

INFLUENTIAL CLIENT FACTORS:
UNDERSTANDING AND ORGANIZING THERAPISTS' PERCEPTIONS OF
CLIENT FACTORS THAT INFLUENCE REPORTED OUTCOME OF THERAPY

Susan N. Perkins

Dissertation Submitted to the Faculty of the Virginia Polytechnic Institute and State University

In partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

In

Human Development
Specialization in Marriage and Family Therapy

Fred P. Piercy, Ph.D., Chair

Megan L. Dolbin-MacNab, Ph.D.

Adrian J. Blow, Ph.D.

Peter E. Doolittle, Ph.D.

April 29, 2010

Blacksburg, Virginia

Key words: Client Factors, Common Factors, Therapy, Outcomes

Copyright © 2010 by Susan N. Perkins. All Rights Reserved.

Influential Client Factors:
Understanding and Organizing Therapists' Perceptions of
Client Factors that Influence Reported Outcome of Therapy

Susan N. Perkins

ABSTRACT

Researchers and clinicians report that they think the client is the most influential component in determining the outcome of therapy. Although a variety of studies have examined the impact of various client factors on the outcome of couple therapy, this research is not cohesive and produces inconsistent results. The purpose of this multi-method study is to present a sense of the range and depth of client factors that influence the outcome of couple therapy. The use of qualitative and quantitative methods allowed the data to build on existing research while expanding the range of client factors considered. Data were gathered using a dynamic, web-based survey which assigned participants to discuss a case of successful or unsuccessful couple therapy. Participants provided their own descriptions of influential client characteristics. Participants also rated how important they thought several literature-based client factors were. Quantitative data analysis utilized descriptive statistics, principal components analysis, and logistic regression. Qualitative data were analyzed in two stages, using content analysis. Results indicated that couples can be conceptualized by five arenas of couple focus; these arenas accurately predicted whether participants were discussing a successful or unsuccessful case of couple therapy 85.9% of the time. Regarding individual client characteristics, in general, clients whose couple therapy was successful tended to be open to each other and committed to the relationship and to therapy. Unsuccessful couple therapy tended to focus on a greater number of individual issues. Couple dynamics characteristics differed according to outcome groups; participants described four types of couple dynamics that influenced couple therapy to be unsuccessful. Data showed that many client factors influenced the outcome of couple therapy, and that uncommon client characteristics could be vital to the outcome of some cases. Participants described a client's life events as impacting the outcome of couple therapy by increasing one person's vulnerability to his or her partner. If the partner acted in a way that created a sense of connection or support, this contributed to successful couple therapy. The results are presented in connection to previous research, when possible. Finally, implications for theory, research, and clinical work with couples are discussed.

DEDICATION

to Esther Leianne

whose big smile, big heart, and sparkling eyes

bring joy to every day

ACKNOWLEDGEMENTS

There is something ironic about calling this an individual project; I could never have done it alone. First, my love for working with clients only makes sense to me if I think of it as God-given. Without the passion to help others and the ability to do the work of learning, I would not even have started on the journey that led me here. Many friends and family have supported me in this journey by making room in their lives for the overflow of mine. I am grateful, not only for the tasks they actually did, but also for the faith they had in me, and in this project, which motivated their sacrifices. Ross Perkins, Lil and David Tice, Hannah Cook, Lanette Smith, Robyn Nunley, Christine Bauer, Kat Hertlein, Kathy Surface, Jeremy Ball, Brenda Freeman, George Lyons—all provided vital support. Perhaps most notable has been Ross' support. I consider myself extremely blessed to be married to a man who is more proud of my small successes than his own monumental accomplishments. In addition, Hannah's unexpected perspective of seeing my discouragement with previous work as evidence of growth helped me accept and believe in myself. The Phinished group kept this independent project from being lonely.

I also want to thank the participants of this study. The depth of information they provided amazed me. I estimated that the survey would take 15-20 minutes to complete. From reading the information they provided, it is obvious that most participants gave much more time. (One participant emailed, saying that she spent two hours taking the survey.) Based on a typical therapy rate of \$100/50-min hr, estimating 20 minutes for completion, and multiplying by the 398 surveys used, participants provided, at minimum, \$15,900 worth of their time. I am very grateful for this generous gift!

Even with the best support in the world, and the richest data, I could not have maneuvered my way through this process without my committee. Adrian Blow and Megan Dolbin-MacNab invested their time in me and challenged me to improve the quality of my ideas and work. What you have taught me will undoubtedly improve my future work, also. Peter Doolittle took on the demanding task of turning my ideas into a dynamic survey. The excellence Peter put into the survey made this a much better project and challenged me to expand my thinking regarding what is important. Finally, it has been a tremendous honor to work with Fred Piercy, the chair of my committee. Fred has steadily guided, mentored, supported, and encouraged me throughout this process. Fred's example of integrity, balance, scholarship, wisdom, maturity, respect, humility, and skill has continually challenged me to grow. I am a better scholar and person for having worked with Fred.

TABLE OF CONTENTS

Chapter I: Introduction	1
Is Couple Therapy Effective?.....	1
The Client’s Role in the Outcome of Couple Therapy.....	3
Purpose of this Study.....	8
Defining Key Terms.....	8
Conclusion.....	10
Chapter II: Literature Review	12
A Brief History of Common Factors.....	12
The foundation of common factors.....	12
Multiple concepts of common factors.....	14
Common Factors Meets Marriage and Family Therapy.....	16
Highlighting the client factor component of the common factors.....	18
Considering the individual in couple therapy.....	22
Client factors interact with other aspects of treatment.....	23
Calls for research of client factors in couple and family therapy.....	25
Critiques of Common Factors.....	28
Critiques of common factors in marriage and family therapy.....	29
Client Factors in Couple Therapy: Selected Empirical Evidence.....	31
Exploratory studies of client factors in couple therapy.....	32
Using client factors to predict the outcome of couple therapy.....	35
Toward a Constellation of Client Factors.....	38
Chapter III: Methods	39
Research Questions.....	39
Research Design Elements.....	40
Multi-method research.....	40
Survey research.....	42
Clinicians’ Views of Couple Therapy Outcome.....	44
Data Collection Process.....	45
Participants.....	45
Procedures.....	50
Measures.....	52
Design Considerations.....	52
Survey.....	55

Piloting	60
Data Analysis Procedures.....	61
Quantitative analyses.	61
Qualitative analyses.	68
Chapter IV: Results	79
Participant and Case Information	79
Participant demographics.....	79
Client demographics.	84
Information about the couple therapy cases.....	89
Research Question #1	93
Quantitative findings.....	93
Principal components analysis: Five arenas of couple focus.....	97
Qualitative findings.....	101
Research Question #2.....	103
PCA for successful couple therapy cases.....	108
PCA for unsuccessful couple therapy cases.....	110
Comparisons of medians and ranks.	112
Research Question #3	118
Overall findings: Complex, interrelated, and dynamic.....	119
Qualitative categories of individual characteristics that influenced couple therapy outcome.	120
Qualitative categories of couple dynamics characteristics that influenced couple therapy outcome.....	126
Indirect impact of life events on couple therapy outcome.....	131
Summary.....	143
Chapter V: Discussion	145
Comparing Participants to AAMFT Members.....	145
Discussion of Findings	148
Overall finding #1: Five arenas of couple focus.....	149
Overall finding #2: A hierarchy of client factors.....	150
Overall finding #3: What matters for this case matters for this case.....	153
Overall finding #4: The indirect impact of life events.....	153
Differences finding #1: Five arenas of couple focus.....	156
Differences finding #2: Overcoming Obstacles vs. Unable to Recover	157
Differences finding #3: Specific client characteristics	158

Differences finding #4: Qualitative differences.....	160
Implications of the Findings.....	162
Theoretical implications.....	162
Research implications.....	166
Clinical implications.....	167
Strengths and Limitations of the Current Study.....	171
Conclusion.....	175
References.....	177
Appendices.....	197

Appendix	Title	Page
A	IRB Approval Letter	198
B	Email Solicitation to Listservs	199
C	Email Solicitation to COAMFTE Program Directors	200
D	IDAMFC State Division Solicitation Email	201
E	Solicitation Email Sent Directly to Couples Therapists	202
F	Consent Form	203
G	Screen Shots of Survey for Participant Perceived Successful Couples Therapy	206
H	Screen Captures of the Survey for Participant-Perceived Unsuccessful Couple	219
I	Separate and Combined Variable Names	229
J	Qualitative Coding of Literature-Based Client Characteristics	230
K	Number of Times Each Theory was Endorsed by Participants	249
L	Scree Plot for Principal Components Analysis of All Data	250
M	Component Loadings for Resulting PCA Components of All Data	251
N	Scree Plot for Principal Components Analysis of Cases Identified as Successful	253
O	Component Loadings for Resulting PCA Components of Cases Identified as	254
P	Scree Plot for Principal Components Analysis of Cases Identified as Unsuccessful	256
Q	Component Loadings for Resulting PCA Components of Cases Identified as Unsuccessful	257
R	Annotated List of Figures; Copyright Information	259

LIST OF FIGURES

Figure	Title	Page
1	Participants' Descriptions of Literature-Based Client Factors	101
2	The Impact of Life Events	132

LIST OF TABLES

Table	Title	Page
1	Literature-Based Client Factors as Seen by Survey Participants	58
2	Participant Ethnicity	80
3	Participant Licensure Status	82
4	Participant Reports of Client Ages	86
5	Participant Reports of Client Diagnoses	88
6	Participant Report of Severity of Couple Therapy Case	90
7	Presenting Problem Categories, Sub-Categories, and Descriptions	91
8	Descriptive Statistics for Participants who rated the Factor as Influencing the Outcome of Couples Therapy.	94
9	Descriptive Statistics of the Ranked Client Factors for All Participants	96
10	Eigenvalues and Percent of Variance Accounted for by the five PCA Components.	98
11	Number of Participants whose Qualitative Responses Overlapped with Literature-Based Client Factors	103
12	Logistic Regression Results with PCA Components as the Independent Variables	106
13	Logistic Regression Results with the Literature-Based Client Factors as the Independent Variables.	108
14	Comparison of Descriptive Statistics for the Literature-Based Client Characteristics	114
15	Mann-Whitney U Results Testing Differences between Groups	115
16	Participant Frequencies of Listing Client Factors, According to Outcome Group	117
17	Participant-Generated Individual Characteristics: Categories and Codes	120
18	Participant-Generated Couple Dynamics Characteristics	127
19	Comparison of Demographics of AAMFT Members versus Study Participants	146
20	Comparison of Professional Identity of AAMFT Members versus Licensure of Study Participants	146
21	Means and Number of Times Endorsed for Client Characteristics which are Different for Successful and Unsuccessful Couple Therapy	159

Chapter I: Introduction

Couples coming to couple therapy walk through the office door in varying states of pain, distress, and disconnection. Their personal and relational histories accompany them and color their experiences. The clinician comes to know the couple, and leads the couple through a variety of conversations, exercises, techniques, and inventories, often while clients are in a state of emotional vulnerability. Clients do this with hope in the possibility that when they leave the office something will change, something will feel different, something will be better. Have they come to the right place? Will the clinician be able to help the couple make the changes they say they desire?

Because the ultimate goal of all theories of couple therapy is to create and maintain desired change, clinicians and researchers have been asking about the effectiveness of couple therapy for many years. But the question does not stop there. If couple therapy is effective, what is it about couple therapy that impacts the outcome? And, perhaps more importantly, how can researchers and clinicians better understand the factors that impact the outcome of therapy so that couple therapy can be as effective as possible?

Is Couple Therapy Effective?

There is good news and bad news. The good news is that overwhelming evidence shows that couple therapy is more effective than no treatment. Studies which compared couples in therapy to either their own change while waiting for therapy or to couples not in therapy have shown that couples benefit from participating in therapies such as emotionally-focused couple therapy (e.g., Denton, Burleson, Clark, et. al, 2000; Goldman & Greenberg, 1992; Johnson & Greenberg, 1985a; 1985b), behavioral marital therapy (Lebow & Gurman, 1995; Snyder & Wills, 1989), and insight-oriented couple therapy (Snyder & Wills, 1989), to name just a few.

To look at the overall picture of the effectiveness of couple therapy, researchers have used meta-analysis. In meta-analysis, the researcher considers quantitative data from a number of individual studies examining the same topic, converts the findings from each study to standardized scores so the data can be used collectively, and analyzes the standardized data of all the studies. Shadish and Baldwin (2003) reviewed the results of 20 meta-analyses on the effects of couple and family therapy. They found that “marriage and family therapies produce clinically significant results in 40%-50% of those treated” (p. 561), with couple therapy being more effective overall than family therapy. Specifically, Shadish and Baldwin reported that, on average, a couple who went through couple therapy had a better outcome than 84% of couples with similar problems who do not go through couple therapy. They also reported that the improvement couples made in therapy tended to last. Other studies have reported varying percentages of successful outcome. For example, Jacobson and colleagues (2000) reported that between 39.4% and 72.1% of couples improved in behavioral marital therapy; Hampson, Prince, and Beavers (1999) reported that 83% of the 139 couples seen in their clinic were classified as making “some,” “moderate,” or “significant” gains.

Based on outcome studies and meta-analysis reviews, Shadish and Baldwin (2003) concluded that “the effects of marriage and family interventions are comparable to or larger than those obtained by alternative interventions ranging from individual therapy to medical interventions” (p. 561). Gurman and Fraenkel (2002) reviewed the theoretical, research, and practice trends in couple therapy’s history for the past millennium. Gurman and Fraenkel described the beginnings of couple therapy as lacking both theory and data. They noted that the current state, in contrast, is becoming theoretically refined and integrated, is based on carefully critiqued research, and shows robust effectiveness. They concluded by claiming,

No other collective methods of psychosocial intervention have demonstrated a superior capacity to effect clinically meaningful change in as many spheres of human experience as the couple therapies, and many have not yet even shown a comparable capacity. . . .

[C]ouple therapy at the millennium has emerged as one of the most vibrant forces in the entire domain of family therapy and of psychotherapy-in-general [italics in original]. (p. 248)

The good news, then, is that couple therapy *is* effective. The bad news is also reflected in the above data. An effectiveness rate of 40%-83% also means that between 17% and 60% of couples do not benefit from couple therapy. The large differences in outcome leads to the question, what contributes to the variance in outcomes of couple therapy?

The Client's Role in the Outcome of Couple Therapy

Marriage and family theorists initially argued that the difference between successful and unsuccessful couple therapy was the theory, with each theorist arguing that his or her own theory of couple therapy produced the most successful results (Luborsky, Diguier, Luborsky, et al., 1993; Sprenkle & Blow, 2004a). Researchers questioned this and used meta-analysis to compare the outcome of different theories of couple therapy. In the specific study described earlier, Shadish and Baldwin (2003) compared the outcomes of different theories of couple therapy and concluded that “different kinds of marriage and family interventions tend to produce similar results” (p. 561). Meta-analysis results have consistently shown that virtually all theories of therapy—many vastly different—created change in clients with about the same rate of success (Jacobson, 1993; Lambert & Bergin, 1994; Lambert, Shapiro, & Bergin, 1986; Shadish, Montgomery, Wilson, & Wilson, 1993; Shadish, Ragsdale, Glaser, & Montgomery, 1995;

Simmons & Doherty, 1995; Smith, Glass, & Miller, 1980; Sprenkle & Blow, 2004a; Wampold, 2001).

If the differences seen in the outcome of couple therapy were not only due to the theory of therapy, they could be due to several other things, including the clinician, the relationship between the clinician and the clients, the expectation that therapy will be effective, or other components. In an effort to better understand which factors contribute to the outcome of individual therapy, Luborsky, Chandler, Auerbach, Cohen, & Bachrach (1971) reviewed 166 studies on the outcome of psychotherapy. They compiled all the lists of factors which impacted the outcome of therapy, grouped them into “patient, therapist, or treatment factors” (p. 145), and compared the impact of those factors on the outcome of therapy. They found that “by far, the largest number [of factors that impact the outcome of therapy] deals with patient factors—relatively few with clinician or treatment” (p. 145).

More recently, Thomas (2006) asked clients and clinicians what they thought contributed to the outcome of therapy and reported that they agree, “clients and therapists believe that the client contributes the most to change in a therapeutic process” (p. 201). Additionally, several clinicians and researchers emphasized the client as the main determinant of the outcome of couple therapy (Asay & Lambert, 1999; Miller, Duncan, & Hubble, 1997). Bohart (2000) edited an issue of the *Journal of Psychotherapy Integration* which focused on the client. In introducing that issue, he wrote, “we all recognize that ultimately how clients grow and change is in their hands” (p. 120). Bohart continued by stating, “the client [is] the single most important common factor in therapy” (p. 121). Similarly, Tallman and Bohart (1999) state, “nearly all approaches [to therapy] recognize the importance of client collaboration to make therapy work” (p. 94).

Despite this recognized importance, theories of couple therapy do not distinctly address client factors. Bohart (2000) wrote,

the role of the client as an active change agent who makes significant contributions to the change process has been neglected in the psychotherapy literature. . . . while we pay lip service to the idea that it is clients who ultimately heal themselves, our theories tend to focus on what we as therapists do. (p. 119-120)

The theory which has created space for client factors is the common factors approach. The common factors approach asserts that most of the change that happens in therapy is due to factors which are common across all theories of therapy. The field of marriage and family therapy recently began building on this concept for therapy with couples and families. Sprenkle and Blow (2004a) identified common factors for all theories and common factors which were specific to marriage and family therapy. They included client factors and relational conceptualization as influential components of marriage and family therapy. The common factors approach in marriage and family therapy will be addressed in Chapter Two.

Consistent with theory, research on client variables has a scattered approach—hitting a topic here and a demographic variable there (Clarkin & Levy, 2004). At this point, according to Garfield (1994), “research on client variables produces conflicting or inconsistent results” (p. 190). This theoretical neglect and the incomplete picture provided by research offer clinicians minimal guidance regarding which client factors deserve attention. There is no sense of the full collection of client factors that need to be considered or how those client factors need to be prioritized.

As a metaphor, in the complex, multi-faceted orchestra of client factors that together produce symphonic change, couple therapy research and theory is currently only talking about

the French horn, flute, violin, and snare drum. While we might recognize those instruments, we know even less about how to play them or how to write music that showcases their beauty and unique contribution to the overall symphonic experience. Certainly, using only a few instruments can make beautiful music, but having more instruments allows for greater richness, variety, and complexity of sound.

Sprenkle and Blow (2004a) noted that the research on client factors in marriage and family therapy has been minimal, and remarked, “this is unfortunate, because we think these client variables are likely to be strongly related to outcome” (p. 121). Asay and Lambert (1999) also believed that therapy was more effective when the clinician used client variables and strengths deliberately. Clarkin and Levy (2004) described the disconnections in current knowledge on client factors and recommended that researchers develop a constellation of client variables that is meaningful for prediction of therapy outcome. It seems that, in individual and marital and family therapy, there is a sense that a better understanding of client factors that impact the outcome of therapy would lead to better outcomes.

Understandably, clinicians and researchers tend to be most interested in successful couple therapy. But, in the same way that focusing exclusively on the statistics of successful therapy misses the rest of the story, focusing only on what contributed to successful couple therapy provides an incomplete picture (Clarkin & Levy, 2004; Lebow & Gurman, 1995). In 1936, Rosenweig first hypothesized that the factors which contribute to the success of therapy might be common across all theories of therapy. He added, “it is by no means being overlooked that there is another far more pressing problem . . . how is it that in so many cases all methods of therapy prove equally *unsuccessful*?” (p. 413).

In considering unsuccessful therapy, Mohr (1995) reviewed studies which included descriptions of clients who deteriorated in psychotherapy. He explained that the value of considering unsuccessful outcomes was “that one must learn to identify patients who are at risk for deterioration in psychotherapy to safe-guard the well-being of the patient” and that “an examination of failed psychotherapy cases can lead to improvements in technique” (p. 1). He concluded, “to the extent that the field avoids examining when psychotherapy fails, the field succeeds only in limiting its own potential” (p. 24). Snyder, Castellani, & Whisman (2006) promoted the idea of researching factors that contribute to unsuccessful therapy and to relapse after therapy.

Although some factors could contribute to both successful and unsuccessful couple therapy, there could be other factors that contribute uniquely to either successful or unsuccessful couple therapy. This has been implied in studies that compared client factors which predicted successful or unsuccessful outcome of therapy and client factors which predicted the maintenance of the improvement made in therapy (e.g., Atkins et al., 2005; Freeman, Leavens, & McCulloch, 1969; Hampson & Beavers, 1996; Hampson, Prince, & Beavers, 1999; Jacobson et al., 2000; Lebow & Gurman, 1995; Snyder, Mangrum, & Willis, 1993; Vansteenwegen, 1996). Understanding the full constellation of client factors that influence the successful and unsuccessful outcomes of couple therapy could likely be valuable in and of itself. This constellation of variables could be used to help clinicians develop strategies for maximizing the impact of client factors that predict successful couple therapy outcome and minimizing the impact of client factors which might be likely to thwart the successful outcome of therapy. Snyder and colleagues (2006) promoted this line of inquiry when they wrote, “*couple therapy research needs to extend beyond initial treatment impact to identify individual, relationship, and*

treatment factors contributing to deterioration or relapse and effective means of reducing or eliminating these effects” (p. 336).

Purpose of this Study

The recognized importance of client factors and the lack of current theory and research guiding the understanding of client factors suggest that research needs to consider the scope of client factors that influence the outcome of couple therapy. To fill this need, the purpose of this project was to identify and describe the wide variety of client factors that impact the outcome of couple therapy by asking a variety of clinicians who work with couples what client factors they perceived to influence a case of couple therapy. Participants were assigned to report on either a case they perceived to be successful or a case they perceived to be unsuccessful. Participants offered their own observations and rated the importance of client factors which have been identified in the literature. This multi-method research design allowed the current project to both build on the available research and also to create a more complete picture of influential client factors by giving participants the opportunity to fill in the gaps of client factors which theory and research have not adequately considered yet.

Defining Key Terms

One of the challenges of research on client factors is that client factors are inconsistently explained and defined. So that readers have a clear understanding of the current study from the beginning, definitions of the terms used are provided here. For purposes of this project, a *couple* was defined as any two people who present as being in a committed, romantic relationship, *couple therapy* included marital therapy, couple counseling, marital counseling, and marital enrichment programs when research on their outcome is provided. *Clinician* referred to any

qualified mental health clinician who practiced couple therapy. This included marriage and family therapists, psychologists, counselors, social workers, and ministers.

Successful couple therapy was defined and measured in a variety of ways, including equating successful couple therapy to marital satisfaction, evaluations of behavioral change, couple report of satisfaction with couple therapy, and clinician's or outside rater's observations of client change of specific behaviors (Christensen, Baucom, Vu, & Stanton, 2005; Fowers, 1990; Jacobson & Truax, 1991; Markman, 1991; Whisman, Jacobson, Fruzzetti, & Waltz, 1989). For the purposes of this study, the definition of *success* presented by Miller, Duncan, and Hubble (1997) was the basis for the definition of *successful couple therapy*. This definition was used because it was intended to encompass the definition of success for all theories of therapy and therefore should apply to all participants. Miller, Duncan, and Hubble explained, "[a]cross all models, therapists expect their clients to do something different—to develop new understandings, feel different emotions, face fears, take risks, or alter old patterns of behavior" (p. 29). The definition of *successful therapy* for this study, which was used in data collection, was

the client couple are 'doing something different' in the direction of desired change. (This can include improvements in understanding, emotions, or behavior.) Clients' changes were significant enough to improve their level of functioning. The therapist and couple think therapy was successful.

Unsuccessful couple therapy then, was defined as

therapy did not produce desired change in clients. That is, clients did not begin to do things differently, did not reach the goals of therapy, and/or reported not being satisfied with the changes that may have occurred.

Many of the varying theoretical definitions of *client factors* are discussed in the literature review. For this study, the overarching definition of *client factors* was based on work by Christensen and colleagues (2005), which stated, “A critical task for future investigators is to isolate the *individual, couple, and environmental* factors that contribute to the documented variability in response to couple treatment” (emphasis added, p. 9). For this study, the above topics of recommended research were combined into defining *client factors* as a) individual characteristics (e.g., demographics, personality, motivation, and diagnosis), b) couple dynamics characteristics (e.g., level of family functioning, patterns of interaction, intimacy, and positive affect between the couple), and c) life events (e.g., key aspects of a person’s situation (such as social support or financial stress), and expected or unexpected changes or events in the lives of individuals and/or families (such as the birth of a child, death of a family member, incarceration, or loss of job)). As research on client factors was reviewed, the client factors considered across a wide variety of studies fit into these categories, confirming that these three categories can be used as a way to organize client factors.

Conclusion

Despite the consensus that couple therapy is effective and the understanding that client factors contribute greatly to the outcome of therapy, theory and research of couple therapy have not yet focused on developing a systematic approach to understanding client factors. The current research, which will be reviewed in the next chapter, is fragmented but should not be ignored. The next step toward a cohesive approach to client factors is to collect information which describes a more complete picture of client factors that influence the successful or unsuccessful outcome of couple therapy by providing some organization to the existing literature and filling in the gaps of influential client factors that have not yet been addressed. This project takes that step

by gathering and summarizing clinicians' views of client factors that influence the successful or unsuccessful outcome of couple therapy, comparing those views to current literature, and allowing clinicians' observations to fill in the gaps.

Chapter II: Literature Review

To provide a clear picture of the current state of theory and research on client factors that impact the outcome of couple therapy, this review begins with an overview of the common factors approach, emphasizing the common factors in the field of marriage and family therapy. It highlights the client factors component of common factors and describes the interconnectedness between the client factors component and other components of common factors. As they relate to client factors, calls for research in the field of marriage and family therapy are also presented. Several critiques of common factors, specifically as they are currently explained in marriage and family therapy, are outlined and the possibility of a meta-perspective of client factors addressing some of these critiques is described. Examples of selected empirical findings of client factors that influence the outcome of couple therapy are presented and critiqued.

A Brief History of Common Factors

The common factors approach in marriage and family therapy is rather new and its roots are still quite connected to the common factors approach in psychology (Sprenkle et al., 2009). To provide a clear picture of the common factors in marriage and family therapy, a brief history of the common factors in psychology will be presented, with emphasis on the aspects from psychology that have most influenced the common factors approach in marriage and family therapy. More thorough histories were provided elsewhere (i.e., Davis, 2005; Duncan, 2002; Hubble, Duncan, & Miller, 1999b; Sprenkle et al., 2009; Wampold, 2001).

The foundation of common factors.

As early as the 1930s, psychotherapists were already developing a plethora of quite different approaches to psychotherapy, using them with clients, and experiencing success. In

1936, Rosenzweig first suggested that the positive outcome of therapy seen by very different clinicians was more likely due to aspects of treatment common among therapies than to anything unique that each of the theories offered. His subtitle for this article referenced the scene in Carroll's *Alice in Wonderland*, in which the dodo bird exclaimed, "Everybody has won and all must have prizes" (Rosenzweig, p. 412). Freud (1937, cited in Luborsky, 1995) supported this idea of common factors in a more limited way, when he claimed that, among all clients, "(a) the degree of distortion caused by the illness and (b) the length of illness" (p. 106) influenced the outcome of treatment.

The idea of common factors was ignored and theorists continued to develop and promote their unique theories, each claiming to have a corner on the market of creating change. To support their theories, researchers used clinical trials to compare the outcome of clients who received one therapy to the outcome of clients who received a different therapy or to a control group who received no therapy. Although some individual studies did show significant differences between treatments in a way that preferred one theory of therapy, results were inconsistent. In 1975, Luborsky, Singer, and Luborsky reviewed research on the outcome of therapy and concluded that no significant differences in outcome existed between theories of therapy. They attributed this finding to Rosenzweig's earlier concept of common factors and named it the "dodo bird verdict."

Since then, meta-analytic and outcome studies of individual psychotherapy have repeatedly shown no significant differences between the outcomes of various theories of individual therapy (Lampropoulos, 2000; Luborsky et al., 2003; Messer & Wampold, 2002; Wampold, 2001). Meta-analysis of couple and family therapy were also conducted and also concluded that there were no significant differences between the outcomes of couple and family

theories (Shadish & Baldwin, 2003; Shadish et al., 1993; Shadish et al., 1995; Smith, Glass, & Miller, 1980; Sprenkle & Blow, 2004a; Wampold, 2001; Wesley & Waring, 1996). Many researchers interpreted these meta-analytic studies of therapy outcome as support for the concept of common mechanisms of change across theories of therapy (e.g., Bohart, 2000; Grencavage & Norcross, 1990; Hubble, Duncan, & Miller, 1999b; Messer & Wampold, 2002; Sprenkle & Blow, 2004a; Sprenkle et al., 2009; Wampold, 2001).

The concept that theory differences might not be completely responsible for the success of therapy challenged researchers and clinicians to expand their focus and include consideration of the client, the therapeutic relationship, the expectancy component of therapy, and other factors that might be common across theories of therapy. Glass (2001) explained the core value of the common factors approach by saying, “The common factors position . . . can move the focus of psychotherapy training and theory itself from therapist to client, from how the therapist ‘cures’ to how the client ‘heals’” (p. ix). This explanation may be a bit narrow as it could overlook the value of the clinician and the therapeutic relationship that is also common across theories of therapy. Clients may well heal regardless of the clinician. However, clients generally come to therapy when they are, as Frank (1995) described, demoralized in their attempts to self-heal. Perhaps the common factors approach could be described as a focus on how clinicians help clients heal.

Multiple concepts of common factors.

Although not accepted by all researchers (e.g., Arkowitz, 1995; Beutler, 2002; Kazdin, 2005), once the concept of common factors across theories of therapy being responsible for the bulk of improvement in clients was introduced, writers speculated as to what those common factors might be. Karasu (1986) took a focused approach, which was later further developed in

the field of marriage and family therapy. He hypothesized that there were common factors, not only in the larger therapeutic context, but also within the theories of therapy. Karasu compared the techniques of 26 theories of therapy and concluded that they all use some form of 1) affective experiencing, 2) cognitive mastery, and 3) behavioral regulation.

Lambert's (1992) list of common factors has been cited in marriage and family therapy literature (Davis, 2005; Hubble, Duncan, & Miller, 1999b; Miller, Duncan, & Hubble, 1997; Sprenkle et al., 2009). Lambert estimated that 40% of desired change during therapy is due to client and extra-therapeutic factors, 30% to "common factors," which he explained as things the clinician does to foster the relationship between the clinician and client, 15% is attributable to a hope, expectancy, or placebo effect, and 15% of change can be accounted for by the actual theory and techniques used. These percentages were intended to be illustrative, not to be taken as actual findings, as Lambert explained, "no statistical procedures were used to derive the percentages . . . which [appear] somewhat more precise than is perhaps warranted" (p. 98). Davis (2005) described Lambert's percentages as "educated estimates" (p. 10).

In a more general and empirical common factors explanation, Wampold (2001) compiled data from meta-analyses and outcome studies and concluded that 70% of the variance in therapy outcome was due to general effects across all theories, 8% of the variance was due to the specific effects of the theory of therapy used, and 22% of the variance could not be explained. Wampold's description of the common factors did not emphasize the client as much as it de-emphasized theories of therapy.

Many more researchers offered lists of their conceptualizations of common factors. These lists became so numerous that Grenavage and Norcross (1990) reviewed common factors literature in an attempt to summarize the wide variety of common factors lists being offered.

They used a five-area framework: “client characteristics, therapist qualities, change processes, treatment structure, and relationship elements” (p. 373) to organize their findings. In their review, they concluded,

the most consensual commonalities were the development of a therapeutic alliance . . . , the opportunity for catharsis . . . , the acquisition and practice of new behaviors . . . , clients’ positive expectancies . . . , beneficial therapist qualities . . . , and the provision of a rationale as a change process (p. 376).

In 1995, Beutler summarized the state of common factors literature when he wrote, “Common factors are both inconsistently described and often ignored” (p. 79).

The factors proposed to be common across theories of couple and family therapy, in contrast, are fairly succinct. This may be due to the newness of the common factors approach in the field of marriage and family therapy, rather than due to a consensus among theorists, researchers, and clinicians.

Common Factors Meets Marriage and Family Therapy

Common factors literature in marriage and family therapy is sparse, being limited to only a handful of articles (Davis, 2005) and one book (Sprenkle et al., 2009). Some of these articles are reviews and offer possible common factors lists (Blow & Sprenkle, 2001; Sprenkle & Blow, 2004a). The empirical studies, specifically meta-analyses, which compared the effects of various treatments, confirmed the findings of similar studies in psychology—no significant differences in treatment effect between models of marriage and family therapies have been found (Shadish & Baldwin, 2003; Shadish et al., 1995). The foundation for common factors in marriage and family therapy appears to be growing.

Sprenkle, Blow, and Dickey (1999) connected marriage and family therapy literature to the concept of common factors. This connection between marriage and family therapy and common factors was presented in the book *The Heart and Soul of Change*. The editors of this text, Hubble, Duncan, and Miller, based their common factors approach on Lambert's list of common factors. Sprenkle, Blow, and Dickey (1999) asserted that theories of marriage and family therapy are in some ways qualitatively different than theories of individual psychology. Sprenkle and Blow (2004a) later developed a "moderate" approach to common factors by emphasizing that the theory of therapy and the skill with which the theory is used are the "vehicles through which common factors operate" (p. 115). Their view was also considered moderate in that it did not present the therapeutic relationship as sufficient for change, it valued clinical trials research, and it resisted the false dichotomy of common vs. specific (theoretical) factors contributing to change (Sprenkle & Blow, 2004a).

Sprenkle and Blow (2004a) listed five factors as common factors among all theories of therapy: (a) the client; (b) therapist effects; (c) the therapeutic relationship; (d) expectancy/placebo; and (e) nonspecific treatment variables, which include behavioral regulation, cognitive mastery, and emotional experiencing. These factors combined Lambert's list with Karasu's (1986) focus on the common factors within theories, which he identified as (a) affective experiencing, (b) cognitive mastery, and (c) behavioral regulation. In addition to the five overall common factors proposed, Sprenkle and Blow offered three factors that they recognized as common among marriage and family therapies which were qualitatively different than theories of individual therapies. These were: a) relational conceptualization, b) the expanded direct treatment system, and c) the expanded therapeutic alliance. These three

marriage and family common factors were consistent with marriage and family clinicians working from a systemic perspective.

In the first book exclusively on the topic of common factors in couple and family therapy, Sprenkle et al. (2009) added to the list of common factors that they believe contribute to change among all theories of therapy. The component they added was “allegiance effects and the organization or coherence of the model employed” (p. 32). They also added a common factor to the list specific to theories of marriage and family therapy: “disrupting dysfunctional relational patterns” (p. 32).

Lest the more complex list of common factors in marriage and family therapy appear to divert attention from the value that marriage and family theories hold for clients, note that Sprenkle and Blow (2004a) wrote, “in our judgment, one of the most significant contributions of the common factors movement has been to highlight the truth that the client (not the model or even the therapist) is the ultimate hero” (p. 120). Similarly, Sprenkle et al. (2009) described their acceptance of common factors as a paradigm shift, after which the importance of the client’s attributes and contribution to therapy became glaringly obvious.

Highlighting the client factor component of the common factors.

Most of the common factors theorists defined and described the client factors component in more detail. Focusing on theorists’ ideas about client factors which impact the outcome of therapy can begin to provide a sense of the full range of client factors. Like the common factors components, the specific client factors component is described differently by various authors. In psychology, Lambert (1992) defined extratherapeutic change as including both client characteristics and environmental influences. He defined extratherapeutic change as, “those factors that are part of the client (such as ego strength and other homeostatic mechanisms) and

part of the environment (such as fortuitous events, social support) that aid in recovery regardless of participation in therapy” (p. 97).

In their first book, Miller et al. (1997) defined extratherapeutic and client factors as “beneficial chance events as well as the helpful qualities that clients bring with them to the treatment relationship” (p. 80). They focused on these beneficial events and helpful factors because these client factors supported desired change. Since change—the client doing something different—is the ultimate goal of therapy (Miller et al.), it is also an appropriate place for researchers and clinicians to begin to consider client factors. This consideration of client factors then becomes the springboard for Miller and colleagues’ recommendation that clinicians maximize the positive influence of these factors in therapy. However, this only captures part of the picture of client and extratherapeutic factors.

In their follow-up book which included research reviews and meta-analytic studies to support common factors concepts, Hubble, Duncan, and Miller (1999b) re-defined client and extratherapeutic factors as

part of the client or the client’s life circumstances that aid in recovery despite the client’s formal participation in therapy. They consist of the client’s strengths, supportive elements in the environment, and even chance events. In short, they are what clients bring to the therapy room and what influences their lives outside it. (p. 9)

Note that while the authors began with focusing on factors that “aid in recovery,” they then broadened the focus to essentially everything about the client. This more broad definition reflects both the reality of working with clients and the available research on client factors. As noted previously, recognizing both client factors that lead to successful therapy and client factors

that lead to unsuccessful therapy allows for a more complete picture of client factors that impact the outcome of couple therapy.

Specific to marriage and family therapy, Sprenkle and Blow (2004a) did not offer a definition of the client factors component, but rather listed several client factors that they believed impact the outcome of couple and family therapy. (The definition of client factors for the current study that was presented previously grouped client characteristics into (a) individual characteristics, (b) couple dynamics characteristics, and (c) life events. To provide consistency in presenting several diverse explanations of client factors, client factors will be presented in those three categories.) Sprenkle and Blow (2004a) listed the following client characteristics:

- a) individual characteristics: age, gender, race, level of motivation, awareness, commitment to change, sexual orientation, expectations, inner strength, preparation, diagnosis, individual learning style, “perseverance, willingness to participate in treatment, and cooperation with homework assignments” (p. 121).
- b) couple dynamics characteristics: level of couple commitment, “level of couple commitment, family cohesion, family expressed emotion” (p. 121)
- c) life events: stressful events, community involvement, religious faith, social support

Blow and colleagues (2009) explain the life event component by writing, “extratherapeutic events are influential happenings outside of therapy that play a major role in change. Whether clients choose to discuss these events in therapy or not, they inevitably influence the process” (p. 352).

In the most recent couple and family therapy common factor publication, Sprenkle and colleagues (2009) added the individual characteristic of “hard work” (p. 46) to the previous list. They also mentioned the individual client factors of recognition of the need for emotional

connection and the ability for clients to use therapy to meet their own needs. In the couple dynamics characteristics category, Sprenkle et al. mentioned level of traditionality and mutual goals for couples. Davis and Piercy (2007b) found the client factors of humility, commitment and hard work, and psychologically/systemically aware to be common themes for successful couple therapy.

While the above lists are sufficient to highlight the importance of client factors and to establish the range of client factors that are currently considered, the following information provides a snapshot of the fragmented way in which client factors have been conceptualized and studied. Hubble, Duncan, and Miller's book (1999) is arguably one of the foundational texts for common factors among therapies. In their edited volume, they empirically supported the common factors approach and offered examples of the common factors at work in a variety of fields (i.e., marriage and family therapy, medicine, and psychiatry).

Consider the diversity of client lists which were offered in different chapters of the same text. In one chapter, Asay and Lambert (1999) recognized the following client factors: "severity of disturbance . . . , motivation, capacity to relate, ego strength, psychological mindedness, and the ability to identify a focal problem" (pp. 30-31). In another chapter, Tallman and Bohart (1999) listed these client factors: client cooperation, "client's 'role investment,' . . . client openness versus defensiveness, . . . client's 'collaborative style,'" (p. 104), client motivation, expectations about therapy, and clear sense of goals. Bachelor & Horvath (1999) offered yet another list: relational capacity, attachment style, psychological functioning, demographics, involvement, attitudes, while Scovern (1999) recognized skills, problem-solving ability, optimism, expectancy, hope, self-efficacy expectancy, health locus of control, affect, stress arousal, and social support.

Sprenkle, Blow, and Dickey (1999), in addressing common factors for marriage and family therapy, divided extra-therapeutic change into three main categories: (a) client factors, (b) fortuitous events, for example, stressful situations; and (c) social support. They described the first of these three, client factors, as including (a) “static characteristics of individuals” (p. 332) such as age, socio-economic status, ethnicity, and strengths; (b) “nonstatic characteristics of individuals, couples, and families” (p. 332) such as learning style, expressed emotion, commitment and goals; and (c) “motivational characteristics” (p. 333) including client collaboration, perseverance, active participation, and homework completion. Finally, Murphy (1999) listed “personal strengths, talents, resources, beliefs, social supports, spontaneous remission, and fortuitous events in the client’s life” (p. 362). Note that, while there is overlap, none of these lists from the same book is totally consistent.

This fragmentation and lack of consistency is also reflected in how other authors have described client factors that may affect the outcome of couple therapy. It seems everyone has his or her own idea of which client factors matter. The range of client factors was captured by Clarkin and Levy (2004), who claimed, “[t]he number of client variables with potential for informing the process and outcome of psychotherapy is virtually limitless” (p. 195).

Considering the individual in couple therapy.

Unlike the distinctiveness between the fields of psychology and marriage and family therapy, practicing couple therapy does not always allow clinicians to draw a clear line between the individual and the couple. The lists above illustrate this. Notice that the client factors listed by marriage and family theorists also included individual characteristics and life events. Clearly, couples include two individuals. Epstein & Baucom (2002) highlighted this by emphasizing the influence that the two individuals have on the couple they become. They discussed how the

individual factors of “partner’s motives, personality styles, and forms of psychopathology . . . may influence the functioning of the couple” (p. 106). Indeed, one of the ironies of the current state of the field of marriage and family therapy is that it is now willing to also focus on the individual (Gurman & Fraenkel, 2002).

Client factors interact with other aspects of treatment.

Client factors do not merely directly impact the outcome of couple therapy. They also interact with and moderate the other common factor components of couple therapy, which confounds the impact of the client. For example, client willingness to disclose (client factor) impacts the therapeutic relationship, as does the clinician’s skill in navigating this (theory and technique). From another perspective, the clinician’s appropriate use of a technique such as reframing (theory and technique), done in a sensitive way (therapeutic relationship) can impact the client’s view of a situation (client factor) and lead to change. To present a more cohesive picture of client factors, consider the following examples, which explore how client factors interact with the theoretical component of couple therapy by taking an active role in therapy, having a theory of change, and influencing the clinician.

Clients take an active role in therapy from beginning to end. The most straightforward support for this is the fact that most clients call to schedule the appointment and then actually show up at the scheduled time. Clients present the problem, conceptualize an explanation and solution, reschedule appointments, explore their issues, sort through clinician recommendations, decide which to accept and which to reject, and usually decide when therapy ends (Bohart, 2000). After reviewing research on client factors that predict the outcome of therapy, Garfield (1994) studied drop-out rates in therapy and emphasized that the decision to continue therapy was ultimately in the client’s hands.

Although it might not be as sophisticated or as complex as a clinician's theory, clients often have their own ideas about what will solve their problems and, when clinicians listen to clients, clinicians can help clients pay attention to and use client's own ideas (Bohart & Tallman, 1999). Duncan and Miller (2000) recommended including clients in the case conceptualization process by asking clients what they think caused the problem and will bring about change; they explained this as the client's theory of change and referred to their therapy as "client-centered." It seems that part of what leads to successful therapy is the clinician's ability to listen to the client's theory and be willing to alter therapy accordingly (Coleman, Kellely, & Kopp, 2004; Frank, 1995).

Finally, process research reflects that the clients act, often deliberately, in ways they think will influence the clinician and the focus of therapy (Olson, 2001; Rennie, 2000). As one example, Rennie (2000) analyzed the opening moments of one client's fourth session. He asked her to listen to the audiotape of the session and comment on what was going on for her during those moments. The client repeatedly described her intentions in the recorded session as deliberate attempts to impact and guide the clinician. At one point, Rennie described that the client was "controlling the relationship with the therapist" (p. 159). At another point in session, the client commented on influencing the pace of the session when she said, "I'm under some time pressure, so sometimes the very fine discriminations [of insights] don't get made because I'm anxious to get on" (p. 160). The client also described setting the direction of therapy away from the homework assignment she had not completed. Rennie described this move by saying, "she had seized control [of the session] with a subtlety that doubtless surpassed any therapist's ability to detect" (p. 163).

Therefore, therapy not only consists of a clinician acting in ways that influence the client, but the opposite is also occurring, perhaps outside the clinician's awareness. In the previous example, the client deliberately guided the clinician, which likely impacted the clinician-client relationship component of this case. The client also guided the direction of therapy, indicating that the client can have a direct impact on how the theory and technique component of client factors play out in session. Her willingness and ability to guide the session also likely came from her expectation that therapy could be effective (the expectancy, placebo component of common factors), and perhaps her success in leading therapy increased her hope that desired change could occur. This example of the interaction of the client with the other components of couple therapy demonstrates that successfully working with client factors in couple therapy could have an exponential, far-reaching impact on the successful or unsuccessful outcome of couple therapy.

As indicated in this review, scholars in both psychology and marriage and family therapy, while all recognizing the value of client factors, define and explain the client factor component of common factors in quite diverse ways. Most specify that individual characteristics, couple dynamics characteristics, and life events are influential client characteristics. Researchers have called for more research in couple therapy that includes these three aspects of client factors. Next, calls for research on client factors in couple and family therapy will be reviewed, and criticisms of common factors will be considered. This chapter will conclude with a summary of selected research on client factors that influence the outcome of couple therapy.

Calls for research of client factors in couple and family therapy

Several researchers have emphasized the need for couple therapy outcome research to address client factors. As early as 1969, researchers began asking which relational factors could predict outcome and trying to prioritize those influential client factors (Freeman et al.). In 1987,

Cline, Jackson, Klein, & Mejia encouraged this line of inquiry when they wrote, “future studies should focus on therapists and couple factors in therapy that predict couple improvement” (p. 266). Recent summaries of the field of couple and family therapy and research agendas presented for the field as a whole wove both individual and couple client factors into the lists of studies needed in the future of marriage and family therapy.

Gottman and Notarius (2002) offered one such research agenda for the next century. Of the five topics they listed, four could be considered to be based in client factors. These included a call for examining the individual client characteristic of personality, the couple dynamics characteristics of patterns of marital interaction, and positive affect in couple relationships. They explained “positive affect” as “intimacy and other affectional processes” and related it to “instrumental humor” (p. 186) and social support in a marital relationship. Gottman and Notarius also recommended that research focus on the life event characteristic of life stress. They explained that “stress from nonmarital situations” (p. 187) could influence the change couples make and maintain in couple therapy.

In a similar call for research, Lebow and Gurman (1995), listed 21 topics and types of research needed. Included in this list are prompts to consider the “common ground and goals” (p. 45) of theories. Regarding client factors, they recommended additional research on the individual client characteristics of gender, culture, and biology, and the life event or situation characteristics: of the “realities of family life” (p. 47) as they impacted the longevity of changes from therapy, the impact of individual and family developmental stages and transitions, and the impact of health crises. These could all be considered client factors which need to be more clearly understood in the arena of couple therapy.

Finally, Snyder et al. (2006) recommended 12 directions for the research and practice of couple therapy. Four of these recommendations are listed below, with the category of client characteristic added and noted in italics:

1. couple therapists should be trained in common factors and mechanisms of change that potentially undergird most forms of successful treatment (p. 338), and
2. couple therapists need to be competent in recognizing and treating the recursive influences of individual and relationship difficulties (p. 339).
3. couple therapy research needs to extend beyond initial treatment impact to identify individual (*individual client characteristics*), relationship, and treatment factors contributing to deterioration or relapse and effective means of reducing or eliminating these effects (p. 336),
4. greater attention needs to be focused on the generalizability of research findings across such potential mediators as age (*individual client characteristic*), family life stage (*life events*), gender (*individual client characteristic*), culture (*life situation or event*) and ethnicity (*individual client characteristic*) (including interethnic couples) (*couple dynamics characteristic*), family structure (including composition of stepfamily and extended family systems) (*couple dynamics characteristic*), and nontraditional relationships (including cohabiting and same-gender couples) (*couple dynamics characteristics*) (p. 337),

The varied definitions and descriptions of the client factor component of common factors, and the three large-picture perspectives of the field of couple and family therapy all highlight the need to better understand individual characteristics, couple dynamics characteristics, and life events so that clinicians can more effectively understand and help couples. This combined

picture suggests that one of the next steps for client factors research would be to develop a more comprehensive (and at the same time, coherent) picture of which client factors impact the successful or unsuccessful outcome of couple therapy.

Critiques of Common Factors

In response to the larger picture of common factors, several critiques can be described by what Arkowitz (1995) called a “uniformity myth” (p. 99). Arkowitz supported the idea of moving away from common factors and focusing on process research. Arkowitz explained his concerns about the focus on common factors when he wrote, “I think that we need to avoid a “uniformity myth” here, and look at common factors that may be important for different problems, rather than assuming that all factors are equally important for all problems” (p. 99). Beutler (2002) echoed this concern.

Because some common factors may be more salient than others for each couple, therapy based on common factors could be argued to run the risk of the opposite of a “uniformity myth.” That is, some may say that it runs the risk of becoming so individualistic that the theoretical underpinnings could be lost. Perhaps a worthy goal for common factors clinicians would be to develop a conceptual framework for working with clients that is both consistent *and* shaped by individual clients. As a metaphor, an architect knows the ‘rules’ and format to follow when designing a structure, but what is created depends entirely on the clients’ purpose, preferences, and expression of those. Without knowledge of the rules, the structure would not be viable. Similarly, therapy needs both the structure that the clinician brings to it, and the purpose, shape, and details provided by the client.

Critiques of common factors in marriage and family therapy.

The main authors in marriage and family therapy who have offered critiques of applying the common factors concept to the field of marriage and family therapy are Sexton, Ridley, and Kleiner (2004; Sexton & Ridley, 2004). Although these authors offer a critique of the research on which the common factors are based, they agreed that “the basic premise of this movement is probably correct: There are central and common factors that contribute to successful outcomes that cut across seemingly different theoretical and practice models” (Sexton, Ridley, & Kleiner, p. 134) and further stated, “without question, finding a common core of factors to explain successful therapy would be a major breakthrough” (p. 131). Sexton, Ridley, and Kleiner then recommended that the field of marriage and family therapy focus on process research rather than common factors.

Sexton, Ridley, and Kleiner’s (2004) main critique is that the common factors approach was too simplistic, that it was a “shorthand explanation for the complexity of practice and the diversity of clients, settings, and sometimes disparate research findings” and that it “overlooks the multilevel nature of practice, the diversity of clients and settings, and the complexity of therapeutic change” (p. 131). They identified that the common factors in marriage and family therapy are only beginning to be established and understood; most of their specific critiques centered on characteristics of this early stage of the common factors (e.g., unclear connection between theory, research, and practice; unclear concepts and lack of operational definitions). They asserted that,

in their current articulation, common factors can never provide a theoretical platform for further theoretical or research development. This is not to say that further development of these ideas might not result eventually in theory development. However, it is to say

that the oversimplification inherent in common factors will need to be replaced by a more accurate representation of the complexity of MFT (p. 140).

While Sexton, Ridley, and Kleiner (2004) did disagree with the underlying approach to common factors, preferring instead a focus on the common processes of change, they also recognized that, if developed into a clear, complex, well-defined approach, the common factors could be a “major breakthrough” in the field of marriage and family therapy (p. 131). As a sidenote, they identified one of the main theory questions in MFT as “what are the critical preexisting client factors that must be accounted for and understood for successful therapy?” (p. 139).

In a way that seems to combine the above recommendations for client factors research and for more thorough development of common factors theory in couple and family therapy, a few researchers have begun to postulate a “meta-perspective” of therapy by considering components of what clients do to be active agents of change in their lives and suggesting how therapy can enhance this process (Bohart, 2000; Bohart & Tallman, 1999; Castonguay & Beutler, 2006; Duncan, Miller, & Sparks, 2004; Gold, 2000). A meta-perspective which focused on the constellation of client factors that influence the outcome of couple therapy and was based on the common factors approach, would be congruent with many theories of couple therapy. This meta-perspective could be added to or integrated with other theories of therapy and would allow clinicians to more clearly conceptualize the impact that client factors have on the outcome of couple therapy. That conceptualization could then inform the treatment planning and practice of couple therapy.

By providing a more comprehensive view of the complicated client and extra-therapeutic factors that influence the successful and unsuccessful outcome of couple therapy, the present

study addresses the critiques above. Several theorists have attempted to postulate and summarize the impact that individual characteristics, couple dynamics characteristics, and life events have on the outcome of couple therapy. However, none have asked about these factors widely enough to ensure consideration of the full constellation of client factors. In addition, no researcher, to date, has suggested a framework for organizing and prioritizing client factors.

This study attempts to present a more comprehensive, organized description of the client's contribution to therapy. Whether this, and additional studies of the common factors of marriage and family therapy, will grow to the point of becoming the complex, multi-faceted, and practical theory that would be a "major breakthrough" has yet to be seen. This chapter will now consider selected research regarding what is already known about individual characteristics, couple dynamics characteristics, and life events that impact the outcome of couple therapy.

Client Factors in Couple Therapy: Selected Empirical Evidence

Researchers have used outcome research to examine whether couple therapy was effective, and have examined more details to learn which factors were correlated with or contributed to couple therapy success or failure. At this point, quite a few studies have explored the outcome of couple therapy. (A PsychInfo search of the collective subject terms "outcome," "marital or marriage or couple," and "therapy or counseling" resulted in 368 sources.) The research on client factors that impact the outcome of couple therapy is often embedded in outcome studies. Several of those studies focused on how specific client factors related to the outcome of couple therapy (e.g., stages of change, Tambling & Johnson, 2008; low-level aggression, Simpson, Atkins, Gattis, & Christensen, 2008; infidelity, Atkins et al., 2005; child maltreatment history, DiLillo et al. 2009). Two qualitative studies could be found which asked

what factors contributed to the outcome of couple therapy (Whisman, Dixon, & Johnson, 1997; Smith, Brown, & Grady, 1994).

Although the studies described below do analyze and report interaction effects, two main assumptions of the research on interaction effects present significant problems. First, in matching a client factor to a specific treatment, the client factor is treated as a static trait, even if the goal of therapy is to change that client factor (e.g., a diagnosis of depression, low functioning). Many client factors are dynamic rather than static, and even the client factors that are static may impact each individual differently (e.g., gender, culture). Second, this research assumes that a client characteristic will play out in therapy with unique individuals in the same way. Finally, research focused on matching a client with a theory of therapy based on client characteristic could guide a clinician to use a theory of therapy which might not work well with that clinician's approach to or style of therapy.

Five studies that considered client factors as the predictors of the success of couple therapy were chosen for more thorough description. The three qualitative studies were chosen based on topic fit. The two quantitative articles were chosen based on quality of design, being more recently published, having larger samples, and considering a greater number of client factors in comparison to other articles on this topic.

Exploratory studies of client factors in couple therapy.

Two qualitative studies in which clinicians were asked what client characteristics they perceived to influence the outcome of couple therapy were examined. These two qualitative studies were chosen for the complementary information they provided and because, although published in 1997 (Whisman et al.) and 1994 (Smith et al.), these were the most recent qualitative studies which could be found on the topic of client factors in couple therapy. The

first of these studies was done by Smith et al. (1994). Fifteen experienced marital clinicians from different disciplines were asked to “list those factors that they felt to be important in producing or facilitating positive change in marital therapy and to rate the frequency of the importance of each factor in producing positive outcome on a 7-point Likert scale” (p. 319). These lists were then qualitatively analyzed and a survey of the resulting 65 items was completed by 210 AAMFT members. These participants rated how often each of the 65 variables impacted the outcome of couple therapy. Client characteristics were one of the five categories of variables included. Participants rated clients’ commitment to therapy and clients’ commitment to their relationship as very important to the outcome of couple therapy (Smith et al., 1994).

The study by Smith and colleagues (1994) began to fill in the gaps of client factors that are considered to be influential to the outcome of couple therapy. The survey was developed based on the views of a diverse group of clinicians, and participants indicated that the list provided reflected their experience. While these results offered the valuable views of a diverse group of clinicians who worked with couples in therapy, they were limited in a few ways. First, the survey did not consider the wide range of quantitative information already available on client factors that influence the outcome of therapy. The results would have been more meaningful if at least some of the items of the survey had been connected to the existing literature. Second, the initial group of clinicians was not prompted to focus specifically on client factors. They therefore followed the trends of the profession and included “structural treatment variables, ... treatment technique and process variables, ... therapeutic relationship variables, ... therapist characteristics, ... and client characteristics” (p. 322). While this may have expressed the variety of variables that influence the outcome of couple therapy, asking clinicians to specifically reflect on client variables might have produced more variety and depth in that category. One of the

main limitations of this study was that the survey focused exclusively on factors that lead to successful therapy, and thus provided an incomplete picture of couples' experiences in couple therapy.

In a study which complemented Smith et al.'s study, Whisman and colleagues (1997) focused on unsuccessful couple therapy by asking clinicians what presenting problems clients brought to therapy. They also included one qualitative question which asked clinicians "what characteristics they believed were related to negative outcome" (p. 362). Their qualitative analysis resulted in the categories of "unwillingness to change or to accept responsibility for change (29%), lack of commitment to the relationship (18%), and severity (including intensity, length, or both) of problems (17%)" (p. 365). These two qualitative studies fit well together, but they both lacked connection to the quantitative information available. Although both contained a qualitative component, in the first study, clinicians did not have the opportunity to add their thoughts to the survey list, and the second study included only one item which asked about client factors. General impressions offered valuable overviews, but may have missed the details obtained through considering a specific case of couple therapy.

The third qualitative study that was reviewed was chosen because of the unique description of a client's life events that it offers. In this study, Blow and colleagues (2009) conducted an in-depth analysis of one case of couple therapy. Using a common factors lens, they attempted to better understand the process by which change occurred in this case. Without neglecting theory, technique, the therapeutic relationship, or therapist attributes, Blow et al. highlighted the importance that client factors had to the successful outcome of this case. They identified client motivation as an important client characteristic, and then addressed three unexpected life events. During the course of therapy, the client couple experienced a cancer

scare, a job loss, and a jail sentence. While all of these might typically be considered negative life events, Blow et al. explained that the couple's response to these events actually brought them closer together as a couple, contributing to the success of couple therapy. Blow et al. described, "the extratherapeutic events seemed to help this couple change. . . . naturally occurring extratherapeutic events provided rich content that highlighted the central part of the couple's relational dynamics" (p. 365). Although this was not a study exclusively on client factors that influenced the outcome of couple therapy, the emphasis on the significance of a client's life events was unique to this study.

Using client factors to predict the outcome of couple therapy.

The two quantitative studies which were examined were based on the same sample; the first (Atkins et al, 2005) examined client predictors of the outcome of couple therapy at the end of the final session, and the follow-up study (Baucom, Atkins, Simpson, & Christensen, 2009) examined client variables two years later. One hundred thirty couples participated in both studies. Participants received a maximum of 26 sessions of traditional behavioral couple therapy or integrative behavioral couple therapy. Couples were excluded from this study if they were unmarried, separated, not consistently distressed, on an unstable medication dosage, diagnosed with any of several Axis I or Axis II disorders, or had a history of any relational physical aggression (Atkins et al., 2005). It is important to point out that these are all client factors which could be hypothesized to influence the outcome of couple therapy.

The client factors assessed were divided in to three categories: 1) demographics: age, education, income, presence of children, years married, and gender; 2) individual characteristics: neuroticism, overall mental health, psychological diagnoses (which were not excluded), history of distress in family of origin, and 3) couple dynamics characteristics: affective communication,

constructive communication, closeness/independence, commitment, sexual satisfaction, influence in decision making, and severity of distress (Atkins et al., 2005). In the two-year follow-up, the additional factors of parental marital status, demand/withdraw patterns, encoded arousal (patterns of vibrations of the vocal cords), and power bases and power processes were also assessed. The authors used standardized instruments with established validity and reliability (Atkins et al., 2005; Baucom et al., 2009).

Couple therapy outcome was assessed using the Dyadic Adjustment Scale and couples were grouped as deterioration, no change, improvement, and recovered (Atkins et al., 2005; Baucom et al., 2009). Immediately after termination, the authors found that more years married predicted better couple therapy outcome, that severely distressed couples experienced greater deceleration in rate of improvement near the end of couple therapy, and that very sexually dissatisfied couples responded differently to the different types of treatment in that the rates of improvement differed (Atkins et al., 2005). At the two-year follow-up, number of years married remained significantly associated with successful couple therapy outcome (this was considered to reflect commitment to the marriage); soft influence tactics interacted with type of treatment while hard influence tactics interacted with pretreatment severity; wife's encoded arousal interacted with type of treatment and with pretreatment severity (Baucom et al., 2009). Additionally, pretreatment distress interacted with wife's encoded arousal and hard influence tactics. The authors also noted that more variables predicted 2-yr response for couples who were less distressed when beginning treatment.

Several of the findings described above contradicted previous research (e.g., length of relationship, demographic predictors, interpersonal variables; Atkins et al., 2005; Baucom et al., 2009). The authors noted that "the search for predictors of successful marital therapy has been

plagued by methodological problems and inconsistent findings, and we believe that the present study is a first step toward a new generation of research on this topic” (Atkins et al., 2005, p. 899). Indeed, these well-designed studies examined a wider range of client factors than previous studies have explored. However, these studies had limitations in their ability to identify influential client factors in three ways. First, as the authors explained, this study was based on a fragmented history of research on client factors. In summarizing previous research, the authors wrote, “the research on interpersonal variables has . . . yielded contradictory and counterintuitive findings,” and “studies of intrapersonal predictors of outcome are sparse, and the results are inconsistent” (Atkins et al., 2005, p. 894). Atkins et al. (2005) also noted that previous studies on demographic variables as predictors of couple therapy outcome produced inconsistent results. Building on inconsistent, fragmented research increases the risk of overlooking important factors, even when the current study is well-designed and implemented.

The second aspect of the studies by Atkins et al. (2005) and Baucom and colleagues (2009) that limited their ability to identify influential client factors in couple therapy was the screening of participants. While this screening allowed for focused analysis of the variables assessed in these studies, it prevented the possibility that the variables which were eliminated could be found to impact the outcome of couple therapy. Third, these studies did not consider the impact of life events, which theorists have hypothesized could have a significant impact on the outcome of couple therapy.

The literature used for this review included empirical studies on client factors that impacted the outcome of couple therapy. The only consistent finding is that they all highlighted the importance of clients’ commitment to the couple and to couple therapy. Building on fragmented research, controlling for client variables, asking for general rather than specific client

factor information, and lack of connection between qualitative and quantitative data limited the comprehensiveness of the findings of these studies.

Toward a Constellation of Client Factors

Although client factors are accepted as valuable to the outcome of couple therapy, theories of therapy tend to overlook them. The common factors approach highlights the importance of the client's contribution to therapy, but inconsistently describes what those client factors are. In marriage and family therapy, the common factors concepts are new enough that a theoretical base is still being established. Research has focused on client factors, but this research is fragmented and inconsistent. Taken together, the assumptions of the common factors approach and current research on common factors create a more complete picture, but there are still significant holes, as evidenced by the multiple calls for research on client factors in couple and family therapy. This study is driven by the current need for research to develop a constellation of client factors that may influence the outcome of couple therapy, and by the need for a clearer common factors theory in marriage and family therapy.

Chapter III: Methods

The purpose of this study is to better understand clinicians' perspectives regarding which client factors influenced the outcome of couple therapy (i.e., successful vs. unsuccessful). This study attempted to understand the importance of client factors by first organizing and prioritizing the client factors that are already mentioned in couple therapy literature. Second, this study invited clinicians to expand the range of client factors that are currently considered important to the outcome of couple therapy in an attempt to fill in any gaps in literature. A multi-methods survey was used to meet both purposes of this study.

Research Questions

Three research questions guided this study. The first two research questions were answered using quantitative data, and the survey questions used to answer the first two research questions were based in previous literature. Qualitative data provided the answer to the third research question. The research questions considered were:

1. Which client factors identified in literature do clinicians perceive to influence the outcome of both successful and unsuccessful couple therapy cases, and what is the relative influence of those client factors?
2. What were the differences in those client factors that participants rated as contributing to successful couple therapy and those that they rated as contributing to unsuccessful couple therapy?
3. What client factors not reported in the literature do participants believe influenced a case of successful and unsuccessful couple therapy?

Research Design Elements

Multi-method research.

Research studies that collect both quantitative and qualitative data without combining the types of data are referred to as multi-methods studies. Sprenkle and Piercy (2005) supported the use of multiple approaches to data collection and analysis when they wrote, “multiple methods add to family therapy researchers’ ability to capture and reflect change” (p. 6).

Both qualitative and quantitative researchers, according to Becker, (1986) “think they know something about society worth telling to others, and they use a variety of forms, media and means to communicate their ideas and findings” (as cited in Denzin & Lincoln, 2000, p. 9).

Putting both methods together in one study “allow[s] the research to capitalize on the synergistic interplay between quantitative and qualitative approaches” (Sprenkle & Piercy, 2005, p. 13). In a multi-methods study, the qualitative information can promote understanding of the characteristics or qualities of a phenomenon in rich detail while the quantitative information can provide information about frequency, intensity, and quantity (Denzin & Lincoln, 2000).

Creswell (2009) explained that using multiple methods enables researchers to develop research problems that “incorporate the need both to explore and explain” (p. 208).

For this study, a multi-methods design allowed the survey to collect quantitative data that prioritized the client factors that are described in current literature. The survey also obtained qualitative data of participants’ own ideas that extended the current scope of client factors. The combination of these data could support a more complete, organized picture of the client factors that clinicians consider influential to the outcome of couple therapy.

Quantitative methodology.

Quantitative methodology can be used in a wide variety of ways, two of which include describing participants' responses collectively, and exploring the quantitative connections among data (Nelson & Allred, 2005). This use of quantitative data allows researchers to identify patterns through considering responses in a collective manner.

For this study, quantitative statistical analyses were used to answer the first two research questions, which focused on prioritizing, organizing, and comparing several of the client factors that were addressed in literature. Quantitative data provided demographic information about the participant, the participants' clients, and the therapy case. Participants were also asked to quantitatively rate the importance of several client factors that have been addressed in literature.

Qualitative methodology.

Social scientists employ qualitative methods to explore a variety of questions (Creswell, 1998; Denzin & Lincoln, 2000; Kazdin, 1998; Merriam, 1998; Rossman & Rallis, 2003; Sprenkle & Moon, 1996). One of the benefits of qualitative methods is that they can capture in detail the experience of individuals who deal personally with the issue being studied (Creswell, 1998; Guba & Lincoln, 1981; Kazdin, 1998; Maxwell, 1998). Qualitative research also provides the opportunity for new ideas to be generated (Patton, 2005; Rossman & Rallis, 2003). Qualitative methods are particularly well suited to research questions related to emerging areas of study (Creswell, 1998; Kazdin, 1998).

The final research question for this project gave clinicians the opportunity to expand the list of client factors that were considered important to the outcome of couple therapy. This expansion allowed for emerging ideas to flow from participants' responses. Qualitative methods of data collection were used in this study to obtain information about participants' personal

experiences with clients in couple therapy. For this section of the survey, participants were asked open-ended questions and given space to provide their own thoughts.

Survey research.

Nelson and Allred (2005) stated, “[s]urvey research . . . is a method of collecting data from or about a group of people, asking questions in some fashion about things of interest to the researcher” (p. 211). According to Nelson (1996), researchers can use survey research “for the purpose of describing, explaining, and/or exploring particular aspects of the participants’ experience” (p. 448). Two strengths of survey research are that researchers can use surveys “to gather large amounts of data from a number of participants in a relatively short amount of time” and, if the study is designed well and appropriate data analysis techniques are used, the data from surveys can be generalized to a larger group (Nelson, 1996, p. 462). Because surveys can be designed to gather a wide variety of types of information, this method allows for obtaining both qualitative and quantitative data.

For this study, I needed to be able to gather information from a relatively large group of participants in order to capture the range of participants’ perceptions of client factors that influence the outcome of couple therapy. I needed a method that would also allow the participants to report their own observations (the qualitative component of the data) and to reflect on their experiences with client factors that have been identified in literature (the quantitative component of the data). Using a survey allowed many participants to provide both qualitative and quantitative information.

Using the internet for survey research.

Researchers in a wide variety of fields are increasingly using web surveys and other forms of research on the Internet for many reasons. Some of these reasons include lower time

and financial costs, convenience of solicitation and data management, potentials for larger, more diverse samples, potential to reach marginalized populations, ease of data formatting before analyzing, ease of anonymity, and novelty (Gosling, Vazire, Srivastava, & John, 2004; Krautk et al., 2004; Smith & Leigh, 1997; Swoboda, Muhlberger, Weitkumat, & Schneeweib, 1997). Qualitative research can particularly benefit from Internet methodology as data collection over the web offers the opportunity to gather participants' views in a way that is convenient for both researcher and participant and also perhaps less threatening for participants (e.g., Albright & Conran, 2003). Despite these benefits, several factors were considered before deciding to use web-based data collection techniques.

One consideration regarding using web-based data collection is the potential for sampling bias. First, the sample is limited to people who have internet access (Courtney & Craven, 2005; Dillman & Bowker, 2001); second, the characteristics of people who take web-based surveys may be different than those who do not take web-based surveys (Meyerson & Tyron, 2003; Schillweaert & Meulemeester, 2005). For this study, I considered these concerns. Although collecting data via the Internet could possibly eliminate some participants, couple clinicians have advanced degrees and work in professional positions, therefore, they are more likely than the general population to have access to and familiarity with computers and technology. It is unlikely that a significant portion of the population for this study would be excluded due to lack of internet access.

The second potential concern with using the Internet for data collection is that, by using this method, it could be possible to recruit a sub-sample of the population that could be qualitatively different than the overall population. Although no studies of couple clinicians have

addressed this question, Murray and Fisher (2002) allege that Internet surveys may provide better, more representative data than do traditional methods.

For this study, a web-based survey was used to collect data. This allowed me to collect data from a wider variety of participants than would have been practical using a paper-based survey due to geographical constraints, shortened the time needed to contact participants (compared to a paper-based survey), decreased the cost of the study, and facilitated the transition of the data into electronic format for analysis. The main benefit of using a web-based survey to collect data for this study was in the design of the survey itself. Using a web-based survey rather than a paper-based survey provided the flexibility needed to design an individualized, interactive survey. The components and design of the survey are described later in this chapter.

Clinicians' Views of Couple Therapy Outcome

Clinicians' evaluations or judgments are often used to evaluate outcome in effectiveness studies (Garfield, 1994). Cline and colleagues (1987) tackled the question of how accurate and useful clinicians' evaluations of couple therapy were. They used several methods to evaluate the outcome of couple therapy, including client ratings, clinician ratings, and observations from outside raters. They found that clinicians' ratings of the success of therapy significantly correlated with all other measures and concluded, "therapists' ratings have a degree of concurrent validity with other assessment measures and should be given serious consideration as one measure of client change or improvement" (Cline et al., p. 265). Based on these findings, which suggest that clinicians' views of couple therapy outcome are valid, data for this study were gathered from clinicians.

Data Collection Process

Participants.

Selection.

The population for this study was clinicians or counselors who work with couples and have completed at least one case of couple therapy. Participants were asked to choose a client couple who “were in a committed, romantic relationship, attended at least two sessions, completed or dropped out of therapy.” No other criteria were required. In addition, the survey asked participants to report their training and their license, which allowed the researcher to screen the responses of participants who may not have had specific education in couple therapy. All participants who provided complete information on couple client cases indicated appropriate training and licensure information.

Sample Size.

The needed sample size was determined based on the analyses which would be used. The main analyses conducted were principal components analysis (PCA) and logistic regression. Number of participants is an important consideration in PCA; with a minimum of 5 participants per variable recommended by Stevens (2002). Tabachnick and Fidell (2007) posit that 300 total cases is a “comfortable” number for PCA (p. 613).

For logistic regression, the sample size needed is somewhat determined by the output of the model. If the parameter estimates or standard errors are very large or the data fail to converge because of too few observations on particular subsets of the data, the sample size may be too small (Tabachnick & Fidell). Pearson (2010) lists several sample size guidelines of other authors, including the recommendation of 15 subjects per independent variable and “50 cases plus eight times the number of independent variables.” For this study, because the independent

variables for the logistic regression were the PCA components, the number of independent variables was unknown when collecting data. PCA can mathematically only produce the number of PCA components as variables considered in the PCA analysis. Following the recommendations above and considering the extremely unlikely possibility of PCA producing 25 PCA components, if 15 subjects are needed for each of 25 independent variables, a sample size of 375 would be needed. Using the other recommendation (which is 50 plus eight times 25) results in a needed sample size of 250. Pearson emphasizes the importance of considering effect size and expresses concern that inadequate sample sizes might miss a small, but valuable, effect size. He concludes, “[f]iles of 400 or more are fine, except for detecting only the smallest effects” (p. 288). Based on these guidelines, a minimum sample size of 300 was needed for the PCA analysis, which would have been adequate for the logistic regression. To distinguish small effects in the logistic regression, a sample size of 400 was desired.

Eight hundred twenty-two people responded to the survey request and began taking the survey online. Of those 822, 422 were eliminated due to significant amounts of missing data. Almost all of these 422 participants dropped out after the first section and did not enter any information about client characteristics. Of the 400 completed surveys, two were eliminated because the qualitative responses provided did not match the outcome the participants were assigned. Specifically, one participant who had been assigned to report on a successful case of couple therapy wrote “this was not a successful case.” A total of 398 surveys were used in the analyses.

Recruitment.

After obtaining IRB approval (see Appendix A for this documentation), an email with the link to the survey and requirements to participate was sent to clinicians and groups of clinicians

who were likely to work with couples. The researcher used nonprobability methods of sampling, beginning with judgmental sampling, in which the researcher uses his or her knowledge of the population to determine who to solicit, based on who the researcher believes will provide the most useful information for a particular study (Patten, 2005; Babbie, 1989). The judgmental sampling technique was used in deciding whether or not to send the solicitation emails to certain groups of people. For this study, *couple clinician* was defined as a clinician who reported that he or she practices couple or marriage counseling or therapy.

If a person or group of people fit the definition of *couple clinician*, and an email address was available, the solicitation email was sent to that person or group. This describes convenience sampling methods (Patten, 2005; Pedhazur & Schmelkin, 1991), or reliance on availability (Babbie, 1989), in which participants are solicited based on availability to the researcher. The solicitation email included criteria for participation to allow participants to self-screen, and a request for the recipient to forward the email solicitation to other couple clinicians who might be willing to participate. This snowballing sampling method allows participants who find the study meaningful to help the researcher by identifying additional potential participants (Patten, 2005). Participants were solicited on the Internet between January and March 2009 through three main methods. These methods are delineated below.

1. A solicitation email was sent to four Listserves, including the Listserv for clinicians who are interested in common factors (approximately 500 subscribers), the Listserv for the Family Psychology division of the American Psychological Association (approximately 500 subscribers), Smart Marriages' Listserv (number of subscribers unknown), and the Listserv for the Association for Behavioral and Cognitive Therapies (ABCT) (number of subscribers unknown). Different emails were composed for each listserv in an attempt to personalize the

survey. The email solicitation is provided in Appendix B.

2. A solicitation email (Appendix C) was also sent to gatekeepers who were asked to forward the email to other couple clinicians. These gatekeepers included 89 program directors for COAMFTE accredited Master's and Doctoral programs and the 18 track coordinators or Marriage and Family professors for CACREP accredited programs that had a Marriage and Family Counseling track. If I knew a professor in a program, I sent the solicitation email to that professor rather than to the program director so the request would be more personal. Thirty-one of these gatekeepers emailed a reply saying they agreed to forward the solicitation email.

Another category of gatekeeper contacted included the 50 Presidents of State or Regional divisions of AAMFT. This solicitation email is provided in Appendix D. Some of these leaders emailed a reply, with the majority saying that forwarding research solicitations was against AAMFT's national policy. Two AAMFT division Presidents emailed, saying they were forwarding the solicitation to a separate listserv which was active in their state.

3. Solicitation emails were sent directly to couple clinicians. See Appendix E for this solicitation email. I obtained these email addresses by searching the internet for organizations of marriage or couple clinicians or counselors. When the organization provided a directory of members which included emails, and when site policy use did not prohibit research solicitation, those email addresses were used to solicit participants. The researcher sent 2,789 emails directly to couple clinicians. Approximately 300 emails (10%) were undeliverable due to invalid email addresses. There is no way for the researcher to know how many emails were valid, how many reached couple clinicians' inboxes, how many were categorized as spam, how many were opened, and how many potential participants read the request and chose not to participate.

Repeated requests were not sent for any of the recruitment methods because it was

impossible to know who had completed the survey. Sending the email only once eliminated the possibility that participants would be solicited a second time. An additional reason that repeated requests were not sent was because of the possibility that potential participants fit into more than one of the above categories of solicitation and would therefore have already received more than one solicitation request. Repeated requests may have been perceived as spam.

Response rate.

New technologies may make it easier for researchers to contact potential participants, but Tourangeau (2004) described a two-decade trend of “widespread decline in response rates for all types of surveys” (p. 775). He reported that researchers address nonresponse in two ways, first by trying to understand and combat nonresponse and second by considering whether low response rates actually increase bias. Tourangeau cited three studies that in which the low response rates did not increase bias. He concluded that this information “suggest[s] that when the variables of interest are unrelated to the factors that produce nonresponse . . . , falling response rates may not be a major worry” (p. 786).

Although researchers recommend several methods used for increasing response rates in web-based surveys (e.g., multiple solicitations, personalization of invitations (Heerwegh, Vanhove, Matthijs, & Loosveldt, 2005), and using mixed modes of solicitation), the solicitation design for this project made it difficult to use these methods. For example, sending repeated requests to participants is one common strategy used to increase response rate. However, solicitations were sent through a variety of channels, most of which would likely not welcome a repeated request (e.g., emails to program directors, postings on listservs). In addition, spam is considered particularly annoying by professionals and I did not want to take advantage of the listservs and publically posted emails by over-soliciting. Personalization of invitations is also

commonly recommended to increase response rates. Individualizing solicitation was not possible for certain aspects of the solicitation for this survey because emails were sent to groups of people rather than to individuals. Emails were crafted to address specific groups, but did not address the individuals who would actually complete the survey. Using mixed modes of solicitation would have been possible if the survey had been administered on the phone or in person and the participants' responses inputted into the web-based survey. However, a paper-based survey would not have been able to duplicate the dynamic aspects of the web-based survey. In addition, individual mail and phone information was not available for the potential participants who were contacted through listserves or through Gatekeepers.

Many factors prevent an actual response rate from being calculated. For instance, for the current study, a solicitation sent to a listserv may reach people who are not practicing couple clinicians but are on the listserv for other reasons. Listserv emails may also be routinely unopened or solicitations within listserv emails may be ignored at a higher rate. Second, emails sent through gatekeepers may or may not actually reach anyone, and there is no way of calculating the number of emails forwarded to potential participants. Again, these emails may not reach practicing couple clinicians even if they are forwarded. Third, email solicitation may have been flagged as spam and blocked before it reached the recipient.

Procedures.

After obtaining IRB approval for this study through Virginia Tech (see Appendix A for the approval letter), I solicited participants using the methods described above. The solicitation email had a link to the survey in the email. Potential participants could click on the link and be sent directly to the survey website, or participants could copy and paste the link into their web browser. When participants went to the survey website, they were initially given an overview of

the study and a link to the Consent Form (see Appendix F for the Consent Form). Participants were required to select “I have read the Informed Consent form and I **agree** to participate” before they could continue. Participants were then asked to choose a case of couple therapy on which to report. See Appendix G for screenshots of the successful version of the survey; see Appendix H for screenshots of the unsuccessful version of the survey.

Once participants gave consent, they were randomly assigned to one of two groups. Participants in the first group were asked to discuss a closed, successful case of couple therapy while participants in the second group were asked to discuss a closed, unsuccessful case of couple therapy. Participants were instructed to “choose a client couple who: were in a committed, romantic relationship, attended at least two sessions, and completed or dropped out of therapy.” A *closed case* is defined by Simmons and Doherty (1995) as “a client(s) who was seen at least two times, who had completed therapy, and for whom no specific follow-up appointments had been scheduled” (p. 6). To simplify the survey instructions, participants were asked to choose a couple who “attended at least two sessions” and “completed or dropped out of therapy.”

Successful couple therapy was defined as “The client couple are ‘doing something different’ in the direction of desired change. (This can include improvements in understanding, emotions, or behavior.) Clients' changes were significant enough to improve their level of functioning. The therapist and couple think therapy was successful.” *Unsuccessful couple therapy* was defined as “therapy did not produce desired change in clients. That is, clients did not begin to do things differently, did not reach the goals of therapy, and/or reported not being satisfied with the changes that may have occurred.”

The surveys for successful couple therapy and for unsuccessful couple therapy were

identical with the exception of (a) the wording of the questions (i.e., “successful case” versus “unsuccessful case”); (b) the examples given (i.e., participants asked to reflect on successful cases were given examples of characteristics that would likely lead to successful couple therapy (e.g., patience) and participants asked to reflect on unsuccessful cases were given examples of characteristics that would likely lead to unsuccessful couple therapy (e.g., bitterness)); and (c) the wording used for the literature terms (e.g., “Commitment” vs. “Lack of Commitment”). This will be explained in more detail in this chapter under “Measures.”

Incentives.

Research on the effect of providing incentives on response rate presented somewhat mixed results, but generally concluded that offering a monetary incentive increased response rates and improved percent of completion (Bosnjak & Tuten, 2003; Yammarino, Skinner, & Childers, 1991). At the end of the survey, participants could provide their email address to enter a drawing for an ipod touch. This drawing was explained in the solicitation email. These emails were reported separately from the survey data, keeping the participants’ responses anonymous. Participants could also enter their email address if they wanted to receive a summary of the study results. After data collection was complete, a drawing was conducted using the email addresses of participants who entered the drawing. The winning participant was contacted via email for his address and was sent the ipod touch.

Measures

Design Considerations.

For this survey, a dynamic web-based design was used. Dynamic web-based survey design uses computer programming to automate various aspects of the survey. For example, if a participant chooses “not married” in response to an item on marital status, the dynamic web-

based survey would automatically skip questions about the participant's spouse. The first dynamic aspect of the survey for the current study was the random assignment of participants to either the group who discussed successful couple therapy or the group who discussed unsuccessful couple therapy. Another dynamic aspect of this survey included asking participants to provide a pseudonym for each person in the couple; the survey then automatically referred to the clients by the names provided throughout the survey. For example, the survey asked participants to provide client information about Person A and Person B (the two people in the couple) at the beginning of the survey and again at the end of the survey. Using the name provided by the participant helped minimize the chances that the participant would forget which individual was Person A and which was Person B. Additionally, the dynamic survey design directed the way participants could report client characteristics. Participants entered one client characteristic, then could indicate if they wanted to enter more characteristics. This allowed each participant to enter as many or as few client characteristics as he or she deemed appropriate.

The final dynamic aspect of the web survey design for the current project allowed participants to rate the influence of the characteristics that a particular participant had said influenced the outcome of couple therapy. For example, one participant may have said that commitment, motivation, concern for each other, and a daughter's graduation were influential client factors. The survey then provided a list of these client factors along with a Likert-type scale and asked the participant to rate the influence each factor had on the outcome of couple therapy. A different participant who entered the client factors of resentment, stonewalling, and fight in front of friends would have been given only those client factors (resentment, stonewalling, and fight in front of friends) to rate on the Likert-type scale.

Dillman (2002) emphasized the importance of careful web survey design to participants' willingness to complete a survey, to the accuracy of information gathered, and to the validity of the results (see also Manfreda, Batagelj, & Vehovar, 2002; Vehovar, Batagelj, Manfreda, & Zaletel, 2002). In an attempt to promote willingness, accuracy, and validity, several authors have recommended the following web design considerations:

1. using a short introduction, clear instructions, simple response options, minimizing the need to scroll down on each page of the survey, and considering the level of computer expertise of participants (Dillman, Tortora, & Bowker, 1998);
2. using a simple rather than fancy design (Dillman, Tortora, Conradt, & Bowker, 1998);
3. providing participants with consistent feedback about what percent of the survey they have completed (Vehovar et al., 2002);
4. presenting questions in easily recognizable formatting (Dillman, Tortora, & Bowker, 1998);
5. beginning each question with a number and providing space between questions for clarification (Dillman, Tortora, & Bowker, 1998);
6. allowing participants to skip questions if they desire (Dillman, Tortora, & Bowker, 1998; Vehovar et al., 2002);
7. putting options from long lists of possible responses in separate boxes to decrease the skim rate (Dillman, Tortora, & Bowker, 1998); and
8. not using advanced graphics (Vehovar et al., 2002).

All of these recommendations were considered and followed as closely as possible in the design of the web-based survey for this project.

Survey.

The web survey used to gather data was developed specifically for the current project. Most of the questions asked in this survey were based on previous literature and research regarding client factors that influence the outcome of individual and couple therapy. The survey also allowed participants to share their own ideas about what client and extra-therapeutic factors influenced the outcome of a case of couple therapy. As previously mentioned, there were two versions of the survey; one version asked participants to reflect on a case of successful couple therapy and the other version asked participants to reflect on a case of unsuccessful couple therapy. Appendix G provides screenshots of the survey for successful couple therapy; Appendix H provides screenshots of the survey for unsuccessful couple therapy. This survey had six sections, which are each explained below. After providing consent, participants were taken to the first section of the web survey.

Survey Section One: Instructions and client selection.

The first section of the survey included instructions and client selection. On this page, participants were directed to report on either a successful or unsuccessful closed case of couple therapy. Participants were given the definitions as previously explained.

Survey Section Two: Couple therapy case information.

The second section of the survey asked participants to provide information about the case they selected. This section began with background information about the context of the couples' therapy. Specifically, participants were asked to report the number of sessions, if sessions were all couple sessions or a combination of couple and individual sessions, if people other than the couple attended sessions, and the participant's prognosis at the onset of therapy. In a general survey of AAMFT members' practices, Northey (2005) found it valuable to ask clinicians their

perception of the overall severity of clients' problems. Therefore, this question was also included. For the previous questions, participants selected from a provided set of responses. Participants were then asked "What was the presenting problem?" and "What were the goals of therapy?" Participants entered their responses in text boxes.

Survey Section Three: Participant-generated client factors.

For the third section of the survey, the open-ended client factors section, participants were asked either "What characteristics of Person A (*name was included here*) do you think contributed to therapy being successful?" or "What characteristics of Person A (*name was included here*) do you think contributed to therapy being unsuccessful?" based on the group to which the participant was assigned. The instructions continued, "Please provide a label for each characteristic (e.g., bitterness) and a short explanation of that characteristic (e.g., he had a difficult time letting go of the past). Please include the characteristics that were most important to the outcome of therapy. *You will be given the opportunity to enter as many characteristics, and explanations, as you like - one at a time.*" Participants were asked slightly different versions of this question in requesting individual characteristics, couple dynamics characteristics, and life events that influenced the outcome of couple therapy. Participants were asked to briefly explain the terms they listed to minimize the incidence of misunderstanding terminology. (Appendix G contains screenshots of the version of the survey that asked about successful couple therapy; Appendix H contains screenshots of the version of the survey that asked about unsuccessful couple therapy.) Participants could list as few or as many characteristics as they wished and had the option of reviewing and editing characteristics after they had been entered.

Participants were asked to indicate whether each factor was directly discussed in session (yes or no options) and rated their perception of the importance of each factor to the perceived

outcome of couple therapy using a six-point Likert-type scale. A six-point Likert-type scale was used to eliminate a middle, neutral option and to allow for a range of variability in responses. The Likert-type scale options were “Not Important,” “Slightly Important,” “Moderately Important,” “Important,” “Very Important,” and “Vitaly Important.”

Survey Section Four: Literature-based client factors.

The fourth section of the survey introduced a list of 25 client factors or life events that previous researchers have identified as being influential to the outcome of therapy. The client factors included in this list were chosen based on whether research is currently available for each factor, how prevalent the factor is in literature on client outcome in therapy, and how frequently common factors literature refers to these client factors. Client factors with more research and more discussion were given priority for inclusion on this list. The researcher also deliberately looked for couple dynamics characteristics to include in this literature-based list. Participants were given the instructions, “Literature and previous studies have identified several client factors that tend to influence the outcome of therapy. Please indicate how important you believe these factors were in influencing the successful [or unsuccessful] outcome of *(name)* and *(name)*’s therapy.” Participants indicated their response on a seven-point Likert-type scale. The Likert-type options were “Not an Issue” (which was the default option), “Not Important,” “Slightly Important,” “Moderately Important,” “Important,” “Very Important,” and “Vitaly Important.” This Likert-type scale differed from the scale used for the open-ended questions by adding the option of “Not an Issue.” “Not an Issue” was not included in the open-ended section of the survey because participants reported that the client factor was an issue for the case by mentioning the client factor.

The list of literature-based client factors had two parts: the first part included fourteen characteristics from the literature that were presented the same way to all participants; the second part had eleven characteristics that were presented differently to participants based on the outcome of couple therapy that the participant was assigned. Table 1 provides the literature-based list of characteristics that participants rated; the table indicates factors that were presented

Table 1

Literature-Based Client Factors as Seen by Survey Participants

Both Conditions	Outcome of Therapy Condition	
	Successful	Unsuccessful
Children Together	Commitment	Lack of Commitment
Financial Stress	Egalitarian Roles	Unequal Roles
Intelligence	Emotional Responsiveness	Lack of Emotional
Job Stress	Flexible Gender Roles	Rigid Gender Roles
Length of Relationship (<i>time</i>)	Motivation	Lack of Motivation
Level of Individual Pathology	Open to Each Other	Closed to Each Other
Life Stage Transition	Positive Regard for Each Other	Contempt for Each Other
Outside Pressure	Problem Solving Skills	Lack of Problem Solving Skills
Personal History	Quality of Participation	Low Quality of Participation
Personality	Resiliency	Lack of Resiliency
Previous Relationships	Social Support	Lack of Social Support
Recent Tragedy		
Job Stress		
Financial Stress		

Note. All therapists received all factors listed in the first column, then received factors listed in either the “Successful” or “Unsuccessful” column depending on the condition to which they were randomly assigned.

to all participants, factors presented to participants assigned to discuss a successful case of couple therapy, and factors presented to participants assigned to discuss an unsuccessful case of couple therapy.

Survey Section Five: Client demographic information.

The fifth section of the survey asked for demographic information about the participants' clients. Demographic information was included to provide information about clients to whom the findings may apply and to allow for comparison between the clients. The demographic questions were based on literature described in the previous chapter of this document which suggests client factors that influence the outcome of therapy and on lists compiled from previously published research (Northey, 2005; Simmons & Doherty, 1995; Doherty & Simmons, 1996). Specifically, participants reported the age and gender of their clients. Participants responded to the question, "Which were true for the client during treatment with you?" by choosing one of the following options: "Taking psychotropic medication," "Chronic or serious physical condition," and "Hospitalized for mental health purposes 6 months before, during, or after the course of therapy." Participants reported any diagnoses for which the clients met criteria by checking the appropriate categories.

Survey Section Six: Participant demographic information

The sixth and final section of the survey for this project asked the participant to report personal demographic information. In 1995, Simmons and Doherty conducted a survey of the practice characteristics and patterns of marriage and family therapists in Minnesota. The next year they used a slightly revised version of their original survey to collect these data for therapists in 15 states (Doherty & Simmons, 1996). In 2005, Northey published a more comprehensive survey of Clinical Members of AAMFT. Northey used the survey developed by

Doherty and Simmons and added another section that would allow the data to be compared to characteristics of other helping professions. The published results of the previous surveys by Doherty and Simmons (1996) and Northey (2005) provided the basis for the participant demographics questions asked in the survey for the current project.

Participants were asked to report their age, gender, ethnicity, earned degrees, years practicing, theoretical approaches to therapy most used in practice (participants were instructed to select all that apply from a list) and licenses or certifications currently held. These items allowed the demographics of the participants of this study to be compared to the demographics of participants of other studies of clinicians. Because the sample for this study was not randomly selected, comparing the demographic characteristics of participants in this study to the demographic characteristics of participants in previously completed studies of the same population can provide data regarding the appropriateness of the participant group for this study.

Piloting

I developed the web survey in stages. I first asked four experienced researchers to read and evaluate a paper version of the survey and provide feedback about the content, word choice, content validity, construct validity, credibility and dependability, length, usability, and format. They also provided any additional feedback they thought was relevant. This committee includes three marriage and family therapists, one of whom focuses on the common factors approach, another who is an expert on methodology and statistics, and a fourth researcher who specializes in using technology for research, specifically the use of web-based surveys. The feedback included recommendations for changing and clarifying definitions of terms, simplifying the wording of some items, categorizing the diagnostic information, and rewriting items so they would take less time to complete. After considering their feedback, implementing their

recommendations, and obtaining IRB permission, I worked with a web designer (Peter Doolittle) to design the survey as a web survey. The web designer created the electronic version of the survey, provided the server for hosting the survey, and compiled and reported the survey results.

Pilot testing the survey was an important step to ensuring that participants would understand the questions being asked, that the information provided fit the information needed, that the instrument solicited all needed information, that the instructions were clear, and that the time the survey took to complete was reasonable (Fowler, 1995; Rea & Parker, 2005). Pilot testing also provided an opportunity to revise any word choice errors, formatting or layout problems, and computer glitches (de Vaus, 2002).

Practicing marriage and family therapists completed pilot testing of the survey by taking the survey and providing feedback. Approximately 10 therapists piloted the survey. Revisions based on pilot testing feedback included deleting some items that were not essential to answering the research questions, rewording some instructions and items to make them more clear, and re-organizing the survey so participants focused on the client information at the beginning of the survey.

Data Analysis Procedures

Quantitative analyses.

All quantitative data analyses were done using the Statistical Package for the Social Sciences (SPSS), a statistical analysis software. The data were provided from the web-based survey electronically and were inputted into SPSS using an automatic input function.

To determine the relative importance of the characteristics, three steps were used. First, the list of characteristics that were provided to participants were ranked according to mean, with higher means indicating that participants perceived that factor to be more influential to the

outcome of couple therapy. Second, because of the large number of factors (25) and the large number of significant Spearman rho correlation between the factors, principal components analysis was done to reduce the number of factors while maximizing the explanation of variance. Third, the components from principal components analysis were entered into a logistic regression.

Sample demographics and descriptive statistics.

Participants rated the importance of 25 literature –based client characteristics on a Likert-type scale of zero (“Not an Issue”) to six (“Vitaly Important”). These ratings provided the data for descriptive statistics. To calculate the descriptive statistics, the client factors that were worded differently for participants who discussed a successful versus unsuccessful case of couple therapy were considered to be two aspects of the same factor and were re-named to reflect both options. For example, “Motivation” and “Lack of Motivation” were combined into a variable that was named “Level of Motivation.” The former and new names of variables are included in Appendix I. Two sets of means were calculated for the ratings of the literature-based client factors. The first set of means provides descriptive data for participants who reported a variable to be a factor to the outcome of the case of couple therapy. To calculate this mean, data from participants who indicated that a given factor was “Not an Issue” to the outcome of the case of couple therapy were removed. These means were then calculated on a scale of one (“Not Important”) to six (“Vitaly Important”). By calculating the means in this way, the data indicate the average importance a variable had to the outcome of couple therapy *when the variable was a factor* in determining the outcome.

For the second set of means, all data were included, even if the variables were not considered influential to the outcome of the case. Calculating the means with all data provides a

more complete picture of how *all* participants rated the importance of the variables listed. Further statistical analysis used the second set of means because this set of means includes a wider scope of the data provided.

Principal components analysis.

The data reduction method of principal components analysis (PCA) provided statistical organization, or categories, to the variables. PCA reduced the number of components being considered by explaining the overall variance in the data using fewer components (Park, Dailey, & Lemus, 2002; Tabachnick & Fidell, 2007; Watson & Thompson, 2006). PCA did not assume that there is an underlying structure to the data, but was used to group a large number of variables into a smaller number of components, allowing for further analysis (Park et al., 2002).

Before conducting principal components analysis, the data were examined to ensure that they met the assumptions for PCA. The first issue considered to determine whether PCA should be used was the number of participants. Stevens (2002) recommended a minimum of five participants per variable, but noted that others have recommended two to 20 participants per variable.

The second check in determining whether data are appropriate for PCA was to use the Bartlett test of sphericity. The Bartlett test questioned whether the correlations among the variables in the data set are strong enough to warrant using PCA. This is considered a test of sampling adequacy (Mertler & Vannatta, 2005). Significant Bartlett test results reject the “null hypothesis that the variables in the population correlation matrix are uncorrelated” (Stevens, 2002, p. 388).

Because PCA is based on correlations between the variables, some researchers include the assumptions of correlations as assumptions for PCA. However, Tabachnick and Fidell

(2007) asserted that when PCA is used for only descriptive or data reduction purposes, rather than to confirm the underlying, theoretical structure of variables which make up pre-determined constructs, the assumptions of normalcy and variable distribution do not need to be met. Mertler and Vannatta (2005) agreed with the approach of Tabachnick and Fidell.

Principal components analysis protocol includes having a strategy for working with missing data and standardizing the variables before conducting the PCA. Using standardized variables ensures that the variables are being evaluated on the same scale (Tabachnick & Fidell, 2007). After considering the initial, unrotated PCA results, rotating the axes in principal components analysis often allows for a more clear interpretation of the components identified through the principal components analysis (Tabachnick & Fidell, 2007; Warner, 2008).

Orthogonal rotation forces the analysis to only identify components that are uncorrelated with each other while oblique rotation allows the components identified through principal components analysis to be correlated (Tabachnick & Fidell, 2007). Researchers choose which rotation to use based on whether there is an assumption that the resulting PCA constructs should or should not be correlated, and based on the interpretability of the resulting components (Mertler & Vannatta, 2005; Stevens, 2002; Tabachnick & Fidell, 2007).

After completing the PCA analysis, I determined how many of the resulting PCA components to keep based on Eigenvalue, scree plot, and interpretability or meaningfulness of the resulting components (Mertler & Vannatta, 2005; Warner, 2008). Eigenvalues above one may be retained (Mertler & Vannatta, 2005; Warner, 2008). Warner explained that the visual analysis of a scree plot could also help the researcher decide how many components to retain, with researchers typically retaining components observed to the left of where the scree plot line flattens. Finally, Stevens (2002), Warner (2008), and Mertler & Vannatta (2005) all highlighted

the importance of interpretability of the PCA components when making decisions in how many PCA components to retain. After determining how many PCA components to retain, PCA is often re-calculated, with the researcher specifying the number of components to retain.

An additional benefit of using PCA for this study was that the resulting components could be used as the independent variables in logistic regression analyses. Stevens (2002) explained that one purpose for using PCA as a data reduction method is to then use the PCA components in regression analysis. Warner confirmed this use of PCA (2008). Stevens noted two aspects of PCA that are beneficial in using PCA components in regression analysis. First, he mentioned that the ability of PCA to reduce a large number of predictor variables to a few, more concise predictor variables allows the regression findings to be more valid. Second, Stevens addressed the problem of multicollinearity of predictor variables in regression. Reducing many correlated variables to a few, more succinct, uncorrelated variables eliminates the problem of predictor multicollinearity while allowing most of the variables to be used in predicting the dependent variable (Stevens).

Logistic regression.

Following the principal components analysis, the PCA components became the independent variables for a logistic regression analysis, and the outcome of couple therapy was the dependent variable. Logistic regression results helped answer the second research question by providing information about which PCA components discriminated whether participants were discussing a case of participant-reported successful couple therapy or unsuccessful couple therapy. Logistic regression results also offered information about which PCA components had more influence in the regression model which predicted whether participants were discussing a case of successful or unsuccessful couple therapy.

Before beginning the logistic regression, the data were screened to ensure that they met the assumptions of logistic regression. The assumptions for logistic regression include that a) the data need to be reasonably equally divided between the two outcome possibilities, b) the data need to have minimal or no outliers, and c) the independent variables need to be only minimally correlated with each other (Warner, 2008). Checking the assumptions can be done by examining the number of responses in each category of the dependent variable and considering presence of outliers in the independent variables using boxplots and histograms. Multicollinearity could also pose a problem for logistic regression.

How the independent variables are entered into a logistic regression analysis has implications for the findings. Using a generic “enter” method considers all independent variables as equal. Stepwise methods of entering independent variables into a regression equation allows for prioritization of independent variables by determining which independent variable accounts for the greatest amount of the variance of the dependent variable. Additional independent variables are then entered into (or removed from) the regression equation based on how much of the variance of the dependent variable they each account for and whether they significantly contribute to the predictive ability of the regression equation. Thus, using the PCA components as the independent variables in a logistic regression equation aided in prioritizing the PCA components. For this study, the stepwise entry method of forward likelihood ratio was used because it entered each PCA component into the regression model in the order of the independent variables’ ability to predict the dependent variable. The stepwise method of forward likelihood ratio enters each independent variable if the overall model produced by including that independent variable is a significantly better fit for the overall data than the previous regression model was. Therefore, the stepwise method of forward likelihood ratio provides a sense of order

to the independent variables by entering them in the order of most to least influential in predicting the dependent variable. It also tests not only that the independent variable significantly predicts the dependent variable, but also that the overall model is a significant improvement over each previous model.

Tests of the fit of the regression model also indicate whether the data set is appropriate for logistic regression. One common way to assess regression model fit is to compare the -2 Log Likelihood for the null model to the -2 Log Likelihood for the model with independent variables. A lower -2 Log Likelihood for the final regression model indicates that the model is a good fit for the data set (Howell, 2002). The chi-square goodness of fit statistic tests whether the -2 Log Likelihood for the null model is significantly different than the -2 Log Likelihood for the final regression model.

A second regression analysis was conducted with the perceived outcome of couple therapy as the dependent variable and the Likert-type ratings of the 25 client characteristics that had been identified in literature as the independent variables. This output was compared to the results of the regression equation which used the PCA components as the independent variables.

Mann-Whitney U.

The nonparametric Mann-Whitney U tested whether participants discussing a case of participant-reported successful couple therapy rated the client factors identified in the literature differently than did participants discussing a case of participant-reported unsuccessful couple therapy. To minimize the chance of making a Type I error when using multiple Mann-Whitney U tests, I used the Bonferroni adjustment and divided the desired significance level (.05) by two times the number of analyses to be conducted.

In examining the second research question, there is a possibility that client factors that contribute to successful couple therapy form different conceptual groupings than do client factors that contribute to unsuccessful couple therapy. To investigate this possibility, separate principal components analyses were done which analyzed the data provided by participants reporting on cases of participant reported successful couple therapy separately from the data provided by participants reporting on cases of participant reported unsuccessful couple therapy. The considerations explained previously were also examined for these PCAs.

Qualitative analyses.

The 398 participants listed a total of 1,466 individual characteristics, 744 couple dynamics characteristics, and 561 life events, for a total of 2,771 client characteristics. On average, participants listed 3.7 individual characteristics per case, 1.9 characteristics or dynamics of the relationship, and 1.4 extra-therapeutic events per case.

The qualitative data for this study were organized using N*Vivo, a computer assisted qualitative data analysis software (Matheson, 2005). Miles and Huberman (1994) described two extremes of approaches to analyzing qualitative data. On one extreme is a “loose” plan, where the researcher approaches the data with no preconceived categories. On the other extreme is a “tight” approach to the data, in which the researcher has categories and constructs that guide data analysis from the beginning. Miles and Huberman explained that “tighter designs are a wise course . . . for researchers working with well-delineated constructs” and emphasized “that qualitative research can be outright ‘confirmatory’—that is, can seek to test or further explicate a conceptualization” (p. 17). One common approach to tighter qualitative data analysis, according to Boyatzis (1998), is guided by “prior data or prior research” (p. 29). For this study, the qualitative data analysis began with a more tight approach, using the client characteristics

identified in literature (i.e., the characteristics that were also asked about in the quantitative section of the survey) as the initial coding scheme.

Qualitative Analysis Stage I: Guided by literature-based client factors.

The analysis technique used throughout the “tight” qualitative analysis was the constant comparative method (Patton, 2005). Although developed by Glasser and Strauss for grounded theory, Merriam (1998) noted that the constant comparative method of data analysis is congruent with most forms of qualitative data analysis and has been used in a variety of types of qualitative analyses. In the constant comparative method, the researcher reads a piece of the data, notes a possibility for how that data might be coded, reads more data, compares that to the first piece of data, adjusts the codes as appropriate, and continues this technique of constantly comparing the data to itself in order to hone the codes to create the best fit possible. This is a recursive, iterative process (Merriam, 1998; Patton, 2005; Rossman & Rallis, 2003).

In beginning the data analysis with the “tight” approach, I first read through the data twice to get a sense of the range of client characteristics which participants discussed. I kept a journal of my reflections while reading the data; these included comments on the content of what participants wrote, observations about the information provided by participants that gave hints into the therapy that was provided, and notations of the information provided by participants that was not directly prompted. I also created memos, which were notes to the researcher regarding categories and themes that were starting to be seen in the data. Then I read the data a third time, specifically noting the language that participants used which overlapped with the 35 literature-based codes.

After becoming familiar with and reflecting on the data participants provided, I considered the list of literature-based client characteristics. These included 25 variables, with 11

of the variables being asked differently for participants who were reporting on a case of successful couple therapy than for participants who were reporting on a case of unsuccessful couple therapy (e.g., Motivation vs. Lack of Motivation, Commitment vs. Lack of Commitment, and Positive Regard for Each Other vs. Contempt for Each Other). To allow the most flexibility in data analysis, these variables were kept separate, leaving 36 literature-based codes as the initial coding scheme.

Although literature provides definitions for each of the 36 literature-based codes, it is likely that participants use the same language to describe slightly different concepts. To allow participants' voices to have priority, the 36 literature-based codes were defined by participants. To allow participants to define the 36 literature-based codes, I searched for the specific literature-based language in the data from participants. For example, when defining the term "Motivation" a word-find function displayed all of the text in which participants used the word "motivation." I read those comments repeatedly and analyzed them content analysis and constant comparison to glean an expanded definition of how participants were using the term. I followed this procedure for each of the 36 literature-based codes.

After the 36 expanded definitions were formed, I used those expanded definitions as the descriptions of each of the 36 codes. I then read through all of the qualitative data again, coding the data based on the expanded definitions for the 36 literature-based codes. As a comment was coded, it was moved from the "uncoded" data set into a "coded" data set. When there was a question about how to categorize a specific participant comment, I noted that a particular comment was unclear at that time and set those comments aside.

After coding the more clear data, the researcher considered the less clear data. The researcher referred to the researcher's journal, the participants' use of the actual literature-based

terms, and the additional participants' comments which had been coded at each of the codes. Using this information, the researcher made notes to clarify each of the 36 literature-based codes. I considered the remaining qualitative data again, using the expanded definitions and notes. I coded the qualitative data at the literature-based codes as appropriate, labeled each comment with the appropriate literature-based code, and moved the coded comments from the "uncoded" data set into the "coded" data set. I repeated this process of coding, re-reading, and refining until none of the remaining client data fit the literature-based codes. Finally, I read the data under each of the 36 literature-based codes to ensure that the comments in each code fit the extended code definitions and notes.

As an example of this process, consider the literature-based code "Intelligence." Participants used the terms in the following ways, "Intelligent: Able to cognitively understand concepts related to couple interaction," and "Intelligence: She was able to take a larger perspective. She was able to analyze and appraise." Based on these and other comments in which participants used the language "Intelligent," the final expanded description for the term was "intelligent, intellectual, analytical, cognitive, and logical." Notes included "themes in this code included that the client can objectively look at a situation and understand what is happening from more than that person's individual perspective and experience." Two examples of other participant comments which were coded as "Intelligence" based on the expanded definition and notes are, "Logical: Able to think things through, find patterns, work on solutions," and "Maturity, life experience: He was able to look at the couple's difficulties from multiple perspectives." Appendix J provides a table which includes the 36 literature-based terms, examples of how participants used the terms, the expanded definition of the terms, notes, and examples of participant data which were coded at that literature-based code.

Through this process, participants' comments defined the 36 literature-based codes, and the information which overlapped with what had previously been addressed in literature was removed from the qualitative data set. The remaining data included only the client factors that participants identified as influencing the perceived outcome of couple therapy which were not included in the 36 literature-based codes.

Qualitative Analysis Stage II: Emergent themes, categories, and codes.

Using the prior research as the initial coding scheme allowed me to identify the overlap between influential client characteristics that had been identified in literature and the client characteristics that participants identified. This helped answer the first two research questions. After these overlapping data were accounted for, I considered the qualitative data that did not overlap with existing research. These were the client characteristics that participants introduced to the list of clinician-perceived client factors. This set of participant-identified client characteristics, then, considered how participants' data filled in the gaps in existing research, creating a more complete picture of client factors that influenced the perceived outcome of couple therapy.

For this stage of the qualitative data analysis, I used a looser approach for the data analysis. The same constant comparative process was used in this stage of the qualitative analysis. The main difference between the analysis of the first and second stages was that the 36 literature-based codes for the first phase of the analysis were already known. In this second stage of the qualitative analysis, the categories, codes, and themes emerged from the data.

The stages of Boyatzis (1998) provided a framework for this stage of the qualitative data analysis. He lists the following stages and steps for data-driven approaches to qualitative analysis:

Stage I: 1. Deciding on sampling and design issues, 2. Selecting subsamples

Stage II: Reducing the raw information, 2. Identifying themes within subsamples, 3.

Comparing themes across subsamples, 4. Creating a code, 5. Determining the reliability

Stage III: 1. Applying the new code to the remaining raw information, 2. Determining validity, 3. Interpreting results. (p. 44)

Although the process is divided into stages and steps, this practice of qualitative analysis is iterative, moving from the data to hypotheses about the data, and then back to the data to confirm or deny these hypotheses (Boyatzis, 1998; Charmaz, 2000; Creswell, 1998; Denzin & Lincoln, 2000; Rafuls & Moon, 1996; Rossman & Rallis, 2003; Strauss & Corbin, 1990). The purpose of content analysis is to develop codes, categories, and themes. Codes are the initial, piece-by-piece notations of what participants are saying, categories contain groups of codes that fit together based on a common thread among the codes, and themes include reflections of the way participants organized the categories in their stories.

In beginning the second stage of qualitative data analysis, I first re-read all the remaining data to get a sense of the range of this set of participants' comments. I again wrote memos to note ideas and possibilities for codes, categories, and themes. I then re-read the data in groups of 50 participants at a time and created codes and categories which fit the data for those 50 participants. I divided the data into eight groups of 50 participants to better manage the large data set. After the codes and categories which fit the first 50 participants were created, I compared those codes and categories with data from the next 50 participants. At each pausing point, I changed the coding schemes and reviewed the previously-analyzed data to ensure that they fit with the new coding scheme. I repeated this process repeated until all the data had been considered, with each scheme a little more refined. The coding scheme changed significantly

from the first to the second iteration (some codes and categories were completely eliminated, new codes emerged, and others were re-organized) and from the second to the third iterations. After that, I made only relatively minor changes, with codes being collapsed a little differently and the names of categories changing to reflect nuances of the data more clearly.

About half way through this process, I began re-reading memos and considering possible themes, or connections between the codes and categories, which were underlying throughout the data set. Unlike the coding schemes, which were continually changing, the themes emerged from observations of the data and questions that were prompted by reading the data, and changed only slightly. For example, one early observation, which I wrote in a memo, was “participants include a LOT of contextual information which is not directly related to client factors. This contextual information provides, at times, more data than the client factors do. If participants spent so much time setting the stage for reporting the client factors, it must be important.” An early question which arose from that observation was, “What are participants trying to tell me by including so much information about the context of couple therapy?” The theme that emerged from those notes and data analysis was that cases were complex and participants believed that the client factors could not be understood in isolation.

Establishing trustworthiness.

Credibility in qualitative research is required by researchers (Anfara, Brown, & Mangione, 2002; Creswell, 1998; Guba & Lincoln, 1981; Kazdin, 1998; Sprenkle & Moon, 1996). This is made difficult by what Anfara et al. (2002) called a lack of common requirements for qualitative researchers in establishing credibility. Trustworthiness is based on whether results are responsibly obtained and believable (Rafuls & Moon, 1996) and on credibility, transferability or fittingness, dependability or auditability, and confirmability (Anfara et al.;

Creswell, 1998; Guba & Lincoln, 1981).

The methods or procedures for establishing trustworthiness used in this study include use of peer debriefing of decision-making through the design of the study, peer examination of data and results, reflexivity and writing memos, negative case analysis, code-recode strategy, and focusing on the use of the study (Creswell, 1998; Guba & Lincoln, 1981; Kazdin, 1998; Rafuls & Moon, 1996; Rossman & Rallis, 2003). Creswell recommended that at least two methods be used to establish trustworthiness in qualitative research.

Peer examination.

Peer examination is recognized by qualitative researchers as a method of establishing trustworthiness in qualitative research (Boyatzis, 1998; Anfara et al. 2002; Merriam, 1998). I enlisted peer debriefing of decision-making through the design of the study when I consulted with a peer qualitative researcher throughout the process. Specifically, when a draft of the coding scheme seemed to no longer fit the data, I discussed the coding scheme, particular participant comments that did not fit the coding scheme, and other possible coding schemes that might be a better fit with the peer qualitative researcher. I also used peer debriefing when deciding on the names for the codes, categories, and themes. I consulted with a peer qualitative researcher by giving examples of some of the data in a code, category, or theme, and talking through appropriate names for that code, category, or theme. The peer consultant also provided ideas about how to include researcher journaling and insights. I discussed observations and personal reflection with a peer qualitative researcher who provided feedback and ideas about how these reflections may add insight into the analysis.

For peer examination of the data and results, I asked a marriage and family clinician/researcher to read through the data and note main ideas and themes. The marriage and

family clinician/researcher then discussed her ideas with me. The marriage and family clinician/researcher read the coding scheme and explanations for the codes, categories, and themes. We considered the data and the findings were considered, discussed differences, and made changes which reflected a consensus between the researcher and the marriage and family clinician/researcher.

Reflexivity.

I practiced reflexivity by keeping a researcher's journal beginning with the selection of the literature-based codes. I periodically reviewed the journal, noted that some of the initial thoughts did not fit with later analysis, and used some of the initial insights as a way to avoid getting too caught in the details. The researcher's journal helped to keep the focus on the purpose of the study and ensure that the decisions made throughout the research process directly connected to the research questions.

Memos.

In addition to the researcher's journal, I also wrote memos (Miles & Huberman, 1994). While the researcher's journal created space for personal reflection and charting decisions made through this study, the memos provided opportunity to jot down hunches related to the data themselves. Memos included rough ideas of what the coding scheme and categories might end up being, observations of the variety of data provided, possibilities for underlying themes which were seen throughout the various categories and codes of data, and questions for future consideration. The memos provided an opportunity to capture participants' ideas that initially seemed to be outside the scope of the project, but later became valuable themes. For example, while reading the data for the first time, I noticed that participants' reporting of life events seemed to have little to do with the event itself, regardless of how unique or meaningful the

event was. Further, the events themselves seemed to not at all distinguish between whether a participant was reporting on successful or unsuccessful couple therapy. These thoughts later connected with the data to allow the participant's conceptualization of the impact that life events have on the outcome of couple therapy to come through more clearly. The report of the steps used in analyzing the data, the researcher's journal, and the memos created an audit trail, which, according to Rodgers and Cowles (1993) enhances the trustworthiness of qualitative research.

Negative cases.

Paying attention to negative cases, which are cases which do not fit the trends of the data, provides one way to establish rigor and enhance the quality of qualitative data analysis (Patton, 2005). Negative cases were noted in this project through frequency tables which reported how many participants from the successful couple therapy group and how many participants from the unsuccessful couple therapy group mentioned each code or category. This allowed readers to recognize trends and data that do not fit the trends in participants' reports of client characteristics and outcomes of couple therapy. When defining the codes, categories, and themes, negative cases provided a more thorough understanding of what it was about the characteristic that was perceived to influence the outcome of couple therapy. Some negative cases were specifically described in the results section for the purpose of creating a more multi-faceted understanding of participants' ideas.

Focus on purpose.

The purpose of this study continually guided the qualitative data analysis and remained a focus throughout the process, which is a valuable component of establishing trustworthiness in qualitative research (Rossman & Rallis, 2003). The separation of literature-based and additional information would have been neglected if the purpose of the study had been forgotten. For the

codes and categories which were generated in the second stage of data analysis, remembering that the purpose of the study included both providing specific client factors and organizing those client factors in a way that clinicians can conceptualize influenced the level of specificity of the codes and categories. If the purpose had just been the larger picture, then many of the categories would have been combined into fewer categories. Instead, categories which were very clearly based on participant comments were kept. Focusing on the purpose of the study challenged the researcher to find a useful balance between details and the big picture.

Chapter IV: Results

Participant and Case Information

Participant demographics.

Three hundred ninety-eight participants provided usable data which could be analyzed for this project. Participants were randomly assigned to report on a case of successful or unsuccessful couple therapy. Of the 398 completed, usable surveys, 217 (54.5%) reported on unsuccessful couple therapy cases and 181 (45.5%) reported on successful couple therapy cases.

Gender.

A total of 265 females (66.6%) and 113 (28.4%) males completed the survey. No participants identified themselves as transgender. Two participants (.5%) checked the “prefer not to answer” option for gender, and 18 participants (4.5%) did not respond to this item. A chi-square goodness of fit test was used to see if the distribution of the gender of participants across the groups of successful couple therapy and unsuccessful couple therapy was the distribution that would be expected. The chi-square results indicated that gender was approximately evenly distributed between groups ($\chi^2(3) = 3.532, p = .317$).

Age.

Participants reported being between 23 and 78 years old, with 50% of the participants reporting an age of over 50 years. The mean age of participants was 47.4 years, with a range of 23 to 78 years, and a standard deviation of 13.3 years. A *t*-test was used to determine whether there was a significant difference between the means of the ages of participants who reported on a case of successful couple therapy ($\bar{x} = 48.78, SD = 12.65$) and participants who reported on a case of unsuccessful couple therapy ($\bar{x} = 46.26, SD = 13.66$). The *t*-test results indicated that the mean ages of the two groups were not significantly different ($t(388) = -1.90, p = .06$). Despite

being close to being statistically significantly different, a difference between groups of one and a half years is not likely to be meaningful.

Ethnicity.

Table 2

Participant ethnicity

Ethnicity	Assigned Therapy Outcome					
	Successful		Unsuccessful		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
American Indian/Alaskan Native	1	0.25	1	0.25	2	0.5
Asian	1	0.25	4	1.01	5	1.3
Black/African American	1	0.25	2	0.50	3	0.8
Hispanic/Latino	7	1.76	5	1.26	12	3.0
Multiracial	2	0.50	7	1.76%	9	2.3
White/Caucasian	158	39.7	178	44.72	336	84.4
Other	1	0.25	4	1.01	5	1.3
Preferred not to answer	2	0.50	2	0.50	4	1.0
Did not respond	173	0.25	203	0.25	22	5.5

Note: N = 398

Table 2 reports the ethnicity of participants. Eighty-four percent ($n = 336$) of participants reported their ethnicity as being White/Caucasian. Three percent ($n = 12$) of participants reported being Hispanic/Latino and 2% ($n = 9$) reported being Multiracial.

One percent ($n = 5$) of participants reported being Asian while less than 1% reported being either American Indian/Alaskan Native ($n=2$) or Black/African American ($n=3$). One percent ($n = 5$) of participants reported being of an ethnicity not listed, another 1% ($n = 4$) indicated that they preferred not to answer, and 5.5% ($n = 22$) did not respond to this item.

A chi-square goodness of fit test was used to determine whether the distribution of the ethnicities between groups was different than what would be expected. The chi-square results indicated that the observed distribution of ethnicity across the two groups of participants would be expected to happen by chance ($\chi^2(7) = 5.88, p = .55$).

Educational attainment.

Participants indicated which degree or degrees they had earned. The highest degree earned by 63% ($n = 252$) of the participants was a Master's degree. These specifically included Master of Arts (M.A.), Master of Science (M.S.), Master of Social Work (M.S.W.), Master of Counseling, Master of Divinity (M.Div.), and Master of Marriage and Family Therapy (M.M.F.T.), or Marriage and Family Therapy (M.F.T.) degrees. Twenty-nine percent ($n = 117$) of the participants reported a Doctoral degree as the highest degree earned. These degrees included the Doctor of Philosophy (Ph.D.), Doctor of Psychology (Psy.D.), Doctor of Medicine (M.D.), and Doctor of Ministry (D.Min.). Fifteen (4%) participants indicated that their highest level of education completed was "Other;" this category included seven participants who reported working on their degree (five Masters and two Doctoral students) and eight who had advanced diplomas or certificates or Education Specialist (Ed.S.) degrees. A Bachelor's degree was the highest level of education reported by 3% of participants ($n = 13$), and one (.25%) participant did not respond to this question.

A chi-square goodness of fit test was used to determine if the distribution of the highest degree held by participants was different between participants groups than would be expected by chance. The chi-square results indicated that the distribution would be expected by chance ($\chi^2(1) = .997, p = .910$).

Licensure.

Table 3

Participant Licensure Status

Licensure	Assigned Therapy Outcome					
	Successful		Unsuccessful		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Licensed Marriage and Family Therapist (LMFT)	62	15.58	95	23.87	157	39.45
Licensed Professional Counselor (LPC)	35	8.79	34	8.54	69	17.34
Licensed Clinical Social Worker (LCSW)	23	5.78	27	6.78	50	12.56
Psychologist	27	6.78	37	9.30	64	16.08
Minister	11	2.76	12	3.02	23	5.78
Intern or In Training	-	-	-	-	52	13.07
Other	40	10.05	30	7.54	70	17.59
None	-	-	-	-	10	2.51
Left Blank	-	-	-	-	4	1.01

Note: Participants could choose more than one licensure status. *N* = 398

Table 3 summarizes the licensure information of participants. The majority of participants reported being licensed (83.7%; *n* = 333), with 13% of participants (*n* = 52) being either in internship or training. Participants could report that they held more than one license; 89 (22.3%) participants did report holding more than one license. Ten participants (2.5%) reported that they had no license and four (1%) participants did not respond to this question. The LMFT was the most frequently reported license (*n* = 157; 39.4%), with “other” being the second most frequently reported license. These “other” licenses included specializations such as sex therapist or addictions counselor, ministerial counseling credentials, medical licensure, or provisional licenses. One participant who reported no licensure noted that he or she lives in Australia and

that no licensure is available there. The survey did not ask where the participant lived, so the number of participants who lived in areas with no available licensure is unknown. Seventeen percent ($n = 69$) of participants reported that they held licensure as a LPC and 16.1% ($n = 64$) reported being licensed as a Psychologist. Interns made up 13.1% of the participants ($n = 52$) and LCSWs were held by 12.6% of participants ($n = 50$). Finally, 5.8% ($n = 23$) of participants reported that they were licensed ministers.

Years practicing therapy.

The number of years that participants reported they had been practicing couple therapy ranged between zero and 50 years ($\bar{x} = 12.8$, $SD = 11.4$). A t -test tested whether there was a significant difference between the mean number of years that participants who discussed successful couple therapy reported practicing couple therapy ($\bar{x} = 12.98$, $SD = 11.76$) and the mean number of years that participants who discussed unsuccessful couple therapy reported practicing couple therapy ($\bar{x} = 12.68$, $SD = 11.08$). The t -test results indicated that there was no difference between groups ($t(396) = -.263$, $p = .79$).

Theoretical orientation.

Participants were asked to select the theories they used most frequently in practice. Twenty-three different theories were listed as options (see Appendix K). Participants could choose any number of theories. The mean number of theories chosen was 4.25 ($SD = 2.52$). Four participants chose no theories, and one person chose 16 theories, which was the largest number selected.

The number of times each theory of therapy was endorsed is listed in Appendix K. Cognitive-behavioral theory was the most often endorsed theory of therapy, with 238 participants (59.8%) indicating that they use this approach. The second-most commonly

endorsed theory was solution-focused therapy, with 186 participants (46.7%) reporting that they use a solution-focused approach to couple therapy. Emotionally focused therapy and psychoeducation were endorsed by 160 (40.2%) and 122 (30.7%) participants, respectively. One hundred six participants (26.6%) reported using Bowen family systems, and 100 (25.1%) participants used experiential theories. Less than 25% of participants reported using the other theories, which included structural, psychodynamic, narrative/constructivist/constructionist, behavioral, strategic family therapy, motivational interviewing, systemic (Milan group), feminist, object-relations, internal family systems, Imago, contextual/ecological, functional family therapy, and relapse prevention approaches. The two theories that were reported least often were multisystemic therapy (15 participants, 3.8%) and multidimensional family therapy (10 participants, 2.5%).

The list of theories used in this study was based on Northey's (2005) survey, which did not include Gottman's theory. In the qualitative data, some participants referred specifically to Gottman's Marital Therapy either by name or by using terms from Gottman's approach (e.g., stonewalling). One participant specifically emailed to say that he used Gottman's Marital Therapy but was unable to indicate that on the survey. It is possible that many participants would have selected Gottman's Marital Therapy if this had been an option.

Client demographics.

Gender and zexual orientation of clients in couple therapy.

Of the 398 participants, 391 (98%) chose to discuss a couple therapy case of a heterosexual couple, four (1%) discussed a case of couple therapy with homosexual females, one (.25%) discussed a case of couple therapy with gay males. One (.25%) participant discussed a case of couple therapy in which one partner was female and the other partner was transgender,

and in one other case, the gender of one partner was female and the gender of the other partner was unclear.

If the participant did not answer the “gender” question regarding each client, the gender was determined by reviewing the pseudonyms the participant chose for the clients (e.g., “Ken,” “Jack,” and “Bob” were assumed to be male; “Barbie,” “Jill,” and “Sue” were considered to be female) and the personal pronouns used in the narrative of participants. For example, one participant chose the gender-neutral name “Chris” for the client, but in the narrative wrote, “She was enjoying having something of her own.” This client was assumed to be female. For analyses purposes, clients were included in their gender category when data were reported by gender, regardless of their sexual orientation. The transgender client and the client whose gender was unclear were treated as missing information in the gender category.

Age of clients in couple therapy.

Participants indicated the age categories of each client. The categories provided were 15-20 years old, 21-30, 31-40, 41-50, 51-60, over 61 years of age, and “I do not know.” Participants reported that 66% ($n = 260$) of male clients were between the ages of 31 and 50 and 63% ($n = 253$) of female clients were in this age range. Fifteen percent ($n = 59$) of male clients and 20% ($n = 79$) of female clients were reported to be 30 or younger, while 16% ($n = 64$) of male clients and 15% ($n = 55$) of female clients were reported to be older than 50. Participants did not indicate the ages of 24 (16.6%) clients ($n = 10$ males; $n = 14$ females). Table 4 summarizes the participants’ reports of client ages.

Table 4*Participant Reports of Client Ages*

Category	Male <i>n</i> =393		Female <i>n</i> =401		Other <i>n</i> =2		Total <i>n</i> =796	
	#	%	#	%	#	%	#	%
15-20 years	1	0.3	2	0.5	0	0	3	0.4
21-30 years	58	14.8	77	19.2	0	--	135	17.1
31-40 years	155	39.4	168	41.9	1	50	224	28.1
41-50 years	105	26.7	85	21.2	--	--	190	23.9
51-60 years	47	12.1	45	11.2	1	50	93	11.7
Over 61 years	17	4.3	10	2.5	--	--	27	3.4

Diagnoses of clients in couple therapy.

Participants indicated whether the clients they discussed met DSM-IV-TR diagnostic criteria, and if so, which categories the clients' diagnoses would fit. The main categories of DSM-IV-TR diagnoses were listed, with the exception of childhood disorders, mental disorders due to a medical condition, and V-Codes. The 393 male clients had a mean of 1.07 diagnoses with a standard deviation of 1.06 and a range from zero to seven diagnoses. The 401 female clients had a mean of 1.19 diagnoses. The standard deviation of the total number of diagnoses for female clients was 1.02. Participants assigned female clients between zero and five diagnoses. One hundred thirty male clients (33%) and 104 (25.9%) female clients did not receive any diagnoses.

In addition to selecting diagnostic categories for each client, participants could choose "Did not fit diagnostic criteria," "I do not know," and "Other." Participants could provide an

explanation for “other” if they chose to do so. Thirty (7.5%) participants chose “Other,” but then listed diagnoses that would have fit into the categories provided. For these data, the researcher moved the diagnostic information into the DSM-IV-TR category in which it fit. Thirty (7.5%) additional participants chose “other” and listed a variety of other diagnoses. These diagnoses included ADHD, V-Codes for Relational Problems and Sexual Abuse of an Adult, Tourettes, Attachment Disorder, medical conditions, traits of personality disorders, codependency, anger management, possessiveness, pornography addiction, gambling addiction, and loyalty issues. While some of these are DSM-IV-TR diagnoses which were not included in the survey’s list of options, several are not actual diagnoses.

Table 5 shows the total number of diagnoses assigned by each of the DSM-IV-TR categories. It also shows the number of diagnoses given in each category for male clients, female clients, and other gendered clients (one transgender client and one client whose gender was unclear).

Table 5*Participant Reports of Client Diagnoses*

Diagnostic Category	Male <i>n</i> =393		Female <i>n</i> =401		Other <i>n</i> =2		Total <i>n</i> =793	
	#	%	#	%	#	%	#	%
Mood Disorder	104	26.5	125	31.2	0	0	229	28.8
Anxiety Disorder	76	19.3	120	30	0	0	196	24.6
Adjustment Disorder	90	23	97	24.2	1	50	188	23.6
Personality Disorder	33	8.4	37	9.2	0	0	70	8.8
Substance Use/Abuse	44	11.2	21	5.2	0	0	65	8.2
Impulse Control Disorder	33	8.4	19	5	0	0	52	6.5
Sex or Gender Disorder	9	2.3	10	2.5	1	50	20	2.5
Sleeping Disorders	4	1	8	2	0	0	12	1.5
Dissociative Disorder	3	0.8	8	2	0	0	11	1.4
Cognitive Disorder	6	1.5	4	1	0	0	10	1.3
Eating Disorders	0	0	9	2.2	0	0	9	1.1
Somatoform Disorder	0	0	3	0.7	0	0	3	0.4
Factitious Disorder	1	0.3	0	0	0	0	1	0.1
Psychotic Disorder	1	0.3	0	0	0	0	1	0.1
Other	15	3.8	15	3.7	0	0	30	3.8
Did not Meet Criteria	85	21.6	69	17.2	1	50	155	865
I don't know	17	4.3	15	3.7	0	0	32	4

Note: The total number of male clients (393) and the total number of female clients (401) do not sum to the total number of clients (796.) This is because one client was reported to be transgender and the gender of one client was unclear.

Psychotropic medication, physical illness, and mental health hospitalization.

Participants indicated if either client in the couple therapy cases were taking psychotropic medication, had serious physical health issues, or were hospitalized for mental health reasons

while the couple therapy case was open. Participants reported that 71 (17.8%) males and 121 (30.4%) females were taking psychotropic medication, eight (2%) males and 21 (5.3%) females had serious physical health issues, and one (.25%) male was hospitalized for a mental health reason.

Information about the couple therapy cases.

Along with demographic information about the clients involved in the couple therapy cases, participants were also asked to provide information about the format of the couple therapy cases. This information included the number of sessions, whether the sessions were all conjoint or a combination of conjoint and individual, if people other than the couple were involved in the couple therapy, the clinicians' (participants') perception of the severity of the presenting problem, the participants' prognosis of the outcome of couple therapy, and a description of the presenting problem and goals.

Couple therapy duration.

Each participant reported how many sessions he or she had with the couple being discussed. Participants were instructed to choose couples they had met with in therapy at least two times; no participants indicated fewer than two sessions. The number of sessions ranged from two to 100 ($\bar{x} = 14.8$, $SD = 15.8$), indicating wide variability in the duration of therapy. Twenty-three percent ($n = 93$) of cases had five or fewer sessions, and 26.8% ($n = 107$) of cases had 15 or more sessions. The most frequently reported number of sessions was 10 ($n = 35$). Ten participants did not respond to this question.

Couple therapy format.

Participants reported whether the therapy sessions were joint couple sessions or whether the therapy included both individual and conjoint sessions. One hundred eighty-one (45.5%)

participants indicated that all sessions were conjoint sessions and 180 (45.3%) participants reported both individual and conjoint sessions as part of the couple therapy. Thirty-seven (9.3%) participants did not indicate the format of the couple therapy.

Participants were asked to indicate whether people other than the couple were ever included in sessions. Thirty-four participants (8.5%) reported that other people did attend at least one session of the couple therapy.

Participants rated their perception of the severity of the couples' presenting problems on a scale of one to five, with one being very severe, three indicating average, and five indicating very mild. On average, participants chose to discuss cases that they saw as more severe than their average case (severity $\bar{x} = 2.13$, $SD = .69$). Table 6 shows the number of times each severity level was endorsed. One participant did not respond to this item.

Table 6

Participant Report of Severity of Couple Therapy Case

Level of Severity	#	%
Very Severe	60	15.1
Severe	233	58.5
Average	97	24.4
Mild	6	1.5
Very Mild	1	.3

Participants' initial prognosis of the case.

Participants were asked to report their prognosis for the couple therapy case when therapy was beginning. They reported their prognosis using a Likert-type scale where one indicated "I thought things would get much worse," two indicated "I thought things would get a

bit worse,” three indicated “I thought there would be no change,” four indicated “I thought things would get a bit better,” and five indicated “I thought things would get much better.” Only 21.9% ($n = 87$) of participants thought things would stay the same or get worse, and 77.6% ($n = 309$) thought things would get a bit or much better. Two participants did not indicate their prognosis for the case

Participants’ report of couples’ presenting problems.

Participants were asked to report the presenting problem(s) and goal(s) for the case of couple therapy that the participants chose to reflect on for this study. This researcher recruited another marriage and family clinician/researcher to review the data. This clinician/researcher independently coded the presenting problems and goals. Coding descriptions and decisions were reviewed. The two researchers achieved consensus on the categories by discussing differences and reaching an agreement. Seven main categories for the presenting problems emerged. Participants could indicate as many presenting problems as they desired. Table 7 provides the presenting problem categories, with their sub-categories.

Table 7

Presenting Problem Categories, Sub-Categories, and Descriptions.

Categories and Sub-Categories	Description
Communication Problems	Participants listed problematic communication, lack of communication, rigid communication patterns, and poor communication skills.
Conflict	Participants mentioned conflict specifically and also included fighting, arguing, and discordance.
Sexual Problems	Participants listed affairs, lack of sex, and physical problems (both specific sexual problems and other health issues that interfered with the couple’s sexual relationship). Other issues with sex included dissatisfaction with the sexual relationship, painful

	sexual history of one partner or in the relationship (e.g., past rape, sexual abuse), and sexual fetishes.
Problematic Couple Patterns in the Relationship	Although all presenting problems could be thought of as problematic couple patterns, some participants explained that a specific interactional pattern was the couples' reason for coming to couple therapy.
a. Specific Pattern of the Couple was Described	Participants described specific patterns of interaction which were unique to the couple and presented a problem for this couple. For example: "stuck in a destructive pattern, undermining each other."
b. Mistrust	This code was used when participants listed lack of trust as the presenting problem. Participants either described one person as mistrusting or explained that a lack of trust permeated the relationship. Participants often connected the lack of trust with an additional presenting problem such as an affair.
c. Differences	Participants described differences between the individuals' personalities, cultural backgrounds, relationship expectations, goals, and values. They listed each of these as presenting problems for couple therapy.
d. Emotional Distance	Participants reported that some couples sought couple therapy to address lack of intimacy, lack of connection, distance, and having too few positive interactions in the relationship.
e. Marital Dissatisfaction	Participants reported that some couples came to couple therapy specifically because they were unhappy with their relationship. While this could be the case with all couples in couple therapy, it was the complete focus of some cases.
Individual Issues	Quite a number of participants described the couple's presenting problem as an individual issue such as addictions, personality disorders, depression, anger issues, or one person being ambivalent about the relationship. Presenting problems were coded as "Individual Issues" when the participant reported the problem as though it were based on one person only.

Family of Origin	These presenting problems centered on a clients' relationship with his or her parents and/or siblings, or a client's relationship with his or her in-laws. Some presenting problems with family of origin issues focused on past events (e.g., childhood abuse, parental divorce) while others focused on current conflict with extended family.
Life Events	At times, participants mentioned a specific event or situation as the reasons for which clients attended couple therapy.
a. Life Stage Change	Some clients reportedly came to couple therapy because of difficulty navigating a life stage change such as deciding whether to marry, deciding whether to divorce, or adjusting to an empty nest.
b. Non-Family Events	Non-family events reported as presenting problems included health issues (e.g., recovery from stroke, back injury) and reintegration into the family after military deployment.
c. Children	Presenting problems which centered on children included unplanned pregnancies, infertility, parenting and step-parenting difficulties.
Legal or Court Involvement	Participants reported that a few couples were in couple therapy only because it was mandated by a court ruling. The court cases reportedly focused on domestic violence or substance abuse.

Research Question #1: *Which client factors identified in literature do clinicians perceive to influence the outcome of both successful and unsuccessful couple therapy cases, and what is the relative influence of those client factors?*

Quantitative findings.

Ranking of factors according to means

Table 8 provides the complete list of means, standard deviations, and number of participants who rated each factor as “Not an Issue.” A Likert-type scale provided the values for

these numbers, with options of “Not Important” (which was coded as one), “Slightly Important,” “Moderately Important,” “Important,” “Very Important,” and “Vitaly Important” (which was coded as six).

Table 8

Descriptive Statistics for Participants Who Rated the Factor as Influencing the Outcome of Couple Therapy.

Client Factor	\bar{x}	<i>sd</i>	<i>n</i>
Level of Openness to Each	4.75	1.18	14
Level of Motivation	4.64	1.44	27
View of Each Other	4.61	1.42	28
Level of Commitment	4.59	1.50	38
Level of Emotional	4.57	1.28	26
Personal History	4.53	1.16	9
Resistance/Reactivity	4.30	1.41	42
Level of Quality Participation	4.27	1.61	44
Personality	4.18	1.14	16
Level of Resiliency	4.16	1.41	33
Level of Individual Pathology	4.00	1.44	30
Amount of Problem Solving	3.85	1.37	30
Life Stage Transition	3.79	1.44	62
Children Together	3.79	1.75	124
Job Stress	3.66	1.49	67
Equality of Roles	3.59	1.55	61
Financial Stress	3.45	1.66	78
Amount of Social Support	3.37	1.51	66
Length of Relationship	3.36	1.40	56
Intelligence	3.09	1.37	71
Flexibility of Gender Roles	3.09	1.48	89
Outside Pressure	3.03	1.57	71
Previous Relationships	2.96	1.62	85
Recent Tragedy	2.83	1.83	164
Religious Beliefs	2.59	1.63	100

Note. The response options ranged from 1 = “Not Important” to 6 = “Vitaly Important.”

Level of Openness to Each Other, Level of Motivation, View of Each Other, Level of Commitment, Amount of Emotional Responsiveness, and Personal History all had means above

4.50 on the scale of one to six, with higher numbers indicating that the client characteristic was considered to be more important to the outcome of the case of couple therapy.

Resistance/Reactivity, Quality of Participation, Personality, Level of Resiliency, and Level of Individual Pathology had means above 4.0. Previous Relationships, Recent Tragedy, and Religious Beliefs were the client factors with the lowest means; each had a mean below 3.0.

The second set of means and standard deviations of each variable included responses from *all* participants and are provided in Table 9, listed in order of highest to lowest mean. For these statistics, the range increased to include the option of “Not an Issue” which was coded numerically as a zero. Therefore, the range for these numbers was zero to six, with higher numbers indicating that participants considered the client characteristic to be more important to the outcome of a case of couple therapy.

Table 9*Descriptive Statistics of the Ranked Client Factors for All Participants.*

Client Factor	Mean	SD	Rank <i>Difference*</i>
Level of Openness to Each Other	4.58	1.46	0
Personal History	4.43	1.33	4
Level of Motivation	4.32	1.81	-1
View of Each Other	4.28	1.81	-1
Level of Emotional Responsiveness	4.27	1.68	0
Level of Commitment	4.15	1.97	-2
Personality	4.01	1.39	2
Resistance/Reactivity	3.85	1.88	-1
Level of Resiliency	3.81	1.77	1
Level of Quality Participation	3.80	2.02	-2
Level of Individual Pathology	3.70	1.74	0
Amount of Problem Solving Skills	3.56	1.66	0
Life Stage Transition	3.20	1.91	0
Job Stress	3.04	1.93	1
Equality of Roles	3.04	1.93	1
Length of Relationship	2.89	1.75	3
Amount of Social Support	2.81	1.86	1
Financial Stress	2.78	2.02	-1
Children Together	2.61	2.28	-5
Intelligence	2.54	1.71	0
Outside Pressure	2.49	1.84	1
Flexibility of Gender Roles	2.40	1.83	-1
Previous Relationships	2.32	1.88	0
Religious Beliefs	1.94	1.80	1
Recent Tragedy	1.66	1.98	-1

Note: The response options ranged from 0 = “Not an Issue” to 6 = “Vitaly Important.” The “Rank Difference” is calculated by subtracting the rank of a variable in the overall list of means from the rank of a variable in the list of means for variables when they were perceived to influence outcome. Therefore, positive rank differences indicate that a variable moved to a higher rank in the overall list and negative rank differences indicate that a variable moved to a lower rank in the overall list.

Table 9 also includes the rank change of each variable from Table 8 to Table 9. The largest rank change was “Children Together,” which moved down five rankings when the clinicians who did not consider this as influential to the participant-reported outcome of couple therapy were not included. “Personal History” moved up four rankings when all data were considered. This indicates that “Children Together” was very important for some of the cases, but was not an issue in a lot of cases. Additionally, “Personal History” was an important factor in almost all of the cases, with only nine participants indicating that “Personal History” was not an issue.

Principal components analysis: Five arenas of couple focus.

For data reduction purposes, principal components analysis (PCA) was used to reduce the number of variables by grouping them into components in a way that described the patterns of the variance of the data. For the PCA, all participants’ responses were analyzed. The variables used for PCA were the 25 client factors that have been identified in literature as influencing the outcome of couples or individual therapy. The variables are listed in Table 1. For PCA, Stevens (2002) recommends a minimum of five participants per variable and notes that some researchers recommend up to 20 participants per variable for PCA. For this study, 25 variables were used in the PCA with data from 398 participants. This results in nearly 16 participants per variable, which is considered acceptable.

To determine whether the data were appropriate for PCA, the Bartlett test of sphericity was conducted. The Bartlett test of sphericity results ($\chi^2(300) = 3029.17, p = < .001$) indicated that the sample size is adequate and that the correlations between the variables support using PCA. An additional consideration of PCA is distribution of the variables. Several of the 25 client factors variables were not normally distributed. Based on Tabachnick and Fidell’s (1996)

and Mertler and Vannatta’s (2005) stance that data used in descriptive PCA do not need to meet the assumptions of normalcy and the significance of the Bartlett test of sphericity, the data were determined to be adequate for PCA. Before conducting the PCA, the data of the 25 variables were converted to standardized scores by using SPSS to calculate and save the standardized scores.

The PCA was conducted using SPSS. The orthogonal rotation method of varimax rotation was used to maximize interpretability and to obtain resulting PCA components which were uncorrelated with each other. Based on Eigenvalues over one, scree plot examination, and interpretability or meaningfulness of the components, five factors were retained. The scree plot, displayed in Appendix L, shows a flattening after the fifth component. PCA was then re-calculated using varimax rotation and specifying that the analysis retain five components.

The resulting five PCA components together accounted for 51.38% of the variance in the data. Table 10 lists the Eigenvalues and percent of variance accounted for by each of the five PCA components. Naming of the PCA components was guided by the following questions: a) “If the variables that load on this factor influenced the outcome of this case, what would these variables collectively say about the couple?” and b) “What might it be like for a participant to work with a case whose outcome was influenced by these client variables?”

Table 10

Eigenvalues and percent of variance accounted for by each of the five PCA components.

Component	Eigenvalue	% of Variance	Cumulative % of Variance
Relationally-Focused	5.75	22.99	22.99
Values-Focused	2.74	10.96	33.95
Outward-Focused	1.62	6.48	40.43
Individually-Focused	1.46	5.85	46.28
Task-Focused	1.28	5.11	51.39

The first PCA component accounted for 22.99% of the variance in the data set and included loadings of the following variables: Level of Openness to Each Other, Amount of Emotional Responsiveness, View of Each Other, Level of Quality Participation, Level of Commitment, Level of Motivation, and Amount of Problem-Solving Skills. The factor loadings for all five components are listed in Appendix M. In asking the questions that guided the naming of the PCA components, I thought that a case in which the above client factors stood out as the influential client factors could indicate that the couple was willing to focus on the couple relationship and was engaged in the therapeutic relationship. It would also seem that the focus of couple therapy sessions might center on relationship factors. To reflect these considerations, the first PCA component was named Relationally-Focused.

The second PCA component accounted for 10.96% of the variance and included the variables of Intelligence, Length of the Relationship, Level of Resiliency, Religious Beliefs, and Children Together. In naming the second component, I considered what these client factors might collectively say about a couple. In the qualitative data, participants described intelligence as the clients' ability to think logically and reasonably about his or her situation, and the clients' ability to analyze the couple's problems intellectually. This description of intelligence, combined with the other client factors that load on the second PCA component, seemed to indicate that the client factors that influenced the outcome of these cases were centered on the client couple being able to analyze the things that matter to them (length of the relationship, beliefs, children together) and that they were able to be resilient. It seemed to make sense that if the couples' analysis of their problems was based on their values, they could focus on the larger picture of their situation, and would be able to be more resilient. Based on these thoughts, the second component was named Values-Focused.

Seven percent of the variance was accounted for by the third PCA component, which included Job Stress, Recent Tragedy, Amount of Social Support, Financial Stress, Outside Pressure, and Life Stage Transition. In naming this component, I noticed that these factors, with the exception of Life Stage Transitions, were things that happened outside the couple's relationship. If these were the factors that influenced a case of couple therapy, the therapy might be quite focused on the couple dealing with and adjusting to contextual issues, or things that were outside the couple. Based on these contributing variables, the third PCA component was named Outward-Focused.

The fourth PCA component accounted for 5.85% of the variance and was primarily comprised of the following variables: Individual Pathology, Personal History, Personality, and Resistance-Reactivity. In naming the fourth PCA component, I considered what it might say about the couple if these client factors influenced the outcome of couple therapy. These client factors might indicate that couple therapy was impacted by individual problems and history, and it would be possible that couple therapy focused on individual issues. Based on this interpretation, the fourth PCA component was named Individually-Focused.

The fifth PCA component accounted for 5.11% of the variance in the original variables and included loadings of Flexible and Rigid Gender Roles and Equal and Unequal Roles. The name for the fifth PCA component was based on the idea that couple therapy which was influenced by these two client characteristics might indicate that the couple was focused on the tasks of life. The label of Task-Focused was used to describe the fifth PCA component.

After completing the PCA, the factor loadings for the PCA components were saved and used as the predictor variables in the Logistic Regression.

Qualitative findings.

To answer the first research question, the qualitative data which participants provided in response to the open-ended survey questions that overlapped with the list of client factors in the literature were analyzed first. These comments were coded using the literature-based codes following the analysis described in Chapter Three. Appendix J provides examples of how the participants used the actual literature-based term, when applicable. Final descriptions for the terms, details about the coding criteria, and examples of other language participants used for each literature-based code are also included.

Figure 1: Participants' Descriptions of Literature-Based Client Factors



To visually display participants' descriptions of client factors, a wordle was created using the website <http://www.tagxedo.com>. I included this wordle to provide a sense of the raw data in an attempt to decrease the distance between the reader and participants' actual words. A wordle is a graphic display of words based on frequency. In a wordle, the size and boldness of words are determined by the number of times each word is mentioned, relative to the other words in the

wordle. The proximity of words to each other is random. Figure 1 displays the wordle created from participants' descriptions of client factors that overlapped with the literature-based codes.

Table 11 reports the number and percentage of participants who identified each of the literature-based client factors as influencing their cases, with the client factors listed in descending order based on frequency. The literature-based factor of “Open or Closed to Each Other” was mentioned by the highest number of participants, with 241 (60.6%) participants spontaneously describing this as a factor as influencing the outcome of the couple therapy. One hundred and forty-four (36.2%) participants listed factors that fit under the literature-based code of “Personality.” “Quality of Participation,” “Amount of Emotional Responsiveness,” “Level of Commitment,” and “View of Each Other” were each listed by between 112 (28.1%) and 128 (32.2%) participants. Seven additional literature-based client factors were identified by 10-20% of the participants ($n = 41-83$). These factors included Level of Motivation, Children Together, Job Stress, Individual Pathology, Level of Resiliency, Financial Stress, and Amount of Problem Solving Skills. The remaining literature-based client factors were identified by fewer than 10% of participants.

Table 11

Number of Participants whose Qualitative Responses Overlapped with Literature-Based Client Factors

Client Factor	Total	
	<i>n</i>	%
Open or Closed to Each Other	241	60.55
Personality	144	36.18
Quality of Participation	128	32.16
Amount of Emotional Responsiveness	125	31.41
Level of Commitment	116	29.15
View of Each Other	112	28.14
Level of Motivation	83	20.85
Children Together	80	20.10
Job Stress	66	16.58
Individual Pathology	51	12.81
Level of Resiliency	47	11.81
Financial Stress	41	10.30
Amount of Problem Solving Skills	41	10.30
Life Stage Transition	39	9.80
Personal History	37	9.30
Amount of Social Support	36	9.05
Resistance/Reactivity	35	8.79
Equality of Roles	29	7.29
Intelligence	28	7.04
Recent Tragedy	19	4.77
Religious Beliefs	16	4.02
Length of Relationship	14	3.52
Previous Relationships	11	2.76
Flexibility of Gender Roles	8	2.01
Outside Pressure	1	.25

Research Question #2: *What were the differences in those client factors that participants rated as contributing to successful couple therapy and those that they rated as contributing to unsuccessful couple therapy?*

Logistic regression.

A logistic regression analysis was used to discriminate between PCA components that predicted a participant was discussing a case of successful couple therapy and PCA components that predicted a participant was discussing a case of unsuccessful couple therapy. For the logistic regression, the independent variables were the PCA components and the dependent variables were the participant-perceived successful or unsuccessful outcome of couple therapy.

The first assumption of logistic regression is that the dependent variable needs to have approximately a 50/50 split (Warner, 2008). This data set had 217 unsuccessful cases and 181 successful cases, for a 54.5% and 45.5% split. Because the total number of participants was 398, this data split was considered acceptable. Second, for logistic regression to produce valid results, the predictor variables should have minimal outliers. To assess outliers, histograms and boxplots of the PCA component scores were visually examined. The number of outliers did not exceed what would be expected based on the characteristics of a normal distribution. Therefore, all PCA components were used as predictor variables. Multicollinearity statistics were not examined because the orthogonal rotation used in PCA produced uncorrelated components.

Logistic regression was conducted using SPSS; the dependent variable was participant-perceived successful or unsuccessful outcome of couple therapy, and the independent variables were the five components produced through the PCA: Relationally-Focused, Values-Focused, Outward-Focused, Individually-Focused, and Task-Focused. The stepwise method of “Forward-Likelihood Ratio” was used for entering the variables, which instructed SPSS to add variables to the regression model as they significantly improved the fit of the data based on the likelihood ratio test. Using forward likelihood ratio allowed the regression model not only to provide information regarding whether the independent variables predicted that a participant was discussing successful or unsuccessful couple therapy, it also allowed the regression model to

input the variables in a hierarchy, indicating the strength of the predictors. Tests of the overall model fit were examined first. The chi-square test of significance was used to test whether the resulting logistic regression model predicted the dependent variable significantly better than the null model. The results indicated that the regression model was a significant improvement over the null model, and thus a better fit than the null model ($\chi^2(4) = 310.251, p = < .000$).

After concluding that the data do fit this model, the classification table was analyzed. The classification table shows that the model accurately predicted the dependent variable, participant-perceived successful or unsuccessful outcome of couple therapy, 85.9% of the time. More specifically, when a case was reported to be successful, the regression model equation accurately predicted the outcome 86.6% of the time. The regression model correctly predicted the outcome of cases which were reported to be unsuccessful 85.1% of the time. Random prediction of the dependent variable would be accurate 54.5% of the time (because 54.5% of the cases were unsuccessful), so this model improved prediction of participant-perceived outcome of couple therapy by 31.4%. The chi-square results reported above indicate that this improvement in prediction is statistically significant ($p = < .000$).

The summary of model variables was considered next. Stepwise regression using forward likelihood ratio resulted in a regression model that included the following PCA components: Relationally-Focused, Values-Focused, Individually-Focused, and Task-Focused. The component Outward-Focused was not a significant predictor of the participant-reported outcome of couple therapy. Table 12 includes the parameter estimates, degrees of freedom, significance levels, and the exponentials of the parameter estimates for each of the PCA components which were included in the regression model. These four PCA components were significant predictors at the .01 level of significance.

Table 12*Logistic Regression Results with PCA Components as the Independent Variables*

PCA Component	β	df	<i>p</i> -value	Exp(β)
Relationally-Focused	2.658	1	.000	14.262
Values-Focused	2.209	1	.000	9.109
Individually-Focused	-1.613	1	.000	.199
Task-Focused	-.579	1	.002	.561
Constant	-.826	1	.000	.438

Because participant-reported successful couple therapy was coded as one and participant-reported unsuccessful couple therapy was coded as zero, positive parameter estimates indicate that a participant was reporting on a case of successful couple therapy. Negative parameter estimates suggest that a participant was reporting on a case of unsuccessful couple therapy. Positive parameter estimates also indicate that, as the independent variable increases, the predicted probability of a successful outcome increases. Negative parameter estimates indicate that as the component increases, the predicted probability of successful outcome decreases. For example, as Relationally-Focused scores increase, the prediction that the case would be perceived as successful would also increase. As the Task-Focused scores increased, the prediction equation would more strongly predict that the case would be perceived as unsuccessful. The parameter estimates for the components of Relationally-Focused and Values-Focused were positive, and the parameter estimates for the components of Individually-Focused and Task-Focused were negative. The component of Outward-Focused was not included in the model, indicating that it was not a significant predictor of whether participants were reporting on a case of successful or unsuccessful couple therapy.

Independent variables whose parameter estimates have larger absolute values factor more heavily into the prediction equation than do independent variables whose parameter estimates have smaller absolute values. In this analysis, an increase of one on the Relationally-Focused

PCA component has more influence on the odds of success than an increase in 1 for the other PCA components. In fact, the exponential of the parameter estimate for the Relationally-Focused PCA component indicates that if there was an increase of one on the Relationally-Focused PCA component, the odds ratio that the case would be successful would increase by a factor of 14 if all else was held constant. The exponential of the parameter estimate for the Value-Focused PCA component, which is 9.11, indicates that an increase of one on the PCA component of Values-Focused would increase the odds ratio by nine times if all else held constant.

A second logistic regression equation was conducted for comparison purposes. This second logistic regression used the perceived outcome of couple therapy as the dependent variable and the participants' Likert-type ratings of the 25 client factors identified in literature as influencing the outcome of therapy as the independent variables. Outliers of the independent variables were assessed using boxplots. No variables had an unexpected number of outliers. Multicollinearity was assessed by examining the Spearman rho correlations between the variables. Although there were a large number of significant correlations, few correlations were categorized as strong.

The stepwise method of "Forward-Likelihood Ratio" was used to enter the variables into the equation. The chi-square test of significance indicated that the resulting logistic regression model was a significantly better predictor of the dependent variable than was the original model which had only the constant ($\chi^2(10) = 353.947, p = < .000$). According to the classification table, the regression model correctly classifies the cases 87.7% of the time. The chi-square results also indicate that this improvement in prediction is significantly better than the null model ($p = < .000$). In the final regression model, 10 of the client factors were found to be significant

predictors of the perceived outcome of couple therapy. These included: Individual Pathology, Intelligence, Resistance-Reactivity, Length of the Relationship, Level of Motivation, Quality of the Participation, Amount of Problem-Solving Skills, Resiliency, Level of Commitment, and Equality of Roles. Table 13 provides the parameter estimates, degrees of freedom, significance levels, and exponential of the parameter estimates for these variables. Eight of the independent variables are significant at the .01 level and two are significant at the .05 level.

Table 13

Logistic Regression Results with the Literature-Based Client Factors as the Independent Variables.

Variable	β	df	<i>p</i> -value	Exp(β)
Individual Pathology	-.760	1	.000	.468
Intelligence	.710	1	.000	2.034
Resistance-Reactivity	-.593	1	.000	.553
Length of the Relationship	.303	1	.021	1.354
Level of Motivation	.443	1	.022	1.558
Quality of Participation	.848	1	.000	2.335
Level of Problem-Solving Skills	-.390	1	.018	.677
Resiliency	.578	1	.000	1.782
Commitment	.586	1	.000	1.796
Equality of Roles	-.404	1	.000	.668
Constant	-7.146	1	.000	.001

PCA for successful couple therapy cases.

Using the quantitative data to investigate whether there are differences between participant groups in the patterns of responses to the 25 client factor variables, PCAs were run separately for each group. The results of the PCA for participant-reported successful couple therapy will be presented first, followed by the PCA for participant-reported unsuccessful couple therapy.

For participant reported successful couple therapy, the data were examined to ensure that PCA was an appropriate analysis to conduct. Assumptions considered the number of participants and Bartlett's Test of Sphericity. For this PCA, 25 variables were considered, and 181 participants reported on participant reported successful couple therapy. That results in 7.24 participants per variable, which is still within Stevens' (2002) recommendation of at least 5 participants per variable. In addition, the Bartlett Test of Sphericity was examined. The results indicated that the data were appropriate for PCA ($\chi^2 = 1290.00, p = < .000$).

The PCA analyses for participant reported successful couple therapy showed eight components with Eigenvalues above 1.0. Examining the scree plot (Appendix N) showed a leveling of the amount of variance explained after the second component with no clear drops after the second component. Therefore, two components were retained and the PCA analysis was re-run with the extraction of two components specified. Varimax rotation provided more clearly interpretable PCA components than did no rotation, quartimax rotation, or equimax rotation, and was therefore used. I used the same two questions previously mentioned to guide the naming of the PCA components: a) "If the variables that load on this factor influenced the outcome of this case, what would these variables collectively say about the couple?" and b) "What might it be like for a participant to work with a case whose outcome was influenced by these client variables?"

The first PCA component for participants reporting on a case of successful couple therapy had an Eigenvalue of 4.72 and accounted for 18.87% of the variance in the data set. The first component was comprised of Financial Stress, Job Stress, Life Stage Transitions, Outside Pressure, Recent Tragedy, Social Support, Previous Relationships, Flexible Gender Roles, Personal History, Equal Roles, Problem-Solving Skills, and Individual Pathology. In naming

this component, it seemed that cases of couple therapy in which these client characteristics influenced the outcome of couple therapy might be focused on the larger picture of what was happening in the couples' lives. This first component described Context. The second component had an Eigenvalue of 2.74 and accounted for 10.94% of the variance in the data. The second component included Positive Regard for Each Other, Openness to Each Other, Emotional Responsiveness, Commitment, Quality of Participation, and Resiliency. In naming this component, couples whose therapy was influenced by these variables appeared to be connected to each other, committed to the relationship, and willing to work in therapy. To reflect these characteristics, the second component was named Invested. Together, the two components accounted for 36.35% of the data variance. The PCA component loadings are listed in Appendix O.

PCA for unsuccessful couple therapy cases.

Of the total 398 participants, 217 participants provided data on participant-perceived unsuccessful couple therapy. Because the PCA was conducted with 25 variables, there were 8.68 participants per variable, which is above the five participants per variable that Stevens recommends (2002). For unsuccessful couple therapy data, the Bartlett Test of Sphericity results indicated that the data set was appropriate for PCA ($\chi^2 = 1487.88, p = < .000$).

Initially, the PCA was conducted with no rotation and resulted in seven components with Eigenvalues above 1.0. Together, the seven components explained 57.72% of the variance in the data. After examining the scree plot (Appendix P), the researcher decided to retain the first three PCA components for several reasons. First, the Eigenvalues allow the PCA components to be retained. Second, there is a slight drop and leveling in the scree plot after the third PCA component. Additionally, retaining only one PCA component resulted in a single PCA

component that was made up of fifteen of the variables. Including two more PCA components allowed the PCA components to capture more of the variance and to include more of the original variables in the findings. The three PCA components collectively provide a more useful overview of the data.

After deciding to retain three components, PCA's were done with the extraction of three components specified. An unrotated solution, varimax rotation, and equimax rotation were considered. The component loadings were examined to determine which method best fit the data and increased interpretability. The unrotated solution offered the most distinct components and was therefore used. Appendix Q contains the component loadings of the three components.

The first PCA component for data on participant-reported unsuccessful couple therapy had an Eigenvalue of 5.70 and accounted for 22.80% of the data variance. This PCA component was comprised of 17 variables, which were: Lack of Motivation, Intelligence, Lack of Commitment, Lack of Problem-Solving Skills, Lack of Social Support, Unequal Roles, Rigid Gender Roles, Low Quality of Participation, Financial Stress, Outside Pressure, Contempt for Each Other, Job Stress, Individual Pathology, Children Together, Recent Tragedy, Length of the Relationship, and Lack of Resiliency. In naming this variable, it seemed that these couples were facing difficulties, had inadequate problem solving skills and social support, were not resilient, had contempt for each other, and did not have the commitment and motivation needed to work through their difficulties. Therefore, the first PCA component was named Unable to Recover.

The second PCA component had an Eigenvalue of 2.06 and accounted for 8.23% of the variance in the data. This PCA component is unique in that it is made of two negative loadings and one positive loading. The two variables that load negatively on the second PCA component were Closed to Each Other and Lack of Emotional Responsiveness. Personal History loaded

positively on this PCA component. The negative loadings indicate that lower scores on these variables contribute to the PCA component. For this PCA component, when Closed to Each Other and Lack of Emotional Responsiveness were less influential to the outcome of the case, this component had a higher score. This combination of loadings seem to indicate that it was significant that relational components were not influencing the outcome of couple therapy, and that Personal History was influencing the outcome. To reflect the lack of relational focus, this component was called Relationally Passive. The Eigenvalue for the third PCA component was 1.71 and 6.82% of the variance was accounted for by the third PCA component. This PCA component, called Intransigent, was comprised of Resistance-Reactivity, Personality, and had a negative loading for Life Stage Transitions. This PCA component was named Intransigent based on the high loading of Resistance-Reactivity, and qualitative data in which many participants who talked about personality influencing couple therapy to be unsuccessful emphasized that it was the client characteristic of rigidity or immaturity that influenced the outcome of couple therapy. Additionally, the negative loading of Life Stage Transition indicates that the case was not influenced by changes in life, which highlights the personality component. Together, the three PCA components accounted for 37.85% of the variance in the data set for participant reported unsuccessful outcome of couple therapy.

Comparisons of medians and ranks.

Additional analysis used to answer the second research question divided the data into two groups according to whether the participant was discussing a successful or unsuccessful case of couple therapy. These analyses focused on comparisons of medians and ranks. The variables used were the same twenty-five variables which were used to answer the first research question. The comparisons provided information on the differences between client characteristics which

influenced the outcome of successful couple therapy and client characteristics which influenced the outcome of unsuccessful couple therapy.

Descriptive data, including means, standard deviations, medians, and rank for each of the variables are reported in Table 14. The variables are listed in order of highest to lowest mean for participant-reported successful couple therapy. The ranking of each variable for unsuccessful couple therapy cases is also listed, with the rank change calculated as the variable’s ranking for successful couple therapy less the variable’s ranking for unsuccessful couple therapy. Therefore, a positive rank change indicates that the variable was ranked that many steps higher for unsuccessful couple therapy and a negative rank change indicates that the variable was ranked that many steps lower for unsuccessful couple therapy. Several variables were ranked quite differently from participants of the two groups. For example, “Quality of Participation” was ranked third for participants who reported on a successful couple therapy case while “Low Quality of Participation” was ranked 16th by participants who reported on participant-identified unsuccessful couple therapy cases.

Table 14

Comparison of Descriptive Statistics for the Literature-Based Client Characteristics

Client Factor	Successful				Unsuccessful				Rank Δ
	\bar{x}	<i>sd</i>	md	rank	\bar{x}	<i>sd</i>	md	rank	
Level of Motivation	5.32	0.94	6	1	3.49	1.94	4	8	-7
Level of Commitment	5.27	0.91	5	2	3.21	2.12	3	9	-7
Level of Quality Participation	5.14	0.75	5	3	2.68	2.07	2	16	-13
Open or Closed to Each Other	5.02	0.94	5	4	4.21	1.69	5	3	1
View of Each Other	4.99	1.09	5	5	3.69	2.05	4	7	2

Amount of Emotional Responsiveness	4.84	1.01	5	6	3.79	1.95	4	6	0
Level of Resiliency	4.68	1.14	5	7	3.09	1.88	3	11	-4
Personal History	4.22	1.35	4	8	4.6	1.29	5	1	7
Amount of Problem Solving Skills	4.04	1.26	4	9	3.15	1.84	3	10	-1
Personality	3.87	1.29	4	10	4.12	1.46	4	4	6
Length of Relationship	3.55	1.52	4	11	2.33	1.73	2	20	-9
Life Stage Transition	3.49	1.75	4	12	2.96	2	3	14	-2
Intelligence	3.49	1.39	4	13	1.76	1.56	1	23	-10
Resistance/Reactivity	3.34	1.92	4	14	4.27	1.74	5	2	12
Individual Pathology	3.32	1.74	4	15	4.01	1.68	4	5	10
Amount of Social Support	3.13	1.73	3	16	2.54	1.93	3	18	-2
Equality of Roles	3.04	1.68	3	17	3.04	2.12	3	13	4
Job Stress	2.98	1.9	3	18	3.09	1.97	3	12	6
Children Together	2.88	2.32	3	19	2.39	2.23	2	19	0
Flexibility of Gender Roles	2.69	1.69	3	20	2.16	1.91	2	22	-2
Financial Stress	2.56	1.93	2	21	2.95	2.09	3	15	7
Outside Pressure	2.39	1.77	2	22	2.58	1.89	3	17	5
Previous Relationships	2.35	1.74	2	23	2.3	1.99	2	21	2
Religious Beliefs	2.3	1.83	2	24	1.64	1.72	1	24	0
Recent Tragedy	1.85	2.07	1	25	1.51	1.89	1	25	0

Note: The response options ranged from 0 = “Not an Issue” to 6 = “Vitaly Important.” MD = median

The Mann-Whitney U test was used to assess differences between the groups on the medians of the variables. Because 25 Mann-Whitney U tests were calculated, the Bonferroni adjustment was made to ensure that significant findings were not the casualty of a Type I error.

To make the Bonferroni adjustment, the error rate of .05 was divided by 25 (the number of tests), which indicated that a significance level of .002 was needed to ensure accurate findings.

The adjusted *p*-values indicate that, for 15 of the 25 variables, there are significant differences between the medians reported by participants who were discussing a case of participant-reported successful couple therapy and participants who were discussing a case of participant-reported unsuccessful couple therapy. Table 15 shows the Mann-Whitney U test statistic, in which significant findings indicate differences between the two groups, and the corresponding *p*-values.

Table 15

Mann-Whitney U Results Testing Differences between Groups

Variable	Mann-Whitney U	<i>p</i> -value
Commitment / Lack of Commitment	8514.00	.000*
Emotional Responsiveness / Lack of Emotional Responsiveness	14149.50	.000*
Individual Pathology	15028.50	.000*
Intelligence	8292.00	.000*
Length of the Relationship	11782.00	.000*
Motivation/ Lack of Motivation	8373.00	.000*
Positive Regard for Each Other / Contempt for Each Other	12700.50	.000*
Problem-Solving Skills / Lack of Problem-Solving Skills	14131.00	.000*
Open to Each Other / Closed to Each Other	14500.50	.000*
Quality of Participation / Low Quality of Participation	6673.00	.000*
Religious Beliefs	15156.00	.000*
Resiliency / Lack of Resiliency	9709.50	.000*

Resistance-Reactivity	13935.00	.000*
Personal History	16221.50	.002*
Social Support / Lack of Social Support	16163.00	.002*
Flexible Gender Roles / Rigid Gender Roles	16251.00	.003
Life Stage Transition	16777.50	.011
Personality	16902.00	.013
Children Together	17381.50	.044
Financial Stress	17473.00	.055
Recent Tragedy	18160.00	.176
Outside Pressure	18613.00	.363
Previous Relationships	18869.50	.495
Job Stress	18949.50	.541
Equal Roles / Unequal Roles	19277.00	.749

Note: *Statistically significant after Bonferroni adjustment.

In contrast to the 13 variables rated as more influential by participants who were reporting in a case of participant-identified successful couple therapy, only three variables were considered significantly more influential to the outcome of couple therapy by participants who were reporting on a case of participant-identified unsuccessful couple therapy. Those two variables were Individual Pathology and Resistance/Reactivity.

Qualitative differences between groups for literature-based client characteristics.

Participants provided qualitative data which overlapped with the literature-based codes. These data offered a contrasting look at the literature-based client factors which impacted couple therapy to be successful and those which impacted couple therapy to be unsuccessful. Table 16 reports the number of participants who spontaneously identified each literature-based client factor as influencing the perceived outcome of couple therapy. This table shows that few

variables were considered influential for both outcomes of couple therapy. It also shows that even client factors which were considered highly influential on one outcome of couple therapy could have the opposite effect for a couple of cases.

Table 16

Participant Frequencies of Listing Client Factors, According to Outcome Group

Client Factor	Successful		Unsuccessful	
	#	%	#	%
Open to Each Other	111	27.89	2	.5
Closed to Each Other	1	.25	127	31.91
Personality	47	11.81	97	24.37
Quality of Participation	85	21.36	5	1.26
Low Quality of Participation	0	0	38	9.55
Emotional Responsiveness	60	15.08	1	.25
Lack of Emotional Responsiveness	1	.25	63	15.83
Commitment	100	25.13	3	.75
Lack of Commitment	0	0	13	3.27
Positive Regard for Each Other	85	21.36	3	.75
Contempt for Each Other	0	0	24	6.03
Motivation	66	16.58	6	1.51
Lack of Motivation	0	0	11	2.76
Children Together	35	8.79	45	11.31
Job Stress	26	6.53	40	10.05
Individual Pathology	3	.75	48	12.06
Resiliency	16	4.02	0	0
Lack of Resiliency	0	0	31	7.79
Financial Stress	12	3.02	29	7.29
Problem Solving Skills	38	9.55	0	0
Lack of Problem Solving Skills	0	0	3	.75

Life Stage Transition	21	5.28	18	4.52
Personal History	6	1.51	31	7.79
Amount of Social Support	21	5.28	15	3.77
Resistance/Reactivity	0	0	35	8.79
Equal Roles	4	1.01	1	.25
Unequal Roles	0	0	24	6.03
Intelligence	27	6.78	1	.25
Recent Tragedy	7	1.76	12	3.
Religious Beliefs	10	2.51	6	1.51
Length of Relationship	11	2.76	3	.75
Previous Relationships	3	.75	8	2.01
Flexible Gender Roles	3	.75	0	0
Rigid Gender Roles	0	0	5	1.26
Outside Pressure	0	0	1	.25

Research Question #3: *What client factors not reported in the literature do participants believe influenced a case of successful and unsuccessful couple therapy?*

The open-ended questions gave participants a chance to expand on the list of which client factors impact the participant reported outcome of couple therapy. After the literature-based coded information was removed from the data set, the remaining qualitative data were analyzed as described in chapter three. Those data were used to answer the third research question. Qualitative data will be reported by describing overall themes, then sub-themes within each of the groupings of individual characteristics, couple dynamics characteristics, and life events. After describing sub-themes within each of those three groupings, specific categories which were observed in each of the groupings will be listed and described, using examples from participants. Participants comments are reported as the term the participant provided followed by a colon and the participants' description of that term.

Overall findings: Complex, interrelated, and dynamic.

Participants typically listed client factors in multi-faceted, complex ways. For example, a description of a life event that influenced the perceived outcome of couple therapy would often include individual factors, information about the context of the situation, and history of the relationship. Participants did not clearly separate these factors from each other. The overall impression that reading the case information gave is that these were complicated cases which were not easily dissected into specific, unique client factors which influenced the case. Another facet of that case complexity was seen when participants included their own characteristics or interactions with the clients in their descriptions of client factors. For some participants, separating influential client factors from their own interaction with the clients was difficult.

One of the key overall findings is that participants' comments ranged from a sense of couple stability or permanency with the presenting problem and client characteristics to the impression that the couple was on the edge of change and something small could have made the difference. Participants commented not only on what the client factors were, but on how the client factors and the outcome of couple therapy could have been different. This sense of uncertainty was seen in both successful and unsuccessful cases. Participants' reflections on what influenced the outcome of couple therapy to be successful, at times, included the qualifier that the client did not do the intervention well, but that the partner was able to meet the client where he or she was. For unsuccessful cases, participants described that the case could have been successful with only a few, relatively minor, client changes. This sense of the cases being constantly dynamic, with moment-by-moment opportunities for change was not connected to any particular client, couple dynamic, or life event characteristic, but was seen as one of

participants' underlying messages and relevant to the understanding of client factors which influence therapy outcomes.

Qualitative categories of individual characteristics that influenced couple therapy outcome.

In describing individual characteristics of clients that influenced the perceived outcome of couple therapy, one theme emerged. This theme centered on how static the individual characteristics seemed. Participants used terms that indicated that some individual characteristics were seen as static (i.e., intelligence, personality traits) and other individual characteristics were seen as malleable (i.e., specifically saying that a client's reaction could have been different). Static characteristics were described as who the client was, while malleable characteristics were described as the clients' choice or response to a situation. As examples of static individual characteristics, one client was described as "Domineering: unable to collaborate" and another participant talked about a client's immaturity as a stable individual characteristic. The individual characteristics which became categories were Responsibility, Rigidity, Four Horsemen, Lack of Trust, Anger, and Humor. These categories and the codes within them are listed in Table 17.

Table 17*Participant-Generated Individual Characteristics: Categories and Codes*

Category	Codes
Responsibility	Self-Awareness Humility Willingness to Make Personal Changes
Rigidity	Lack of Self-Awareness, Refusal to Look at Self Stubborn/Inflexible Unwilling to Let Go of the Past
Four Horsemen	Stonewalling Defensiveness Criticism Contempt *
Lack of Trust	Untrusting Characteristic Suspicious Situations
Anger	
Humor	Playfulness Individual Characteristic with Shared Benefits

Note: Contempt was coded in the literature-based code “Contempt for Each Other”

Responsibility.

Individual characteristics in the Responsibility category were described by participants as clients who were willing to look at themselves, look honestly at their flaws and contribution to the problem, take responsibility, and make changes. Participants highlighted self-awareness and humility as valuable aspects of responsibility. Participants describing responsible clients wrote things like, “Accountable: Charlotte was willing to own her part in the emotional affair and her actions in the relationship before the emotional affair,” “Insightful: He could see and understand his own patterns when I pointed them out to him,” and “Transparency: He was very willing to take responsibility for what he had done and was open about discussing it.” Other participants

emphasized the client's willingness to make personal changes. For example, one participant described a client as, "Resolute: Determined to understand what was going wrong and change himself in accordance with what he found." Some participants connected this client characteristic with the process of therapy, such as the participants who wrote, "Humility: Jane had a sense of humbleness around her weaknesses and trigger points that allowed for a flexible stance in our communication around issues" and "Open mindedness: Natasha was open to the idea that she was engaging in toxic producing behaviors. Natasha understood that she needed to change."

Rigidity.

Client characteristics that reflected a lack of self-awareness were coded as Rigidity. The Rigidity characteristics were linked to clients who were described as being closed to themselves, to the therapy, and to personally changing. Participants often described these clients as "inflexible," "selfish," "stubborn," "immature," "unwilling to let go of the past," and having a "one-sided view." Participants expanded on these concepts by writing, "Lack of self-awareness: Shannon did not realize the impact of her behavior," and "Stubbornness: He was probably the most stubborn client I've ever had. I think he'd argue with a wall if he could." One participant described a clients' "Inflexibility" by writing, "Nathan spoke of wanting to preserve his marriage, but was unwilling to make even minor changes in his expectations of Heather." A participant who gave more context wrote,

"Stubbornness, unforgiveness: Carmen believed that if his wife just did everything he said that things would be okay. He was unwilling to look at his own attitudes and style of communication as being unhealthy and further contributing to the distance between them.

He was resentful of Belinda's treatment of him, and said that until she started doing things his way he wouldn't forgive her of the ways she'd hurt him."

"Four Horsemen."

Several participants specifically used Gottman's terms of stonewalling, defensiveness, withdrawal, and contempt in describing individual characteristics of their clients; even more participants described the dynamics created by the Four Horsemen. Therefore, even though the Four Horsemen were listed as an individual characteristic, they often build to create a couple dynamic. The following three examples came from the same case and illustrate how the Four Horsemen can accumulate:

"Defensive: He was often overwhelmed by the number and complexity of the complaints by his partner. Verbose: She would often layer numerous complaints on top of one another to the point that neither of them could remember what they were originally arguing about. Critical: She often had a difficult time acknowledging his attempts to repair the relationship and would negate, minimize these attempts within a globally negative perspective of him."

One participant pointed out the interaction between the Four Horsemen, "Defensiveness: Monica was the target of much criticism by her husband. This fact increased emotional intensity in Monica and she responded with defensiveness." Withdrawal was described as "When hurt very withholding: When she felt hurt, criticized, misunderstood, etc. she would withdraw in the therapy office. Her demeanor would be very silent and inward looking" and "Withdrawn: Would shut down emotionally and refuse to communicate."

Lack of trust.

Lack of Trust was an individual characteristic which overlapped with some of the categories associated with the life events. Some clients were described as untrusting, some events aroused suspicion, and the overlap of those two made for especially difficult cases. Participants often mentioned the reason for the lack of trust, which were most often affairs, followed by financial deception, past abuse, and jealousy. Whatever the reason, when a lack of trust was mentioned as a factor that influenced the outcome of couple therapy, it was described as the pervasive experience of one of the individuals in the couple. One participant captured this clearly by writing, “Untrusting: Cannot trust anything in his marriage.” In some cases, the lack of trust seemed to be a difficulty the couple was struggling to overcome (e.g., “Relationship insecurity: On a deeper level, both of them were struggling to develop and maintain a more consistent sense of security and safety in the relationship,”) while in other cases, participants described the lack of trust as a stubborn, unconquerable, issue. For example, “Mistrust: Jack thought he could get past her infidelities during their marriage but as we proceeded he became more and more angry and distrustful,” and “Mistrust: No matter what Jorge did to make amends she insisted that there is no reason for her to believe him.” In one case, the history was so painful that nothing could convince the wife to trust again. The participant describes,

“Inability to rebuild trust: Nora was unable and unwilling to trust Jim after having been proven wrong so many times in the past for trusting him. Despite written contracts that she requested he sign, there appeared to be nothing he could actually do to regain her trust, and she was unwilling to risk losing her self-respect again.”

Anger.

Participants discussed clients’ anger in two ways: a) as part of a couple dynamic or life event, and b) as an individual characteristic. This code includes comments in which participants

reported anger as an individual characteristic. The theme that emerges was that, with some clients, anger was more than an emotion and became an issue in and of itself. In some cases, the participants described the anger as being focused on the other person or an event in the relationship history, but more often, they described the person as having an overall angry stance on life. One example of this perspective on anger was provided by the participant who wrote,

“Anger, short temper: Timothy was very regimented in how he expected life to revolve around his ideas and ways of doing things. Since life doesn’t obey our whims, he was constantly angry at everyone around him and let them know it in unkind ways which further drove away those closest to him, deepening his sadness and loneliness.”

In the following examples, participants elucidated the negative impact that an individual’s anger had on the outcome of couple therapy. “Angry: . . . Her anger got in the way of increasing positive interactions or noticing positive changes.” “Hostility: Anger had helped to poison marriage and masked emotions that would help wife understand him better.” “Hostility: Very angry and would be very hurtful with words and actions.”

Humor.

When participants talked about clients’ humor, they often used the word “humor.” Participants were careful to say that the humor which contributed to the perceived success of couple therapy was appropriate rather than sarcastic or hurtful. When clients could laugh at themselves and life, participants explained, the humor eased the tension and allowed those involved to have a positive experience with each other. Participants wrote, “Sense of humor: Homer was able to use his sense of humor to ease tense situations and lighten the mood,” and “Sense of humor: Couple often found themselves laughing or making sarcastic jokes (that weren’t too harmful), showing a bond between them.”

Two components of the Humor category were more evident. The first was that participants described a playfulness and lightness when discussing client's humor. For example, one participant wrote, "Playfulness: That they were willing to "play" with the idea of getting more romantic." The second was how frequently participants described the humor as an individual characteristic that the partner shared in enjoying. The Humor category overlapped the individual and couple dynamics themes, as seen by the participant who wrote, "Mutual sense of humor: Pattern of making each other laugh, including themselves." The following quote also captures the impact of humor on couple dynamics, "Sense of humor: Couple are very playful with each other as the hostility has decreased. They seem to really want to be in each other's company and like being together."

Qualitative categories of couple dynamics characteristics that influenced couple therapy outcome.

Some participants' responses to the prompt for "relationship factors" that influenced the outcome of a case of couple therapy used systematic language or concepts. More often, though, participants listed a characteristic of one or both of the individuals and explained how that characteristic influenced the other person and created a problematic couple dynamic. For example, one participant described the clients as "controlling" and "passive." That participant then went on to describe how these individual characteristics played out in creating an interactional pattern where one person was running the family and the other was following along unhappily. As noted previously, Four Horsemen were listed as individual characteristics, but then were described in a way that indicated that they built to create a couple dynamic. One theme that emerged from the data on couple dynamic characteristics was that one partners' problematic action prompted a problematic response from the other partner, which prompted the first partner

to do more of the original problematic action. Therefore, problematic couple dynamics were created by the accumulation of individual actions. While some participants wrote this in a way that indicated they were aware that the individual actions were creating couple dynamics, other participants listed individual actions without connecting the partners' actions to each other.

Couple dynamics which were not addressed in the Literature-Based codes were categorized into Problematic Couple Dynamics and Sex/Affection. The Problematic Couple Dynamics included the subcategories of Pursuit-Withdrawal, Boundary Problems, Control, and Stalemate. These categories and codes are listed in Table 18.

Table 18
Participant-Generated Couple Dynamics Characteristics

Category	Codes
Problematic Couple Dynamics	Pursuit-Withdrawal Boundary Problems Control Stalemate
Sex/Affection	Great Sex/Affection Lack of or Unsatisfying Sex/Affection

Problematic couple dynamics.

Pursuit-Withdrawal.

Participants frequently used the term “Pursuit-withdrawal” in explaining a commonly observed couple dynamic that contributed to the outcome of couple therapy. Several participants provided a play-by-play of this interaction, with more participants saying the female pursued and the male withdrew than said the male pursued and the female withdrew. Seven participants described that the individuals would trade places with each pursuing at times and each withdrawing at other times. The pursuit centered on relational issues, anger, or desire for emotional closeness, and left the couple with increased distance and decreased emotional

engagement. This pattern was described in one couple as “Pursuit-withdrawal patterns: She would pursue him regarding numerous issues and he would withdraw as he became overwhelmed. She saw him as irresponsible and he saw her as attacking.” Another participant described the alternating pattern as “Emotional engagement: The male would pursue, the female would respond defensively, the male would pull away, and female would pursue. The emotional dysregulation continued to the point that no communication was possible and hurt and fear were left in its place. Interestingly, one participant uniquely described using this pattern to benefit therapy. This participant wrote, “Withdrawal-pursuit: Although problematic at times, this pattern was reliable enough to use as needed for healing and change.”

Boundary problems.

Another problematic couple dynamic mentioned by participants was Boundary Problems. The problematic boundaries were almost always diffuse boundaries, with a few instances of rigid boundaries within the relationship creating diffuse boundaries with others. A few people were described as very lonely, indicating rigid boundaries with everyone. However, most boundary problems described were diffuse. Diffuse boundaries created difficulties with co-dependency in the couple relationship, families of origin, children, and friends. Participants described boundary problems as “Dependency: Deborah was dependent on Jerry. Jerry was emotionally dependent on Deborah,” “Enmeshment: was pathologically enmeshed with the 2 children,” “Loyalty: I’m not sure if that is the correct word. He had a duty to his family or origin that continually jeopardized his relationship with his wife,” and “Emotional neediness: Patty’s needs were not being met by Leonard and she had turned to friends &/or a new romantic interest to satisfy herself.”

Control.

Participants depicted the couple dynamic of one partner controlling the other as occurring through direct, overt actions as well as manipulative, covert actions. Some participants focused on the person who was controlling, while others focused on the person being controlled.

Participants who connected this couple dynamic to a cause included descriptions of problems with trust and insecurities, for example, “Control: John was unable or unwilling to let go of being in control of a situation long enough to realize that his wife could be trusted to manage things well. Specifically, he did not trust her to manage money.” In other cases, the client seemed to have a more selfish outlook, as in the case where the participant wrote, “Demandingness: She demanded her way in the marriage and was comfortable with threatening anything to get it” and the participant who reported, “Shared Family Values: Vicky knew Tom valued Family and she controlled him knowing he would bear the pain, rather than risk the loss.”

Stalemate.

Participants described couples who could not work together, who pulled in different directions and had specific, significant individual differences in personality, values, and cultural background. For example, one participant wrote, “Intimacy: Jack believed sex was the first necessary step to closeness. Jill believed closeness had to happen first. Result was stalemate.” Some of these differences were described as being insurmountable by the couple—these are personality differences, clashing goals or expectations, or different cultures. One personality difference that a participant described was:

“Pace of information processing: Cathy is bright and thinks and moves quickly through life. Jeff is slower and more thoughtful in his approach. Cathy continually pushed for an

answer from Jeff. Jeff continually asked for more time to think things through. Mutual frustration erupted due to this dynamic.”

Examples of other stalemates included, “Differed in intimacy needs: Donna wished to be intimate with many partners, Carl would prefer to be intimate with only Donna,” “Knowing what they wanted: Each of them had a clear picture of their future, and those pictures didn’t cross over,” and “Culture: Paul was British and Suzie was American. Their families were different, their cultures were different, and this seemed to contribute to a general lack of understanding between each other.” The concept of this category overlaps somewhat with the Individual Characteristic category of Rigidity, but in the cases presented here, participants were characterizing the couple dynamic as polarized, rather than only one person being inflexible.

Sex/affection.

Participants illustrated the importance of sex and affection by including it as an impactful couple dynamic factor for both reported successful and unsuccessful couple therapy. Regardless of outcome, participants included the quality of sex, the amount of affection in the relationship, and the connection between emotional and physical intimacy as important components of Sex/Affection that influence the outcome of couple therapy. According to one participant, “Intimacy: Great sex” contributed to the perceived successful outcome of that case of couple therapy. In contrast, another participant explained that “Intimacy behaviors: Sexual behavior was scheduled, predictable and unsatisfying” contributed to the case being unsuccessful.

Along with quality of the sexual relationship, affection and emotional connection were integral aspects of this category. A participant who reported a successful outcome wrote, “Quality of affection: We discussed both of their needs for affection and ways they needed affection displayed as part of daily requirements (their determination as daily) to enhance

relationship, trust, intimacy.” Whereas what contributed to the reported unsuccessful outcome, according to a different participant, was “Low level of affection: Difficult for either spouse to show affection to the other.” A participant who reported a case of successful couple therapy explained the connection between emotional and physical intimacy in this way:

“Strong attachment: Despite all the many difficulties, this couple has a powerful pull towards each other that keeps them engaged and trying. Some of this is sexual but also emotional. Even when not obvious, something works.”

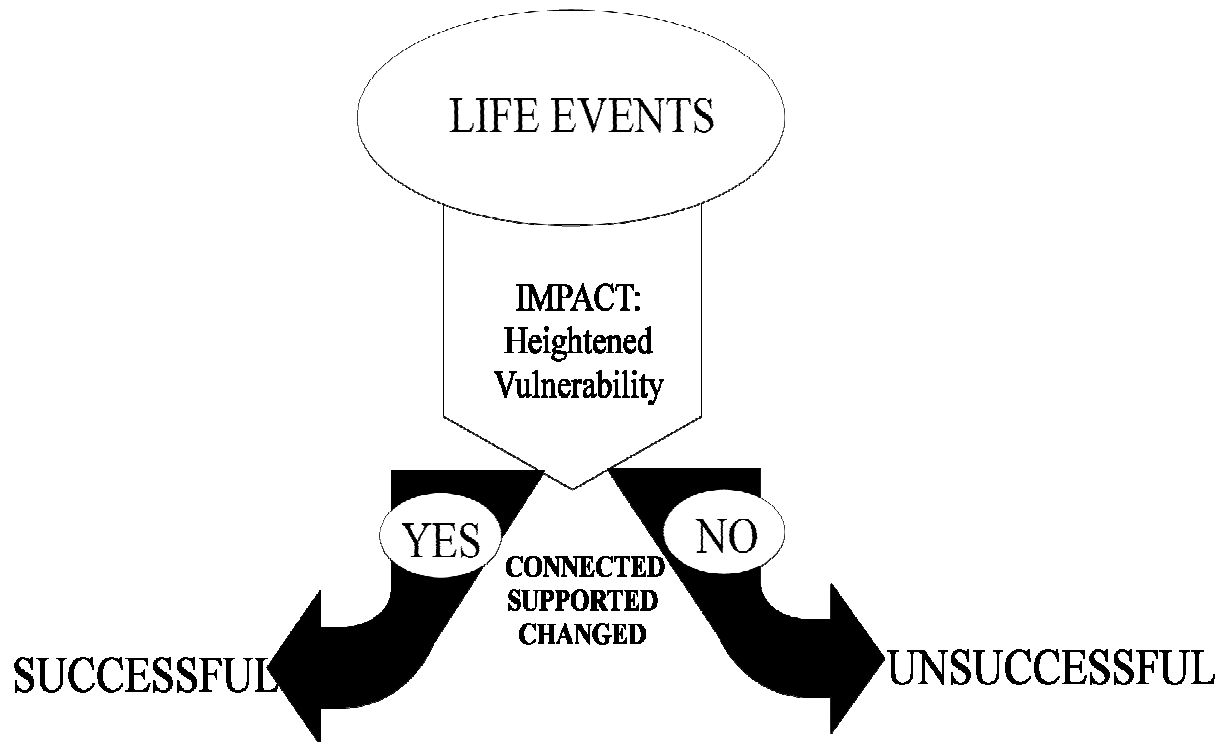
Participants mentioned lack of sex as a couple dynamics characteristics that influenced couple therapy to be unsuccessful. This was delineated as lack of desire or a lack of opportunity, at times due to a medical condition. In some cases, this lack of sex was mutually agreed upon by the partners, but more often, it was one-sided. The partner who did want sexual relationships was described as angry or hurt, as seen in this example, “Intimacy was withdrawn: Charlize would not have sex and had not for 6 months, nor would she ever instigate leaving Scott feeling undesirable.”

Indirect impact of life events on couple therapy outcome.

Life Events included key aspects of a clients’ situation (e.g., social support, financial stress), tragedies, and expected or unexpected changes in a clients’ situation, which includes life stage transitions. The major theme that ran throughout the Life Events provided by participants was that participants often reported the life event and then provided information regarding *how* that life event impacted the perceived outcome of couple therapy. In contrast, when participants were describing individual and couple dynamics characteristics, participants did not explain *how* the characteristics impacted the outcome of couple therapy, they just stated that it did impact the outcome. The message from participants seemed to be that the life events themselves were not

what mattered, but that significant life events created vulnerable moments, and a couples' response to those life events could have an extremely dramatic impact on that couples' future. This concept is visually displayed in Figure 2. For example, when describing two separate cases, participants listed nearly the same event (i.e., death of a loved parent), but then explained nearly opposite impacts (i.e., a partner was tender and supportive during this time which influenced successful couple therapy vs. a deep hurt created when a partner missed the funeral for a work obligation, which influenced unsuccessful couple therapy). The sections that follow provide the categories of life events as well as the categories reflecting the ways the events impacted the couple.

Figure 2: The Impact of Life Events



Specific life events.

Life Events participants discussed (in addition to the literature-based client factors) centered on these main categories: Affairs, Instances of Aggression or Disrespect, Events which

Highlighted Change or Lack of Change, Family of Origin Issues, Life Situations, and Substance Use. As explained above, the life events themselves did not tend to be directly connected to the participant-perceived successful or unsuccessful outcome of couple therapy, but was moderated by the impact the event had on the couple's relationship.

Affairs.

Thirty-six participants listed at least one affair as part of the Life Events that contributed to the perceived successful or unsuccessful outcome of couple therapy. The affairs described ranged from suspected to actual affairs, from emotional to sexual affairs, from one-night-stands to 20-year long affairs. Some affairs occurred years ago and others happened during the course of couple therapy; some were secret while others were initially encouraged by the person's partner. In a reportedly unsuccessful case, Jennifer's affair was described as "Infidelity: Jennifer chose to maintain and pursue a relationship that originally began through encouragement by Harold. Jennifer finally chose this relationship and discarded her marriage."

A few of the affairs which were described included a context that made the affair seem more painful. For example, one participant wrote, "The discovery of the extent of Tom's betrayal: Connie discovered before the last session that the other woman had written checks totaling more than \$100,000 during their affair, while she was struggling financially." Most participants described affairs that were sexual, somewhat ongoing, and recently revealed. "He kept cheating," one participant wrote, "He continually lied, maintained his secret life and cheated." Participants emphasized whether the partner who had the affair had cut off emotional and physical contact with that person or not.

Instances of aggression or disrespect.

Descriptions of Life Events that included aggression and disrespect were combined because they were both described as insulting and demeaning for the other person. This sense is captured by the participant who listed “Parenting problems” as an event that influenced couple therapy to be unsuccessful. The participant continued, “The children violated Tania’s personal space and belongings without meaningful interventions from Caleb.” That sense of violation is seen through many of the events described in this category, whether or not actual abuse was mentioned. Some of the events were described as stemming from the influence of alcohol and some were described as outbursts, such as the participant who wrote, “Chad became rageful and threatened suicide: Chad initially complied with Fran’s request that he temporarily live separately, but returned one weekend and asserted his right to live in the house. When Fran insisted that he not move back in, he began throwing objects and breaking things and threatening to kill himself.” Participants also mentioned sexual insults or abuse, verbal abuse, and actual and threatened physical abuse.

Events which highlighted change or lack of change.

Seven participants described eight life events in which it was apparent that one or both partners in the couple were not making changes. One participant described a Lack of Change event as, “No attempts to change: Conflict continued to escalate, or was sought to be avoided.” Another wrote, “Lack of affection or gratitude: Bill wanted affection or gratitude between sessions in a very specific manner and Amanda did not meet his expectations.”

In contrast, other participants specifically listed instances in which clients made changes. Because successful couple therapy is defined as making significant desired changes, it is no surprise that all but six of these events were perceived as influencing couple therapy to be

successful. Some of the changes described overlapped with the Literature-Based code, “Quality of Participation;” for example, one participant wrote, “Practice: Both people willing to practice their new communication strategy.” When participants included the impact of the event, they often mentioned that the event helped the couple connect emotionally and see each other differently. “Sharing about the past” was recognized by one participant, “Bonnie was able to reveal to Dan about her past relationships and how these relationship experiences may influence her perceptions of his behaviors. This event increased understanding and compassion between partners.”

Family of origin issues.

Several participants mentioned that a client’s experiences with his or her family of origin (the family in which the client was reared) impacted the outcome of couple therapy. In some cases, clients’ family of origin history or current situation was just painful. One participant poignantly described the lasting impact of one client’s early family experiences by relating, “Family of origin: Teresa’s father gave her negative messages about sex (women who have sex are sluts, sex is bad, etc.), and in fact she believed her first sexual experience and her father’s death a week afterward were somehow related. These messages had a powerful effect on her.” Family of Origin patterns were also described as being repeated in the clients’ marriage. One participant described, “Tina’s mom insulted: Joe had conflict with Tina’s mom and insulted her in similar way to how he insults Tina.” In a couples case reported as successful, a participant wrote, “Observing family dynamics: Both Moriah and Tim were able to see each of their parents models of how to be in a relationship clearly for the first time. . .”

Many of the events coded as Family of Origin Issues had to do with one partner having good (often enmeshed) relationships with his or her family, but conflict between that person’s

family of origin and his or her partner. For example, one participant wrote, “Her parents’ disapproval: Her parents were not supportive of the relationship (he was older than she was) which made their work toward a more successful relationship difficult because her parents were very involved in her life.” Some participants reported that clients stood up to their parents during the course of couple therapy and set boundaries. Other participants reported that a family of origin was extremely supportive of the couple. One such participant said that “family support” influenced the couple therapy to be successful. According to this participant, the couple had two children who were severely disabled and “Fia’s family was very supportive in helping with the children so that Fia and Jorge could have individual and couple time without worrying about the children.”

Life situations.

Life Situations encompassed a variety of types of contexts and couple choices, but all included participants’ descriptions of a situation which contributed to the perceived outcome of couple therapy. The Life Situations were grouped into codes of Life Situation Changes, Illnesses, Separation or Reunification, and Proximity of the Partners. Some of these situations were out of the couples’ control, some were the choice of the couple as a unit, and some situations were the cause of one partner’s decision. For example, when describing a Life Situation that was the choice of one partner, a participant wrote, “School: She was trying to finish school and go to community college in addition to finding a new job.” Another participant described a Life Situation Change that both partners agreed to make, “Moving: Although the move was stressful, both Donna and James believed this could be a new start for them and get them away from old influences and a support system they didn’t want to have anymore.” A back injury provides an example of an Illness Event that was out of the couples’ control, “Maggie’s Injury: Several years

prior to entering couple therapy, Maggie fell and suffered a severe back injury. She had surgery, which was reportedly botched, resulting in chronic severe back pain with no apparent medical cure.” One participant reported a Proximity Life Event which was one partner’s decision, but was described as prioritizing the couple, “Robert retired from performing: Robert decided that his performing career interfered with his relationship with Donna and he looked for a job that would keep him closer to her.”

Addictions.

Twenty-three participants referred to addictions 29 times as a factor that influenced the perceived successful or unsuccessful outcome of couple therapy. Most of these addictions were alcohol, although some were drug addictions, and pornography use was included if the participant specifically called it an addiction. Gambling was also mentioned in connection with the other addictions. Several participants reported that, in addition to the addiction, clients’ actions when they were under the influence of alcohol created problems for the couple and impacted the outcome of therapy. One participant wrote, “Suicide attempt: Frank got drunk and put his head in an oven with the gas turned on. He was found by their little girl.”

Several participants noted that they referred clients to addictions treatment when the addiction became apparent in couple therapy. For some, this influenced couple therapy to be successful. One case in which substance abuse treatment was helpful was reported by the participant who wrote, “Betty stopped drinking: many of the fights occurred when Betty was drinking alcohol. Stopping the drinking enabled them to discuss and deal with problems in a more positive way.” However, not all of the addictions treatments were effective, as one participant explained, “Therapy for drug use: Jamie found therapy that minimized his addiction problem and thus could minimize Chris’s concerns in our sessions.” Even when addictions

treatment was effective, participants reported a few instances when it influenced couple therapy to be unsuccessful. For example, “Drug abuse, relapse” one participant began, “Both partners used drugs in the past but quit; Both partners also stopped drinking alcohol, but Ernie resumed drinking.”

Means through which life events impacted couple therapy outcome.

Occasionally, participants’ comments went beyond simply listing the Life Events and delved into explaining how the couple’s relationship was different because of that life event. Those comments seemed especially worthy of noting since this happened very often, and were not at all prompted by the survey questions. The overarching message seemed to be that clients were particularly vulnerable to each other during significant Life Events and these events created an opportunity for the clients either to set a new tone for the relationship or to highlight that change was not going to happen. That is, clients’ responses to these Life Events either provided new hope for the couple or emphasized the relationship difficulties. Several categories emerged when participants’ explanations of the significance of the life events were analyzed. The most common categories included Sense of Couple Identity, Stress, New Awareness, Level of Plasticity, and Impact on Logistics of Couple Therapy.

Sense of couple identity.

A sense of client vulnerability to each other was threaded through many of these participants’ comments. Participants described Life Events as opportunities for the couple to connect and support each other or to make the relationship a priority. Regardless of the actual life event, when opportunities to connect, support, and privilege the relationship were taken, participants identified the life events as influencing couple therapy to be successful. A “Job crisis” was one opportunity that was seized, according to one participant; “Simon took gamble

and quit job he didn't like ... Bunny supported him." The participant reported that this influenced couple therapy to be successful. In another case reported to be successful, the participant said "Fatherhood" was the Life Event. "During one of their conversations," the participant continued, "he was able to communicate his own self-doubts about being a father for her children. Knowing that his wife could be accepting of his input and that the children respect him as "dad" made a huge difference in their own relationship."

In contrast, when life and life events get in the way of the couple's ability to connect and support each other, and they instead go in different directions, participants identified these events as impacting couple therapy to be unsuccessful. Work got in the way of connecting for several couples. "Business demands," as one participant put it, "Vince's business has grown to include hundreds of employees and international business and Vince is frequently away from home." "Ann's mother visited," another participant listed, "Ann was close to her mother in a way that made Brian feel excluded, and made Ann feel disconnected from Brian."

Stress.

Participants described life events that decreased stress and life events that increased stress for the client couple. Stress came from all of the previously described life events and exhibited itself in many forms, including time demands, money difficulties, pressure to connect, and pressure from outsiders. "Daughter moved in" was the Life Event listed by one participant. The couple's stress could be either increased or decreased by that event, but this participant continued, "Adult child moved into the home, able to assist with childcare, provided distraction and focus outside of relational conflict." For this case, the participant indicated that this Life Situation Change influenced couple therapy to be successful. However, one participant wrote, "Birth of child: Vinnie unable to emotionally connect. Veronica became more insistent that he

did which led to Vinnie feeling more intruded upon and pressured.” This participant identified this case as unsuccessful.

Although the trend was that decreased stress contributed to successful couple therapy, and vice versa, this was not always what participants described. One participant who identified his or her couple therapy case as being successful, listed “Financially motivated” as the Life Event and expounded, “had recently moved into a condo. Both were worried about having to sell if they couldn’t save the marriage.” Another participant believed that the decreased stress of “Dismissal of domestic violence charges” contributed to the couple therapy case being unsuccessful because, “After domestic violence charges were dropped, clients cancelled shortly afterward. Believe motivation to address communication diminished.”

New awareness.

When a client in couples counseling experienced a dramatic life event and reflected on that event, participants reported that these life events, at times, impacted the outcome of couple therapy by creating a New Awareness in the client. These instances of New Awareness seemed to be either a deliberate re-evaluation or an “Ah Ha” moment as a person saw himself or herself or his or her partner differently in an instant. The deliberate re-evaluations which participants described can be exemplified by the participant who listed “Infidelity” as the Life Event. According to that participant, the impact of the infidelity was that “Anita chose to maintain and pursue a relationship that originally began through encouragement by Jose. Anita finally chose this relationship and discarded her marriage.” Another type of re-evaluating occurred when individuals deliberately learned about family of origin or personal issues. Ariel and Jacob did this, according to one participant, through the event, “Visits with Family of Origin.” That participant described,

“Both Jacob and Ariel had several visits with their parents during marital therapy. During those visits they could see some of the sad things in their parents’ marriages. This increased their motivation and respect for each other. They also became aware of regressive behaviors that they practiced around their parents; which they sometimes practiced with each other. In both sets of relationships those regressive behaviors were unsatisfying and stagnating. . .”

Other participants also described sudden “Ah Ha” moments of New Awareness. One such experience was described by one participant as, “Rekindling love: Travis’ near death reminded them both of their deep love for each other.” According to another participant, Mike’s Life Event of “Quitting drinking” prompted change in that, “Mike quit using alcohol while in therapy and recognized his dependence as a major factor in his difficulties.” Both of the previous cases were perceived as having a successful outcome. In the case in which the Life Event was “Breast cancer,” the couple therapy was reported to be unsuccessful. The participant described the impact of the event by explaining, “Wife had breast cancer and decided that she needed to be more demanding of the life she wanted.”

Level of plasticity.

This code was named Level of Plasticity, with *plasticity* referring to the clients’ ability to adjust as needed and act appropriately in his or her current situation, to be shaped as needed without breaking. Participants described clients with Appropriate Plasticity (which influenced successful couple therapy) and clients with Inappropriate Plasticity (which influenced unsuccessful couple therapy). Participants described clients with Appropriate Plasticity as clients who were able to make good personal decisions, learn to stand up for themselves, and set appropriate boundaries. One such case was described as “Healthier boundaries: They chose to

have increased healthy boundaries with those who were causing stressors in their relationship and increased supports from those who were supportive of their success in staying together. . .”

Another client’s changes were described by the participant as:

“Denise confronting her parents: Denise has been abused verbally and emotionally by both her parents. In the sessions, she came to understand that her anxiety and lack of confidence was a result of her parents’ treatment of her. She successfully confronted both parents. Her father handled it perfectly and apologized. Her stepmother was manipulative and dismissive when confronted. Denise was able to handle both parents appropriately. It was very freeing to her.”

In contrast, other clients were described as having low or Inappropriate Plasticity for their situations, specifically, these clients had difficulty adjusting to new Life Stages, had personal issues that expounded problems, were manipulated or manipulative, and responded to their present situation based on their past experiences. “Childhood trauma” was listed by a participant as influencing the outcome of couple therapy and was explained as “John grew up very poor and when he finally had some money of his own, he guarded it closely. When they entered into marriage, it was very important that he kept what was coming in separate, “just in case it didn’t work out.” Another participant reported “Emotional Meltdowns” as the Life Event, and described, “As therapy continued, Albert came to the point where he began to tell Roberta he wanted to leave and her response was a meltdown. It appeared that Albert stayed because this was his way of stopping Roberta’s meltdowns.”

Impact on logistics of couple therapy.

The majority of participants’ comments focused on the couple, but at times, participants interjected information about other aspects of the cases, such as the participants’ reaction to the

clients, the client-clinician relationship, and logistics of the couple therapy. These participants noted that certain events directly impacted not only the couple and the outcome of couple therapy, but also the logistics of couple therapy, such as scheduling and payment issues. Most of these comments centered on whether the couple had resources to attend couple therapy. The main three areas seen in this category are resources, expectations, and willingness. In describing limitations of resources, one participant listed the Life Event as “Finances” and then explained the situation and impact by writing, “The couple was hoping that each could find a job in the near future and was worried about being able to afford therapy until they did find jobs.”

The couple’s expectations of couple therapy also impacted the perceived outcome of couple therapy. The participant who wrote “Quick fix” as the Life Event explained, “They decided they would give this seven weeks to “heal” the relationship. They wanted to be on a time schedule for relationship health without doing the work.” One client’s willingness to attend therapy was hindered by a different experience of success. That participant wrote, “ADHD Dx: Clark was clinically diagnosed with ADHD; created excuse to “quit” therapy because he was on drugs and feeling better.” Another participant described the problem as “Actors,” and continued, “Both were actors and often had auditions on the day of therapy, so were less focused on the work of therapy. Example: Marsha would not want to cry if she had an audition.”

Summary

In the qualitative data, participants described complex cases and often included contextual information. The individual, couple dynamic, and life events categories were both unique and overlapping. Participants described individual characteristics of two people that interacted to create patterns of couple dynamics and were highlighted by life events. Life Events

themselves did not impact the outcome of couple therapy, but created vulnerable moments in which each individual's reactions were more poignantly experienced.

Chapter V: Discussion

Building on the research, theory, and calls for research on client factors in couple therapy (e.g., Gottman & Notarius, 2002; Snyder et al., 2006), this project explored clinicians' perceptions of which client characteristics, couple dynamics characteristics, and life events influenced the successful or unsuccessful outcome of couple therapy. To address the contradictory and incomplete literature on client factors (Atkins et al., 2005), the current project focused on answering the following three research questions:

1. Which client factors identified in literature do clinicians perceive to influence the outcome of both successful and unsuccessful couple therapy cases, and what is the relative influence of those client factors?
2. What were the differences in those client factors that participants rated as contributing to successful couple therapy and those that they rated as contributing to unsuccessful couple therapy?
3. What client factors not reported in the literature do participants believe contribute to the outcome of successful and unsuccessful couple therapy?

Comparing Participants to AAMFT Members

According to Cook, Heath, and Thompson (2000), the representativeness of a sample to the population is more important than response rate in determining the usefulness of the data. The population for this study included credentialed helping professionals who work with couples. To provide a sense of whether the participants might be typical of clinicians who work with couples and families, the demographic information of the American Association of Marriage and Family Therapists (AAMFT) was used for comparison. AAMFT publishes limited demographic information of members on its website

(http://www.aamft.org/resources/Advertising_Opportunities/Demographics.asp). Table 19 and Table 20 compare the characteristics of AAMFT members to the characteristics of participants.

Table 19

Comparison of Demographics of AAMFT Members versus Study Participants

	AAMFT Members	Study Participants
Caucasian	91%	84.4%
Female	60%	66.6%
Mean age (in years)	54	47.4 (<i>sd</i> = 13.3)
Mean years in clinical work	17	12.8 (<i>sd</i> = 11.4)

Table 20

Comparison of Professional Identity of AAMFT Members versus Licensure of Study Participants.

AAMFT		Participants	
Identity	%	Licensure	%
Marriage & Family Therapist	81	LMFT	39.4
Psychologists	7	Psychologist	16.1
Professional Counselors	4	LPC	17.3
Pastoral Counselors	2	Minister	5.8
Other	2	LCSW	12.6
		Intern/Training	13.1
		Other	

The AAMFT website reported that 91% of AAMFT members are Caucasian, 60% are female, the average age is 54 years, and AAMFT members had been practicing clinical work for

17 years, on average. Regarding professional identities, 81% of AAMFT members reported that they identified as marriage and family therapists, 2% reported to be psychologists, and professional counselors comprised 4% of AAMFT members. Another 2% of AAMFT members were pastoral counselors and 2% reported that their professional affiliation was not on the list of options. Participants for the current study were similar in ethnicity, with a higher percentage of minorities participating in the study than were members of AAMFT. The percentage of female participants was 6.6% higher than the percentage of AAMFT members who were female. Participants' average age and years in clinical work were both lower for this study, but the AAMFT Membership averages were within one standard deviation of the participants' mean. Ethnicity, gender, age, and years in practice were very similar between AAMFT members and study participants. When comparing the professional identity of AAMFT members to the reported licenses held by AAMFT members, several differences were apparent. Although 81% of AAMFT members identified as marriage and family therapists, only 39.4% of participants reported that they were licensed as marriage and family therapists. A higher percentage of participants than of AAMFT members identified or were licensed as psychologists, professional counselors, ministers, licensed clinical social workers, and other clinicians.

Based on these data, it appears that the participants had similar demographic characteristics to AAMFT members, but came from a broader range of helping professions. It could be possible that the survey did not reach many AAMFT members due to the inability to contact AAMFT members directly. It could also be possible that AAMFT members chose to participate in this research less frequently than did other helping professionals.

Discussion of Findings

To address the lack of cohesiveness in research on client factors, Clarkin and Levy (2004) recommended that a constellation of client factors be developed. They, like others, noted that research on client factors currently offers only a fragmented sense of client factors that impact the outcome of therapy (Atkins et al., 2005; Clarkin & Levy). The current disconnected picture does provide valuable information, but lacks a sense of the landscape of client factors that need to be considered. Because the client factors research is fragmented, sections of the findings for the current study do not clearly connect with previous research. This could indicate that the current findings are indeed providing the larger picture landscape into which previous research fits. Therefore, findings from the current study will be connected to previous research when possible. However, some of the findings seem to be filling in the gaps in previous research and thereby do not seem to directly connect with prior studies.

While the research questions worked in guiding the separate analysis of the qualitative and quantitative information, the discussion focuses on merging the qualitative and quantitative findings. Therefore, the discussion first addresses the questions, “*Which client factors did participants perceive to influence the outcome of most cases of couple therapy?*” and “*What were the differences in client factors that participants perceived as contributing to successful couple therapy and those that they perceived as contributing to unsuccessful couple therapy?*” Implications for theory, research, and clinical work will be included. This discussion chapter concludes with a summary of the strengths and limitations of this study.

“Which client factors did participants perceive to influence the outcome of most cases of couple therapy?”

There were four main findings regarding the client factors that influence the outcome of most cases of couple therapy, regardless of successful or unsuccessful outcome. Each of these findings will be described below and explained in the context of current research. First, five categories described the focus of couples in a way that could allow clinicians to conceptualize the couple as a unit; second, in most cases, a wide variety of client factors contributed to the outcome. Third, every client factor was vital to some couple therapy cases, and finally, clients' life events set up pivotal moments and indirectly impacted couple therapy outcome.

Overall finding #1: Five arenas of couple focus.

The principal components analysis (PCA) components of the data from all cases seemed to describe the couple as a unit, based on the current main focus of the couple. The PCA components that described couples could be seen as Relationally-Focused, Values-Focused, Outward-Focused, Individually-Focused, or Task-Focused. These couple descriptions were:

1. The Relationally-Focused couples were couples who were open to each other, emotionally responsive, had a positive view of each other, were motivated and participated in couple therapy, were committed to the relationship, and could solve problems together.
2. The Values-Focused couples were couples who were impacted by the fact that they had been married several years and had children together, who were resilient, religious, and intelligent. It could be that these couples were able to gain perspective by thinking through what matters to them, and then acted based on their values.
3. Couples described as Outward-Focused were couples in which most of their energy was taken by job and/or financial stress, pressure in life, or recent tragedies, who were

focused on their transition into another stage of family life, and who relied on social support.

4. Some couples seem to be de-railed by individual issues. Those couples were Individually-Focused couples. Most of the energy of Individually-Focused couples seemed to be focused on dealing with individual pathology in the history of one or both of the individuals, personality issues, or the resistance or reactivity of the individuals.
5. Finally, Task-Focused couples were couples whose relationship was focused on the to-do list of family life; these couples were consumed with who does what. They focus on whether the tasks were equally distributed and whether they will follow stereotypical gender roles or not.

When entered into a regression equation, which predicted the perceived outcome of couple therapy, these components accurately predicted the perceived outcome of couple therapy 85.9% of the time. Compared to the regression equation which started with 25 client factor variables, the regression equation using the PCA components was only 2% less accurate at predicting outcome. That suggested that these five PCA components could be a simple, concise, relationally-focused way to understand the client factors that impact the outcome of couple therapy.

Overall finding #2: A hierarchy of client factors.

The second main finding regarding client factors that were perceived to influence the outcome of couple therapy was that *many* client factors were reported as influencing the outcome of most cases of couple therapy. So many were influential, in fact, that it became difficult to distinguish which were the most influential. This was congruent with theorists' perceptions of client factors, as illustrated by the multiple lists of client factors provided in the various chapters

of Hubble and colleagues' text (1999). Each author provided a list of client characteristics, and while some of the lists overlapped, each was largely unique.

Although simple data, the descriptive statistics of participants' ratings of the impact of the client factors on the outcome of couple therapy provided valuable insight into their perceptions. Forty percent of the 25 variables presented were considered to be factors in 90% of the couple therapy cases discussed, while only three variables were considered to be factors by 75% or fewer participants. This demonstrated that nearly all of the client variables listed were important in most couple therapy cases.

Combining the ratings of client factors with the qualitative information and the PCA components indicated that some of the most influential client factors for all cases centered on the connection that the couple had with each other (willingness to be open with each other, emotional connectedness), their commitment to the relationship, participation in therapy, and individual characteristics (responsibility, personal history, level of individual pathology).

Several previous research findings connected with these important client factors, but no previous research provided a complete picture. The importance of an emotional connection was emphasized by both Gottman and Gottman (2006), who proposed that friendship is the key to a successful marriage, and by emotionally focused couple therapy, which was based on the concept that the individuals in a couple need a deep, safe, emotional connection with each other (Johnson, 2008).

Gottman and Gottman (2008) posited that couples connect when they respond to each other's bids, or small requests for attention. They explain that when the individuals in a couple were responsive toward each other, they were then able to move up the "*emotional connection hierarchy*" (p. 149), which included "(1) attention, (2) interest, (3) conversations of various types

..., (4) shared humor, (5) affection, and (6) emotional support and empathy” (p. 149).

Participants in the current study described clients being open to each other as very important to the outcome of couple therapy. They also described humor and affection as individual characteristics or actions from which the other person also benefited. Connecting this with Gottman and Gottman’s explanation of the emotional connection hierarchy could indicate that when couples are open to each other and responsive even to simple bids, they were able to share in enjoying each other’s individual characteristics of humor and affection, and this directly led to a more meaningful emotional responsiveness and connection within the couple.

The importance of a couple’s commitment to the relationship and to therapy confirmed previous research. Commitment was the only consistently significant client factor in the studies reviewed in the literature review (Atkins et al., 2005; Baucom et al., 2009; Smith et al., 1994; Whisman et al., 1997). Davis and Piercy (2007b), in interviews with clinicians and their clients, found that the client factors of a) humility (which is needed for couples to be able to connect as described above), b) commitment and hard work, and c) psychological/systemic awareness influenced the successful outcome of couple therapy. The current study consistently confirmed the importance of client commitment to the relationship and to therapy, although commitment was reported to have more influence in successful cases than lack of commitment had in unsuccessful cases.

Findings from the current study could be seen as combining the above points into an overall picture of successful couple therapy prognosis for couples:

1. who are *open* to
 - a. connecting with each other
 - b. facing personal issues, and

- c. new ideas in therapy,
2. who are *committed* to the relationship and to couple therapy, and
3. whose *personal issues* do not get too much in the way of the progress of couple therapy.

Any one of the above components being missing or opposite might hinder the success of couple therapy. While these more specific client factors do provide useful details, it is worth noting that these client factors are largely seen in the PCA components described previously.

Overall finding #3: What matters for this case matters for this case

Although research is interested in presenting findings with broad applications, one of the key findings of the current project was that every case of couple therapy was unique.

Highlighting this concept was the descriptive finding that every client factor from the literature-based list was vital to the outcome of some cases of couple therapy. This finding may help explain the inconsistent findings of previous research on client factors (Atkins et al., 2005).

Statistically, when the variance of client factors within any group is so great, it is difficult to find consistent, significant differences between groups. This finding that a less-frequently important client factor may be vital to a few cases may also help explain the tremendous variety of ways that theorists and researchers describe client factors.

Overall finding #4: The indirect impact of life events

In his study of client perceptions of couple therapy, Olson (2001) interviewed clients about experiences that led to change in their relationships. He found that clients discussed out-of-session experiences that led to change. Olson highlighted that the key to these out-of-session events was that they were emotionally charged in some way. His participants described that, in these experiences, there was a shift in perception or experience that opened the way for change

to occur. In the current study, participants were asked to list clients' life events that impacted the outcome of couple therapy. Many participants also spontaneously described the impact of the life event. The fact that so many participants provided similar types of unsolicited information heightened my perception of the importance of this information. The description of the impact of life events from participants in the current study mirrored Olson's findings. This replication of findings is particularly noteworthy because Olson interviewed clients, while participants for the current study were clinicians. It seems that clients and clinicians describe the impact of clients' life events similarly.

In their case study of one case of couple therapy, Blow and colleagues (2009) emphasized the significance that the couple's unexpected life events had for the outcome of this case. Based on their analysis of this case, Blow et al. (2009) concluded that "extratherapeutic events occur frequently, often without warning" (p. 359). The authors continued, "in some cases these events may represent the key doorway or perhaps the only chance to address the couple's underlying issues" (p. 365).

Congruent with Olson's (2001) participants and with Blow et al.'s (2009) conclusions, participants of the current study also explained that if clients responded to life events by being supportive, caring, and making changes, then couple therapy was influenced to be successful. On the other hand, clients' responses to life events which were unsupportive, did not create connection with the other person, and repeated problematic patterns, influenced couple therapy to be unsuccessful. Participants did not connect any particular types of life events with successful or unsuccessful couple therapy outcome, indicating that the event itself was not the key. In fact, very difficult life events often contributed to successful couple therapy outcome, as

noted by Blow et al's case study. Blow and colleagues noted, "even the worst events present an opportunity for change that might be missed if they are only viewed as negative events" (365).

Participants did not describe individual characteristics or couple dynamics as turning points or "Ah-Ha" decisive moments, but did describe life events as prompting these moments of awareness in which the fate of the couple was determined. It is possible that the clients' participation in couple therapy allowed clients to be self-aware, which may have increased the impact of live events.

What were the differences in client factors that participants perceived as contributing to successful couple therapy and those that they perceived as contributing to unsuccessful couple therapy?

In addition to the above client factors, there were differences in the client factors that influenced successful couple therapy and the client factors that influenced unsuccessful couple therapy. Before considering the specific client factors, two aspects of these data are important to note. First, Mann-Whitney U results showed that there was a difference between successful and unsuccessful therapy groups in the medians of 15 of the 25 client factors which had been identified in the literature. Most of these differences were confirmed by the qualitative data. While this did indicate a significant and meaningful difference between groups for these data, most of the client characteristics had means that indicated that they did impact the outcome of couple therapy for both groups. This leads to an interesting both/and conclusion, in which there were both significant differences between groups and indications that the client factors impacted the outcome of both groups, albeit in different directions.

Four findings highlighted the differences in which client factors influenced couple therapy to be successful and which client factors influenced couple therapy to be unsuccessful. Each will be explained below in the light of current research.

Differences finding #1: Five arenas of couple focus

Using couple typologies to predict outcome is not a new idea. Both Gottman (1993) and Fowers, Montel, and Olson (1996) used their couple typologies to predict whether couples remain married or separate/divorce. The five arenas of couple focus from the findings of the current study differed from previous research in that the typology was different and the arenas were used to predict the outcome of couple therapy rather than to predict divorce. The PCA components predicted whether a participant was discussing a successful or unsuccessful couple therapy case 85.9% of the time. In this analysis, the Outward-Focused component did not help to predict whether a participant was describing successful or unsuccessful couple therapy. The Relationally-Focused and Values-Focused components were the strongest predictors, and higher scores on these components increased the prediction that successful therapy was being discussed. The Individually-Focused and Task-Focused components were also significant predictors, but higher scores on these components influenced the equation to predict that unsuccessful therapy was being discussed.

When compared to the regression that used all the individual characteristics, the PCA analysis chose from five independent variables rather than 25 to predict whether a participant was discussing a case of successful or unsuccessful couple therapy. In addition, the regression with the PCA components as independent variables was only two percent less accurate in predicting outcome than the regression equation which used all 25 client factors as independent variables. The regression indicated that the PCA components allowed for quite accurate

prediction using five components rather than 25 individual variables. Further, the five components were made of the 25 variables, which allowed the five components to capture the impact of nearly all of the 25 variables.

Differences finding #2: Overcoming Obstacles vs. Unable to Recover

Principal components analysis was conducted separately for data from successful and unsuccessful couple therapy cases. The results were quite different, which could indicate that different patterns of client factors may have some influence on the outcome of successful or unsuccessful couple therapy. For successful couple therapy, the resulting principal components were Overcoming Obstacles and Invested. These two components accounted for 29.6% of the variance in the data set, leaving 70.3% of the variance unaccounted for. The PCA component, Overcoming Obstacles, was comprised of common stressors such as job stress, life stage transition, and financial pressure. The Invested component was made of the variables of positive regard, openness, emotional responsiveness, commitment, quality of participation, and resiliency. These two components together may indicate that couples who come to couple therapy to work through a difficult situation, but who are committed to each other and the therapy and are able to connect with each other are likely to be successful in couple therapy.

For unsuccessful couple therapy, participants' data were grouped into principal components which were named Unable to Recover, Relationally Passive, and Intransigent. Together, these three components accounted for 37.9% of the variance in the data set. These components could indicate that couple therapy cases were derailed by many unrelated variables that continually threatened the success of therapy, by a relationship which was characterized by lack of energy, and by at least one person who was resistant.

The PCA results for the contrasting successful vs. unsuccessful cases overlapped in that several variables contributed to the first PCA component of both sets of PCA results. The similarities seemed to indicate that all couples being discussed were struggling with difficult situations. Successful cases may have had the benefit of resources as indicated by the variables Problem-Solving Skills and Social Support. The differences between the successful and unsuccessful cases are also apparent in the variables which are included in the first PCA component for unsuccessful couple therapy, but are not included in the first PCA component for successful couple therapy. These variables include Lack of Motivation, Intelligence, Lack of Commitment, Low Quality of Participation, Contempt for Each Other, and Lack of Resiliency. That these are highlighted in the unsuccessful cases may indicate that all couples in therapy face difficult situations, but the couples who are unsuccessful in therapy do not have a solid relationship connection or the resiliency to recover from difficult setbacks. Additionally, these couples may not have the commitment, motivation, and participation required to endure through the very difficult times in the relationship and in couple therapy.

These client characteristics, and their influence on the outcome of therapy, have not been addressed in any known literature.

Differences finding #3: Specific client characteristics

The ratings of the importance of literature-based client factors to the outcome of successful couple therapy or unsuccessful couple therapy only had one of the top five most influential client characteristics in common (the client characteristic that made both top-five lists was Level of Openness to Each Other). Table 21 summarizes the means and number of times a client factor was mentioned for the client characteristics which differentiated between successful and unsuccessful couple therapy outcome.

Table 21

Means and Number of Times Endorsed for Client Characteristics which are Different for Successful and Unsuccessful Couple Therapy

Characteristic	Successful		Unsuccessful	
	Qualitative	Quantitative	Qualitative	Quantitative
	<i>n</i>	\bar{x}	<i>n</i>	\bar{x}
Motivation <i>or</i> Lack of Motivation*	60	6.32	11	4.49
Commitment <i>or</i> Lack of Commitment*	100	6.27	13	4.21
Quality of Participation <i>or</i> Lack of Quality Participation*	85	6.14	38	3.68
Positive Regard <i>or</i> Contempt for Each Other*	85	5.99	24	4.69
Personal History*	6	5.22	31	5.6
Problem-Solving Skills <i>or</i> Lack of Problem-Solving Skills*	38	5.04	3	4.15
Personality	47	4.87	97	5.12
Length of Relationship*	11	4.55	3	3.33
Intelligence*	27	4.49	1	2.76
Resistance/Reactivity*	0	4.34	35	5.27
Individual Pathology*	3	4.32	48	5.01

* Mann-Whitney U results indicated a significant difference between the medians of this variable for participants discussing a case of successful couple therapy and participants discussing a case of unsuccessful couple therapy ($p \leq .002$).

According to both quantitative and qualitative data, the client factors that were more influential to successful couple therapy were Motivation, Commitment, Quality of Participation, Length of Relationship, Problem-Solving Skills, Positive Regard for Each Other, and Intelligence. When participants described Intelligence, they explained that the client was able to think rationally about the situation, recognize his or her own issues, and conceptualize the couple's interactional patterns.

In contrast, the most influential client characteristics reported by participants discussing an unsuccessful couple therapy case focused on individual factors. The client factors which participants consistently considered more influential for unsuccessful couple therapy than for successful couple therapy included Personal History, Personality, Resistance/Reactivity, and Individual Pathology. All of these client characteristics except Personality were found to have significantly different medians between successful and unsuccessful outcome groups by Mann-Whitney U tests. Qualitative data followed these quantitative trends, and the number of participants who mentioned a client factor increased as the mean for that factor increased.

These data seemed to suggest that it took a lot of work and willingness to be successful in couple therapy, but if one person had a difficult history, personality, or level of pathology, that person could close the other out and strongly contribute to couple therapy being unsuccessful.

Differences finding #4: Qualitative differences

In a previous study asking clinicians which problems and client factors they thought influenced the outcome of couple therapy, clinicians identified "lack of loving feelings, power struggles, communication, extramarital affairs, unrealistic expectations, inability or unwillingness to change, and lack of commitment" (Whisman et al., 1997, p. 361) as important problems and client characteristics. Research by Smith and colleagues (1994) confirmed that

clinicians perceived client commitment to the relationship and to therapy as “important for successful treatment” (p. 317).

The current study confirmed the importance of all of the above client characteristics, with the exception of the client characteristic of unrealistic expectations. However, participants did mention that clients were stuck or refused to see a situation from the other person’s point of view. This could be an indication of unrealistic expectations. Participants presented a larger scope of client factors which impacted the outcome of couple therapy.

In the current study, differences were seen in the client characteristics that participants described as impacting the outcome of couple therapy. The individual characteristics that participants mentioned as influencing couple therapy to be successful were responsibility and humor. In this case, the term “responsibility” described a willingness to be open to one’s own issues and to one’s part of problematic couple patterns. This characteristic seems similar to the client characteristic recognized in Davis and Piercy’s (2007b) study as Humility. Regarding humor, Gottman and Gottman (2008) also highlighted the value of humor in helping a couple move toward emotional intimacy. The couple dynamics characteristics that participants described as unique to successful couple therapy all fit within the literature-based codes; no new couple dynamics characteristics were suggested by participants as influencing the success of couple therapy.

For unsuccessful couple therapy, participants filled in gaps in existing literature by identifying individual characteristics and couple dynamics characteristics. The individual characteristics which participants identified as influencing couple therapy to be unsuccessful were Rigidity, the Four Horsemen, Lack of Trust, and Anger. Participants also identified four

problematic couple dynamic characteristics: a) Pursuit-Withdrawal, b) Boundary Problems, c) Control, and d) Stalemate.

Of these qualitative findings for unsuccessful couple therapy, the concept of the Four Horsemen, proposed by Gottman and Gottman (2008), has research support. Specifically, Gottman and Gottman (2008) have combined data on the Four Horsemen with additional data, and have predicted which married couples would divorce (or separate). No studies could be found which investigated the impact of the Four Horsemen on the outcome of couple therapy. It would make sense that client factors which predict divorce would also contribute to unsuccessful couple therapy, but no known literature has addressed this question. Some of the other client factors listed, while not directly addressed in studies of client factors which predict the outcome of couple therapy, may be confounding variables in other outcome studies. For example, Lack of Trust may be a confounding factor in research asking about the impact of affairs on the outcome of couple therapy. Similarly, anger may be an influential client factor in studies of the impact of domestic violence on the outcome of couple therapy. The four problematic couple dynamic patterns have not been collectively researched regarding how they impact the outcome of couple therapy.

Implications of the Findings

Theoretical implications.

This study confirmed that a wide variety of client factors permeate couple therapy. Although it is rare for clinicians to have the client as a core of their theory of therapy, a few do. For example, Bohart (2000) gave clients priority in his theory of therapy. He explained, it is clients who are the healers. Clients are intelligent, thinking beings who are not merely operated on by supposedly “potent” interventions and treatments which change

them. Rather, clients are active agents who operate on therapist input and modify it and use it to achieve their own ends (p. 132).

The book by Bohart and Tallman (1999) was based in this view of clients, and explained how clinicians join with the client in the work that clients are doing. In a slightly different approach, Duncan and Miller (2000) based their work with clients on the idea that the therapy needs to be congruent with the client's theory of change, and that the client needs to be the "star" and the "hero" of therapy.

Other clinicians took a more specific approach to working with client characteristics. For example, Epstein and Baucom (2002) talked about individual characteristics that influenced the outcome of couple therapy and how clinicians could tailor cognitive-behavioral couple therapy to couples based on the individual characteristics. Another example of considering client characteristics in the approach to therapy was provided by Borum and Philpot (1993), who considered the impact that the "high-risk lifestyle" of law enforcement work had on the couples with whom they worked. Borum and Philpot provided ideas about how to consider these factors in treatment with couples who fit this category.

There seem to be two possibilities for developing a more thorough, applicable theory of client factors that impact the outcome of couple therapy. One idea would be to develop a meta-perspective of therapy which could conceptualize the theory as part of what creates change. This meta-perspective would also consider non-theoretical aspects of change, specifically client factors, and would connect those non-theoretical aspects to the theory of therapy. Another possible approach would be for theorists to weave client factors into the theory itself, so that various aspects of the theory might be adjusted based on client factors. Because the second idea would be specific to each theory, the first idea will be explored.

Findings of the current study could be used to begin developing a meta-perspective of therapy which includes client factors (Bohart, 2000; Bohart & Tallman, 1999; Castonguay & Beutler, 2006; Duncan, Miller, Sparks, 2004; Gold, 2000). Because common factors cut across all theories of therapy, a meta-perspective based in common factors would likely be congruent with all theories of therapy. Findings from this study indicated that a meta-perspective of therapy which includes client factors would need to include information about which individual client factors promote healthy relationships, would need to consider the couple dynamic characteristics from a systemic, or interactional, perspective, and would need to address how life events can lead to pivotal moments. Additionally, a meta-perspective of couple therapy could include ideas about conceptualizing the couple as a unit, as was exemplified in the five arenas of couple focus in the current study.

One aspect needed in a meta-perspective of therapy which includes client factors is a sense of which client factors contribute to healthy and to dysfunctional relationships. At one point, while I was deeply engrossed in reading through the 2,771 client characteristics which participants described, I forgot that clinicians were describing client factors which impact therapy. Participants just seemed to be listing what people do to make relationships healthy or dysfunctional. This made sense, as most theories of couple therapy strive to help couples move from dysfunctional to functional (Gurman, 2008). Davis (2005) described this connection between theory and healthy relationship functioning by writing,

The obvious role of a model is to take a couple from dysfunction to health. *Less obvious, but perhaps more important, is what the model describes as dysfunction and health. ...*

Research that focused on common aspects of healthy and dysfunctional relationships

could have as much or more clinical relevance as research focusing on whether or not a model works (p. 145-146).

A meta-perspective of therapy that described client factors in terms of their impact on the couple relationship could possibly connect with theories at the point where the theory describes healthy and dysfunctional relationships.

Couple dynamic characteristics comprise a valuable portion of client factors. Participants in this study, though, did not tend to use systematic language in describing their clients. This was particularly noticeable in participants' descriptions of the presenting problems and goals for couple therapy and in the client characteristics that participants listed as couple dynamic characteristics that impacted the outcome of couple therapy. It is possible that not all participants had been specifically trained in systems theory, since only 39.4% of participants identified as marriage and family therapists. Another possibility could be that clinicians struggle to find systemic terms for couple dynamics. It might be useful for a meta-perspective of therapy which includes client characteristics to provide terms for couple dynamic patterns which would support systemic conceptualization of cases.

Life events were described as turning points for both successful and unsuccessful couple therapy. Aside from transitions through developmental stages, none of the main theories of couple therapy specifically discusses the impact of life events or offers guidelines regarding how to address significant life events in couple therapy. However, both the clinicians in this study and the clients in Olson's study (2001) explained that how life events are handled can become turning points for couples' relationships. Because of the lasting impact of these events, it would seem that a useful meta-perspective of therapy would need to include a component addressing life events.

Research implications.

The breadth of client factors addressed in this study helps explain and connect what Atkins and colleagues (2005) called the “contradictory ... counterintuitive ... inconsistent” (p. 894) findings regarding client factors that impact the outcome of couple therapy. It seems that client factors *do* matter, that a wide range of client factors matter, and that the client factors which matter for each case can be as unique as the clients themselves. Given the variety of client factors which impact the outcome of couple therapy, it is no surprise that research studies have produced inconsistent results.

It would appear that both theory and research on client factors that impact the outcome of couple therapy are needed. The more entwined the processes of research and theory development are, the more useful each could be to clinical work with couples. Research and theory on client predictors of couple therapy outcome may be more able to reach consistent conclusions if client factors can be grouped in ways that are both meaningful and that allow for unique characteristics to impact each case. Research and theory could present possibilities regarding how client factors impact the outcome of couple therapy. Further, research that investigates how clinicians work with client characteristics to enhance the impact of client factors that support the success of couple therapy and to buffer the negative effect of client factors that tend to impact couple therapy to be unsuccessful could enable clinicians to be more effective with a greater percentage of clients (Mohr, 1995; Snyder et al., 2006).

In terms of the common factors approach, research on how clinicians work with client factors to benefit the outcome of couple therapy could, in effect, create a much greater overlap between the client factors component and the theory and techniques component of client factors (see Craighead, Sheets, Bjornsson, & Arnarson, 2005). Currently, the client factors component

has often been described as being out of clinicians' control (Lambert, 1992; Tallman & Bohart, 1999). While clinicians surely do not have control over client factors and many client factors are unable to change (e.g., age, length of the relationship, certain aspects of personality, personal history), it would seem useful for clinicians to develop strategies for working effectively with a variety of client characteristics (Mohr, 1995; Snyder et al., 2006). For example, previous findings and data from the current study indicated that client's level of commitment influenced the outcome of couple therapy. Perhaps researchers could identify clients who are committed to their relationship and to therapy, and study what clinicians can do to capitalize on the impact of client commitment. Additionally, researchers could identify clients who appear to be uncommitted to their relationship and to therapy. Researchers could focus on strategies that might help increase client commitment, or that might help couple therapy be effective despite lack of client commitment.

This development of theory and research regarding the client factors component of the common factors approach could help establish the common factors in marriage and family therapy into the valuable approach that even its critics recognize it could be (Sexton, Ridley, & Kleiner, 2004).

Clinical implications.

Several authors have been moving beyond using client, relational, and extra-therapeutic factors to explain and predict outcome and have begun discussing how this information can be used so that clinicians can individualize treatment based on client factors (Bohart & Tallman, 1999; Duncan, Miller, & Sparks, 2004). Goals for therapy can be adjusted accordingly, focus of treatment may be altered, cultural awareness is being considered a basic competency issue, and

even impact of gender is being considered a factor clinicians can knowledgeably address in therapy (Rampage, 2002; Schneider & Schneider, 1991).

The main message for clinicians is that client factors matter. Tuning in to client strengths and recognizing client factors that could derail therapy would appear to be useful in keeping couple therapy on track. While it is useful to recognize client factors that most often influence the outcome of couple therapy, it is also vital to remember that a unique client factor may be key for a particular case of couple therapy. For example, many clients deal with the death of a parent, but for some clients this may be a devastating crisis which could prevent further change if not addressed directly. Although research looks for general themes and trends, couple therapy happens one couple at a time.

The findings of the current study indicate that life events may become pivotal moments for some couples. Some of Olson's (2001) participants described life events as significant to their outcome, and Blow et al.'s (2009) case study highlighted the impact of life events. Unfortunately, as Blow et al. noted, "we wondered if therapists ask enough about events outside of therapy on a routine basis in that they are not written into treatment manuals or theories. . . . we have few instructions as to how to deal with them, yet these events can have a significant influence on change processes" (p. 365). Blow and colleagues offered the following recommendations, "therapists should ideally ask about these events and use them as mechanisms to help change. Positive extratherapeutic events need to be utilized for a therapeutic advantage Negative extratherapeutic events can identify patterns of coping that can help the therapeutic process" (p. 359). Findings of the current study confirm the importance of discussing a client's life event(s) in a neutral way and helping the couple recognize their responses to these significant events as potential turning points for their relationship.

The Possible Impact of the Clinician's Perspective

In reflecting on the interpretations and implications of the findings of this study, I browsed through the memos and journaling I created while coding the qualitative data. My previous notes reminded me how much participants' own personalities and viewpoints came through in what they wrote. That was appropriate, as this is a study of participants' perceptions. The tone of some of the comments reminded me that the data for this project were not a measure of actual client characteristics, but of participants' perceptions of client characteristics. For example, a verbal and insightful client may have been perceived by his or her clinician as intelligent, but may actually have a low IQ. Research on therapy has traditionally focused on theory, technique, and therapist attributes rather than on the client, even when studies might have offered information about clients. If the current study of clinician perspectives of client factors exclusively considered the client factors, it may have missed valuable information about clinician perspectives. It could be possible that the data for the current study also provided insight into how clinicians view clients.

Blow, Sprenkle, and Davis (2007) emphasized the importance of the clinician, specifically highlighting the clinician's skills, attributes, and attitudes. They wrote, "it is rather surprising, indeed shocking, that relatively little attention is paid to therapists variables as contributors to outcome" (p. 300). Blow et al. (2007) explained that clinician's contribution to the variability in couple therapy outcome is significant and needs to be better understood. One possibility for clinician variability that they mentioned was inferred traits. Although Blow et al. (2007) did not specifically mention the importance of clinicians' perspective of clients, they do list that clinicians' "personality, coping patterns, emotional well-being, values and beliefs, and

cultural attitudes” (p. 305) may contribute to the outcome of their cases. When interacting with clients, each of these clinician attributes could color the clinician’s perceptions of the client.

As an example of how a clinician’s views could alter his or her perception of a client, consider the PCA findings for the unsuccessful couple therapy. The first component was named Unable to Recover. This component reflected that couples who were unsuccessful in couple therapy were facing difficulties, did not have the needed problem-solving and social support resources, may not have had a solid relational foundation, and were unable to commit to the relationship and to participate in therapy in a way that might have brought about changes. Although this relational characteristic may make sense when it is explained in a linear fashion, couples who present with these characteristics in couple therapy may just seem chaotic to the clinician. A complementary interpretation of this finding could be that the outcome of couple therapy was not only influenced by the variety of issues clients brought to therapy, but also by the clinician’s perspective in sorting through those issues.

For example, if a couple comes to therapy with a variety of issues and the clinician struggles to decide what to focus on in sessions (perhaps partially because of a clinician’s personal struggle to cope with multiple issues at once), or if some of the presenting problems are outside the scope of theories that the clinician typically uses, then the clinician may perceive the case to be chaotic, sessions may lack focus and cohesiveness, and the outcome may be unsuccessful. That same couple might work with a different clinician who hones in on a few of the presenting issues and applies a theory of therapy cohesively. The couple’s therapy with the second clinician is more likely to be successful. In another example, the same client may be perceived by one clinician as stubborn and by another clinician as committed. It may be easier

for clinicians to work with clients whom they perceive as committed than with clients whom they perceive as stubborn.

Therefore, in addition to working with clients to identify client strengths and to enhance the client characteristics that lead to successful couple therapy outcomes, clinicians could also consider their own perspective of the client. It may be possible that clinicians could, at times, change their own perspective of a client by deliberately finding client strengths, and this more positive clinician perspective may influence couple therapy to be successful.

Strengths and Limitations of the Current Study

This project had several strengths and limitations. This study focused on clinicians' perceptions of client factors. This could create two main limitations. First, clinician observations of client factors might not accurately reflect the outcome of therapy or of client factors. However, in a study by Cline and colleagues (1987), clinicians' judgments of the outcome of therapy were significantly related to clients' self-report of improvement. Cline and colleagues concluded, "therapists' ratings have a degree of concurrent validity with other assessment measures and should be given serious consideration as one measure of client change or improvement" (p. 265). Therefore, the limitation of collecting data from clinicians only may be a minor limitation.

Second, although clinicians are likely quite perceptive of client characteristics, clients might know about client factors that they do not share with clinicians. For example, clients might not disclose a history of affairs, history of sexual abuse, relationship violence, or substance abuse issues. Clients may even lie to clinicians about these issues. A clinician might have a sense that a piece of the puzzle is missing, but not know which client factor is influencing the

outcome of couple therapy. Research which obtains data from clients may provide information that clinicians do not know.

One significant limitation of this study was the lack of emphasis on the cultural aspects of cases. A few participants did specifically state that the cultural differences of the individuals in the couple impacted the outcome of couple therapy. In these cases, the cultural differences were perceived to be a challenge to the couple, and participants reported that these cultural differences impacted couple therapy to be unsuccessful. However, so few participants mentioned cultural differences that these comments were coded into other categories. It is possible that participant's comments regarding cultural differences did not completely capture the experience of clients. This could have happened for several reasons. First, while clinicians are typically very tuned in to clients, clinicians often overlook cultural factors in therapy. This can happen when clinicians see through their own cultural lens and interpret cultural aspects of clients as client characteristics. It would make sense that this tendency in clinicians was reflected in participants. It is also possible that the cases which participants chose to discuss included few cases of clients who were from different cultures. Finally, when working with a couple, a participant may have initially conceptualized couple issues as having a cultural component to them, but through the work of the case, the participant may have shifted focus to seeing these issues as only issues that needed to be addressed in couple therapy. Future research focusing on the impact that cultural differences have on the outcome of couple therapy could provide valuable insight.

While not inherent in the design of the survey, the small number of non-heterosexual couples could be a limitation of this study. Only seven of 398 participants reported on cases of non-heterosexual couples. It could be that the same client characteristics impact the outcome of couple therapy with non-heterosexual couples, but this should not be assumed. More

information on clinician's perceptions of non-heterosexual couples may be needed before generalizing the findings of this study to non-heterosexual couples.

The breadth of the professional identities of participants was both a strength and limitation of the current study. This study was originally intended to gather information from clinical members of AAMFT. However, it became impossible to solicit AAMFT members as email addresses were not available for purchase and AAMFT state division listserves are currently prohibited from posting research requests. A more focused sample of AAMFT members may have provided data that were more indicative of the clients with whom marriage and family therapists tend to work. As it happened, obtaining the perceptions of a range of clinicians was consistent with the broad purpose of this study. Because it is possible that the professional identity and training of clinicians could sensitize them to noticing different client factors, having a broad range of clinicians may have provided a more comprehensive picture of client factors that influence the outcome of couple therapy. Additionally, the diversity of clinicians may offer greater application of the findings.

The web-based method of collecting data had both limitations and strengths. As a limitation, the response rate is unknown, but low. While the sample appeared to have similar demographic characteristics of AAMFT members, it is possible that certain characteristics of non-responders were different than characteristics of responders. In addition, the survey program reported the number of respondents who opened the survey, which survey pages they saw, and if they completed the survey. The drop-out rate for this survey was about 50%. Based on pilot testing and emails from participants, this could be due to technical difficulties if the participants' internet was not consistently connected. However, most of the drop-outs happened very early in the survey, indicating that it was more likely that the potential participant did not

want to take the time to reflect on a case of couple therapy. Although there is support in literature for using web-based data collection methods for qualitative research, including open-ended questions in the survey seemed cumbersome. One participant emailed saying she spent over two hours on the survey. Although I did provide examples (which were brief) for each question, some participants were extremely reflective. While drop-out rates for paper-based surveys could also be a problem, it is impossible to know how many participants begin, but do not complete, a paper-based survey. It is also possible that the technological skills of potential participants prevented them from beginning and/or completing the survey for the current study. Specifically, I received several emails saying that the link to the survey did not work. These potential participants did not know that copying the link from the email text and pasting it into their browser window would take them to the survey.

A specific weakness became apparent early in the data collection process when I realized that I did not include Gottman Method in the list of theories. Many of the findings seemed to confirm what Gottman has said about couples. It could be useful to know how many of the clinicians were trained in Gottman Method and how many would say they work from that approach. This could offer a clue about whether participants were seeing these concepts because they used the Gottman Method, and how many of the findings were confirmatory of Gottman's work aside from proponents of his approach.

One of the main strengths of this study was that it addressed the client factors of real clients. By doing so, the findings should apply to the clinicians in general, rather than clients in carefully controlled situations. Another strength of this study was that the focus was narrow enough to allow participants to spend time reflecting on client factors, but the scope within that focus was broad in prompting participants to list individual characteristics, couple dynamics

characteristics, and life events. The connection between existing research and new information can provide the constellation of client factors needed to guide future research on client factors.

Conclusion

Although client factors are considered important contributors to the outcome of couple therapy, previous research has been inconsistent and disconnected. Using previous research to comprehend the full scope of client factors would be like trying to understand the beauty of a symphony while only having information about the French horn, violin, and snare drum. This study has attempted to present a comprehensive and concise picture of client factors that clinicians perceive to influence the outcome of couple therapy. The results suggested that clinicians saw couple therapy as complex, and discussed couple cases as on the verge of change. Client factors that influence the outcome of couple therapy include couple descriptions based on the five arenas of couple focus. The individual characteristics that were found to influence the outcome of couple therapy include how open clients are to each other, to themselves, and to therapy; client level of commitment; and the extent to which individual issues overwhelm therapy. Couple dynamics characteristics that influence couple therapy to be successful included the couple's views of each other and their ability to connect emotionally. Couple dynamics characteristics that influenced couple therapy to be unsuccessful included the patterns of pursuit/withdrawal, boundary problems, control patterns, and stalemate. Participants described that life events indirectly influenced the outcome of couple therapy by creating situations in which one client was extremely vulnerable to his or her partner. In these vulnerable moments, if the couple connected in a supportive way, or if the relationship was treated as a priority, therapy was likely to be successful. However, if the couple did not connect or if it seemed apparent to the client that change was not going to occur, the impact of the life event led to unsuccessful

couple therapy. These data offered a step toward understanding client factors in a way that can guide theory development, research, and practice. Implications of theory development, future research, and clinical practice were addressed.

References

- Albright, J. M., & Conran, T. (2003). Desire, love and betrayal: Constructing and deconstructing intimacy online. *Journal of Systemic Therapies, 22*(3), 42-53.
- Anfara, V. A., Jr., Brown, K. M., and Mangione, T. L. (2002). Qualitative analysis on stage: Making the research process more public. *Educational Researcher, 7*(31), 28–38. doi: 10.3102/0013189X031007028
- Arkowitz, H. (1995). Common factors or processes of change in psychotherapy? *Clinical Psychology: Science and Practice, 2*(1), 94-100. doi: 10.1111/j.1468-2850.1995.tb00031.x
- Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23-55). Washington, DC: American Psychological Association.
- Atkins, D. C., Berns, S. B., George, W. H., Doss, B. D., Gattis, K., & Christensen, A. (2005). Prediction of response to treatment in a randomized clinical trial of marital therapy. *Journal of Consulting and Clinical Psychology, 73*(5), 893-903.
- Babbie, E. (1989). *The practice of social research*. Belmont, CA: Wadsworth.
- Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.). *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.
- Baucom, B. R., Atkins, D. C., Simpson, L. E., & Christensen, A. (2009). Prediction of response to treatment in a randomized clinical trial of couple therapy: A 2-year

- follow-up. *Journal of Consulting and Clinical Psychology*, 77(1), 160-173. doi: 10.1037.a0014405
- Beutler, L. E. (2002). The dodo bird is extinct. *Clinical Psychology: Science and Practice*, 9(1), 30-34. doi: 10.1093/clipsy.9.1.30
- Beutler, L. E. (1995). Common factors and specific effects. *Clinical Psychology: Science and Practice*, 2(1), 79-82. doi: 10.1111/j.1468-2850.1995.tb00027.x
- Blow, A. J., Morrison, N. C., Tamaren, K., Wright, K., Schaafsma, M., & Nadaud, A. (2009). Change processes in couple therapy: An intensive case analysis of one couple using a common factors lens. *Journal of Marital & Family Therapy*, 35(3), 350-368. doi: 10.1111/j.1752-0606.2009.00122.x
- Blow, A. J., & Sprenkle, D. H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital & Family Therapy*, 27(3), 385-401. doi: 10.1111/j.1752-0606.2001.tb00333.x
- Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, 33(3), 298-317.
- Bohart, A. C. (2000). Introduction to the special issue. *Journal of Psychotherapy Integration*, 10(2), 119-126.
- Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.
- Borum, R., & Philpot, C. (1993). Therapy with law enforcement couples: Clinical management of the 'high-risk lifestyle.' *American Journal of Family Therapy*, 21(2), 122-135. doi: 10.1080/01926189308250911

- Bosnjak, M., & Tuten, T. (2003). Prepaid and promised incentives in web surveys: An experiment. *Social Science Computer Review*, *21*(2), 208-217.
doi:10.1177/089443930303021002006
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.
- Castonguay, L. G., & Beutler, L. E. (Eds.). (2006). *Principles of therapeutic change that work*. New York: Oxford University Press.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage.
- Christensen, A., Baucom, D. H., Vu, C. T.-A., & Stanton, S. (2005). Methodologically sound, cost-effective research on the outcome of couple therapy. *Journal of Family Psychology*, *19*(1), 6-17. doi: 10.1037/0893-3200.19.1.6
- Clarkin, J. F., & Levy, K. N. (2004). The influence of client variable on psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (5th ed., pp. 194-226). New York: John Wiley & Sons.
- Cline, V. B., Jackson, S. L., Klein, N., & Mejia, J. (1987). Marital therapy outcome measured by therapist, client, and behavior change. *Family Process*, *26*(2), 255-267.
- Coleman, S., Kellely, L., & Kopp, S. (2004). The client's theory of change: Integrating approaches one client at a time. In B. L. Duncan, S. D. Miller & J. A. Sparks (Eds.), *The heroic client: A revolutionary way to improve effectiveness through*

- client-directed, outcome-informed therapy, revised edition* (pp. 119-146). San Francisco, CA: Jossey-Bass.
- Cook, C., Heath, F., & Thompson, R. L. (2000). A meta-analysis of response rates in web- of Internet-based surveys. *Educational and Psychological Measurement, 60*(6), 821-836. doi: 10.1177/00131640021970934
- Courtney, K., & Craven, C. (2005). Best practices in research methods: Factors to weigh when considering electronic data collection. *CJNR: Canadian Journal of Nursing Research, 37*(3), 150-159.
- Craighead, W., Sheets, E., Bjornsson, A., & Arnarson, E. (2005). Specificity and nonspecificity in psychotherapy. *Clinical Psychology: Science and Practice, 12*(2), 189-193. doi:10.1093/clipsy/bpi024
- Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.
- Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Davis, S. (2005). *Common and model-specific factors: What marital therapy therapists, their students, and their clients say about change* (Doctoral dissertation). Retrieved from <http://scholar.lib.vt.edu/theses/available/etd-03232005-172348/>
- Davis, S. D., & Piercy, F. P. (2007a). What clients of couple therapy model developers and their former clients say about change, Part I: Model-dependent common factors across three models. *Journal of Marital and Family Therapy, 33*(3), 318-343. doi:10.1111/j.1752-0606.2007.00030.x

- Davis, S., & Piercy, F. (2007b). What clients of couple therapy model developers and their former students say about change, Part II: Model-independent common factors and an integrative framework. *Journal of Marital & Family Therapy*, 33(3), 344-363. doi:10.1111/j.1752-0606.2007.00031.x
- Denton, W., Burlison, B., Clark, T., Rodriguez, C., & Hobbs, B. (2000). A randomized trial of emotion-focused therapy for couples in a training clinic. *Journal of Marital & Family Therapy*, 26(1), 65-78. doi:10.1111/j.1752-0606.2000.tb00277.x
- Denzin, N. K., & Lincoln, Y. S. (2000). (Eds.), *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.
- Denzin, N. K., & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 1-28). Thousand Oaks, CA: Sage.
- De Vaus, D. (2002). *Surveys in social research* (5th ed.). Crows Nest, Australia: Allen & Unwin.
- DiLillo, D., Peugh, J., Walsh, K., Panuzio, J., Trask, E., Evans, S. (2009). Child maltreatment history among newlywed couples: A longitudinal study of marital outcomes and mediating pathways. *Journal of Consulting and Clinical Psychology*, 77, 680-692. doi: 10.1037/a0015708
- Dillman, D. A. (2002). Presidential address: Navigating the rapids of change: Some observations on survey methodology in the early 21st century. *Public Opinion Quarterly*, 66, 473-494.

- Dillman, D. A., & Bowker, D. K. (2001). The web questionnaire challenge to survey methodologists. In U.-D. R. M. Bosnjak (Ed.), *Dimensions of internet science*. Lengerich, Germany: Pabst Science.
- Dillman, D. A., Tortora, R. D., & Bowker, D. (1998). *Principles for constructing web surveys* (SESRC Technical Report 98-50). Pullman, WA: Washington State University. Retrieved from <http://www.sesrc.wsu.edu/dillman/papers/websurveyppr.pdf>
- Dillman, D. A., Tortora, R. D., Conradt, J., & Bowker, D. (1998). Influence of plain vs. fancy design on response rates for web surveys. Proceedings of the Survey Research Methods Section, American Statistical Association, Dallas, TX. Retrieved from <http://www.sesrc.wsu.edu/dillman/papers/asa98ppr.pdf>
- Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital & Family Therapy*, 22(1), 9-25. doi:10.1111/j.1752-0606.1996.tb00183.x
- Duncan, B. L. (2002). The founder of common factors: A conversation with Saul Rosenzweig. *Journal of Psychotherapy Integration*, 12(1), 13-31. doi:10.1037//1053-0479.12.1.10
- Duncan, B. L., & Miller, S. D. (2000). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. San Francisco, CA: Jossey-Bass
- Duncan, B. L., Miller, S. D., & Sparks, J. A. (2004). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy (Rev. ed.)*. San Francisco, CA: Jossey-Bass

- Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association.
- Fowers, B. J. (1990). An interactional approach to standardized marital assessment: A literature review. *Family Interventions, 39*, 368-377.
- Fowers, B. J., Montel, K. H., & Olson, D. H. (1996). Predicting marital success for premarital couple types based on PREPARE. *Journal of Marital and Family Therapy, 22*, 103-119.
- Fowler, F. J. (1995). *Improving survey questions: Design and evaluation*. Thousand Oaks, CA: Sage.
- Frank, J. D. (1995). Psychotherapy as rhetoric: Some implications. *Clinical Psychology: Science and Practice, 2*(1), 90-93.
- Freeman, S. J. J., Leavens, E. J., & McCulloch, D. J. (1969). Factors associated with success or failure in marital counseling. *The Family Coordinator, 18*(2), 125-128.
- Garfield, S. (1994). Research on client variables in psychotherapy. *Handbook of psychotherapy and behavior change* (4th ed., pp. 190-228). Oxford England: John Wiley & Sons.
- Glass, G. V. (2001). Foreword. In B. E. Wampold (Ed.), *The great psychotherapy debate: Models, methods, and findings* (pp. ix-x). Mahwah, NJ: Lawrence Erlbaum Associates.
- Gold, J. (2000). The psychodynamics of the patient's active episodes. *Journal of Psychotherapy Integration, 10*(2), 207-219.
- Goldman, A., & Greenberg, L. (1992). Comparison of integrated systemic and emotionally focused approaches to couples therapy. *Journal of Consulting and Clinical Psychology, 60*(6), 962-969. doi:10.1037/0022-006X.60.6.962

- Gosling, S. D., Vazire, S., Srivastava, S., & John, O. P. (2004). Should we trust web-based studies? A comparative analysis of six preconceptions about internet questionnaires. *American Psychologist, 59*(2), 93-104.
- Gottman, J. M. (1993). The roles of conflict engagement, escalation, and avoidance in marital interaction: A longitudinal view of five types of couples. *Journal of Consulting and Clinical Psychology, 61*, 6-15.
- Gottman, J. M., & Gottman, J. S. (2008). Gottman Method couple therapy. In A. Gurman (Ed.), *Clinical Handbook of Couple Therapy* (4th ed., pp. 138-164). New York: Guilford.
- Gottman, J. M., & Gottman, J. S. (2006). *Ten lessons to transform your marriage: America's love lab experts share their strategies for strengthening your relationship*. New York, NY: Three Rivers Press.
- Gottman, J. M., & Notarius, C. I. (2002). Marital research in the 20th century and a research agenda for the 21st century. *Family Process, 41*, 159-197.
- Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*(5), 372-378.
- Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco, CA: Jossey-Bass.
- Gurman, A. S. (2008). A framework for the comparative study of couple therapy: History, models, and applications. In A. Gurman (Ed.), *Clinical Handbook of Couple Therapy* (4th ed., pp. 1-26). New York: Guilford.

- Gurman, A., & Fraenkel, P. (2002). The history of couple therapy: A millennial review. *Family Process, 41*(2), 199-260. doi:10.1111/j.1545-5300.2002.41204.x
- Hampson, R. B., & Beavers, W. R. (1996). Measuring family therapy outcome in a clinical setting: Families that do better or do worse in therapy. *Family Process, 35*(3), 347-361.
- Hampson, R. B., Prince, C. C., & Beavers, W. R. (1999). Marital therapy: Qualities of couples who fare better or worse in treatment. *Journal of Marital & Family Therapy, 25*(4), 411-424.
- Heerwegh, D., Vanhove, T., Matthijs, K., & Loosveldt, G. (2005). The effect of personalization on response rates and data quality in web surveys. *International Journal of Social Research Methodology: Theory & Practice, 8*(2), 85-99.
- Howell, D. C. (2002). *Statistical methods for psychology* (5th Ed.). Pacific Grove, CA: Duxbury.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999a). Directing attention to what works. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 407-447). Washington, DC: American Psychological Association.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999b). Introduction. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 1-19). Washington, DC: American Psychological Association.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999c). *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association.

- Jacobson, N. S. (1993). Introduction to special section on couples and couple therapy. *Journal of Consulting & Clinical Psychology, 61*(1), 5.
- Jacobson, N. S., Follette, W. C., Revenstorf, D., Baucom, D. H., Hahlweg, K., & Margolin, G. (2000). Variability in outcome and clinical significance of behavioral marital therapy: A reanalysis of outcome data. *Prevention & Treatment, 3*. doi: 10.1037/1522-3736.3.1.315a
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.
- Johnson, S. M. (2008). Emotionally focused couple therapy. In A. Gurman (Ed.), *Clinical Handbook of Couple Therapy* (4th ed., pp. 107-137). New York: Guilford.
- Johnson, S., & Greenberg, L. (1985a). Differential effects of experiential and problem-solving interventions in resolving marital conflict. *Journal of Consulting and Clinical Psychology, 53*(2), 175-184. doi:10.1037/0022-006X.53.2.175
- Johnson, S., & Greenberg, L. (1985b). Emotionally focused couples therapy: An outcome study. *Journal of Marital & Family Therapy, 11*(3), 313-317. doi:10.1111/j.1752-0606.1985.tb00624.x
- Karasu, T. B. (1986). The specificity versus non-specificity dilemma: Toward identifying therapeutic change agents. *American Journal of Psychiatry, 143*, 687-695.
- Kazdin, A. (1998). *Methodological issues & strategies in clinical research* (2nd ed.). Washington, DC: American Psychological Association.
- Kazdin, A. E. (2005). Treatment outcomes, common factors, and continued neglect of mechanisms of change. *Clinical Psychology: Science and Practice, 12*, 184-188.

- Kouneski, E. F., & Olson, D. H. (2004). A practical look at intimacy through the lens of the ENRICH couple typology. In D. J. Mashek & A. Aron (Eds.), *Handbook of closeness and intimacy* (pp. 117-133). Mahwah, NJ: Erlbaum.
- Kraut, R., Olson, J., Banaji, M., Bruckman, A., Cohen, J., & Couper, M. (2004). Psychological research online: Report of the Board of Scientific Affairs' Advisory Group on the conduct of research on the internet. *American Psychologist*, *59*(2), 105-117.
- Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.
- Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed. ed., pp. 143-189). New York: Wiley.
- Lambert, M. J., Shapiro, D. A., & Bergin, A.E. (1986). The effectiveness of psychotherapy. In S.L. Garfield and A.E. Bergen (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 157-212). New York: Wiley.
- Lampropoulos, G. K. (2000). Definitional and research issues in the common factors approach to psychotherapy integration: Misconceptions, clarifications, and proposals. *Journal of Psychotherapy Integration*, *10*, 415-438.
- Lebow, J. L. , & Gurman, A. S. (1995). Research assessing couple and family therapy. *Annual Review of Psychology*, *46*, 27-57. doi: 0066-4308/95/0201-0027

- Luborsky, L. (1995). Are common factors across different psychotherapies the main explanation for the Dodo Bird verdict that 'Everyone has won so all shall have prizes'? *Clinical Psychology: Science and Practice*, 2(1), 106-109.
- Luborsky, L., Chandler, M., Auerbach, A. H., Cohen, J., & Bachrach, H. M. (1971). Factors influencing the outcome of psychotherapy: A review of quantitative research. *Psychological Bulletin*, 75, 145-185.
- Luborsky, L., Diguier, L., Luborsky, E., Singer, B., Dickter, D., & Schmidt, K. A. (1993). The efficacy of dynamic psychotherapies: Is it true that "Everyone has won and all must have prizes"? In N. Miller, Ed. *Psychodynamic treatment research: A handbook for clinical practice*. New York: Basic Books.
- Luborsky, L., Rosenthal, R., Diguier, L., Andrusyna, T. P., Levitt, J. T., Seligman, D. A., Berman, J. S., & Krause, E. D. (2003). Are some psychotherapies much more effective than others: *Journal of Applied Psychoanalytic Studies*, 5, 455-460.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that 'everyone has won and all must have prizes'? *Archives of General Psychiatry*, 32(8), 995-1008.
- Manfreda, K., Batagelj, Z., & Vehovar, V. (2002). Design of web survey questionnaires: Three basic experiments. *Journal of Computer-Mediated Communication*, 7(3). Retrieved at <http://jcmc.indiana.edu/vol7/issue3/vehovar.html>
- Markman, H. J. (1991). Backwards into the future of couples therapy and couples therapy research: A comment on Jacobson. *Journal of Family Psychology*, 4(4), 416-425.
- Matheson, J. (2005). Computer-Aided Qualitative Data Analysis Software: General Issues for Family Therapy Researchers. In D. H. Sprenkle & F. P. Piercy (Eds.),

- Research methods in family therapy* (2nd ed., pp. 119-135). New York: Guilford Press.
- Maxwell, J. A. (1998). Designing a qualitative study. In L. Bickman & D. J. Rog (Eds.), *Handbook of Applied Social Research Methods* (pp. 69-100). Thousand Oaks, CA: Sage.
- Merriam, S. B. (1998). *Qualitative research and case study application in education*. San Francisco, CA: Jossey-Bass.
- Mertler, C. A. & Vannatta, R. A. (2005). *Advanced and multivariate statistical methods: Practical application and interpretation* (3rd ed.). Los Angeles, CA: Pyrczak.
- Messer, S. B., & Wampold, B. E. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice*, 9(1), 21-25.
- Meyerson, P., & Tryon, W. W. (2003). Validating internet research: A test of the psychometric equivalence of Internet and in-person samples. *Behavior Research Methods, Instruments & Computers*, 35(4), 614-620.
- Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice*. New York: W. W. Norton.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*, (2nd ed.). Thousand Oaks, CA: Sage.
- Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice*, 2, 1-27. doi: 10.1111/j.1468-2850.1995.tb00022.x

- Murphy, J. W. (1999). Common factors of school-based change. In M. A. Hubble, B. L. Duncan & B. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 361-386). Washington, DC: American Psychological Association.
- Murray, D. M., & Fisher, J. D. (2002). The internet: A virtually untapped tool for research. *Journal of Technology in Human Services, 19*(2-3), 5-18.
- Nelson, T. (1996). Survey research in marriage and family therapy. In D. H. Sprenkle & S. M. Moon (Eds.), *Research methods in family therapy* (pp. 447-468). New York: Guilford Press.
- Nelson, T., & Allred, D. (2005). Survey research in marriage and family therapy. In D. H. Sprenkle & F. P. Piercy (Eds.), *Research methods in family therapy* (2nd ed., pp. 211-237). New York: Guilford Press.
- Nichols, M., & Schwartz, R. (1998). *Family therapy: Concepts and methods* (4th ed.). Needham Heights, MA: Allyn & Bacon.
- Northey, W. F., Jr. (2005). Studying marriage and family therapists in the 21st Century: Methodological and technological issues. *Journal of Marital & Family Therapy, 31*(1), 99-105. doi: 10.1111/j.1752-0606.2005.tb01546.x
- Olson, M. M. (2001). *Clients' perceptions of the process of couple therapy: A qualitative and quantitative investigation*. Unpublished Dissertation, Kansas State University, Manhattan, KS.
- Park, H., Dailey, R., & Lemus, D. (2002). The use of exploratory factor analysis and principal components analysis in communication research. *Human Communication Research, 28*(4), 562-577. doi:10.1111/j.1468-2958.2002.tb00824.x

- Patten, M. L. (2005). *Understanding research methods: An overview of the essentials* (5th ed.). Glendale, CA: Pyrczak Publishing.
- Pearson, R. W. (2010). *Statistical persuasion: How to collect, analyze, and present data ...accurately, honestly, and persuasively*. Los Angeles: Sage.
- Pedhazur, E. J., & Schmelkin, L. P. (1991). *Measurement, design, and analysis: An integrated approach*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Rafuls, S. E., & Moon, S. M. (1996). Grounded theory methodology in family therapy research. In D. H. Sprenkle & S. M. Moon (Eds.), *Research methods in family therapy* (pp. 64-80). New York, NY: Guilford.
- Rampage, C. (2002). Working with gender in couple therapy. In A. S. Gurman and N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 533-545). New York: Guilford Press.
- Rea, L. M., & Parker, R. A. (2005). *Designing and conducting survey research: A comprehensive guide* (3rd ed.). San Francisco, CA: Jossey-Bass.
- Rennie, D. L. (2000). Aspects of the client's conscious control of the psychotherapeutic process. *Journal of Psychotherapy Integration, 10*(2), 151-167.
- Rodgers, B. L., & Cowles, K. V. (1993). The qualitative research audit trail: A complex collection of documentation. *Research in Nursing and Health, 16*, 219-226.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*, 412-415.
- Rossman, G. B., & Rallis, S. F. (2003). *Learning in the field: An introduction to qualitative research*. Thousand Oaks, CA: Sage.

- Schillewaert, N., & Meulemeester, P. (2005). Comparing response distributions of offline and online data collection methods. *International Journal of Market Research*, 47(2), 163-178.
- Schneider, P., & Schneider, H. (1991). Mutuality in couples therapy: Addressing the effects of sexism in the marital relationship. *American Journal of Family Therapy*, 19, 119-128. doi:10.1080/01926189108250842
- Scovern, A. W. (1999). From placebo to alliance: The role of common factors in medicine. In M. A. Hubble, B. L. Duncan & B. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 259-296). Washington, DC: American Psychological Association.
- Sexton, T., & Ridley, C. (2004). Implications of a moderated common factors approach: Does it move the field forward?. *Journal of Marital & Family Therapy*, 30(2), 159-163. doi:10.1111/j.1752-0606.2004.tb01231.x
- Sexton, T., Ridley, C., & Kleiner, A. (2004). Beyond common factors: Multilevel-process models of therapeutic change in marriage and family therapy. *Journal of Marital & Family Therapy*, 30(2), 131-149. doi:10.1111/j.1752-0606.2004.tb01229.x
- Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy*, 29, 547-570.
- Shadish, W. R., Montgomery, L. M., Wilson, P., & Wilson, M. R. (1993). Effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 61(6), 992-1002.
- Shadish, W. R., Ragsdale, K., Glaser, R. R., & Montgomery, L. M. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-

- analysis. *Journal of Marital & Family Therapy*, 21(4), 345-360. doi: 10.1111/j.1752-0606.1995.tb00170.x
- Simmons, D., & Doherty, W. (1995). Defining who we are and what we do: Clinical practice patterns of marriage and family therapists in Minnesota. *Journal of Marital & Family Therapy*, 21(1), 3-16. doi:10.1111/j.1752-0606.1995.tb00134.x
- Simpson, L. E., Atkins, D. C., Gattis, K. S., & Christensen, A. (2008). Low-level relationship aggression and couple therapy outcomes. *Journal of Family Psychology*, 22, 102-111. doi: 10.1037/0893-3200.22.1.102
- Smith, J., Brown, R., & O'Grady, K. (1994). Ingredients of successful marital therapy: A survey of therapists' views. *The Family Journal*, 2(4), 317-329. doi:10.1177/1066480794024005
- Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore, MD: Johns Hopkins University Press.
- Smith, M. A., & Leigh, B. (1997). Virtual subjects: Using the internet as an alternative source of subjects and research environment. *Behavior Research Methods, Instruments & Computers*, 29(4), 496-505.
- Snyder, D., Castellani, A., & Whisman, M. (2006). Current status and future directions in couple therapy. *Annual review of psychology* (Vol. 57, pp. 317-344). Palo Alto, CA: Annual Reviews.
- Snyder, D. K., Mangrum, L. F., & Wills, R. M. (1993). Predicting couples' response to marital therapy: A comparison of short- and long-term predictors. *Journal of Consulting and Clinical Psychology*, 61(1), 61-69.

- Snyder, D., & Wills, R. (1989). Behavioral versus insight-oriented marital therapy: Effects on individual and interspousal functioning. *Journal of Consulting and Clinical Psychology, 57*(1), 39-46. doi:10.1037/0022-006X.57.1.39
- Sprenkle, D. H., & Blow, A. J. (2004a). Common factors and our sacred models. *Journal of Marital & Family Therapy, 30*(2), 113-129. doi: 10.1111/j.1752-0606.2004.tb01228.x
- Sprenkle, D. H., Blow, A. J., & Dickey, M. H. (1999). Common factors and other nontechnique variables in marriage and family therapy. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 329-359). Washington, DC: American Psychological Association.
- Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York: Guilford.
- Sprenkle, D. H., & Moon, S. M. (Eds.). (1996). *Research methods in family therapy*. New York: Guilford.
- Sprenkle, D. H., & Moon, S. M. (1996). Toward pluralism in family therapy research. In D. H. Sprenkle & S. M. Moon (Eds.), *Research methods in family therapy* (pp. 3-23). New York: Guilford.
- Sprenkle, D. H., & Piercy, F. P. (2005). Pluralism, diversity, and sophistication in family therapy research. In D. H. Sprenkle & F. P. Piercy (Eds.), *Research methods in family therapy* (2nd ed., pp. 3-18). New York: Guilford Press.
- Sprenkle, D. H., & Piercy, F. P. (2005). *Research methods in family therapy* (2nd ed.). New York: Guilford Press.

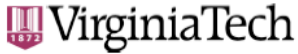
- Stevens, J. P. (2002). *Applied multivariate statistics for the social sciences* (4th ed.). Mahwah, NJ: Lawrence Erlbaum Associates.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.
- Swoboda, W. J., Muhlberger, N., Weitkumat, R., & Schneeweib, S. (1997). Internet surveys by direct mailing: An innovative way of collecting data. *Social Science Computer Review*, 15(3), 242-255.
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston, MA: Pearson.
- Tallman, K., & Bohart, A. C. (1999). The client as a common factor: Clients as self-healers. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 91-131): American Psychological Association.
- Tambling, R. B., & Johnson, L. N. (2008). The relationship between stages of change and outcome in couple therapy. *The American Journal of Family Therapy*, 36, 229-241. doi: 10.1080/01926180701290941
- Thomas, M. L. (2006). The contributing factors of change in a therapeutic process. *Contemporary Family Therapy*, 28, 201-210. doi: 10.1007/s10591-006-9000-4
- Tourageau, R. (2004). Survey research and societal change. *Annual Review of Psychology*, 55, 775-801. doi:10.1146/annurev.psych.55.090902.142040
- Vansteenwegen, A. (1996). Who benefits from couple therapy? A comparison of successful and failed couples. *Journal of Sex & Marital Therapy*, 22(1), 63-67. doi: 10.1080/00926239608405307

- Vehovar, V., Batagelj, Z., Manfreda, K. L., & Zaletel, M. (2002). Nonresponse in web surveys. In R. M. Groves, D. A. Dillman, J. L. Eltinge, & R. J. A. Little. (Eds.). *Survey nonresponse*. New York: Wiley
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum Associates.
- Warner, R. (2008). *Applied statistics: From bivariate through multivariate techniques*. Thousand Oaks, CA: Sage.
- Watson, R., & Thompson, D. R. (2006). Use of factor analysis in *Journal of Advanced Nursing*: Literature review. *Journal of Advanced Nursing*, 55(3), 330-341. doi: 10.1111/j.1365-2648.2006.03915.x
- Wesley, S., Waring, E. M. (1996). A critical review of marital therapy outcome research. *Canadian Journal of Psychiatry*, 41, 421-428).
- Whisman, M., Dixon, A., & Johnson, B. (1997). Therapists' perspectives of couple problems and treatment issues in couple therapy. *Journal of Family Psychology*, 11, 361-366. doi:10.1037/0893-3200.11.3.361
- Whisman, M. A., Jacobson, N. S., Fruzzetti, A. E., Waltz, J. A. (1989). Methodological issues in marital therapy. *Advances in Behavior Research and Therapy*, 11, 175-189.
- Yammarino, F. J., Skinner, S. J., & Childers, T. L. (1991). Understanding mail survey response behavior: A meta-analysis. *Public Opinion Quarterly*, 55(4), 613-639.

Appendices

Appendix A

IRB Approval Letter




Office of Research Compliance
Carmen T. Green, IRB Administrator
2000 Kraft Drive, Suite 2000 (0497)
Blacksburg, Virginia 24061
540/231-4358 Fax 540/231-0959
e-mail ctgreen@vt.edu
www.irb.vt.edu
FWA00000572(expires 1/20/2010)
IRB # is IRB00000667

DATE: July 3, 2008

MEMORANDUM

TO: Fred P. Piercy
Susan Perkins
Megan Dolbin-MacNab

FROM: Carmen Green 

SUBJECT: **IRB Exempt Approval:** "Influential Client Factors: Understanding and Organizing Therapists' Perceptions of Client Factors that Influence Reported Outcome of Therapy", IRB # 08-319

I have reviewed your request to the IRB for exemption for the above referenced project. The research falls within the exempt status. Approval is granted effective as of July 3, 2008.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in the research protocol. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

cc: File
Department Reviewer: Joyce A. Arditti

Invent the Future

VIRGINIA POLYTECHNIC INSTITUTE UNIVERSITY AND STATE UNIVERSITY

An equal opportunity, affirmative action institution

Appendix B

Email Solicitation to Listservs

Hello! I'm working on my dissertation titled "Influential Client Factors in Couples Therapy" through Virginia Tech and would like to ask for the help of (*organization name*) members. In this online survey, I ask therapists to reflect on a case of couples therapy and tell me your thoughts about what helped or hurt therapy's success. When you finish, you can enter a drawing to win an iPod Touch. This is not your average survey--it is individualized, interactive, and engaging.

Participants need to have done couples therapy and be willing to take 15 minutes to reflect on a case.

To start, just click the following link. The first two pages give more information and criteria, then the fun begins!

<https://secure3.hostek.net/edpsychsurveys-com>

Please feel free to pass this request to other therapists who might be willing to participate. Thank you so much for your input. Your experience and opinions are valuable!

Susan Perkins, M.A.
Doctoral Candidate, Virginia Tech
sperkins.research@gmail.com

Appendix C

Email Solicitation to COAMFTE Program Directors

Dear Dr. (*name*),

Hello! My name is Susan Perkins. I'm working on my dissertation at Virginia Tech and need help finding therapists who would be willing to participate in my online study. Does (*name of program*) have a listserv of current students and/or alumni? If so, would you consider posting the following request on that listserv?

Thank you so much!

Susan Perkins

Hello! My name is Susan Perkins. I'm working on my dissertation titled "Influential Client Factors in Couples Therapy" through Virginia Tech and would like to ask for your help. In this online survey, I ask therapists to reflect on a case of couples therapy and tell me their thoughts about what helped or hurt therapy's success. When you finish, you can enter a drawing to win an iPod Touch. This is not your average survey--it is individualized, interactive, and engaging. Participants need to have done couples therapy and be willing to take 15-20 minutes to reflect on a case.

To learn more or to participate in this online study, just follow this link:

<https://securec3.hostek.net/edpsychsurveys-com>

Please feel free to pass this request to other therapists who might be willing to reflect on a case.

Thank you so much for your input. Your experience and opinions are valuable!

Thank you!

Susan Perkins, M.A.
Doctoral Candidate, Virginia Tech
sperkins.research@gmail.com

Appendix D

IDAMFC State Division Solicitation Email

Dear Dr. *(name)*,

I am writing to inquire if *(division name)* has a listserv to which I could post a request for participation for my web survey about client factors. The survey is for therapists who work with couples and is data for my dissertation from Virginia Tech. Please let me know if there is a listserv, if I can join the listserv, or if you would be willing to post the following request.

Thank you!

Susan Perkins

Hello! I'm working on my dissertation titled "Influential Client Factors in Couples Therapy" through Virginia Tech and would like to ask for the help of *(division name)* members. In this online survey, I ask therapists to reflect on a case of couples therapy and tell me your thoughts about what helped or hurt therapy's success. When you finish, you can enter a drawing to win an iPod Touch. This is not your average survey--it is individualized, interactive, and engaging. Participants need to have done couples therapy and be willing to take 15 minutes to reflect on a case.

To start, just click the following link. The first two pages give more information and criteria, then the fun begins!

<https://secure3.hostek.net/edpsychsurveys-com>

Please feel free to pass this request to other therapists who might be willing to participate. Thank you so much for your input. Your experience and opinions are valuable!

Susan Perkins, M.A.
Doctoral Candidate, Virginia Tech
sperkins.research@gmail.com

Appendix E

Solicitation Email Sent Directly to Couples Therapists

Hello! I'm working on my dissertation titled "Influential Client Factors in Couples Therapy" through Virginia Tech and would like to ask for your help. In this online survey, I ask therapists to reflect on a case of couples therapy and tell me your thoughts about what helped or hurt therapy's success. When you finish, you can enter a drawing to win an iPod Touch. This is not your average survey--it is individualized, interactive, and engaging.

Participants need to have done couples therapy and be willing to take 15 minutes to reflect on a case.

To start, just click the following link. The first two pages give more information and criteria, then the fun begins!

<https://secure3.hostek.net/edpsychsurveys-com>

Please feel free to pass this request to other therapists who might be willing to participate. Thank you so much for your input. Your experience and opinions are valuable!

Susan Perkins, M.A.
Doctoral Candidate, Virginia Tech
sperkins.research@gmail.com

Appendix F

Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants

In Research Project Involving Human Subjects

Title of Project: Influential client factors: Understanding and organizing therapists' perceptions of client factors that influence reported outcome of therapy

Investigator: Susan N. Perkins, M.A.

I. Purpose of the Research/Project

The purpose of this project is to identify and organize client factors that therapists perceive to influence the outcome of therapy. 5,300 licensed therapists who work with couples will be solicited; the researcher expects a response of about 2,000 therapists.

II. Procedures

Therapists will be asked to complete a web survey that will take approximately 10-20 minutes. There are two versions of the web survey—one version that asks therapists to identify a case in which the couple successfully completed therapy and a second version that asks therapists to identify a case in which the couple was unsuccessful in completing therapy. Therapists will be randomly assigned one version of the survey.

III. Risks

There are no more than minimal risks involved. Possibly, reflecting on a past case could be somewhat emotionally distressful. However, therapists typically reflect on cases as part of their routine professionalism. Therapists experiencing distress are encouraged to see supervision or consult with a marriage and family therapist. If referrals are needed, therapists may contact the investigator for referral information.

IV. Benefits

Therapists who participate may benefit from being given the opportunity to reflect on a case. The researcher will use the information from this survey to help couples therapists better understand the client factors that therapists perceive to influence the outcome of therapy. Reporting this information to therapists has the potential to help therapists work more effectively with couples. The researcher has also agreed to email a summary of the findings to participants who request this information.

In addition, participants who complete the survey and provide their email address will be entered in a drawing to win an ipod touch. The chances of winning are approximately 1 in 350. The email address will not be connected with the participants' survey responses in any way.

V. Extent of Anonymity and Confidentiality

Participants will be assigned a participant number which will only be connected to their identifying information for solicitation purposes. The responses participants provide will not be connected to their email or any other identifying information in any way.

It is possible that the Institutional Review Board (IRB) may view this study's collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

VI. Compensation

Participants are not compensated for their participation in this project. However, participants who complete the survey and provide their email address will be entered in a drawing to win an ipod touch. The chances of winning are approximately 1 in 350. The email address will not be connected with the participants' survey responses in any way.

VII. Freedom to Withdraw

Subjects are free to withdraw from the study at any time without penalty. Subjects are also free to choose not to answer any question.

VIII. Subject's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:
Complete the web survey and click on the "Submit" button.

IX. Subject's Permission

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent by checking the "I agree" box on the web survey.

Should I have any pertinent questions about this research or its conduct, and research subjects' rights, and whom to contact in the event of a research-related injury to the subject, I may contact:

Susan N. Perkins, M.A.

Investigator
540-392-0688
stice@vt.edu

Dr. Fred Piercy

Faculty Advisor
540-231-4794
piercy@vt.edu

Dr. Joyce Arditti

Departmental Reviewer
540-231-5758
arditti@vt.edu

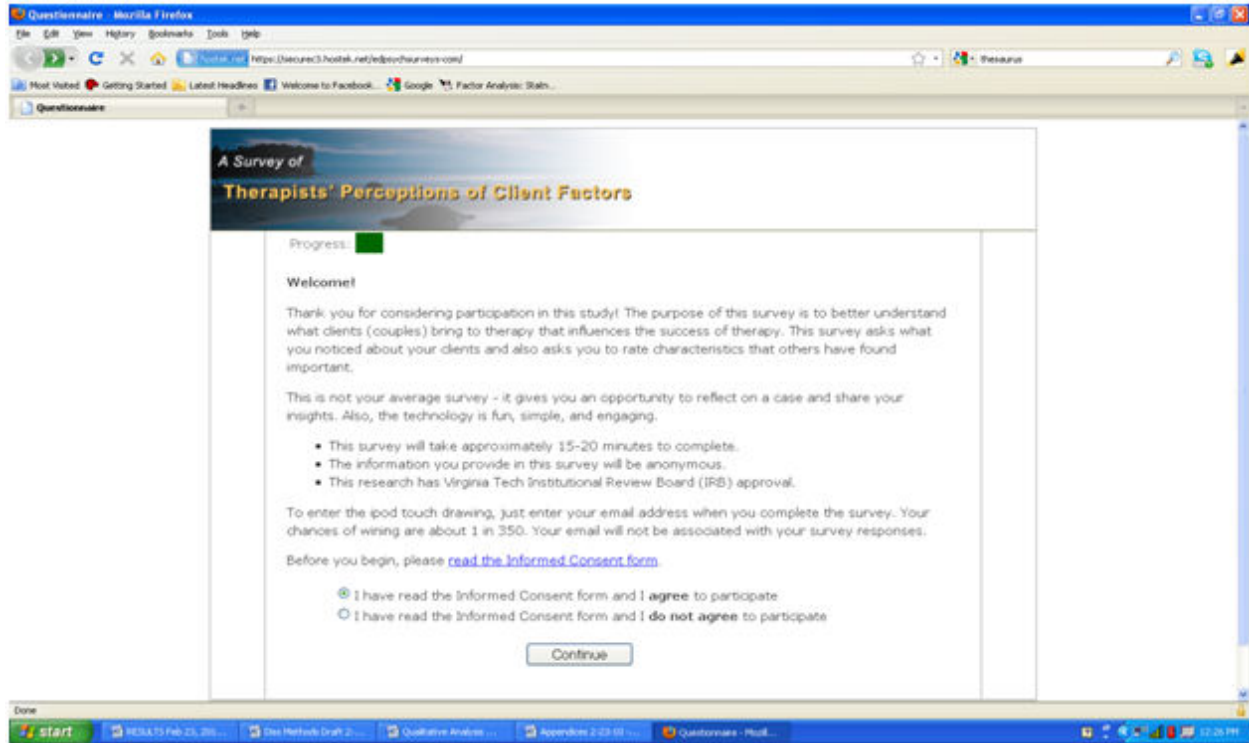
David M. Moore

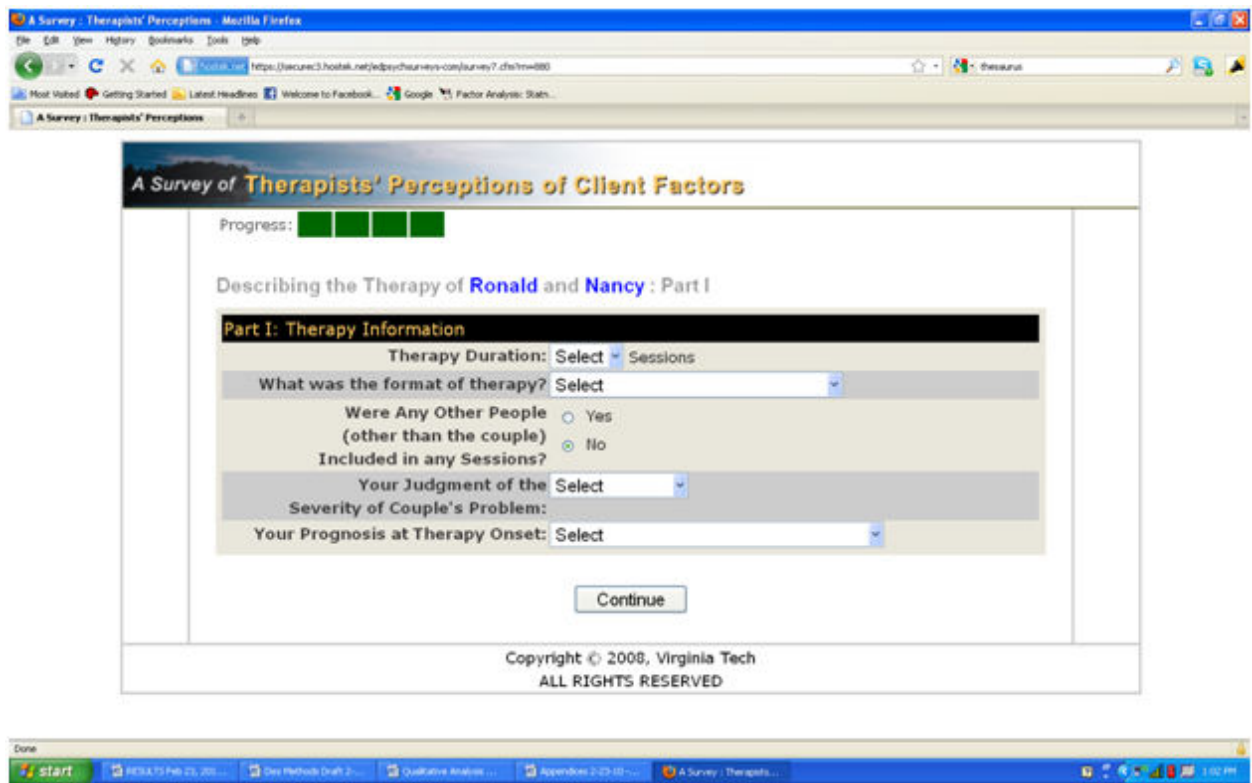
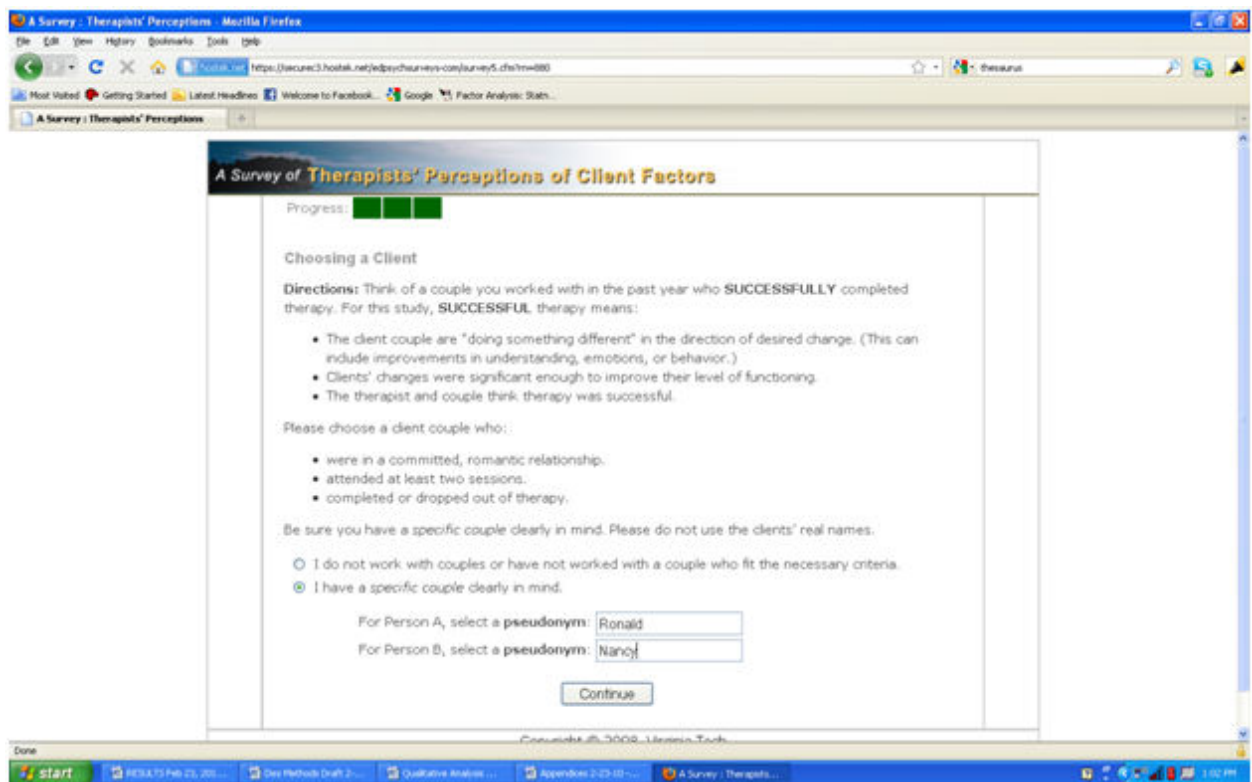
Chair, Virginia Tech Institutional Review
Board for the Protection of Human Subjects
Office of Research Compliance
2000 Kraft Drive, Suite 2000 (0497)
Blacksburg, VA 24060
540-231-4991
moored@vt.edu

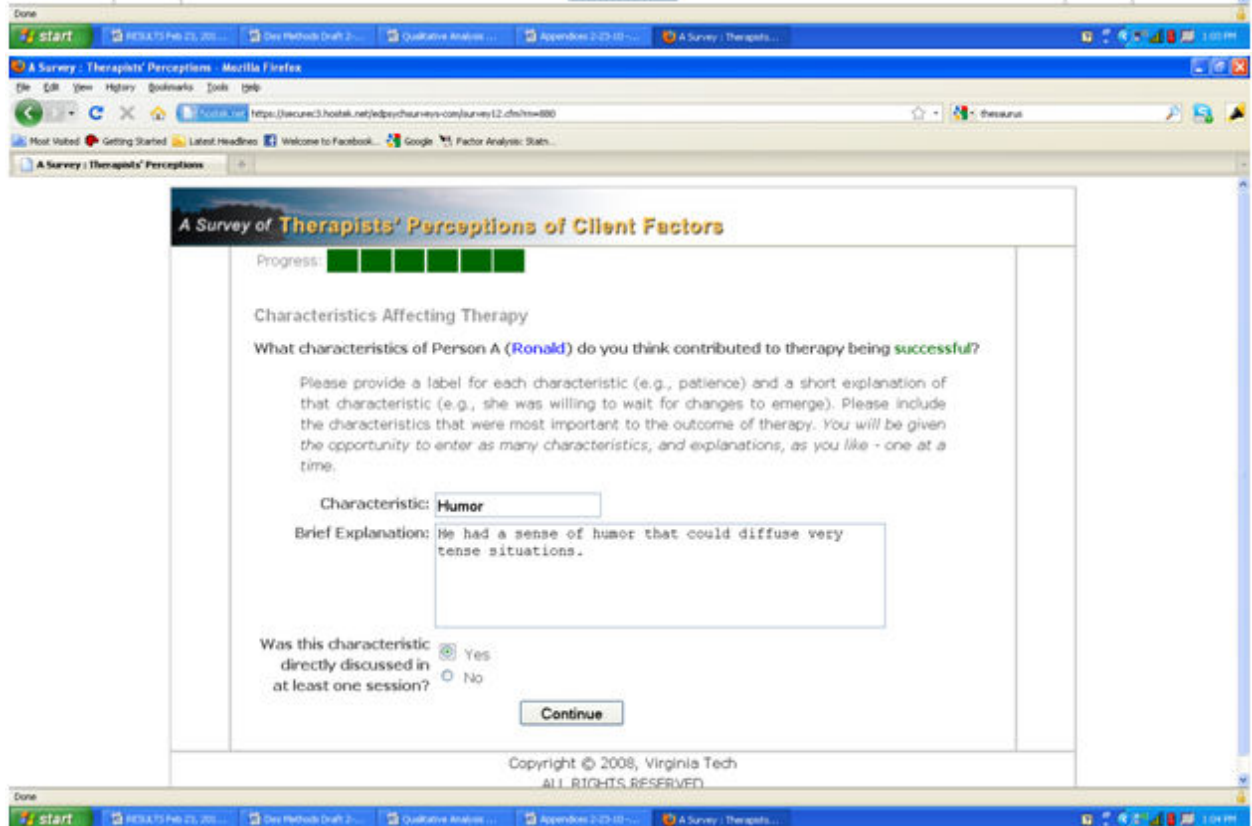
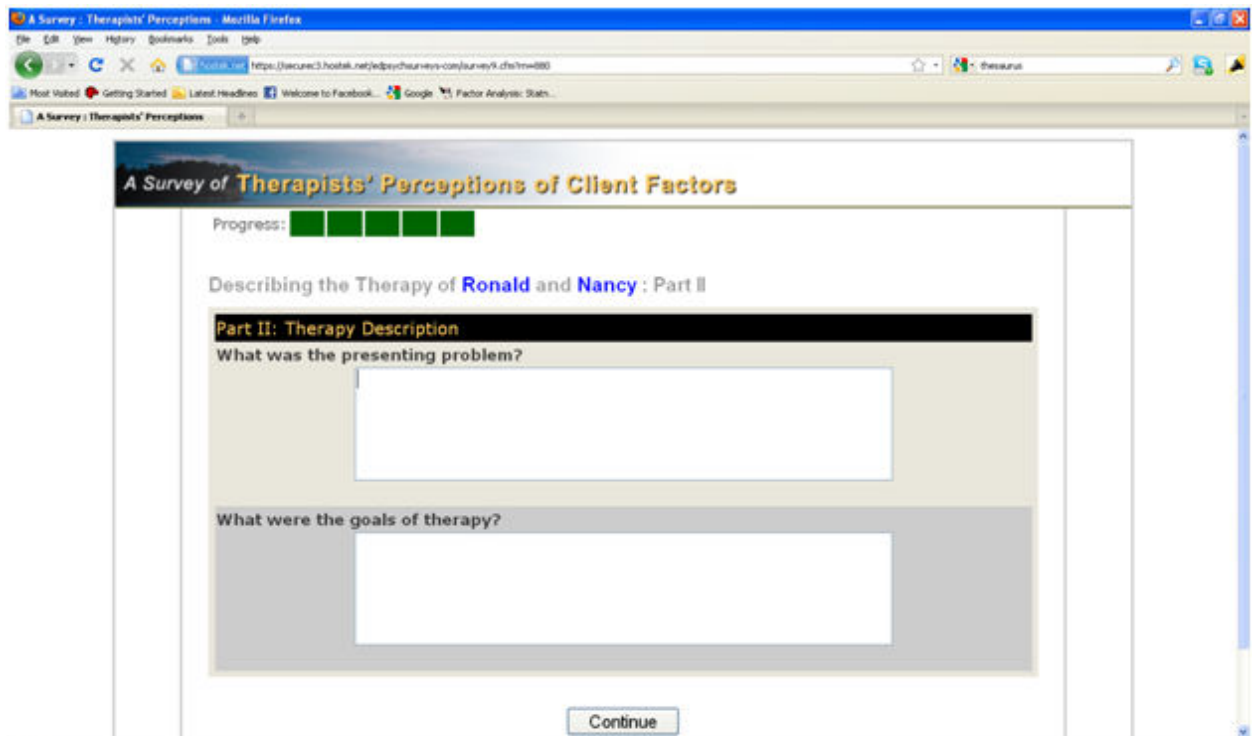
*If you would like a copy of this Consent Form, either print it from your computer or email Susan Perkins at stice@vt.edu requesting a consent form.

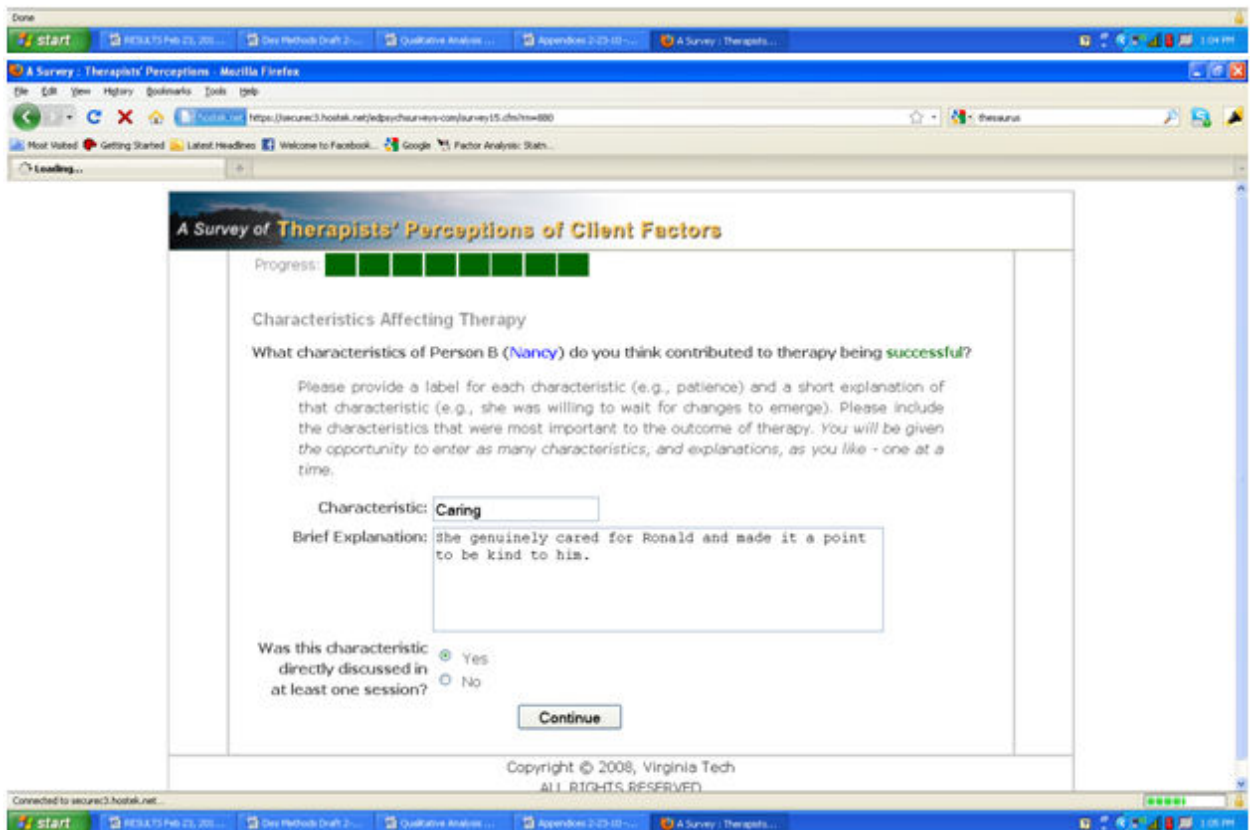
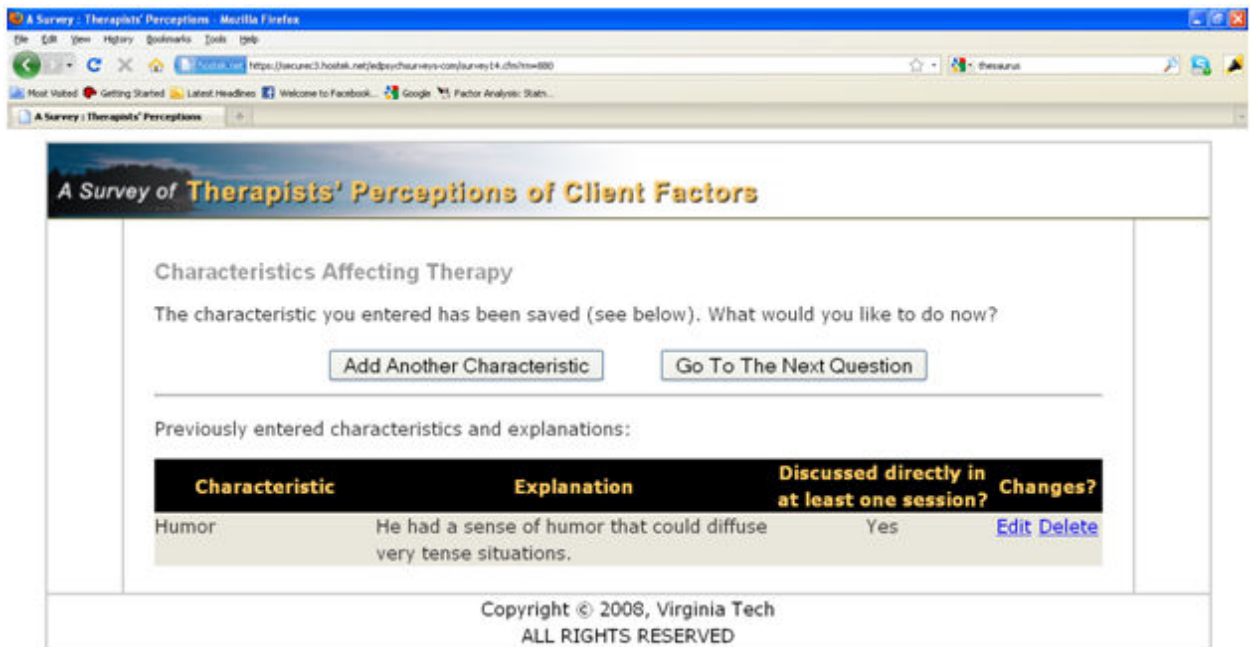
Appendix G

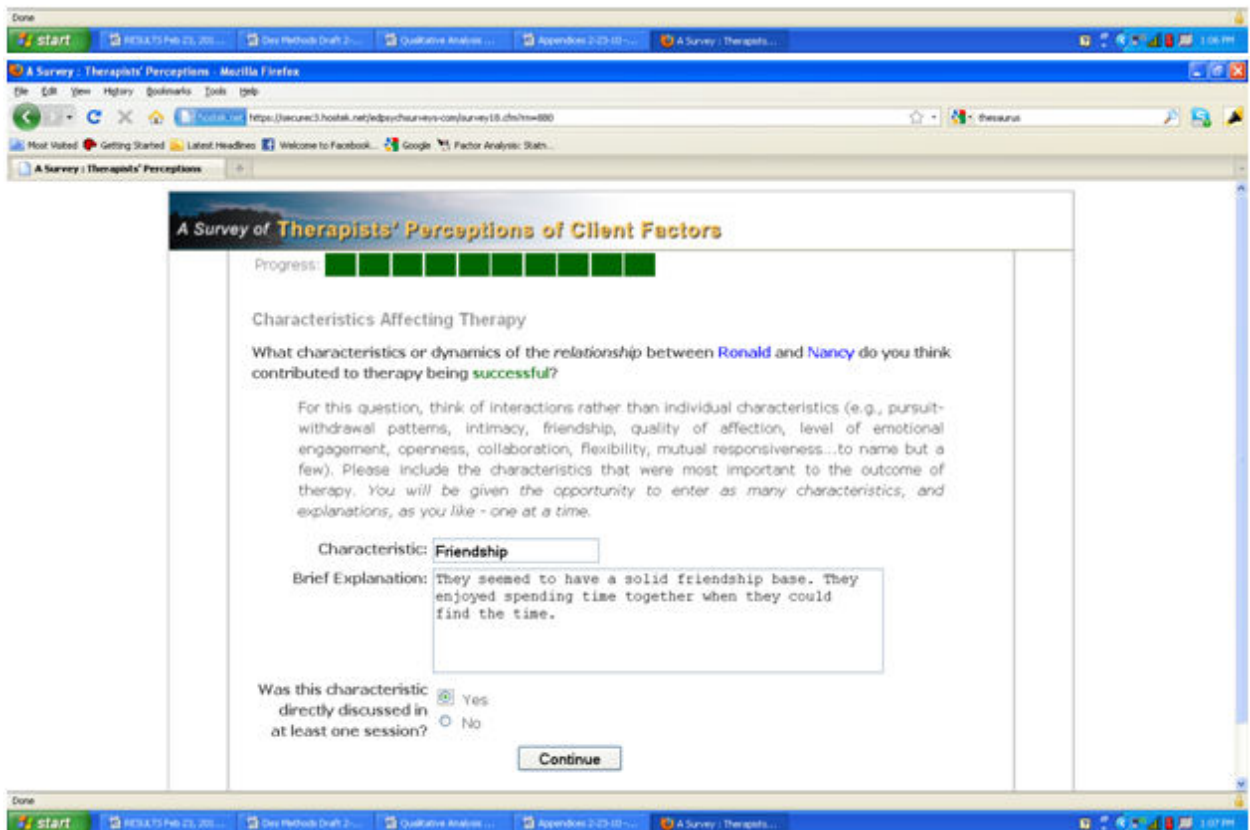
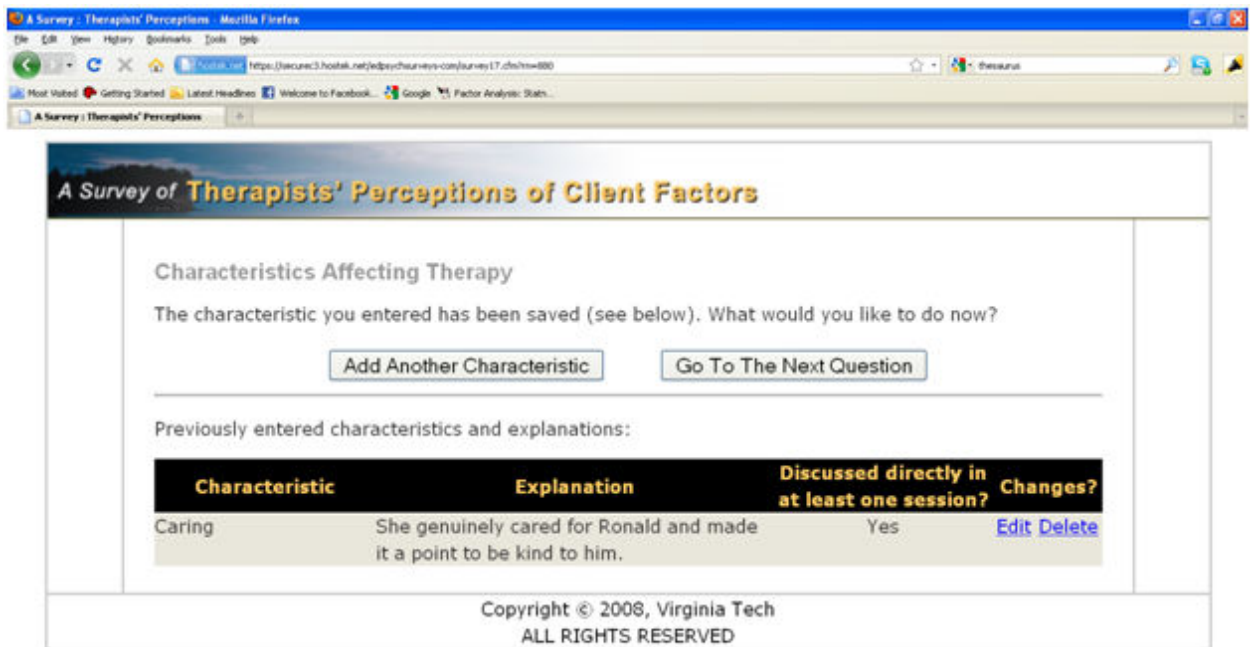
Screen Shots of Survey for Participant Perceived Successful Couples Therapy

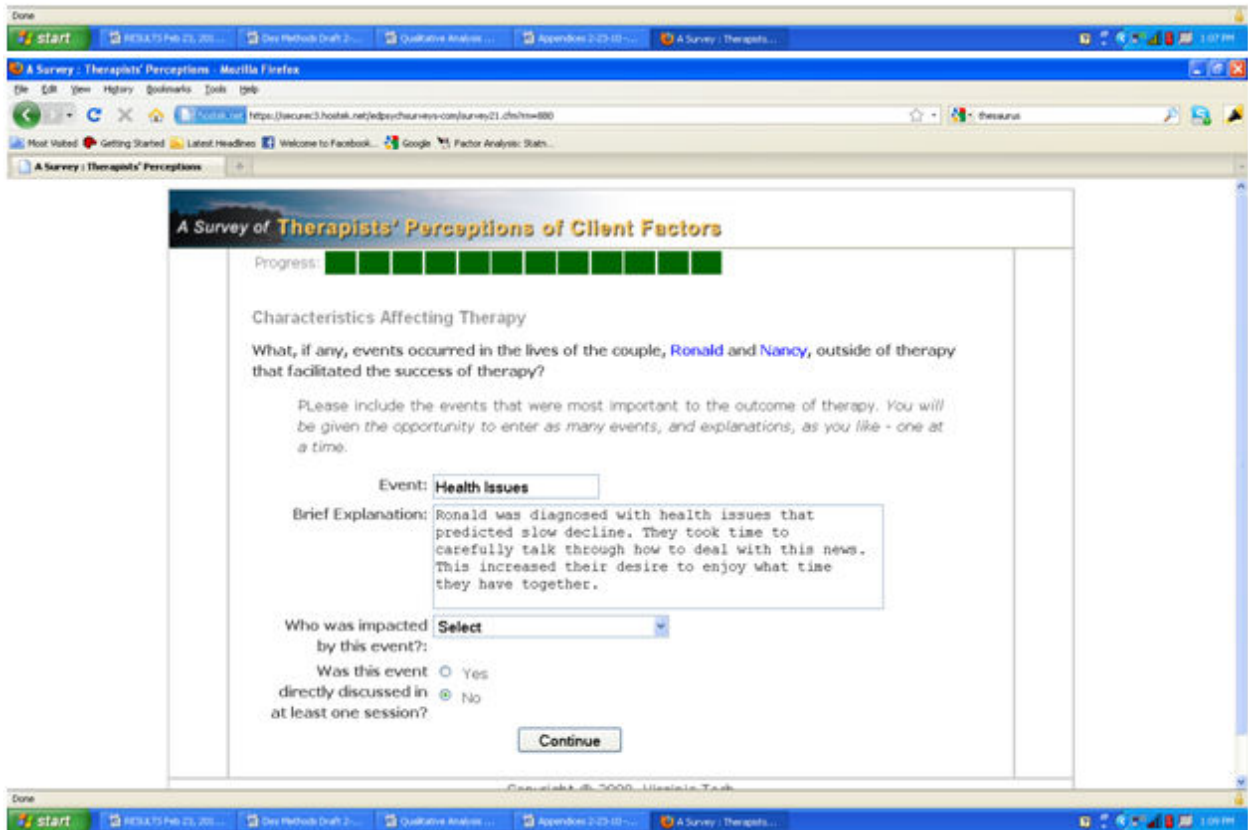
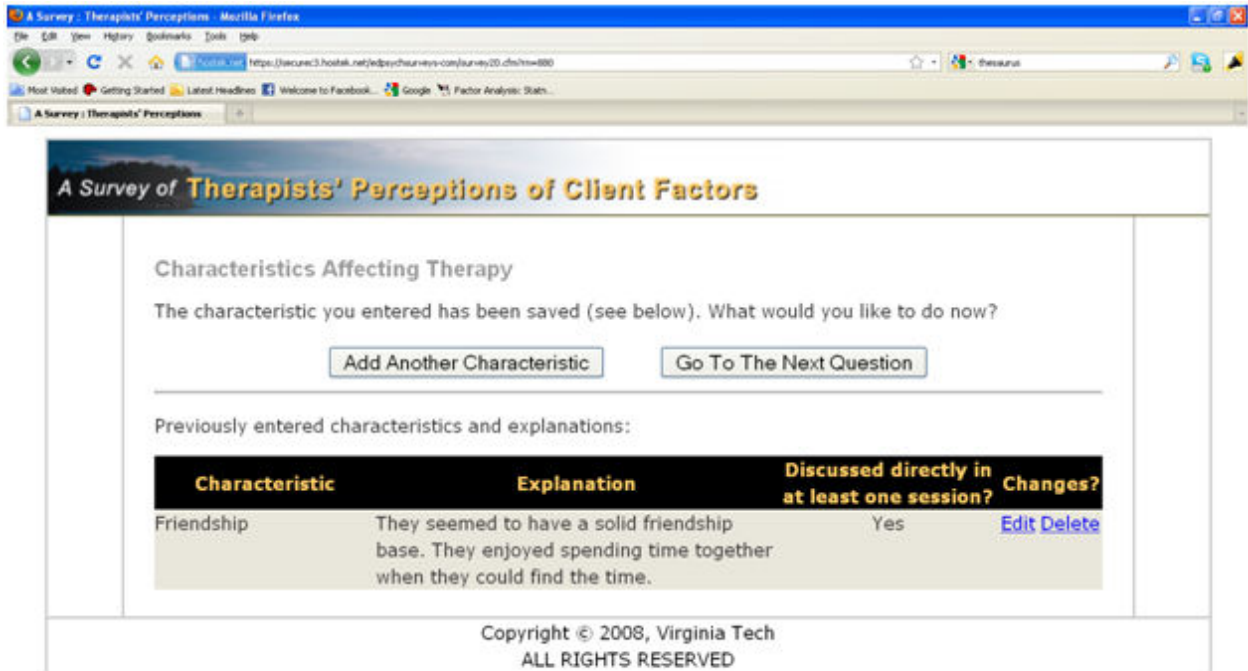












A Survey of Therapists' Perceptions

A Survey of Therapists' Perceptions of Client Factors

Characteristics Affecting Therapy

The event you entered has been saved (see below). What would you like to do now?

[Add Another Event](#) [Go To The Next Question](#)

Previously entered characteristics and explanations:

Event	Explanation	Discussed directly in at least one session?	Changes?
Health Issues	Ronald was diagnosed with health issues that predicted slow decline. They took time to carefully talk through how to deal with this news. This increased their desire to enjoy what time they have together.	No	Edit Delete

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED

A Survey of Therapists' Perceptions

A Survey of Therapists' Perceptions of Client Factors

Progress:

The Importance of Client Characteristics

You listed several characteristics of client **Ronald** that contributed to therapy being **successful**. Now, please rate the importance each characteristic had on the **success** of therapy:

Not Characteristic Important Slightly Important Moderately Important Very Vitaly Important

Humor

You listed several characteristics of client **Nancy** that contributed to therapy being **successful**. Now, please rate the importance each characteristic had on the **success** of therapy:

Not Characteristic Important Slightly Important Moderately Important Very Vitaly Important

Caring

You listed several characteristics of **client dynamics or interactions** that contributed to therapy being **successful**. Now, please rate the importance each characteristic had on the **success** of therapy:

Not Characteristic Important Slightly Important Moderately Important Very Vitaly Important

Friendship

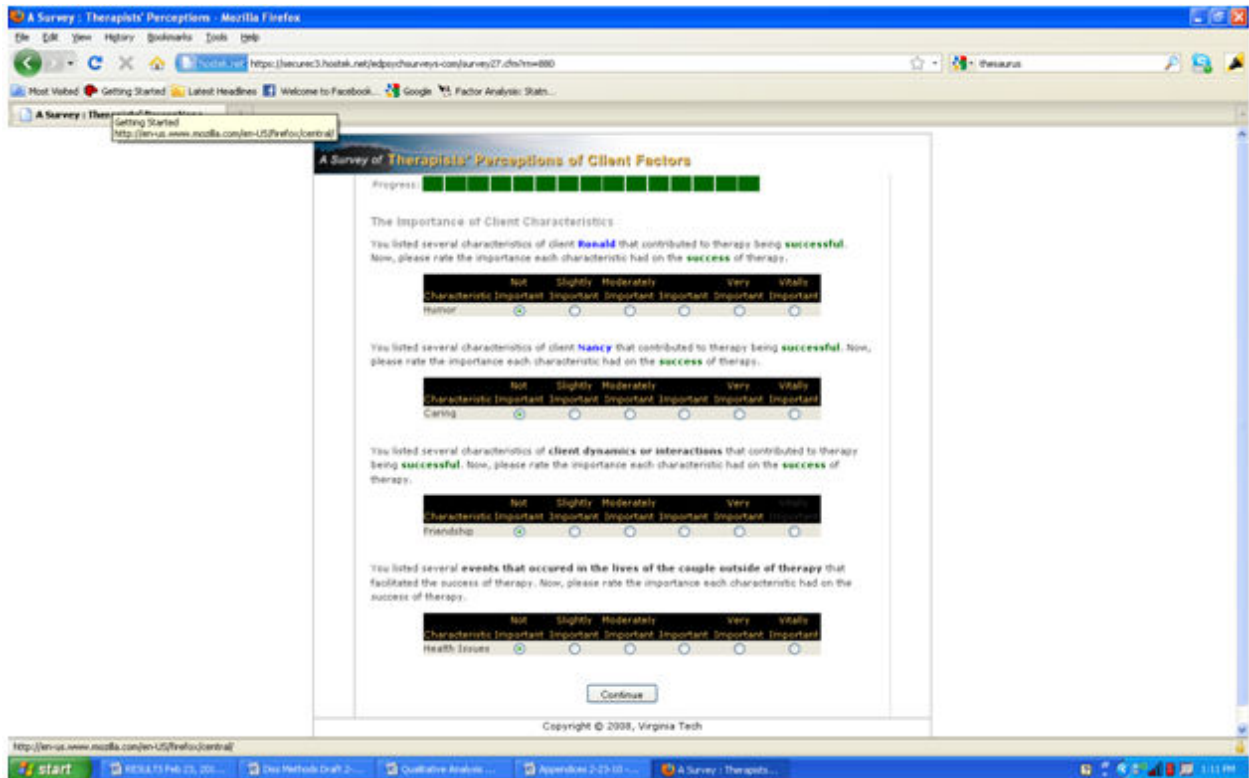
You listed several **events that occurred in the lives of the couple outside of therapy** that facilitated the success of therapy. Now, please rate the importance each characteristic had on the success of therapy:

Not Characteristic Important Slightly Important Moderately Important Very Vitaly Important

Health Issues

[Continue](#)

Copyright © 2008, Virginia Tech



A Survey of Therapists' Perceptions of Client Factors

Progress: 

The Importance of Client Characteristics

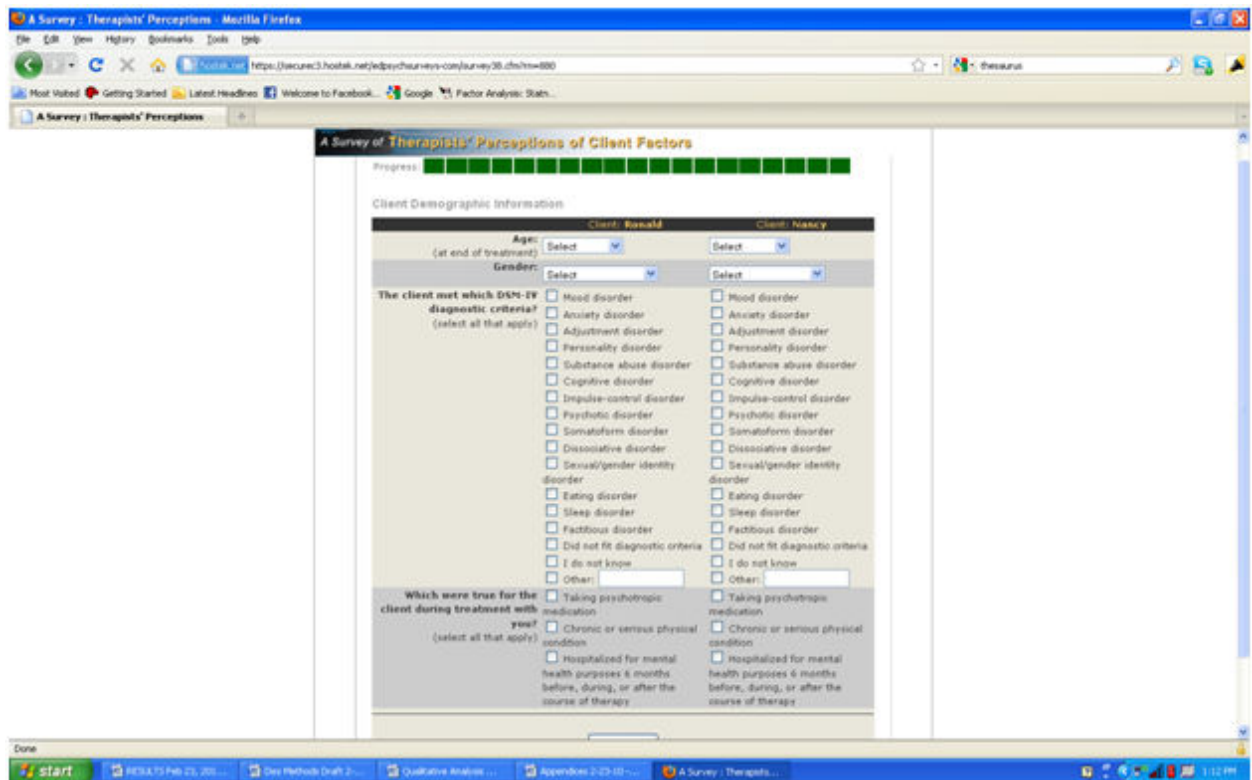
Literature and previous studies have identified several client factors that tend to influence the outcome of therapy. Please indicate how important you believe these factors were in influencing the **successful** outcome of **Ronald** and **Nancy's** therapy

Characteristic	Not Important	Slightly Important	Moderately Important	Very Important	Vitally Important	Not an Issue
Personality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal History	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Level of Individual Pathology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Motivation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intelligence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Religious Beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of Participation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resiliency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resistance Reactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Characteristic	Not Important	Slightly Important	Moderately Important	Very Important	Vitally Important	Not an Issue
Length (time) of Relationship	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Commitment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Positive Regard for Each Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Openness to Each Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional Responsiveness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Previous Relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flexible Gender Roles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Egalitarian Roles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Children Together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Characteristic	Not Important	Slightly Important	Moderately Important	Very Important	Vitally Important	Not an Issue
Outside Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social Support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Life Stage Transition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recent Tragedy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Job Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Continue



A Survey of Therapists' Perceptions of Client Factors

Progress: 

Therapist Demographic Information



Part I: Personal Demographic Information - About You, the Therapist

Age:

Gender:

Ethnicity:

Earned Degrees:
(Check all that apply)

- BA/BS
- MA/MS
- M.Div.
- Ph.D.
- Psy.D.
- Ed.D.
- M.D.
- Other, please specify:

Part II: Practice Information

Years Practicing:

Approaches to
Therapy
Most Used in Practice:
(Check all that apply)

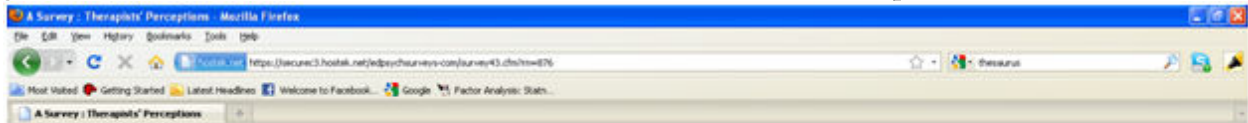
- Behavioral
- Bowen Family Systems
- Cognitive Behavioral
- Contextual/Ecological
- Emotion Focused Therapy
- Experiential
- Feminist
- Functional Family Therapy
- Imago
- Integrative Therapy
- Internal Family Systems
- Motivational Interviewing
- Multidimensional Family Therapy (MDFT)
- Multisystemic Therapy (MST)

- Narrative Constructivist/Constructionist
- Object Relations
- Psychodynamic
- Psychoeducation
- Relapse Prevention
- Solution Focused
- Strategic Family Therapy
- Structural
- Systemic (Milan Group)

Part III: Licensure Information

- Licenses/Certifications Currently Held:**
(Check all that apply)
- Licensed Marriage and Family Therapist (LMFT)
 - Licensed Professional Counselor (LPC)
 - Licensed Clinical Social Worker (LCSW)
 - Psychologist
 - Minister/Ordained
 - Intern/Trainee
 - Other, please specify:
 - None

Continue



A Survey of Therapists' Perceptions of Client Factors

Survey Completed!
Thank you very much for participating!

To enter the iPod touch drawing, enter your email here. Your email will not be connected with your responses in any way.

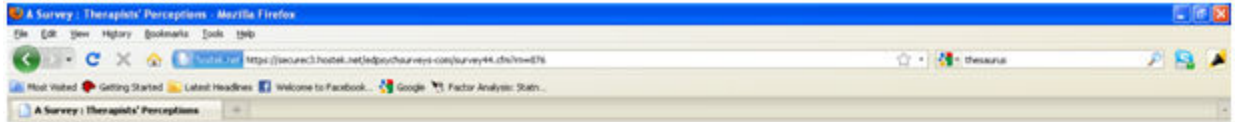
Email Address:

If you are interested receiving a copy of the results of this survey, please enter your email below or contact Susan Perkins, sperkins.research@gmail.com. Your email will not be connected with your responses in any way.

Email Address:

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED





A Survey of Therapists' Perceptions of Client Factors

Email Saved
Thank you very much for participating!

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED



Appendix H

Screen Captures of the Survey for Participant-Perceived Unsuccessful Couple Therapy

A Survey of **Therapists' Perceptions of Client Factors**

Progress:

Choosing a Client

Directions: Think of a couple you worked with in the past year who **UNSUCCESSFULLY** completed therapy. For this study, **UNSUCCESSFUL** therapy means:

- therapy did not produce desired change in clients. That is, clients did not begin to do things differently, did not reach the goals of therapy, and/or reported not being satisfied with the changes that may have occurred.

Please choose a client couple who:

- were in a committed, romantic relationship.
- attended at least two sessions.
- completed or dropped out of therapy.

Be sure you have a specific couple clearly in mind. Please do not use the clients' real names.

I do not work with couples or have not worked with a couple who fit the necessary criteria.

I have a specific couple clearly in mind.

For Person A, select a pseudonym:

For Person B, select a pseudonym:

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED

A Survey of **Therapists' Perceptions of Client Factors**

Progress:

Describing the Therapy of **Adam** and **Eve** - Part I

Part I: Therapy Information

Therapy Duration: Sessions

What was the format of therapy?

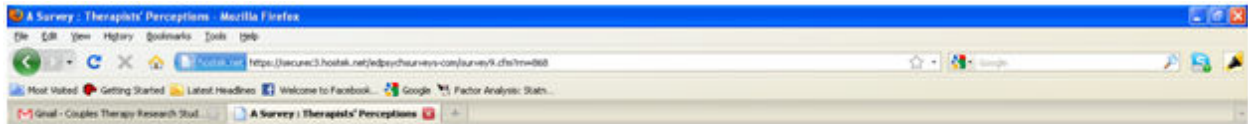
Were Any Other People (other than the couple) Included in any Sessions? Yes No

Your Judgment of the Severity of Couple's Problem:

Your Prognosis at Therapy Onset:

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED





A Survey of Therapists' Perceptions of Client Factors

Progress:

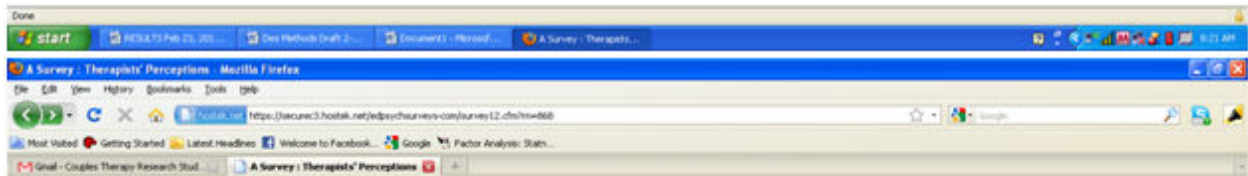
Describing the Therapy of **Adam** and **Eve** - Part II

Part II: Therapy Description

What was the presenting problem?

What were the goals of therapy?

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED



A Survey of Therapists' Perceptions of Client Factors

Progress:

Characteristics Affecting Therapy

What characteristics of Person A (**Adam**) do you think contributed to therapy being **unsuccessful**?

Please provide a label for each characteristic (e.g., bitterness) and a short explanation of that characteristic (e.g., he had a difficult time letting go of the past). Please include the characteristics that were most important to the outcome of therapy. You will be given the opportunity to enter as many characteristics, and explanations, as you like - one at a time.

Characteristic:

Brief Explanations:

Was this characteristic directly discussed in at least one session?

Yes

No

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED



A Survey: Therapists' Perceptions - Mozilla Firefox

https://secure3.hostek.net/edpsychsurveys-com/survey14.dcf?w=668

A Survey of Therapists' Perceptions of Client Factors

Characteristics Affecting Therapy

The characteristic you entered has been saved (see below). What would you like to do now?

Previously entered characteristics and explanations:

Characteristic	Explanation	Discussed directly in at least one session?	Changes?
Pansie	He let Eve walk all over him and would not stand up to her.	No	Edit Delete

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED


https://secure3.hostek.net/edpsychsurveys-com/index.dcf

start MSN 4.75 Feb 23, 2008 Day Method Draft 2... Documents - Recent... A Survey - Therapists...

A Survey: Therapists' Perceptions - Mozilla Firefox

https://secure3.hostek.net/edpsychsurveys-com/survey15.dcf?w=668

A Survey of Therapists' Perceptions of Client Factors

Progress 

Characteristics Affecting Therapy

What characteristics of Person B (Eve) do you think contributed to therapy being **unsuccessful**?

Please provide a label for each characteristic (e.g., bitterness) and a short explanation of that characteristic (e.g., he had a difficult time letting go of the past). Please include the characteristics that were most important to the outcome of therapy. You will be given the opportunity to enter as many characteristics, and explanations, as you like - one at a time.

Characteristic:

Brief Explanation:

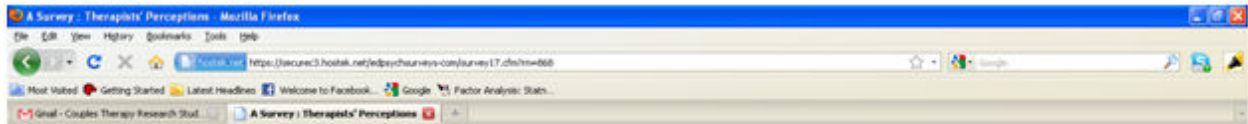
Was this characteristic directly discussed in at least one session?

Yes No

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED

Done

start MSN 4.75 Feb 23, 2008 Day Method Draft 2... Documents - Recent... A Survey - Therapists...



A Survey of Therapists' Perceptions of Client Factors

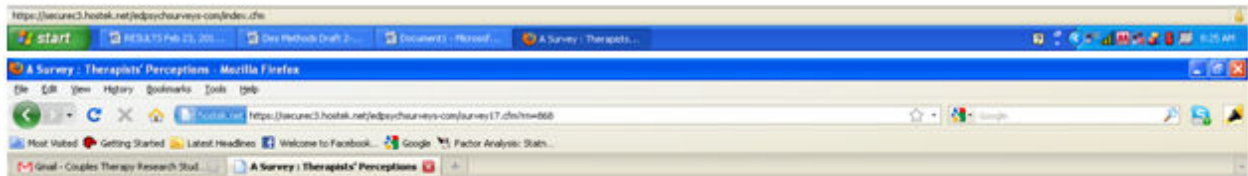
Characteristics Affecting Therapy

The characteristic you entered has been saved (see below). What would you like to do now?

Previously entered characteristics and explanations:

Characteristic	Explanation	Discussed directly in at least one session?	Changes?
Egotistical	She arrogantly disregarded Adam's concerns.	No	Edit Delete

Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED



A Survey of Therapists' Perceptions of Client Factors

Characteristics Affecting Therapy

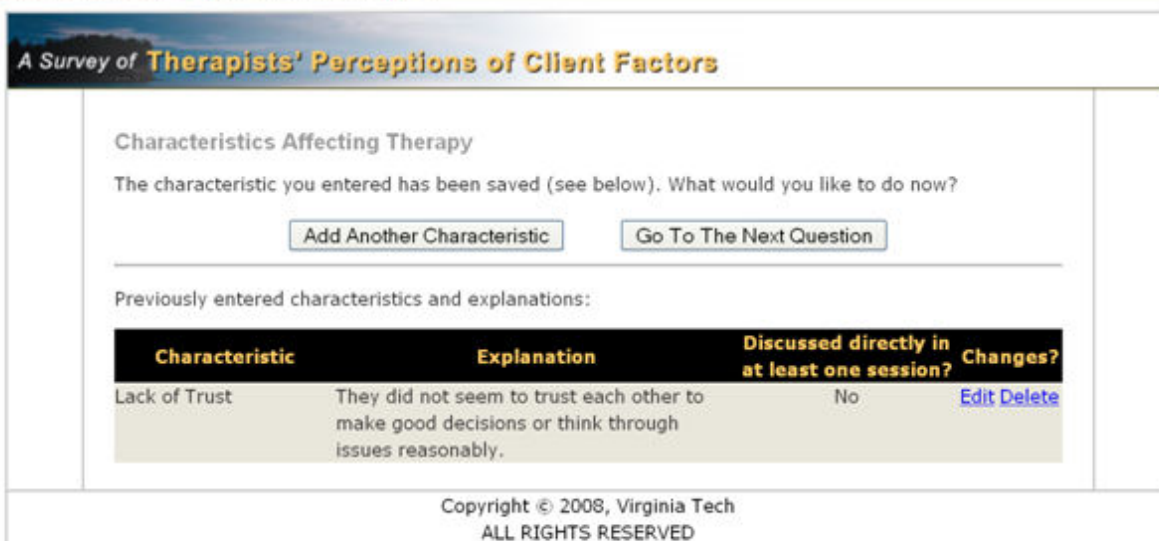
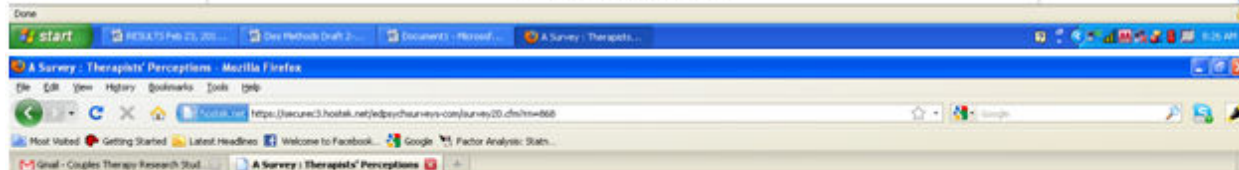
The characteristic you entered has been saved (see below). What would you like to do now?

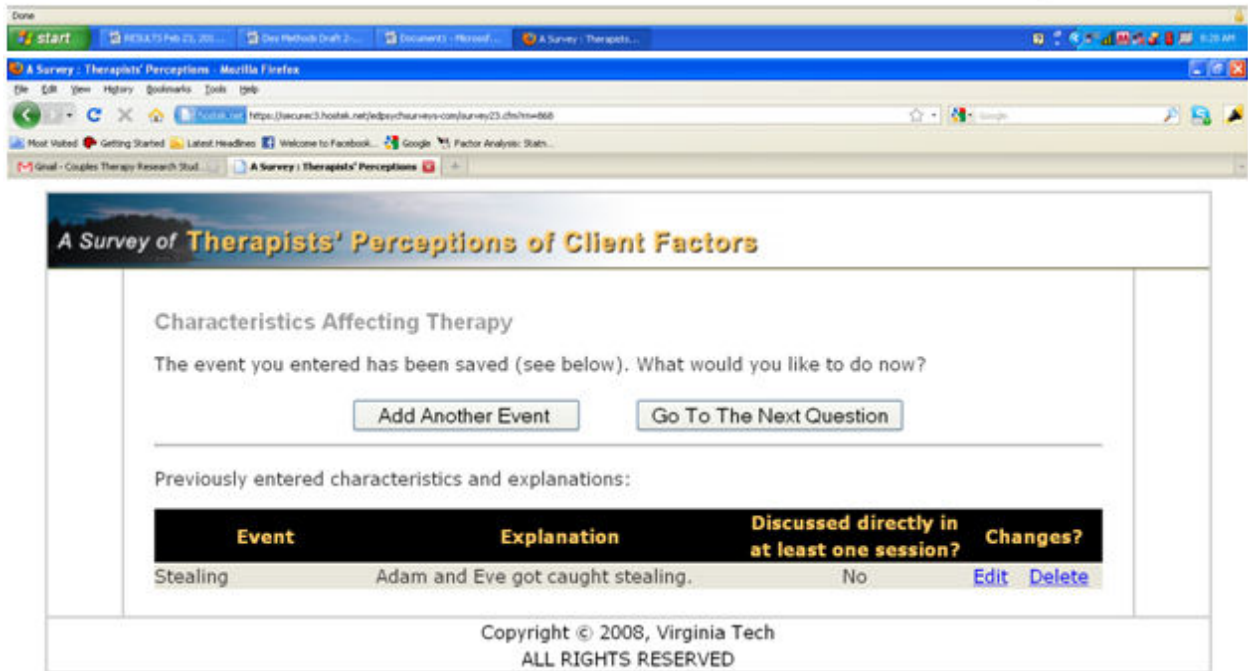
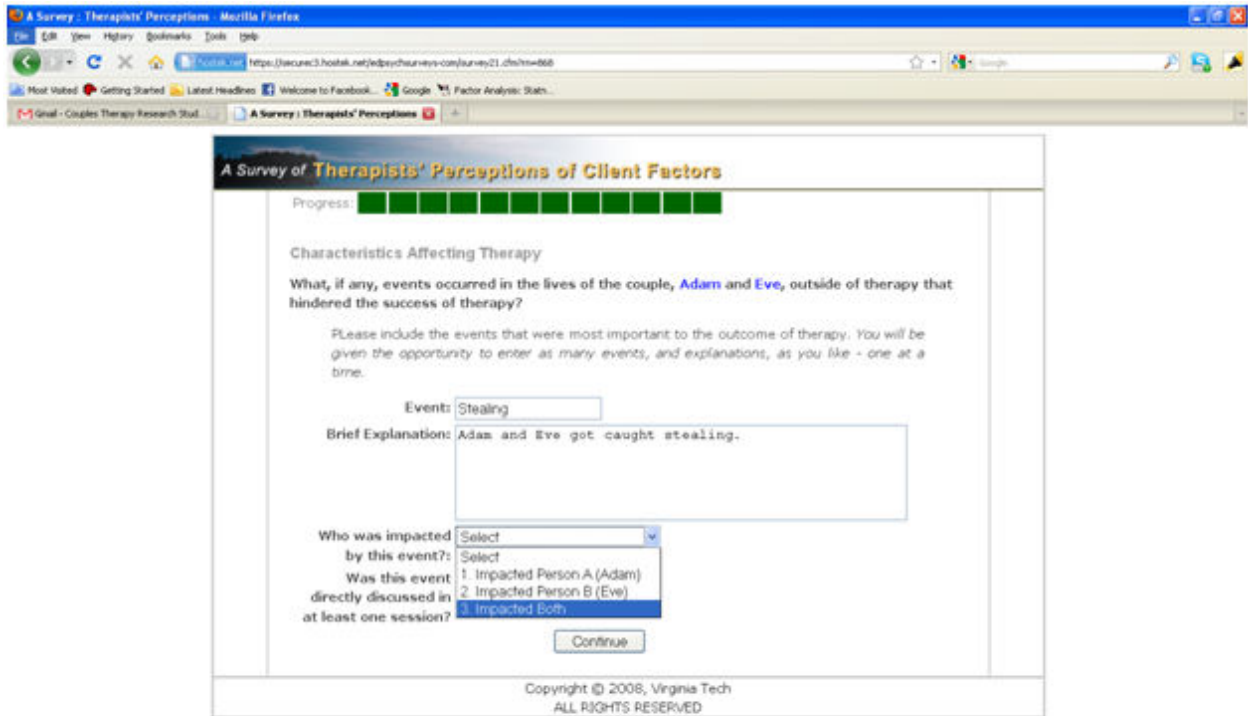
Previously entered characteristics and explanations:

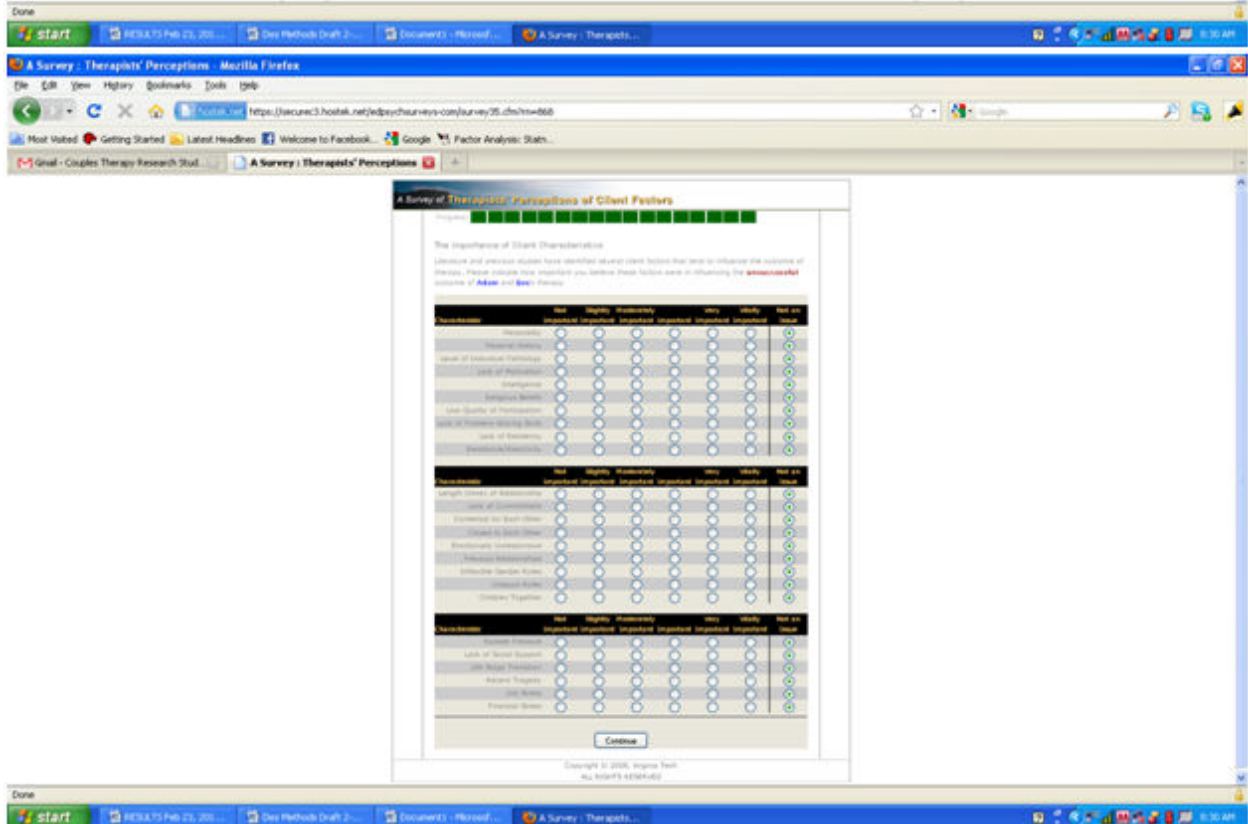
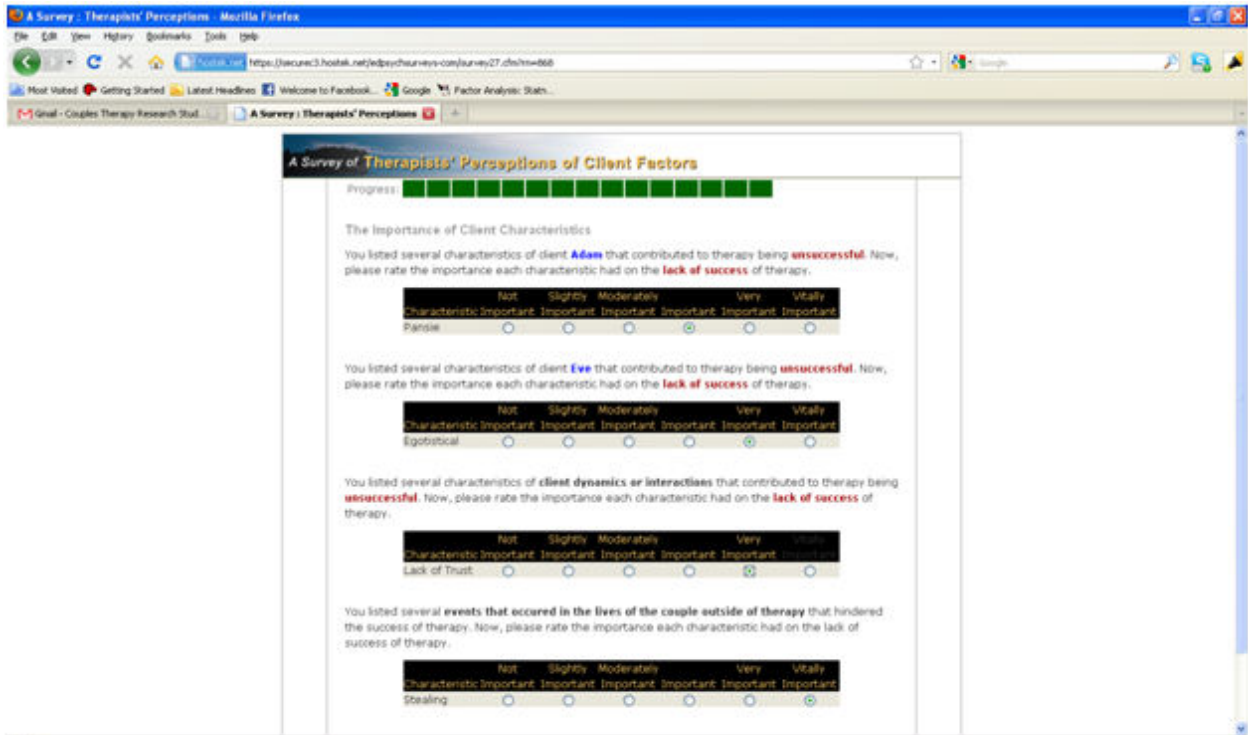
Characteristic	Explanation	Discussed directly in at least one session?	Changes?
Egotistical	She arrogantly disregarded Adam's concerns.	No	Edit Delete

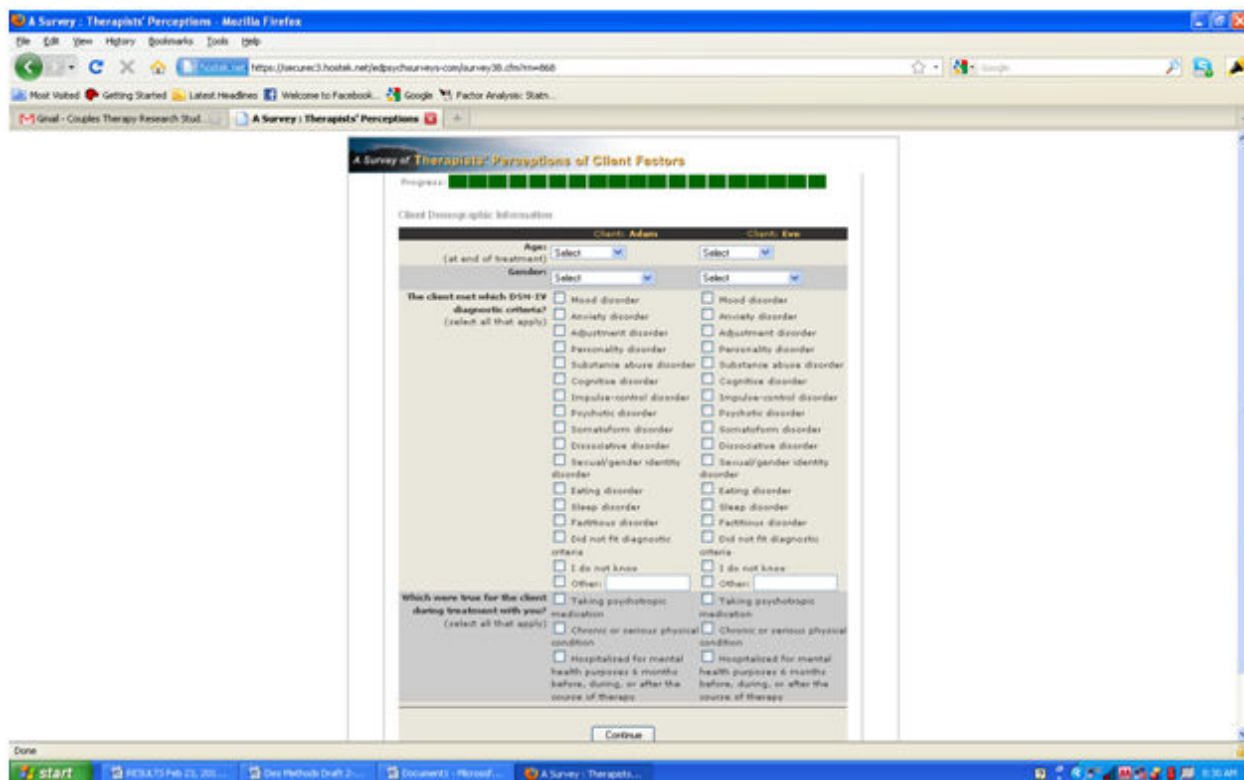
Copyright © 2008, Virginia Tech
ALL RIGHTS RESERVED











A Survey of Therapists' Perceptions of Client Factors

Progress:

Therapist Demographic Information



Part I: Personal Demographic Information - About You, the Therapist

Age:

Gender:

Ethnicity:

- Earned Degrees:
(Check all that apply)
- BA/BS
 - MA/MS
 - M.Div.
 - Ph.D.
 - Psy.D.
 - Ed.D.
 - M.D.
 - Other, please specify:

Part II: Practice Information

Years Practicing:

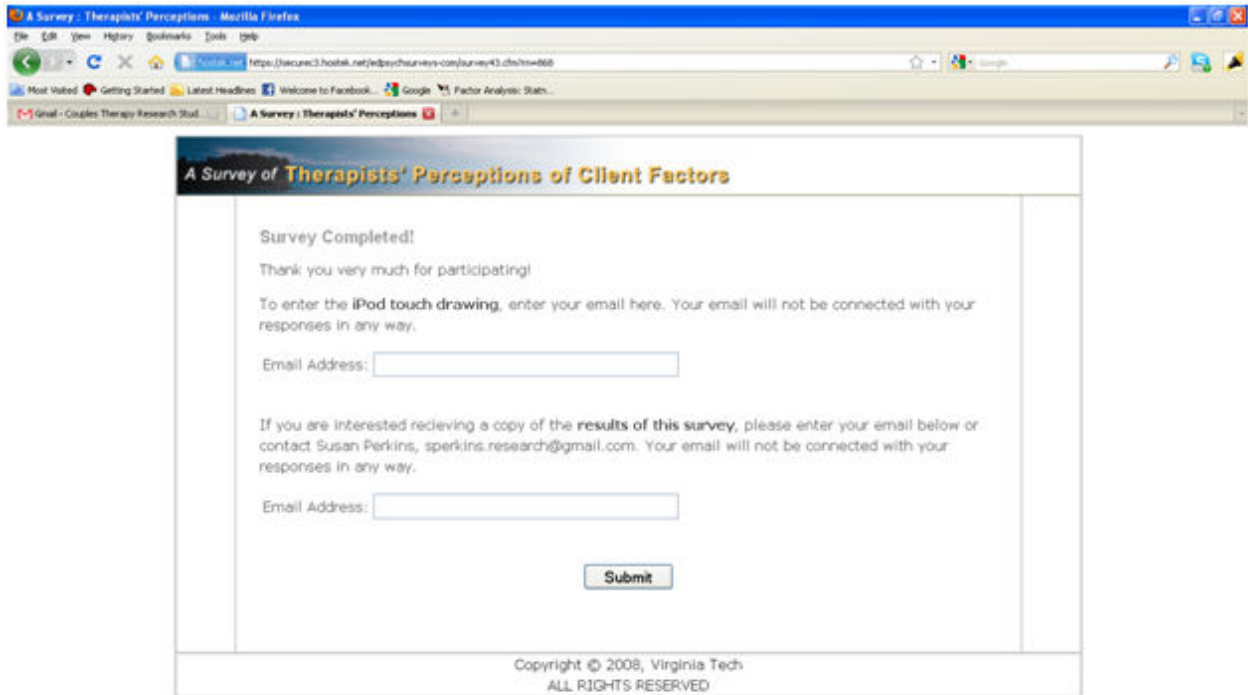
- Approaches to Therapy**
- Most Used in Practice:** (Check all that apply)
- Behavioral
 - Bowen Family Systems
 - Cognitive Behavioral
 - Contextual/Ecological
 - Emotion Focused Therapy
 - Experiential
 - Feminist
 - Functional Family Therapy
 - Imago
 - Integrative Therapy
 - Internal Family Systems
 - Motivational Interviewing
 - Multidimensional Family Therapy (MDFT)
 - Multisystemic Therapy (MST)

- Narrative/Constructivist/Constructionist
- Object Relations
- Psychodynamic
- Psychoeducation
- Relapse Prevention
- Solution Focused
- Strategic Family Therapy
- Structural
- Systemic (Milan Group)

Part III: Licensure Information

- Licenses/Certifications Currently Held:** (Check all that apply)
- Licensed Marriage and Family Therapist (LMFT)
 - Licensed Professional Counselor (LPC)
 - Licensed Clinical Social Worker (LCSW)
 - Psychologist
 - Minister/Ordained
 - Intern/Trainee
 - Other, please specify:
 - None

Continue



Appendix I

Separate and Combined Variable Names

New Variable Name	Name for Successful Cases	Name for Unsuccessful Cases
Amount of Problem Solving Skills	Problem Solving Skills	Lack of Problem Solving Skills
Level of Resiliency	Resiliency	Lack of Resiliency
Quality of Participation	Quality of Participation	Low Quality of Participation
Level of Motivation	Motivation	Lack of Motivation
Level of Commitment	Commitment	Lack of Commitment
View of Each Other	Positive Regard for Each Other	Contempt for Each Other
Level of Openness to Each Other	Open to Each Other	Closed to Each Other
Amount of Emotional Responsiveness	Emotional Responsiveness	Lack of Emotional Responsiveness
Flexibility of Gender Roles	Flexible Gender Roles	Rigid Gender Roles
Equality of Roles	Egalitarian Roles	Unequal Roles
Amount of Social Support	Social Support	Lack of Social Support

Appendix J

Qualitative Coding of Literature-Based Client Characteristics

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data Which did not Include the Literature Term but Were Consistent with the Description for This Code
Intelligence	<p>“Intelligent: Able to cognitively understand concepts related to couple interaction”</p> <p>“Intelligence: She was able to take a larger perspective. She was able to analyze and appraise.”</p>	<p>Intelligent, intellectual, analytical, cognitive, and logical fit in this code.</p> <p>Willingness to address issues was coded as “Quality of Participation.”</p> <p>Looking at personal mistakes is the main component of the “Humble” code.</p>	<p>Themes in this code included the idea that the client can objectively look at a situation and understand what is happening from more than that person’s individual perspective and experience.</p>	<p>“Logical: Able to think things through, find patterns, work on solutions”</p> <p>“Maturity, life experience: He was able to look at the couple’s difficulties from multiple perspectives.”</p>
Length of Relationship	<p>“History: They had a long history (high school sweethearts) and positive memories of the past with each other”</p> <p>“Longevity: Had invested 14 years in their relationship”</p> <p>“Quality of communication: Healthy communication never established consistently. Long history of verbally abusive communication.”</p>	<p>If the participant specifically mentioned that the length of time of the relationship is an important component, “Length of Relationship” was used.</p>	<p>Most of the data in this code reflect investment in each other and a sense of history together. A few participants said the history of the relationship worked against the couple in that they had struggled the whole marriage and were hopeless that things would change.</p> <p>Short length of the relationship was not mentioned by these participants.</p>	<p>“Shared experiences: As [ethnicity] refugees, they both endured horrific hardships before coming to this country. This has given them a deep emotional bond.”</p> <p>“Longevity: With a 22 year marriage under their belt, the couple had “a lot to lose” and also a lot to learn from.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Level of Individual Pathology	<p>"Mental illness: I believe 'Mary' was bi-polar. She had never been evaluated or medicated for this. She experienced classic symptoms & struggled daily."</p> <p>"Depression: His depression symptoms were very significant, including some indicators in the first session that he had contemplated suicide. He was not willing to talk much about these symptoms."</p>	<p>Specific mention of diagnosable mental illness, especially if a DSM term is used. Look for diagnosis terms such as "symptoms" and "pathology." Addictions, including alcohol, drug, and sexual addictions were coded at this code.</p>	<p>Depression and Anxiety were mentioned most frequently. Personality disorders were mentioned.</p>	<p>"Alcohol abuse: Described as weekend use mostly but to point of acting out angrily against children (no physical violence but verbal)"</p> <p>"Anxiety: Gary was under significant work stress and was generally anxious as well. He was a competent professional but was having some interpersonal problems at work."</p>
Personal History	<p>"Fear: Jill seemed to be re-experiencing trauma of abuse from past. Psychiatric symptoms were not addressed"</p> <p>"Combat trauma: He had undergone significant trauma on multiple occasions while in the war. This was prior to therapy, but affected who he was as a person, emotions, etc."</p> <p>"Easily offended: Raised in an alcoholic, neglectful family; one major job firing as an adult; client almost paranoid about being disrespected."</p>	<p>Comments in this code focus on things in the person's past that have shaped the way this person views the world or experiences others.</p> <p>Primarily includes comments on the client's family of origin influences.</p>	<p>Different from "Lack of Resiliency" in that "Personal History" focuses on how the past events have shaped the person's current experiences. "Lack of Resiliency" includes comments that the person has not been able to let go of or move on from a difficult past event.</p> <p>"Previous Relationships" code is used if the comment primarily mentions a previous romantic relationship or marriage as the influencing factor.</p>	<p>"More passive than wife: His own mother similarly "dictator" so had trouble negotiating with wife's similar behavior. His own mother so irritable and father similarly passive, that father left for another women who has nothing to do with family now."</p> <p>"Guarded: Sally had had many boyfriends in the past as well as being sexually abused by a relative as a child. She has difficulty trusting anyone including herself."</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data
Personality	"Rigidity: John had compulsive traits and a rigid personality structure."	Only one participant used the term "personality" to describe the main aspect of a client that impacted the outcome of therapy. Because almost anything could be considered "Personality," any other literature term that could be applied was applied first. The researcher looked for comments that seemed to make a global statement about a client, giving the impression that "He was such a ___ person."	Some of the most commonly mentioned characteristics that were coded as "Personality" were: Patience and impatience, maturity and immaturity, insecurity or low self-esteem, fearfulness, impulsiveness, arrogance, and the individual's demeanor.	<p>... "Patient: Alice was willing to give Adam the space to think about the marriage before quickly ending it." "Impatient: Sherry would see a small change in Chris but would quickly redirect her attention to the fact that he had not already made all of the changes she wanted." "Immaturity: Mike depended on family members and on Betty to take care of most of life's details. He had difficulty tolerating frustration and accepting responsibility for an adult relationship." "Low self-esteem: Didn't feel like he could ever do a good enough job." "Fear of Judgment: His primary value was to maintain public appearance of propriety and success." "Demeanor: Was sarcastic but had no idea of the ill remarks he made about his wife." "Chauvinistic: Felt he should not have to "answer" to his wife, should be able to pursue activities (hunting/ fishing) despite her needs or health issues which made it difficult."</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Previous Relationship	<p>“Previous marriage partner had been unfaithful: This was a second marriage for both. Each had been betrayed by past spouse. Trust was very difficult for them.”</p> <p>“Conflict with ex-spouse: Bo had a very contentious relationship with his ex spouse with whom he had two children and with whom he could not effectively co-parent.”</p>	<p>The “previous relationship” code was used when the characteristic described primary focused on the events or influence of a previous romantic relationship.</p>		<p>“Attachment: He was bitter about the break up of his former relationship and that he was not able to see his children. That relationship ended when his wife had an affair. Jack attacked his wife’s paramour and did jail time and anger management.”</p> <p>“Distance Regulation: Both spoke of difficulties with dependency and intimacy inherited from their experience with their first families. They were desperate for closeness, but determined not to give away their ‘power.’”</p>
Religious Beliefs	<p>“Religious: Mary used prayer to hold an open and positive position in her marriage and to remain loyal to the possibility of increased trust.”</p> <p>“Beliefs: They both held religious beliefs and this enabled them to stick together.”</p>	<p>Comments on spirituality, church, belief systems, and religious faith were included in the “Religious Beliefs” category.</p>	<p>Religious beliefs or spirituality were primarily described as providing motivation for the couple to remain committed to each other. Shared beliefs were mentioned a few times.</p>	<p>“Spirituality: He used his spirituality to help him deal with challenges in the relationship that helped him continue working towards improving the relationship.”</p> <p>“Blind faith: Strong faith in God, to the exclusion of taking responsibility for her future, saying God would make it happen if it should.”</p>

LITERATURE/ TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data
Resistance/ Reactivity	<p>“Reactivity: Both Ben and Vera were highly reactive to one another and lacked differentiation.”</p> <p>“Passive: Bill didn't appear to show interest in therapy or his wife's struggles. He was more reactive to problems instead of discussing prevention. Bill had a big sense of humor which he used to deflect & defuse many deep conversations.”</p> <p>“Resistant: Refused to talk about particular events/feelings if he didn't feel like it.”</p> <p>Resistance: She kept saying she didn't want to come in and she didn't want to talk to me, and she didn't need help, but when they send me long angry, bitter emails...she desperately wanted help, but couldn't let herself receive it.”</p>	<p>The overall sense of this category is that a client's response was too closely tied to the stimulating event, that the client did not take time to think through what the client wanted and respond accordingly. Some of the characteristics described as “Resistant/Reactive” were angry or aggressive in tone while others were passive or created distance.</p>	<p>A few of the comments that had “resistant” or “reactive” in them also fit another code. For example, one participant wrote, “Resistant: He would not complete homework assignments given in therapy.” This also fits well with “Low Quality of Participation.” For data in which one comment would fit more than one code, the researcher used the specific wording to determine which code to use. The above example was coded as “Resistant/Reactive” because of the specific word choice.</p>	<p>...</p> <p>“Rebelliousness: Lori does not want to be told what to do. The more Lori feels to be attached, the more Lori fought and moved to the opposite direction.”</p> <p>“Independence: You could call it many things, maybe undifferentiated, problems with authority, insecurity even. He stated many times that he didn't like being ordered around, but this would follow a simple comment from Autumn saying she would like it if he'd do something. Even a request was treated as some barbaric order. This made therapy very difficult.”</p> <p>“Volatile: When something upset Lori, she quickly became angry and harsh.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Children Together	<p>“Time spent with their children: Any time spent with their children was very positive in all aspects of their life.”</p> <p>“Patty became pregnant with their second child: This added to the responsibility and completeness of the family which helped Gary take more ownership of his part in the system.”</p>	<p>Participants at times mentioned the couple's children mixed in with other information. To capture the impact of children, any mention of children was coded as “children together.” This often included parenting issues.</p>	<p>Participants often overlapped mentioning children with the life stage transition of becoming new parents.</p> <p>Children were described as both a stressor and a motivator.</p> <p>Parenting differences were often highlighted.</p>	<p>“Children : Devotion and same goals”</p> <p>“Defiant son: Son contributed to the stress in the marriage”</p> <p>“Naming of child: Sally unilaterally named the oldest son without Bobby's input . . . this was particularly egregious in their culture”</p> <p>“Child rearing: They disagreed upon how to assign chores to their children. Also, their oldest went away to school and cut off all communications.”</p>
Outside Pressure	<p>No participants used the term “pressure” in describing a client factor that influenced the outcome of couples therapy.</p> <p>The closest descriptions of this were participants who described clients being under court pressure to attend therapy for various reasons.</p>	<p>Pressure to attend individual or couples therapy.</p>	<p>Often seemed to overlap with “Social Support” and “Lack of Social Support.”</p> <p>Also overlapped with descriptors of stressors.</p> <p>Most of these stressors fit more clearly in other categories.</p> <p>This was not a useful code and would have been eliminated if it were not included in the literature list.</p>	<p>“DHS Involvement. Omar left red marks on Wendy's youngest son. DHS was called.”</p> <p>“Dismissal of domestic violence charges: After domestic violence charges were dropped, clients cancelled shortly afterward.</p> <p>Believe motivation to address communication diminished.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Life Stage Transitions	Participants did not use the term "Life Stage Transitions," but did list and describe several transitions. Marriage, birth of children, adolescence of children, empty nest, retirement, and caring for older parents were specifically mentioned.	Descriptions of typical, developmental life stage tasks were included in this code.	Life stage transitions were described in more positive terms when they were expected and wanted. Unplanned pregnancy, for example, was described as a stressor. At times, participants discussed the impact of the life stage transition and the couples' ability to adjust to the changes.	<p>"Wedding: Abby and Paul experienced many family and cultural clashes around their proposal and the planning of their wedding, and they had difficulty discussing the residual hurt (or even describing the events clearly)."</p> <p>"Birth of child: The couple had a baby that was less than 1 year old. This served as a strong motivation to work out problems and stay together."</p> <p>"They made a plan for his retirement: He is a police officer and the stress of indecision was a major factor. They had many discussions and a mutual plan was developed and is being followed. The stress of being in limbo has been resolved."</p>
Recent Tragedy	No participant used the term "tragedy." The closest events to tragedies that participants mentioned were deaths of family members and/or friends. Illnesses were also mentioned.	Significant, difficult events which were described as traumatic were included in this code.	The events themselves were difficult, but participants often described the impact of the event as either helping or hurting the relationship. Events which happened more than a year ago were not included in this category.	<p>"Son's attempted suicide: The couple's son (15) had been having difficulties with peers at school, was being treated (medication) for depression, and made a suicide attempt approximately 1 month before the couple entered treatment."</p> <p>"Death of her mother: Shannon became very involved with her sisters and mother and extremely anxious. She longed for a very high level of support from David. David felt shut out, helpless, and blamed for everything wrong between them."</p> <p>"Rekindling love: Jarrod's near death reminded both of them of their deep love for each other."</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Job Stress	<p>“Job crisis: Aaron took gamble and quit job he didn’t like... Bunny supported him.”</p> <p>“Job: Elise has a busy job which takes up most of her time.”</p>	<p>Situations which included job, work, or education were included in this code.</p>	<p>Very connected to financial stress</p> <p>At times these comments included a sense of priorities and values, but other times work stress just created logistical difficulties, such as difficulty scheduling appointment.</p>	<p>“Negative evaluation at work: Mike got a negative evaluation at work which was very painful for him. Hannah was able to support him through this and help him to put it in perspective.”</p> <p>Husband had pay cut: Due to economic situation of husband’s employer, forced to take pay cut; wife wanted husband to make up lost income with part time work; husband chose to play sports instead.”</p> <p>“Gary’s promotion: Gary’s promotion at work freed up time for the family/couple to spend more time and prioritize their life domains differently.”</p>
Financial Stress	<p>“Financial instability: The couple had been out of work for some time. I feel this added stress and blame to an already unstable union.”</p> <p>“Employment/money difficulties: Couple struggled with money management issues; employment difficulties also contributed to this.”</p>	<p>Comments related to money and finances were included in this category.</p>	<p>Very connected to job stress</p> <p>Often connected to the larger picture of the economic situation</p>	<p>“Finances: The couple was hoping that each could find a job in the near future and was worried about being able to afford therapy until they did find jobs.”</p> <p>“Finances: This couple has financial security despite the turn down in the economy. They are not overly anxious about financing their retirement.”</p> <p>“Finances: Roy finally allowed Vienna to join with him in making financial decisions.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Commitment	<p>“Commitment: Despite a relapse by George, Tammy remained committed to the relationship.”</p> <p>“Commitment: They were committed to staying in the marriage, and to working out their difficulties, and to each other's welfare.”</p>	<p>Includes commitment to the other person in the couple, or to the marriage. Many participants also included commitment to work on the relationship, or commitment to therapy.</p> <p>Participants used words like “reliable,” “persistent,” “perseverance,” “tenacious,” “dedicated,” and “patient.”</p> <p>This was differentiated from “Quality of Participation” by putting characteristics that only focused on participation in therapy, or commitment to sessions, in the “Quality of Therapy” code. Characteristics that mentioned being committed to the relationship or person were included in this “Commitment” code.</p>	<p>Many of the characteristics that fit the “Commitment” code also had themes of working hard in therapy and sticking with the other person through difficult situations.</p> <p>Although usually used when talking about <i>individuals</i>, participants also talked about a <i>couple</i> as being committed.</p>	<p>“Determination: Tom was determined to work toward a positive solution.”</p> <p>“Reliable: Showed regularly for sessions.”</p> <p>“Loyal: James is very loyal and wanted things to work with Nicole. He felt that she was “the one” for him.”</p> <p>“Perseverance: Kept coming back, in his attempt to understand himself, his wife, and their patterns.”</p>
Lack of Commitment	<p>“Lack of commitment: John indicated from the onset of therapy that he didn't think he had time for marriage counseling as he was a fulltime graduate student in a very demanding program. . . .”</p> <p>“Lack of commitment to change: Both wanted something different but neither was prepared to be the one that made changes.”</p>	<p>Data were coded as “Lack of Commitment” when the participant described ambivalence about therapy, and inconsistency in making changes.</p> <p>Descriptions of clients who came to therapy looking for a way to tell their partner the relationship was over were also coded as “Lack of Commitment.”</p>	<p>Participant comments about lack of commitment included themes of ambivalence, avoidance, and not sustaining changes even when changes were made.</p> <p>Although usually used when talking about <i>individuals</i>, participants also talked about a <i>couple</i> as having lack of commitment.</p>	<p>“Apathy: Curt did not seem to care about Jackie and was just looking for an excuse to end the relationship.”</p> <p>“Ambivalence about changing behavior: Agreement to try something new, but then not following through. Some additional effect of ‘it won't help anyhow.’”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Equal Roles	<p>“Mutual Respect: Both Jeremy and Sarah saw the other as an equal in the relationship.”</p> <p>“Independence: Determined to be seen as autonomous and an equal partner in the relationship.”</p>	<p>None of the participants used these exact terms. The researcher used characteristics in which participants used the term “equal” in a way that described the roles clients played or the position the clients were in with regard to each other. Participants discussed clients as “equal” by describing the clients as being on the same level, having the same amount of family-oriented work, or the power being balanced in the relationship.</p>		<p>“Partnership: While this quality was missing when they entered marital therapy, with Danielle complaining that she had more than her fair share of household responsibilities, both made changes to develop real mutuality and true partnership in parenting and running the household.”</p>
Unequal roles	<p>No participants used these terms. After reading the data and coding the other literature codes, the researcher looked at the remaining data to see what would fit this category. The researcher also considered the “Equal Roles” code and looked at a description of “Unequal Roles” that would have the opposite tone of “Equal Roles.”</p>	<p>The researcher decided on the following description: “Unequal Roles” includes descriptions of couples whose functioning in the relationship was described as unequal or whose power is clearly unequal between individuals.</p>	<p>Themes in this code included overfunctioning and underfunctioning, unequal control of family finances, and unequal value of the jobs of the couple.</p>	<p>“Overfunction-underfunction patterns: Terry would take on responsibility for Chris' underfunctioning; Chris would constantly defer to Terry's opinion.”</p> <p>“High focus on work: The vast amount of time he spent on work leaving her with 4 kids to raise alone.”</p> <p>“Uneven power structure: The relationship's homeostasis revolved around a hierarchy in which Julie retained the power as evidenced by her frequent chastisement of Peter's behavior as she would that of her 'son.’”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Motivation	<p>“Motivated: He desired change so strongly he was willing to try anything to change. Very open to feedback.”</p> <p>“Separation and divorce of friends: Seeing the marriages of their friends fall apart around issues of infidelity and inability to come to joint agreement motivated them to make certain the same thing would not be the outcome of their marriage.”</p>	<p>Most of the participants' uses of the term “motivation” included a sense that there was something that the client either wanted or did not want to that supported clients' commitment or participation in therapy.</p>	<p>The “Motivation” code addressed clients' values and goals that prompted them to change and helped them get through the struggles involved in marriage and in therapy. Some of the motivating factors mentioned included clients' concern for their children, desire for closeness, love for each other, personal trait of not wanting to fail, and just simply wanting change.</p>	<p>“Loved his kids: He came from a childhood of angry divorced parents, and wanted to ensure that he and Tamara would do better in divorce by their own children than his own parents had been able to do.”</p> <p>“Mutual desire to see it work: Both partners stated a desire to be with each other and to do what was necessary to make it work.”</p>
Lack of Motivation	<p>“Motivation: Not much distress about the problem.”</p> <p>“Dramatic: . . . when it came to working on the problem, she did not seem motivated to change, just wanted attention for her being mistreated.”</p> <p>“Dismissal of domestic violence charges: After domestic violence charges were dropped, clients cancelled shortly afterward. Believe motivation to address communication diminished.”</p>	<p>Participant comments that specifically described “lack of motivation” were focused on the client's perception that he or she did not have an important enough reason to change.</p>	<p>Themes of “Lack of Motivation” included hopelessness and lack of interest in the relationship and therapy.</p>	<p>“Defeatist: Would feel stronger and then give up, finding change too hard to sustain, tempted to return to simpler solutions, such as addictions, or old patterns of marriage.”</p> <p>“Divested: Wife was unconcerned about her behavior.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Positive Regard for Each Other	Mutual positive regard: Even though there were hurts, they both held each other in a very high positive regard.	<p>Only one participant used the term "positive regard." Others used the word "positive" in different ways (e.g., positive feelings, positive time together, positive vacation) that did not apply to this concept. A high percentage of couple client characteristics that participants described had to do with the clients thinking highly of each other.</p> <p>The researcher described "Positive Regard for Each Other" as a description of the clients liking or loving each other, having respect for each other, or having a friendship base.</p>	The data in this code have the sense that even though the couple have been through difficult times, they have been able to preserve a basic positive view of the other person or treat the other person with respect even during difficult times.	<p>Loving: She loved her partner very much despite the hurt and wanted to work it out. Friendship: They really did like each other. Intimacy: The couple loved each other and wanted to move past this problem. Respect for each other/ respect for the marriage: Their respect for each other enabled them to feel safe and expose very vulnerable parts of themselves. Neither wanted to "divorce" Respect: Both individuals knew that they cared for one another on a level that they did not understand.</p>
Contempt for Each Other	<p>"Contempt: Criticism with superior stance, putting the other down as a person. Not separating the person from the problem." "Contempt: She seemed to have resentment toward him for getting pregnant outside of marriage and so young (she was 10 yrs younger--early 20s)."</p>	Participants who used "contempt" described the clients as thinking negatively of the other person, harboring resentment, or being sarcastic and rude to each other. This is in stark contrast to "Positive Regard for Each Other."	The overall theme for the "Contempt for Each Other" category seemed to be that the people in the couple really thought poorly of each other and showed it to the other person.	<p>"Negative attribution: She interpreted everything he did and said from a negative perspective, or set of beliefs." "Feeling Superior: Enjoying holding the blame over Kevin's head. 'He was bad, she was good.'"</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Quality of Participation	<p>“Commitment: Mark, in the past did not take therapy seriously. This time he was open about his dislike of therapy which allowed us to openly address his concerns and create an approach which was engaging rather than problematic.”</p> <p>“Engaged: Jarrod paid attention in counseling sessions, both to me and to his wife and took homework assignments seriously.”</p> <p>“Engaged: Christina was fully cooperative in therapy and tried hard to make changes in herself.”</p>	<p>None of the participants talked about “quality” or “participation” when discussing clients’ involvement in therapy. However, several comments clearly described the clients’ participation in therapy. These were used to create the description of the “Quality of Participation” code.</p> <p>The “Quality of Participation” code includes comments about the clients’ participation in therapy, with therapy homework, and applying changes in therapy to life.</p>	<p>There were themes of willingness to change, openness to new ideas from the therapist, and descriptions of small changes that clients made. Flexibility was seen throughout this code.</p> <p>Both individuals and couples were described in this code.</p>	<p>“Openness: The couple was very open to my interpretations and interventions, and willing to try different things.”</p> <p>“Willingness to change: She typically withdrew and avoided. She really opened herself to changing and not being so conflict avoidant.”</p>
Low Quality of Participation	<p>“Lack of commitment and investment in therapy: Cancelled three sessions of seven scheduled, nearly 50%, arrived 40 minutes late to another session, eyes appeared glassy as if under the influence in one session. Wore hat in sessions regularly. Did not seem interested in changing any behavior, just talk.”</p> <p>“One stop fix: Husband and wife often did little after therapy to work on assignments given. Husband also did not want to talk about upsetting things in session. Did not like leaving with negativity in the air after a session.”</p> <p>“No communication skills: They did not know basic communication skills, but did not want to practice in therapy, and although they stated they felt it would be much better at home, they didn’t do it.”</p>	<p>Although no participants used “low quality of participation” in describing client’s interactions in therapy, many comments were made about difficulty in session with clients.</p> <p>Participant comments that specifically addressed clients not being invested or cooperative in session were used to develop the description of this code. The researcher also considered the “Quality of Participation” code and included the opposite of “Quality of Participation” when deciding how to describe “Low Quality of Participation.”</p> <p>The “Quality of Participation” code includes comments about clients missing sessions, not following through with homework, and clients not engaging in sessions.</p>	<p>Themes of unwillingness to look at personal issues, inability to regulate emotions that arose during difficult discussions, and rigidity in thought and actions were seen at this code. Comments at this code might relate well to the idea of client readiness for therapy.</p> <p>Both individuals and couples were described in this code.</p>	<p>“Minimizing/avoiding: Sue presented issues that bothered her in their marriage and then when they were explored she would back off to normalize mood.”</p> <p>“Guarded: Was very guarded, refused to meet with therapist alone for an individual session. Had a difficult time opening up in therapy.”</p> <p>“Not invested: He was going through the motions of therapy to satisfy his wife but was not very invested in the process.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Emotional Responsiveness	<p>“Emotionally responsive: They were both respectful and responsive to their emotional pains. They were sensitive to what was happening to each other.”</p> <p>“Mutual responsiveness: Each heard and responded to the partner’s requests for verbal and behavioral change.”</p> <p>“Mutual responsiveness: It took some time for Josh and Kate to get beyond their anger and hurt but once they got beyond it, they demonstrated the ability to mutually respond to one another’s feelings in a nurturing, positive way.”</p> <p>“Emotional connection: When things were good they were very good and they really felt the connection and strongly valued that.”</p> <p>“Emotional Engagement: Both supported the other.”</p>	<p>Only one participant used the exact term “emotionally responsive,” but several more used the terms “mutual responsiveness” and “emotional engagement.”</p> <p>Comments were coded as “Emotional Responsiveness” when the participant described one client doing something and the client’s partner responding in a way that would increase the positive emotional tone of the relationship. These comments went beyond describing the client just listening to his or her partner and included the client’s response to his or her partner.</p> <p>Comments that described the nature of the relationship as emotionally connected were coded as “Emotional Responsiveness.” In these comments, the clients were described as responding to each other in positive ways.</p>	<p>Some common themes among the “Emotional Responsiveness” data include clients who were described as loving, affectionate, tender, caring, empathetic, and making changes that the other person specifically requested.</p> <p>Many participants just said that clients “emotionally engaged” or “responded” and did not describe the response, but described that the impact of the response was positive.</p>	<p>“Acceptance: George was willing to listen to Ellen and respected her request for distance while she worked on increasing intimacy in the relationship.”</p> <p>“Sensitivity: The male showed a unique sense of sensitivity/tenderness to the hurt feelings and insecurities of his wife.”</p> <p>“Affectionate: Client often responded to partner’s expression of hurt and anger with compassionate physical touch.”</p> <p>“Mutual responsiveness: When Sean began to be more open, Jessica felt more trusting, and this led to more attention from Sean. They had not felt safe with one another for about a year.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Lack of Emotional Responsiveness	<p>“Emotionally disconnected: Each was hurting so badly and self medicating so much, they had pretty much lost their grip on feeling.”</p> <p>“Emotional distance: Long history of not sharing emotions in a safe, intimate manner.”</p> <p>“Level of emotional engagement: Never seemed to honestly and openly connect emotionally in session.”</p> <p>“Mutual responsiveness: This was poor in the couple, with outright rejection of repair attempts each made toward the other.”</p> <p>“Level of emotional engagement: Donna was disengaged, David began to disengage more over time as it was painful to him to be rebuffed.”</p> <p>“Level of emotional engagement: Couple avoiding emotional intimacy.”</p>	<p>Participants did not use the term “lack of emotional responsiveness,” but they did mention similar terms such as “lack of mutual responsiveness” and “emotionally disconnected.” Those related terms were used to form the description for this code.</p> <p>“Lack of Emotional Responsiveness” seemed to be descriptive of clients being unable or unwilling to emotionally respond or engage with each other. This includes the concepts of distance, lack of friendship, and lack of connection.</p> <p>If the couple were described as contemptuous toward each other, then the “Contempt for Each Other” code was used.</p>	<p>The lack of emotional responsiveness was attributed either to the client being unable or unwilling to personally express emotion or to the client being unable or unwilling to emotionally respond to his or her partner.</p> <p>Participants often described one client as reaching out to his or her partner and the partner not responding emotionally.</p> <p>One of the main themes in this code is lack of friendship or connection. Participants describe relationships that have grown apart and become very distant.</p>	<p>“Unresponsive to her pleas for more intimacy: Vern found her clingy and bossy and refused to grant her longing for more intimacy.”</p> <p>“Lack of connection: This couple did very little together. They had not developed a friendship prior to or during their romantic relationship.”</p> <p>“Distant: Not emotionally connected to Sherry.”</p> <p>“Over-practicality: Connie responded on a surface, practical level to Aaron's complaints, which glossed over his emotional needs.”</p> <p>“Friendship: It seemed like more of a relationship out of convenience or necessity than one based on friendship and love.</p>
Flexible Gender Roles	<p>“Flexible in gender role expectations: Despite his working full time and Betty's working part time or not at all, Bob was able to be empathic to Betty's needs and not expect/demand things of her simply because he was the wage earner.”</p> <p>“Flexibility: Anthony could conceive of changing his weekly routine to provide respite from child care duties for Elizabeth.”</p>	<p>Participants discussed “Flexible Gender Roles” by describing clients who were willing to be involved in the family in ways that are stereotypically male and female roles.</p> <p>This code is different than “Equal Roles” in that “Flexible Gender Roles” adds the gender component to the comment. “Equal Roles” comments only addressed equality of work or respect and in “Flexible Gender Roles” comments, participants also mentioned the gender of the parties.</p>		<p>“Respect for one another's careers: Began with lopsided respect, with Michelle expected to be elevate Seth's work to position of higher importance than hers. But this changed to be more equal.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Rigid Gender Roles	<p>“Immaturity: Jim did not relish the thought of becoming more responsible for the children and wanted to place most of the blame for the children's behavior on Jane's anger. Both of them had very rigid sex role expectations.”</p> <p>“Closed minded: John remained very conservative and fixed in his role as the man in the sexual relationship; i.e. he believed the problem was not his, but his wife's, therefore he was resistant to looking at his contribution.”</p>	<p>“Inflexible Gender Roles” includes descriptions of stereotypical gender expectations and roles and clients' difficulty or unwillingness to change from those stereotypical roles</p>	<p>Only six comments were coded as “Inflexible Gender Roles.” All six comments highlighted the male client in these comments; one comment included the female by writing. “Both of them had very rigid sex role expectations.”</p>	<p>“Rigid: Jack was born and raised in Germany, with stay at home mom and very traditional family. Verbally supported Jane's career but struggled to provide other support.”</p> <p>“Traditional: Dick was very old school and was not looking for a soulmate.”</p> <p>“Dominant-submissive roles: John took on a very much macho male role in the relationship and Jane the submissive, which lasted for the first 25 years of their marriage. By the time they decided to come to sex therapy, breaking out of these roles became too uncomfortable to bear and they relapsed into old patterns of relating.”</p>
Open to Each Other	<p>“Openness: Jay was extremely open about his hurt feelings.”</p> <p>“Honesty: Patient openly disclosed private details of feelings and experiences to move therapy forward.”</p> <p>“Willingness to talk about the tough stuff: Openness and willingness to talk about the hurt and to listen to each other.”</p> <p>“Openness: Both were able to listen and respond to the ideas and experiences of the others without defensiveness.”</p>	<p>Participants who used the word “open” in describing that clients were open to each other talked about openness in three main ways: 1. client willingness to express feelings and experiences with his or her partner and 2. Client willingness to listen to feelings and experiences of the partner, and 3. Clients being accepting of each other. Open to the therapist or therapy was coded at “Quality of Participation.”</p>	<p>Themes of honesty, vulnerability, and willingness were primary in this code. Assertiveness and emotion regulation were themes also described in the “Open to Each Other” code.</p>	<p>“Verbal skills: Able to verbally express emotions and cognitions in a way that is understandable.”</p> <p>“Empathy: Ability to demonstrate understanding of wife's point of view.”</p> <p>“Accepting: He was accepting of himself and his life and also of her when she wasn't nagging him.”</p> <p>“Accepting: She was able and willing to accept her partner as a flawed individual who makes mistakes.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Closed to Each Other	<p>“Closed: Janelle felt that the situation between herself and Larry would not change, because she had spent so much time trying to get him to understand. Was not willing to be vulnerable w/ her husband any more.”</p> <p>“Closed minded: Could not appreciate Violet as a person outside of her experience with him. Did not believe her painful past SHOULD be a factor in their relationship.”</p> <p>“Closed: Unwilling to self-disclose, especially about his behaviors.”</p> <p>“Closed down emotionally: Not good at asking to have his needs met.”</p>	<p>Participants who used the word “closed” generally referred to 1. the client being unwilling to disclose personal thoughts, feelings, and experiences to his or her partner, or 2. being unwilling to listen or accept what his or her partner was saying or experiencing.</p>	<p>Deception, hiding from each other, and lack of acceptance of the partner were common themes in the code “Closed to Each Other.”</p> <p>Many reasons were given for the clients being unwilling either to open up to his or her partner or to listen and accept his or her partner. Some of the more reasons described most commonly included immaturity, anger, low self-esteem, past experiences, and fear.</p>	<p>“Openness: Neither were able to be truly open to the other’s needs.”</p> <p>“Passivity: Did not assert his wishes or desires for himself or the family.”</p> <p>“Lack of openness: Eddie had his own secretive, private life for a really long time.”</p> <p>“Neither of them is able to be very open with their feelings. Neither felt safe enough to open up.”</p> <p>“Doesn’t listen when wife talks: Husband not open to new information.”</p>
Problem Solving Skills	<p>“Rational/ problem solving: This is her lead strength. She could be clam when he was overly emotional. The break - through came when she moved into also being vulnerable and curious as well as problem solving.”</p> <p>“Problem solving: They learned how to find solutions as a couple rather than acting independently or acquiescing to the other.”</p>	<p>Participants discussed problem solving skills primarily as the couple’s ability to work together in addressing and solving a problem.</p>	<p>Collaboration, teamwork, and complementarity were mentioned in this code.</p>	<p>“Collaboration: S and T developed an ability to work together to implement consistent parenting and make decisions as a couple.”</p> <p>“Collaboration: The couple worked as a team, developing into a team check routine. They reported improvements when they began to do more together.”</p>
Lack of Problem Solving Skills	<p>“Low efficacy: Couple did not believe in their ability to solve their problems and did not think that their situation would improve no matter what.”</p>	<p>Only one participant made a comment that implied lack of problem solving skills. No further descriptions by participants were coded at “Lack of Problem-Solving Skills.”</p>	<p>Although many of the clients may have had lack of problem-solving skills, it seems most participants described what clients did that demonstrated the lack of skill.</p>	

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Resiliency	<p>“Resilience and determination to stay in the marriage: She was very determined and willing to forgive and work at re-defining the relationship.”</p> <p>“Resilience: Sometimes I thought Joan would be much more upset from previous session but she was able to get back on track...she knew her partner better than me sometimes and was not as quick to "give up" as I thought she might be.”</p>	<p>Participants who used the term “resilience” discussed being forgiving and able to move forward in the relationship despite past hurts.</p>	<p>Forgiveness was the main theme in this code. Participants wrote about forgiveness as the key to allowing the client to put the past behind and re-engage in positive ways. Resiliency was discussed in terms of the couple’s relationship and was not mentioned as an overall trait of the individuals regarding life as a whole.</p>	<p>“Ability to forgive: Both began to understand the mutual nature of the hurt and need for forgiveness and were both able to come forward and eventually offer this to each other.”</p> <p>“Forgiveness: Willingness to forgive past hurts, engage in repair.”</p> <p>“Forgiving: Matt was quite forgiving and that seemed to give him more energy to focus on reconnecting with his wife and healing their relationship.”</p>
Lack of Resiliency	<p>“Resentment: She had a hard time letting go of the past and seeing how her husband was beginning to change.”</p> <p>“Unforgiveness: Both continued to refer to past experiences and to not let them go.”</p>	<p>Participants did not specifically mention “lack of resiliency,” therefore the researcher used the “Resiliency” code to develop an opposite definition for “Lack of Resiliency.”</p> <p>Comments were coded at “Lack of Resiliency” when the participant mentioned that one or both members of the couple could not let go of past hurts and move forward in relating to each other differently.</p>	<p>Specific terms used most commonly included “resentment,” “unforgiveness,” “bitterness,” and “unresolved.”</p>	<p>“Bitterness: She held onto, and quite regularly (at least once per session) brought up situations from many years past that may or may not have actually happened.”</p> <p>“Confusion/ guilt: Couldn’t understand what had led her astray and guilt that it had happened and that she was making too much of it.”</p>
Social Support	<p>“Church Support: Both were emotionally supported by their pastor and friends at church.”</p> <p>“They found a supportive group: They found a church that gave them a lot of support/as well as some training.”</p> <p>“Support of physician: Couple have confidence, trust in their primary care physician who referred couple to me.”</p>	<p>Descriptions of receiving support from others in a way that strengthened the couple relationship</p>	<p>Several of the examples of social support were connected with religion, church, and family. Friendships were helpful when they were mutual friendships or when they were seen to take the pressure off the relationship</p>	<p>“Extended family network: Darrel and Denise benefited from a positive and supportive extended family network.”</p> <p>“Friendship: They had mutual interests outside the marriage; they enjoyed similar friends.”</p>

LITERATURE TERM	Examples of Participants' Use of the Term	Final Description for the Terms	Note(s)	Examples of Participant Data ...
Lack of Social Support	No participants directly used the term "lack of social support" as a factor that influenced the outcome of couples therapy	Descriptions of relationships outside the couple that impacted the couple.	<p>Most often, participants discussed relationships with others that did not support the marriage as a connection that one person had outside the relationship that reduced the need for that person to connect with his or her partner.</p> <p>Lack of social support most often contributed to unsuccessful couples therapy, but in other cases, it helped the couple turn to each other.</p>	<p>"Flirtatious relationships at work: Both had flirtations relationships with co-workers on an ongoing basis."</p> <p>"Isolation: They were very dependent on each other but had little social interactions with others. They made several attempts but one of them would become critical and negative of the other."</p> <p>"Proximity of the other woman: The other woman (affair) lived in the house directly behind Daniel and Martha. . . . Martha and Daniel had to lose their home, their friends, and their activities to save their marriage."</p> <p>"Poor relations with other family members: This kept them interdependent with each other in a positive way—neither of them wanted to lose their "best friend" or the person they felt most safe with."</p>

Appendix K

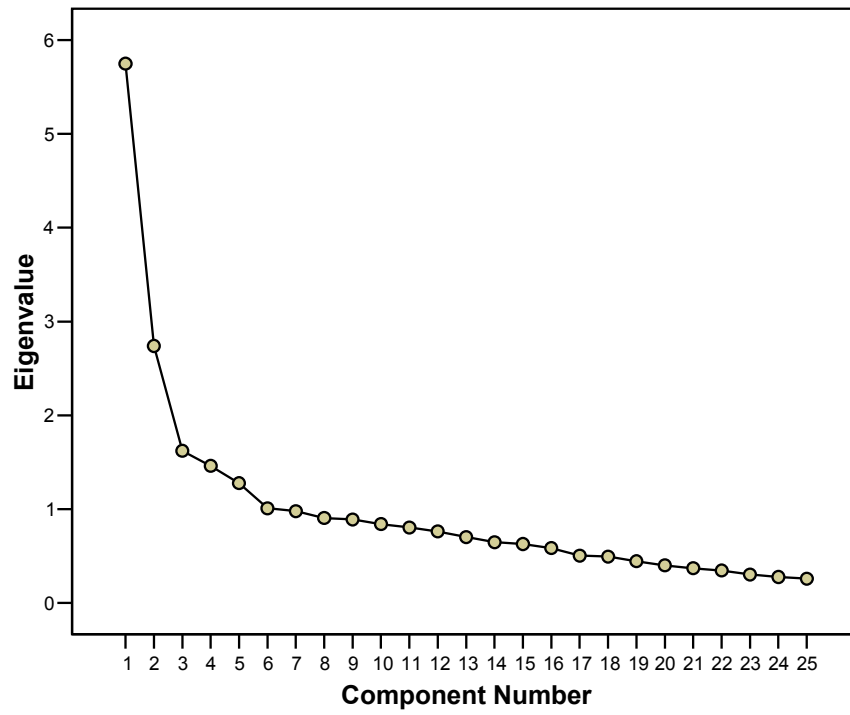
Number of Times Each Theory was Endorsed by Participants

Theory	#	%
Cognitive-Behavioral	238	59.8
Solution Focused	186	46.7
Emotionally Focused Therapy	160	40.2
Psychoeducation	122	30.7
Bowen Family Systems	106	26.6
Experiential	100	25.1
Structural	99	24.9
Psychodynamic	96	24.1
Narrative/Constructivist/Constructionist	78	19.6
Behavioral	75	18.8
Strategic Family Therapy	75	18.8
Motivational Interviewing	49	12.3
Systemic (Milan Group)	46	11.6
Feminist	41	10.3
Object Relations	39	9.8
Internal Family Systems	38	9.5
Imago	35	8.8
Contextual/Ecological	29	7.3
Functional Family Therapy	27	6.8
Relapse Prevention	27	6.8
Multisystemic Therapy (MST)	15	3.8
Multidimensional Family Therapy (MDFT)	10	2.5

Appendix L

Scree Plot for Principal Components Analysis of All Data

Scree Plot



Appendix M

Component Loadings for Resulting PCA Components of All Data

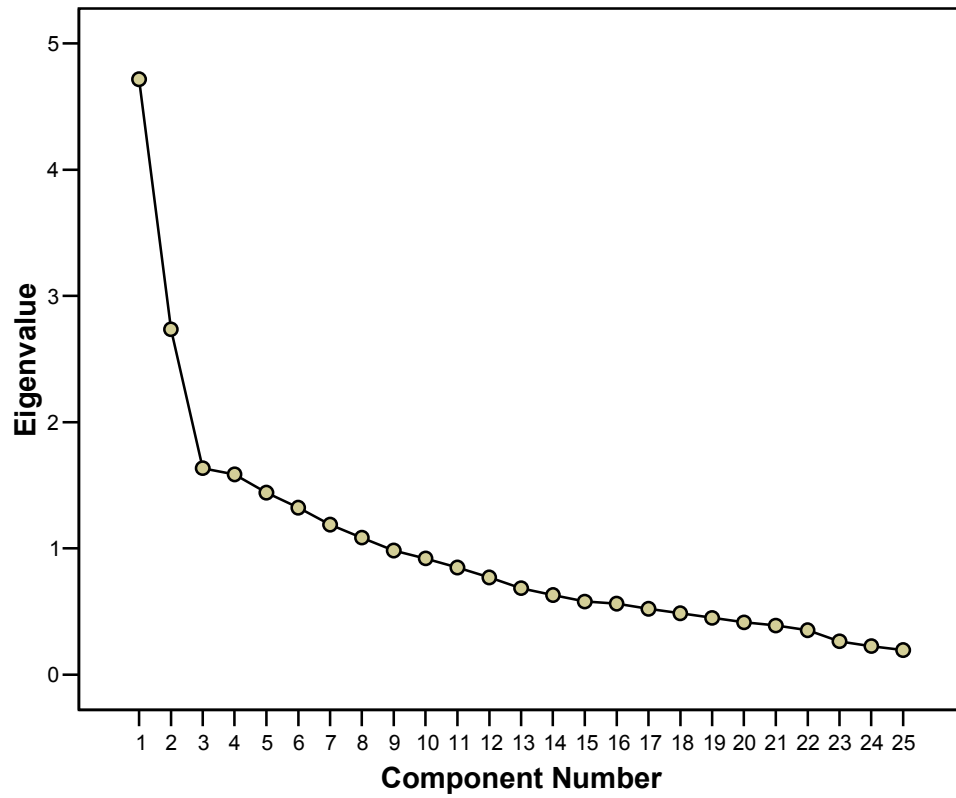
	Component				
	Relationally-Focused	Values-Focused	Outward-Focused	Individually-Focused	Task-Focused
Level of Openness to Each Other	.809	-.066	.026	.016	.220
Amount of Emotional Responsiveness	.766	-.020	.127	-.057	.166
View of Each Other	.714	.064	.036	.162	.105
Quality of Participation	.705	.385	.069	-.130	-.102
Level of Commitment	.672	.403	.065	-.071	.052
Level of Motivation	.662	.416	.077	.016	-.042
Amount of Problem-Solving Skills	.384	.380	.227	.200	.076
Intelligence	.347	.652	.087	.061	.105
Length of the Relationship	.129	.646	.097	.055	.177
Level of Resiliency	.322	.573	.044	.186	-.007
Religious Beliefs	-.021	.568	.157	-.068	.009
Children Together	.027	.450	.117	.057	.311
Job Stress	.042	-.090	.659	.105	.298
Recent Tragedy	.123	.082	.656	-.011	-.074
Amount of Social Support	.181	.252	.626	.047	-.025
Financial Stress	-.009	-.112	.607	.221	.331
Outside Pressure	-.054	.216	.597	.174	-.015

	Relationally-Focused	Values-Focused	Outward-Focused	Individually-Focused	Task-Focused
Life Stage Transitions	.097	.240	.552	.004	.098
Individual Pathology	.000	.024	.178	.703	-.011
Personal History	-.040	.086	.149	.694	.118
Personality	.063	.135	-.085	.680	.047
Resistance-Reactivity	.009	-.091	.071	.624	.042
Previous Relationships	.027	.198	.218	.258	.210
Flexibility of Gender Roles	.192	.231	.101	.050	.808
Equality of Roles	.166	.125	.111	.126	.794

Appendix N

Scree Plot for Principal Components Analysis of Cases Identified as Successful

Scree Plot



Appendix O

Component Loadings for Resulting PCA Components of Cases Identified as Successful

Variable	Overcoming Obstacles	Invested
Financial Stress	.628	-.216
Job Stress	.619	-.024
Life Stage Transitions	.605	.060
Outside Pressure	.594	-.058
Recent Tragedy	.502	-.159
Social Support	.492	.029
Previous Relationships	.457	.225
Flexible Gender Roles	.443	.348
Personal History	.437	.317
Equal Roles	.431	.376
Problem-Solving Skills	.412	.389
Individual Pathology	.409	.172
Length of the Relationship	.393	.275
Resistance-Reactivity	.339	.018
Children Together	.337	.174
Intelligence	.312	.262
Religious Beliefs	.310	-.049
Positive Regard for Each Other	.082	.758
Open to Each Other	-.156	.752

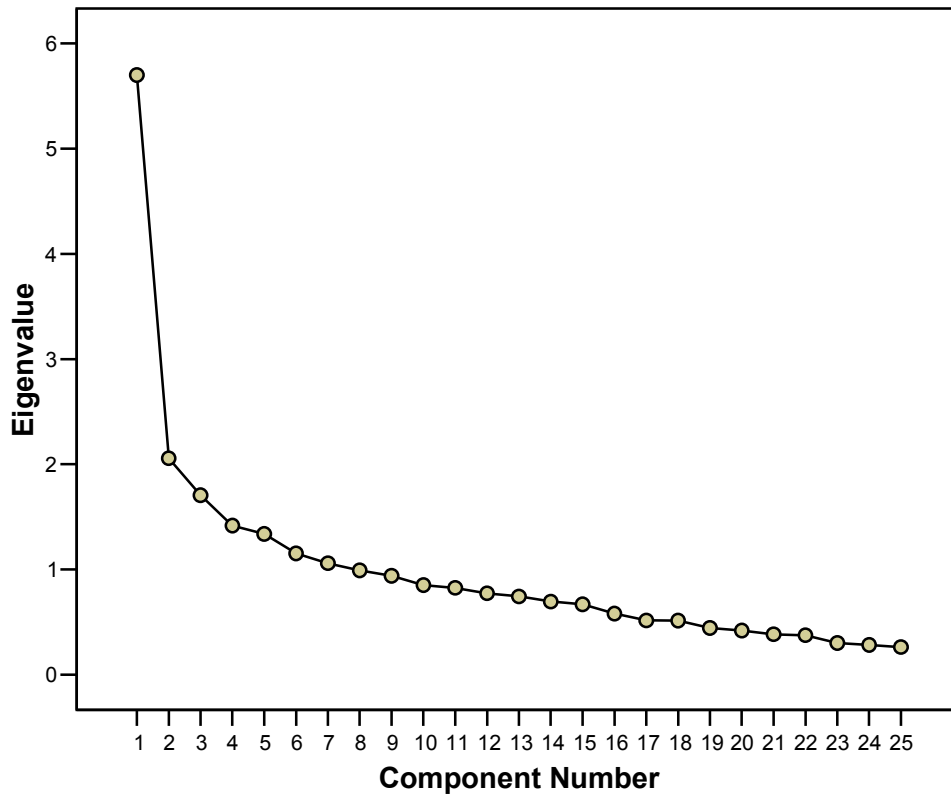
Appendix O continued

Variable	Overcoming Obstacles	Invested
Emotional Responsiveness	-.049	.691
Commitment	.066	.575
Quality of Participation	-.105	.499
Resiliency	.403	.414
Personality	.216	.383
Motivation	.020	.379

Appendix P

Scree Plot for Principal Components Analysis of Cases Identified as Unsuccessful

Scree Plot



Appendix Q

Component Loadings for Resulting PCA Components of Cases Identified as Unsuccessful

Variable	Unable to Recover	Relationally Passive	Intransigent
Lack of Motivation	.632	-.331	.129
Intelligence	.607	.116	-.015
Lack of Commitment	.583	-.400	.075
Lack of Problem-Solving Skills	.553	.051	.111
Lack of Social Support	.549	.192	-.275
Unequal Roles	.545	-.012	-.086
Rigid Gender Roles	.542	-.046	-.193
Low Quality of Participation	.522	-.457	.081
Financial Stress	.518	.279	-.190
Outside Pressure	.464	.223	-.300
Contempt for Each Other	.463	-.334	.263
Job Stress	.447	.256	-.303
Individual Pathology	.439	.349	.366
Children Together	.438	.053	-.145
Recent Tragedy	.432	.082	-.355
Length of the Relationship	.426	.218	-.080
Lack of Resiliency	.407	.235	.399
Previous Relationships	.327	.194	-.052
Religious Beliefs	.315	.080	-.055

Closed to Each Other	.525	-.559	.079
Lack of Emotional Responsiveness	.503	-.551	-.085
Personal History	.384	.451	.289
Resistance-Reactivity	.374	.136	.525
Personality	.342	.286	.492
Life Stage Transitions	.408	.145	-.436

Appendix R

Annotated List of Figures

Figure	Title	Page
1	<p>Participants' Descriptions of Literature-Based Client Factors</p> <p><i>This wordle was created using http://www.tagxedo.com. According to the tagxedo website (see: http://www.tagxedo.com/faq.html), "The images created by Tagxedo, and their derivatives, are licensed under a Creative Commons Attribution-Noncommercial-ShareAlike License 3.0, and must be attributed to http://www.tagxedo.com. The images created by Tagxedo and their derivatives are free for personal use, including usage on personal blogs, non-profit organizations, and non-profit education institutions, subject to the Creative Commons Attribution-Noncommercial-ShareAlike License. For more information on licensing please contact licensing@tagxedo.com"</i></p> <p><i>This figure provides a visual summary of the qualitative data that overlapped with the literature-based codes.</i></p>	101
2	<p>The Impact of Life Events</p> <p><i>This figure was created by the author using Microsoft Publisher.</i></p> <p><i>This figure illustrates participants' descriptions of the impact of life events on the outcome of couple therapy.</i></p>	132

No previously published illustrations were included in this paper. Therefore, no permission letters, fair use checklists, or public domain determinations were needed for this document.

IRB permission letter is included in Appendix A