit from couple therapy, a study of 42 couples who received either integrative systemic therapy (IST), emotionally-focused therapy (EFT), or who served as a control group found that two thirds of the couples who received IST or EFT reached clinically significant levels of change, given that their relationship satisfaction scores on the DAS were within the non-distressed range. Although both treatments were effective, IST produced slightly greater effects at the four-month follow-up (Goldman & Greenberg, 1992).

A study that compared techniques from two of the most commonly and rigorously examined treatment models, BMT (examined using cognitive behavioral therapy with a problem solving (PS) component – referred to as the PS treatment group in the study) and EFT (Johnson, Hunsley, Greenberg, & Schindler, 1999) among 45 couples (15 couples in each the PS, EFT, and waitlist control groups) found that couples in both treatment groups experienced improvements in overall marital adjustment compared to the control group. Those in the EFT group, however, reported greater increases in marital adjustment and intimacy than those in the PS group (Johnson & Greenberg, 1985).

In order to investigate if the effectiveness of BMT could be enhanced with the addition of interventions aimed at addressing couple cognitions and emotions, Baucom, Sayers, and Sher

(1990) conducted a randomized treatment study among 60 distressed couples. Each couple was assigned to either BMT, BMT with the addition of cognitive restructuring (CR), BMT with the addition of emotional expressiveness training (EET), BMT with the additions of both CR and EET, or a waitlist control group. The study found that couples in all treatment groups improved in terms of marital adjustment, but that the addition of CR or EET did not produce results any more positive than BMT alone. The authors posit that their findings may have been due to the limited total treatment time (12 weeks) which necessitated reducing the amount of one type of intervention in order to add another type, and they suggest that further examination of the effectiveness of integration of cognitive and emotional interventions is warranted.

Although many of the couple therapy outcome studies have been conducted in the U.S., similar studies and outcomes have been reported in other countries. For example, a treatment outcome study involving 300 Swedish couples who received an integrative form of couple therapy found that both male and female partners reported greater relationship satisfaction post-treatment and at a two-year follow-up (Lundblad & Hansson, 2006). Although the study was limited in that it did not utilize a control group, the findings suggest that whereas it is important to investigate cultural variations in effective treatments, it is also likely that there are similarities in what types of interventions are effective cross-culturally. The question of cultural variation in common factors involving therapist behavior is beyond the scope of the present study, but this clearly is an important question to address in future research.

In addition to studies that have compared treatments designed to work with both partners in a couple conjointly in session, other treatment outcome studies have examined the effectiveness of group couple therapy. These studies also offer promising findings that group couple therapy is as effective, if not more effective, than conjoint couple therapy. A study by

Hahlweg, Schindler, Revenstorf, and Brengelmann (1984) of 85 couples who participated in either conjoint BMT ($n = 17$), a conjoint BMT group ($n = 16$), conjoint communication skills training ($n = 16$), or a waitlist control group ($n = 17$) found that all couples who received treatment had better outcomes than those who were put on the waitlist. Couples who received conjoint BMT had the best therapeutic outcomes in terms of relationship happiness. Older couples and those who were less committed to the relationship had lower levels of treatment success.

A study by Stith, Rosen, McCollum, and Thomsen (2004) examined the effect of conjoint couple therapy and multi-couple group therapy for couples who were experiencing aggressive behavior in their relationships. The study consisted of 51 couples, 20 who were assigned to conjoint couple therapy, 22 who were assigned to conjoint group couple therapy, and nine who served as an untreated comparison group. They found that the aggressors in these couple relationships (who happened to be all men) responded better to the multi-couple group therapy. Those who completed multi-couple group therapy did not reoffend at the high rates of those men who participated in individual couple therapy. Furthermore, those who participated in the multi-couple group therapy reported decreases in marital aggression as well as decreases in their acceptance of relationship violence, and increases in relationship satisfaction as the result of participation in this form of treatment.

Examining the effectiveness of treatment for couples who engage in psychologically or physically abuse behaviors toward each other is of critical importance given the risks that aggressive behavior pose for a decrease in partners' physical and psychological well-being, and evidence that psychological violence commonly leads to the development of physical violence among couples. A seminal study was conducted by Murphy and O'Leary (1989) with 213

husbands and 184 wives who reported no physical aggression in their premarital relationships. The couples were assessed four times over the first 30 months of marriage to examine the relationship between psychological aggression and physical aggression in couple relationships. The authors found that both the individual's level of previous psychological aggression and the partner's previous level of psychological aggression were associated with the later development of physical aggression in the relationship. This indicates that careful assessment of relationship violence is key when conducting research on couple therapy outcome, especially given the high rates of abuse that exist within couple relationships among couples who seek treatment (Holtzworth-Munroe et al., 2003).

Meta-Analyses of Couple Therapy Effectiveness

Given the large quantity of studies examining the effectiveness of couple and family therapy, meta-analyses serve as a useful guide to understanding the effectiveness of these treatments as the treatment effects of many studies are aggregated as a group (Neuman, 2006). An early meta-analysis of 163 clinical studies found that marital therapy was successful at producing clinically significant positive results for couples (Shadish et al., 1993). A smaller meta-analysis aimed at investigating treatment effectiveness of three couple therapy models also concluded that couple therapy had positive impacts on couple relationships. Specifically, this meta-analysis of 15 marital therapy outcome studies revealed that BMT, cognitive-behavioral marital therapy (CBMT) and IOMT all made significant contributions to positive changes in couples' behaviors toward each other, and in measures of overall relationship satisfaction (Dunn & Schwebel, 1995).

A review of 20 meta-analyses concluded that couple therapy was associated with positive outcomes for 40 to 50 percent of the couples who sought treatment (Shadish & Baldwin, 2003).

A more recent meta-analysis (Shadish & Baldwin, 2005) on the effects of BMT examined the results of 30 clinical trials and found that BMT was more effective in resolving marital concerns than was no treatment at all. The authors, however, point to an issue that requires careful consideration both when designing and evaluating treatment efficacy studies. They note that many outcome studies may be influenced by publication bias in which studies with small sample sizes, and/or those in which no effect was found, rarely make it into publication. Although what is currently known about couple therapy indicates that treatment for relationship distress holds a great deal of promise for those couples who seek it out, it is important for future couple therapy researchers to keep this publication bias in mind.

Reviews of Therapy Outcome Studies

In addition to outcome studies and meta-analyses that produce and evaluate empirical information regarding the effectiveness of couple therapy, a number of reviews have been published that synthesize what is known to date about the effectiveness of couple therapy. Most of these reviews offer an optimistic view of the outcomes associated with couple therapy. The following is an overview of the major published reviews on the outcomes of couple therapy.

An early and widely cited review of the effectiveness of couple therapy by Gurman and Kniskern (1981) found that approximately two thirds of couples who sought treatment exhibited improvements. Other reviews that have only considered studies that included control groups and randomized assignment of couples to treatments report that positive improvements are found among approximately one third to one half of couples as the result of couple therapy (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Jacobson et al., 1984). It is clear that in the review literature the rigor of the studies reviewed is at times haphazardly considered, limiting consensus about the current status of the effectiveness of couple therapy. Most reviews, however, state that

there is a great deal of evidence suggesting that couple therapy is effective in reducing overall relationship distress for a large proportion of those couples who seek treatment (Snyder, Castellani, & Whisman, 2006).

Many treatment outcome studies focus on the comparison of two distinct clinical treatments; therefore the focus of many reviews is the effectiveness of these specific treatments. In their decade review of the state of couple therapy, Johnson and Lebow (2000) state that there is clear empirical support for the effectiveness of couple therapy, and that most of this evidence of the positive effects of couple therapy comes from the study of two popular models of couple therapy: behavioral marital therapy (BMT) and emotionally-focused therapy (EFT). Similarly, a review by Whisman, McKelvie, and Chatav (2005) of treatments for couple distress notes that behavioral couple therapy (BCT) and cognitive behavioral couple therapy (CBCT) have both been empirically supported as effective treatments for couple distress in the literature. Yet another review of rigorous studies concludes that BMT and EFT are effective couple treatments, and that IOMT and cognitive therapy for couples are possibly effective in alleviating couple distress (Baucom et al., 1998).

Despite the fact that much empirical evidence supports the effectiveness of a number of approaches to couple therapy for reducing relationship distress, there are many gaps that remain within the existing body of literature regarding several key factors. Lebow (2000), while agreeing that the current literature on couple therapies generally suggests that they do have positive impacts on clients, also points to several shortcomings in the empirical literature. First, he states that although much is known about some specific models of couple therapy, there is very little empirical information on the effectiveness of other treatment models. He also states that there is little information on the *clinical significance* of the changes that couples experience

throughout the process of couple therapy, meaning that although studies commonly find statistically significant (i.e., unlikely to be due to chance) reductions in presenting concerns immediately following treatment, little attention is given to the size of these effects or to whether the improvements placed treated couples' functioning in the range of non-distressed couples in the general population. Finally, Lebow (2000) states that little is known about the duration of couple therapy effects. In addition, most studies assess global relationship satisfaction as the index of therapy effectiveness, and there is a need for assessment of other outcome indices when considering treatment effectiveness.

In their review of the current status of couple therapy, Christensen et al. (2006) make several recommendations for future directions in the field of couple therapy research while also acknowledging that many couples are not helped by couple therapy. Included in these recommendations are that some studies be conducted that focus on in-depth assessment of effects on small samples, to identify *what* is working in the treatment, and *how* it is working. Others (Heatherington, Friedlander, & Greenberg, 2005) have also made this recommendation that therapy outcome studies shift their focus to the processes through which change occurs throughout the course of treatment. They also make this recommendation recognizing that many couple therapy researchers, both present and future, will be bound by financial constraints that make studies of large populations fiscally impossible. Christensen, Baucom, Vu, and Stanton (2005) echo this recommendation.

Luborsky et al. (1999) highlight an important, and frequently overlooked, component of therapy outcome studies that may bias the findings: the researcher's allegiance to a specific therapy model. The authors note that there have been discrepancies in the individual psychotherapy outcome literature with regard to which treatments are most effective. Their

review of therapy outcome research led those authors to conclude that researcher allegiance to a therapy model accounted for 69% of the variance in how effective treatments were found to be, with positive allegiances having greater effects than negative allegiances. This finding is an important contextual factor to consider when examining treatment outcome studies, and one that will be important for future couple therapy researchers to consider given that the field's history is grounded in therapists' allegiance to specific models of treatment (Sprenkle, 2002).

Types of Common Factors Affecting Therapy Outcome

Common factors are those treatment variables that are not specific to any one model of psychotherapeutic treatment and that are important components in influencing therapeutic change (Sprenkle, Davis, & Lebow, 2009). The most frequently used conceptualization of common factors was developed by Lambert (1992) and subsequently modified by Miller, Duncan, and Hubble (1997), and consists of 4 factors. The factors included in this model are 1) client/extratherapeutic factors, 2) relationship factors, 3) model/technique factors, and 4) placebo, hope, and expectancy factors.

Common factors are frequently conceptualized in terms of their breadth, with a differentiation made between a narrow definition of common factors and a broad definition of common factors. The narrow definition of common factors includes intervention techniques that are similar across therapy models but are simply called by different names in different models (Lambert, 1992; Sprenkle, Davis, & Lebow, 2009). For example, in structural couple or family therapy the process of getting clients to act out an interaction pattern that tends to occur in their relationship and that is relevant to their presenting problem is called an enactment, whereas, in cognitive-behavioral therapy this type of intervention would be labeled using a role play. The narrow definition approach to common factors seeks to identify those techniques that are used in

multiple therapeutic models but are not necessarily universal to all psychotherapy models. In contrast, the broad definition of common factors refers to general client, therapist, and client-therapist relationship variables that are likely to influence the course of treatment regardless of the model that is being used (Sprenkle et al., 2009). These broad factors that influence therapy include such client characteristics as the quality of communication that couples tend to engage in as they enter therapy, therapist characteristics such as warmth toward clients, and therapist-client relationship characteristics such as collaboration in working toward goals.

The Common Factors Debate

Although most clinicians and researchers agree that common factors play an important role in therapy outcome, the dialogue regarding common factors research in the literature has been heated at times. Some researchers propose that empirical consideration of common factors is necessary to obtain an understanding of the processes through which therapy works (Sprenkle et al., 2009), whereas others contest that the study of common factors is relatively senseless given their vague nature and atheoretical underpinnings (Beutler, 2002). Given that the present proposed study investigated client and therapist common factors as they relate to therapeutic outcomes, it is important to consider the ambiguous context in which this study has been conducted. Consideration of both sides of the debate regarding the importance of common factors guided the procedures that were designed to make this study rigorous, both methodologically and theoretically.

One of the most frequently cited reasons for the investigation of common mechanisms that exist for all psychotherapeutic treatments comes from findings that psychotherapy is generally helpful to those who present for treatment (Rosenzweig, 1936). Several meta-analyses conducted to investigate treatment outcome studies of the past 40 years have concluded that the

outcomes of psychotherapy, regardless of specific psychotherapeutic model, are generally positive and similar (Luborsky et al., 1975; Luborsky et al., 2002). These findings are often referred to as supportive of the “dodo bird verdict” (Luborsky et al., 1975; Luborsky et al., 2002; Rosenzweig, 1936), meaning that any therapy will work for anyone.

Understandably, many clinicians who have spent years in training to learn the specifics of certain models, and those who have dedicated their careers to developing new models of treatment, find this verdict to be quite troubling, with many stating that the notion that common factors are the source of therapeutic change is an over-simplification of a complex process (Beutler, 2002). Others view these findings as an opportunity to obtain a greater understanding of the common factors that play a role in therapeutic outcomes, and the processes through which these common factors influence therapeutic outcomes (Sprenkle et al., 2009). In fact, many of the published works addressing common factors in the psychotherapy literature highlight this debate, indicating that there is little consensus in the field about future directions for common factors research. Given that the present project examined the influence of common factors on couple therapy outcome, it is important for the study to be understood in the context of the current debate surrounding the status of common factors research in treatment outcome studies.

Beutler (2002) criticizes many of the arguments that have made the case for the dodo bird verdict. First, he states that too often these studies homogenize clients and therapeutic treatments when in fact investigations of which specific therapeutic techniques work for which specific type of client would be more accurate in assessing the effectiveness of treatments. As previously noted, there is some evidence for this in the couple therapy literature (Brown & O’Leary, 2000; Raytek et al., 1999). Beutler (2002) also notes that often the dodo bird verdict is explained by the relationship between the therapeutic alliance and client outcome but cautions that studies rarely

consider the effect of specific treatments and techniques on the formation of the therapeutic alliance.

Chambless (2002) echoes Beutler's (2002) concern over the validity of Luborsky et al.'s (2002) assertion that there are no significant differences in treatment effects among various therapy approaches. She states that this assertion has been inappropriately generalized to populations and treatments for which generalizations cannot be made based on the current data. She adds that it is possible for errors in data analysis to result in the finding of few differences among treatments.

Rounsaville and Carroll (2002) agree with Luborsky et al. (2002), in that to date empirical studies have not found sufficient and consistent evidence for the superiority of any one treatment over another. However, they agree with Beutler (2002) and Chambless (2002) that there are many possible reasons for these findings. Primarily, they argue that the literature has ignored the likely importance of matching clients who have specific characteristics or presenting concerns with particular treatments that target those characteristics, in order to test what type of therapy works, and for whom.

Schneider (2002) points to the limitations intrinsic to meta-analyses as a possible explanation for the findings of few differences in outcomes of alternative treatments. Rather than conducting further meta-analyses of previous quantitative studies, he recommends that researchers combine qualitative methods with quantitative methods to investigate more subtle aspects of treatment including which treatments are the most effective for specific types of clients. Through conducting and analyzing interviews with clients, therapists, and other important people in clients' lives in conjunction with quantitative measures of client functioning, the models of therapy and therapist strategies that are most helpful to clients who present to

treatment with specific presenting concerns, as well as how these models and strategies facilitate positive change among clients can be revealed and understood in a way that is unattainable by conducting meta-analyses of previous studies. Schneider (2002) asserts that qualitative investigations of treatment efficacy will “deepen, clarify, and contextualize” (p. 26) prior findings that there are few outcome differences across varying forms of psychotherapy.

The common factors debate also exists within the couple and family therapy literature. Sexton, Ridley, and Kleiner (2004) agree with the common criticisms of the common factors approach to psychotherapy in that they believe that it simplifies a complex change process that occurs in the therapeutic process, and that there is no concrete theoretical explanation underlying the idea of common factors. They believe that common factors are an important piece of understanding a much larger change process that occurs in the context of couple and family therapy, but that examining common factors without considering the overall mechanisms for change that exist in relational therapy does not accurately reflect the complexity that is associated with client change as the result of therapy. These authors claim that although common factors are necessary for positive therapeutic outcomes, they are not sufficient for producing these outcomes. Rather, they propose that the field of CFT embrace a more complex and theoretical view of change processes in therapy that accounts for the unique interaction between client and therapist variables. Making the distinction between factors and process is a key element in their argument – factors are static characteristics, meaning that they stay the same, whereas processes are dynamic, meaning they are constantly evolving. For example, common factors are commonly investigated as specific characteristics associated with the therapist such as the degree to which they offer their clients empathy. These characterizations do not provide insight on the processes through which therapists offer this empathy and the ways in which

empathy is helpful in facilitating positive therapeutic change. Given that therapy is an evolving process between clients and therapists Sexton et al. (2004) advocate that more complex conceptualizations of change in therapy are more useful than the examination of simple characteristics associated with treatment.

Sexton and Ridley (2004) argue that much of the evidence supporting the need for an examination of common factors comes from the individual psychotherapy literature, and they make the claim that CFT is qualitatively different from individual psychotherapy in that models of CFT conceptualize change in relational, rather than individual, ways. They also highlight that much of the data on common factors and their relation to treatment outcome come from meta-analyses and are dated. Similarly to Sexton et al. (2004), they recognize the importance of common factors, but instead they believe that a more complex consideration of the mechanisms underlying relational change is critical in understanding why and how therapy works for couples and families.

In contrast to Sexton and Ridley (2004), Sprenkle and Blow (2004b) believe that common factors can be mechanisms through which change processes occur in therapy, and they do not concur with the notion that there are salient differences between common factors and common change mechanisms. In contrast to the argument that common factors conceptualizations of how therapy produces positive outcomes are atheoretical, Sprenkle and Blow (2004a, 2004b) and Blow et al. (2007) believe that models of CFT are necessary for change. However, they state that they believe that change often results from these different approaches because their techniques facilitate the delivery of common factors in CFT that influence common processes in couple functioning. A key to such a view will be identifying common change processes that are elicited by a variety of CFT models.

The present study examined the relations between specific client common factors characteristics and couple therapy outcomes. The study also examined the relations between therapist behaviors that fit into the category of common factors and treatment outcomes. This study is unique in that it also examined the moderating influence that therapist common factor behaviors may have on the relations between specific client characteristics and therapy outcomes. Furthermore, in addition to being guided by the previous literature on couple therapy outcomes, as well as on common factors influencing psychotherapy and couple therapy outcome, this study was grounded in theory – an all-too-often neglected component of treatment outcome and common factor research.

Common Factors as Predictors of Therapy Success

Philosophical debate aside, common factors are frequently discussed as important agents for therapeutic change and are connected in many studies to therapeutic success for clients. The therapeutic alliance between the therapist and client(s) is certainly the most frequently researched common factor, and most evidence leads to the conclusion that this alliance is a key component in the outcome of therapy, with stronger predictive value than the specific model of therapy used by the therapist (Castonguay & Beutler, 2006; Roth & Fonagy, 1996). The therapeutic alliance is itself a dyadic relationship influenced by both client and therapist factors (Roth & Fonagy, 1996). Although much is known about the association between therapeutic alliance and therapy outcome, the field is in the beginning stages of understanding how and why the therapeutic alliance as well as other common factors have such a salient effect on treatment outcomes, with many making calls to the research community to investigate how these factors influence the course of treatment (Gurman & Kniskern, 1981; Sprenkle et al., 2009).

Other common factors commonly linked to positive treatment outcome in the literature, beyond the therapist-client alliance, include therapist warmth (Green & Herget, 1991; Lambert & Barley, 2001; Strupp et al., 1969), therapist use of empathy (Castonguay & Beutler, 2006; Gaston, 1990; Greenberg et al., 2001; Lambert & Barley, 2001; Orlinsky et al., 1994), therapist collaboration (Bachelor, 1995; Davis & Piercy, 2007b; Tyron & Winograd, 2001), therapist positive regard for the client (Orlinsky et al., 1994), and therapist use of systemic techniques (Blow & Sprenkle, 2001; Davis & Piercy, 2007a, 2007b) as well as session control (Green & Herget, 1991; Gurman & Kniskern, 1981). Each of these factors has been associated with positive therapeutic gains for clients. There are many other studies that have examined common factors more generally and have found that the relationship between the client and the therapist has a significant impact on therapeutic outcomes.

An ethnographic interview study of 12 families consisting of 37 individuals who participated in family therapy found that those clients who perceived their therapist as caring and understanding reported higher levels of satisfaction with their overall treatment (Kuehl, Newfield, & Joanning, 1990). Alexander, Barton, Schiavo, and Parsons (1976) conducted a study to examine the influence that family therapist behaviors and characteristics had on therapy outcome. The study consisted of 21 families who received systems-behavioral therapy with therapists who had been trained in the model. Prior to treatment, a clinical supervisor evaluated the therapists on eight dimensions after observing them throughout the interactive therapy training process. These dimensions included: affect-behavior integration, humor, warmth, directiveness, self-confidence, self-disclosure, blaming, and clarity. The study found that these characteristics accounted for approximately 60% of the variance in treatment outcome. The authors state that at the time of publication of their study (1976) exceptionally little was known

about the contributions of therapist behaviors and characteristics to family therapy outcome; however, they conclude that future research needs to consider therapist variables in treatment outcome studies as they appear to be quite salient to the process and outcome of therapy.

A seminal study, the Penn Psychotherapy Project, of 73 individual clients who presented for treatment for a variety of presenting concerns found that the alliance between the client and the therapist (termed the helping alliance in the authors' paper) was predictive of positive therapy outcome (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). Johnson and Talitman (1997) found that the alliance between client and therapist accounted for 22% of the variance in marital satisfaction post-treatment, and 29% at the three month follow-up. Additionally, those couples who reported higher levels of alliance with their therapists had significantly greater increases in marital satisfaction and intimacy at post-treatment and follow-up. The positive effect of the client-therapist relationship has been continually documented in the psychotherapy literature for several decades.

Given the consistent association between client-therapist relationship and treatment outcomes, some researchers have chosen to examine client characteristics, rather than therapist characteristics, that may account for some of the variation in the formation of the therapeutic alliance or the client-therapist relationship. A clinical study by Bourgeois, Sabourin, and Wright (1990) of 63 couples who participated in nine sessions of group marital therapy found that the couples' pre-therapy levels of distress did not have an influence on the formation of an alliance between therapist and clients. The therapeutic alliance, which was reported by the clients and therapist at the third session, explained five to eight percent of the variance in the outcome measures, including overall relationship satisfaction.

The positive influence of common factors on treatment outcome is not, however, found in all studies. One study of 32 couples found that the more that therapists utilizing behavioral marital therapy (BMT) structured the therapy session, the poorer outcome the couples exhibited with regard to post-treatment relationship satisfaction (Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989). Furthermore, therapist collaboration was not predictive of couple outcomes; however, the authors cite that this finding may have been due to a methodological error. This study also found that clients who were engaged in the therapy process had better treatment outcomes, but did not find that therapist nurturance was predictive of therapy outcome. The authors note the possibility of methodological errors when discussing their findings, but studies such as this one have contributed to the rather ubiquitous philosophical debate on the importance and utility of understanding the mechanisms through which common factors influence psychotherapy, as discussed in the previous section of this literature review.

The Application of a Common Factors Approach to Couple Therapy

Identifying and defining common factors in couple therapy. Much of the literature on common factors, especially in the field of couple and family therapy, has been dedicated to articulating exactly what common factors are. The study of common factors in couple and family therapy emerged in the 1980s with the operationalization of therapeutic alliance as it applied to couple and family therapy. Bordin's (1979) model of therapeutic alliance stated that there were three dimensions of the alliance: tasks (agreement between therapist and clients on the tasks associated with therapy such as how the client and therapist will engage in specific therapeutic processes including empathy and communication), goals (agreement between therapist and clients on the goals of therapy such as utilizing therapy to eliminate a specific maladaptive client behavior), and bonds (a sense of connection between the client and the therapist). Pinsoff and

Catherall (1986) developed the integrative psychotherapy alliance (IPA) model to expand concepts of therapeutic alliance to couple and family therapy. One of the components of their model, labeled 'content,' is composed of three of Bordin's (1979) conceptualizations of client-therapist alliance: tasks (client-therapist agreement on specific therapeutic tasks), goals (client-therapist agreement on therapy goals), and bonds (client-therapist connection) (as summarized by Pinsof, Zinbarg, & Knobloch-Fedders, 2008). In addition, they expanded on these categorizations by adding the interpersonal system domain that includes four characterizations of alliance relationships: 1) self-therapist (alliance between the client and the therapist), 2) other-therapist (alliance between the therapist and other important people in the client's life), 3) group-therapist (alliance between the therapist and the group involved in therapy), and 4) within-system (alliance between the client and those people important to him or her) (as summarized by Pinsof, Zinbarg, and Knobloch-Fedders, 2008). This categorization is important given that it identifies the complexity of the various mechanisms that influence, and are influenced by, common factors in couple therapy.

In an attempt to identify common and unique factors between two well-studied and frequently taught models of family therapy, Friedlander, Ellis, Raymond, Siegel, and Milford (1987) extensively examined six therapy tapes from founders of two major models. Structural therapy, practiced by Salvador Minuchin, and experiential therapy, practiced by Carl Whitaker, were compared because they differ philosophically in many ways. After coding the practitioners' therapy tapes, the authors concluded that there were few meaningful clinical differences between the work of Minuchin and the work of Whitaker with regard to how much each therapist spoke in session; the amount of encouragement, reassurance, and reflection given to clients by each therapist; and the focus of therapeutic discussion. The therapists differed slightly in that

Whitaker used higher levels of self-disclosure, sought more information from clients during session, and focused on past family events to a greater extent than did Minuchin. Minuchin, on the other hand, utilized higher levels of confrontation with clients and offered them more advice. The findings of this study continue to be important today because they highlight that couple and family therapists, even those who are using supposedly unique models, employ similar intervention strategies with their clients. Subsequent to findings of the Friedlander et al. (1987) study, couple and family therapy researchers have called for increased understanding of common mechanisms of change across treatment models.

Gurman (1981), approaching the concept of therapeutic alliance as an aspect of the process of couple therapy, identified three types of alliances involved in couple therapy: 1) the alliance between the therapist and each member of the couple; 2) the alliance between the therapist and the couple; and 3) the alliance between the two members of the couple. Lebow (1997) notes that couple and family therapy has moved toward integrative practice, not only through the combining of techniques from multiple models, but also by those in the field beginning to accept a common language. “Therapeutic alliance” is one term that he says is now commonly used by those who practice and research many different therapeutic models, indicating broad acknowledgement in the field of its universal importance to couple and family therapy.

A resurgence in the interest in common factors as they relate to couple therapy seems to be emerging in the contemporary CFT literature. In a continued attempt to articulate common factors as they relate to CFT, recent studies have been conducted to more clearly define what the common factors are in the process of couple and family therapy. For example, Davis and Piercy (2007a, 2007b) conducted a qualitative study involving semi-structured interviews with three

prominent couple and family therapy model developers, their clinical students, and their clients, in order to define common factors across the models. The findings revealed that common factors fit into two broad categories: model-dependent common factors, and model-independent common factors, in keeping with the notion that the scope of common factors can be conceptualized in a narrow or a broad way. The model-dependent common factors were commonalities in components shared by all three therapy models (narrow conceptualization of common factors), whereas the model-independent common factors were common elements of therapy that were not directly associated with a specific therapeutic model (broad conceptualization of common factors). The model-dependent common factors that were shared by the three models included therapists conceptualizing their cases based on the influence of family of origin on their clients' presenting problems and on their clients' current behavioral, cognitive, and emotive processes. The study found that the therapists' case conceptualizations were largely dependent upon their therapeutic models, but that there was overlap among the models in that in all of the models the therapists considered how family of origin experiences influenced each person's current patterns of interaction with his or her partner. The therapists' interventions also overlapped quite a bit across models in that the therapists paid attention to the partners' dyadic interaction cycles, noted each client's role in relational cycles, attempted to modify the cycles, and used metaphors to increase clients' awareness of their relational cycles (e.g., describing members of a couple as being like "tanks shooting at each other" (Davis & Piercy, 2007a, p. 331) across the three models of therapy investigated. Common outcomes reported by clients were that they believed they "softened" as the result of therapy and were slower to lose control over their behaviors and emotions than they were prior to participation in treatment. Additionally, couples reported that they were better able to give each other personal

space in that they were less controlling of each other as the result of therapy (Davis & Piercy, 2007a). These findings all reflected common techniques and outcomes associated with several different models of couple therapy – namely emotionally-focused therapy, cognitive-behavioral therapy, and internal family systems therapy -- and they support the need for a narrow conceptualization of common factors in that they demonstrate the commonalities among specific treatment approaches and techniques *across* various treatment models.

The model-independent factors, factors that are not specifically associated with the concepts and methods of a therapy model, that were found in the study included therapist factors, client factors, therapeutic alliance factors, therapy process factors, and expectancy/motivational factors. The therapist factors that were noted were therapist patience, expression of caring while maintaining professional boundaries, and expression of respect for the clients' culture. The client factors included accepting ownership of their roles in the problem, dedication to treatment and hard work, and an awareness of the systemic nature of problems. The therapeutic alliance factors included the therapist serving as a model for the couples' relationships and mutual respect and trust between clients and therapists. The factors that fell under the umbrella of therapy process variables included the therapist's ability to structure some parts of sessions while not being overly rigid, the therapist maintaining a neutral stance and not taking sides with clients, collaboration between therapists and clients, and the therapist and client establishing a level of safety in their relationship (Davis & Piercy, 2007b). Clearly, these findings support the necessity of a broad conceptualization of common factors in addition to a narrow conceptualization, because these are factors that are common to all models of treatment, not just similar ways of implementing particular types of therapeutic interventions in different therapy models.

Other researchers have conducted interviews with seasoned couple and family therapists in order to identify the common factors that exist in the CFT field. Blow and Sprenkle (2001) interviewed experienced CFT clinicians with regard to what the clinicians believed were the common factors attributable to both the client and to the therapist that are involved in producing therapeutic change. The findings of the study revealed that CFT clinicians believe that therapist factors are more important than client factors in producing change. The interviewed clinicians focused on factors such as creating a positive therapist-client relationship and offering systemically oriented therapy by incorporating client collaboration as an important component of that relationship. The categories of common factors that were revealed by the study served, in large part, as the basis for the development of the therapeutic relationship factors and technique factors components of the set of general therapist clinical skills and qualities factors that were investigated in the present study (see Chapter 3 for details).

The relevance and importance of articulating both what common factors are and understanding how they facilitate meaningful therapeutic change for couples is evidenced by the fact that a small study was published recently in one of the field's leading journals, *The Journal of Marital and Family Therapy*, that focused on the course of therapy with just one distressed couple (Blow et al., 2009). In order to obtain an in-depth perspective on the role that common factors play in the process of therapeutic change, the study investigated the process of change throughout therapy for that one distressed couple by collecting both quantitative and qualitative data. The quantitative data collection involved assessing demographic information, client relationship satisfaction, client major life events, client and therapist therapy session ratings, and videotaping of each of 15 therapy sessions. The qualitative data collection involved treatment follow-up interviews with the couple and the therapist specifically aimed at understanding the

process of change. Five research team members independently coded session videotapes and then re-watched each session tape together and discussed themes as a group. As a result of their group discussions, as well as the client and therapist interviews regarding the process of change throughout therapy, the authors concluded that the couple did change during the course of therapy, and that much of this change was attributable to extra-therapeutic events that were outside the control of the therapist's behaviors, therapeutic model and techniques, and the therapeutic environment. In the case of this specific couple, the extra-therapeutic events that influenced their change process included the fear of cancer for the female partner and the loss of a job and a jail sentence for the male partner. The client-therapist alliance was also found to influence change in therapy. Alliance factors that were reported included the therapist's validation of each member of the couple. Other therapist factors that were associated with therapeutic change include the therapist's genuineness with the clients and the therapist's creation of an environment in which the clients could remain engaged with their process of change. The degree to which clients and therapists *hoped* therapy would be helpful to the clients as well as the degree to which the clients and therapists *expected* therapy to be helpful to the clients also influenced the client's change process.

Unique challenges faced by couple and family therapists when considering common factors. There are several qualities of couple therapy that make it quite distinct from other forms of psychotherapy. Most obviously, couple therapists work with more than one client simultaneously. Frequently, these clients are at odds with each other. Given that the therapeutic alliance is regarded as one the most influential common factors in individual psychotherapy (Sprenkle, Davis, & Blow, 2009), couple therapists are faced with the challenge of forming this alliance with more than one client, and doing so with partners who likely are experiencing high

levels of distress and disagreement. Due to these unique characteristics of couple therapy, researchers interested in the influence of common factors in work with couples have articulated common factors that are specific to couple and family therapy.

Sprenkle et al. (2009) and Sprenkle, et al. (1999) outline four common factors that are distinct to couple and family therapy: “1) conceptualizing difficulties in relational terms, 2) disrupting dysfunctional relational patterns, 3) expanding the direct treatment system, and 4) expanding the therapeutic alliance” (Sprenkle et al., 2009, p. 34). Sprenkle et al. (1999) also state that privileging client experiences by considering the client’s perspective and ideas about his or her problems is a common factor that is not unique to CFT but is of critical importance and is often emphasized in CFT models. Conceptualizing difficulties in relational terms means that couple and family therapists examine client difficulties as they exist within a relationship system rather than within an individual client. This contrasts with the common medical model view of psychological distress in which client difficulties are believed to be caused by factors specific to and within an individual client (Sprenkle et al., 2009). In keeping with Davis and Piercy’s (2007a, 2007b) findings, couple therapists identify cycles in couple relationships and work to disrupt those patterns that are destructive to the couple relationship, thus making this another therapist common factor unique to CFT (Sprenkle et al., 2009). Couple therapy includes two clients in each therapy session, thus requiring that therapists form a therapeutic alliance with both clients and at the same time assess both members’ contributions to relational cycles (Sprenkle et al., 2009).

Empirical support for the investigation of common factors in CFT. Given the recent consideration of common factors as they relate to couple therapy, Christensen, Doss, and Atkins (2005) address concerns about what kind of empirical information couple therapy researchers

should be trying to obtain regarding what works for couples in therapy. They first review evidence for empirically supported treatments; however, they dismiss focused study of them, stating that it is too difficult to study empirically how an entire therapeutic model works with varying populations. They then note that it has been common to study how the client-therapist relationship influences the course of therapy, but they dismiss this as a potential future focus of empirical work given that they find its study too broad and not particularly useful. They conclude that the direction researchers should take in empirically studying therapy is to examine specific principles of change in therapy. These principles of change include how client characteristics, the type of treatment, and the therapist actions and behaviors interact to influence the course of treatment. The authors state that specific focus should be given to the therapist behaviors that influence client outcomes in future research.

Most empirical literature to date, however, has not focused on general therapist behaviors as they relate to couple therapy outcome. Rather, following the common factors literature in general psychotherapy research, couple and family therapy research investigating common factors as they influence couple therapy outcome has focused on the client-therapist relationship. Numerous studies have found a significant relationship between the therapeutic alliance and couple therapy outcome.

Pinsof, Zinbarg, and Knobloch-Fedders (2008) conducted a study with 80 couples to investigate the relationship between alliance and couple therapy outcome. Total alliance scores for male partners at session one were predictive of improvements in communication and problem solving at the conclusion of treatment. For female partners, other-therapist alliance and within-system alliance at session one were predictive of improvements in individual well-being. Total

alliance scores at session eight were positively associated with changes in communication post-treatment.

A study of 17 couples who received therapy for a variety of relationship concerns (Quinn, Dotson, & Jordan, 1997) found that when female partners reported higher levels of alliance to the couple's therapist the couple reported better treatment outcomes in terms of meeting the goals of therapy and believing that the changes would persist for an extended period of time. Furthermore, if the female partner reported that she believed her partner had a strong alliance with the therapist, treatment outcomes were higher. These findings highlight the varying treatment alliances that exist within the couple therapy treatment system (Gurman, 1981; Pinsof & Catherall, 1986) and point to the influence that perception of therapeutic alliance may also have in treatment outcomes for couples.

Johnson and Talitman's (1997) study of the effectiveness of emotionally-focused therapy (EFT) for couples in which 34 couples received 12 sessions of therapy revealed that 22% of the variance in relationship satisfaction post-treatment was accounted for by the therapeutic alliance. A study of 40 males and 40 females (35 couples, and 10 individuals whose partners were missing data) who received integrative problem-centered therapy (IPCT; Pinsof, 1995), revealed that the client-therapist alliance, while not predictive of outcome in individual functioning, was predictive of 5-22% of the variance in marital distress post-treatment. The study found that the alliance formed between the clients and their therapists during the first therapy session remained fairly stable by the eighth therapy session. When male partners reported higher levels of alliance with the therapist at session eight, the couple experienced increased improvement in marital distress post-treatment, and when female partners reported that their male partners had a strong

alliance with their therapist, the outcomes in marital distress were more favorable (Knobloch-Fedders, Pinsof, & Mann, 2007).

Anderson and Johnson's (2010) study examined the associations between both the client-therapist alliance ("between alliance") and partners' alliance to each other ("within alliance") and relational and psychological distress at therapy session four among a sample of 173 couples who presented to treatment at university-based clinics. They found that the female partner's own between alliance was associated with her own lower levels of psychological distress at session four. When male partners had better between alliances with the therapist, females reported higher levels of psychological distress at session four, but when male partners had better within alliances, the females reported lower levels of psychological distress at session four. In terms of alliance predicting relational distress, higher levels of male and female within alliance, or the alliance with each other, were predictive of less relationship distress when controlling for each partner's pre-treatment level of distress. These authors concluded that different alliances may be more helpful for individual distress and relational distress. They also highlighted the importance of the two partners' alliance to one another, not the client-therapist alliance, when considering how alliances influence the course of couple therapy.

Anker, Owen, Duncan, and Sparks (2010) also examine how both the male and female alliances with the therapist predicted therapeutic outcome among a sample of 250 couples. They found that men's alliance at the last session was more predictive of therapy outcome than their alliance at other sessions. Women's alliance at the third session, however, was a stronger predictor of long-term therapy outcome. Anker et al. (2010) suggest that therapists pay particular attention to men's connection to therapy, and they note that the client-therapist alliance with the male partner may be more predictive of positive outcomes when therapy is short-term whereas

the therapist-female alliance may be more important in predicting positive outcomes for longer-term therapy.

Studies have also been conducted to see how the therapeutic alliance influences treatment outcomes for couples presenting for treatment with specific presenting concerns. When investigating specific populations of couples, the influence of therapeutic alliance on treatment outcome appears to become more complex, perhaps revealing important dynamics between client characteristics and therapist characteristics. For example, a study of 66 couples who received treatment for alcoholism revealed that therapists with more experience (range of experience from one to 15 years) were observed to employ higher levels of positive alliance behaviors and lower levels of negative alliance behaviors. This association, however, did not predict treatment outcome either in terms of reductions in substance abuse or increases in marital happiness. Higher levels of alliance were, however, associated with increased attendance at therapy sessions and higher rates of therapy completion (Raytek, McGrady, Epstein, & Hirsch, 1999).

Similarly complex findings resulted from a study of 70 heterosexual couples in which the male partner engaged in physical aggression toward the female partner, and who received 14 sessions of group couple therapy. The results indicated that the male's therapeutic alliance at session one was predictive of successful treatment outcome, in that those husbands who were observed to have a greater therapeutic alliance perpetrated lower levels of physical and psychological violence toward their wives post-treatment. Wives' alliances were not predictive of therapy outcome; however, husband and wife alliances were significantly correlated (Brown & O'Leary, 2000).

Just as studies have investigated how pre-treatment levels of distress influence couple therapy outcome (Johnson & Lebow, 2000; Johnson & Talitman, 1997; Snyder, Mangrum, &

Wills, 1993; Whisman & Jacobsen, 1990), studies have also examined how pre-treatment levels of distress influence the formation of the therapeutic alliance. An investigation of factors that influence the formation of therapeutic alliance in couples found that among a sample of 79 couples, marital adjustment (as measured by the Dyadic Adjustment Scale; Spanier, 1976) was predictive of alliance formation, in that couples with higher levels of distress reported lower levels of alliance, but that psychiatric symptoms (including anxiety and depression) were not predictive of alliance formation (Mamodhousen, Wright, Tremblay, & Poitras-Wright, 2005).

Given the likely important, and clearly complex, nature of the therapeutic alliance as it exists in couple therapy, Gurman (2002) recommends that couple therapists spend significant time and energy in the beginning of a couple's treatment developing an alliance with each partner and with the couple as a unit. Couple therapy sessions often involve more overt conflict than individual psychotherapy sessions. Because of this, therapists working with couples have to balance alliances with clients who are at odds with each other. This means that couple therapists often have to find different strategies than the individual psychotherapist to find useful ways to form an alliance with each member of the couple (Rait, 2000).

Therapist and Client Common Factors that Influence the Course of Therapy

Beutler (1997) stated that psychotherapy studies and literature published during the 1990s abandoned the study of therapist and client common factors that influence the course of treatment in favor of randomized controlled trials that compare different treatments with each other without considering those types of common factors. He believes this redirection to be misguided, given that there is evidence that therapist and client factors influence the course of treatment. He notes, however, that the study of therapist and client factors can be particularly challenging because it is difficult to define or operationalize many of these characteristics.

Although their study presents challenges, there is both a history and resurgence in the study of common factors, including global characteristics that clients bring to therapy, therapist common factors behaviors, and qualities of the therapeutic setting as they influence the course of treatment. Guided by the literature that will be reviewed in this section, the proposed study investigates the degree to which client common factor characteristics pre-treatment and therapist common factor behaviors during treatment influence couple therapy outcome. The client common factors considered include negative communication and negative attributions. Negative communication is a behavioral common factor clients may bring to treatment, whereas negative attributions are a cognitive common factor clients may bring to treatment. The therapist common factors considered include relationship factors and technique factors employed by the therapist during a session about halfway through the course of conjoint couple treatment. The empirical status of each of these common factors in the current literature is examined in this section.

Client common factors. Despite a fairly convincing literature base indicating that couple therapy is effective for a large percentage of couples who seek treatment for relationship distress, less is known about the client common factors that influence the course of treatment (Sprenkle, 2002). Many studies have investigated client factors that may influence treatment outcomes. There is little consensus in the literature, however, regarding if, and which, client factors influence treatment outcome.

It is well documented in the general psychotherapy literature (primarily evaluations of individual therapies) that those clients who suffer from higher levels of psychological distress make fewer positive gains as the result of treatment (Luborsky et al., 1993). In the literature specific to couple therapy, a frequently investigated predictor of client outcome is the initial level of couple distress. Given what is known about psychotherapy in general, most couple therapy

researchers have predicted that those couples who experience higher levels of distress at the beginning of treatment will experience fewer positive outcomes as the result of treatment (Castonguay & Beutler, 2006). In their decade review, Johnson and Lebow (2000) point to earlier findings by Whisman and Jacobsen (1990) in which 46% of the variance in couple therapy outcome was accounted for by the couples' initial levels of distress. They contrast this with Johnson and Talitman's (1997) finding that only 12% of the variance in post-treatment outcome was accounted for by client initial level of distress, and that this variance was reduced to 4% at the three month follow-up.

In keeping with the common hypothesis that initial distress levels will influence the course of treatment, a four-year follow-up to a clinical study comparing the effectiveness of behavioral and insight-oriented couple treatment approaches for 59 distressed couples found that partners' higher pre-treatment levels of negative affect about each other were associated with higher levels of relationship distress and divorce at the follow-up (Snyder, Mangrum, & Wills, 1993). Johnson and Talitman (1997) found a weaker than expected association between initial level of couple distress and treatment outcome; however, their study revealed other more powerful predictors of treatment outcome. They found that the female partner's level of belief and trust in her partner significantly predicted relationship satisfaction at a three-month follow-up (Johnson & Talitman, 1997).

Other studies have found results that conflict with the expectation that couples who present for treatment with higher levels of distress will have poorer treatment outcomes. A study by Hahlweg, Schindler, Revenstorf, and Brengelmann (1984) of 85 distressed couples found that, contrary to the authors' hypothesis, those couples who had higher levels of negative communication behaviors pre-treatment actually had better treatment outcomes in terms of

relationship happiness than those couples who reported lower levels of negative communication behavior. Whisman, McKelvie, and Chatav (2005), after reviewing predictors of couple therapy outcome in the literature, concluded that there are no couple characteristics that are consistently predictive of couple therapy outcome.

Overall, the literature suggests that what clients bring to therapy can influence the course of treatment. However, no consistent relation has been found between these client factors and therapeutic outcome. The present study examines the relations between couple characteristics at the outset of treatment and their treatment outcome. Specifically, the degree to which couples engage in negative communication behaviors and the degree to which each member makes negative attributions about each other pre-treatment will be examined as potential predictors of smaller improvements in relationship satisfaction and levels of psychological abuse from pre-treatment to post-treatment. The following are brief overviews of couples' negative communication behaviors and negative attributions as client common factors that may influence the process and outcome of couple therapy.

Negative couple communication. Epstein and Baucom (2002), in their review of empirical findings, state that most couples who seek treatment experience high levels of negative communication in their relationships, and that this negative communication needs to be addressed by couple therapists early in the therapeutic process. Consistent with this, Bornstein and Bornstein (1986) state that communication difficulties are one of the primary reasons couple seek therapy, with approximately 90% of couples reporting communication difficulties at the beginning of treatment. There is clear consensus that one of the primary complaints among distressed couples is communication problems (deficits in clear, constructive messages and excesses of aversive messages). Furthermore, distressed couples are more likely than non-

distressed couples to interpret their partner's comments as negative (Gottman et al., 1976). These findings illuminate two processes that exist within distressed couple relationships: 1) couples who are distressed engage in more negative communication behaviors; and 2) couples who are experiencing relationship distress are more likely to perceive their partner's remarks and actions as negative.

Negative attributions. A second type of common factor involving a characteristic that members of couples may bring to their couple therapy experience and that has the potential to interfere with progress in therapy is negative attributions they make about their partner. Attributions are inferences that people naturally make about determinants of events that they observe in their environment. In interpersonal relationships, individuals commonly make attributions regarding causes of others' actions toward them. Negative attributions that a person makes about his or her partner's actions involve inferences about the partner having malevolent intentions or other negative motives and traits. Those who believe that their partners have ill will toward them perceive their partner's acts more negatively than those who believe that their mates have good intentions (Vanzetti, Notarius, & NeeSmith, 1992).

Members of distressed couples are more likely than members of nondistressed relationships to make negative attributions about their partners and the causes of relationship problems (Bradbury & Fincham, 1990; Gottman, 1998). These negative attributions include placing blame on each other for negative exchanges and relationship problems. Prior studies have indicated that an individual's negative attributions frequently influence their behavior toward their partner, in that those who have more negative attributions about their partners behave more negatively toward them (Epstein & Baucom, 2002). Studies have indicated that an individual's negative attributions regarding a partner's behavior predict the individual's

subsequent negative communication toward the partner (Bradbury & Fincham, 1992; Sanford, 2006).

Therapist common factors. Since Rosenzweig's (1936) assertion that therapy generally tends to lead to positive client outcomes regardless of the specific therapeutic model employed by the therapist, clinicians in most psychotherapy disciplines have investigated the validity of the assumption that there are common mechanisms across therapeutic disciplines and treatment approaches that influence client changes in the therapeutic process. Much of this common factors literature has focused on therapist common factors, particularly the importance and utility of a strong healing relationship between the client and the therapist. Hubble, Duncan, and Miller (1999) state that "the therapeutic relationship lies at the very heart of psychotherapy" (p. 14). In fact, entire models of therapy have been developed on the notion that the relationship between the therapist and client is the most important aspect required for therapeutic change. Carl Rogers (1957), the founder of client-centered therapy, asserted that a therapist's positive regard for his or her client(s), empathy, and congruence were necessary and sufficient factors for positive therapeutic outcomes. These ideas are not different from many contemporary theorists' thoughts regarding the necessary and important components of therapeutic change. There is considerable empirical support regarding the importance of therapist behaviors and the client-therapist relationship in the psychotherapy literature, and it is not specific to any one model of therapy. Consequently, many researchers have called for further investigation of therapist common factors as they relate to psychotherapy outcomes.

More contemporary reviews have echoed this sentiment. Wampold (2001) after reviewing psychotherapy outcome research for effectiveness, states, "a preponderance of evidence indicates that there are large therapists effects . . . and that the effects greatly exceed

treatment effects” (p. 200). Expanding on this notion of the importance of continuing the investigation of common factors, Messer and Wampold (2002) state that the evidence supporting the utility of common factors far exceeds the evidence supporting the effectiveness of specific therapeutic techniques or models. They propose that psychotherapy research limit its continued investigation of empirically supported treatments (ESTs) in favor of examining the processes through which common factors and therapist effects influence the outcome of treatment.

Earlier reviews also point to the relevance of therapist common factors for positive treatment outcomes. In their extensive review of treatment outcome and therapy process studies, Orlinsky, Grawe, and Parks (1994) found that a therapist’s degree of empathy, level of focus on the client’s presenting problem, positive regard toward the client, and affirmation of the client were positively correlated with positive therapeutic outcomes. The present study investigates two broad categories of therapist common factors: relationship factors and technique factors. Literature on each of these is reviewed in the following section.

Therapist-client relationship/Therapeutic alliance. Further support for the magnitude of influence that common factors have on therapy outcome comes from Lambert and Barley’s (2001) review of psychotherapy outcome literature. The authors concluded that “decades of research indicate that the provision of therapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship” (p. 357). They cite that common factors, including the client-therapist relationship, accounted for approximately 30% of client improvement throughout the process of therapy, whereas specific therapeutic techniques accounted for only 15% of client improvement as the result of participation in psychotherapy. These findings are consistent with Lambert’s earlier (1992) review.

Given the consistent findings that common factors play a significant role in therapeutic outcomes, the Division of Psychotherapy Task Force on Empirically Supported Therapy Relationships (Division 29 Task Force) was formed by the American Psychological Association (APA) to further investigate these common factors. Norcross (2001), in his introduction to the goals of the Division 29 Task Force, states that most studies designed to evaluate the effectiveness of psychotherapy techniques and models attempt to control for or ignore individual therapist effects, client-therapist relationship factors, or non-diagnostic client characteristics, despite the fact that there is considerable evidence that therapist effects, client-therapist relationship, and client characteristics significantly contribute to therapeutic outcomes. Norcross states that he urged the APA to form a task force to investigate the therapeutic relationship as it influences therapeutic outcome, adapting the definition of psychotherapy relationship from Gelso and Carter (1985, 1994) so that “the relationship is the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed” (Norcross, 2001, p.348).

The efforts of the APA Division 29 Task Force consistently found that the therapeutic alliance, empathy, goal consensus, and collaboration had effects on treatment outcomes. Therapist positive regard for clients was also found to have promising implications for treatment effects (Ackerman et al., 2001). These findings must be considered, given that the most commonly investigated common factors in the psychotherapy literature include therapist empathy, warmth, congruence, and the therapeutic alliance (Lambert & Barley, 2001); thus, much more is known about the influence of these factors than others.

The Division 29 Task Force drew a number of conclusions about the relationship between the client-therapist relationship and therapeutic outcome. First, and perhaps most

importantly, they concluded that “the therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of specific type of treatment” (Ackerman et al. 2001, p. 495). They also found that client characteristics, the therapeutic relationship, and therapist characteristics all interact to influence the outcome of psychotherapy. They suggest that researchers and clinicians recognize the therapeutic relationship as an important component of the work they do.

Several meta-analyses have examined the influence of the client-therapist relationship on psychotherapy outcome. One such analysis of 24 psychotherapy outcome studies conducted between 1978 and 1990 found a statistically significant effect size of .26 between client-therapist alliance and treatment outcome (Horvath & Symonds, 1991). A more recent meta-analysis of 79 psychotherapy outcome studies (58 published studies) conducted between 1977 and 1997 found a moderate relationship ($r = .22$) between client-therapist alliance and treatment outcome (Martin, Garske, & Davis, 2000).

In a review of therapist variables that contribute to therapy outcome, Beutler, Machado, and Neufeldt (1994) state that there is an important and well-documented association between therapeutic alliance and therapy outcome. Pinsof (1995), in his detailed description of integrative problem-centered therapy, highlights the importance of the therapeutic alliance in the process of therapy. He says, “maintaining the alliance between the therapist and the patient system takes priority over principles of application” (p. 61).

The terms therapeutic relationship and therapeutic alliance tend to be used interchangeably in the literature; however, some authors have made distinctions between the two. According to Pinsof and Catherall (1986), the therapist-client relationship refers to the thoughts, feelings, and responses that a therapist and client have about each other or give to each other.

The therapeutic alliance, however, is composed of the “clinically relevant” components of the therapist-client relationship (Pinsof, 1995, p. 61). More specifically, the therapeutic alliance “consists of those aspects of the relationship between and within the therapist and patient systems that pertain to their capacity to mutually invest in and collaborate on the tasks and goals of therapy” (Pinsof, 1994, p. 176). Beutler et al. (1994) encourage readers to conceptualize the therapeutic alliance not as a static entity that some therapists have and others do not, but as something that is formed via a process between the client and the therapist. Given that not all literature reports the distinction between the therapeutic relationship and the therapeutic alliance, the terms are used interchangeably throughout this paper.

An important consideration regarding therapeutic alliance when working with couples is the possibility that a split alliance may form. A split alliance refers to the alliance patterns in which the relationship between the therapist and one client is different than it is between the therapist and another client (Pinsof, 1995). It is possible for a split alliance to occur in individual therapy if the relationship between the therapist and competing parts or interests of the client differ, but there are far more opportunities for a split alliance to occur when working with multiple clients, such as members of a couple (Pinsof, 1995).

Therapist warmth. In addition to the client-therapist relationship, therapist warmth is commonly reported to be an important common factor in the psychotherapy literature (Lambert & Barley, 2001), and higher levels of warmth are associated with more positive therapeutic outcomes. An early examination of the effect of warmth on psychotherapy outcome by Strupp, Fox, and Lessler (1969) found that clients who reported success in therapy stated that their therapists were “warm, attentive, interested, understanding, and respectful” (p. 116). In addition to the association between positive therapeutic outcome and therapist warmth as reported by the

client, positive effects of therapists' warmth have also been reported from studies in which an observer of the therapy rates the therapist level of warmth. A small study of 11 clients (Green & Herget, 1991) found that those clients who received treatment from a therapist who was rated as warm by a clinical evaluator had better global improvement in terms of their presenting problem, and reported reaching their therapeutic goals upon assessment at one month following treatment termination, and that these effects were maintained at a three year follow-up assessment. It has been suggested that warmth facilitates positive therapeutic change in that when therapists offer warmth to clients it sends clients the message that their feelings are important, thus validating their emotions and experiences (Greenberg & Paivio, 1997).

Therapist empathy. Therapist empathy is another one of the most commonly examined therapist common factors (Lambert & Barley, 2001). Gaston (1990) states that the therapist's empathic understanding of the client is an important component of the therapeutic alliance. Empathy is consistently linked to positive client therapeutic outcomes (Castonguay & Beutler, 2006; Greenberg, Elliot, Watson, & Bohart, 2001; Orlinsky et al., 1994). A qualitative study on clients' perceptions of the therapeutic alliance found that 46% of the 61 clients interviewed described the alliance in terms of the nurturance offered to the client from the therapist. Clients described these relationships as trusting when the therapist offered the client empathy (Bachelor, 1995). Given the extent to which empathy has been studied in the psychotherapy literature, many authors have posited reasons for how and why empathy facilitates positive therapeutic change.

Some clinicians believe that empathy works by providing clients with a setting in which their own natural ability to heal themselves can be accessed (Boahrt & Tallman, 1999), and that empathy facilitates engagement in this self-healing process (Greenberg et al., 2001). Clients, in their descriptions of trusting therapeutic alliances in which they felt heard, state that this type of

alliance with their therapist made them feel safe enough to disclose important information to their therapist (Bachelor, 1995).

Emotion-focused therapists posit that one of the major tasks associated with treatment is that of the therapist using empathic responses with clients. They believe that empathy provides the client with access to experiencing his or her emotions in ways that will bring about therapeutic change (Greenberg & Paivio, 1997). Therapeutic empathy has also been hypothesized to influence the client's self-relationship in that the use of empathy can facilitate clients taking their own concerns seriously, ultimately leading to more self-acceptance (Bohart & Greenberg, 1997).

Greenberg et al. (2001) posit four explanations for why empathy positively influences treatment outcomes: "1) empathy as a relationship condition; 2) empathy as corrective emotional experience; 3) empathy and cognitive-affective processing; and 4) empathy and the client as active self-healer" (pp. 382-383). The authors believe that empathy encourages the development of a trusting relationship between the therapist and the clients, and that the therapist's efforts to build and maintain this trusting environment through the use of empathy helps clients learn that they are worthy of being treated well. This promotes client active exploration of their presenting concerns, while also allowing clients to cognitively process their experiences in such a way that creates meaningful connections about their feelings and experiences regarding their presenting concerns. Finally, the authors believe that empathy encourages a client's willingness to be open to therapeutic intervention.

Collaboration. Collaboration between the therapist and the client is also a therapist driven common factor believed to facilitate positive client therapeutic outcomes. Tryon and Winograd's (2001) review of literature found that when clients and therapists agree about the

treatment goals and work together toward these goals, clients have better therapeutic outcomes. A qualitative study by Bachelor (1995) of 61 clients who were asked to define the therapeutic relationship found that 15% of clients stated that the alliance relationship they had with their therapists was defined by the collaborative relationship between the client and the therapist. Clients who discussed this type of alliance recognized that they needed to be active contributors to the therapeutic process, and that together, they could create a space along with their therapist that would be helpful to them. The importance of therapist-client collaboration has also been noted in the couple and family therapy literature in that prominent therapists across varying models of therapeutic practice identify a collaborative relationship as important to positive therapeutic outcomes for clients (Davis & Piercy, 2007b).

Therapist positive regard. The importance of the therapist experiencing positive regard for clients has been highlighted as a key therapist common factor in the literature since the 1950s (Rogers, 1957). Positive regard, or therapist affirmation of the client's worth as a person (investigated as therapist validation in the present study) has been associated with positive therapeutic outcomes for clients in 50% of cases (Orlinsky et al., 1994). In a more recent review of the literature, Farber and Lane (2001) conclude that there are modest positive effects of therapist positive regard on client outcome in that about 50% of the studies they reviewed found a significantly positive association between these two variables.

Systemic techniques and session structure. Although less is known about the influence of therapist systemic techniques and session structure on therapeutic outcomes, both are believed to have important implications for couple therapy outcome. Davis and Piercy (2007a, 2007b) and Blow and Sprenkle (2001) found that conceptualizing couple interactions as circular wherein each partner influences the other is identified by couple and family therapists as a therapeutic

strategy that, in their eyes, facilitates positive changes for clients regardless of the therapeutic model that is being used. Specifically, the therapist noting cyclical patterns in couple interactions and balancing attention in therapy between the partners have been identified as systemic techniques that therapists and clients believe are associated with positive therapeutic outcomes. This highlights that one of the unique qualities of couple and family therapists is their ability to conceptualize client concerns systemically and relationally, independent of the specific model of treatment that they are using.

The ways therapists structure couple therapy sessions to focus on specific therapeutic goals for each partner and the couple as a dyad while controlling conflict and reinforcing positive change have been identified as strategies that allow for positive therapeutic change (Blow & Sprenkle, 2001; Davis & Piercy, 2007b). Gaston (1990) states that therapist and client agreement on the goals and tasks of homework is an important component of forming an effective therapeutic alliance. Gurman and Kniskern (1981) also state that there is evidence supporting the relationship between how couple therapists structure therapy sessions and positive treatment outcomes. Green and Herget (1991) found that among 11 clients who received treatment for a variety of difficulties, those who were treated by therapists who used active structuring during the therapy sessions reported higher levels of goal attainment three years following the termination of treatment. More recent studies have found similar associations between session structure and therapeutic outcomes. A review of therapist behaviors and psychotherapy outcome found that a therapist's structuring of session, including remaining focused on specific interventions, was associated with positive therapeutic outcomes (Castonguay & Beutler, 2006).

Indices of Couple Therapy Outcome

The present study investigated the relations among client common factors that couples bring to treatment, therapist common factors occurring during therapy sessions, and indices of couple therapy outcome. Couple therapy treatment outcome studies typically investigate overall couple relationship satisfaction or relationship adjustment as the primary indicator of treatment success (Fincham & Bradbury, 1987). Although this “gold standard” outcome variable is of critical importance when examining the effectiveness of couple therapy, there are many other variables that are of equivalent importance. Consideration of specific couple circumstances is necessary when determining salient outcome variables of interest. Given that data for the present study were collected from couples who experience mild to moderate levels of abuse in their relationships, psychological abuse also was investigated as an outcome variable in addition to relationship satisfaction.

Relationship Satisfaction

The aim of couple therapy is typically to improve the relationship between partners in order to increase each partner’s satisfaction with the relationship. As such, most, if not all, couple therapy outcome studies examine changes in relationship satisfaction from pre-treatment to post-treatment as the key indicator of therapy success. Relationship satisfaction is a key outcome variable in that it is consistently connected to the partners’ overall relationship functioning (Halford, Markman, Stanley, & Kline, 2002), and as such, it was examined in the present study.

Psychological Abuse

The present study also investigated partners’ levels of psychologically abusive behavior toward each other as a key index of couple therapy outcome because of the prevalence of

psychological abuse in distressed relationships and the considerable evidence that such behavior has pervasive negative effects on partners' individual well-being as well as happiness with their relationship. Specifically, receiving psychological abuse from one's partner increases the likelihood that individuals will experience depression, anxiety, lowered self-esteem, and a variety of other problems in individual functioning (O'Leary, 1999). In addition, psychological abuse leads many individuals to be unhappy with their couple relationship and to consider leaving them (Arias & Pape, 2001; Marshall, 1996). Furthermore, psychological abuse commonly precedes physical abuse (Murphy & O'Leary, 1989; O'Leary, 2001). Given that the sample for the present study presented to treatment with mild to moderate levels of physical and/or psychological abuse in their relationships, the investigation of changes in levels of psychological abuse is key for understanding the outcome of couple therapy with this sample.

Thus, outcomes of couple therapy that were examined in the present study include a subjective global measure of relationship satisfaction and a more specific index of the quality of partners' interactions, in the form of individuals' reports of their partner's specific forms of psychologically abusive behavior. Outcomes were examined in terms of changes on the measures from pre-therapy to post-therapy.

Theoretical Base for the Study

Although common factors conceptualizations and research have been criticized for being atheoretical, this study is grounded within a theoretical framework that provides explanations for why common factors influence psychotherapy outcome. Symbolic Interaction (SI) theory provides this theoretical framework. SI theory is grounded in the idea that people's actions are rooted in how they interpret the events in their lives, and the meanings they attribute to these events (Burr, Leigh, Day, & Constantine, 1979; LaRossa & Reitzes, 1993; White & Klein,

2008). The meanings that individuals assign to events help “them make sense of their world” (White & Klein, 2008, p. 97). These SI assumptions, along with the concepts of socialization, role, definition of the situation, and identity (White & Klein, 2008) guide this study.

Socialization, as defined by SI theory, is the process through which individuals learn the core beliefs of their given culture (White & Klein, 2008) For example, in an individualist society individuals learn to put their needs before others’, whereas in a collectivist society individuals learn to put the needs of the community before their own. Roles, as defined by SI theory, are the normative characteristics and expected behaviors associated with one’s social position (LaRossa & Reitzes, 1993). Identity is the extension of a role, in which an individual assigns ‘self meaning’ to him/herself associated with the learned characteristics associated with the role that he or she occupies (LaRossa & Reitzes, 1993). The meanings that an individual has come to associate with the self and with specific situations or life events are shaped by the person’s interactions with the environment and those in it. According to LaRossa and Reitzes (1993), “individuals are not born with a sense of self but rather develop self concepts through social interaction” (p. 144). For example, a child whose parents consistently neglect to give him/her the emotional attention he/she deserves is more likely to develop a self-concept that he or she is a person who is not worthy of care than a child who receives adequate emotional attention from his/her parents. Both of these children’s development of self concept has been influenced by their environment and is not attributable to an in-born set of characteristics. An individual’s perception of these events, the definition of the situation, has real consequences for subsequent meanings that they assign to it, and how they act in response to it (White & Klein, 2008).

According to SI, the formation of self, and identification with specific roles, is important not only for an individual’s understanding of him or herself, but is also critical to the person’s

understanding and relating to others. For example, how one conceptualizes his or her role in relation to a person who is in a complementary role will influence his or her behavior toward the person in that complementary role. White and Klein (2008) use as an example an article by Stets (1992) on couple dating aggression to exemplify their definition of role within SI theory. Stets (1992) found that an individual's role-taking ability is associated with higher levels of relationship satisfaction and lower levels of negative interactions between partners in couple relationships. This means that members of couples who are better able to understand and put themselves in each other's role will be more likely to have positive sentiments about their relationships and behave more positively toward each other. In this case, this role-taking ability is synonymous with empathy.

SI theory posits that the meaning an individual attributes to a specific life situation or event has influences on his or her life. Further, an individual's perception of a given situation will likely influence his or her behavioral response to the situation. In the therapeutic setting this might mean that a client who perceives his or her therapist as particularly warm will adjust his or her behavior in response to this perception. The meanings that clients attribute to their therapeutic experiences and relationships with their therapists likely have consequences for treatment outcomes. Messer and Wampold (2002), in their commentary on the importance of acknowledging and working with common factors in the psychotherapy context state that, "Therapists should realize that specific ingredients are necessary but active only insofar as they are a component of a larger healing context of therapy. It is the *meaning* that the client gives to the experience of therapy that is important." (p. 24 – emphasis added). Even if a therapist is utilizing a specific technique, intervention, or style that research has shown is associated with

positive therapeutic outcomes, the use of these will make little difference if clients do not interpret or experience the therapy as meaningful to their own lives in some way.

The present study posited that therapists are very important in influencing their clients' constructions of the meaning of therapy and of the therapeutic relationship. For example, a therapist who lacks warmth with his or her clients may send a message to the clients that they are not worthy of receiving the therapist's warmth. This is an example of how a client's self-concept can be shaped by experiences with other people, including therapists whose feedback commonly is taken quite seriously. A therapist can, however, through his or her actions positively influence the meanings that clients give to their therapy experiences. Contrary to the previous example, a therapist who exudes high levels of warmth toward his or her clients sends them the message that their feelings are important, and that their emotions and experiences are worthy of validation (Greenberg & Paivio, 1997). As such, it was hypothesized that clients whose therapists use higher levels of warmth, empathy, presence, validation, and collaboration will have increased improvements in relationship satisfaction and decreased levels of psychological abuse as these therapist processes will influence clients' self and relationship conceptualizations in such a way that they will be better able to handle their couple relationship more effectively.

Similarly, a therapist who has limited ability to control client couples' conflict during sessions might implicitly convey one of two meanings to the clients: 1) the therapist is not skilled enough to control their conflict; or 2) the couple's conflict is uncontrollable. Both of these meanings that the clients might attach to their therapy experience will likely have a detrimental influence on treatment outcome, thus it was hypothesized that clients whose therapists utilize higher levels of systemic techniques and session structuring will obtain more positive therapeutic gains than those clients whose therapists do not utilize these techniques. In addition, when a

therapist exerts sufficient control over partners' aversive interactions with each other during sessions, the couple may interpret this as meaning that there is hope for improving their relationship. Consistent with SI theory, the therapist's behaviors, by influencing the ways that clients view themselves and their relationships, can have consequences for therapy outcomes.

In addition to the therapist's powerful role in influencing the meaning that a client gives to his or her specific situation, and to the overall meaning of the therapeutic experience, the therapist also serves as a model for many couple interactions. Davis and Piercy (2007b) posit that an important component, and clinically relevant aspect, of the therapeutic alliance is that the therapist, and the client's relationship with the therapist, serves as a model for the couple's own relationship. Davis and Piercy term this relationship modeling "isomorphism." Thus, if the therapist provides the clients with warmth, presence, empathy, validation, and collaboration, then each member of the couple will be more able, and more likely, to provide these things to each other. Similarly, if the therapist models how to investigate relationship problems in a systemic way (identifying partners' mutual influences on each other) while also structuring therapy sessions in an organized fashion, the couple will internalize these patterns in their conceptions of their roles as intimate partners and may begin to be able to do these things themselves when faced with disagreement or conflict. SI theory is helpful in understanding these relationships in that the therapist's behavior has influenced the meanings that clients attribute to themselves and to their relationship by serving as a role model of sorts for the couple. In doing so, the clients can then change the meanings that they associate with events in their relationship, and their roles within the relationship. Given that each of the types of therapist behaviors that were examined in this project is also a constructive behavior within the context of couple relationships, couples who can imitate with each other the behaviors that are modeled by their therapists will likely

experience more positive therapeutic outcomes than those clients who were not exposed to these relationship factors.

Gaps in the Literature on Common Factors in Couple Therapy Outcome

There are many gaps in the literature on couple therapy outcome and common factors as they relate to couple therapy. With regard to client characteristics and couple therapy outcome, much remains to be understood about how certain couple characteristics influence the course of treatment. Relatively little is known about what, how, and why therapy is effective (Lebow, 2000; Sprenkle, 2002). The present study was intended to begin to fill these gaps.

Although there is convincing empirical support for the importance of the therapeutic alliance in individual psychotherapy outcome, and an expressed importance that the therapeutic relationship has in most couple and family therapy models, there has been little study of the characteristics of clients and therapists that contribute to effective couple and family therapy (Rait, 2000). The present study contributes to the emerging literature that corrects for the historical neglect of common factors research in CFT (Sprenkle & Blow, 2004a). The study directly uses data from a clinic sample of therapy couples rather than conducting a meta-analysis of multiple studies, and a measure was designed specifically to assess therapist behaviors that fall within the category of documented common factors, which has also been a fairly neglected methodology to date (Blow et al., 2007; Sprenkle et al., 2009). Lastly, the use of observational coding to assess therapist common factor behavior as well as couple characteristics has frequently been neglected in the study of couple therapy due to the time, energy, and additional measurement techniques it takes to do this (Gottman, 1998). The benefit of doing this, however, is that a degree of the depth of understanding that many researchers are calling for (Christensen et al., 2006; Schneider, 2002) may be obtained through this form of quantitative work.

Definitions of Variables

Pre-Treatment Couple Common Factors Characteristics (Independent Variables)

Negative communication behaviors. Amount of negative communication behaviors including conflictual behaviors, invalidating behaviors, and withdrawal behaviors that each member of the couple exhibits during a 10-minute pre-treatment communication sample.

Negative attributions. The degree to which each partner makes negative attributions, or inferences about determinants of the other's actions, about the other partner in the past week (e. g., "when things aren't going well between us I feel like my partner doesn't love me").

Therapist Common Factors Process Variables (Moderator Variables)

Relationship factors. The degree to which the therapists express **warmth, empathy, presence, validation, and collaboration** with the clients during the duration of the 90-minute fourth couple therapy session.

Technique factors. The degree to which the therapists utilize **systemic techniques and structure the session** during the duration of the 90-minute fourth couple therapy session.

Couple Therapy Outcomes (Dependent Variables)

Change in relationship satisfaction. The overall change (difference score between the post-treatment assessment and the pre-treatment assessment) in relationship satisfaction reported by each member of the couple, as measured by the degree of relationship happiness ranging from extremely unhappy to perfect.

Change in levels of psychologically abusive behavior. The overall change (difference score between the post-treatment assessment and the pre-treatment assessment) in the amount of psychologically abusive behavior that each partner enacted toward his/her partner during the past four months.

Research Questions and Hypotheses

This research study will address three broad research questions and examine the corresponding hypotheses:

1. Are pre-treatment couple characteristics related to couple therapy outcome?

Hypothesis 1: The more that couples exhibit negative communication behaviors pre-treatment, the less improvement they will experience in degree of relationship satisfaction from pre-treatment to post-treatment.

Hypothesis 2: The more that couples exhibit negative attributions about each other pre-treatment, the less improvement they will experience in degree of relationship satisfaction from pre-treatment to post-treatment.

Hypothesis 3: The more that couples exhibit negative communication behaviors pre-treatment, the less decrease they will experience in degree of psychologically abusive behavior from pre-treatment to post-treatment.

Hypothesis 4: The more that couples exhibit negative attributions about each other pre-treatment, the less decrease they will experience in degree of psychologically abusive behavior from pre-treatment to post-treatment.

2. Are couple therapist behaviors related to couple therapy outcome?

Hypothesis 5: Couples who work with therapists who exhibit higher levels of warmth, empathy, presence, validation, and collaboration will have a greater increase in relationship satisfaction from pre-treatment to post-treatment.

Hypothesis 6: Couples who work with therapists who exhibit higher levels of warmth, empathy, presence, validation, and collaboration will have a greater decrease in degree of psychologically abusive behavior from pre-treatment to post-treatment.

Hypothesis 7: Couples who work with therapists who utilize higher levels of systemic techniques and session structure will have a greater increase in relationship satisfaction from pre-treatment to post-treatment.

Hypothesis 8: Couples who work with therapists who utilize higher levels of systemic techniques and session structure will have a greater decrease in degree of psychologically abusive behavior from pre-treatment to post-treatment.

3. Do couple therapist behaviors moderate the relation between pre-treatment couple characteristics and couple therapy outcome?

Hypothesis 9: The degree to which therapists utilize warmth, empathy, presence, validation, and collaboration will moderate the negative relation between degree of couple negative communication behavior and change in relationship satisfaction, such that the higher the level of therapist warmth, empathy, presence, validation, and collaboration, the lower the association between couple negative communication behavior and change in relationship satisfaction from pre-treatment to post-treatment.

Hypothesis 10: The degree to which therapists utilize warmth, empathy, presence, validation, and collaboration will moderate the negative relation between degree of couple negative communication behavior and change in psychologically abusive behavior, such that the higher the level of therapist warmth, empathy, presence, validation, and collaboration, the lower the association between couple negative communication behavior and change in psychologically abusive behavior from pre-treatment to post-treatment.

Hypothesis 11: The degree to which therapists utilize systemic techniques and session structure will moderate the negative relation between degree of couple negative

communication behavior and change in relationship satisfaction, such that the more the therapists utilize systemic techniques and session structure, the lower the association between couple negative communication behavior and change in relationship satisfaction from pre-treatment to post-treatment.

Hypothesis 12: The degree to which therapists utilize systemic techniques and session structure will moderate the negative relation between degree of couple negative communication behavior and change in psychologically abusive behavior, such that the more therapists utilize systemic techniques and session structure, the lower the association between couple negative communication behavior and change in psychologically abusive behavior from pre-treatment to post-treatment.

Hypothesis 13: The degree to which therapists utilize warmth, empathy, presence, validation, and collaboration will moderate the negative relation between degree of couple negative attributions about each other and change in relationship satisfaction, such that the higher the level of therapist warmth, empathy, presence, validation, and collaboration, the lower the association between couple negative attributions about each other and change in relationship satisfaction from pre-treatment to post-treatment.

Hypothesis 14: The degree to which therapists utilize warmth, empathy, presence, validation, and collaboration will moderate the negative relation between degree of couple negative attributions about each other and change in psychologically abusive behavior, such that the higher the level of therapist warmth, empathy, presence, validation, and collaboration, the lower the association between couple negative attributions about each other and change in psychologically abusive behavior from pre-treatment to post-treatment.

Hypothesis 15: The degree to which therapists utilize systemic techniques and session structure will moderate the negative relation between degree of couple negative attributions about each other and change in relationship satisfaction, such that the more the therapists utilize systemic techniques and session structure, the lower the association between couple negative attributions about each other and change in relationship satisfaction from pre-treatment to post-treatment.

Hypothesis 16: The degree to which therapists utilize systemic techniques and session structure will moderate the negative relation between degree of couple negative attributions about each other behavior and change in psychologically abusive behavior, such that the more therapists utilize systemic techniques and session structure, the lower the association between couple negative attributions about each other and change in psychologically abusive behavior from pre-treatment to post-treatment.

Chapter 3: Method

Sample

The sample used in this study was comprised of 40 heterosexual couples who sought couple therapy at a university-based training clinic, the Center for Healthy Families (formerly named the Family Service Center) at the University of Maryland, College Park. The couples sought treatment between 2000 and 2009. The couples were recruited for participation in a larger treatment outcome study (*Project Title: An Evaluation of Couple Treatments for Domestic Abuse*, more commonly referred to as the *Couple Abuse Prevention Program (CAPP) Study*) that examines the effectiveness of different therapeutic models on couple therapy outcome for couples who are experiencing mild to moderate levels of abusive behavior in their relationship. Each member of each couple voluntarily participated in the larger study.

Descriptive Statistics for Participating Couples

The sample consists of 40 females and 40 males who completed assessments for the larger treatment study. The mean age for females was 31 years (range: 20-51 years), and the mean age for males was 33 years (range: 22-51 years). The mean relationship length was six years. Of the 40 couples, 83% were married (and living together) or cohabitating. With respect to race, the sample demographics for females are 62% Caucasian, 21% African American, 10% Hispanic, and 8% Other, and for males are 74% Caucasian, 15% African American, 3% Hispanic, and 8% Other. Tables 1 and 2 include other demographic information including participants' education, income, and employment status.

Table 1

Demographic Information for Male Partners, Pre-Treatment

<i>Male Characteristics</i>		Percentage of Sample
Level of Education	<i>n</i> = 40	
Less than high school	1	3%
High school degree/some college	19	48%
College degree or higher	20	50%
Income	<i>n</i> = 39	
Less than \$10,000	0	0%
\$10,000-\$19,999	1	3%
\$20,000- 29,999	5	13%
\$30,000- \$39,999	9	23%
Greater than \$40,000	24	62%
Employment Status	<i>n</i> = 40	
Employed outside the home	35	88%
Homemaker	0	0%
Student	2	5%
Unemployed	2	5%
Retired	1	3%

Table 2

Demographic Information for Female Partners, Pre-Treatment

<i>Female Characteristics</i>		Percentage of Sample
Level of Education	<i>n</i> = 40	
Less than high school	2	5%
High school degree/some college	18	45%
College degree or higher	20	50%
Income	<i>n</i> = 38	
Less than \$10,000	10	26%
\$10,000-\$19,999	5	13%
\$20,000- 29,999	4	11%
\$30,000- \$39,999	10	26%
Greater than \$40,000	9	24%
Employment Status	<i>n</i> = 40	
Employed outside the home	29	73%
Homemaker	5	13%
Student	3	8%
Unemployed	3	8%
Retired	0	0%

Note: Total percentages for the sample regarding employment status total 102 due to rounding.

Descriptive Statistics for Participating Therapists

Each couple in the study worked with a co-therapy team. 84% of the therapists who worked with the participating couples were female, and 16% were male. The majority of the co-therapy teams (68%) were composed of two female therapists, although one third of the participating couples worked with co-therapy teams composed of one female therapist and one male therapist. There were no co-therapy teams composed of two male therapists.

Inclusion Criteria

In order for couples to participate in the larger CAPP study, they had to meet the following criteria: 1) both members of the couple were at least 18 years of age; 2) the partners had been in an intimate relationship with each other for at least six months; 3) at least one member had experienced psychological or physical abuse within the relationship during the past four months; 4) both members of the couple expressed a desire to improve their relationship; and 5) the couple saw each other at least once a week during the duration of the treatment program. Additionally, in order to be included in the study each partner needed to report that he or she felt safe participating in conjoint treatment with each other, and also felt safe living with each other.

For the present project, only couples who completed both the pre-treatment and post-treatment self-report assessments were included. Additionally, the protocol for the CAPP study includes saving videotapes of sessions 1, 4, 8, and 10 for research purposes, and for the present study the videotape for therapy session number four must be present in order for the couple to be included. There are several cases for which a session four tape is unavailable either due to therapist error or a technological malfunction with the video recorder.

Exclusion Criteria

Couples were excluded from participation in the CAPP study if: 1) one member reported injury as the result of abuse within the past four months that required or should have required medical attention; 2) one or both members of the couple reported a history of untreated drug or alcohol abuse; and/or 3) the couple was in concurrent couples treatment. All of the cases that remained in the CAPP study after screening with these exclusion criteria qualified for the present study as well.

Participant Compensation

Those couples who volunteered to participate in the CAPP study received treatment according the Center for Healthy Families (formerly the Family Service Center) sliding fee scale. If the couples completed all 10 required therapy sessions, they received a retroactive discounted therapy session fee for their participation in CAPP.

Procedures

Data Gathering

The data for the present study all were derived from the data set collected for the original CAPP study. The CAPP data collection procedures are as follows. All clients who receive treatment at the Center for Healthy Families are required to complete a pre-treatment assessment. Each couple, regardless of their participation in the CAPP study, also completes a battery of self-report and observational assessments during a Day 1 Assessment. If the couple is eligible and volunteers to participate in the CAPP study they must also complete a Day 2 Assessment which includes another set of self-report questionnaires. The present study used the following measures gathered during the Day 1 Assessment: the *Dyadic Adjustment Scale (DAS)*, the *Multi-dimensional Measure of Emotional Abuse Scale (MMEA)*, and the partners' communication

behavior coded from a 10-minute communication sample by means of the *Marital Interaction Coding Scale - Global* (MICS-G), each of which is described in detail in the Measures section of this proposal. A measure gathered from the Day 2 Assessment that was used for this study includes the *Marital Attitude Survey* (MAS), which is also detailed in the Measures section.

After completing the assessments and volunteering to participate in the study, couples in the CAPP study are assigned randomly to one of two treatment groups. One group receives a manualized Cognitive Behavioral Therapy (CBT) designed specifically for use with couples who are experiencing psychological abuse and mild to moderate levels of physically abusive behavior. Components of the CBT protocol include psychoeducation, anger management, communication skill training, and problem-solving training. The second group receives treatment as usual (UT) within the clinic, in which therapists can utilize any model of couple therapy (structural, strategic, narrative, emotion-focused, etc.), with the exception of CBT, to treat the couple. The therapists in both the CBT and UT groups are trained in intervention with couple violence. Each couple is assigned to two master's level student co-therapists who work with them for the duration of their participation in the study, and for additional therapy sessions (continuing with the same therapy model) if the therapists and couple judge it to be appropriate.

Each component of the treatment study is designed to maximize the safety of each member of the couple throughout the assessment and therapy processes. All clinicians receive extensive training in couple violence as well as therapeutic techniques and approaches designed to address and work with couples who display levels of psychological and/or physical violence in their relationships. Before couples are seen conjointly, each member is interviewed individually to assess for his or her degree of safety in the relationship. Although behavioral contracts are commonly utilized by clinicians employing a cognitive-behavioral model of therapy with clients,

clinicians in both the CBT and UT group are required to develop safety contracts with couples should a concern for safety arise. Furthermore, the clinicians can redirect the course of treatment, no longer seeing the couple conjointly, if fears regarding the risk of violence arise. If this occurs, couples are only reunited in therapy after the therapists have consulted with their clinical supervisors.

Couples in both treatment groups receive 10 sessions of therapy with their co-therapists. Each session is videotaped for supervision purposes; however, only the tapes from sessions 1, 4, 8, and 10 are kept (in locked files) in order to allow subsequent coding for therapy process and treatment fidelity. Should the couple experience a crisis requiring therapeutic attention during the course of the study, each couple can be offered up to two crisis intervention sessions in addition to the 10 standard sessions required for the study. The couple, however, must complete the study within four and a half months in order to be included in the study and compensated for their participation.

At the conclusion of the 10 therapy sessions, couples are asked to complete a post-treatment assessment. Measures gathered from this assessment period that are to be included in the present study include the DAS and the MMEA. After the couple completes this assessment, their participation in the CAPP study ceases; however, as noted earlier, the couple is welcome to continue treatment with the therapists if they desire, and the therapists believe that it would be helpful to the couple.

Development of Instrument for Coding Therapist Behavior

In order to assess therapist behavior toward client couples during treatment sessions, an instrument was developed by the PI of the CAPP study, his doctoral level graduate assistant, and the author of this dissertation in consultation with clinical faculty members in the Couple and

Family Therapy Program at the University of Maryland, College Park. This measure was designed to assess aspects of therapist behavior across treatments (i.e., therapist common factors).

In order to develop the *Ratings of Therapists' General Clinical Skills/Qualities* component of the measure, literature on common factors in couple and family therapy was consulted. Weekly meetings between the PI of the CAPP study, his doctoral level graduate assistant, and the author of this dissertation were held to discuss which components should be included in the scale. Blow and Sprenkle's (2001) report on the factors that therapists often report as influencing positive therapeutic change served as a guide for the development of categories for rating therapist behavior. These authors identify therapist warmth, empathy, presence, validation of the client, and therapist-client collaboration as relationship factors that are commonly employed by couple and family therapists regardless of treatment model. Additionally, Blow and Sprenkle (2001) state that therapists' systemic conceptualizations of client problems, and their ability to be in control of sessions are important model/technique factors operating across theoretical models that are frequently employed by couple and family therapists. These findings served as the foundation for the development of two components of the Ratings of Therapists' General Clinical Skills/Qualities measure: Relationship Factors (warmth, empathy, validation, therapist presence, and therapist collaboration), and Technique Factors (systemically-based techniques, session structure).

The Ratings of Therapists' General Clinical Skills/Qualities measure, including the Relationship Factors and Techniques Factors subcomponents, were used to code therapist behavioral process during therapy session four. The process by which the coding took place is discussed in the next section.

Observational Coding

In addition to the use of self-report questionnaires, the proposed study utilized two sources of observational data in order to more objectively define and describe couple characteristics and therapist process. One measure of couple common factor characteristics, an independent variable, utilizes the observational coding of a 10-minute communication sample completed by the couple during the pre-treatment assessments. For the purpose of this study, the amount of negative communication between partners was used as a couple factor that may influence progress in therapy. The measure of therapist common factor behaviors toward clients during therapy sessions, the moderator variables, utilizes observational coding of therapist behavior during the fourth 90-minute therapy session in the CAPP study.

Couple communication sample coding. As part of the pre-treatment assessment, each couple participates in a 10-minute videotaped communication sample. The couple is asked to discuss an issue on which they have reported experiencing mild to moderate disagreement. These videotapes are then coded by highly trained undergraduate student coders for forms of positive and negative couple communication, using the global version of the Marital Interaction Coding system – Global (MICS-G) described below.

Coding of therapist behavior toward clients during therapy sessions. A recruitment and selection process similar to that used to develop a team of undergraduate coders for the communication sample coding was put in place to recruit a group of undergraduate students to code therapy sessions for the CAPP study. Students completed a rigorous interview process, and only a select few were invited to participate in the coding. The students made a two-semester commitment to the project. During the first semester students met with graduate instructors for an hour and a half each week for instruction. Course topics include human subjects issues such

as confidentiality, basic research methods, an introduction to couple therapy models and techniques, and instruction on how to reliably apply the *Treatment Protocol Adherence Rating Scale* and the *Ratings of Therapists' General Clinical Skills/Qualities*. Coding of couple therapy tapes began during the first semester of the students' involvement in the project; however, the majority of the coding for the proposed study was completed during the students' second semester of involvement with the project. Students were expected to spend between six and eight hours per week outside of class completing the coding.

Measures

The following are descriptions of the measures used to assess the variables in the research model:

Independent Variables: Couple Common Factors Characteristics Pre-Treatment

Negative communication behaviors were measured using the *Marital Interaction Coding Scale-Global* (MICS-G; Tolman & Weiss, 1990). The MICS-G is a set of rating scales designed to assess dimensions of couple communication behavior based on an observational analysis. It is composed of six subscales: conflict, problem-solving, validation, invalidation, facilitation, and withdrawal. Three of the subscales (problem-solving, validation, and facilitation) describe positive couple communication behaviors, whereas three others (conflict, invalidation, and withdrawal) describe negative couple communication behaviors. The present study utilized data collected from the subscales representing negative communication behaviors.

A score on each subscale is obtained after two trained undergraduate coders use the MICS-G to code a 10-minute communication sample of the couple. Each coder independently watches the sample and provides ratings of the six types of behavior. The ratings are completed for each two-minute interval of a couple's ten-minute discussion of their conflict topic, for each

subscale, for each of the male and the female partners. The MICS-G requires that both content (what happened) and affect (how it happened) cues be coded. A score of 0 (meaning the partner being coded did not exhibit the behavior at all) to 5 (meaning that the partner being coded engaged in the behavior frequently or with intensity) is assigned to each content and affect cue. After each cue was coded, an average score for each cue was calculated in addition to a total score for the subscale which includes all of the cues. Consensus and reliability were obtained by having two undergraduate coders code each communication sample, taking the average of their two coding scores, which must not be greater than 1 point different from each other.

The conflict subscale is composed of five content cues (complain, criticize, negative mindreading, put downs/insults, and negative command) and five affect cues (hostility, sarcastic tone, whining voice tone, angry voice tone, and bitter voice tone). The invalidation subscale is composed of four content cues (disagreement, denial of responsibility of the self, changing the subject of discussion, and excuse) and four affect cues (consistent interruption of the partner, turn-off behaviors, inconsiderate or rude behaviors, and domineering behaviors). The withdrawal subscale consists only of six affect cues (negation, no response, increases physical distance, erects physical barriers, and noncontributive). The Cronbach alpha for the scale for males is .67 and for females is .70. The total scores for each of the three negative subscales were summed for this study in order to get an overall measure of observed negative communication behavior.

Negative attributions that each individual makes about his or her partner were measured using the *Marital Attitude Survey* (MAS; Pretzer, Epstein, & Fleming, 1991). The MAS is a 31-item self-report questionnaire in which the respondent, using a 5-point Likert scale, reports how much they agree (1= strongly agree) or disagree (5 = strongly disagree) with each of the statements considering the last week of their relationship. Total negative attribution scores were

obtained by summing scores obtained on four previously established subscales: lack of love (example item: “when things aren’t going well between us I feel like my partner doesn’t love me”), malicious intent (example item: “my partner intentionally does things to irritate me”), partner personality (example item: “my partner and I would get along better if it weren’t for the type of person he/she is”), and partner behavior (example item: “whatever problems we have are caused by the things my partner says and does”). The MAS originally included eight subscales, but the four that were chosen for this study specifically address attributions that are made by the respondent about his or her partner (Pretzer, Epstein, & Fleming, 1991). In the present sample the Cronbach alpha for the scale for males was .88 and for females it was .80. Individual scores on each of the four subscales were summed for use in the final analysis.

Moderator Variables: Therapist Common Factors Process

Therapist common factors behaviors toward client couples is measured using the *Ratings of Therapists’ General Clinical Skills/Qualities Scale* (TGCSQ; Epstein, McDowell, & Evans, 2009) developed for this study. The TGCSQ assesses two broad components of therapist behavior: **relationship factors** and **technique factors**. The TGCSQ is designed to code 90-minute couple therapy tapes. Two trained undergraduate coders independently code therapy session number four for each participating couple, and an average of the coders’ scores determines the final score for each category of therapist behavior. Each behavioral cue associated with each type of therapist behavior (e.g., cues of therapist warmth) is given a code of 0 (“not at all,” meaning that the therapist did not engage in the behavior) to 4 (“very much,” meaning that the therapist engaged in the behavior to a large extent). One score is given for each co-therapy team. In some cases the camera position in the therapy rooms made it difficult to simultaneously view both therapists. Because of this, the therapists were coded as a unit. In cases where one

therapist behaved in one way and the other therapist behaved in a way contradictory to this, the coded score reflected consideration of each of these behaviors. Given that the coded therapists are in training, it is not uncommon that one therapist takes the lead and the other is relatively quiet during the session. In these cases, the coding reflects the behavior of the lead therapist as well as the contributions, if any, from the co-therapist.

The **relationship factors** component of the TGCSQ is composed of scales for rating five aspects of therapist relationship behavior toward clients: **warmth**, **empathy**, **presence**, **validation**, and **collaboration**. **Warmth** is coded using three types of behavior (use of humor to connect with clients, smiling, and voice tone), **empathy** is coded using one type of behavior (reflective statements), **validation** is coded using two types of behavior (agreement and affirming/legitimizing), **presence** is coded using four types of behavior (asking personal questions/showing interest in clients' lives, staying on topic, eye contact, and body language), and **collaboration** is coded using two types of behavior (asking clients for their opinions and preferences regarding interventions, tasks, and goals, and collaborative language use displayed by the therapist). Although it was initially planned to run the analyses using a composite score consisting of the set of these relationship factors, the average scores for the therapist behaviors of warmth, empathy, validation, and presence were used as separate variables in the analyses given that they did not correlate highly with one another. The therapist behavior of collaboration was not included in the analysis given that it correlated with the therapist technique factors rather than the therapist relationship factors.

The **technique factors** component of the TGCSQ is composed of two types of therapist behavior: use of **systemically-based techniques** and **session structure** which were examined independently in this study. The **systemically-based techniques** component of the TGCSQ is

composed of four types of behavior: 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. Average scores for each of these behaviors are summed in order to arrive at the final coded score for the systemically-based techniques component of the TGCSQ. The **session structure** component of the TGCSQ is also composed of four types of therapist behavior: control of conflict, pacing and efficient use of time, opportunity for both members of couple to express concerns and goals, and therapist reinforcement of positive change using positive feedback, encouragement, etc. Average scores for each of these factors are summed in order to arrive at the final score for the session structure therapist behavior component of the TGCSQ. Because they were correlated, the average summed score for therapist behaviors of systemically-based techniques and session structure were summed into a single variable of *technique factors* for the purposes of analysis. The Cronbach alpha for the scale in the sample was .66.

Dependent Variables: Couple Therapy Outcomes

Relationship satisfaction was measured using part of the *Dyadic Adjustment Scale* (DAS; Spanier, 1976), a 32-item self-report measure designed to assess an individual's overall satisfaction with his/her couple relationship. Although it often is appropriate to evaluate the success of therapy in terms of measures of specific targets of treatment (e.g., reduction of abusive behavior, as in the present study), most couple therapy treatment outcome studies also measure outcome by evaluating changes in partners' overall relationship satisfaction scores (Gottman & Ryan, 2005). Fincham and Bradbury (1987) advocate for using a simple global relationship quality variable (such as relationship happiness) to assess this type of change in subjective feelings about one's relationship in order to avoid confounding the measurement of

relationship satisfaction by items that overlap with aspects of other variables being examined. In the present study, the use of the entire DAS raises the potential for such confounding, because some of the DAS items assess the amount of positive and negative behavior occurring between partners, possibly overlapping with this study's measure of partners' negative communication. Consequently, rather than using the total DAS score, the present study utilizes information from one item (#31) that simply asks the respondent to rate his or her level of happiness with the relationship along a continuum ranging from 0 (extremely unhappy) to 6 (perfect). Individuals' scores on DAS item #31 tend to correlate highly with their total DAS scores.

Relationship satisfaction was assessed for both partners pre-treatment and post-treatment. In order to calculate the treatment outcome score, each partner's pre-treatment score was subtracted from his or her post-treatment score. This difference score was used in the analyses.

Psychologically abusive behavior enacted by each partner was measured with the *Multi-dimensional Measure of Emotional Abuse* scale (MMEA; Murphy & Hoover, 2001). The MMEA is a 28-item self-report questionnaire with which individuals are asked to report the frequencies with which specific forms of psychologically abusive behavior were enacted by the self and by one's partner during a specific time frame (the past four months in this study). For the current study the index of each individual's amount of psychologically abusive behavior was his or her partner's reports of the person's behavior, given that people commonly under report their own abusive behaviors (Archer, 1999). For each MMEA item, the respondent makes two ratings, reporting how often the specific type of psychologically abusive behavior was enacted by the self, and then how often it was enacted by the other person during the past four months. The response options are 0 = not at all, 1 = once, 2 = twice, 3 = 3-5 times, 4 = 6-10 times, 5 = 11-20 times, 6 = more than 20 times, or 9 = this has never happened. Items are scored such that higher

scores indicate higher frequencies of abusive behavior. A total psychological abuse score was computed by summing each partner's scores on four previously established MMEA subscales: denigration (e.g., "called the other person worthless"), hostile withdrawal (e.g., "intentionally avoided the other person during a conflict or disagreement"), domination/intimidation (e.g., "threatened to hit the other person"), and restrictive engulfment (e.g., "tried to stop the other person from seeing certain friends or family members") (Murphy & Hoover, 2001). In the present sample, the Cronbach alpha for males was .94 and for females it was .89.

Psychologically abusive behavior perpetrated by each member of the couple was assessed at both pre-treatment and post-treatment. In order to calculate the treatment outcome score, each partner's pre-treatment score was subtracted from his or her post-treatment score. This difference score was used in the analyses.

Chapter 4: Results

Statistical Analyses

The Actor-Partner Interdependence Model (APIM; Kenny, Kashy, & Cook, 2006) was used to examine (a) the main effect relationships between client factors and therapy outcomes, (b) main effects of therapist behaviors on therapy outcomes, and (c) the interaction effects between client factors and therapist behaviors on therapy outcomes. APIM was used in order to account for the interdependence of partners' scores on measures within the couple data set used for this project. In this case, scores on the independent variables (client negative attributions and client negative communication) varied *within* couples, meaning that within each couple the two members had separate scores, whereas the scores on the moderator variables (therapist warmth, empathy, validation, presence, and technique factors) varied *between* couples, meaning that each couple as a dyad had a single score for each characteristic of their co-therapist team. By accounting for the interdependence of the independent variables, it is possible to see how each member's scores on these variables influence his/her own therapy outcome (actor effects) and influence his/her partner's therapy outcome (partner effects). Additionally, the influence of the therapist behaviors on each member of the couple can be explored. Considering that the interdependence of couple data is a key concern when investigating couple therapy outcome (Cook & Snyder, 2005), it is notable that many couple therapy process studies have not employed statistical procedures that allow for this depth of investigation. The present study's analysis strategy takes into account the continuous process through which members of an intimate relationship influence each other, both in daily life and in couple therapy.

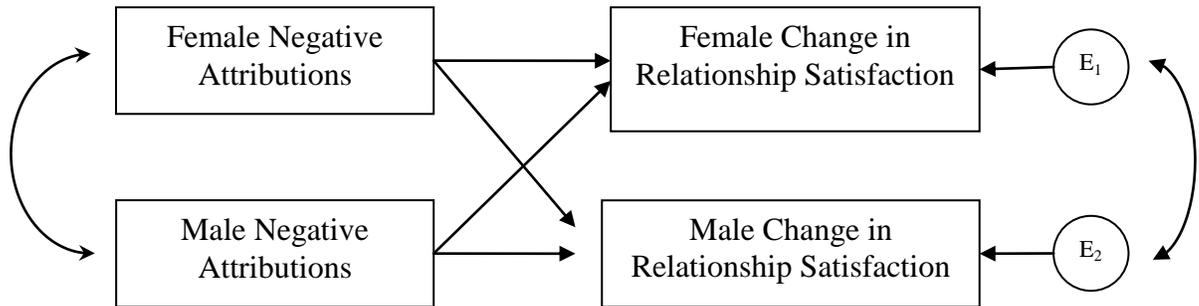
In order to prepare the data for analysis, dummy variables for male and female genders were constructed. Two SPSS (SPSS, Inc., 2006) data files were constructed: one containing the

within-couple data (client characteristics and outcome variables), and the other containing the between-couple data (therapist behaviors). Female and male actor and partner variables were constructed within the within-couple data file using the male and female dummy variables. For example, ‘female actor’ scores represented the female’s own scores on either negative attributions or negative communication and were associated with the female dummy variable, and ‘female partner’ scores represented the female’s scores on either negative attributions or negative communication but were associated with the male dummy variable. ‘Male actor’ and ‘male partner’ variables were also constructed for negative attributions and negative communication (see Cook & Kenny (2005) for detailed instruction on variable construction) Information from the two data files was matched by each couple’s case identification number. The therapist behaviors of warmth, empathy, validation, and presence were used as separate variables in the analysis given that they did not correlate highly with one another. The therapist behavior of collaboration was dropped from the analysis of therapist relational behavior given that it correlated more highly with the therapist behaviors regarding use of systemically-based techniques and control of the session. Because they were correlated, the therapist behaviors of systemically-based techniques and session structure were combined into a single variable of *technique factors* for the purposes of analysis. Mean replacement was used in instances in which there were only a few values missing on one of the independent variable subscales. Cases missing more than several values on a subscale were excluded from the analysis, resulting in a final sample size of 40 couples.

The APIM analyses were conducted using a multilevel modeling approach with the statistical software Hierarchical Linear Modeling version seven (HLM7; Raudenbush, Bryk, & Congdon, 2009). Four sets of two-level models were conducted using data imported from the

two SPSS data files. The outcome variable (dependent variable) in the first and second models was change in relationship satisfaction/happiness (scored such that higher scores indicate an increase in satisfaction), and all variables with the exception of the male and female dummy variables were centered around the grand mean. The first model (see Figure 2) included a within-couple level that examined negative attributions in the two members of the couple as predictors of change in relationship satisfaction, and a between-couple level that examined variation in the therapist behaviors between couples as predictors of change in relationship satisfaction.

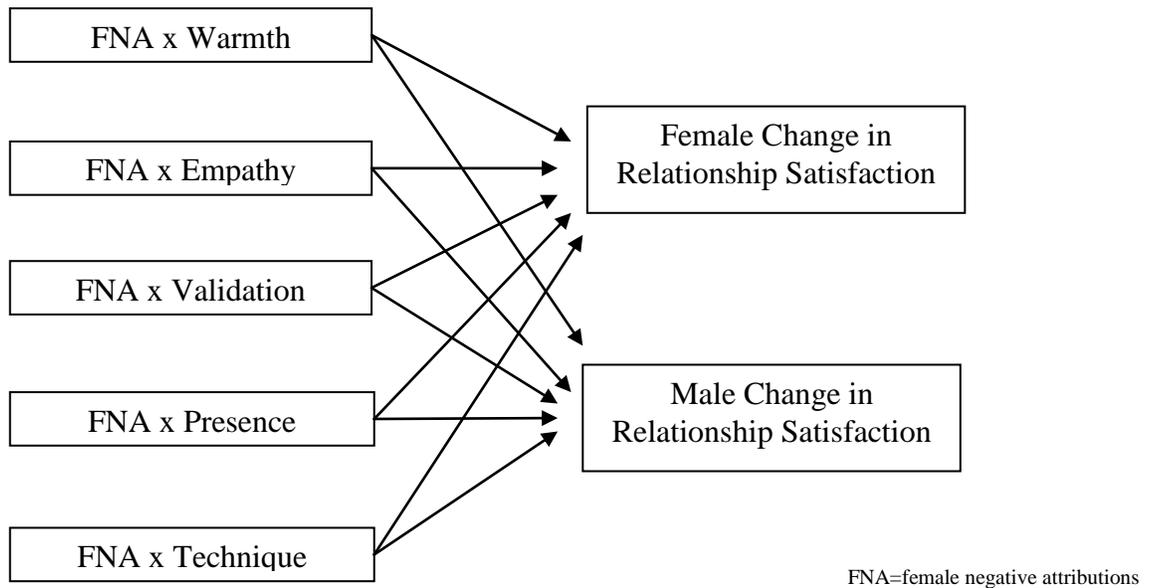
Figure 2. Model 1 for statistical analysis.



Note. E_1 is the unexplained portion of the female's change in relationship satisfaction and E_2 is the unexplained portion of the male's change in relationship satisfaction.

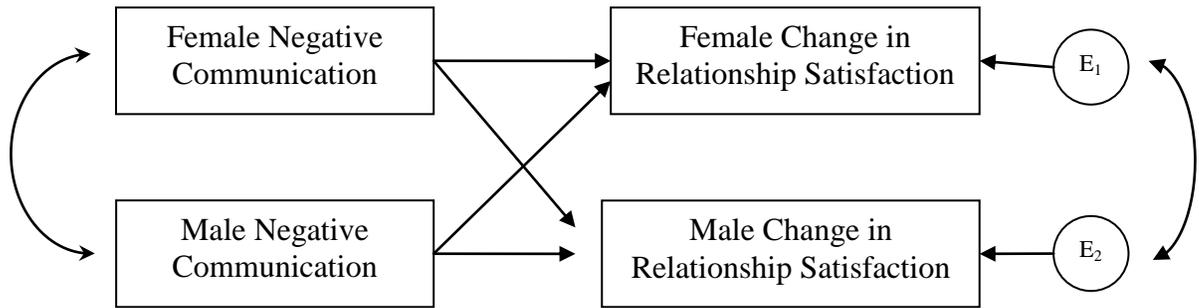
A mixed model that examined the interaction effects of client negative attributions and therapist behaviors on change in relationship satisfaction was also obtained. A visual example of the statistical interaction model is seen Figure 3. It is important to note that this figure is provided as an example because a complete statistical model that includes all of the actor-partner effects and interaction effects is not presented due to its complexity and lack of utility for understanding the findings.

Figure 3. Example of the statistical model for testing interaction effects.



The second model (see Figure 4) included a within-couple factor that examined negative communication between members of the couple as predictors of change in relationship satisfaction, as well as a between-couple level that examined variation in therapist behaviors between couples as predictors of change in relationship satisfaction. A mixed model that examined the interaction effects of client negative communication and therapist behaviors on change in relationship happiness was also obtained.

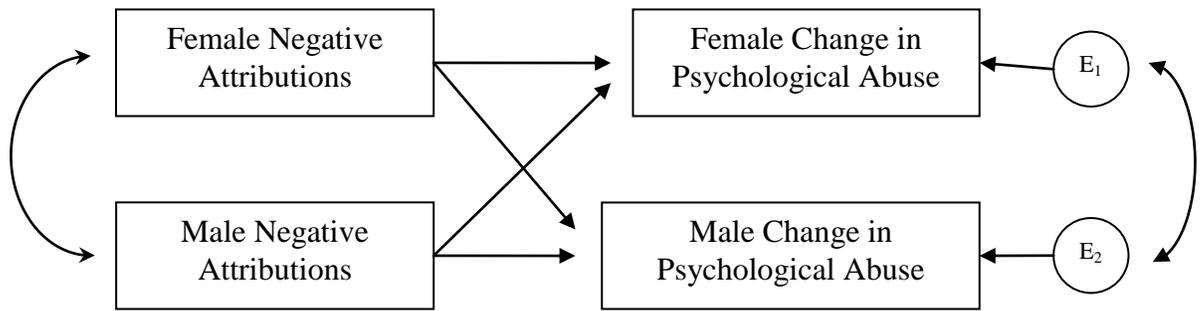
Figure 4. Model 2 for statistical analysis.



Note. E_1 is the unexplained portion of the female's change in relationship satisfaction and E_2 is the unexplained portion of the male's change in relationship satisfaction.

The outcome variable in the third and fourth models was change in amount of psychological abuse, and all variables with the exception of the male and female dummy variables were entered centered around the grand mean. The third model (see Figure 5) included a within-couple level that examined negative attributions among members of the couple as predictors of change in the amount of psychological abuse, and a between-couple level that examined the therapist behaviors between couples as predictors of change in the amount of psychological abuse. A mixed model that examined the interaction of client negative attributions and therapist behaviors on change in amount of psychological abuse was also obtained.

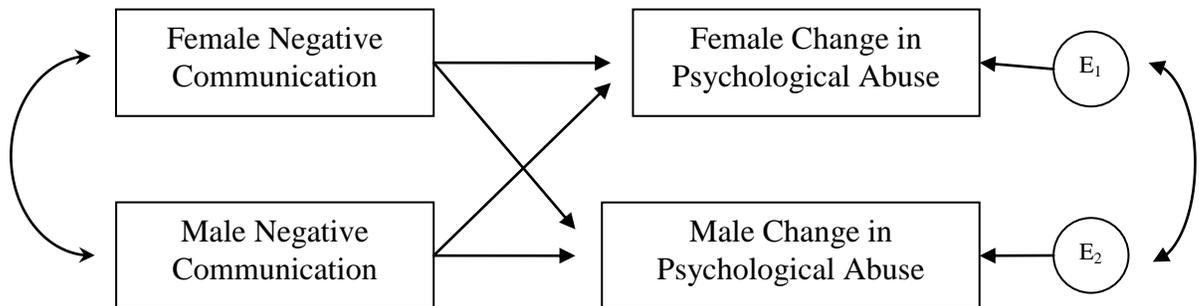
Figure 5. Model 3 for statistical analysis.



Note. E_1 is the unexplained portion of the female's change in psychological abuse and E_2 is the unexplained portion of the male's change in psychological abuse.

The fourth model (see Figure 6) included a within-couple level that examined negative communication among members of the couple as predictors of change in the amount of psychological abuse, and a between-couple level that examined the therapist behaviors between couples as predictors of change in amount of psychological abuse. A mixed model that examined the interaction of client negative communication and therapist behaviors on change in the amount of psychological abuse was also obtained. The equations for each model are provided in Appendix F.

Figure 6. Model 4 for statistical analysis.



Note. E_1 is the unexplained portion of the female's change in psychological abuse and E_2 is the unexplained portion of the male's change in psychological abuse.

Prior to running these models, two completely unconditional models (models including no predictor variables, just the dependent variables) were run to examine the variance partitioning in change in relationship satisfaction and change in psychological abuse within couples and between couples. For change in relationship satisfaction, 29% of the variance was within couples and 71% of the variance was between couples. The χ^2 statistic for the between couples variance component was significant ($df = 39, n = 40, \chi^2 = 230.903, p < .001$), meaning that there was significant variance in change in relationship satisfaction between couples. For change in psychological abuse, 77% of the variance was within couples and 23% of the variance was between couples. The χ^2 statistic for the between couples variance component was significant ($df = 39, n = 40, \chi^2 = 62.918, p = .009$), meaning that there was significant variance in change in psychological abuse between couples.

The descriptive statistics for the female variables, the male variables, and the therapist variables can be found in Table 3, Table 4, and Table 5 respectively.

Table 3

Descriptive Statistics for Female Variables, n=40

<i>Variable</i>	<i>Mean (SD)</i>	<i>Minimum/Maximum</i>
Pre-Treatment Negative Attributions	62.66 (13.09)	30/103
Pre-Treatment Negative Communication	1.07 (0.95)	0/3.40
Pre-Treatment Relationship Satisfaction	1.88 (1.22)	0/5
Post-Treatment Relationship Satisfaction	2.78 (1.51)	0/5
Change in Relationship Satisfaction	0.90 (1.72)	-4/4
Pre-Treatment Psychological Abuse Perpetrated	27.95 (29.03)	0/135
Post-Treatment Psychological Abuse Perpetrated	15.29 (13.95)	0/58
Change in Psychological Abuse Perpetrated	-12.67 (24.67)	-119/16

Table 4

Descriptive Statistics for Male Variables, n=40

<i>Variable</i>	<i>Mean (SD)</i>	<i>Minimum/Maximum</i>
Pre-Treatment Negative Attributions	62.20 (16.07)	31/95
Pre-Treatment Negative Communication	1.00 (0.94)	0/3.60
Pre-Treatment Relationship Satisfaction	2.43 (1.57)	0/5
Post-Treatment Relationship Satisfaction	3.08 (1.46)	0/5
Change in Relationship Satisfaction	0.65 (1.55)	-4/4
Pre-Treatment Psychological Abuse Perpetrated	30.42 (21.44)	2/98
Post-Treatment Psychological Abuse Perpetrated	15.03 (14.37)	0/55
Change in Psychological Abuse Perpetrated	-15.39 (18.30)	-59/18

Table 5

Descriptive Statistics for Therapist Variables, n=40

<i>Variable</i>	<i>Mean (SD)</i>	<i>Minimum/Maximum</i>
Therapist Warmth	2.63 (0.65)	1.5/3.75
Therapist Empathy	3.26 (0.52)	2.5/4
Therapist Presence	3.34 (0.37)	2.5/4
Therapist Validation	2.44 (0.48)	1.25/3.5
Therapist Technique Factors	5.52 (0.79)	3.38/7.17

Male and female partners did not differ significantly on the pre-treatment variables. There was no significant difference between males and females in terms of pre-treatment negative communication ($t = 0.34, p = .57, 2$ -tailed), negative attributions ($t = 0.14, p = .89, 2$ -

tailed), or psychological abuse ($t = 0.43, p = .67, 2$ -tailed). There was a non-significant trend for females to report less satisfaction with their relationships than males ($t = -1.75, p = .08, 2$ -tailed).

Test of Hypotheses

The APIM model was used to test each of the study's 16 hypotheses. Four multilevel models were run: the first examining the relationship between client negative attributions about one another and change in relationship satisfaction as a result of therapy, the second examining the relationship between client negative communication and change in relationship satisfaction as a result of therapy, the third examining the relationship between client negative attributions about one another and change in amount of psychological abuse as a result of therapy, and the fourth examining the relationship between negative communication and change in the amount of psychological abuse. The variables of therapist warmth, empathy, validation, presence, and technique factors (composed of systemically-based techniques and control of the session) were included as moderator variables in each of the four models.

Although not explicitly outlined in the study's hypotheses, it is important to note several relevant treatment outcomes prior to considering the results for each of the hypotheses. The results for Model 2 indicate that both males and females became happier with their relationship during the course of therapy, given that the change in the DAS satisfaction index was significantly different from zero and in a positive direction (males: $\gamma = 0.831, p = .014$; females: $\gamma = 0.962, p = .002$). In the sample, the mean pre-treatment relationship satisfaction score for females was 1.88 (indicating 'a little' unhappiness in their relationships), and the mean post-treatment relationship satisfaction score for females was 2.78 (indicating happiness in their relationships), representing an average change of 0.9 on the 7-point scale. For males, the mean pre-treatment relationship satisfaction score was 2.43 (indicating 'a little' unhappiness in their

relationships), and the mean post-treatment relationship satisfaction score for males was 3.07 (indicating happiness in their relationship), representing an average change of 0.65 on the 7-point scale. The results for Model 4 indicate that psychological abuse perpetrated by males and females, as measured by the MMEA, decreased over the course of therapy, given that the change in level of psychological abuse was significant from zero and in a negative direction (males: $\gamma = -13.500, p = .002$; females: $\gamma = -16.473, p < .001$). For females, the mean pre-treatment amount of psychological abuse perpetrated was 27.95, and the mean post-treatment amount of psychological abuse perpetrated was 15.285, representing an average decrease of 15.39. For males, the mean pre-treatment amount of psychological abuse perpetrated was 30.42, and the mean post-treatment amount of psychological abuse perpetrated was 15.03, representing an average decrease of 12.67. These findings indicate that over the course of treatment participants were becoming happier with their relationships and utilizing less abusive behavior in them as well. All results including the gamma statistics, standard errors, degrees of freedom, and t -statistics can be found in Appendix G.

The following are the results associated with the study's first four hypotheses regarding the relationship between pre-treatment couple characteristics and couple therapy outcome:

Test of Hypothesis 1: *The more that couples exhibit negative communication behaviors pre-treatment, the less improvement they will experience in degree of relationship satisfaction from pre-treatment to post-treatment.* This hypothesis was not supported by any of the APIM models.

Test of Hypothesis 2: *The more that couples exhibit negative attributions about each other pre-treatment, the less improvement they will experience in degree of relationship satisfaction from pre-treatment to post-treatment.* This hypothesis was not supported by any of the APIM models.

Test of Hypothesis 3: *The more that couples exhibit negative communication behaviors pre-treatment, the less decrease they will experience in degree of psychologically abusive behavior from pre-treatment to post-treatment.* This hypothesis was not fully supported. There was a significant female actor effect in that higher levels of female negative communication pre-treatment were actually associated with an increase, not just a smaller decrease, in the amount of psychological abuse she perpetrated against her partner over the course of therapy, $\gamma = 16.934$, $p = .005$. Conversely, there was a significant male actor effect in which higher levels of male pre-treatment negative communication were associated with a decrease in males' use of psychologically abusive behavior, $\gamma = -11.853$, $p = .015$. There was also a significant male partner effect in which higher levels of male pre-treatment negative communication were associated with a decrease in the amount of female psychologically abusive behavior over the course of treatment, $\gamma = -22.533$, $p = .001$. This indicates that females' own high levels of negative communication behaviors are associated with their increased use of psychologically abusive behavior over the course of therapy, whereas males' own high levels of negative communication behaviors are associated with decreased use of psychologically abusive behavior over the course of treatment both by themselves and by their female partners.

Test of Hypothesis 4: *The more that couples exhibit negative attributions about each other pre-treatment, the less decrease they will experience in degree of psychologically abusive behavior from pre-treatment to post-treatment.* This hypothesis was not fully supported. There were significant male actor and female partner effects. The significant male actor effect indicated that higher levels of male pre-treatment negative attributions are associated with a greater decrease in the amount of psychologically abusive behaviors that the male uses with his partner over the course of treatment, $\gamma = -0.778$, $p = .012$. However, the significant female partner effect indicates

that the more that females make negative attributions about their male partners at pre-treatment, the more the male partner's use of psychologically abusive behaviors against his partner increases during the course of treatment, $\gamma = 0.544, p = .044$. Thus, counter to the hypothesis, higher levels of male pre-treatment negative attributions about his partner are associated with his decreased use of psychological abuse over the course of treatment. Although it was not expected that pre-treatment negative attributions would be associated with an increase in the use of psychologically abusive behavior, the finding that high levels of female negative attributions about her partner at pre-treatment are associated with an increase in the amount of psychologically abusive behavior perpetrated by male partners aligns more closely with this hypothesis.

The following are the results associated with Hypothesis 5 through Hypothesis 8 regarding the relationship between therapist behaviors and couple therapy outcome:

Test for Hypothesis 5: *Couples who work with therapists who exhibit higher levels of warmth, empathy, presence, validation, and collaboration will have a greater increase in relationship satisfaction from pre-treatment to post-treatment.* This hypothesis was not supported. There was an instance, in fact, in which the opposite of the hypothesized effect was found. In Model 2, which included client negative attributions as well as therapist behaviors as predictor variables, higher levels of therapist presence were associated with less positive change in relationship satisfaction for males, $\gamma = -2.884, p = .002$.

Test of Hypothesis 6: *Couples who work with therapists who exhibit higher levels of warmth, empathy, presence, validation, and collaboration will have a greater decrease in degree of psychologically abusive behavior from pre-treatment to post-treatment.* This hypothesis was not supported.

Test of Hypothesis 7: *Couples who work with therapists who utilize higher levels of systemic techniques and session structure will have a greater increase in relationship satisfaction from pre-treatment to post-treatment.* This hypothesis was not supported. There was a single instance in which the opposite of what was expected was found. In Model 1, in which negative attributions and therapist behaviors were entered as predictor variables, the more that therapists used systemic technique factors the *less* positive change in relationship happiness females experienced, $\gamma = -1.968, p = .025$.

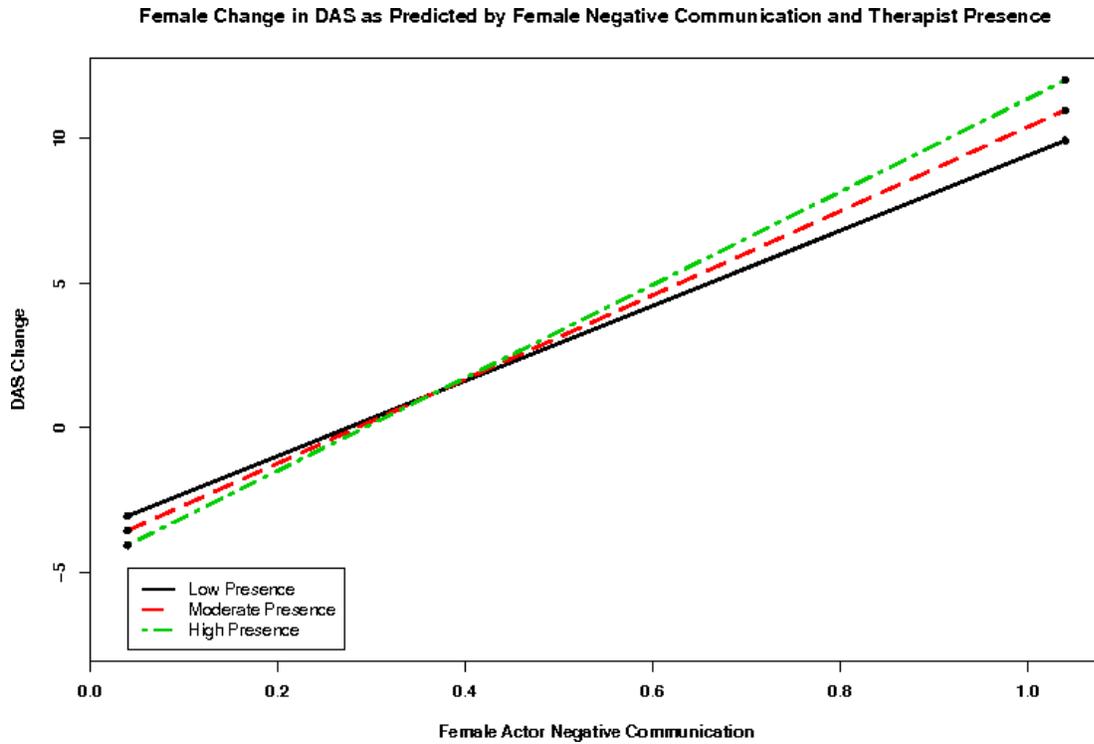
Test of Hypothesis 8: *Couples who work with therapists who utilize higher levels of systemic techniques and session structure will have a greater decrease in degree of psychologically abusive behavior from pre-treatment to post-treatment.* This hypothesis was supported in one instance for Model 3, in which client negative attributions were level 1 predictors and therapist behaviors were level 2 predictors, in that for males the more that therapists used systemic technique factors, the less males perpetrated psychological abuse against their female partners, $\gamma = -41.120, p = .005$. For females, however, in the same model, the more that therapists used systemic technique factors, the *more* the females perpetrated psychological abuse against their partners, $\gamma = 49.119, p < .001$.

The following are the results associated with the study's last eight hypotheses regarding how therapist behaviors moderate the relationship between pre-treatment couple characteristics and couple therapy outcome:

Test of Hypothesis 9: *The degree to which therapists utilize warmth, empathy, presence, validation, and collaboration will moderate the negative relation between degree of couple negative communication behavior and change in relationship satisfaction, such that the higher the level of therapist warmth, empathy, presence, validation, and collaboration, the lower the*

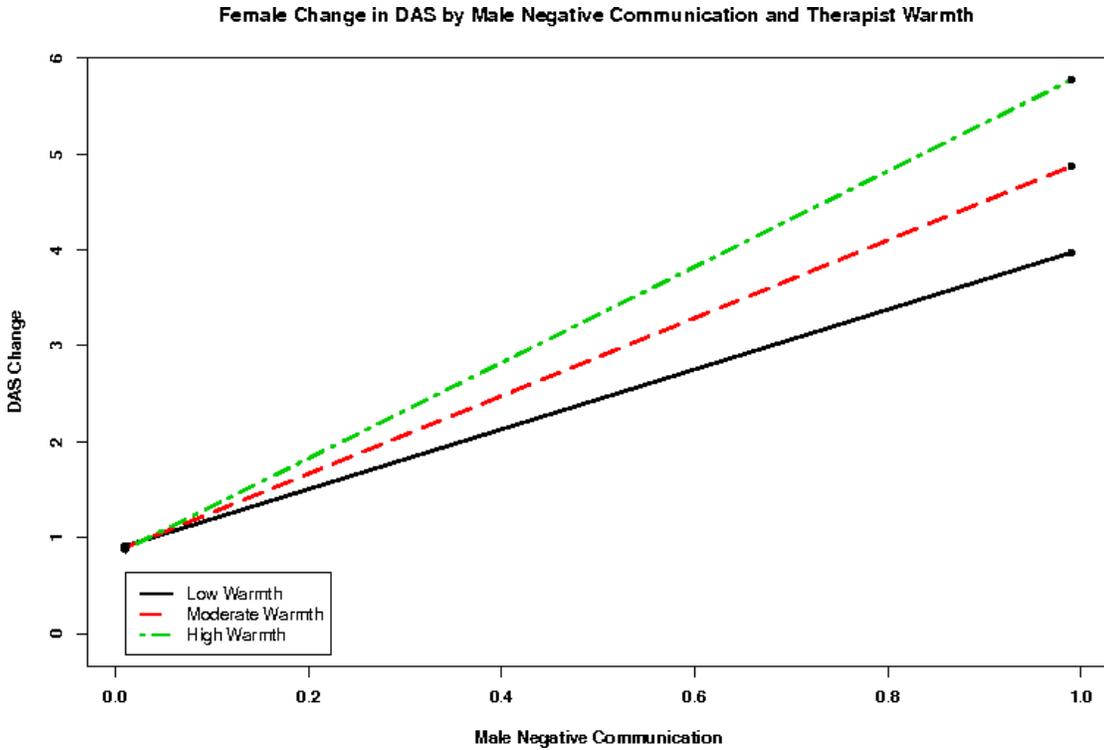
association between couple negative communication behavior and change in relationship satisfaction from pre-treatment to post-treatment. It was expected that there would be a negative association between negative communication and positive change in relationship satisfaction, such that those clients who had higher levels of pre-treatment negative communication would experience less improvement in relationship satisfaction. It was then expected that therapist use of relationship factors would buffer the negative influence that detrimental communication patterns had on therapy outcome in terms of relationship satisfaction. Rather than finding an association between higher levels of negative communication and less improvement in relationship satisfaction, there was a positive, although non-significant, main effect association between negative communication and improvement in relationship satisfaction. Regarding moderation effects by level of therapist behavior, at higher levels of therapist presence, the relationship between female negative communication and positive change in female relationship satisfaction was stronger than at moderate and lower levels of therapist presence, $\gamma = 4.185, p = .003$. This moderating influence of therapist presence can be seen graphically in Figure 7 by noting that the slopes of the three lines which represent levels of therapist presence indicate that greater therapist presence enhanced the overall tendency for greater initial female negative communication to be associated with more improvement in her own relationship satisfaction over the course of treatment. The slope for the relationship between female negative communication and improvement in female relationship satisfaction was steeper when level of therapist presence was higher.

Figure 7. Female change in relationship satisfaction as predicted by female negative communication and therapist presence.



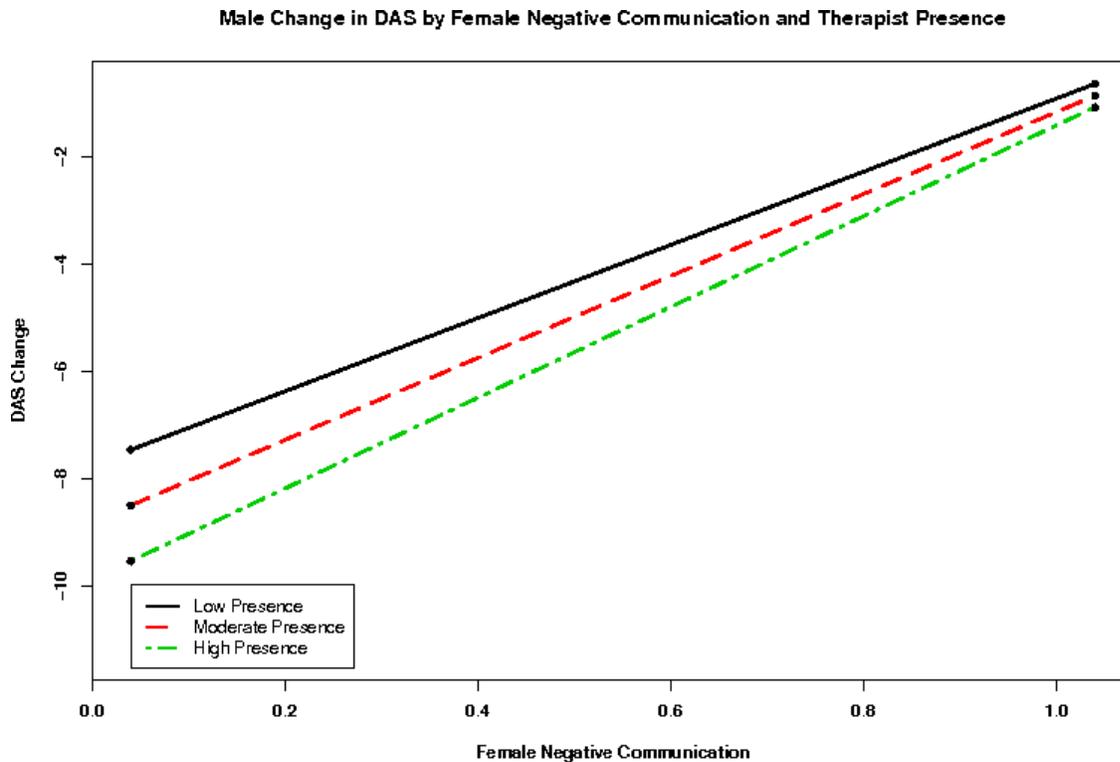
Therapist warmth also had a moderating influence on the male partner's relationship between negative communication and change in relationship satisfaction, such that at higher levels of therapist warmth the relationship between male negative communication and female positive change in relationship satisfaction was stronger than at moderate and lower levels of warmth, $\gamma = 1.443, p = .047$. As seen in Figure 8, the slopes of the three lines representing levels of therapist warmth indicate that greater therapist warmth enhanced the overall tendency for greater initial male negative communication to be associated with more improvement in their female partner's relationship satisfaction over the course of therapy.

Figure 8. Female change in relationship satisfaction as predicted by male negative communication and therapist warmth.



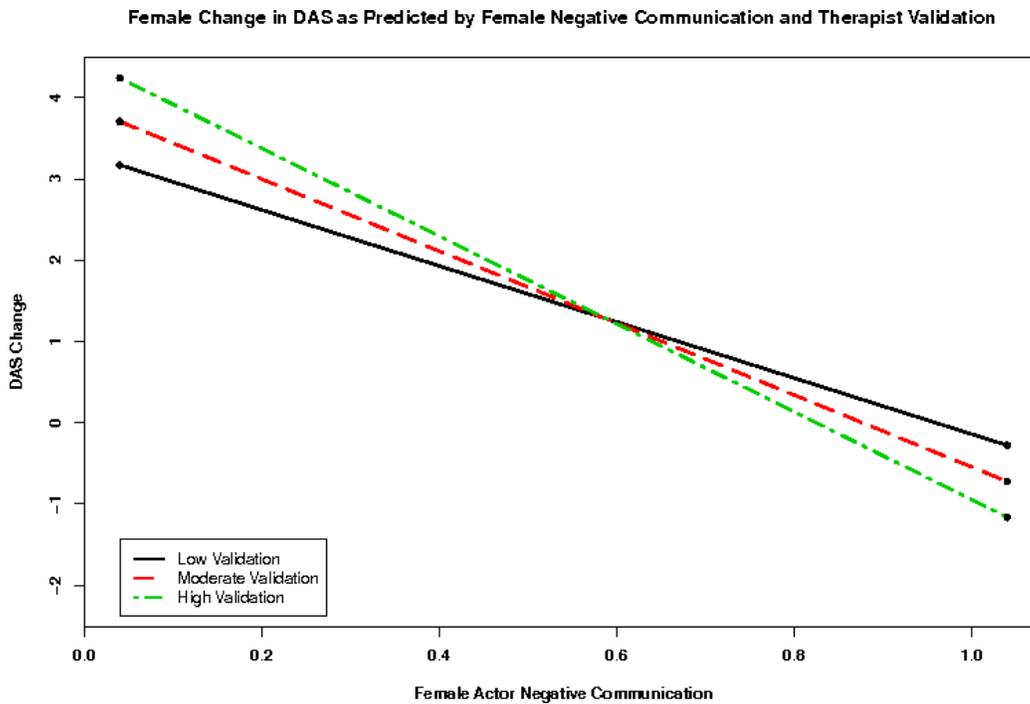
Therapist presence also had a significant moderating influence on the relationship between female initial negative communication and male positive change in relationship satisfaction, $\gamma = 2.207$, $p = .015$, such that at higher levels of therapist presence the relationship between these two variables was stronger than at moderate and lower levels of therapist presence. As seen in Figure 9, the slopes for the three levels of therapist presence indicate that greater therapist presence enhanced the positive relationship between greater initial female negative communication and less decrease in relationship satisfaction for males over the course of treatment.

Figure 9. Male change in relationship satisfaction as predicted by female negative communication and therapist presence.



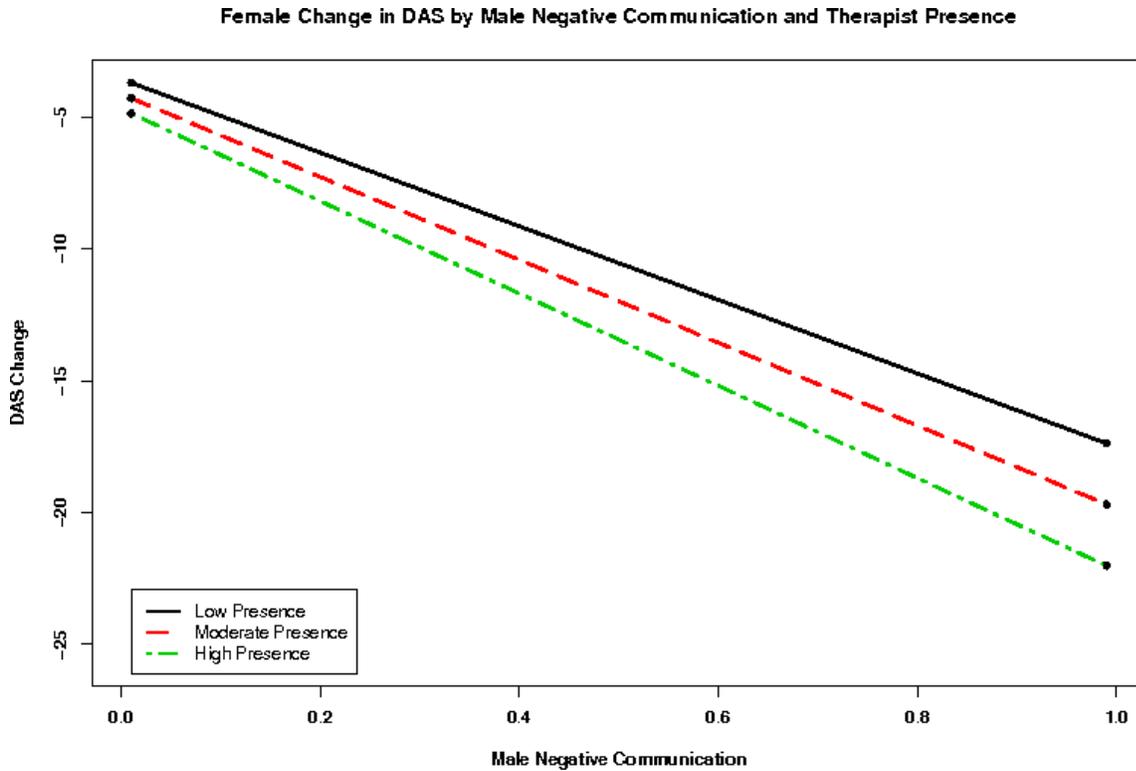
There were two findings that were counter to this hypothesis. First, the relationship between initial level of female negative communication and female decrease in relationship satisfaction over the course of treatment was stronger at higher levels of therapist validation than it was at moderate and lower levels of validation $\gamma = -2.040, p = .023$. As seen in Figure 10, the slopes for the three levels of therapist validation indicate that greater therapist validation enhanced the negative relationship between greater initial female negative communication and greater decrease in relationship satisfaction over the course of treatment. Although the hypothesized main effect association between initial female negative communication and decreased female relationship satisfaction was not significant, Figure 10 illustrates how higher levels of therapist validation increased the strength of this relationship.

Figure 10. Female change in relationship satisfaction as predicted by female negative communication and therapist validation.



Second, therapist presence had a significant moderating influence on the relationship between initial male negative communication and decrease in female relationship satisfaction, such that at higher levels of therapist presence the relationship between these two variables was stronger than at moderate and lower levels of therapist presence, $\gamma = -4.785, p = .003$. As seen in Figure 11, the slopes for the three levels of therapist presence indicate that greater therapist presence enhanced the negative relationship between greater initial male negative communication and greater decrease in female relationship satisfaction over the course of treatment.

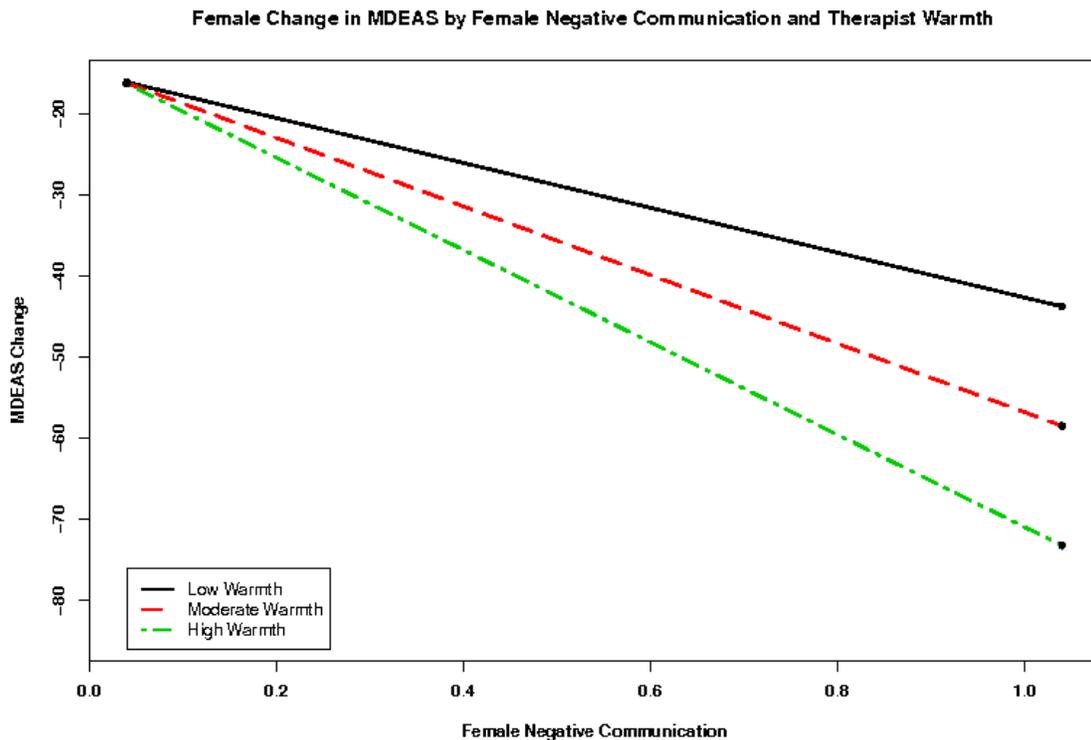
Figure 11. Female change in relationship satisfaction as predicted by male negative communication and therapist presence.



Test of Hypothesis 10: *The degree to which therapists utilize warmth, empathy, presence, validation, and collaboration will moderate the negative relation between degree of couple negative communication behavior and change in psychologically abusive behavior, such that the higher the level of therapist warmth, empathy, presence, validation, and collaboration, the lower the association between couple negative communication behavior and change in psychologically abusive behavior from pre-treatment to post-treatment.* It was expected that there would be an overall negative association between negative communication and positive change in psychological abuse, such that those clients who had higher levels of pre-treatment negative communication would experience less decrease in the use of psychological abuse. It was then expected that therapist use of relationship factors would buffer the negative influence that destructive communication patterns had on therapy outcome in terms of use of psychologically

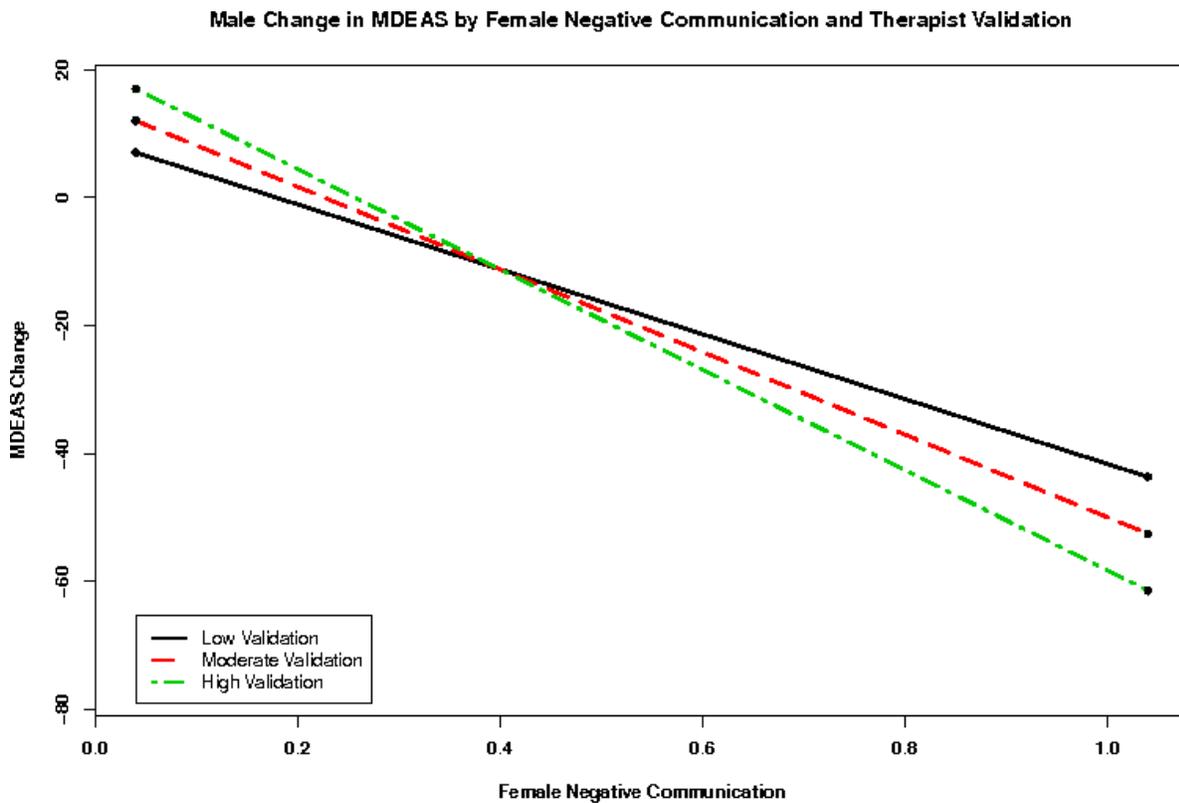
abusive behavior. Rather than finding an association between higher levels of negative communication and less decrease in amount of psychologically abusive behavior, there was a positive, although non-significant, main effect association between pre-treatment negative communication and decreases in the amount of psychologically abusive behavior. This hypothesis was supported in a couple of instances. First, at higher levels of therapist warmth the association between female negative communication and decrease in the amount of psychological abuse used by the female was stronger than at moderate and lower levels of therapist warmth, $\gamma = -22.523, p = .036$. As seen in Figure 12, the slopes of the three levels of therapist warmth indicate that greater therapist warmth enhanced the relationship between greater initial female negative communication and greater decrease in the amount of psychological abuse used by the female over the course of therapy.

Figure 12. Female change in psychological abuse as predicted by female negative communication and therapist warmth.



Also in keeping with the hypothesis was a significant finding for the moderating influence of therapist validation on the relationship between the female partner's initial negative communication and change in the male's psychologically abusive behavior, $\gamma = -28.900, p = .027$, such that at higher levels of therapist validation the relationship between female negative communication and males' decreased use of psychological abuse is stronger than it is at moderate and lower levels of therapist validation. As seen in Figure 13, the slopes for the three levels of therapist validation indicate that greater therapist validation enhanced the negative relationship between amount of initial female negative communication and greater decrease in the use of psychological abuse by males over the course of therapy.

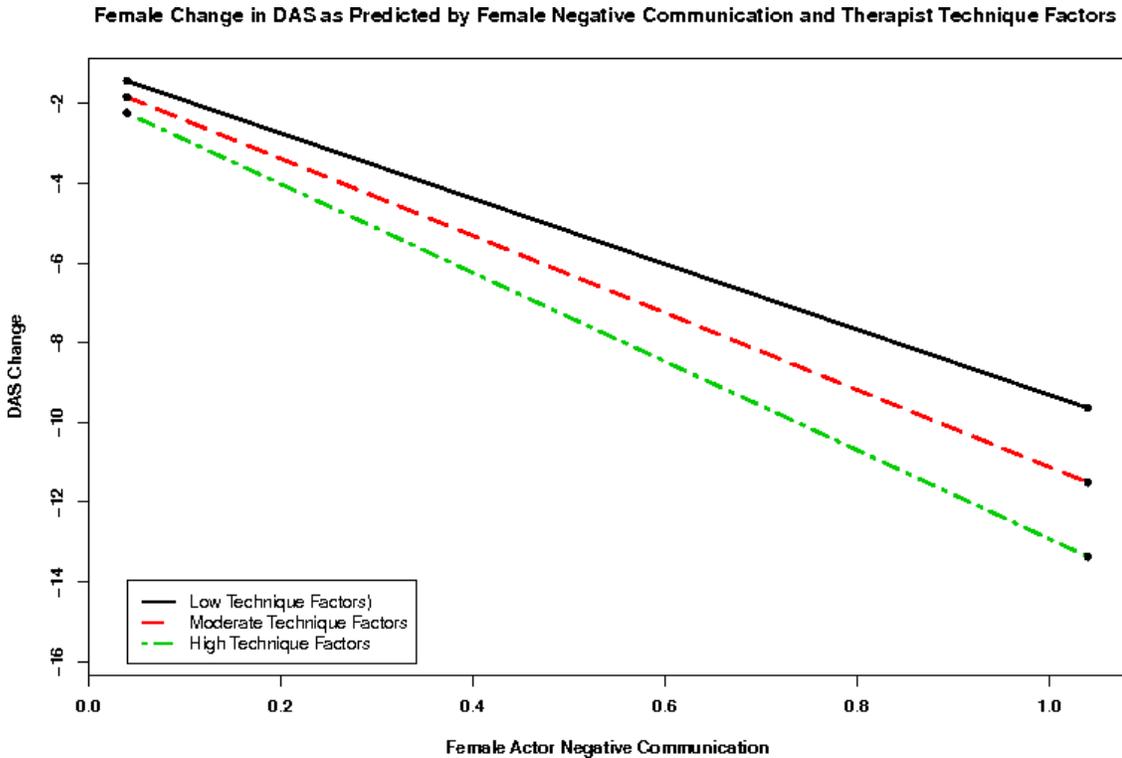
Figure 13. Male change in psychological abuse as predicted by female negative communication and therapist validation.



Test of Hypothesis 11: *The degree to which therapists utilize systemic techniques and session structure will moderate the negative relation between degree of couple negative communication behavior and change in relationship satisfaction, such that the more the therapists utilize systemic techniques and session structure, the lower the association between couple negative communication behavior and change in relationship satisfaction from pre-treatment to post-treatment.* It was expected that there would be a negative association between pre-treatment negative communication and degree of positive change in relationship satisfaction, such that those clients who had higher levels of pre-treatment negative communication would experience less improvement in relationship satisfaction. It was then expected that therapist use of systemic and session structuring technique factors would buffer the negative influence that detrimental communication patterns had on therapy outcome in terms of relationship satisfaction. A non-significant negative main effect association between negative communication and positive change in relationship satisfaction was found, but there were no significant findings consistent with this hypothesis for the predicted moderating influence of therapist technique factors on these two variables. However, there were two significant findings that were counter to the hypothesized pattern. Therapist use of technique factors (systemic techniques and session structure) did have a significant moderating influence on the relationship between the female actor's initial negative communication and change in the female's own relationship satisfaction, $\gamma = -1.851, p = .006$, such that at higher levels of therapist technique factors the relationship between female negative communication and female decreased relationship satisfaction was stronger than at moderate and lower levels of therapist technique factors. As illustrated in Figure 14, the slopes for the three levels of therapist use of technique factors indicate that greater therapist use of technique factors enhanced the negative relationship between initial female

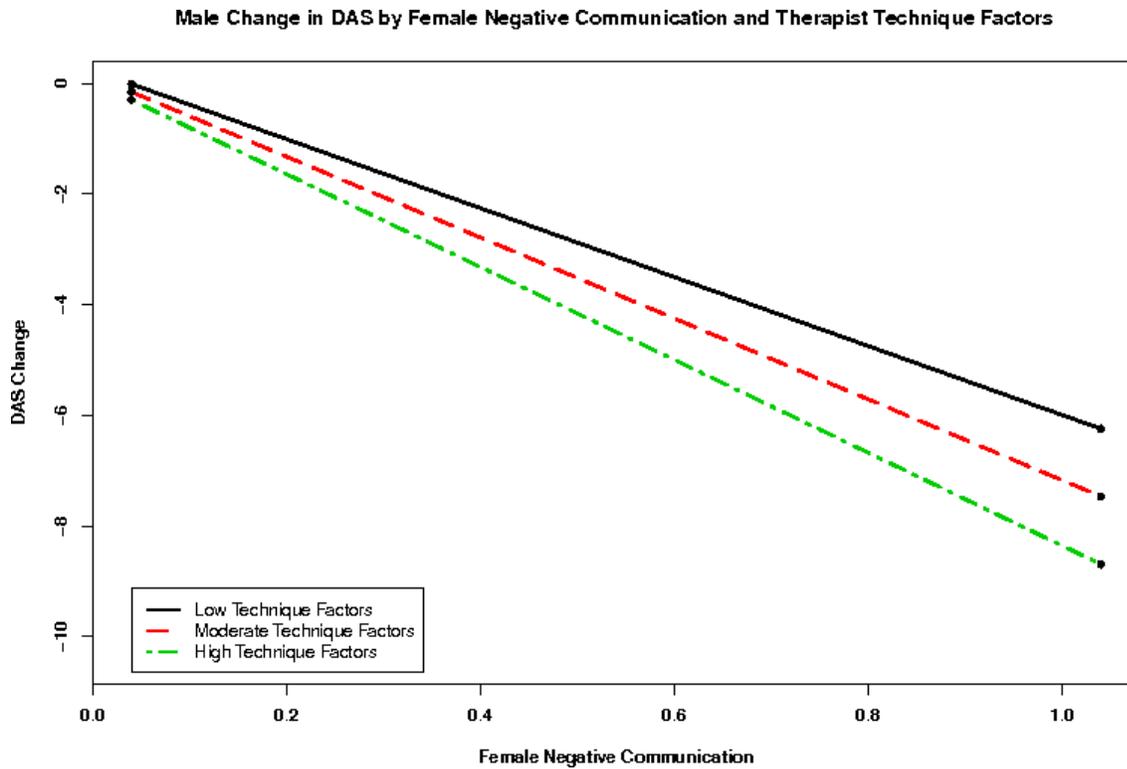
negative communication and positive change in relationship satisfaction for females over the course of treatment.

Figure 14. Female change in relationship satisfaction as predicted by female negative communication and therapist technique factors.



Similarly, technique factors significantly moderated the female partner relationship between negative communication and change in relationship satisfaction, $\gamma = -1.371, p = .015$, such that at higher levels of therapist technique factors the relationship between female negative communication and decreased male relationship satisfaction was stronger than at moderate and lower levels of therapist technique factors. As seen in Figure 15, the slopes for the three levels of therapist use of technique factors indicate that greater therapist use of technique factors enhanced the relationship between greater initial female negative communication and greater decrease in male relationship satisfaction over the course of treatment.

Figure 15. Male change in relationship satisfaction as predicted by female negative communication and therapist technique factors.

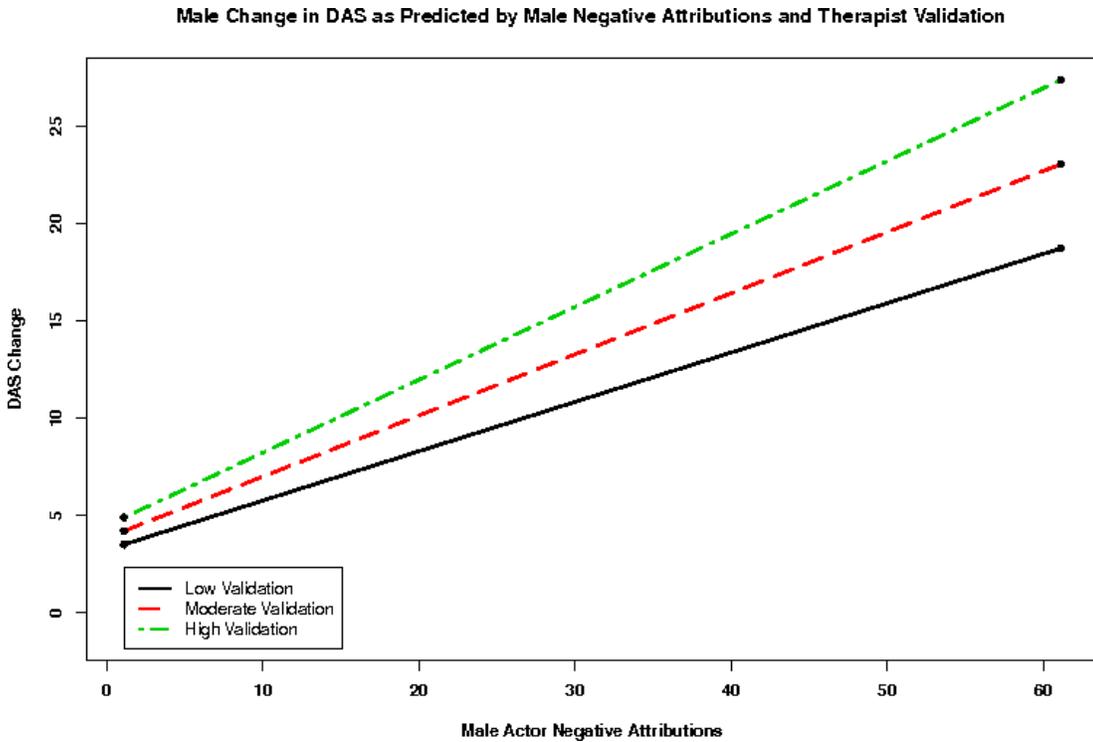


Test of Hypothesis 12: *The degree to which therapists utilize systemic techniques and session structure will moderate the negative relation between degree of couple negative communication behavior and change in psychologically abusive behavior, such that the more therapists utilize systemic techniques and session structure, the lower the association between couple negative communication behavior and change in psychologically abusive behavior from pre-treatment to post-treatment.* This hypothesis was not supported.

Test of Hypothesis 13: *The degree to which therapists utilize warmth, empathy, presence, validation, and collaboration will moderate the negative relation between degree of couple negative attributions about each other and change in relationship satisfaction, such that the higher the level of therapist warmth, empathy, presence, validation, and collaboration, the lower*

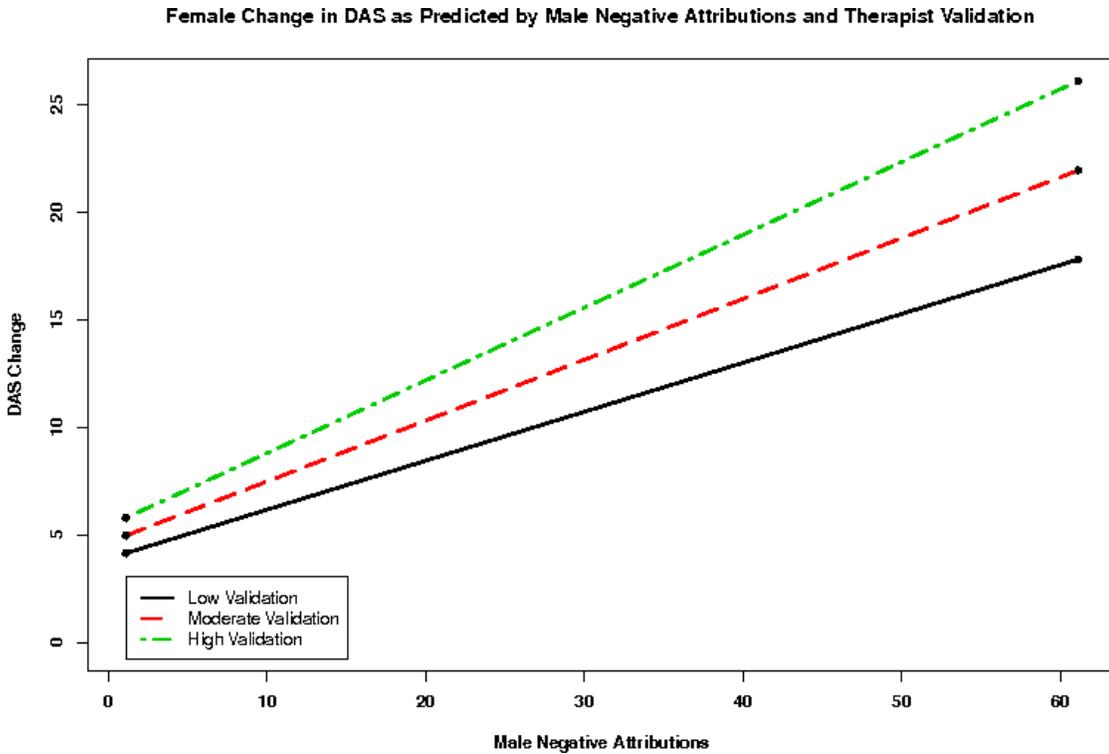
the association between couple negative attributions about each other and change in relationship satisfaction from pre-treatment to post-treatment. It was expected that there would be a negative association between negative attributions and positive change in relationship satisfaction such that those clients who had higher levels of pre-treatment negative attributions about their partners would experience less improvement in relationship satisfaction over the course of treatment. It was then expected that therapist use of relationship factors would buffer the negative influence that these negative attributions had on therapy outcome in terms of relationship satisfaction. A non-significant main effect association between level of pre-treatment negative attributions and degree of improvement in relationship satisfaction was found in two instances, but the direction of the moderating influence of therapist relationship factors was unexpected. The moderating influence of therapist relationship factors was supported in two instances in which the non-significant positive main effect association between negative attributions and improved relationship satisfaction occurred. Validation had a significant moderating influence on the male actor relationship between negative attributions and change in relationship satisfaction ($\gamma = 0.126, p = .007$), such that at higher levels of therapist validation the relationship between male negative attributions and improved relationship satisfaction was stronger than at moderate and lower levels of therapist validation. As illustrated in Figure 16, the slopes for the three levels of therapist validation indicate that greater therapist validation enhanced the relationship between greater pre-treatment male negative attributions and more improvement in male relationship satisfaction over the course of treatment.

Figure 16. Male change in relationship satisfaction as predicted by male negative attributions and therapist validation.



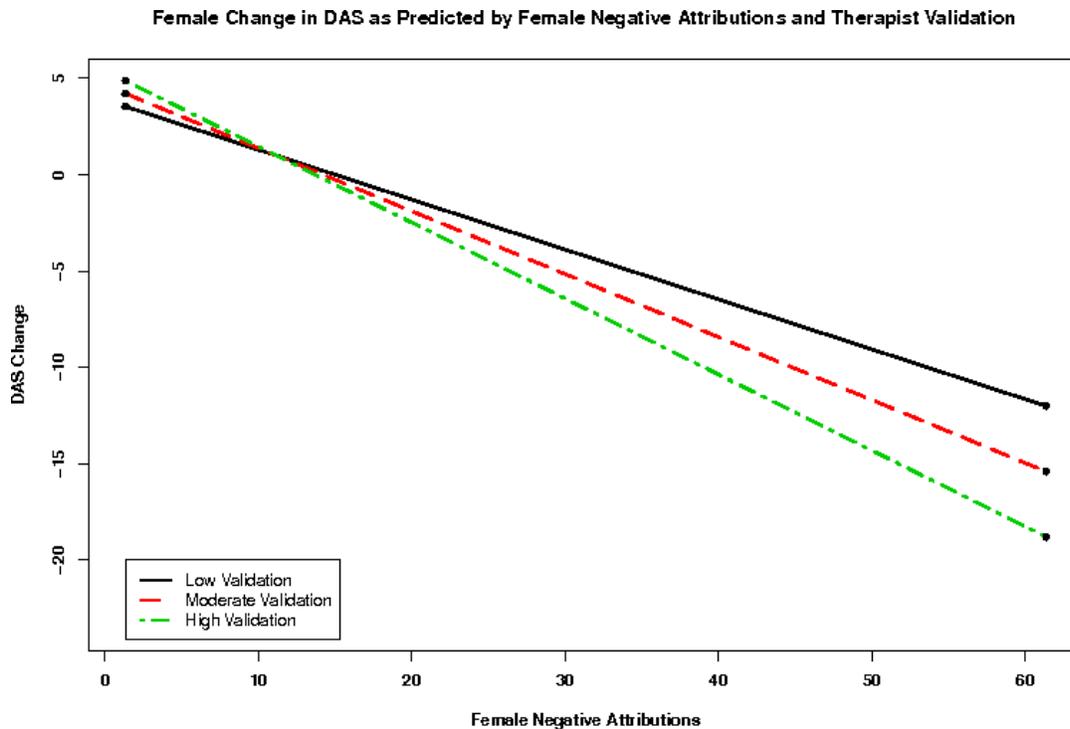
Validation also had a significant moderating influence on the male partner relationship between negative attributions and change in relationship satisfaction ($\gamma = 0.115, p = .010$), such that at higher levels of therapist validation the relationship between male negative attributions and improved female relationship satisfaction was stronger than at moderate and lower levels of therapist validation. As seen in Figure 17, the slopes for the three levels of therapist validation indicate that greater therapist presence enhanced the relationship between greater male pre-treatment negative attributions and more improvement in female relationship satisfaction over the course of treatment.

Figure 17. Female change in relationship satisfaction as predicted by male negative attributions and therapist validation.



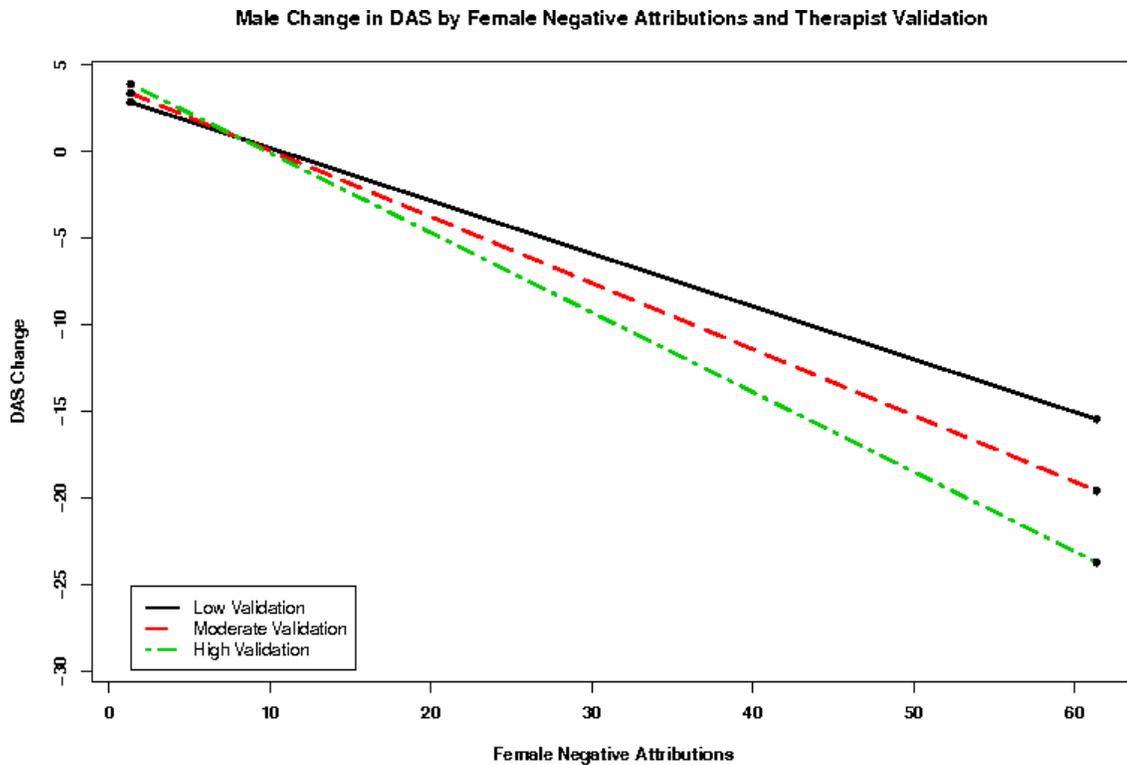
Several findings were counter to this hypothesis. Validation had a significant moderating influence on the female actor relationship between negative attributions and change in relationship satisfaction ($\gamma = -0.141, p = .030$), such that at higher levels of therapist validation the relationship between initial female negative attributions about her partner and decreased gains in her relationship satisfaction was stronger than at moderate and lower levels of therapist validation. As illustrated by Figure 18, the slopes for the three levels of therapist validation indicate that greater therapist validation enhanced the negative relationship between initial female negative attributions and declines in relationship satisfaction over the course of therapy.

Figure 18. Female change in relationship satisfaction as predicted by female negative attributions and therapist validation.



Similarly, validation had a significant moderating influence on the female partner relationship between negative attributions and change in relationship satisfaction ($\gamma = -0.162$, $p = .008$), such that at higher levels of therapist validation the relationship between female negative attributions about her partner and decreased gains in male relationship satisfaction was stronger than at moderate and lower levels of therapist validation. As seen in Figure 19, the slopes for the three levels of therapist validation indicate that greater therapist presence enhanced the negative relationship between female pre-treatment negative attributions and greater decrease in male relationship satisfaction.

Figure 19. Male change in relationship satisfaction as predicted by female negative attributions and therapist validation.



Test of Hypothesis 14: *The degree to which therapists utilize warmth, empathy, presence, validation, and collaboration will moderate the negative relation between degree of couple negative attributions about each other and change in psychologically abusive behavior, such that the higher the level of therapist warmth, empathy, presence, validation, and collaboration, the lower the association between couple negative attributions about each other and change in psychologically abusive behavior from pre-treatment to post-treatment. This hypothesis was not supported.*

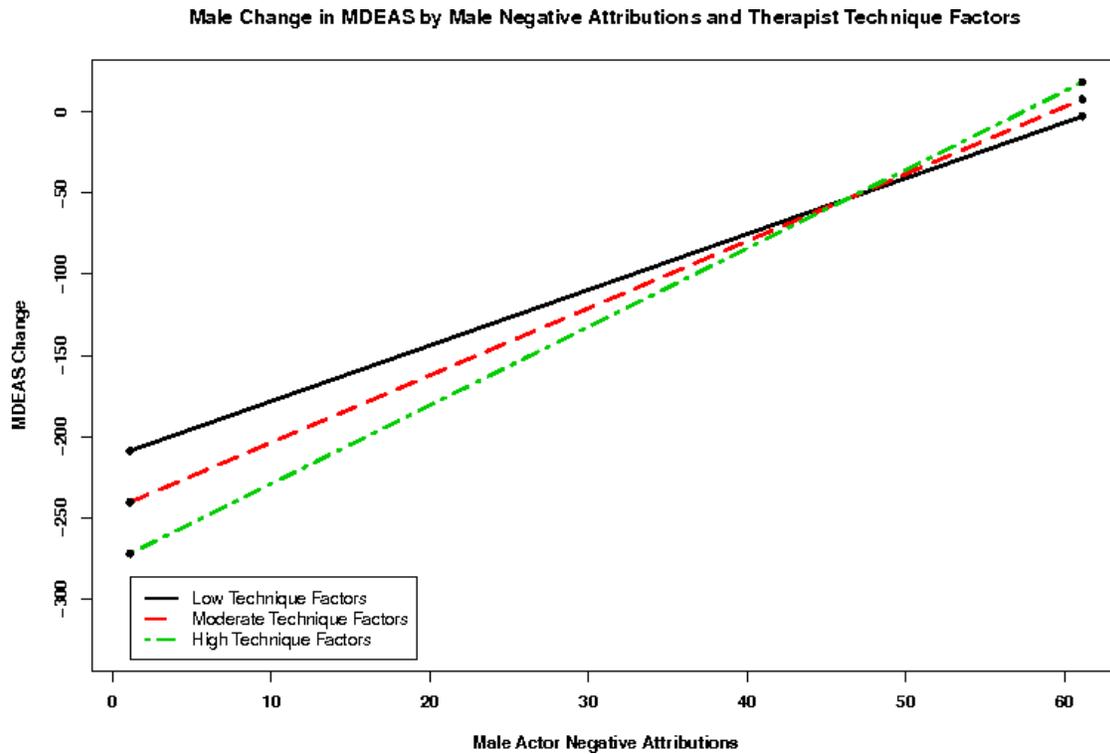
Test of Hypothesis 15: *The degree to which therapists utilize systemic techniques and session structure will moderate the negative relation between degree of couple negative attributions about each other and change in relationship satisfaction, such that the more the therapists utilize systemic techniques and session structure, the lower the association between couple negative*

attributions about each other and change in relationship satisfaction from pre-treatment to post-treatment. This hypothesis was not supported.

Test of Hypothesis 16: *The degree to which therapists utilize systemic techniques and session structure will moderate the negative relation between degree of couple negative attributions about each other behavior and change in psychologically abusive behavior, such that the more therapists utilize systemic techniques and session structure, the lower the association between couple negative attributions about each other and change in psychologically abusive behavior from pre-treatment to post-treatment.* It was expected that there would be a negative association between degree of negative attributions and positive change in psychological abuse, such that those clients who had higher levels of pre-treatment negative attributions about their partners would experience less decrease in the use of psychological abuse over the course of treatment. It was then expected that therapist use of technique factors would buffer the negative influence that negative attributions had on therapy outcome in terms of use of psychologically abusive behavior. There was a non-significant main effect association in the hypothesized direction between males' initial negative attributions and change in males' psychological abuse, in that higher levels of male negative attributions were associated with less decrease in their use of psychologically abusive behaviors over the course of treatment. The pattern of the significant moderating influence of therapist technique factors, however, was unexpected. At higher levels of therapist use of technique factors, the relationship between male negative attributions and decreased use of psychological abuse was stronger than at moderate and lower levels of therapist technique factors, $\gamma = 0.891$, $p = .042$. As illustrated in Figure 20, the slopes for the three levels of therapist technique factors indicate that greater therapist use of technique factors enhanced the

relationship between greater initial male negative attributions and less decrease in the use of psychological abuse by males over the course of therapy.

Figure 20. Male change in psychological abuse as predicted by male negative attributions and therapist technique factors.



Summary of Findings

Overall Change in Symptoms

Encouragingly, those couples who participated in ten sessions of couple therapy did report improvements in their relationship in terms of both of the study dependent variables. Both male partners and female partners reported increases in relationship happiness, indicating that at the beginning of treatment they were slightly unhappy with their relationships, and by the end of treatment they were happy with their relationships. Given that the couples who participated in this study all had mild to moderate levels of abuse in their relationships pre-treatment, it is very

promising that both males and females perpetrated a significantly lower amount of psychological abuse against their partners, as reported by their partners, by the end of treatment.

Negative Attributions Predicting Therapy Outcome

Negative attributions on their own did not predict therapy outcome as had been expected. It was hypothesized that higher levels of negative attributions would be associated with less positive change in relationship satisfaction for males and females over the course of treatment, and that they would also be associated with less decrease in the psychological abuse over the course of treatment. There was no significant relationship between negative attributions and change in relationship satisfaction. In terms of change in psychological abuse, male and female negative attributions influenced the amount of psychological abuse that males used against their female partners differentially. Higher levels of male pre-treatment negative attributions were associated with a decrease over the course of treatment in the amount of psychological abuse that they used against their female partners, whereas higher levels of female pre-treatment negative attributions were associated with an increase over the course of treatment in the amount of psychological abuse that males used against their female partners. This demonstrates that male negative attributions and female negative attributions have different impacts on the course of couple treatment in terms of affecting psychologically abusive behaviors.

Negative Communication Predicting Therapy Outcome

The results regarding the relationship between negative communication and therapy outcome were also inconsistent with the study's hypotheses that higher levels of male and female negative communication would be associated with less improvement in relationship satisfaction over the course of treatment, and with less decrease in psychologically abusive behavior over the course of treatment. There was no significant association between negative communication and

relationship satisfaction. It was not expected that higher levels of pre-treatment negative communication would be associated with increases in psychological abuse, as it was found to be the case for females in predicting their use of psychologically abusive behaviors from their own use of negative communication. However, this finding was more closely aligned with the study's hypotheses than the findings that higher levels of male pre-treatment negative communication were significantly associated with decreases in the use of psychological abuse for both males and females, given that it was expected that higher levels of pre-treatment negative communications would impede positive couple outcomes over the course of therapy.

Therapist Relationship Factors Predicting Therapy Outcome

It was hypothesized that couples whose therapists utilized higher levels of warmth, empathy, validation, and presence would have more improvement in relationship satisfaction and greater decreases in the use of psychologically abusive behaviors over the course of treatment than couples whose therapists implemented lower levels of these relationship behaviors. Counter to this study's hypotheses, and the existing literature, this was not found. The only significant main effect finding for therapist relationship factors and therapy outcome was in the opposite direction of what was expected, in that higher levels of therapist presence were associated with less positive change in relationship satisfaction for males in one of the study's statistical models.

Therapist Technique Factors Predicting Therapy Outcome

It was hypothesized that therapist use of technique factors (systemic techniques and control of the session) would be associated with greater improvement in relationship satisfaction and a greater decrease in psychological abuse. A single instance of this effect was found in the findings for Model 3, in that the more therapists employed technique factors the more that males' psychological abuse against their female partners decreased over the course of treatment. The

other significant findings, however, indicate that therapist use of technique factors was actually associated with declines in relationship satisfaction and increases in the use of psychological abuse over the course of therapy. In Model 1, greater therapist use of technique factors was associated with less positive change in relationship satisfaction for females. In Model 3, the more that therapists used technique factors the more the females increased their psychological abuse against their partners. These findings suggest that therapist technique factors differentially influence the therapy experiences of male and female members of couples.

Therapist Relationship Factors Moderating the Relationship between Client

Characteristics and Therapy Outcome

Expected findings. It was hypothesized that therapist use of relationship factors such as warmth, empathy, validation, and presence would moderate the relationship between client pre-treatment characteristics and therapy outcome such that these relationship factors would buffer the detrimental influence of negative attributions and negative communication on change in relationship satisfaction and psychological abuse. Empathy did not significantly moderate the relationship between the independent variables and the dependent variables as expected. Higher levels of therapist warmth were associated with greater therapeutic gains than lower levels of therapist warmth in two instances. At higher levels of therapist warmth, the relationship between male negative communication and female positive change in relationship satisfaction was stronger than at lower levels of therapist warmth. Also, at higher levels of therapist warmth the association between female negative communication and decrease in the amount of psychological abuse used by the female was stronger than at moderate and lower levels of therapist warmth. Although it had been hypothesized that greater therapist warmth would facilitate positive outcomes by dampening the negative impact of negative communication, the

finding indicated that therapist warmth enhanced a *positive* impact of males' and females' negative communication. Thus the overall hypothesis that higher levels of therapist warmth will facilitate therapeutic gains or reduce therapeutic declines was supported even though it involved an unexpected positive effect of males' and females' negative communication behavior.

The findings indicate that therapist presence and validation have a more complex moderating influence on the relationship between couple pre-treatment characteristics and therapy outcomes than was hypothesized, in that there were both several cases in which these relationship factors moderated the relationships between the independent and dependent variables in the expected direction and several others in which they moderated the relationship in an unexpected fashion. In terms of therapist presence, at higher levels of therapist presence, the relationship between female negative communication and positive change in female relationship satisfaction was stronger than at moderate and lower levels of therapist presence, meaning that the more that therapists were present with couples in which female partners presented to treatment with higher levels of negative communication, the greater gains those females had in terms of their relationship satisfaction. Although it had been hypothesized that greater therapist presence would facilitate positive outcomes by dampening the negative impact of negative communication, the finding indicated that therapist presence enhanced a *positive* impact of females' negative communication. Thus the overall hypothesis that higher levels of therapist presence will facilitate therapeutic gains or reduce therapeutic declines was supported even though it involved an unexpected positive effect of females' negative communication behavior. Also, at higher levels of therapist presence, the relationship between female negative communication and increased male relationship satisfaction was stronger than at moderate and lower levels of therapist presence, meaning that the more that therapists conveyed presence with

couples in which females presented to treatment with higher levels of negative communication, the greater gains their male partners had in relationship satisfaction over the course of treatment. Again, the overall hypothesis that higher levels of therapist presence will facilitate therapeutic gains or reduce therapeutic declines was supported even though it involved an unexpected positive effect of females' negative communication behavior.

Similarly, in terms of therapist validation, at higher levels of therapist validation the relationship between female negative communication and decreased use of male psychological abuse was stronger than it was at moderate and lower levels of therapist validation, meaning that the more that therapists validated couples in which the female partner presented to treatment with high levels of negative communication, the more male partners decreased their use of psychological abuse over the course of treatment. Although it had been hypothesized that greater therapist validation would facilitate positive outcomes by dampening the negative impact of negative communication, the finding indicated that therapist validation enhanced a *positive* impact of females' negative communication. Thus the overall hypothesis that higher levels of therapist validation will facilitate therapeutic gains or reduce therapeutic declines was supported even though it involved an unexpected positive effect of females' negative communication behavior. Higher levels of therapist validation were also associated with a stronger relationship between male negative attributions and improved relationship satisfaction for both males and females than lower levels of therapist validation, meaning that the more that therapists validated couples in which the male partner presented to treatment with negative attributions about the female partner, the greater gains male and female partners had in relationship satisfaction over the course of treatment. Although it had been hypothesized that greater therapist validation would facilitate positive outcomes by dampening the negative impact of negative attributions,

the finding indicated that therapist presence enhanced a *positive* impact of males' negative attributions. Thus the overall hypothesis that higher levels of therapist validation will facilitate therapeutic gains or reduce therapeutic declines was supported even though it involved an unexpected positive effect of males' negative attributions.

Unexpected findings. A finding that was counter to the study's hypotheses regarding the moderating influence of therapist presence was that higher levels of therapist presence were associated with a stronger relationship between male negative communication and decreased female relationship satisfaction, meaning that the more that therapists conveyed presence with couples in which the male partner presented to treatment with negative communication, the less satisfied female partners became over the course of treatment. Also unexpectedly, at higher levels of therapist validation the relationship between female negative communication and decreased relationship satisfaction over the course of treatment was stronger, meaning that the more that therapists validated couples in which the female partner presented to treatment with negative communication, the less satisfied female partners became over the course of treatment. Furthermore, at higher levels of therapist validation the relationship between female negative attributions about her partner and decreases in both her own and her male partner's relationship satisfaction was stronger than at moderate and lower levels of therapist validation, meaning that the more that therapists validated couples in which the female presented to treatment with negative attributions, the less satisfied both partners became over the course of treatment.

Therapist Technique Factors Moderating Relationship between Client Characteristics and Therapy Outcome

Expected findings. Therapist use of systemic and session control technique factors did not significantly moderate the relationship between client characteristics and therapy outcome in the expected direction.

Unexpected findings. It was hypothesized that level of therapist use of technique factors would moderate the relationship between initial negative client characteristics and therapy outcome such that greater use of therapist technique factors would minimize the detrimental impact of higher levels of negative attributions and negative communications on therapy outcome. The findings of the study, however, were counter to this hypothesis. At higher levels of therapist technique factors the relationship between female negative communication and decreased relationship satisfaction for both females and males was stronger than at moderate and lower levels of therapist technique factors, meaning that the more that therapists used technique factors with couples in which the female presented to treatment with negative communication, the less satisfied both partners became over the course of treatment. At higher levels of therapist technique factors, the relationship between male negative attributions and less decrease in the use of psychological abuse was stronger than at moderate and lower levels of therapist technique factors, meaning that the more that therapists used technique factors with couples in which the male presented to treatment with negative attributions about his female partner, the less decrease males had over the course of treatment with regard to use of psychological abuse.

Chapter 5: Discussion

Interpretation of Findings

Overall Change in Relationship Satisfaction and Psychologically Abusive Behavior

It is encouraging that both males and females experienced positive therapeutic gains with regard to increases in relationship satisfaction and decreases in the use of psychological abuse over the course of treatment. On average, male and female partners indicated ‘a little’ unhappiness with their relationship pre-treatment, and by the end of ten sessions of conjoint treatment they indicated that they were happy with their relationships. Increases in overall relationship satisfaction for male and female partners have previously have been reported for the sample from which the data used in this study were drawn (LaTaillade, Epstein, & Werlinich, 2006). Considering that this was a sample of couples who were distressed enough to seek professional assistance for problems in their relationships, such gains from relatively brief treatment are impressive. Both partners also used significantly less psychologically abusive behavior against one another by the end of the ten treatment sessions. These findings are consistent with those from prior studies on couple therapy outcome (as reported by Christensen et al., 2006 and many others), and indicate that, overall, conjoint therapy enhanced relationship satisfaction and facilitated partners’ decreased use of negative behavior. However, although these overall outcome findings are encouraging, they do not address the calls made by Lebow (2000), Heatherington et al. (2005), or Christensen et al. (2006) among others to explore the processes through which couple therapy facilitates improvements in relationships. This study’s other findings regarding the client and therapist common factors related to treatment outcomes for each partner do provide important new information about process factors in couple therapy.

The Influence of Client Common Factors on Couple Therapy Outcome

Although there is a large body of literature substantiating client improvements through the course of couple therapy, less is known about client common factors that influence therapy outcome (Sprenkle, 2002). Whisman et al. (2005) even conclude that there is no consistent evidence in terms of how client characteristics influence the course of treatment. Specifically, there is inconsistency with regard to how client pre-treatment distress influences the course of treatment. A number of studies have found that higher levels of distress are associated with fewer therapeutic gains (see Johnson and Lebow, 2000), whereas fewer have indicated that partners' initially higher levels of distress or negative behavior are associated with greater therapeutic gains (see Hahlweg et al., 1984). One of the aims of this study was to investigate how the client common factors of partners' pre-therapy negative attributions about each other and negative communication behaviors toward each other influenced the couple therapy outcomes.

Negative attributions predicting therapy outcome. Prior studies have found that members of distressed couples are more likely to make negative attributions about each other (that one's partner is responsible for relationship problems and behaves negatively due to negative intentions) than are non-distressed partners (Bradbury & Fincham, 1990; Gottman, 1998), and that these negative inferences about one's partner are associated both with perceiving the partner's actions more negatively (Vanzetti et al., 1992) and behaving more negatively toward the partner (Epstein & Baucom, 2002). Consequently, in the present study it was hypothesized that members of couples who presented to treatment with higher levels of negative attributions about each other would experience fewer therapeutic gains in terms of relationship satisfaction and psychological abuse than couples whose members presented with lower levels of negative attributions about one another. The results of the study, however, indicate that negative

attributions influenced treatment outcome in several ways counter to this hypothesis. First, negative attributions were not directly predictive of change in relationship satisfaction. Second, counter to the hypothesis, males' higher levels of negative attributions about their partner were associated with the males' *decrease* in psychologically abusive behavior over the course of treatment. Interestingly, females' higher levels of negative attributions about their male partners were associated with an *increase* in males' psychological abuse over the course of treatment. This indicates that negative attributions influence the male partner's behavior very differently over the course of treatment depending on whether or not he is the one who has negative attributions about his partner or if his partner has negative attributions about him. It also indicates that therapy had different effects depending on whether the male or the female partner entered treatment with negative attributions, such that male negative attributions opened the door for therapy to facilitate male partners becoming less psychologically abusive, whereas female negative attributions amplified negative male behavior. This finding is similar to Huston and Vangelisti's (1991) finding that wife baseline relationship satisfaction is predictive of husband negativity, in that here we find that the female partner's negativity has detrimental influences on therapeutic outcomes and does not lead to the same opportunity for positive therapeutic gains as the male's own negativity does. This finding suggests that the more the female partner blames her partner for relationship problems and attributes negative motives to him, the less that couple therapy is able to reduce the male's negative behavior, and in fact the greater the chance that the male will behave even more negatively. In contrast, the more that males enter couple therapy with blaming attributions, the more that the processes occurring in couple therapy have potential to reduce their negativity. Given the common finding that in couple conflicts females are more likely to express dissatisfaction and demand changes (Eldridge, Sevier, Jones, Atkins &

Christensen, 2007), perhaps the present finding indicates that females who make more blaming attributions express them during sessions and elicit more frustration, defensiveness, and psychologically aggressive behavior by their male partners. In a sense, for females, the therapeutic environment does not offer a format for communicating in a way that differs from their usual pattern of taking the lead in expressing relationship concerns and in asking for changes from their male partners. For males, however, who are more likely to withdraw from partner demands (Eldridge, et al., 2007), the environment of couple therapy, in which there is a therapist present to listen and hear from both partners, may offer an opportunity for them to express their relationship concerns in a different and more constructive way. This novel way of being heard and of communicating may facilitate distressed male partners to try new and positive ways of behaving in relation to their female partners. Considering these findings in terms of the demand-withdrawal patterns found in many couple relationships is speculative, and further research will be needed to uncover the potentially different experiences of males and females during couple therapy that account for the different consequences that follow from their initial levels of negative attributions regarding their partners.

Negative communication predicting therapy outcome. Over thirty years of empirical findings indicate that couples who present to couple therapy have high levels of communication difficulties, and that distressed couples are more likely than non-distressed couples to report and exhibit negative patterns of communication (Bornstein & Bornstein, 1986; Epstein & Baucom, 2002; Gottman, 1976). Despite one study that found that higher levels of pre-treatment negative communication behaviors were associated with greater gains in relationship happiness than lower levels of pre-treatment negative communication (Hahlweg et al., 1984), in the present study it was hypothesized that higher levels of pre-treatment negative communication would be

associated with smaller increases in relationship satisfaction and smaller decreases in the use of psychological abuse over the course of treatment, given prior evidence of overall improvements in satisfaction and abusive behavior over the course of therapy in this sample (LaTaillade, et al., 2006). The present study found no significant relationship between initial level of negative communication and change in relationship satisfaction for male or female partners. Although it was not expected that pre-treatment negative communication would be predictive of increases in the use of psychological abuse, it was found that females' negative communication predicting their own greater use of psychological abuse by the post-therapy assessment. This finding is, however, consistent with the hypothesis in that negative communication would have a negative impact on couple therapy outcome; rather than this negative outcome being less improvement, it actually involved deterioration in females' behavior toward their partners. In contrast, males' pre-treatment negative communication was associated with their use of less psychologically abusive behavior toward their female partners over the course of treatment, as well as with the female partners' decreased use of psychological abuse over the course of therapy. As was found regarding the client common factor of negative attributions, we see that male and female levels of pre-treatment negativity have very different influences on couple therapy outcomes. Again, greater male negativity is associated with greater improvements in abusive behavior by himself and by his partner, whereas greater female negativity is associated with therapeutic declines in relationship functioning. This again indicates that couple therapy has different effects with male and female negativity, and that male negativity creates an opportunity for therapy to intervene in such a way that male and female partners experience improvements in their relationships that female negativity does not.

It is also important to consider differences between male and female partners in their pre-treatment levels of relationship distress. In the present sample, the mean pre-treatment scores on DAS item 31 for both males and females indicated that both presented to treatment with “a little unhappiness” with their relationships on a scale ranging from extremely unhappy to perfect. However, there was a non-significant trend for females to report less satisfaction with their relationships (1.88 points out of 6) than males (2.43 points out of 6) ($t = -1.75, p = .08$, 2-tailed). Perhaps if females are entering couple therapy with greater negativity than males are, their elevated relationship unhappiness may make it more difficult for conjoint couple therapy to intervene positively with the couple. It is important to consider the complex processes that occur during conjoint couple therapy, in which negativity on one partner’s part can influence both partners’ functioning. In conjoint couple therapy, if one partner is thinking negatively about the other and expressing negativity, the other partner is observing this and likely reacts to it. The results of this study suggest that conjoint couple treatment handles the dyadic processes that result when a male partner enters treatment with negatively cognitions and behavior toward his partner in a way that is helpful to both members of the couple, whereas conjoint couple treatment does not handle the complex dyadic exchanges that result from females who think and behave negatively toward their male partners. Because the measures used in this study could not tap the male and female partners’ subjective experiences in sufficient depth to explain the gender differences that were found, future research should include more comprehensive assessment of such responses that may moderate the relationship between initial negativity and change over the course of therapy.

The Influence of Therapist Common Factors on Couple Therapy Outcome

This study also examined the association between therapist common factors (how therapists behave toward clients during sessions that is not tied to a particular therapy model per se) and couple therapy outcome. There is an extensive literature base that suggests that therapist common factors account for a significant portion of therapeutic change in individual psychotherapy (see Hubble et al., 1999; Lambert & Barley, 2001; Wampold, 2001), and emerging evidence that these common factors, especially the client-therapist alliance, have a significant influence on the course of couple therapy (Anderson & Johnson, 2010; Anker, et al., 2010; Johnson & Talitman, 1997; Knobloch-Fedders et al., 2007; Pincus et al., 2008). This study examined the associations between the therapist relationship common factors of warmth, empathy, presence, and validation, as well as the therapist technique common factors of systemically-based techniques and session structuring, and couple therapy outcomes.

Therapist relationship factors predicting therapy outcome. The client-therapist relationship or client-therapist alliance is well-documented in the literature as a common factor influential in individual psychotherapy outcome. Some studies suggest that this relationship is also a key predictor of couple therapy outcome, but less is known about how client-therapist relationship factors influence couple therapy (Sprenkle & Blow, 2004). Given what is already known about therapist common factors, it was hypothesized in the present study that the therapist relationship factors of warmth, empathy, presence, and validation would have main effect associations with greater gains in positive therapeutic outcomes. Specifically, it was expected that clients who worked with therapists who expressed higher levels of warmth, empathy, presence, and validation would have greater improvements in relationship satisfaction and greater decreases in the use of psychologically abusive behavior than those couples who worked

with therapists who exhibited lower levels of these factors. However, these direct effect relationships between therapist relationship variables and client outcomes were not found in this study. In fact, greater therapist presence, or the degree to which therapists showed interest in the clients' lives, offered clear lines of questioning, and maintained eye contact and posture directed toward the clients, was associated with less positive change in relationship satisfaction for males in the statistical model that also included negative attributions. This indicates that rather than being helpful and supportive, greater therapist presence is harmful to the male's change in relationship satisfaction. These results are surprising considering the current literature base that consistently finds associations between positive forms of therapist common factors behaviors and positive therapy outcome. It is important, however, to consider that the measure of therapist presence is a single aspect of the client-therapist alliance, and that most studies examining the relationship of common factors have more broadly investigated the influence of the client-therapist alliance rather than investigating individual components of the alliance.

These findings may, in part, be due to the limitations of the present study (as discussed later in this chapter), or they may indicate that these aspects of the client-therapist relationship are not key in predicting therapy outcome. The fact that only one type of therapist behavior, presence, significantly predicted couple therapy outcome, and that it predicted outcome in an unexpected direction, indicates that there was something particularly salient about how the therapists inquired about the couples' lives, and how they facilitated staying on topic in session. Given that one of the components of the presence subscale was inquiring about clients' lives in order to show interest in who each of the clients was as a person, it is possible that clients did not experience this as helpful, or it might have been a therapeutic strategy that prevented couples from actually discussing their presenting concerns and resolving relationship issues. Another

component of the presence subscale was therapists' use of consistent lines of questioning. If the topics being discussed were not those that partners considered salient for resolving their relationship concerns, then therapists were remaining "present" with questioning that clients may not have found constructive. More specifically, the finding regarding a negative relationship between therapist "presence" behavior and change in male partners' relationship satisfaction may indicate that among distressed couples who present to therapy, males do not experience the therapists' inquiry about the clients' personal lives, their consistent lines of inquiry, and their eye contact and body language as helpful, and in fact these therapist behaviors may lead to decreases in relationship satisfaction for the male. Given that it is not possible to determine whether the therapists were being more present with the male's presenting concerns or the female's presenting concerns, it is impossible to know whether an imbalance in who the therapist was paying attention to influenced the males' treatment outcome. It seems plausible that this decrease in male relationship satisfaction could be the result of males being put in the 'hot seat' in couple therapy, and not enjoying this position, or the result of the therapist being more present with the female partner and neglecting the male partner. The fact that the large majority of the cotherapist teams in the study were comprised of two females also should be considered, as this often created a situation in which a male partner participated in sessions with three women. Although the specific dynamics that occurred in the couple therapy sessions cannot be determined, whatever the observers' ratings of greater therapist presence reflected was not helpful to males over the course of therapy.

Therapist technique factors predicting therapy outcome. It is not as customary to investigate therapist technique factors as common factors influencing therapeutic outcomes as it is to investigate client-therapist alliance or relationship factors, although several authors suggest

that it is important to investigate these factors as well. For the present study, therapist technique factors included therapist use of systemically-based techniques and therapist session structuring. Blow and Sprenkle (2001) and Davis and Piercy (2007a, 2007b) suggest that therapist use of systemically-based techniques positively influences therapeutic outcomes, and others find that the more that a therapist structures sessions (versus allowing the pace and content to unfold based on client responses), the more positive therapeutic gains clients make (Castonguay & Beutler, 2006; Green & Herget, 1991; Gurman & Kniskern, 1981). In couple therapy there is a danger that distressed partners' upset feelings toward each other and their typical negative interaction patterns will dominate sessions, so the therapist's ability to maintain control and facilitate more productive interactions seems important. Regarding the findings of this study, in one instance the hypothesis regarding the relationship between therapist technique factors and couple therapy outcome was supported, in that higher levels of therapist technique factors were associated with greater decreases in psychological abuse for males in the model tested that included negative attributions. Thus, when therapists used systemically-based techniques and structured sessions in a constructive and productive manner, males decreased their psychologically abusive behavior toward their female partners over the course of treatment. The opposite, however, was true for female partners in the same model, as the more that therapists used technique factors the more that females increased their psychologically abusive behavior toward their male partners over the course of treatment. Therapist use of technique factors had a similar impact on change in female relationship satisfaction, in that the more therapists utilized technique factors the less positive change in relationship satisfaction females experienced over the course of therapy. This pattern is consistent with the pattern of findings emerging from this study in which male and female partners experience therapy quite differently, and similar

common factor characteristics lead to different therapy outcomes depending on gender. Here we see that therapist use of technique factors is helpful in reducing male partners' amount of psychological abuse, whereas it is associated with both a decrease in females' relationship satisfaction and an increase in their use of psychologically abusive behavior. When therapists illuminate the couple's interactional process (particularly its circular nature) and attempt to balance and control conflict between the partners during sessions, females become more distressed and psychologically aggressive, whereas males become less aggressive toward their partners. Therapist behaviors that are commonly assumed to be constructive (and have been found to be so in individual therapy) have mixed effects in couple therapy, based on gender of the partner.

Therapist Common Factors Moderating the Relationship Between Client Pre-Treatment Common Factors and Therapy Outcome

In addition to the hypotheses that therapist common factors would have a direct effect on therapeutic outcomes, it was also hypothesized that these common factors would moderate the relationships between client pre-treatment common factors and couple therapy outcomes. It was hypothesized that high levels of both therapist relationship factors and technique factors would buffer, or minimize, the negative impacts that the client common factor characteristics of negative attributions and negative communication had on improvements in relationship satisfaction and psychological abuse. These hypotheses were based on the assumption that there would be negative associations between the client common factors of negative attributions and negative communication and the therapeutic outcomes, which was not always the case. As described below, in a number of instances rather than buffering a negative effect of client pre-treatment common factor characteristics, the therapist relationship factors actually enhanced a

positive relationship between pre-treatment client characteristics and therapeutic outcomes, or they detracted from the positive relationship between the client factors and the therapeutic outcomes.

Warmth. Therapist warmth, as reported by clients and as observed by raters of therapy, has been found to be associated with greater positive therapy outcomes (Greenberg & Paivio, 1997; Lambert & Barley, 2001). This study supports previous findings and was consistent with the hypotheses that therapist warmth would have a positive influence on the relationship between client pre-treatment characteristics and couple therapy outcomes. With regard to negative communication, the relationship between male negative communication and positive change in females' relationship satisfaction was stronger at higher levels of therapist warmth than at moderate and lower levels of therapist warmth. Although the overall association between males' initial levels of negative communication and improvement in females' relationship satisfaction was unexpected, this positive outcome occurred and was enhanced by greater therapist warmth. Similarly, at higher levels of therapist warmth the association between initial level of female negative communication and decrease in females' amount of psychological abuse over the course of couple therapy was stronger than at moderate and lower levels of therapist warmth. These findings indicate that therapist warmth has a particularly positive influence on therapy outcomes for females when male and female partners enter couple therapy with higher levels of negative communication. When interpreting these findings, it is important to note that all of the couples worked with co-therapy teams that consisted of at least one female co-therapist, and that the large majority of couples worked with co-therapy teams composed of two female co-therapists. Therefore, the warmth being offered to both members of the couple most often was coming from female therapists. Perhaps female members of couples in which either partner presents to

treatment with a higher level of negative communication are more receptive to warmth from female therapists than are male members of the couples.

Greenberg and Paivio (1997) suggest that therapist warmth facilitates therapeutic gains because therapist warmth communicates to the clients that their feelings are important, thus validating their emotions and experiences. When clients enter therapy with higher levels of negative communication, they may present their therapists with more expressions of distress that the therapist can respond to in a warm way, and female partners may be more likely to experience the warmth from the female therapists as helpful to their situation. Given the complex dyadic exchanges that occur within couple therapy, when either male or female negative communication is met with higher levels of therapist warmth, including the therapist's use of humor, smiling, and supportive tone, the positive therapy environment may enhance females' relationship satisfaction and encourage them to use less psychologically abusive behavior. It is possible that the therapist's use of warmth either makes the couple's situation seem less dire to female partners, leading the females to perceive that the couple's problems can be solved and leading them to engage in less psychologically abusive behavior. In addition, the atmosphere created in sessions by the therapists' warmth may facilitate greater self-disclosure by male partners than typically occurs in the couple's home environment, resulting in the females gaining more insight into their partners' distress and increasing their satisfaction with their couple relationships.

Therapist warmth softened the influence of male and female negativity for female partners and was associated with improvements on the outcome measures for women, but therapist warmth was not associated with therapeutic declines or improvement for men. Perhaps receiving warmth from female therapists was comforting to female partners and allowed them to

form a closer relationship with their therapists that facilitated engagement with treatment and elicited positive gains for females over the course of treatment. As suggested by Greenberg and Paivio (1997), females seem to be experiencing warmth directed to the couple by the therapists as reinforcing to their emotional and relational experiences. Perhaps female clients were better able to connect with the warmth offered by the therapists because the therapists, who were mostly female themselves, were offering warmth in a way that was more compatible with offering hope and support to female clients. Female clients may have understood the warmth to be reflective of the therapists' concern for themselves as individuals and for their couple relationship because they were connected to the therapists based on their common gender, and assumed, whether accurately or not, that the female therapists connected with her experiences within the couple's relationship. For the third of the couples who had a female-male co-therapist team, it is not possible to determine whether the female partner offered more warmth to the couple than the male therapist did, or that the female partner connected with the female therapist's warmth in a way that the male partner did not. Regarding the male partners, although the warmth offered by the therapists may have provided an opportunity for men to disclose more information about their distress to their female partners during sessions, men may not have experienced the warmth offered in this therapeutic context that most often included three females in such a way that motivated him to change cognitively or behaviorally.

Empathy. It was hypothesized that degree of therapist empathy would have a significant moderating influence on the relationship between client pre-treatment common factor characteristics and couple therapy outcomes such that higher levels of therapist empathy would minimize the detrimental impact that client negative communication and negative attributions had on gains in relationship satisfaction and decreases in psychological abuse over the course of

therapy. This hypothesis was based on considerable prior empirical support for a positive relationship between therapist empathy and improvements over the course of therapy (Greenberg et al., 2001). Empathy, however, did not significantly moderate the relationship between client pre-treatment characteristics and couple therapy outcome in any of the tested models. This absence of findings may be due to therapist empathy playing a relatively minimal role in couple therapy process and outcome compared to its effect on individual therapy, or it may be a function of the specific method used to measure empathy in this study.

Although a meta-analysis conducted by Greenberg et al. (2001) found that observer rated empathy was predictive of therapy outcome, others have found that client-perceived empathy is more predictive of therapy outcome than observer rated empathy (Barrett-Lennard, 1981; Gurman, 1977). Given that observer rated empathy was used in this study, it is possible that this measurement of empathy did not accurately capture the level of empathy that the members of couples experienced, and that client-perceived empathy may have been associated with therapeutic outcomes. It is also possible that the measurement of empathy was too restricted, given that it was the only therapist relationship factor category that consisted of only one code. The range of observer rated empathy was from 2.5 to 4 (on a scale of 0 to 4), which may not have been enough variability to allow detection of a significant association with couple therapy outcome.

This absence of findings could also point to an unexpected role of empathy in couple therapy process. Perhaps empathy is not a therapist common factor behavior that is predictive of couple therapy outcome for couples who present to therapy with mild to moderate levels of abuse. Perhaps members of these couples do not experience positive gains from their therapist empathically reflecting their sentiments to them because each member is more focused on the

other partner's understanding of their situation rather than on the therapist's understanding. It may even be frustrating to some individuals to experience the contrast between an empathic therapist and the usual lack of understanding from their partner. Thus, although it is just as likely that the finding was due to methodological limitations in the assessment of therapist empathy, the absence of a moderating influence of empathy on the relationship between negative client pre-treatment common factors and therapy outcome might indicate that the role of empathy in conjoint couple therapy is not as powerful as it is in individual therapy. Couple therapists likely need to be aware that when they are exhibiting empathy for one member of a couple the other member may not perceive it favorably.

Presence. It was hypothesized that higher levels of therapist presence, or the degree to which therapists showed interest in the clients' lives, stayed on topic during session, and maintained eye contact and engaging body language during session, would minimize the negative associations between client pre-treatment negativity and couple therapy outcome. As with the other therapist relationship common factor behaviors, it was expected that higher levels of therapist presence would be associated with either greater therapeutic gains or smaller therapeutic declines for couples than would moderate or lower levels of therapist presence. This expected relationship was found in two instances: 1) higher levels of therapist presence were associated with greater gains in relationship satisfaction for females who presented to treatment with higher levels of negative communication behavior; and 2) higher levels of therapist presence were associated with greater gains in relationship satisfaction for males whose female partners presented to treatment with higher levels of negative communication behavior. The influence of therapist presence, however, becomes more complicated upon the examination of one other finding: higher levels of therapist presence were associated with greater declines in

relationship satisfaction for females when their male partners presented to treatment with higher levels of negative communication.

These findings indicate that whatever therapists are attending to, or being present with, in therapy sessions affects the relationship between male and female pre-treatment negative communication and change in relationship satisfaction differently. Greater therapist presence is helpful to females who present to treatment with higher levels of negative communication, yet when it is the male partner who presents to treatment with greater negative communication, greater therapist presence is unhelpful in facilitating females' positive relationship change. This indicates that the consequences of therapists conveying their close attention to members of couples depends on which partner entered therapy experiencing negativity. Given that negative communication is a common presenting concern for clinical couples, it is likely that these negative behaviors will be attended to by the therapists, and given that an element of how therapist presence was coded included how well the therapist stayed on topic, it can be argued that therapist attention to female negative communication behaviors created an opportunity for females to make more positive relationship gains, whereas therapist attention to male negative communication did not create this same opportunity, and was, in fact, less helpful in terms of the female's relationship satisfaction. Whereas therapist attention to female negativity may increase the female's relationship satisfaction, therapist attention to male negativity may lead to a decrease in female relationship satisfaction.

Validation. Therapists' affirmations of their clients' self worth is typically referred to as positive regard in the psychotherapy literature (Rogers, 1957) and is frequently associated with positive therapeutic outcomes (Farbe & Lane, 2001; Orlinsky et al., 1994). For this study, therapist positive regard for clients was operationalized as therapist validation by evaluating the

degree to which therapists agreed with and affirmed or legitimized the clients throughout the therapy session. It was hypothesized that in the context of higher therapist validation the detrimental impact of negative pre-treatment client common factors on positive therapeutic gains would be minimized compared to therapeutic contexts in which therapists did not offer their clients high levels of validation. What was found, however, indicates that therapist validation has a much more complex influence on the relationship between client common factor characteristics and couple therapy outcome, and that this influence of therapist validation is quite different for male and female partners.

In several cases, therapist validation intensified negative relationships between client pre-treatment characteristics and couple therapy outcome. The relationships of initial level of female negative communication and negative attributions with declines in female relationship satisfaction were stronger at higher levels of therapist validation than at lower levels of therapist validation, meaning that therapist validation had a detrimental influence on positive therapeutic gains for females who presented to treatment with cognitive and behavioral negativity. Therapist validation also strengthened the negative relationship between female negative attributions and increase in male relationship satisfaction.

In other cases, greater therapist validation made positive relationships between client pre-treatment characteristics and therapy outcomes stronger. The relationship between female negative communication and decreased use of psychological abuse by males over the course of treatment was stronger at higher levels of therapist validation than at lower levels of therapist validation. Similarly, higher levels of therapist validation strengthened the positive associations between male negative attributions and improvements in both male and female relationship satisfaction over the course of treatment. Here we see that therapist validation opens the door to

more positive gains in relationship satisfaction for males and females when males present to treatment thinking negatively about their partners, whereas greater therapist validation was associated with fewer therapeutic gains in relationship satisfaction for male and females when females presented to treatment thinking negatively about their partners. Therapist validation was also helpful in decreasing over the course of treatment the amount of psychological abuse that men exhibited when their female partners presented to treatment with more negative communication behavior. It was not helpful, however, to increases in female partners' relationship satisfaction over the course of treatment when females entered therapy with higher levels of negative communication.

Although one can only speculate about the reasons for these associations, it is not surprising that the findings with regard to this variable that taps the degree to which therapists agree with and affirm client statements are so varied, given the nature of conducting couple therapy with two individuals who disagree with each another. The complexity surrounding one member of the couple being validated by the therapist while the other partner is there to witness this validation is great, given that this validation may be perceived very differently by the two partners depending on what the therapist is validating. It is also important to consider these findings in relation to what is known about the therapists who had treated the couples included in this study: that most were young and female. When the male partner presented to treatment with negativity and these female therapists were validating and supportive of both members of the couple, both male and female partners experienced enhanced relationship satisfaction. Perhaps females were more open to hearing their male partners' distress and complaints when other women modeled support for the male's expression of such feelings, and the support that the males experienced, as well as the validation that they simultaneously observed their female

partners receiving from the therapists, softened their negativity. In contrast, when females with higher initial levels of negativity and their male partners both were offered higher levels of support and validation by female therapists, the female partners became less satisfied with their couple relationships. This may be an indicator that with the support of other women the female partners increased their existing negativity and relationship distress, to the extent that they may have dismissed the therapist's validation of their male partner.

A slightly different explanation is necessary when considering the relationship between female negative communication and male use of psychologically abusive behavior over the course of treatment in the context of higher levels of therapist validation. Here we see that when therapists offer support to couples in which the female partner came into therapy with higher levels of negative communication, the male actually uses less psychological abuse than if the female entered therapy with lower negative communication. Here the therapists' support and inquiry about the experiences of the female partner who presented to treatment with higher levels of negativity was likely an opportunity for the male partner to hear more about his female partner's experience and perhaps become more empathic, and as a result less abusive than if his female partner had presented without much negativity. It is important to reiterate that we cannot directly identify the processes underlying the relationships between the independent and dependent variables in this study, and that further investigation is needed in order to determine how therapist validation, among the other therapist common factors examined in this study, influences the relationship between client pre-treatment common factors and couple therapy outcome. Recommendations for future research directions are included later in this chapter, as these associations raise numerous questions regarding the influence of therapist common factor behaviors on treatment outcome.

Technique factors. The way that therapists structure sessions and maintain consistency in their interventions has been associated with positive therapeutic outcomes in the individual psychotherapy literature (Castonguay & Beutler, 2006; Green & Herget, 1991), and couple and family therapists consistently reference these strategies as therapeutic processes that they believe are influential in creating positive therapeutic outcomes in relational therapy (Blow & Sprenkle, 2001; Davis & Piercy, 2007a, 2007b). However, less is known empirically about how systemic techniques and session structuring influence couple therapy outcome. Given these previous findings, as well as theoretical understanding and clinical experience of the role of technique factors in influencing couple therapy outcome, it was hypothesized in the present study that therapist use of higher levels of technique factors including systemically based techniques and session structuring would minimize the detrimental influence of client pre-treatment negativity on therapeutic outcome. This, however, was not found, and in fact the opposite was found to be true in several instances for both male and female partners. The therapists' use of higher levels of technique factors strengthened the negative relationship between initial female negative communication and decreased relationship satisfaction for both male and female partners. Similarly, higher levels of therapist technique factors strengthened the negative association between male negative attributions and decrease in the use of psychological abuse by the male partner over the course of treatment.

These findings indicate that therapist use of technique factors may amplify client pre-treatment negativity. Given that technique factors were coded using a variety of components, it is difficult to determine if one of these components is more responsible than the others for this surprising association. Perhaps therapist use of circular questioning leads both members of the couple to more fully understand their negative communication patterns and to accept them as

detrimental to their relationships, thus becoming more dissatisfied. Perhaps the therapists constrained conflict in such a way that it was managed rather than resolved, leading to fewer positive therapeutic outcomes. It is not unusual for early sessions of couple therapy to bring negative patterns to the partners' attention and elicit an increase in distress, and couple therapists commonly warn the partners that they may experience some added distress while initially increasing their focus on problematic issues (Epstein & Baucom, 2002). Because the present study used a sample of couples who had received a relatively brief treatment (only ten sessions), it is possible that the negative effects of therapist techniques that focus on negative couple patterns would have diminished if therapy outcomes had been assessed later. Consideration of how the impact of each of the individual components of techniques, and the set of technique factors more generally, can be more fully understood is important, and is subsequently discussed in the future research directions section of this chapter.

General Conclusions

This study revealed that the relationships among client common factors, therapist common factors, and couple therapy outcomes are more complex than initially expected, and many of the findings challenge the existing knowledge on the influence of common factors on couple therapy outcome. Although many of the findings are inconsistent with the existing literature, others who have also recently employed the APIM to examine the relationship between the client-therapist alliance and couple therapy outcome have found complex relationships between client distress and treatment outcome. One study found that a strong therapist alliance with the male partner was associated with higher levels of distress in the female partner over the course of treatment (Anderson & Johnson, 2010), whereas others found that the male-therapist alliance was more predictive of positive therapeutic outcomes for couples (Anker

et al, 2010). These authors as well as Garfield (2004) conclude that a careful consideration of client and therapist gender is of critical importance when working with alliance in couple therapy, and they urge clinicians and researchers to 1) consider how the gender of the therapist influences the dynamic of treatment (Garfield, 2004); 2) look beyond gender to determine other commonalities between male and female partners (such as who initiated treatment) (Anker et al., 2010); and 3) consider not only the alliance between the therapist and each member of the couple, but also the alliance between partners (Anderson & Johnson, 2010). The use of more sophisticated statistical analyses offers a more detailed, yet less concise, view of the impact of common factors on couple therapy. Although the present study did not intend to examine the influence of gender on the relationship between common factors and treatment outcome, it is impossible to ignore these effects when considering the findings. Given that this study examined both client and therapist common factors, an even more complex picture emerges with regard to the interaction between what clients bring to therapy and what therapists offer clients over the course of treatment, and how client and therapist factors interact to influence treatment outcome. Many authors (e.g., Anker et al., 2010; Garfield, 2004) have recommended that therapists engage male clients first or focus on their alliance with the male partner, but the present study's findings suggest that careful assessment of both male and female pre-treatment characteristics guide therapists' attention to alliance formation.

Unexpectedly, pre-treatment negative attributions and negative communication behaviors were not significantly associated with changes in relationship satisfaction over the course of treatment, and higher levels of male pre-treatment negative attributions were associated with greater decreases in the males' own amount of psychologically abusive behavior. Female pre-treatment negative attributions, however, were associated with an increase in the amount that

males engaged in psychological abuse, and female negative communication was associated with increases in the amount of females' own psychologically abusive behavior. Thus, examination of these main effect relationships between client pre-treatment characteristics and therapy outcome reveals a pattern of a positive influence of male negativity and a negative influence of female negativity on treatment outcome.

When examining the main effect relationships between therapist common factor behaviors and treatment outcome, the findings were for the most part also unexpected. Perhaps most surprising were the few statistically significant relationships between the therapist behaviors and treatment outcomes. Of the significant findings, only one was in the expected direction, in which therapist use of technique factors was associated with male partners' decreased use of psychological abusive behavior. Therapist use of technique factors, however, was associated with an increased occurrence of psychological abuse and less positive change in relationship satisfaction among female partners. Here we see that therapist behaviors have quite different influences on how males and females experience couple therapy, and on their treatment outcomes. Again, it appears that the links between therapist common factors and treatment outcomes may be quite different between individual therapy and couple therapy in which two members of the couple react not only to the therapist's relationship with the self but also to the therapist's relationship with the partner.

It was interesting that the influence of the therapist common factors behaviors consistently strengthened the relationship between client pre-treatment characteristics and treatment outcome regardless of whether those relationships were positive or negative. This demonstrates a significant pattern of relationships between client common factors and therapist common factor behaviors on treatment outcome, in that higher levels of the therapist behaviors

had a stronger influence on the relationship between the independent variables and dependent variables, for better or worse. Although it was expected that therapist relationship and technique factors would buffer the negative relationship between client pre-treatment negativity and therapeutic outcomes, it was often the case that rather than buffering a negative relationship between these variables, the therapist behaviors actually enhanced a positive relationship between client pre-treatment negativity and positive therapeutic outcome. These findings are consistent with the study's hypotheses that the therapist behaviors would positively influence the therapeutic process. As expected, higher levels of therapist warmth strengthened the positive relationship between initial male negative communication and female relationship satisfaction, and the negative relationship between initial amount of female negative communication and decrease over the course of treatment in the amount of psychological abuse in which females engage. Higher levels of therapist presence strengthened the positive relationship between female negative communication and both her own and her male partner's increase in relationship satisfaction. Higher levels of therapist validation strengthened the positive association between initial level of female negative communication and males' decreased use of psychological abuse over the course of treatment, and higher validation also enhanced the positive relationships between initial male negative attributions and both male and female gains in relationship satisfaction over the course of couple therapy. Here we see instances in which the therapists' use of higher levels of warmth, presence, and validation enhance the relationships between both male and female pre-treatment negativity and increased therapeutic gains.

There were also several instances in which higher levels of therapist common factor behaviors were not helpful to the relationship between client pre-treatment negativity and treatment outcome. Higher levels of therapist presence strengthened the negative relationship

between male negative communication and gain in female relationship satisfaction. When therapists offered clients higher levels of validation, the negative association between initial female negative communication and increase in female relationship satisfaction, as well as between female negative attributions and female and male relationship satisfaction, were strengthened. Thus, therapist validation was unhelpful at intervening positively in the therapeutic process in these instances. Similarly, higher levels of therapist use of technique factors strengthened the negative relationship between initial female negative communication and gain in relationship satisfaction. Higher levels of therapist technique factors were also associated with a stronger relationship between male negative attributions and less decrease in the use of psychological abuse by males over the course of treatment. Here we see that female negativity in the context of higher levels of therapist common factor behaviors is frequently associated with fewer therapeutic improvements, and also several instances in which male negativity in the context of higher levels of therapist common factor behaviors is associated with fewer therapeutic improvements.

These findings suggest that the blanket use of warmth, empathy, presence, validation, and technique factors by therapists may not be helpful to the process and outcome of couple therapy. Therapists must consider the levels of pre-treatment negativity for each member of the couple when offering common factor behaviors to their clients. Although the present study does not allow for the interpretation of how the therapists' alliance with each member of the couple, or the therapists' use of the relationship and technique factors specific to one member of the couple influenced the course of treatment, it does offer a more complex understanding of the influence of both client and therapist common factors on couple therapy outcome, and it has theoretical, clinical, and research implications. The complexity of couple therapy makes it quite distinct from

individual psychotherapy in that two people who are usually at odds with each another present to treatment with a therapist (or in this case, therapists) who attempt to disrupt problematic relational patterns between the two people (Sprenkle, et al., 2009). The inclusion of multiple people in the therapeutic process, and the focus on changing interactional patterns between the two people, creates multiple, complicated therapeutic relationships. It follows, then, that understanding the impact of client common factors, therapist common factors, and the interaction between what clients bring to treatment and what therapists offer during treatment on couple therapy outcome would be complex and perhaps divergent from findings in the individual psychotherapy literature. This study illuminates some of the intricate processes that influence the course of couple therapy, and its findings challenge couple therapists and couple therapy process researchers to examine and be mindful of the factors that make effects of couple therapy unique and complex.

Theoretical Interpretations

The hypotheses for this study were grounded in Symbolic-Interaction theory, given that fundamental to this theory is that people's actions are grounded in how they interpret events in their lives, and the meanings they assign to these events facilitate an understanding of their experiences and relationships (Burr et al., 1979; LaRossa & Reitzes, 1993; White & Klein, 2008). This study was guided by the notion that therapist common factors behaviors influence: 1) clients' active constructions of meaning regarding their experience with therapy; 2) clients' development and understanding of themselves and their relationships over the course of therapy; and 3) the ways in which members of the couple treat one another as a result of following the model presented by the therapists' behavior. It was believed that therapists who utilized higher levels of warmth, empathy, presence, validation, and technique factors would send their clients a

message that both each partner and their relationship was worthy of being treated well, and that in using these behaviors therapists would model positive patterns of interaction that the clients could imitate and practice in their own relationships. In some instances, it appears that this was an accurate application of the theory and in other instances it appears that clients were creating different meanings regarding their therapeutic experiences than had been expected.

Symbolic-Interaction theory is useful when conceptualizing the findings of a study such as this one, in that it allows for each member of each couple to generate a unique interpretation of the events occurring in therapy. The application of this theory is limited, however, in the present study because there is no direct report available of the meanings that clients attributed to their therapists' behaviors. It appears, however, that the meanings and interpretations of therapist common factors behaviors differed depending on the client's own pre-treatment common factor characteristics and gender. Furthermore, it seems that some of the therapist common factors behaviors were more likely to be linked with client positive associations with therapy (such as warmth), whereas others were more likely to be linked with negative client associations with therapy (such as technique factors), and still others had less clear, or inconsistent, links with client associations with therapy (such as presence or validation). Guided by Symbolic-Interaction theory, it appears that clients created meanings from their therapeutic experiences depending on what they had learned about their relationships based on their own and their partner's characteristics, and how the therapist attended to this information during the therapy session.

Limitations of the Study

The findings of this study must be considered in terms of several key limitations. The study utilized a small, non-representative sample; therefore, caution must be exercised not to generalize the findings to all couples, especially non-distressed, non-abusive couples.

Additionally, therapist behaviors were coded at a single point in time, during session four, and they only represent a very small fraction of the overall therapist-client interactions over the course of ten sessions of therapy. It is possible that the therapist's behaviors during session four were not representative of the therapist's behaviors during the other treatment sessions with the participating couples. In addition, the coding system used to assess therapist behaviors has not been validated, and to date this is the first and only study that has utilized it to measure the therapist common factors that are central to this study.

It is also important to note the limitations that might result from coding the behavior of co-therapist teams. Co-therapist teams were coded collectively, and the unique contributions of each therapist were not considered independently. Rather, a composite score for the co-therapist team's behavior with each couple was obtained. For example, if one co-therapist offered high levels of empathy throughout session four, but the other co-therapist did not offer much empathy, coders were instructed to code for what they saw, not for what they did not see. In this case, the co-therapist team would be given a high score for therapist empathy. If, however, one co-therapist offered high levels of empathy, and the other co-therapist offered statements that were non-empathic, coders were instructed to take both therapists' behaviors into consideration and report an average of the two therapists' levels of empathy. In this case, the co-therapy team would receive a moderate score for empathy because one therapist was quite empathic and the other engaged in behaviors that were non-empathic. This coding strategy was utilized because both therapists were not always visible in the therapy session recordings. It is possible, however, that therapist behaviors do not have a cumulative influence on couple therapy outcome, and that one therapist's behavior might be more predictive of therapy outcome than another's. For example, the contributions of a highly empathic therapist or an un-empathic therapist might be

more influential on the course of treatment for a couple than the combined or averaged influence of both of these therapists.

Another potential limitation is that the study examined the influence of therapist behaviors on couple therapy outcome, but there was no measure of how the clients experienced the therapists' behaviors. Therapist behaviors were coded by observers who were not part of the therapeutic process, and the coders' assessments of the therapists' behavior may have been quite different than the clients' assessments experience of the therapists' behavior would have been. It is also possible that the clients' pre-treatment characteristics influenced the therapists' behaviors over the course of treatment, but it was not possible to test for this relationship given the study's limited sample size.

It is also possible that some of the differences in therapist common factors behaviors were the result of the differences in session structuring due to the therapists' therapeutic models, and that the results reflect the effects of a specific model being implemented rather than of the common factors behaviors. For example, a co-therapy team using cognitive-behavioral therapy (CBT) might have obtained a higher score on the session structuring component of the TGCSQ because active structuring of sessions is a standard component of CBT, and therapists using this model might be more likely to discuss the plan for session explicitly with a couple and address each partner's goals. A therapist using narrative therapy or emotionally-focused therapy (EFT) would certainly be guided by a specific therapeutic structure, but it may not be as overtly communicated, and thus coded, in therapy sessions. Similarly, a co-therapy team using EFT, a model in which therapist conveying of empathy is a technique for helping clients better understand their attachment processes to one another, might have obtained higher scores on the empathy component of the TGCSQ than a co-therapy team using CBT. Although this study was

designed to examine factors that were common across various therapy models, it is possible that the factors measured are to some degree reflective of specific therapeutic models.

Study Strengths

Despite the study's limitations, it is also important to highlight its strengths. Of particular note is that this study quantitatively examined the relationships between both client and therapist common factors and treatment outcome in a clinical sample. This is not only an important step in understanding the complex relationships between common factors and couple therapy outcome; it also begins to fill a longstanding empirical gap in the common factors literature regarding common factors in couple therapy. Furthermore, by examining specific aspects of the client-therapist relationship, the study has begun the job of identifying components of the client-therapist alliance that are specifically influential in conjoint couple therapy.

Methodologically, the study also had several key strengths. First, data were collected at multiple time points, so that an understanding could be reached of how the independent and moderator variables influenced the course of treatment. Second, the study utilized observational coding of couple pre-treatment communication and therapist behaviors, and it integrated this information with self-report data, providing multiple data perspectives, as well as a parallel methodology for the measurement of client and therapist common factors, given that they both involved behavioral observation and coding. A strength of the use of self-reports of the dependent variable of psychological abuse is that the study used the partner's report of each person's psychological abuse rather than the person's own self-ratings, in order to correct for the potential that individuals would under-report their own levels of psychological abuse perpetrated against their partners. Furthermore, rather than studying the influence of the therapist common factors behaviors of a handful of therapists, this study examined these behaviors among many

different co-therapy teams who worked in the clinic over a period of ten years, with any one therapist working with couples for no more than two years.

The analyses used in the study are also a major strength, given that they took the interdependence of the data for members of a couple into consideration. The Actor-Partner Interdependence Model (APIM) is only recently being applied to common factors research in couple therapy, and it is of great utility in examining questions regarding how therapist common factor behaviors influence the course of treatment, given that it does not assume that treatment has the same influence on the male and female partners (Cook & Snyder, 2005). The APIM approach also allows for the influence that each partner has on their own therapeutic outcomes as well as on their partner's therapeutic outcomes.

Future Directions for Research

Although this study begins to fill in the historical gap in empirical knowledge regarding the influence of specific client and therapist common factor behaviors on couple therapy outcome, it also raises many questions about how these common factors influence treatment outcome. The following recommendations for future research directions are closely related to limitations of the study: 1) investigating therapist common factors behaviors during a single treatment session; 2) collectively coding the common factor behaviors of co-therapy teams; and 3) having no client reports of their experiences of the therapist common factors behaviors. Considerations and strategies for future work are considered.

In order to more fully understand the influences that therapist behaviors such as warmth, empathy, presence, validation, systemically-based techniques, and session structuring have on couple therapy outcomes, an examination of these factors across several therapy sessions should be considered. Although the coded therapy sessions were of considerable length (90 minutes),

they represent only a single snap-shot of the entire couple-therapist working relationship. As such, it is possible that this snap-shot is not reflective of the overall working relationship over the course of the ten sessions of therapy. The present study could be expanded upon using the same sample, given that there are video recordings from sessions 1, 8, and 10 in addition to the recordings of session 4 that were used for this study. These session recordings should be coded so that a more comprehensive view of the therapist behaviors over the course of treatment can be obtained.

The present study assumes a collective influence of co-therapist common factors behaviors on couple therapy outcome, given that the behaviors of co-therapy teams were coded collectively, rather than separate coding of each therapist's behavior. This was done due to logistical limitations in the quality of the session recordings, in which it was not possible to see both therapists in many recordings, and therefore not possible for coders to definitively assign ratings to one therapist or the other. This limitation in separate assessment of the two therapists' behaviors possibly influenced the results substantially. This study used an average of the two therapists' behaviors over the duration of the session. If future studies examine co-therapy therapist common factor influences on couple therapy outcome, separate ratings of the two therapists would be preferable. In this study, a co-therapy team in which one therapist offered a high level of warmth and the other offered exhibited behavior lacking warmth was coded similarly to a co-therapy team in which one or both therapists offered the couple moderate levels of warmth. It is possible that the influence of these two patterns of therapist warmth on couple therapy outcome is similar, but it is also possible that they are quite different. Future studies should use video-recordings that clearly show each therapist's behavior and should code the behaviors of each member of the co-therapy team separately, to allow examination of the relative

influences of the two therapists on therapy outcomes. Minimally, coding for differences or conflicts between co-therapists should be assessed, as the relationship between co-therapists may be influential to treatment outcome, and negative co-therapy relationships may detract from therapeutic gains (as summarized by Hendrix, Fournier, & Briggs, 2001). Future studies should also examine these therapist common factors behaviors when a single therapist is working with a couple. Furthermore, future studies should investigate the role of therapist gender when examining the relationship between couple therapy process and couple therapy outcome to see if therapist gender influences client comfort level and treatment outcome.

The findings of this study unquestionably highlight the need for further investigation of how therapist common factors behaviors influence the process of couple therapy and couple therapy outcomes, as well as how they interact with client common factors to influence treatment outcome. This study did not obtain client reports of each partner's experience of the therapist's behaviors throughout the therapy session. As previously noted in the discussion on empathy, some studies have found that observational assessments of therapist behaviors are similarly powerful predictors of therapy outcome as are client reports of therapist behaviors, but other studies have found that client reports of therapist behaviors and the client-therapist relationship are most predictive of therapy outcome. In order to more completely understand the role of the therapist behaviors of warmth, empathy, presence, validation, systemically-based techniques, and session control, client reports of their experiences during sessions should be obtained in future investigations.

Client reports of their experiences could be obtained for a new study by asking them to rate their experiences of therapy following each session and at the end of treatment. Rather than having coders observe treatment sessions and code for the therapist behaviors of warmth,

empathy, presence, validation, systemically-based techniques, and session control using the TGCSQ that was used in this study, the TGCSQ could be adapted to be a self-report scale and given to each member of the couple to fill out at the end of session. Additionally, the TGCSQ could be given to the clients at the termination of therapy for them to reflect on their experiences with their therapists' use of relationship factors and technique factors over the course of treatment.

It would also be useful to conduct qualitative interviews with clients after each session to inquire about their experiences with the therapist(s) during the therapy session. Specific information about aspects of the therapists' behavior that were helpful or unhelpful could be obtained by directly asking the client about his or her experiences with the therapists. Although this cannot be done retrospectively with the sample included in this study, it could be done as subsequent data are collected in the clinic where this study's couples were assessed and treated, and by others who are conducting common factors and couple therapy process research. These interviews would perhaps shed light on the differential influences of both client and therapist common factor behaviors for both male and female partners. This study often found that male pre-treatment negativity created an opportunity for greater change for both the male and female partners, especially in the context of higher levels of therapist common factors, whereas female negativity was not associated with these same opportunities for positive growth. One can only speculate about the causes of these gender differences. Asking clients about their experiences would potentially illuminate reasons for the differences and may help clinical researchers and clinicians to understand some of the complex relationships among partner gender, the characteristics and behaviors that each partner brings to couple therapy, the characteristics and behaviors that each therapist brings to couple treatment, and couple therapy outcome. It might

also be informative to obtain the therapist's report of his or her own behavior during session and his or her report of the session quality. This could be used as another measure of therapist common factor behavior, and the congruence between client reports and therapist reports of the therapist's behaviors could be investigated in relation to couple therapy outcome.

It might also be important to consider other variables when attempting to increase our understanding of the influence that therapist common factors behaviors have on treatment outcome for couples. One recent study by Anker, et al. (2010) that also utilized the APIM to examine the relationship between client-therapist alliance and couple therapy outcome found varied influences of the alliance depending on the client's gender. Anker et al. (2010) are keen to point out that these gender effects may actually be a function of some other commonality associated with each gender, such as which member of the couple initiated therapy. In their sample, female partners were more likely to have initiated therapy, and the authors state that this might have implications for how the therapist-client alliance is formed, as well as how clinicians work with each member of the couple. Future studies should include variables such as who initiated contact for clinical services and how comfortable the partner who did not initiate treatment is regarding participation in couple therapy. The degree to which the therapist or therapists facilitate partners increasing positive behaviors (warmth, empathy, validation, and presence) toward each other might also be associated with more positive therapeutic outcomes, perhaps moreso than if the therapist offers these positive forms of behavior to the couple, as discussed by Anderson and Johnson (2010). Additionally, a model in which therapist common factor behaviors mediate between client common factor characteristics and treatment outcome should be examined, in order to see if client pre-treatment negativity influences therapist common factor behaviors, which in turn influence therapy outcomes.

In order for the TGCSQ to be used by other research teams, a manual needs be created that more fully describes both the coding categories and the process of training non-clinician coders to use the measure. For example, the code for “circular questioning” needs to be expanded so that other research teams and coders can have a clearer understanding of this code, so that it can be applied similarly across teams. Given that coders who did not have training in dyadic or systemic therapies coded the data for the present study, it is especially important that the coding mechanism is specific and detailed.

Clinical Implications

This study’s findings have four key implications for clinicians, regarding 1) evaluation of client pre-treatment negativity, 2) consideration of the relative importance of client and therapist common factors to therapy outcome, 3) consideration of client and therapist gender, and 4) consideration of the complexity surrounding the implementation of therapist common factor behaviors. First, the findings suggest that it is of critical importance for therapists to evaluate their clients’ levels of negativity in terms of both their thoughts and their actions at the onset of treatment. This study indicated that male negativity was frequently an opportunity for greater therapeutic gains, whereas female negativity was frequently associated with poor therapeutic outcomes for both members of the couple. Given that male and female partners’ own negative thoughts and behaviors influence both their own and their partner’s therapy outcomes differentially, therapists should take ample time to assess each partner’s negativity at the beginning of treatment.

Second, therapists must consider both how their own actions are going to influence the course of therapy and how their clients’ actions and characteristics are going to influence therapy. This study found that client factors might be more important than therapist factors in

determining treatment outcome, and they are certainly influential in how clients experience couple therapy. This is consistent with findings that much of the change that occurs over the course of therapy can be attributable to factors not associated with the therapeutic process itself (Lambert, 1992), but is counter to therapists' own notions that they are the most important contributor to therapeutic change and outcome (Blow et al., 2007). Also, although the present study is limited in terms of sample size and population, the results indicate that it might be helpful for therapists to educate their clients about the process of couple therapy so that each member of the couple knows what to expect from the therapist in terms of the therapist's line of questioning and balance in attention to each partner.

Third, clinicians must carefully consider their own gender and the gender of their clients and how both client pre-treatment characteristics and the therapists' actions will differentially influence outcome in relation to gender, given that this study indicates that male and female partners experience therapy differently, and that client negativity regarding the couple relationship frequently has dissimilar influences on treatment outcome for males and females. Although the alliance between the therapist and each member of the couple cannot be determined from the present study, the findings are fairly consistent with literature that suggests that the male's alliance with the therapist is more predictive of therapeutic gains than the female's alliance with the therapist (Anker et al., 2010). However, the present study also reveals that female negativity in the context of higher levels of therapist common factors behaviors may be predictive of poorer therapy outcomes. Again, the alliance between the therapist and each member of the couple cannot be determined based on the present study, but the findings do suggest that male and female partners experience therapist behaviors differently, and that therapists should attend to how both partners are experiencing the therapist's actions.

Finally, the study's findings indicate that some of the relationship building behaviors that are generally accepted as universally positive in individual therapy may actually operate differently in couple therapy. For example, the present study did not find support for empathy as a variable predictive of positive therapeutic outcomes. Clinicians must consider that it means something different to offer the therapeutic factors such as warmth, empathy, presence, and validation to a client who is in individual in therapy than it does to offer these factors to someone in therapy when their partner with whom they are having conflict is also present in the room. Clinicians should consider taking time to ask clients how they experience the therapist's implementation of therapy to find out from the clients what they experience as particularly helpful or unhelpful. These dialogues could also be useful therapeutic tools as the therapist can highlight the process surrounding each partner's varied treatment needs, and can work to create a therapeutic context that works for both partners rather than assuming that warmth, empathy, presence, validation, and technique factors are helpful to all clients. Couple therapists are presented with the unique challenge of working with clients who are at odds with one another, and therapists who work with couples who present to treatment with mild to moderate levels of abusive behavior in their relationship need to pay particular attention to how each member is experiencing both their partner's actions and the therapist's actions, in order to create a therapeutic arrangement that maximizes each partner's motivation and resources for positive change.

Conclusion

The present study contributes to the empirical base for understanding how common factors influence the course of couple therapy, and it begins to answer the call for more quantitative investigations of common factors as they relate to therapy process and outcomes in

relational therapy. The findings indicate that the future study of client and therapist common factors using advanced research and statistical methods is both needed and warranted.

Furthermore, careful consideration of both client and therapist gender must be considered in subsequent investigations of common factors as they influence couple therapy. Although the present study perhaps creates more questions about the role of both client and therapist common factors in couple therapy than it answers, it contributes new empirical insights into the complexity of the relationships between these factors, and it begins to pave the way for future examination of the influence of specific client and therapist common factors on couple therapy outcome. The findings challenge relational therapists to consider what we know of common factors from the individual psychotherapy literature with caution, and they highlight the need to translate these findings to the systemic work we do with consideration to how relational therapy is distinctly different from individual therapy. As part of this translation, research needs to be conducted to examine these relationships in an empirical manner. Although this type of work is in its relative infancy, and preliminary findings do not present easily applied conclusions, it is hoped that studies such as this will ultimately enhance the work that relational and systemic therapists do by facilitating a deeper understanding of the mechanisms of change in the work they do.

Appendix B
Marital Attitude Survey (MAS)

Directions: Please circle the number which indicates how much you agree or disagree with each statement this week, using the rating scale below:

Rating Scale:

- 1= Strongly agree
- 2= Agree somewhat
- 3= Neutral
- 4= Disagree somewhat
- 5= Strongly disagree

1. When we aren't getting along I wonder if my partner loves me.....	1	2	3	4	5	LL
2. My partner doesn't seem to do things just to bother me.....	1	2	3	4	5	MI
3. My personality would have to change for our relationship to improve.....	1	2	3	4	5	OP
4. My partner intentionally does things that irritate me.....	1	2	3	4	5	PB
5. Even if my partner's personality changed we still wouldn't get along any better.....	1	2	3	4	5	PP
6. It seems as though my partner deliberately provokes me.....	1	2	3	4	5	MI
7. If my partner did things differently we'd get along better.....	1	2	3	4	5	PB
8. My partner's personality would have to change for us to get along.....	1	2	3	4	5	PP
9. Any trouble we have getting along with each other is because of the type of person I am.....	1	2	3	4	5	OP
10. I don't think that the things I say and do make things worse between us.....	1	2	3	4	5	OB
11. Any problems we have are caused by the things I say and do.....	1	2	3	4	5	OB
12. I don't think our relationship would be better if my partner was a different type of person.....	1	2	3	4	5	PP
13. Even if my personality changed, my partner and I still wouldn't get along any better.....	1	2	3	4	5	OP
14. The way my partner treats me determines how well we get along.....	1	2	3	4	5	PB
15. Whatever problems we have are caused by the things my partner says and does.....	1	2	3	4	5	PB
16. My partner and I would get along better if it weren't for the type of person he/she was.....	1	2	3	4	5	PP
17. My partner doesn't intentionally try to upset me.....	1	2	3	4	5	MI

18. When things aren't going well between us I feel like my partner doesn't love me.....	1	2	3	4	5	LL
19. Whatever difficulties we have are not because of the type of person I am.....	1	2	3	4	5	OP
20. What difficulties we have don't lead me to doubt my partner's love for me.....	1	2	3	4	5	LL
21. When things are rough between us it shows that my partner doesn't love me.....	1	2	3	4	5	LL
22. If I did things differently my partner and I wouldn't have the conflicts we have.....	1	2	3	4	5	OB
23. My changing how I act wouldn't change how our relationship goes.....	1	2	3	4	5	OB
24. I'm sure that my partner sometimes does things just to bother me.....	1	2	3	4	5	MI
25. Even when we aren't getting along, I don't question whether my partner loves me.....	1	2	3	4	5	LL
26. I think my partner upsets me on purpose.....	1	2	3	4	5	MI
27. When my partner isn't nice to me I feel like he/she doesn't love me.....	1	2	3	4	5	LL
28. I'm certain that my partner doesn't provoke me on purpose.....	1	2	3	4	5	MI
29. Even when we have problems I don't doubt my partner's love for me.....	1	2	3	4	5	LL
30. The things my partner says and does aren't the cause of whatever problems come up between us.....	1	2	3	4	5	PB
31. I doubt that my partner deliberately does things to irritate me.....	1	2	3	4	5	MI

Subscale Key:

LL = Lack of Love

MI = Malicious Intent

OP = Own Personality

OB = Own Behavior

PP = Partner's Personality

PB = Partner's Behavior

Appendix C

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”			

Relationship Factors		Item Score	Total Scale Score	Scale Score Average
Validation	Agreement E.g: Client- “I think we are just really tired all the time, and that’s why we’re fighting” Therapist: “Yes, that could be.”			
	Affirming/legitimizing: Verbally conveying that the therapist takes the clients’ thoughts and feelings seriously E.g: Client- “I think we are just really tired all the time, and that’s why we’re fighting” Therapist: “Yes, that could be. <i>It is more difficult to constructively deal with problems when we are tired.</i> ”			
Therapist Presence	Asking personal questions, showing interest in clients’ lives: Therapist asks questions about the clients in order to learn more about them as people			
	Staying on topic: Therapist follows a clear line of questioning, follows up on client statements, and does not 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 D

Dyadic Adjustment Scale (DAS)

Question #31

The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness in most relationships. Please circle the dot which best describes the degree of happiness, all things considered, in your relationship:

•
Extremely
Unhappy

•
Fairly
Unhappy

•
A Little
Unhappy

•
Happy

•
Very
Happy

•
Extremely
Happy

•
Perfect

Appendix E

Multi-dimensional Measure of Emotional Abuse Scale (MMEA)

Directions: No matter how well a couple gets a long, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things **IN THE PAST 4 MONTHS**, and how many times your partner did them **IN THE PAST 4 MONTHS**. If you or your partner did not do one of these things in the past 4 months, but it happened before that, circle 0.

- (0) Not in the past four months, but it did happen before
- (1) Once
- (2) Twice
- (3) 3-5 times
- (4) 6-10 times
- (5) 11-20 times
- (6) More than 20 times
- (9) This has never happened

Never in the past 4 months	Once	Twice	3-5	6-10	11-20	20+	Never in relationship
0	1	2	3	4	5	6	9

1. Asked the other person where s/he had been or who s/he was with in a suspicious manner. RE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
2. Secretly searched through the other person's belongings. RE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
3. Tried to stop the other person from seeing certain friends or family members. RE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
4. Complained that the other person spends too much time with friends. RE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
5. Got angry because the other person went somewhere without telling him/her. RE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
6. Tried to make the other person feel guilty for not spending enough time together. RE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
7. Checked up on the other person by asking friends where s/he was or who s/he was with. RE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
8. Said or implied that the other person was stupid. DE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
9. Called the other person worthless. DE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
10. Called the other person ugly. DE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9

11. Criticized the other person's appearance. DE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
12. Called the other person a loser, failure, or similar term. DE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
13. Belittled the other person in front of other people. DE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
14. Said that someone else would be a better girlfriend or boyfriend. DE	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
15. Became so angry that s/he was unable or unwilling to talk. HW	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
16. Acted cold or distant when angry. HW	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
17. Refused to have any discussion of a problem. HW	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
18. Changed the subject on purpose when the other person was trying to discuss a problem. HW	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
19. Refused to acknowledge a problem that the other felt was important. HW	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
20. Sulked or refused to talk about an issue. HW	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
21. Intentionally avoided the other person during a conflict or disagreement. HW	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
22. Became angry enough to frighten other people. DI	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
23. Put her/his face right in front of the other person's face to make a point more forcefully. DI	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
24. Threatened to hit the other person. DI	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
25. Threaten to throw something at the other person. DI	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
26. Threw, smashed, hit, or kicked something in front of the other person. DI	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
27. Drove recklessly to frighten the other person. DI	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9
28. Stood or hovered over the other person during a conflict or disagreement. DI	You:	0	1	2	3	4	5	6	9
	Your partner:	0	1	2	3	4	5	6	9

Subscale Key:

HW = Hostile Withdrawal

DI = Domination/Intimidation

DE = Denigration

RE = Restrictive Engulfment

Appendix F

Model Equations

Model 1:

$$\text{Level 1: } DAS\ CHANGE_{ij} = \beta_{1j}*(M_DUM_{ij}) + \beta_{2j}*(F_DUM_{ij}) + \beta_{3j}*(FA_NEGAT_{ij}) + \beta_{4j}*(MA_NEGAT_{ij}) + \beta_{5j}*(FP_NEGAT_{ij}) + \beta_{6j}*(MP_NEGAT_{ij}) + r_{ij}$$

$$\text{Level 2: } \beta_{1j} = \gamma_{10} + \gamma_{11}*(WARMTH_j) + \gamma_{12}*(EMPATHY_j) + \gamma_{13}*(VALIDATION_j) + \gamma_{14}*(PRESENCE_j) + \gamma_{15}*(TECHFAC_j) + u_{1j}$$

$$\beta_{2j} = \gamma_{20} + \gamma_{21}*(WARMTH_j) + \gamma_{22}*(EMPATHY_j) + \gamma_{23}*(VALIDATION_j) + \gamma_{24}*(PRESENCE_j) + \gamma_{25}*(TECHFAC_j) + u_{2j}$$

$$\beta_{3j} = \gamma_{30} + \gamma_{31}*(WARMTH_j) + \gamma_{32}*(EMPATHY_j) + \gamma_{33}*(VALIDATION_j) + \gamma_{34}*(PRESENCE_j) + \gamma_{35}*(TECHFAC_j) + u_{3j}$$

$$\beta_{4j} = \gamma_{40} + \gamma_{41}*(WARMTH_j) + \gamma_{42}*(EMPATHY_j) + \gamma_{43}*(VALIDATION_j) + \gamma_{44}*(PRESENCE_j) + \gamma_{45}*(TECHFAC_j) + u_{4j}$$

$$\beta_{5j} = \gamma_{50} + \gamma_{51}*(WARMTH_j) + \gamma_{52}*(EMPATHY_j) + \gamma_{53}*(VALIDATION_j) + \gamma_{54}*(PRESENCE_j) + \gamma_{55}*(TECHFAC_j) + u_{5j}$$

$$\beta_{6j} = \gamma_{60} + \gamma_{61}*(WARMTH_j) + \gamma_{62}*(EMPATHY_j) + \gamma_{63}*(VALIDATION_j) + \gamma_{64}*(PRESENCE_j) + \gamma_{65}*(TECHFAC_j) + u_{6j}$$

$$\begin{aligned} \text{Mixed Model: } DAS\ CHANGE_{ij} = & \gamma_{10}*M_DUM_{ij} + \gamma_{11}*WARMTH_j * M_DUM_{ij} + \\ & \gamma_{12}*EMPATHY_j * M_DUM_{ij} + \gamma_{13}*VALIDATION_j * M_DUM_{ij} + \gamma_{14}* \\ & PRESENCE_j * M_DUM_{ij} + \gamma_{15}*TECHFAC_j * M_DUM_{ij} + \gamma_{20}*F_DUM_{ij} \\ & + \gamma_{21}*WARMTH_j * F_DUM_{ij} + \gamma_{22}*EMPATHY_j * F_DUM_{ij} + \\ & \gamma_{23}*VALIDATION_j * F_DUM_{ij} + \gamma_{24}*PRESENCE_j * F_DUM_{ij} + \gamma_{25}* \\ & TECHFAC_j * F_DUM_{ij} + \gamma_{30}*FA_NEGAT_{ij} + \gamma_{31}*WARMTH_j * \\ & FA_NEGAT_{ij} + \gamma_{32}*EMPATHY_j * FA_NEGAT_{ij} + \gamma_{33}*VALIDATION_j * \\ & FA_NEGAT_{ij} + \gamma_{34}*PRESENCE_j * FA_NEGAT_{ij} + \gamma_{35}*TECHFAC_j * \\ & FA_NEGAT_{ij} + \gamma_{40}*MA_NEGAT_{ij} + \gamma_{41}*WARMTH_j * MA_NEGAT_{ij} + \\ & \gamma_{42}*EMPATHY_j * MA_NEGAT_{ij} + \gamma_{43}*VALIDATION_j * MA_NEGAT_{ij} + \\ & \gamma_{44}*PRESENCE_j * MA_NEGAT_{ij} + \gamma_{45}*TECHFAC_j * MA_NEGAT_{ij} + \\ & \gamma_{50}*FP_NEGAT_{ij} + \gamma_{51}*WARMTH_j * FP_NEGAT_{ij} + \gamma_{52}*EMPATHY_j * \\ & FP_NEGAT_{ij} + \gamma_{53}*VALIDATION_j * FP_NEGAT_{ij} + \gamma_{54}*PRESENCE_j * \\ & FP_NEGAT_{ij} + \gamma_{55}*TECHFAC_j * FP_NEGAT_{ij} + \gamma_{60}*MP_NEGAT_{ij} + \\ & \gamma_{61}*WARMTH_j * MP_NEGAT_{ij} + \gamma_{62}*EMPATHY_j * MP_NEGAT_{ij} + \\ & \gamma_{63}*VALIDATION_j * MP_NEGAT_{ij} + \gamma_{64}*PRESENCE_j * MP_NEGAT_{ij} + \\ & \gamma_{65}*TECHFAC_j * MP_NEGAT_{ij} + u_{1j} \end{aligned}$$

Model 2:

$$\text{Level 1: } DAS_CHANGE_{ij} = \beta_{1j}*(M_DUM_{ij}) + \beta_{2j}*(F_DUM_{ij}) + \beta_{3j}*(FA_NEGCO_{ij}) + \beta_{4j}*(MA_NEGCO_{ij}) + \beta_{5j}*(FP_NEGCO_{ij}) + \beta_{6j}*(MP_NEGCO_{ij}) + r_{ij}$$

$$\text{Level 2: } \beta_{1j} = \gamma_{10} + \gamma_{11}*(WARMTH_j) + \gamma_{12}*(EMPATHY_j) + \gamma_{13}*(VALIDATION_j) + \gamma_{14}*(PRESENCE_j) + \gamma_{15}*(TECHFAC_j) + u_{1j}$$

$$\beta_{2j} = \gamma_{20} + \gamma_{21}*(WARMTH_j) + \gamma_{22}*(EMPATHY_j) + \gamma_{23}*(VALIDATION_j) + \gamma_{24}*(PRESENCE_j) + \gamma_{25}*(TECHFAC_j) + u_{1j}$$

$$\beta_{3j} = \gamma_{30} + \gamma_{31}*(WARMTH_j) + \gamma_{32}*(EMPATHY_j) + \gamma_{33}*(VALIDATION_j) + \gamma_{34}*(PRESENCE_j) + \gamma_{35}*(TECHFAC_j) + u_{1j}$$

$$\beta_{4j} = \gamma_{40} + \gamma_{41}*(WARMTH_j) + \gamma_{42}*(EMPATHY_j) + \gamma_{43}*(VALIDATION_j) + \gamma_{44}*(PRESENCE_j) + \gamma_{45}*(TECHFAC_j) + u_{1j}$$

$$\beta_{5j} = \gamma_{50} + \gamma_{51}*(WARMTH_j) + \gamma_{52}*(EMPATHY_j) + \gamma_{53}*(VALIDATION_j) + \gamma_{54}*(PRESENCE_j) + \gamma_{55}*(TECHFAC_j) + u_{1j}$$

$$\beta_{6j} = \gamma_{60} + \gamma_{61}*(WARMTH_j) + \gamma_{62}*(EMPATHY_j) + \gamma_{63}*(VALIDATION_j) + \gamma_{64}*(PRESENCE_j) + \gamma_{65}*(TECHFAC_j) + u_{1j}$$

$$\begin{aligned} \text{Mixed Model: } DAS_CHANGE_{ij} = & \gamma_{10}*M_DUM_{ij} + \gamma_{11}*WARMTH_j * M_DUM_{ij} + \\ & \gamma_{12}*EMPATHY_j * M_DUM_{ij} + \gamma_{13}*VALIDATION_j * M_DUM_{ij} + \gamma_{14}* \\ & PRESENCE_j * M_DUM_{ij} + \gamma_{15} *TECHFAC_j * M_DUM_{ij} + \gamma_{20}*F_DUM_{ij} \\ & + \gamma_{21}*WARMTH_j * F_DUM_{ij} + \gamma_{22}*EMPATHY_j * F_DUM_{ij} + \\ & \gamma_{23}*VALIDATION_j * F_DUM_{ij} + \gamma_{24}*PRESENCE_j * F_DUM_{ij} + \gamma_{25} * \\ & TECHFAC_j * F_DUM_{ij} + \gamma_{30}*FA_NEGCO_{ij} + \gamma_{31}*WARMTH_j * \\ & FA_NEGCO_{ij} + \gamma_{32}*EMPATHY_j * FA_NEGCO_{ij} + \gamma_{33}*VALIDATION_j * \\ & FA_NEGCO_{ij} + \gamma_{34}*PRESENCE_j * FA_NEGCO_{ij} + \gamma_{35} * TECHFAC_j * \\ & FA_NEGCO_{ij} + \gamma_{40}*MA_NEGCO_{ij} + \gamma_{41}*WARMTH_j * MA_NEGCO_{ij} + \\ & \gamma_{42}*EMPATHY_j * MA_NEGCO_{ij} + \gamma_{43}*VALIDATION_j * MA_NEGCO_{ij} + \\ & \gamma_{44}*PRESENCE_j * MA_NEGCO_{ij} + \gamma_{45} * TECHFAC_j * MA_NEGCO_{ij} \\ & + \gamma_{50}*FP_NEGCO_{ij} + \gamma_{51}*WARMTH_j * FP_NEGCO_{ij} + \gamma_{52}*EMPATHY_j * \\ & FP_NEGCO_{ij} + \gamma_{53}*VALIDATION_j * FP_NEGCO_{ij} + \gamma_{54}*PRESENCE_j * \\ & FP_NEGCO_{ij} + \gamma_{55} * TECHFAC_j * FP_NEGCO_{ij} + \gamma_{60}*MP_NEGCO_{ij} + \\ & \gamma_{61}*WARMTH_j * MP_NEGCO_{ij} + \gamma_{62}*EMPATHY_j * MP_NEGCO_{ij} + \\ & \gamma_{63}*VALIDATION_j * MP_NEGCO_{ij} + \gamma_{64} * PRESENCE_j * MP_NEGCO_{ij} + \\ & \gamma_{65} * TECHFAC_j * MP_NEGCO_{ij} + u_{1j} \end{aligned}$$

Model 3:

$$\text{Level 1: } MMEA_CHANGE_{ij} = \beta_{1j}*(M_DUM_{ij}) + \beta_{2j}*(F_DUM_{ij}) + \beta_{3j}*(FA_NEGAT_{ij}) + \beta_{4j}*(MA_NEGAT_{ij}) + \beta_{5j}*(FP_NEGAT_{ij}) + \beta_{6j}*(MP_NEGAT_{ij}) + r_{ij}$$

$$\text{Level 2: } \beta_{1j} = \gamma_{10} + \gamma_{11}*(WARMTH_j) + \gamma_{12}*(EMPATHY_j) + \gamma_{13}*(VALIDATION_j) + \gamma_{14}*(PRESENCE_j) + \gamma_{15}*(TECHFAC_j) + u_{1j}$$
$$\beta_{2j} = \gamma_{20} + \gamma_{21}*(WARMTH_j) + \gamma_{22}*(EMPATHY_j) + \gamma_{23}*(VALIDATION_j) + \gamma_{24}*(PRESENCE_j) + \gamma_{25}*(TECHFAC_j) + u_{1j}$$

$$\beta_{3j} = \gamma_{30} + \gamma_{31}*(WARMTH_j) + \gamma_{32}*(EMPATHY_j) + \gamma_{33}*(VALIDATION_j) + \gamma_{34}*(PRESENCE_j) + \gamma_{35}*(TECHFAC_j) + u_{1j}$$

$$\beta_{4j} = \gamma_{40} + \gamma_{41}*(WARMTH_j) + \gamma_{42}*(EMPATHY_j) + \gamma_{43}*(VALIDATION_j) + \gamma_{44}*(PRESENCE_j) + \gamma_{45}*(TECHFAC_j) + u_{1j}$$

$$\beta_{5j} = \gamma_{50} + \gamma_{51}*(WARMTH_j) + \gamma_{52}*(EMPATHY_j) + \gamma_{53}*(VALIDATION_j) + \gamma_{54}*(PRESENCE_j) + \gamma_{55}*(TECHFAC_j) + u_{1j}$$

$$\beta_{6j} = \gamma_{60} + \gamma_{61}*(WARMTH_j) + \gamma_{62}*(EMPATHY_j) + \gamma_{63}*(VALIDATION_j) + \gamma_{64}*(PRESENCE_j) + \gamma_{65}*(TECHFAC_j) + u_{1j}$$

$$\text{Mixed Model: } MMEA_CHANGE_{ij} = \gamma_{10}*M_DUM_{ij} + \gamma_{11}*WARMTH_j*M_DUM_{ij} + \gamma_{12}*EMPATHY_j*M_DUM_{ij} + \gamma_{13}*VALIDATION_j*M_DUM_{ij} + \gamma_{14}*PRESENCE_j*M_DUM_{ij} + \gamma_{15}*TECHFAC_j*M_DUM_{ij} + \gamma_{20}*F_DUM_{ij} + \gamma_{21}*WARMTH_j*F_DUM_{ij} + \gamma_{22}*EMPATHY_j*F_DUM_{ij} + \gamma_{23}*VALIDATION_j*F_DUM_{ij} + \gamma_{24}*PRESENCE_j*F_DUM_{ij} + \gamma_{25}*TECHFAC_j*F_DUM_{ij} + \gamma_{30}*FA_NEGAT_{ij} + \gamma_{31}*WARMTH_j*FA_NEGAT_{ij} + \gamma_{32}*EMPATHY_j*FA_NEGAT_{ij} + \gamma_{33}*VALIDATION_j*FA_NEGAT_{ij} + \gamma_{34}*PRESENCE_j*FA_NEGAT_{ij} + \gamma_{35}*TECHFAC_j*FA_NEGAT_{ij} + \gamma_{40}*MA_NEGAT_{ij} + \gamma_{41}*WARMTH_j*MA_NEGAT_{ij} + \gamma_{42}*EMPATHY_j*MA_NEGAT_{ij} + \gamma_{43}*VALIDATION_j*MA_NEGAT_{ij} + \gamma_{44}*PRESENCE_j*MA_NEGAT_{ij} + \gamma_{45}*TECHFAC_j*MA_NEGAT_{ij} + \gamma_{50}*FP_NEGAT_{ij} + \gamma_{51}*WARMTH_j*FP_NEGAT_{ij} + \gamma_{52}*EMPATHY_j*FP_NEGAT_{ij} + \gamma_{53}*VALIDATION_j*FP_NEGAT_{ij} + \gamma_{54}*PRESENCE_j*FP_NEGAT_{ij} + \gamma_{55}*TECHFAC_j*FP_NEGAT_{ij} + \gamma_{60}*MP_NEGAT_{ij} + \gamma_{61}*WARMTH_j*MP_NEGAT_{ij} + \gamma_{62}*EMPATHY_j*MP_NEGAT_{ij} + \gamma_{63}*VALIDATION_j*MP_NEGAT_{ij} + \gamma_{64}*PRESENCE_j*MP_NEGAT_{ij} + \gamma_{65}*TECHFAC_j*MP_NEGAT_{ij} + u_{1j}$$

Model 4:

$$\text{Level 1: } MMEA_CHANGE_{ij} = \beta_{1j}*(M_DUM_{ij}) + \beta_{2j}*(F_DUM_{ij}) + \beta_{3j}*(FA_NEGCO_{ij}) + \beta_{4j}*(MA_NEGCO_{ij}) + \beta_{5j}*(FP_NEGCO_{ij}) + \beta_{6j}*(MP_NEGCO_{ij}) + r_{ij}$$

$$\text{Level 2: } \beta_{1j} = \gamma_{10} + \gamma_{11}*(WARMTH_j) + \gamma_{12}*(EMPATHY_j) + \gamma_{13}*(VALIDATION_j) + \gamma_{14}*(PRESENCE_j) + \gamma_{15}*(TECHFAC_j) + u_{1j}$$

$$\beta_{2j} = \gamma_{20} + \gamma_{21}*(WARMTH_j) + \gamma_{22}*(EMPATHY_j) + \gamma_{23}*(VALIDATION_j) + \gamma_{24}*(PRESENCE_j) + \gamma_{25}*(TECHFAC_j) + u_{1j}$$

$$\beta_{3j} = \gamma_{30} + \gamma_{31}*(WARMTH_j) + \gamma_{32}*(EMPATHY_j) + \gamma_{33}*(VALIDATION_j) + \gamma_{34}*(PRESENCE_j) + \gamma_{35}*(TECHFAC_j) + u_{1j}$$

$$\beta_{4j} = \gamma_{40} + \gamma_{41}*(WARMTH_j) + \gamma_{42}*(EMPATHY_j) + \gamma_{43}*(VALIDATION_j) + \gamma_{44}*(PRESENCE_j) + \gamma_{45}*(TECHFAC_j) + u_{1j}$$

$$\beta_{5j} = \gamma_{50} + \gamma_{51}*(WARMTH_j) + \gamma_{52}*(EMPATHY_j) + \gamma_{53}*(VALIDATION_j) + \gamma_{54}*(PRESENCE_j) + \gamma_{55}*(TECHFAC_j) + u_{1j}$$

$$\beta_{6j} = \gamma_{60} + \gamma_{61}*(WARMTH_j) + \gamma_{62}*(EMPATHY_j) + \gamma_{63}*(VALIDATION_j) + \gamma_{64}*(PRESENCE_j) + \gamma_{65}*(TECHFAC_j) + u_{1j}$$

$$\text{Mixed Model: } MMEA_CHANGE_{ij} = \gamma_{10}*M_DUM_{ij} + \gamma_{11}*WARMTH_j*M_DUM_{ij} + \gamma_{12}*EMPATHY_j*M_DUM_{ij} + \gamma_{13}*VALIDATION_j*M_DUM_{ij} + \gamma_{14}*PRESENCE_j*M_DUM_{ij} + \gamma_{15}*TECHFAC_j*M_DUM_{ij} + \gamma_{20}*F_DUM_{ij} + \gamma_{21}*WARMTH_j*F_DUM_{ij} + \gamma_{22}*EMPATHY_j*F_DUM_{ij} + \gamma_{23}*VALIDATION_j*F_DUM_{ij} + \gamma_{24}*PRESENCE_j*F_DUM_{ij} + \gamma_{25}*TECHFAC_j*F_DUM_{ij} + \gamma_{30}*FA_NEGCO_{ij} + \gamma_{31}*WARMTH_j*FA_NEGCO_{ij} + \gamma_{32}*EMPATHY_j*FA_NEGCO_{ij} + \gamma_{33}*VALIDATION_j*FA_NEGCO_{ij} + \gamma_{34}*PRESENCE_j*FA_NEGCO_{ij} + \gamma_{35}*TECHFAC_j*FA_NEGCO_{ij} + \gamma_{40}*MA_NEGCO_{ij} + \gamma_{41}*WARMTH_j*MA_NEGCO_{ij} + \gamma_{42}*EMPATHY_j*MA_NEGCO_{ij} + \gamma_{43}*VALIDATION_j*MA_NEGCO_{ij} + \gamma_{44}*PRESENCE_j*MA_NEGCO_{ij} + \gamma_{45}*TECHFAC_j*MA_NEGCO_{ij} + \gamma_{50}*FP_NEGCO_{ij} + \gamma_{51}*WARMTH_j*FP_NEGCO_{ij} + \gamma_{52}*EMPATHY_j*FP_NEGCO_{ij} + \gamma_{53}*VALIDATION_j*FP_NEGCO_{ij} + \gamma_{54}*PRESENCE_j*FP_NEGCO_{ij} + \gamma_{55}*TECHFAC_j*FP_NEGCO_{ij} + \gamma_{60}*MP_NEGCO_{ij} + \gamma_{61}*WARMTH_j*MP_NEGCO_{ij} + \gamma_{62}*EMPATHY_j*MP_NEGCO_{ij} + \gamma_{63}*VALIDATION_j*MP_NEGCO_{ij} + \gamma_{64}*PRESENCE_j*MP_NEGCO_{ij} + \gamma_{65}*TECHFAC_j*MP_NEGCO_{ij} + u_{1j}$$

Appendix G

APIM for Change in DAS as Predicted by Negative Attributions and Therapist Behaviors

Fixed Effects	γ Coefficient	Standard Error	<i>t</i>	<i>df</i>	<i>p</i> -value
For M_DUM					
Intercept	0.668341	0.547935	1.220	34	.231
Warmth	0.895635	0.809536	1.106	34	.276
Empathy	0.258119	1.208842	0.214	34	.832
Validation	1.304885	1.082239	1.206	34	.236
Presence	-3.640479	2.652475	-1.372	34	.179
Technique Factors	0.811436	1.014688	0.800	34	.429
For F_DUM					
Intercept	0.788229	0.441724	1.784	10	.105
Warmth	0.139262	0.559694	0.249	10	.809
Empathy	0.474810	1.287973	0.369	10	.720
Validation	1.582023	0.744953	2.124	10	.060
Presence	2.210416	1.985846	1.113	10	.292
Technique Factors	-1.968114	0.744405	-2.644	10	.025
For FA_NEGAT					
Intercept	0.017999	0.028918	0.622	10	.548
Warmth	-0.034486	0.035712	-0.966	10	.357
Empathy	0.136123	0.066713	2.040	10	.069
Validation	-0.141432	0.055849	-2.532	10	.030
Presence	0.059684	0.072730	0.821	10	.431
Technique Factors	0.045143	0.040225	1.122	10	.288
For MA_NEGAT					
Intercept	0.006255	0.020378	0.307	10	.765
Warmth	-0.020405	0.022845	-0.893	10	.393
Empathy	-0.056721	0.034230	-1.657	10	.129
Validation	0.126208	0.037201	3.393	10	.007
Presence	-0.038779	0.045150	-0.859	10	.411
Technique Factors	0.019413	0.022302	0.870	10	.404
For FP_NEGAT					
Intercept	0.012077	0.021100	0.572	10	.580
Warmth	-0.029489	0.026428	-1.116	10	.291
Empathy	0.122260	0.057686	2.119	10	.060
Validation	-0.161680	0.048442	-3.338	10	.008
Presence	0.077365	0.072085	1.073	10	.308
Technique Factors	-0.005589	0.028558	-0.196	10	.849
For MP_NEGAT					
Intercept	0.001306	0.018554	0.070	10	.945
Warmth	-0.007550	0.027653	-0.273	10	.790
Empathy	-0.073515	0.053295	-1.379	10	.198
Validation	0.115414	0.036210	3.187	10	.010
Presence	-0.095820	0.049800	-1.924	10	.083
Technique Factors	0.003159	0.033600	0.094	10	.927

APIM for Change in DAS as Predicted by Negative Communication and Therapist Behaviors

Fixed Effects	γ Coefficient	Standard Error	<i>t</i>	<i>df</i>	<i>p</i> -value
For M_DUM					
Intercept	0.830677	0.321018	2.588	34	.014
Warmth	0.539051	0.551373	0.978	34	.335
Empathy	-0.029190	0.790751	-0.037	34	.971
Validation	0.400327	0.743673	0.538	34	.594
Presence	-2.884014	0.861494	-3.348	34	.002
Technique Factors	-0.125926	0.604918	-0.208	34	.836
For F_DUM					
Intercept	0.961778	0.228284	4.213	10	.002
Warmth	-0.041000	0.493802	-0.083	10	.935
Empathy	0.548705	0.704429	0.779	10	.454
Validation	1.197095	0.580652	2.062	10	.066
Presence	-1.525489	0.990049	-1.541	10	.154
Technique Factors	-0.436463	0.467825	-0.933	10	.373
For FA_NEGCOM					
Intercept	0.550426	0.413029	1.333	10	.212
Warmth	-0.780860	0.635196	-1.229	10	.247
Empathy	-1.280533	0.838935	-1.526	10	.158
Validation	-2.040204	0.763750	-2.671	10	.023
Presence	4.185289	1.079426	3.877	10	.003
Technique Factors	-1.851227	0.531406	-3.484	10	.006
For MA_NEGCOM					
Intercept	0.428063	0.285052	1.502	10	.164
Warmth	0.697116	0.645806	1.079	10	.306
Empathy	-0.002406	0.882915	-0.003	10	.998
Validation	0.759618	0.728589	1.043	10	.322
Presence	-1.486423	0.936889	-1.587	10	.144
Technique Factors	0.763502	0.675519	1.130	10	.285
For FP_NEGCOM					
Intercept	0.253890	0.401304	0.633	10	.541
Warmth	-0.452740	0.657710	-0.688	10	.507
Empathy	-1.013518	0.894659	-1.133	10	.284
Validation	-1.076725	0.863820	-1.246	10	.241
Presence	2.206601	0.754064	2.926	10	.015
Technique Factors	-1.370874	0.466684	-2.937	10	.015
For MP_NEGCOM					
Intercept	0.265227	0.271430	0.977	10	.352
Warmth	1.443292	0.635849	2.270	10	.047
Empathy	0.260317	0.823229	0.316	10	.758
Validation	1.592540	1.222448	1.303	10	.222
Presence	-4.785191	1.247307	-3.836	10	.003
Technique Factors	1.077413	0.598351	1.801	10	.102

APIM for Change in MMEA as Predicted by Negative Attributions and Therapist Behaviors

Fixed Effects	γ Coefficient	Standard Error	<i>t</i>	<i>df</i>	<i>p</i> -value
For F_DUM					
Intercept	-10.954639	11.064803	-0.990	34	.329
Warmth	-9.959910	19.982585	-0.498	34	.621
Empathy	-23.748645	35.245569	-0.674	34	.505
Validation	18.959825	28.115933	0.674	34	.505
Presence	29.291961	49.203418	0.595	34	.556
Technique Factors	49.119112	13.024361	3.771	34	<.001
For M_DUM					
Intercept	-18.198489	10.708461	-1.699	10	.120
Warmth	4.477637	19.805843	0.226	10	.826
Empathy	10.464618	34.313393	0.305	10	.767
Validation	-27.175542	27.007164	-1.006	10	.338
Presence	-42.475407	45.537316	-0.933	10	.373
Technique Factors	-41.120388	11.510504	-3.572	10	.005
For FP_NEGAT					
Intercept	0.543662	0.236174	2.302	10	.044
Warmth	-0.116376	0.304195	-0.383	10	.710
Empathy	-0.436469	0.683770	-0.638	10	.538
Validation	-0.253355	0.493894	-0.513	10	.619
Presence	0.433567	0.575617	0.753	10	.469
Technique Factors	0.106833	0.290484	0.368	10	.721
For MP_NEGAT					
Intercept	-0.450689	0.295831	-1.523	10	.159
Warmth	0.348081	0.583680	0.596	10	.564
Empathy	0.247100	0.859158	0.288	10	.780
Validation	-1.481424	0.684653	-2.164	10	.056
Presence	-0.052683	0.672566	-0.078	10	.939
Technique Factors	-0.858777	0.424086	-2.025	10	.070
For FA_NEGAT					
Intercept	0.145876	0.327110	0.446	10	.665
Warmth	-0.475535	0.538979	-0.882	10	.398
Empathy	-0.114446	0.991387	-0.115	10	.910
Validation	0.581140	1.010861	0.575	10	.578
Presence	-0.398013	1.342281	-0.297	10	.773
Technique Factors	0.228767	0.464655	0.492	10	.633
For MA_NEGAT					
Intercept	-0.778045	0.254927	-3.052	10	.012
Warmth	-0.156153	0.270887	-0.576	10	.577
Empathy	0.090434	0.477859	0.189	10	.854
Validation	0.135322	0.360481	0.375	10	.715
Presence	-0.160555	0.678636	-0.237	10	.818
Technique Factors	0.891415	0.382853	2.328	10	.042

APIM for Change in MMEA as Predicted by Negative Communication and Therapist Behaviors

Fixed Effects	γ Coefficient	Standard Error	<i>t</i>	<i>df</i>	<i>p</i> -value
For F_DUM					
Intercept	-16.473483	4.064591	-4.053	34	<.001
Warmth	0.750843	9.037298	0.083	34	.934
Empathy	-10.578665	13.501401	-0.784	34	.439
Validation	1.295901	11.313625	0.115	34	.909
Presence	-2.178859	11.494534	-0.190	34	.851
Technique Factors	-0.620872	6.793959	-0.091	34	.928
For M_DUM					
Intercept	-13.500090	3.291563	-4.101	10	.002
Warmth	-8.523724	5.541083	-1.538	10	.155
Empathy	-8.019291	11.705760	-0.685	10	.509
Validation	11.516780	9.243102	1.246	10	.241
Presence	0.213163	9.959915	0.021	10	.983
Technique Factors	7.209821	5.621768	1.282	10	.229
For FP_NEGCOM					
Intercept	5.932777	4.413554	1.344	10	.209
Warmth	4.229290	7.299211	0.579	10	.575
Empathy	-20.049140	11.296869	-1.775	10	.106
Validation	-28.898806	11.172755	-2.587	10	.027
Presence	0.782436	15.888729	0.049	10	.962
Technique Factors	13.391961	8.435722	1.588	10	.143
For MP_NEGCOM					
Intercept	-22.532917	4.944832	-4.557	10	.001
Warmth	8.252660	10.964699	0.753	10	.469
Empathy	-36.223474	17.276955	-2.097	10	.062
Validation	-1.390264	19.524785	-0.071	10	.945
Presence	-9.834418	19.693361	-0.499	10	.628
Technique Factors	6.974458	10.701929	0.652	10	.529
For FA_NEGCOM					
Intercept	16.933820	4.657876	3.636	10	.005
Warmth	-22.522754	9.292338	-2.424	10	.036
Empathy	26.153179	12.214859	2.141	10	.058
Validation	4.241792	15.011022	0.283	10	.783
Presence	10.254446	14.116712	0.726	10	.484
Technique Factors	1.259442	8.838775	0.142	10	.890
For MA_NEGCOM					
Intercept	-11.853426	4.062828	-2.918	10	.015
Warmth	-12.803617	8.089515	-1.583	10	.145
Empathy	27.496089	12.398088	2.218	10	.051
Validation	25.521225	15.809159	1.614	10	.138
Presence	-23.407310	22.735149	-1.030	10	.327
Technique Factors	-10.032842	9.819006	-1.022	10	.331

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