

**CLIENTS' PERCEPTIONS OF THE THERAPEUTIC PROCESS:
A COMMON FACTORS APPROACH**

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(ABSTRACT)

The purpose of this study was to explore the aspects of therapy as proposed by “common factors” literature (e.g., extratherapeutic change, hope and expectancy, therapy technique, and therapeutic relationship) by surveying the clients of a university based family therapy clinic. Data were used to provide information about what factors are therapeutically helpful according to the client’s perspective. Surveys provided a quantitative and qualitative description of the client's therapeutic experience and were compared with those aspects of therapy found in the research.

Quantitative results indicate that therapeutic relationship, client motivation, factors outside of therapy, and hope and expectancy accounted for around 49% of the variance of clients’ perception of change and about 73% of the variance of clients’ perceptions of therapy helpfulness. Findings further suggest that the clients’ level of hopefulness and expectancy for positive change is the most significant predictor for both client change and therapy helpfulness. Qualitative results indicate that the therapeutic relationship is considered by clients to be the most helpful aspect of their therapeutic experience.

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CHAPTER I

INTRODUCTION

Statement of the Problem

While research has generally confirmed the effectiveness of family therapy (Hazelrigg, Cooper, & Borduin, 1987; Henggeler, Borduin, & Mann, 1992; Markus, Lange, & Pettigrew, 1990), the field has many different models claiming to be the most effective type of family therapy (Gurman & Kniskern, 1978; Gurman & Kniskern, 1981; Lambert & Bergin, 1994). Sprenkle and Bischoff (1995) state that this competition between models can be “confusing at best and divisive at worst” (p. 551). They point out that conducting family therapy research that avoids comparing models is a first step in bridging the distance between models and “moving beyond the us-against-them competitions of the past” (p551).

In an effort to move away from this competitive research approach, recent research has found that there are aspects of therapy common among all models that are important to therapeutic change (Hubble, Duncan, & Miller, 1999). These therapeutic aspects are derived from 40 years of outcome research (Lambert, 1992). Lambert (1992) has found through meta-analysis of this research that client improvement in therapy can be attributed to four key factors: extratherapeutic change, hope and expectancy (placebo effects), therapy technique, and therapeutic relationship. This research offers percentages that clarify the relative importance of each of these factors. Lambert reports that 40% of change comes from extratherapeutic factors, 30% from therapeutic relationship, 15% from hope and expectancy, and 15% from therapeutic technique (see definitions of these factors at the end of Chapter 1).

These therapeutic aspects have now become known under the umbrella term “common factors” (common because they seem to span across all models of therapy). Extratherapeutic change, the therapeutic relationship, hope and expectancy, and therapeutic technique are aspects of therapy common to all models (Hubble, Duncan, & Miller, 1999). It is believed that due to the large impact that common factors (not related to therapeutic technique) have on the outcome of psychotherapy, the field of family therapy should place less emphasis on model. Instead the focus should be shifted toward

what aspects of the therapeutic process are helpful across all models (Miller, Duncan, & Hubble, 1997). This study intends to investigate whether clients in a university family therapy clinic find these common factors important to their therapeutic experience.

Rationale

It is clear that more research needs to be conducted before the relationship between treatment and outcome is understood (Lambert & Bergin, 1994). The field of family therapy is calling for more information about how and why therapy is effective (Pinsof & Wynne, 1995). Greenberg and Pinsof (1986) describe a long-standing tradition regarding the separate domains of outcome and process research. The authors state that the field of family therapy has conducted outcome research to better understand whether or not therapy produces positive change for clients. Process research, on the other hand, explores what is going on within the therapeutic process that causes positive change for clients. It is suggested that knowing whether or not therapy is effective has been an essential first step for family therapy researchers. Greenberg and Pinsof suggest that we combine these past efforts with research that explores what therapists are doing that is helpful in promoting positive change with their clients. This study will follow that suggestion and attempt to further investigate the process of therapy through the experiences and perceptions of clients.

With some exceptions (Bugge, Hendel, & Moen, 1985; Strupp, Fox, & Lessler, 1969), much of the current research about therapeutic process is based on the therapist's or researcher's experiences and assessments rather than from the client's perception (Dunkle & Friedlander, 1996; Peyrot, 1995; White, Edwards, & Russell, 1997). It is clear that clients have views and thoughts regarding what they find to be most helpful in their therapeutic journey. As Miller, Duncan, and Hubble (1997) have stated, "the client is the unsung hero of psychotherapy" (p. 34). Exploring these factors with the client in rich detail is the next step in determining how to provide quality mental health services to clients (Sprenkle & Bischoff, 1995). Miller, Duncan, and Hubble (1997) make the point that the client's view matters. Our purpose in providing therapeutic services is to help the client with their problems; so respecting the client's ideas and concerns is of utmost importance. The authors state that "respect[ing] the client's point of view, understanding

of the problem, ideas about its solution, and interaction with chance events that affect its course” (p. 36) are vital in providing the most helpful and effective therapy. Accounts of clients’ perceptions of therapy have recently begun to appear more frequently in the literature (Gershefski, Arnkoff, Glass, & Elkin, 1996). This study will further enhance our understanding of what aspects of therapy clients view as important.

Traditionally, quantitative methods have been used in research about what factors are helpful in therapy (Hubble, Miller, & Duncan, 1999). Although some qualitative studies have been conducted (Bachelor, 1988; Rennie, 1992; Shilts, Rambo, & Hernandez, 1997), the majority of the research has been quantitative (Heppner & Heesacker, 1983; Horvath & Luborsky, 1993; Luborsky, 1994; McNeill, Lee, & May, 1987). Although the quantitative method is valuable in giving the field a clear, linear view of discrete events, quantitative research can also decontextualize complex phenomena and processes (Sprenkle & Bischoff, 1995).

Recently, family therapy research has begun to increase the amount of discovery-oriented qualitative research to better understand the complexities of the therapeutic process (Mahrer, 1988). While qualitative studies of therapeutic factors are sparse, qualitative researchers are well on their way to making some persuasive, although reticent, statements about what is occurring in therapy (Hubble, Duncan, & Miller, 1999). Chenail (1994) proposes that this type of inquiry is effective in “creating evocative descriptions and interpretations” of a phenomenon rather than making “inferential statements” (p. 1).

The current study will provide descriptive quantitative data as well as a qualitative discovery-oriented inquiry into what clients consider important in therapy, as opposed to using hypothesis-testing methods. Recently, researchers have described the benefits of combining quantitative and qualitative methods (Sprenkle & Bischoff, 1995; Sprenkle & Moon, 1996). Sprenkle and Moon (1996) state that this mixed methods approach “allows researchers synergistic interplay between the quantitative and qualitative” (p. 15) methods. Sprenkle and Bischoff (1995) support this trend, proposing, “the field is...in desperate need of more studies that integrate qualitative and quantitative methods” (p. 570). This approach can provide rich, descriptive data that illustrates numerical data. This study will explore the client’s perceptions of the therapeutic process by using both

methods. Qualitative survey data will enhance our understanding of the quantitative survey data.

This study has several implications for clinical practice. Survey results can offer some descriptive data about what clients perceive as important aspects of therapy. Findings can add to the growing body of research that explores the client's experiences in therapy by offering an account from their perspective. This will help therapists to better understand what specific aspects of the therapeutic process clients consider most helpful. Clinicians will have a better understanding of what is helpful about therapy, leading to more effective interactions with clients. This research can contribute to program planning and aid in quality assurance (Greenfield, 1983), providing family therapists with a better understanding of what factors in the therapeutic process relate to gains for the client across theoretical models (Lambert, 1992; Lambert & Bergin, 1994).

Theoretical Framework

The current evaluation explores the client's perceptions of their experiences in therapy using a constructivist theoretical lens. The constructivist research perspective is not concerned with conventional research matters such as sample size, measurement, or generalizability, but rather, "focuses on subjective relevance and constitutive validity" (p. 659, Gubrium & Holstein, 1993). Constructivist theory has emerged from a growing dissatisfaction with traditional methods, which assert that experts (clinicians and researchers) know what is most helpful and effective for their clients and subjects. Goncalves (1995) states that historically, quantitative research has fallen short by attempting to measure linear affects between therapist and client behavior, thus providing research with less of a constructivist perspective. He concludes that the complexities of therapeutic process have forced researchers to turn to more constructivist methods.

Constructivist theory proposes that the definition of "reality" is that which is created through the client's individual experiences, perceptions, and ideas (von Glasserfeld, 1984). The meaning of reality in a constructivist view is one that is continually being created during constant interaction between individuals and their environments. The construction of reality, then, allows individuals to define their

experiences in ways that are unique to their own interactions and ideas (Anderson, 1997; Freedman & Combs, 1996; Watzlawick, 1984).

Qualitative methods are guided by a more constructivist viewpoint. Watzlawick (1984) asserts that constructivism in its purest form is opposed to the traditional assumption that “a real reality exists and that certain theories [and] ideologies...reflect it...more correctly than others (p. 15).” Similarly, clinical constructivist theory proposes that clients are the experts of their own invented experiences. The constructivist position allows the role of therapist and/or researcher to be more of a collaborator rather than an expert (Anderson, 1997; Freedman & Combs, 1996). Anderson (1997) brings to light some questions that are derived from the constructivist model on which the perspective of this study is based. These questions are: “How does what happens in the therapy room make any difference in the person’s life outside it? Where does the ‘newness’ that clients often describe as a *sense of freedom* or *feeling of hope* come from? What does a therapist do, if anything, that contributes to that?” (p. 2).

It is the constructivist theory that provides the framework for this study to capture clients’ understanding about what is helpful in therapy. The meaning that they apply to their own unique, individual experiences creates their views about therapy. As it applies to this study, clients through their own experiential world continually invent therapeutic meaning. Problems, outcomes, and change will be different from client to client, as no two clients share the same experiences, perspectives, or understanding. It is these constructivist ideas that will provide this research with an individual and distinct description of how clients experience therapy through their own views, ideas, and realities.

Purpose of the Study

The purpose of this study was to explore the aspects of therapy as proposed by “common factors” literature (e.g., extratherapeutic change, hope and expectancy, technique, and therapeutic relationship) by surveying the clients of a university based family therapy clinic. This data was used to provide information about what factors are therapeutically helpful according to the client’s perspective. Surveys provide a quantitative and qualitative description of the client's therapeutic experience and will be

compared with those aspects of therapy found in the research (Lambert, 1992). The goals of this exploratory study about clients' perceptions of the therapeutic process are:

1. To provide descriptive data obtained from the Client Perception Survey about therapeutic relationship, hope and expectancy, extratherapeutic factors, client motivation, therapy helpfulness, client change, and therapist technique.
2. To compare and analyze demographic differences for common factor data.
3. To examine relationships between the common factors (therapeutic relationship, hope and expectancy, and extratherapeutic factors) and the dependent variables client change and therapy helpfulness.

From these goals, the following research questions are highlighted: What factors play a role in clients' therapeutic experience at a university-based family therapy clinic? Are there differences between demographic groups in related factors?

Definitions

Lambert (1992) defines each of the aspects of common factors as follows:

1. Extratherapeutic Change: Those factors that are...part of the environment (such as fortuitous events, social support) that aid in recovery regardless of participation in therapy.
2. [Hope]/Expectancy (placebo effects): That portion of improvement that results from the client's knowledge that she/he is being treated and from the differential credibility of specific treatment techniques and rationale.
3. Techniques: Those factors unique to specific therapies (such as biofeedback, hypnosis, or systematic desensitization).
4. Therapeutic Relationship: Include host of variables that are found in a variety of therapies regardless of the therapist's theoretical orientation: such as empathy, warmth, acceptance, encouragement of risk taking, et cetera.

CHAPTER II

LITERATURE REVIEW

Introduction

This study examines how clients perceive the therapeutic process through the filter of common factors research. Historically, therapists and researchers have sought to understand what makes therapy effective and have recently begun exploring the role of common factors in psychotherapy outcome. There has also been an interest in finding out how clients perceive their experiences in therapy. This literature review examines the current research regarding the exploration of client's perceptions of therapy, as well as common factors research in general psychotherapy and more specifically, common factors research in the field of marriage and family therapy.

Clients' Perceptions of the Therapeutic Experience

Traditionally, much of the research about what clients experience in therapy has been based on the therapist's or researcher's experiences and assessments rather than from the client's perception. More recently, however, subjective data collected from the viewpoint of the client has taken a larger role in psychotherapy research. This may have resulted from the challenge that some researchers have offered to the psychotherapy field in an effort to move away from a traditionally objective outcome approach toward a more "discovery-oriented" process approach (Mahrer, 1988). This section reviews the literature that has begun to move in the direction of using this approach in collecting information about the therapeutic experience from the client's perceptions.

In their comprehensive chapter on the subject of researching the therapeutic process, Greenberg and Pinsof (1986) further describe this new perspective in psychotherapy research. The authors offer a view that essentially incorporates both process and outcome research, which have in the past been considered two separate domains. They propose that outcome research of the past has determined successful outcome without necessarily identifying what about the process produces the success. Greenberg and Pinsof also point out that it has become essential not only to inquire about what it is that therapists are doing, but also about how clients experience therapy. The use of self-report measures has been found to reliably assist researchers in collecting data

about the client's experiences of therapy. They urge the field of therapy research to continue in this direction, stating that such a young field can only benefit from further progression of therapeutic inquiry, hopefully leading to the eventual enhancement of our ability to predict and understand therapeutic change.

This trend started about 15 years ago, with studies such as Greenfield's (1983), which explored the role of client satisfaction in the evaluation of university counseling services. This study illustrated the previous challenge in measuring client's perceptions of therapy due to lack of measures in this area. Using the Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979), clients were surveyed over a period of five years at a university clinic in an effort to establish a reliable source for measuring client's opinions about the therapy experience. The CSQ was found to have excellent psychometric properties and relationships were determined between client satisfaction and a number of variables ($r = .53$, $p < .001$), including demographics, expectancy, problem type and severity, counselor differences, and length of treatment.

Bugge, Hendel, and Moen (1985) also focused on client evaluation of a university mental health center in their investigation of therapeutic process and outcome. Their inquiry differed, however, in that the focus was on specific therapist and client tasks and their relationship to outcome rather than overall general satisfaction. All 287 clients who used services at a large university within a two-week period completed a questionnaire. Results of the study indicate that different types of questions elicit different results (e.g., problem improvement for a particular problem), having varied relationships with overall measures such as quality of therapy and satisfaction with therapist helpfulness. Bugge et al. state that this indicates a need for a multidimensional approach to measuring clients' evaluations of therapy. Findings also illustrate the prevalence of gender differences in overall satisfaction ratings, revealing that women were more satisfied than men with the process and outcome of their therapy experience.

Another study conducted by Friedberg, Viglione, Stinson, Beal, Fidaleo, and Celeste (1999), examined clients perceptions of treatment helpfulness by examining 123 psychiatric inpatients' responses to the Treatment Experience Questionnaire (TEQ). The TEQ measures helpfulness of cognitive versus non-cognitive methods of psychotherapy.

It was hypothesized that cognitive therapy would be perceived as more helpful than non-cognitive therapy components of the inpatient program and that the perception of helpfulness of both types of therapy would predict therapy outcome, as measured by using the Beck Depression Inventory (BDI) at discharge. The results indicated that patients found both cognitive and non-cognitive aspects of the program are equally as helpful and that there was a modest yet significant relationship between perception of helpfulness and symptom improvement. In other words, patients who perceived overall that their therapy was helpful, regardless of therapy model, had more positive therapeutic outcome, as evidenced by lower BDI scores at discharge.

Duncan and Moynihan (1994) take these types of findings a step further by suggesting that client's experiences of therapy are so essential to the therapeutic process that they should direct the course of therapy. Their article offers the argument that with the recent results regarding the importance of extratherapeutic and common factors, the therapist may serve the client better as the intentional guide of the client's frame of reference rather than the therapist's. The authors offer this perspective as a way to deliberately enhance the outcome effects of the common factors. This proposal seeks to de-emphasize theory and to instead, generate a maximum collaboration between therapist and client during all phases of treatment.

Many comparative studies have investigated client's perceptions by examining differences between groups based on diagnosis and therapy model, often without finding significant differences in treatment outcome between groups (Lambert & Bergin, 1994; Miller, Duncan, & Hubble, 1997). Some studies appear, however, to be incorporating a broader view of possible common factors impacting positive therapy outcome rather than confining their explorations only to presenting problem and model of treatment. A recent example of research that includes common aspects while investigating a specific diagnosis and treatment model is the work of Gershefski, Arnkoff, Glass, and Elkin (1996). Their study examined clients' perceptions of treatment for depression by collecting clients' opinions about the helpful aspects of their therapeutic experience. The researchers address these perceptions in the NIMH Treatment of Depression Collaborative Research Program (TDCRP; Elkin, Parloff, Hadley, & Autrey, 1985), which uses "a common and specific factors conceptualization." Treatment methods

included cognitive behavior therapy, interpersonal psychotherapy, medication (imipramine) plus supportive clinical management, and pill-placebo plus clinical management. Findings indicate that the 239 clients treated found common aspects of the treatments, such as the helpfulness of the therapist, to be reported most frequently. There were no differences between treatment groups for aspects specific to any particular treatment method, implying that client's perceive certain aspects found in all treatments to have been helpful to their treatment of depression.

Studies exploring client's perceptions of the therapeutic experience specific to the field of marriage and family therapy have also begun to increase. Howe (1996) performed a qualitative study of family views of family therapy by gathering clients' experiences of therapy interventions. In his article describing the benefits of the exploration of personal experience and its relation to family therapy, Howe explains that the purpose of his study was to gather family members perceptions, understanding, experiences, and feelings of family therapy. He did so by interviewing 22 family members who were receiving services from a family therapy practice. Responses were coded, analyzed, and categorized, producing a broad framework in which to contain more detailed interpretations. From this broad framework emerged findings indicating that clients considered three core areas to be of the most importance in their experience of family therapy. These areas are: to be engaged, to understand, and to be understood. These results imply that family members consider being engaged by the therapist, understanding what is happening during treatment, and feeling understood by the therapist to be the most important aspects of their family therapy treatment.

Barrett and Lynch (1999) explored the perceptions of family therapy outcome among parents, adolescents, and therapists in their recent study. By assessing multiple family members, the authors propose that a more comprehensive picture of therapeutic outcome can be obtained. Following each session, 19 families receiving services at a university family therapy clinic rated their level of distress in ten specific areas during the course of their family therapy treatment. Prior to the beginning of treatment, each adult caregiver in the family completed the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983). The results of the study indicate that family therapy is effective in reducing areas of distress for both adult caregivers and adolescents. These findings

suggest that clients perceive family therapy to affect adolescents' improvement in the specific areas of depression, fighting/arguing, and trouble with the law.

Common Factors Research in Psychotherapy

The term "common factors" refers to components common to all models of therapy that influence eventual outcome. Common factors (also called nonspecific factors) that have been identified by some scholars encompass four primary areas: extratherapeutic change, therapeutic relationship, hope and expectancy, and therapeutic technique (Lambert, 1992). Although there have been other studies in this arena supporting Lambert's findings (Patterson, 1984) as well as additional research that conceptualizes common factors in a variety of ways (such as Frank, 1971, 1989; Frank & Frank, 1991; Grencavage & Norcross, 1990; Lambert & Bergin, 1994; Strupp & Hadley, 1979; Weinberger, 1995), his meta-analysis results seem to be the most widely recognized within the literature. Therefore, Lambert's (1992) results are the basis for the development and conceptualization of this study.

In his chapter for the edited book Handbook of psychotherapy integration (Norcross & Goldfried, 1992), Lambert introduced the field to his comprehensive meta-analytical findings regarding the implications of outcome research for the field of psychotherapy. In his review of over 40 years of outcome studies, Lambert concluded that there appear to be four primary factors that influence positive therapy outcome. These factors were each given a percentage of relevance to the outcome of therapy. He proposed that extratherapeutic factors accounted for 40% of positive therapy outcome, the therapeutic relationship for 30%, hope and expectancy factors for 15%, and therapeutic model or technique for only 15% of positive psychotherapy outcome (for Lambert's definitions of these factors, see Chapter 1).

These findings are controversial in the field of psychotherapy, as currently the field is divided into factions based upon their adherence to a specific clinical model or theory. This controversy has resulted in a split in the field, creating two schools of thought on the subject. One school of thought believes that psychotherapy should be more integrated, allowing clinicians to focus more on the factors involved in practicing effective therapy and less on model or theory (Hanna & Ritchie, 1995; Lambert &

Bergin, 1994; Prochaska, 1995; Weinberger, 1995). Other researchers believe that more studies need to be done in this area, proposing that these factors having an effect on the outcome of therapy regardless of theory may be a premature conclusion (Beutler, 1991; Jones, Cumming, & Horowitz, 1988; Messer, 1996; Norcross, 1995). Due to this split in the field, research has become more prolific in the debate over the common factors and their influence on successful psychotherapy outcome.

It should be mentioned that the impetus and inspiration for this study are based on two volumes of work by Scott Miller, Barry Duncan, and Mark Hubble (1997, 1999). In both their hallmark text Escape From Babel: Toward a Unifying Language for Psychotherapy Practice and the more recent edited book The Heart & Soul of Change: What Works in Therapy, the authors have set the standard for making a case for psychotherapy integration and common factors exploration. Both of these volumes have become commonly read works, found on the shelves of practicing therapists and offered as required reading in clinical academia. Although their stance is controversial, it is presented in a way that seems to invite the clinical practitioner into considering very carefully how they conduct their therapy sessions. Most of the literature presented in this review has also been previously presented in the work of Miller, Duncan, and Hubble. Their comprehensive knowledge of this area of research has proved to be an indispensable resource for this investigation.

The majority of exploration in this area has used quantitative methods. As a result, an empirical basis for the common factors theory has developed. Recently, however, an increasing number of qualitative studies have come to the forefront of common factors research. Research using either method of study will be presented in this chapter, divided into sections by each of the four factors.

Extratherapeutic Factors

In a recent chapter by Asay and Lambert (1999) much of the research on extratherapeutic factors has been presented in summary. These authors describe this domain as an amalgamation of components external to the therapy itself including

various aspects of clients and their experiences, such as their history, diagnosis, support networks, coping skills, and life stressors. They also state that within each client there are aspects that can be considered to have an impact on the outcome of therapy. These include the severity of the problem, motivation level, ego strength, and the ability of the client to identify a problem on which to focus. Asay and Lambert present the following example as representative of how client factors might play a role in therapy outcome:

“...a withdrawn, alcoholic client, who is ‘dragged into therapy’ by his or her spouse, possesses poor motivation for therapy, regards mental health professionals with suspicion, and harbors hostility toward others is not nearly as likely to find relief as the client who is eager to discover how he or she has contributed to a failing marriage and expresses determination to make personal changes.”

Historical research on client factors is represented in Strupp’s extensive body of work (1980; Strupp, Fox, & Lessler, 1969; Strupp & Hadley, 1977, 1979). Throughout his work, Strupp has been a strong proponent in the case for client factors playing a significant role in therapeutic outcome. By analyzing both case histories and pencil-and-paper measures of 131 psychotherapy clients, Strupp, Fox, & Lessler’s (1969) mixed methods approach found that clients who are more highly motivated have the fewest amount of cancelled sessions and describe themselves as experiencing a great amount of internal pressure to do something to improve their situation. These results indicate that motivated clients appear to be more eager for help, more willing to work with another person on their problems, and more able to withstand the painful feelings that often emerge as a result of therapy than clients who are less motivated. This early landmark study on client factors spawned a wave of client factors research in the psychotherapy field, broadening the search for the key ingredients to successful therapy results.

Lambert and Asay (1984) examined client characteristics and their relationship to psychotherapy outcome, identifying client characteristics as possibly the most important factor affecting positive therapy outcome. Their extensive review of the research in this area presents many of the aspects of client

characteristics that impact success in therapy. According to Lambert and Asay, these aspects include client motivation and expectation, demographic variables (including social class, race, intelligence, gender, age, and marital status), manner of client participation in the therapeutic relationship, severity of the client's presenting problem, personality characteristics, and client/therapist match. They conclude that research has repeatedly found that clients who are highly motivated and have positive expectations about therapy experience more successful therapeutic results. Their findings also identified the impact that demographic variables have on the success of therapy, reporting that the literature has shown in general that lower-class clients have less positive outcome results than higher-class clients and that younger clients generally have more positive outcome results than older clients, although some studies have found results opposing these generalizations. It was also pointed out that the predictive relationship between each of the demographic variables race, intelligence, gender or marital status and success in therapy has not been clearly agreed upon by researchers. Patient's participation in therapy also seems to have a direct effect on therapy outcome, in that the more negatively disposed a client is with their therapist, the less success they will experience as a result of therapy. Research regarding the severity of the presenting problem indicates that clients who are more disintegrated and severely disturbed have less of a chance of experiencing positive therapy results than those clients who are more integrated and less disturbed. Personality characteristics—such as ego strength, locus of control, anxiety, and suggestibility—all appear to be promising as predictors of therapeutic outcome. And lastly, the area of client-therapist match seems to be significant to therapy outcome, although this topic has received a small amount of attention in the literature. Lambert and Asay conclude, “client variables are clearly important, if not the most important, factors affecting psychotherapy outcome” (p. 349).

More recent research has also focused on client factors and their effect on psychotherapy outcome. Garfield (1994) has explored much of the research involving client factors. In his summary, he identifies that general diagnosis, used as an identifying factor of common mental illness symptomology, is in itself a

problem for therapists. He states that even when two individuals are given the same diagnosis, other aspects of each person create a very different therapy experience and outcome. These individual client factors include one's previous life experiences, existing personality traits, ethnicity, previous therapy experiences, and perceptions of the therapist. Since each individual has varying experiences in these areas, their experience in therapy, and thus the outcome of therapy, would differ from individual to individual.

Qualitative studies have also contributed to the body of research in extratherapeutic factors. Rennie (1992) explored clients' experiences of the therapeutic process by reviewing a recent therapy session with them. Clients were asked to bring to the researcher a video or audiotape of a therapy session that they had just completed. Participants were asked to point out anything of significance that they recall experiencing in the session as they replayed the tape with the researcher. Qualitative analysis of the clients' interviews produced the core category of "client's reflexivity," defined as "turning back on oneself" (p. 225). Four main categories were also conceptualized: the client's relationship with personal meaning, the client's perception of the relationship with the therapist, the client's experience of the therapist's operations, and the client's experience of outcomes.

In conclusion, both quantitative and qualitative methods of study of extratherapeutic factors have identified many areas of individual client traits that affect how the client experiences therapy and the outcome of the therapeutic process. Lambert (1992) proposes that this factor plays the largest role among the common factors, affecting 40% of outcome results.

Therapeutic Relationship Factors

According to much of the literature, it is agreed that the therapeutic relationship is essential to successful therapy (Bordin, 1979; Horvath & Symonds, 1991; Rogers, 1957). As Dunkle and Friedlander (1996) state in their work on the therapeutic relationship,

“When psychotherapy is successful, client and therapist create a secure base upon which to explore the client's problems and possible solutions. The sense of working collaboratively toward a common goal is nurtured in a supportive, trusting

atmosphere...[setting] the stage for a successful therapeutic outcome regardless of theoretical approach or presenting problem.”

The research in this area explores various aspects of the therapeutic relationship, including the alliance between therapist and client, as well as the therapists’ ability, skill, attitudes, and personal characteristics.

In their extensive review, Horvath and Luborsky (1993) traced the development of the concept of the therapeutic alliance and the relationship between a positive alliance and success in therapy. Within their review they also discuss the various methods of measuring the alliance and summarize the large body of research in the area of alliance-outcome relations. It is this research from which Horvath and Luborsky confirm that there is an important relationship between good alliance and positive outcome in clinical practice. The authors suggest that due to the major clinical implications of these types of findings, clinicians and researchers should pay increasing attention to the nurturance and further development of the therapeutic relationship in therapy practice and research. Specifically, the authors conclude that clinicians may benefit from using a collaborative approach with their clients, in which the clinician makes special use of the therapeutic relationship within their theoretical framework. They urge researchers to widen the focus on alliance research, suggesting that the field would benefit from further understanding of the alliance and its components, the differences between therapists’ and clients’ perceptions of the alliance, and the relation between therapeutic gains and changes in the level of the alliance throughout the course of therapy.

The construct of alliance as it applies to the therapeutic relationship has several components. In summarizing the literature on therapeutic alliance, Gaston (1990) suggests there are four primary components: (a) the client’s affective relationship to the therapist; (b) the client’s capacity to purposefully work in therapy (working alliance); (c) the therapist’s empathic understanding and involvement; and (d) the client-therapist agreement on the goals and tasks of treatment. Gaston presents three major roles played by the alliance in psychotherapy: that the alliance is therapeutic in and of itself, that the alliance is a prerequisite for therapist interventions to be effective, and that the alliance interacts with various therapist interventions for determining positive psychotherapy

outcome. According to Gaston, empirical evidence indicates there is a strong relationship between therapeutic alliance and psychotherapy outcome.

For example, Luborsky (1994) examined the therapeutic alliance as related to effective psychotherapy outcome. He offers interpretation of the alliance-outcome trends of the past 15 years by identifying factors that may influence the association of alliance with outcome and their degree of association with outcome. Some of these factors are: the type of alliance measure (which was found to have little or no degree of association with outcome), the type of treatment (little or none), views of patient, therapist, or observer (moderate degree of association by all views, especially the patient's), positive versus negative alliance (positive alliance is most predictive of positive treatment outcome), facilitation by therapist's behavior (much association with outcome), and facilitation by similarities of patient and therapist (some association with outcome). He concludes with suggestions for enlarging the field's clinical perspective, offering three broad curative factors in psychotherapy. These curative factors include the necessity to establish a positive therapeutic relationship, the patient's expression of their conflicts and the collaboration between patient and therapist about ways to cope with them, and the incorporation of gains of treatment so that they are maintained after termination. Luborsky supports the conclusion that therapists who can establish an at least partly positive alliance have fulfilled one main condition for positive client change in therapy.

Another example is the work of Klee, Abeles, and Muller (1998), who also investigated the therapeutic alliance and its relationship to significant change in therapy. This study explored aspects of the therapeutic alliance for 32 adults participating in outpatient therapy. Participants completed the SCL-90, which is designed to reflect the current psychological symptom status of the individual, and the Therapeutic Alliance Rating Scale (TARS). Results of this research indicate that patients with a strong capacity for relatedness early in therapy are predictive of their contributions to the alliance throughout treatment, which in turn results in more successful treatment. This study also found that the therapeutic alliances strengthen as the length of the therapeutic relationship increases. Therefore, those clients who have been in therapy for a longer amount of time have a more collaborative and involved role in the work of the therapy, also resulting in more successful therapy outcome.

Therapists' level of experience and personal characteristics are another area of the therapeutic relationship that has been studied. In one such study, Heppner and Heesacker (1983) examined the relationship between clients' perceptions of counselor characteristics and their experience of therapy. Three different areas of interpersonal influence on client satisfaction were explored. These areas were: (a) the relationship between perceived counselor expertness, attractiveness, and trustworthiness and client satisfaction; (b) the relationship between several specific client expectations on perceived counselor expertness, attractiveness, trustworthiness, and clients satisfaction; and (c) the effects of actual counselor experience level on perceived counselor expertness, attractiveness, trustworthiness, and client satisfaction. Fifty-five counselors and 72 clients at a university-counseling center participated in the study. Clients completed an Expectations About Counseling (EAC) questionnaire before entering counseling and a Counseling Evaluation Inventory (CEI) and Counselor Rating Form (CRF) after several weeks of counseling. The results of this study suggest that perceptions of counselor characteristics (specifically expertness, attractiveness, and trustworthiness) are related to client satisfaction. Findings also revealed that more experienced counselors do not necessarily establish better relationships with their clients than do less experienced counselors.

More recently, Dunkle and Friedlander (1996) also found that therapist experience level was not predictive of therapeutic alliance, but that therapist characteristics were a strong indicator for the establishment of a strong bond between therapist and client. In this study, 73 therapists completed instruments that assessed level of self-directed hostility, perceived social supports, and degree of comfort with attachment, and their clients completed a working alliance measure. The research found that these factors were highly predictive of the bond component of the working alliance, indicating that the personal characteristics of the therapist have an important relationship in development of an alliance between therapist and client.

Researchers have also generated some significant qualitative investigations of therapeutic relationship factors. One example is the research conducted by Bachelor (1988) on clients' perceptions of "received" empathy. This study examined how clients perceive their therapists' empathy toward them and it's relationship to therapeutic

outcome. Empathy was defined as the client feeling that their therapist “demonstrated the ability to put him or herself in [the client’s] place.” Twenty-seven clients currently receiving therapy were asked to describe times when they experienced the expression of empathy toward them, resulting in the identification of four empathetic perceptual styles: cognitive, affective, sharing, and nurturant empathy. Of the clients participating in the study, 44% perceived their therapist’s empathy as cognitive, 30% as affective, 18% as sharing, and 7% as nurturant. These findings suggest the positive impact that an empathetic therapeutic relationship has on therapy outcome.

The therapeutic relationship has been a long studied aspect of what makes therapy a success. As cited in Horvath and Luborsky (1993), various schools of clinical practice have explored the therapeutic relationship, including cognitive therapy, psychodynamic therapy, gestalt therapy, and behavioral therapy. They report that a strong alliance appears to make a significant impact on positive therapy outcome across all of these models of psychotherapy. In his meta-analysis, Lambert (1992) attributes the therapeutic relationship to 30% of what makes for successful therapy results.

Hope and Expectancy

The third domain of the common factors that is found to affect positive therapeutic change is hope and expectancy (Miller, Duncan, & Hubble, 1997). Miller et al. (1997) define the hope and expectancy domain (also called “placebo factors” [Lambert, 1992] in the literature) as a curative aspect of the psychotherapeutic process, one that is derived from the client-therapist interaction. The authors state that all models of therapy have ways of working with clients that facilitate hope and positive expectation for change. This facilitation of hope by the therapeutic interaction and the resulting expectation of the client for positive change are believed to have an important impact on the success of psychotherapy outcome (Hubble, Duncan, & Miller, 1999; Lambert, 1992; Miller et al., 1997).

In their recent chapter, Snyder, Michael, and Cheavens (1999) offer a unifying framework for considering this factor, called *hope theory*. In their review of the literature in this area, it is proposed, “hope may be understood in terms of how people think about goals” (p. 180). They emphasize two components in thinking about goals: thoughts that a

person has about their ability to produce one or more workable routes to their goals and thoughts that a person has regarding their ability to begin and continue working toward these goals. Snyder et al. theorize that both types of this thinking (known respectively as *pathways thinking* and *agency thinking*) need to be present in order for a client to experience hope and positive expectation for change.

In their chapter of the review of the health perspective of social and clinical psychology, Snyder, Irving, and Anderson (1991) described the relationship between hope and health. They begin by relating hope to different individual constructs such as optimism, self-efficacy, helplessness, and resourcefulness, explaining that these constructs may be related in many ways to the construct of hope, but that they may also have some important distinctions. They also describe hope as it is related to health-relevant outcomes such as goal setting, problem solving, health symptom reporting, and objective health status. Their review indicates that client's high levels of hope were associated with improved ability to set therapeutic goals and more positive self-perception of being able to problem-solve as well as the improvement of physical and/or mental health symptoms, through both self-report and objective assessments. Snyder et al. conclude that this review indicates a need for the therapists to focus on both components of hope by nurturing clients in their development of a strong sense of goal-directed determination (agency) as well as a strategy for pursuing that goal (pathway). It is proposed that the reciprocal relationship between these two components defines the essence of hoping and that "hope is one important wellspring by which we nourish our psychological and physical health" (p. 300).

In their attempt to create a measure for hope in psychotherapy, Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle, and Harney (1991) presented their work on the development and validation of an individual differences measure of hope. The authors developed the measure based upon the agency (goal-directed determination) and pathways (planning of ways to meet goals) definition of hope detailed above. The study indicates that the measure has acceptable internal consistency and test-retest reliability, and the factor structure identifies the agency and pathways components of the Hope Scale. Findings also suggest that the Hope Scale is a better measure of goal-related activities and coping strategies than other self-report measures.

Snyder et al. point out that the concept of hope may be a rather ambiguous one and that it is the obligation of the psychotherapy field to clearly define and measure this concept in order to effectively anchor this aspect of the therapeutic process with our clients.

In conclusion, hope and expectancy have received a growing amount of attention as key factors in the attribution of positive psychotherapy outcome. It has been found that these factors play an important role across all models of therapy practice. Lambert (1992) reports that hope and expectancy account for 15% of the variance in treatment outcome. This is the same amount of impact that the factors therapeutic models and techniques are proposed to make.

Therapeutic Models and Techniques

Research that explores the efficacy of specific models and techniques of psychotherapy has consistently demonstrated that various treatment approaches achieve nearly equal, although positive, results (Lambert, 1992; Lambert & Bergin, 1994; Miller, Duncan, & Hubble, 1997). It is this aspect of the research in common factors that has been met with such controversial derision, as it implies that one orientation in the field of psychotherapy has no more of an impact on client change than any other orientation. As the training of therapists has traditionally been divided by theoretical model, these findings directly challenge the current establishment of how therapy is learned and taught. Some researchers suggest that because of these findings, training in specific models and techniques is relatively purposeless (Strupp & Anderson, 1997). Lambert and Bergin (1992) explain the findings in this way:

“ Psychologists, psychiatrists, social workers, and marriage and family therapists as well as patients can be assured that a broad range of therapies, when offered by skillful, wise, and stable therapists, are likely to result in appreciable gains for the client...[however] there is little evidence of clinically meaningful superiority of one form of psychotherapy over another with respect to moderate outpatient disorders.”

The research in this area is vast, encompassing hundreds of comparative studies and component analyses (Ogles, Anderson, & Lunnen, 1999). Due to this expansive amount of research, many meta-analytical investigations have been performed comparing

the results of these studies. This section offers a definition of this domain and presents the findings of these meta-analyses that explore the differences and similarities among various therapeutic models and techniques.

In an attempt to define the intended meaning of the terms “therapeutic models and techniques,” Ogles, Anderson, and Lunnen (1999) offer clarification. In their recent chapter, it is pointed out that there have traditionally been some vast and confusing definitions for models and techniques. By their definition, a *model* is “a collection of beliefs or unifying theory about what is needed to bring about change with a particular client within a particular treatment context” (p. 202). A model, therefore, is made up of *techniques*, defined as “actions that are local extensions of the beliefs or theory” (p. 202). It is emphasized that models and techniques are not identical concepts. By this definition, it is implied that all therapists work from a set of beliefs or assumptions about what facilitates positive change in their clients.

Lambert and Bergin (1994) published a chapter in Bergin and Garfield’s edited volume, Handbook of Psychotherapy and Behavior Change. This chapter, titled “The Effectiveness of Psychotherapy,” offers a comprehensive review of both meta-analytical research and individual comparative studies. In their analysis of hundreds of pieces of literature, Lambert and Bergin confirmed the overall effectiveness of psychotherapy on symptom reduction as compared to wait-list and no-treatment control groups. Their review also compares the effectiveness of different schools of therapy. These schools (or therapy models) include psychodynamic, cognitive, behavioral, and humanistic therapies. Their findings support the conclusion that there is little or no difference between therapy models when comparing outcome results. Lambert and Bergin offer three possible explanations for these findings. They are: (a) different therapies can achieve similar goals through different processes; (b) different outcomes do occur but are not detected by past research strategies; or (c) different therapies embody common factors that are curative although not emphasized by the theory of change central to a particular school. Any of these interpretations, they conclude, may be advocated and defended, as there is not enough evidence available to rule out any one of them.

In response to the controversial suggestion that outcome is not affected by treatment modality, Beutler (1991) states that it is premature to conclude that all

treatments have equal effects. His review proposes that there are a large number of patient, therapist, and treatment variables that may mediate the effects of treatment, thus affecting the comparative results of previous research in this arena. The need for clearly defined theoretical constructs is identified as a barrier for concluding that treatment model has little effect on therapeutic efficacy. It is pointed out that there are some 300-plus types of therapy that have been included in some comparative analyses, with narrow theoretical differences between these models. Because of this overabundance of supposedly different types of psychotherapy which all claim to have successful outcome results, Beutler reports that further studies need to be conducted before concluding that consensual meanings (common factors) are the important variable that result in positive treatment outcome.

In an effort to heed this advice, Wampold, Mondin, Moody, Stich, Benson and Ahn (1997) further supported Lambert and Bergin's (1994) findings by performing a clearly defined meta-analysis studying only "bona fide" psychotherapies, in an attempt to further increase the level of rigor in these meta-analyses. The authors point out that opponents to the idea of common factors findings argue that those meta-analyses of the past that compare models might have resulted as they did (by finding no differences between models) due to some possible confounding variables within the studies. To allay further questioning of past results, Wampold et al. described the problems that could be associated with prior meta-analyses. The first of these possible problems is a lack of direct comparisons between models, meaning that models may differ on several other different variables that are not accounted for in the comparisons. If these confounding variables existed, findings would conclude that there are no differences between treatments when actually the unexamined variables (such as length of treatment or presenting problem) could be affecting the results. Secondly, studies may have come to their findings due to difficulty in classification of treatments into categories (for example defining particular treatments as solely behavioral or psychodynamic) then comparing the effect sizes produced by these classified categories. And lastly, past studies may have included psychotherapies that were not "bona fide" treatments, or treatments that were not intended to be therapeutic. Bona fide psychotherapies were defined as those that were delivered by trained therapists and were based on psychological principles, were

offered to the psychotherapy community as viable treatments, or contained specific components. This definition did not include “alternative” therapies. Wampold et al. attempt to eliminate these possible problems in their study by reviewing only those studies that (a) directly compared two or more treatments; (b) did not classify treatment into general types; and c) used “bona fide” treatments. Despite the increased rigor of their comparisons, their findings strongly supported previous meta-analyses. In fact, the authors cited Lambert and Bergin’s (1994) previous findings of different types of comparisons, then presented their own. In Lambert and Bergin (1994), comparisons were made between psychotherapy vs. no treatment (producing an effect size of .82), psychotherapy vs. placebo (producing an effect size of .48), and placebo vs. no treatment (producing an effect size of .42). Wampold et al. then presented their findings in comparisons between bona fide psychotherapies, which produced an effect size of zero. Even when considering the estimate of an upper bound on the effect sizes, it was found to be small (.21). Moreover, the effect sizes were not related positively to publication date, indicating that improving research methods are not detecting effects and the effect sizes were not related to the similarity of the treatments, indicating that more dissimilar treatments did not produce larger effect. This analysis concludes that the effect size for the comparison of bona fide psychotherapies (in the interval of .00 and .21) strongly supports the previous meta-analytical findings that the efficacy of treatment models is roughly equivalent.

Interestingly, some comparative studies are beginning to emerge that attempt to identify differences between a particular model of therapy and therapy that is devoid of model but contains all elements of the common factors. For example, Svartberg, Seltzer, and Stiles (1998) conducted a pilot process-outcome study comparing short-term anxiety provoking psychotherapy (STAPP) and a form of non-directive therapy with common factors intact, but absent of psychodynamic elements. This comparison was an attempt at identifying the necessary and sufficient change factors in STAPP. Both treatments were 20 sessions long and both were manualized. Most of the 20 participants had a diagnosis of anxiety. Results showed that patients in both treatment groups greatly improved symptomatically. This implies that both treatments were equally as effective; opening to

question the level of importance model has to treatment outcome when all of the other common factors are present.

Contrary to most of the above-mentioned research, there are concrete findings that have identified particularly difficult diagnoses that appear to benefit from specific methods of treatment. Lambert and Bergin (1994) identify these problems as anxiety disorders (panic, phobias, and compulsion) and particular non-neurotic diagnoses (childhood aggression, psychotic behavior, and health-related behaviors, such as sexual dysfunctions). In these cases it has become evident that behavioral and cognitive methods of psychotherapy add a significant amount of outcome efficacy.

Research in the area of therapeutic models and techniques has found that there is generally little consistent difference in therapeutic outcome between varying orientations. Lambert (1992) concludes that only 15% of variance in treatment outcome can be attributed to models and techniques.

Common Factors Research in Marriage and Family Therapy

According to Sprenkle, Blow, and Dickey (1999), the field of marriage and family therapy has not devoted as much attention to the recent interest in common factors research as the general field of psychotherapy has. They suggest that this hesitance to study the factors common to all therapeutic approaches in marriage and family therapy research is in part because the field was born in the tradition of competing techniques and models. As an up and coming new field, marriage and family therapy has had to make a dynamic claim about its effectiveness. In the past, this has been done through the creation of competing models of therapy, championed by attention-grabbing leaders with little research to back up their claims of effectiveness. This trend has led to the development of a field with competing views about model and technique, and little research on what these models might have in common. Unfortunately, the field has gone so far in its attempt to stand out that it has marginalized itself from other disciplines (Sprenkle et al., 1999).

Recently, however, there has been a shift from a position of establishing unique models to one that suggests the field of marriage and family therapy begin to integrate therapeutic models (Miller, Duncan, & Hubble, 1997; Lebow, 1997). This shift is now

leading the field of marriage and family therapy to consider “moving the profession in the direction of greater attention to the common factors” (Sprenkle, Blow, & Dickey, 1999, p. 330) and away from the competition between models.

At the risk of repeating relatively similar results as the general psychotherapy research presented in the previous section by offering a complete review of marriage and family findings, a summary and comparison of the field’s common factors literature is presented.

Extratherapeutic Factors

It is theorized in general psychotherapy literature that extratherapeutic factors play the largest role in affecting positive treatment outcome (Lambert, 1992). Conversely, it is an area that has received very little attention in the marriage and family therapy literature (Sprenkle, Blow, & Dickey, 1999). In their recent review of research in this domain, Sprenkle et al. (1999) conclude that the various aspects of extratherapeutic factors, including client factors, fortuitous events, and social support, have received little to no exploration. Although some initial studies have been performed, namely in the area of client characteristics (Bischoff & Sprenkle, 1993), it would be premature to conclude that extratherapeutic factors predict positive marriage and family therapy outcome considering the lack of findings. Sprenkle et al. state, however, that they would not be surprised if research in this area eventually produces supporting evidence to Lambert’s findings.

Therapeutic Relationship Factors

The therapeutic relationship has played a key role in the development of the clinical practice of marriage and family therapy. Family therapy literature describes the development of this relationship between therapist and client in varying terms, including “joining” (Minuchin & Fishman, 1981), “empathic attunement” (Johnson, 1996), “setting the stage” (Haley, 1976), and “establishing a useful rapport” (Ackerman, 1966). As Wynne (1988, cited in Quinn, Dotson, & Jordan, 1997) stated, “What can no longer be accepted in family therapy research, in my opinion, is a concept of the therapist as an

outsider...therapeutic alliance of therapist and family interacting with one another is crucial for the study of process” (p. 431).

Marriage and family therapy research has been increasingly focused on the therapeutic relationship and its relation to successful family therapy outcome. In general, exploration of the association between therapeutic alliance and therapy outcome specific to marriage and family therapy has found results similar to those in the general psychotherapy research. That is, studies have found a significant causal relation between the therapeutic relationship and successful marital and family therapy outcome (Beck & Jones, 1973; Gurman & Kniskern, 1978).

Marriage and family therapy, however, is different than individual psychotherapy practice in one important way that may affect therapeutic alliance. Marriage and family therapy often involves multiple clients, producing multiple relationships per client system. Research in this area is minimal, but growing. In one specific example, Quinn, Dotson, and Jordan (1997) explored the various aspects of the therapeutic alliance and its association with treatment outcome in family therapy. Specifically, one of their research questions examined how differences between family member’s perceptions of the alliance were related to family therapy outcome. This study collected data from 17 couples receiving marital or family therapy treatment at a university-based marriage and family therapy clinic. The Interpersonal Psychotherapy Alliance Scale (IPAS, Pinsof & Catherall, 1986) was used to gather data in three areas: the therapist and the client, the therapist and other members of the client’s family or important member of the client’s interpersonal system, and the therapist and the interpersonal system of which the client is a part. Treatment outcome was determined at the completion of therapy by collecting responses to two questions. The first question asked clients to report the degree to which they believed the goal of therapy to have been met. The second question asked clients to evaluate the degree to which they believed changes made in therapy would last for the next 3 to 6 months. Quinn et al. suggest that successful therapy is more highly associated with women who, more so than their husbands, feel aligned with their therapists and believe other family members are working well with the therapist. Unlike the majority of the research in the field, no causal relationship could be inferred between therapeutic alliance and therapy outcome in this study.

In conclusion, it appears that the significant majority of current marriage and family therapy literature on the therapeutic relationship supports the stance that this domain is predictive of marriage and family therapy outcome. This conclusion, then, is also in support of the finding in the general psychotherapy outcome research.

Hope and Expectancy Factors

The facilitation of hope and expectancy has recently taken a larger role in the clinical practice of marriage and family therapy, particularly within the more newly developed competency-based models (Eron & Lund, 1996; O'Hanlon & Weiner-Davis, 1989). Despite this recent theoretical attention to hope and expectancy, it appears that little research has been conducted in this area (Sprenkle, Blow, & Dickey, 1999). Due to the absence of a substantive body of literature in this arena, the relationship of hope and expectancy and therapy outcome has yet to be inferred in the field of marriage and family therapy.

Therapeutic Models and Techniques

Although it appears that great strides have been taken in this area in the last ten years, comparisons of the effectiveness of marriage and family therapy models (i.e. Bowenian, structural, strategic, narrative, solution-focused, or other family therapies) are limited and inconclusive (Sprenkle, Blow, & Dickey, 1999).

One primary meta-analytical study in this area (Shadish, Ragsdale, Glaser, & Montgomery, 1995) concludes that no orientation in the field of marriage and family therapy produces more successful outcome results than any other model. They propose that the slight theoretical differences that do appear may be a result of confounding variables, such as client characteristics. Their results also showed evidence that supports the literature in individual psychotherapy research, which concludes that differences between orientations are minimal.

According to Sprenkle et al. (1999), the suggestion that therapeutic models and techniques produce a limited portion of positive therapy outcome in individual therapy can tentatively be concluded for the field of marriage and family therapy as well.

CHAPTER III

METHODS

Introduction

The purpose of this study was to explore the aspects of therapy as proposed by “common factors” literature (e.g., extratherapeutic change, hope and expectancy, therapy technique, and therapeutic relationship) by surveying the clients of a university based family therapy clinic. The study was conducted at an on-site university marriage and family therapy clinic in a graduate center in the Washington D.C. metropolitan area. The university’s clinic is an outpatient facility where marriage and family therapy interns provide services. The clinic provides therapeutic services to families, couples, and individuals with varying problems and mental health issues, including substance abuse, domestic violence, parenting concerns, marital problems, depression, and anxiety. The therapy provided is based on a family systems theoretical framework. The therapist interns who participated had a range of experience levels, from first-year practicum students to advanced graduate students with years of post-masters degree experience. All therapist interns are required to complete six credit hours of systems theory coursework prior to working in the clinic. Licensed marriage and family therapists supervise the therapist interns and much of the supervision is live via one-way mirrors and videotapes.

Instruments

The Client Perception Survey (CPS). The CPS is a 23-question survey that consists of 20 Likert-scale type questions and three open-ended questions. It was developed specifically for this study. The survey measured clients’ perceptions in six areas: whether or not they notice change in the situation that brought them to therapy (client change), how helpful they feel the therapeutic process is for them (therapy helpfulness), the therapeutic relationship, hope and expectancy about the therapeutic process, factors other than treatment that may impact positive change in their lives (extratherapeutic factors), and what specific things their therapist does that is helpful or not helpful for them (therapy technique). Questions are based on research that tends to show that extratherapeutic factors, therapeutic relationship, and hope and expectancy are the aspects of therapy across all models that affect positive change and outcome. Each

client assessed the extent of his or her agreement with twenty 5-point scale statements from “strongly agree” to “strongly disagree.” Eight of the items were reverse coded. A pilot test of the client survey was done to assess length of time necessary to complete the survey and to correct any questions that seemed confusing or were difficult to answer.

It should be explained that the scale for extratherapeutic factors was divided into two subscales. These subscales are client motivation and outside factors affecting positive change in the client’s life. Due to the expansive number of variables that contribute to the extratherapeutic factors category, only two were measured in this instrument. Because the two variables were found to be unique in what they were measuring as two different parts of the arena of extratherapeutic factors, the variables were each given their own individual subscale.

Cronbach alpha coefficients were determined for each subscale as follows: client change (.91, n = 38), therapy helpfulness (.93, n = 39), therapeutic relationship (.79, n = 40), hope and expectancy (.88, n = 41), motivation (.83, n = 38) and outside factors (.88, n = 41). The seventh variable, therapy technique, was not included in the quantitative portion of the survey, but was assessed qualitatively with the open-ended questions, “In what specific ways, if any, has your therapist been helpful?” and “In what specific ways, if any, has your therapist not been helpful?” The remaining open-ended question on the CPS was question #1, which asked, “In general, as you think about what (if anything) has helped you to feel better about the situation that brought you to therapy, what comes to mind?” This question was asked to discover what factors clients attributed to positive change in a way that would not limit their responses to the factors intending to be measured in the remainder of the survey. The CPS is presented in Appendix A.

The Therapist Questionnaire. The therapist questionnaire was also developed for this study. It is a four-item instrument that asked therapists to provide data about their client or their work with their client. The four items are: the client’s gender, the number of sessions they have seen the client, the client’s primary presenting problem(s), and the primary family therapy model or models they used with this particular client. Therapists were asked to select from a list of models. Model choices included Bowenian/intergenerational, narrative, solution-focused, structural/strategic, behavioral, experiential, psychoanalytic, and other. These models were offered as choices based on

their prominence in the publication of marriage and family theory text (Nichols & Schwartz, 1995). The “other” option allowed therapists the opportunity to report any model not listed on the survey. The therapist questionnaire is presented in Appendix B.

Sample Selection

All clients who had three or more previous therapy sessions and who came to the university clinic during two weeks of the fall semester (October 1999) and two weeks in the spring semester (February 2000) were asked by their therapists to complete the survey at the end of their regularly scheduled session. All clients were required to be 18 years or older. If a client system included more than one person meeting the age and number of session criteria, each person was asked to participate individually. Eighty clients were eligible to respond to the survey. Forty-three of these clients (55%) responded to the survey; two of the surveys were not included in the data due to incomplete information.

Participants

Participants were 41 clients seeking mental health assistance at the university clinic during the 1999-2000 academic year. A higher percentage of the respondents were female (N = 31, 76%) than were male (N = 10, 24%). The mean age of the sample was 35 years. The ethnicity of the sample was as follows: Caucasian (68.3%), African American (17.1%), Hispanic (9.8%), and Asian (4.9%). The mean number of 50-minute family therapy sessions for the sample was 13.46. Table 1 below describes the sample in more detail, including presenting problem and therapy model used by the therapist interns.

There were 19 therapist intern participants who completed therapist questionnaires about their clients’ gender, presenting problem, number of sessions, and the model(s) of therapy they used most frequently. These therapist participants consisted of seven post-Master’s and twelve Master’s level interns

Table 1
Demographics of Sample (N = 41)

	n	%
<i>Gender</i>		
Female	31	75.6
Male	10	24.4
<i>Age</i>		
	<u>Mean = 35.32</u>	
20-29 years	11	26.8
30-39 years	15	36.6
40-49 years	13	31.7
50+ years	2	4.9
<i>Ethnicity</i>		
Non-Minority	28	68.3
Minority	13	31.7
<i>Number of Sessions</i>		
	<u>Mean = 13.46</u>	
3-5 sessions	13	31.7
6-15 sessions	14	34.1
16 or more sessions	14	34.1
<i>Presenting Problem ^a</i>		
Parenting	11	26.8
Marital Problems	10	24.4
Anger Management	8	19.5
Interpersonal Relationships	6	14.6
Trauma	5	12.2
Depression	5	12.2
Substance Abuse	3	7.3
Personal Enrichment	2	4.9
Separation/Divorce	2	4.9
Sexual Problems	1	2.4
<i>Therapy Model ^a</i>		
Solution-Focused	24	58.5
Structural/Strategic	13	31.7
Bowenian/Intergenerational	10	24.4
Cognitive/Behavioral	10	24.4
Experiential	10	24.4
Narrative	9	22.0
Other	4	9.8

^a Percents sum to more than 100 percent as multiple responses were possible.

Procedures

Surveys were provided to clients at two different periods of time, each distribution period separated by three months. The first distribution of the survey took place in October 1999 and the second and final distribution in February 2000. This increased the number of respondents as more clients came into the clinic throughout the academic year. Clients who had answered the survey in October were not surveyed again in February. The purpose of the second distribution of the survey was to include clients who had begun therapy since the previous distribution.

The therapists in the clinic were informed of the study procedures one-week prior to the distribution of the survey by memo (Appendix C). Therapist interns and their supervisors were informed of their role in distributing the survey to their clients and questions about the procedures were answered during the week prior to the survey distribution. The researcher contacted each therapist in order to obtain therapists' informed consent (Appendix D) prior to the distribution of the surveys. Therapists received one packet for each of their adult clients who had been attending therapy for three or more sessions. These packets included a therapist cover letter and therapist questionnaire, a client cover letter and client survey (with the clinic case number at the top of the survey), a blank envelope, and a pencil.

The survey was given to the clients following their regularly scheduled session with their therapist interns. Therapist interns provided participants with the CPS, answering any possible questions about the survey process as necessary. Along with the CPS, clients were provided with an informed consent (Appendix E), which informed participants of the purpose of the survey and assured their confidentiality.

Participants were asked to complete the survey in the clinic waiting area independent of their therapist intern. Completed client surveys were then put into envelopes to be sealed and deposited in a box in the clinic waiting area. Clients who were not able to fill out the surveys immediately were offered another opportunity to participate the following week at their next scheduled appointment time. Therapist interns informed clients that their answers were completely confidential and would in no way affect their work in the future. Due to the sensitivity of the content of the survey, confidentiality was ensured to help avoid participants' answering with more 'positive'

responses. Ensuring the participants' confidentiality has been found to be helpful in reducing higher ratings (than if their answers were not confidential) and provides a more realistic view of the client's level of satisfaction (McNeill, May, & Lee, 1987; Soelling & Newell, 1983).

Therapists also completed their portion of the investigation at this time. Nineteen therapist interns completed therapist surveys. Twelve of the therapists who completed surveys were master's degree students and the remaining seven were post-master's degree students. Therapists were provided with a therapist cover letter and a therapist questionnaire. Once out of the presence of their client(s), therapist interns reviewed the therapist cover letter (Appendix F) and completed the therapist questionnaires after signing an informed consent form. Completed therapist questionnaires were then placed in a box in the clinic.

Once the completed surveys were collected, a research assistant matched the completed therapist data with their client's completed survey(s) by case number. Case numbers initially identified all surveys in order to perform this matching of therapist/client data. Once the research assistant completed this process, the client case number was removed from both forms and the data was given a new number. This new number was used to identify completed data and was not connected to the client case number. This measure was taken to protect the anonymity of both the client and the student therapist intern, recognizing the important issues of the clinician/researcher role and protecting the integrity of relationships among clinical colleagues.

Design and Analysis

Both quantitative and qualitative data were collected and analyzed. Quantitative data were collected in the 20 five-point closed-ended CPS questions. Preliminary descriptive analysis was used to illustrate clients' perceptions of important therapeutic factors. Reports are provided regarding the factors of therapy with which clients agreed or disagreed with as helpful to their therapeutic experience. Demographic differences among client groups have also been studied with the use of t-tests and analysis of variance testing. Correlational analyses were used to examine the relationship between CPS subscales. Regression analysis was also performed to explore whether or not

therapeutic relationship, hope and expectancy, client motivation, and outside factors are predictors for perceived client change and therapy helpfulness. All statistical analyses were completed using *SPSS for Windows, v10.0* (Norusis, 1999).

Qualitative data were also gathered in the three open-ended CPS questions (questions 17, 18, and 19). Data analysis in qualitative research is an iterative and recursive process (Sprenkle & Moon, 1996). The constant comparative method (Strauss & Corbin, 1990) was used to analyze, code, categorize, and interpret the collected data. Participant responses were categorized using cross-coding methods between three individual coders, a cross coding “team.” Each individual on the team coded the qualitative data separately, then the team met together to discuss their individual coding results and reached consensus in defining the categories. Using this method of triangulation provided the findings with an increased level of trustworthiness (Lincoln & Guba, 1985). Routine meetings with the advisor for this research project served to test interpretations for validity and control for bias. This qualitative data is being used with the purpose of illustrating and clarifying the quantitatively derived findings of the survey (Strauss & Corbin, 1990).

CHAPTER IV

RESULTS

Introduction

The purpose of this study was to explore the aspects of therapy as proposed by common factors literature (e.g., extratherapeutic change, hope/expectancy, technique, and therapeutic relationship) suggests are critical to therapy outcome. This study surveyed the clients of a university based family therapy clinic to explore these factors. The Client Perception Survey (CPS) was distributed to clients during two different time periods: for two weeks in October 1999 and for two weeks in February 2000. In the first distribution, 31 clients completed the questionnaires. In the second distribution, 10 clients completed questionnaires, making a total of 41 completing the CPS for both survey distributions. The following data from the study is presented by total responses received and the information reported in this section is separated into quantitative responses and qualitative responses to the CPS.

Quantitative Responses to the Client Perception Survey

The CPS contains 20 quantitative questions containing five different variable subscales, with four questions per scale. The five variable subscales are client change, therapy helpfulness, therapeutic relationship, extratherapeutic factors (which include the two subscales motivation and outside factors affecting positive change in their lives), and hope and expectancy. Subscale scores were calculated by summing responses to the questions for that subscale. The types of analysis performed on this data are descriptive analyses, comparisons of means, correlations, and multiple regressions.

Descriptive Analyses of Responses to the Client Perception Survey

Table 2 presents the subscale means and percent of respondents who agreed and strongly agreed (e.g., answered 4 or 5 on the 5-point scale) and who neither agreed nor disagreed, moderately disagreed, and strongly disagreed (e.g., answered 1, 2, or 3 on the 5-point scale) with each CPS subscale. Total possible scores range from 4-20 for the variables client change, therapy helpfulness, therapeutic relationship, and hope and

expectancy. Total possible scores range from 2-10 for the variables motivation and outside factors.

Three of the twenty items were associated with extremely high levels of strong agreement across all respondents (75% or greater). All three of these items were therapeutic relationship questions (#3-“I have a positive relationship with my therapist,” #15-“I do not feel respected by my therapist,” [reverse code] and #20-“I feel respected by my therapist”). The remaining item on the therapeutic relationship subscale (#12-“I trust my therapist”) was associated with a moderately high level of agreement across all respondents (65.9%) as well. The higher percentages for the four items in this subscale indicate that in general, most of the clients agree or strongly agree (97.5%) that they perceive their relationships with their therapists as positive ones in which they feel respected by and trust in their therapists.

Total percentages on three of the remaining subscales of the CPS were also associated with moderately high levels of agreement across all respondents (75% or greater). The higher percentages of positive responses across respondents for the hope and expectancy subscale (84.6%), client motivation subscale (81.6%), and the therapy helpfulness subscale (79.5%) indicate that in general, most clients perceive themselves as hopeful about the therapy process, perceive themselves as motivated in therapy, and perceive that their therapy has helped them to deal more effectively with their problems. Moderate levels of agreement were associated with the two remaining subscales, client change (63.2%) and outside factors (61.0%). Table 2 presents further details about the agreement and disagreement for subscales of the CPS. An item-by-item summary is presented in Table 3.

Table 2
Total Means and Percentages of Agreement and Disagreement
 for Client Perception Survey Items

	<u>n</u>	<u>M</u>	<u>SD</u>	<i>% Neither Agree nor Disagree, Moderately Disagree and Strongly Disagree</i>	<i>% Moderately Agree and Strongly Agree</i>
Client Change (items 5, 11 ¹ , 16 ¹ , and 19)	38	15.79	4.09	36.8	63.2
Therapy Helpfulness (items 2, 9, 13 ¹ , and 18 ¹)	39	17.31	3.11	20.5	79.5
Therapeutic Relationship (items 3, 12, 15 ¹ , and 20)	40	19.10	1.50	2.5	97.5
Hope and Expectancy (items 6 ¹ , 8 ¹ , 14, and 21)	39	17.90	2.72	15.4	84.6
Motivation (items 4 ¹ and 10)	38	8.97	1.40	18.4	81.6
Outside Factors (items 7 and 17)	41	7.81	1.57	39.0	61.0

¹ Reverse code.

Table 3
Percentages for Item-by-Item Responses of
Agreement and Disagreement for Client Perception Survey Items

	<i>Strongly Disagree</i> (1)	<i>Moderately Disagree</i> (2)	<i>Neither Agree nor Disagree</i> (3)	<i>Moderately Agree</i> (4)	<i>Strongly Agree</i> (5)
<u>Client Change</u>					
My life seems better now than it was before the start of therapy	5.1	2.6	25.6	30.8	35.9
The problem that I came to therapy about has not improved since I started therapy ¹	2.4	12.2	7.3	41.5	36.6
My life does not seem better now than it was before the start of therapy ¹	7.5	2.5	17.5	25.0	47.5
The problem that I came to therapy about has improved since I started therapy	2.4	12.2	14.6	31.7	39.0
<u>Therapy Helpfulness</u>					
The therapy that I am receiving has helped me deal more effectively with my problem(s)	2.6	2.6	12.8	41.0	41.0
The therapy I am receiving has been helpful	--	--	7.3	31.7	61.0
The therapy that I am receiving has not been helpful ¹	--	7.3	2.4	31.7	58.5
The therapy that I am receiving has not helped me to deal more effectively with my problem(s) ¹	2.4	2.4	9.8	34.1	51.2
<u>Therapeutic Relationship</u>					
I have a positive relationship with my therapist	--	--	2.4	22.0	75.6
I trust my therapist	--	--	4.9	29.3	65.9
I do not feel respected by my therapist ¹	--	--	2.5	2.5	95.0
I feel respected by my therapist	--	--	2.4	12.2	85.4

Table 3 (cont.)
Percentages for Item-by-Item Responses of
Agreement and Disagreement for Client Perception Survey Items

<u>Hope and Expectancy</u>					
I do not feel hopeful that things will get better as a result of therapy ¹	--	7.3	7.3	24.4	61.0
I do not have a positive expectation that therapy will help me ¹	--	2.5	7.5	27.5	62.5
I feel hopeful that things will get better as a result of therapy	--	2.5	--	40.0	57.5
I have a positive expectation that therapy will help me	--	2.4	4.9	26.8	65.9
<u>Motivation</u>					
When I came to therapy I was not motivated to make my life better ¹	--	2.6	15.8	18.4	63.2
When I came to therapy I was motivated to make my life better	--	--	9.8	31.7	58.5
<u>Outside Factors</u>					
Things have happened in my everyday life outside of therapy that have led me to make positive changes	2.4	--	26.8	46.3	24.4
Things that are independent of my therapy have led me to make positive changes in my life	--	2.4	29.3	43.9	24.4

¹ Reverse code.

Demographic Analyses

Means were compared for the demographic groups gender, ethnicity, age, and number of sessions (Tables 4 and 5). T-tests comparing the mean responses of the demographic variables gender and ethnicity indicate significant differences in two of the six variables. The results reveal significant differences between male and female participants for the variable motivation ($t = -1.90$, $df = 36$, $F = 5.78$, $p < .05$), suggesting that female respondents tend to perceive themselves as more motivated in therapy than their male counterparts. There were no significant mean score differences for males and females for any of the other common factor variables (client change, therapy helpfulness, therapeutic relationship, hope and expectancy, or outside factors). For ethnicity, the results reveal differences in non-minority versus minority clients for the variable hope and expectancy ($t = -1.73$, $df = 37$, $F = 7.50$, $p < .01$), suggesting that minority clients tend to perceive themselves as significantly more hopeful about their therapy than non-minority clients. Differences are also approaching significance between non-minority and minority groups for the variable motivation ($t = .94$, $df = 36$, $F = 2.93$, $p < .10$), suggesting that non-minority respondents perceive themselves as being more motivated at the beginning of the therapy process than minority clients. There were no significant mean score differences for minorities and non-minorities for any of the other common factor variables (client change, therapy helpfulness, therapeutic relationship, or outside factors).

Table 4
T-Test Results by Variable for Gender and Ethnicity

	t	Gender				t	Ethnicity			
		Female		Male			Non-Minority		Minority	
		<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
Client Change	-.08	<u>n = 28</u> 15.82	4.08	<u>n = 10</u> 15.70	4.35	-1.71	<u>n = 26</u> 15.04	4.3 5	<u>n = 12</u> 17.42	3.03
Therapy Helpfulness	.58	<u>n = 29</u> 17.14	2.97	<u>n = 10</u> 17.80	3.61	-1.27	<u>n = 27</u> 16.89	3.3 5	<u>n = 12</u> 18.25	2.38
Therapeutic Relationship	-.48	<u>n = 30</u> 19.17	1.58	<u>n = 10</u> 18.90	1.29	-1.35	<u>n = 28</u> 18.89	1.6 6	<u>n = 12</u> 19.58	.90
Hope/Expectancy	.00	<u>n = 29</u> 17.90	2.70	<u>n = 10</u> 17.90	2.92	-1.73*	<u>n = 27</u> 17.41	3.0 0	<u>n = 12</u> 19.00	1.54
Client Motivation	-1.90*	<u>n = 29</u> 9.21	1.21	<u>n = 9</u> 8.22	1.79	.94***	<u>n = 27</u> 9.11	1.2 8	<u>n = 11</u> 8.64	1.69
Outside Factors	1.15	<u>n = 31</u> 7.65	1.54	<u>n = 10</u> 8.30	1.64	-1.88	<u>n = 28</u> 7.50	1.5 3	<u>n = 13</u> 8.46	1.51

* $p < .01$. *** $p < .10$.

Analysis of variance tests were performed for the demographic variables age and number of sessions (see Table 5). The results suggest that there were no significant mean score differences for age groups (20-29 years, 30-39 years, 40-49 years, and 50 years and older) of clients for any of the common factors variables (client change, therapy helpfulness, therapeutic relationship, hope/expectancy, client motivation, or outside factors). Differences were revealed, however, among groups by number of sessions. Scheffe's post-hoc analyses revealed differences between clients who had been in therapy for a longer amount of time (16 or more sessions) than for those clients who had been in therapy for only a brief amount of time (3-5 sessions) for the variables client change ($F = 2.99, p < .10$), therapy helpfulness ($F = 3.47, p < .05$), and hope and expectancy ($F = 3.80, p < .05$). These results imply that clients who have been in therapy longer perceive themselves as experiencing more positive change in their lives, perceive therapy as more helpful, and feel more hopeful about therapy helping them than clients who have been in therapy for only a limited amount of time. Significant mean score differences were not

found between clients' number of sessions for any of the remaining factors (therapeutic relationship, client motivation, or outside factors).

Table 5
Analysis of Variance for Age and Number of Sessions

	<u>Age</u>			<u>Number of Sessions</u>		
	<u>M</u>	<u>df</u>	<u>F</u>	<u>df</u>	<u>F</u>	
Client Change	<u>n = 38</u> 15.79	3	.23	2	2.99***	
Therapy Helpfulness	<u>n = 39</u> 17.31	3	.48	2	3.47**	
Therapeutic Relationship	<u>n = 40</u> 19.10	3	.70	2	2.35	
Hope/ Expectancy	<u>n = 39</u> 17.90	3	1.07	2	3.80**	
Client Motivation	<u>n = 41</u> 8.97	3	.61	2	.25	
Outside Factors	<u>n = 38</u> 7.80	3	1.69	2	.42	

** $p < .05$. *** $p < .10$.

Correlations of the Client Perception Survey Subscales

Table 6 presents a summary of the Pearson-product moment correlations between client ratings of client change, therapy helpfulness, therapeutic relationship, client motivation, and hope and expectancy. Of these variables, all revealed a strong statistically significant relationship except for the variable motivation, which was not significantly correlated with the any of the other variables. The significant correlations for all variables ranged from .47 to .84.

Table 6
Correlations of the Client Perception Survey Subscales

Subscale	1	2	3	4	5	6
1. Client Change	--					
2. Therapy Helpfulness	.70**	--				
3. Therapeutic Relationship	.57**	.67**	--			
4. Client Motivation	-.06	-.21	-.09	--		
5. Outside Factors	.47**	.57**	.47**	-.29	--	
6. Hope/Expectancy	.67**	.84**	.73**	-.09	.56**	--

** Correlation is significant at the .01 level (two-tailed).

Predictors of Perceived Positive Client Change

To test the hypothesis that there is a relationship between positive client change and each of the three “common factors” variables (therapeutic relationship, extratherapeutic factors, which includes the subscales client motivation and outside factors, and hope and expectancy), a multiple regression analysis was performed. One dependent variable and four independent (predictor) variables that represented individual client scores were entered into the equation to determine the predictive effect of the three independent variables on perceived client change. The variables were obtained by summing the scores of each subscale on the CPS. The standardized beta coefficients, standard errors, and significance values for these regressions for the variable client change are reported in Table 7.

Strong overall support was found for the hypothesis that common factors variables have a predictive relationship to positive client change. The linear combination of the independent variables of therapeutic relationship, client motivation, outside factors, and hope and expectancy were predictive of perceived client change ($R^2 = .49$, $F = 7.12$, $p = .000$) explaining about 49% of the variance with the adjusted variance about 42%. The results indicate that hope and expectancy accounts for more variance on perceived positive client change ($\hat{a} = .513$; $p < .05$) than therapeutic relationship, client motivation, and outside factors. These results suggest that clients who feel more hopeful about therapy and expect that therapy will help them tend to report experiencing positive change in their lives.

Table 7
Summary of Linear Regression Analysis for
Predictors of Perceived Client Change (N = 35)

Variable	<u>Standard Error</u>	\hat{a}	<u>t</u>
Therapeutic Relationship	.568	.186	.887
Client Motivation	.420	.031	.218
Outside Factors	.493	.055	.305
Hope and Expectancy	.318	.513*	2.381

Note. $R^2 = .49^{**}$; Adjusted $R^2 = .42$.

** $p < .01$, * $p < .05$.

Predictors of Perceived Therapy Helpfulness

To test the prediction that there is a relationship between the perceived helpfulness of therapy and the three “common factors” variables (therapeutic relationship, extratherapeutic factors, which includes client motivation and outside factors, and hope and expectancy), a multiple regression analysis was performed. One dependent variable and four independent (predictor) variables that represented an individual client’s score were entered into the equation to determine the predictive effect of the three independent variables on perceived therapy helpfulness. The standardized beta coefficients, standard errors, and significance values for these regressions for the variable therapy helpfulness are reported in Table 8.

Very strong overall support was found for the hypothesis that common factors variables have a predictive relationship to therapy helpfulness. The linear combination of the independent variables of therapeutic relationship, client motivation, outside factors, and hope and expectancy were highly predictive of clients’ perceptions of therapy helpfulness ($R^2 = .73$, $F = 19.97$, $p = .000$) explaining about 73% of the variance with the adjusted variance about 70%. The results indicate that hope and expectancy accounts for more of the variance on perceived therapy helpfulness ($\hat{a} = .687$, $p < .01$) than therapeutic relationship, client motivation, and outside factors. These results suggest that clients who feel more hopeful about therapy and expect therapy tend to report a more positive therapeutic outcome.

Table 8
Summary of Linear Regression Analysis for
Predictors of Perceived Therapy Helpfulness (N = 34)

Variable	Standard Error	\hat{a}	t
Therapeutic Relationship	.313	.148	.979
Client Motivation	.236	-.119	-1.143
Outside Factors	.270	.043	.332
Hope and Expectancy	.172	.687**	4.548

$R^2 = .73^{**}$; Adjusted $R^2 = .70$.

** $p < .01$.

Secondary Analyses

Upon examination of these findings, secondary multiple regression analyses were conducted to better understand the predictors for clients' perceptions of client change and therapy helpfulness. Due to the multi-collinearity between independent variables (particularly, the high level of correlation between clients' perceptions of the therapeutic relationship and hope and expectancy), analyses were conducted again after removing each of these variables.

Secondary Analyses for Predictors of Perceived Positive Client Change

Table 9 presents the standardized beta coefficients, standard errors, and significance values for these multiple linear regressions for the variable perceived positive client change. The dependent variable therapeutic relationship was removed for this analysis. Findings indicate that the linear combination of the independent variables of hope and expectancy, outside factors, and client motivation were predictive of clients' perceptions of positive client change ($R^2 = .47$, $F = 9.29$, $p = .000$) explaining about 47% of the variance with the adjusted variance about 42%. These findings are approximately the same as the findings in the previous analysis for perceived positive client change that included the independent variable therapeutic relationship. The secondary results similarly indicate that hope and expectancy accounts for more of the variance on perceived client change ($\hat{a} = .636$, $p < .01$) than client motivation and outside factors. The removal of the fourth independent variable, however, increased the level of significance for hope and expectancy, from $p < .05$ to $p < .01$. The secondary analysis produced standardized beta coefficients for the independent variables outside factors and client motivation that were nearly the same as the previous analyses for perceived positive client change.

Table 9
Linear Regression Analysis for Predictors of Perceived Client Change with Therapeutic Relationship Variable Removed

Variable	Standard Error	\hat{a}	t
Hope and Expectancy	.242	.636**	3.878
Outside Factors	.481	.089	.505
Client Motivation	.418	.037	.259

Note. $R^2 = .47^{**}$; Adjusted $R^2 = .42$.

** $p < .01$.

Table 10 presents the standardized beta coefficients, standard errors, and significance values for multiple linear regressions for the variable perceived positive client change. The dependent variable hope and expectancy was removed for this analysis. Findings indicate that the linear combination of the independent variables of therapeutic relationship, outside factors, and client motivation were predictive of clients' perceptions of positive client change ($R^2 = .39$, $F = 6.60$, $p = .001$) explaining about 39% of the variance with the adjusted variance about 33%. These variables predicted a lower level of overall variance than the findings in the dependent variable than the independent variables in the previous analysis for perceived positive client change that included the independent variable hope and expectancy. The secondary results also indicate that therapeutic relationship accounts for more of the variance on perceived client change ($\hat{a} = .507$, $p < .01$) than client motivation and outside factors. The removal of the fourth independent variable (hope and expectancy) significantly increased the level of variance that is accounted for by therapeutic relationship. In fact, the level of variance in the previous analyses for the independent variable therapeutic relationship was not at a significant level. These results suggest that the clients who perceive having a positive therapeutic relationship with their therapist tend to report experiencing more positive change in their lives.

Table 10
Linear Regression Analysis for Predictors of Perceived Client Change with Hope and Expectancy Variable Removed

Variable	Standard Error	\hat{a}	t
Therapeutic Relationship	1.377	.507**	2.955
Outside Factors	.520	.190	.309
Client Motivation	.189	.064	.677

Note. $R^2 = .39^{**}$; Adjusted $R^2 = .33$.

** $p < .01$.

Secondary Analyses for Predictors of Perceived Therapy Helpfulness

Table 11 presents the standardized beta coefficients, standard errors, and significance values for these multiple linear regressions for the variable perceived therapy helpfulness. The dependent variable therapeutic relationship was removed for this analysis. Findings indicate that the linear combination of the independent variables of hope and expectancy, outside factors, and client motivation were highly predictive of clients' perceptions of positive client change ($R^2 = .72$, $F = 26.59$, $p = .000$) explaining about 72% of the variance with the adjusted variance about 69%. These findings are approximately the same as the findings in the previous analysis for perceived therapy helpfulness that included the independent variable therapeutic relationship. The secondary results similarly indicate that hope and expectancy accounts for more of the variance on perceived client change ($\hat{a} = .778$, $p < .01$) than client motivation and outside factors. The removal of the fourth independent variable affected these secondary results very little. The secondary analysis produced standardized beta coefficients for the independent variables hope and expectancy, outside factors, and client motivation that were nearly the same as the previous analyses for perceived therapy helpfulness.

Table 11
Linear Regression Analysis for Predictors of Perceived Therapy Helpfulness with Therapeutic Relationship Variable Removed

Variable	Standard Error	\hat{a}	t
Hope and Expectancy	.134	.778**	6.702
Outside Factors	.261	.084	.679
Client Motivation	.232	-.092	-.896

$R^2 = .72^{**}$; Adjusted $R^2 = .69$.

** $p < .01$.

Table 12 presents the standardized beta coefficients, standard errors, and significance values for multiple linear regressions for the variable perceived therapy helpfulness. The dependent variable hope and expectancy was removed for this analysis. Findings indicate that the linear combination of the independent variables of therapeutic relationship, outside factors, and client motivation were predictive of clients' perceptions of positive client change ($R^2 = .54$, $F = 12.34$, $p = .000$) explaining about 54% of the variance with the adjusted variance about 50%. These variables predicted a lower level of overall variance than the findings in the dependent variable than the independent variables in the previous analysis for perceived therapy helpfulness that included the independent variable hope and expectancy. The secondary results also indicate that therapeutic relationship accounts for more of the variance on perceived client change ($\hat{a} = .563$, $p < .01$) than client motivation and outside factors. The removal of the fourth independent variable (hope and expectancy) significantly increased the level of variance that is accounted for by therapeutic relationship. In fact, the level of variance in the previous analyses for the independent variable therapeutic relationship was not at a significant level. These results suggest that the clients who perceive having a positive therapeutic relationship with their therapist tend to report experiencing more positive change in their lives.

Table 12
Linear Regression Analysis for Predictors of Perceived
 Therapy Helpfulness with Hope and Expectancy Variable Removed

Variable	Standard Error	\hat{a}	t
Therapeutic Relationship	.301	.563**	3.892
Outside Factors	.307	.230	1.515
Client Motivation	.289	-.092	-.713

$R^2 = .54^{**}$; Adjusted $R^2 = .50$.

** $p < .01$.

Qualitative Responses to the Client Perception Survey

The Client Perception Survey contains three open-ended questions that participants can answer in their own words. Since multiple responses were possible for each participant in the qualitative portion of the survey, the percentages sum to more than 100 percent for the categories. Reported percentages reflect the number of participants who responded in a similar way (which were then assigned a category label) and are illustrated as a percentage of the total participants who completed that particular question on the survey. Categories emerged by looking through the lens of common factors research, which identifies extratherapeutic factors, the therapeutic relationship, hope and expectancy, and therapeutic technique as aspects of therapy common to all models (Hubble, Duncan, & Miller, 1999; Lambert, 1992). Some participants' answers were coded into several categories, others into one or a few different categories, and some participants left one or more questions blank. The following definitions of categories of interest were developed based on the results of this study's cross-coding process and many are conceptualized as occurring on a continuum which allowed the coding team to consider the presence or the absence of a particular factor within a response when coding the data. The categories are:

1. Therapeutic Relationship: An interaction or dynamic between client and therapist that is indicative of an alliance (e.g., understanding, empathetic, non-judgmental) or the client's sense of security within his or her relationship with the therapist. All responses fall toward the positive end of the continuum for this category.

A. Talk/Listen: Subcategory of therapeutic relationship. Indicators of the therapist listening to the client or the client being able to talk to the therapist.

2. Hope and Expectancy: Evidence that the client anticipates that change will occur as a result of coming to therapy. This category contains responses that fall on either side of the continuum: Hopefulness or positive expectation for change and lack of hope or expectation for change.

3. Extratherapeutic Factors: Factors that seem to relate to change in the client, which are outside of the therapeutic interaction. Responses fall toward both the

positive and negative ends of the continuum for this category. Four subcategories emerged from the data:

A. Client's Beliefs: General opinions held by clients about therapy or therapists.

B. Outside Support and/or Resources: The presence or client's use of outside sources that help to improve the situation that brought them to therapy.

C. Structure: Meeting at a set time and/or place each week or having a forum for discussion.

D. Goodness of Fit: A match in style and/or personality between the client and his or her therapist.

4. Therapy Technique: An action or actions that the therapist takes in-session. Responses fall at both the positive and negative ends of the continuum for this category.

5. Therapy Effect: The degree and/or type of change in the client that seems to be a result of the therapy. All responses fall toward the positive end of the continuum for this category.

6. Client Change: The degree and/or type of change in the client that is not necessarily identified as occurring as a result of the therapy. This category is divided into two types of client change that fall on either side of the continuum: Positive client change and no or little client change. There were four types of positive change identified: cognitive change, behavioral change, emotional change, and non-specific or generic change.

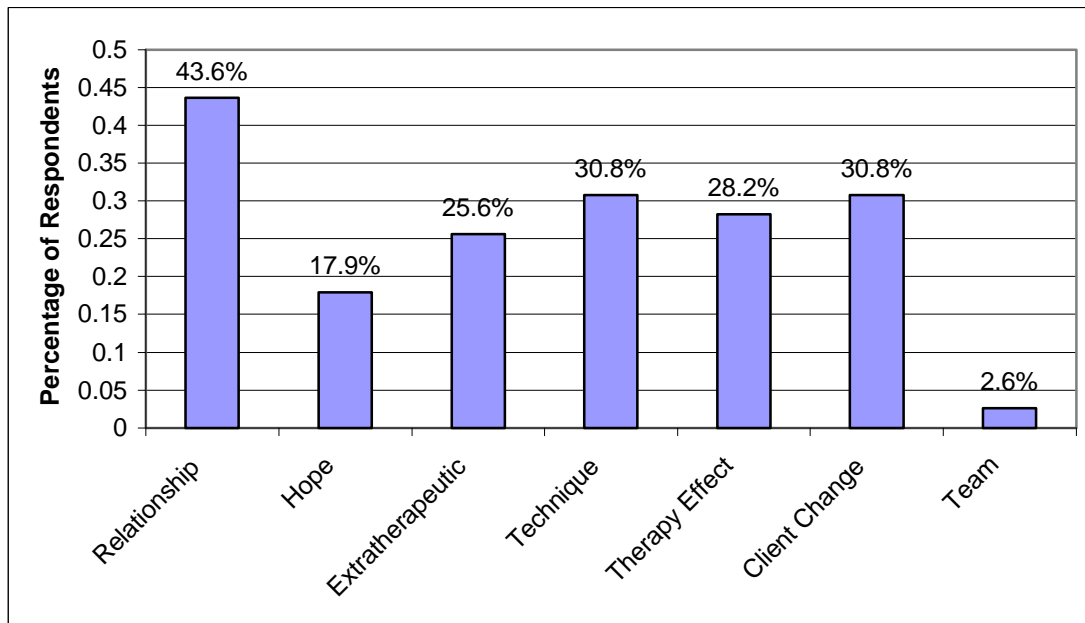
7. Team: This category refers to responses relating to the team of observers used in the university clinic. Responses fall at both the positive and negative ends of the continuum for this category.

Qualitative Survey Question #1 (Q1 of Appendix A):

In general, as you think about what (if anything) has helped you to feel better about the situation that brought you to therapy, what comes to mind?

Of the 41 clients who completed the Client Perception Survey, 39 answered this question. Of the 39 participants who answered this question, responses were categorized into the following seven categories as defined above: Therapeutic relationship, hope/expectancy, extratherapeutic factors, therapy technique, effect of therapy, client change, and team (see Figure 1).

Figure 1
Qualitative Question #1 Responses



Seventeen participants (43.6%) answered this question with a response that was labeled therapeutic relationship. For example, participants made statements such as, “I feel safe,” and “Knowing that [my therapist] understands,” that implies a relationship dynamic between therapist and client. This category also included responses about trusting the therapist, being able to share emotions with the therapist, the therapist being an objective party, and receiving empathy and/or sympathy from the therapist.

One theme that seems to stand apart from the rest of the responses in the therapeutic relationship category is the subcategory talk/listen. Of the 17 participants who answered this question with a response labeled therapeutic relationship, 11

participants (64.7%) gave a response that was also labeled talk/listen. Examples of these responses include statements such as, “I have someone to talk to...someone who will listen to me” and “I have someone who listens.” Talking about their problems and having someone listen to their problems seemed to be considered a most helpful aspect of the therapeutic relationship as evidenced by the number of responses in this subcategory.

Twelve participants (30.8%) answered this question with a response that was labeled therapy technique. Some examples of responses in this category include, “Charting feelings, decisions trees, recommended readings,” and “Assertiveness training and putting behavior plans into action.” Problem solving, complimenting, brainstorming, giving feedback, providing solutions, and normalizing were also identified as therapy techniques that clients found helped them to feel better about the situation that brought them to therapy.

Twelve participants (30.8%) answered the question with a response that was labeled client change. These responses included, “I’ve been able to organize my thoughts and therefore my actions, resulting in a better perception of my world,” and “The situation [that brought us to therapy] is much better now. It is now possible to discuss problems and work our solutions without a blow up.” Client change responses are divided into two subcategories of positive client change and no change or little change in the situation that brought them to therapy. Seven participants (58.3%) identified the change that they experienced as positive client change. These positive client change responses fall into four subcategories, with some respondents identifying change in more than one of each of the four areas. These four subcategories include: cognitive change (71.4%), behavioral change (42.9%), emotional change (28.6%), and non-specified or generic change (28.6%). Five of the participants (41.7%) that answered this question with a client change response reported no change or little change in their situation, indicating a response on the more negative end of the client change continuum. For example, “No real progress” and “Right now I can’t think of anything that has radically helped me to feel better about the specific situation that brought me to therapy” were both categorized as responses that fell toward the negative end of the client change continuum.

Eleven participants (28.2%) responded to this question with a response that was labeled effect of therapy. Sample responses for this category include, “Therapy has

helped me to resolve and find different solutions to problems I face day to day,” “My daughter and I are learning to communicate much better...I think therapy has been very good for both of us,” and “I think about having to think. Before therapy I would focus on externals and not on myself.” Other aspects of the effect therapy has had on participants include personal growth, clarity of the problem, being introduced to someone else’s perspective, the making of more appropriate life choices, increased self-esteem and self-assurance, feeling validated, and improved marital relations.

Ten participants (25.6%) answered this question with a response that was labeled extratherapeutic factors. Examples of responses in this category include, “Therapists are a true asset to the world,” “...numerous comments of support from friends [and] associates... reinforce that I’m doing the right thing about seeking help,” and “...having a set-aside time and place to deal with [the situation].” Of the ten participants who answered in this category, responses fall into four basic subcategories: structure (50.0%), clients’ beliefs about therapy (33.3%), support and/or resources outside of the therapeutic interaction (50%), and goodness of fit between client and therapist (16.7%).

Seven participants (17.9%) answered this question with a response that was labeled hope/expectancy. Examples of these responses include, “Knowing that at the end of therapy, things will be better” and “That there are positive things to look forward to.” Participants also mentioned looking forward to attending the therapy sessions, seeing the light at the end of the tunnel, and therapy helping them to keep a positive perception about their situations. One of the seven participants who answered this question with a hope/expectancy response indicated a lack of hope about change occurring as a result of coming to therapy, suggesting a response on the more negative end of the continuum for this category.

One participant (2.6%) answered this question with a response that was labeled team. This response was, “Knowing that there are several people actually sitting in on our meeting and advising us is an extra comfort.” This response fell on the positive side of the category continuum.

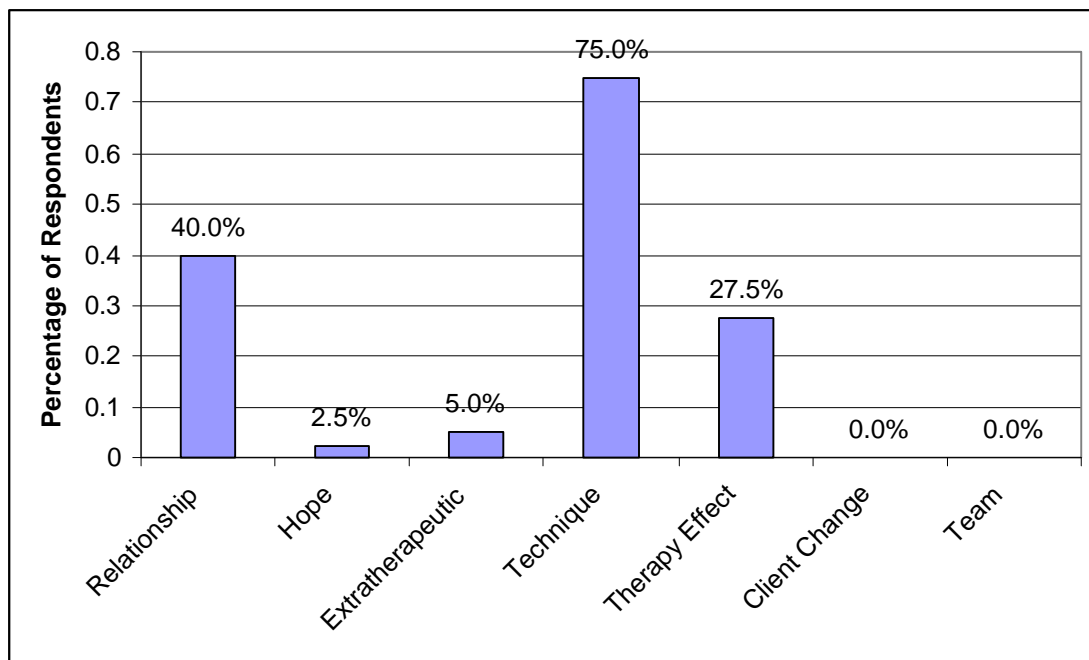
Qualitative Survey Question #2 (Q23 of Appendix A):

In what specific ways, if any, has your therapist been helpful?

Of the 41 clients surveyed, 40 answered this question. Of the 40 participants who answered this question, responses were placed in the following categories: Therapy technique, therapeutic relationship, effect of therapy, client change, hope/expectancy, and extratherapeutic factors. No participants answered this question with a client change or team response (see Figure 2).

The majority of respondents (75.0%) answered this question with a response that was labeled therapy technique. Examples of responses in this category include, “[My therapist] can put my thoughts and comments and concerns into perspective and can see things clearer than I am able to,” “[My] therapist has been very helpful by...searching for ways to help me adjust,” and “[My therapist] has given me homework to do that has been helpful.” Other therapy techniques specifically identified by participants as helpful to them include encouragement, suggestions for improvement, the use of different media, goal-setting, giving feedback, asking questions, offering alternative options, providing new perspectives, remaining positive, searching for solutions, clarifying, discussion of the past, and complimenting.

Figure 2
Qualitative Question #2 Responses



Sixteen participants (40.0%) answered this question with a response that was labeled therapeutic relationship. Examples of these responses include, “[My therapist] is very involved and empathetic” and “He seems to have our interest[s] truly at heart and really wants to help us.” Objectivity, active and patient listening, understanding, sincerity, honesty, and caring were other aspects of the therapeutic relationship that participants found helpful to them. Of the 16 participants who answered this question with a response that was labeled therapeutic relationship, seven of these participants (43.8%) gave a response that was also labeled talk/listen. Examples of these responses include, “[My therapist is] a good listener” and “[My therapist] provided an audience for saying [my] thoughts.” Talking about their problems and having someone listen to their problems seemed to be considered the most helpful aspect of what specifically therapists were doing for these clients within the therapeutic relationship.

Eleven participants (27.5%) answered this question with a response that was labeled effect of therapy. Some sample responses in this category include, “[My therapist] has helped me think about things in ways that I had never considered,” “[My therapist] has helped me to develop and keep a positive perception of my life and myself. He has helped me organize my thought[s]...” and “My therapist has started to empower me to believe in myself and recognize [that] I have many of the answers to my own questions.” Other responses that indicate the effect that therapy has on clients include improved relationships, increased motivation, increased self-esteem, improved parenting skills, increased self-awareness, change in perspective, development of a positive outlook, and better conflict resolution skills.

Two participants (5.0%) answered this question with a response that was labeled extratherapeutic factors. These responses are, “[My therapist is] a visual person” and “She wants to help me help myself.” Both of these responses fell into the extratherapeutic theme of goodness of fit between client and therapist.

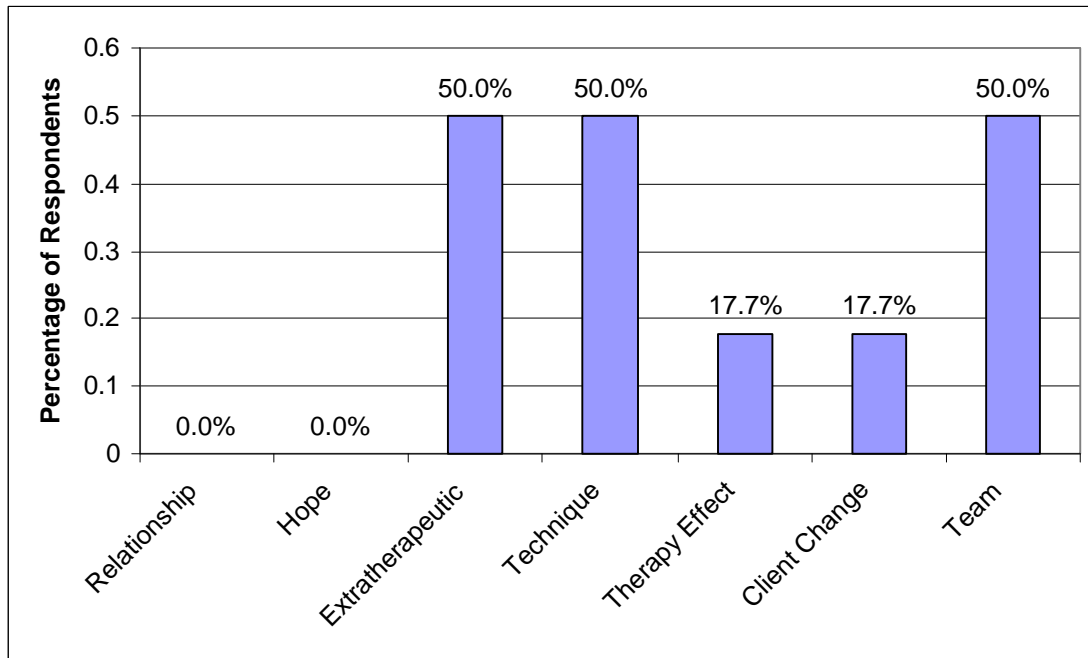
One participant (2.5%) answered this question with a response that was labeled hope/expectancy. This response is, “[My therapist] has helped me to develop and keep a positive perception of my life and myself...”

Qualitative Survey Question #3 (Q24 of Appendix A):

In what specific ways, if any, has your therapist not been helpful?

Of the 41 clients surveyed, only six participants answered this question. Of the six participants who answered this question, responses were placed in the following categories: Extratherapeutic factors, therapy technique, team, therapy effect, and client change. No participants answered this question with a therapeutic relationship or a hope/expectancy response (see Figure 3).

Figure 3
Qualitative Question #3 Responses



Three participants (50%) answered this question with a response that was labeled extratherapeutic factors. The first response in this category is, “Not directly unhelpful, per se. I think that [the therapist’s] relative inexperience sometimes makes the conversation/process halting, but [the therapist] is overall very helpful.” The second response is, “No attempt has been made to speak with my daughter alone in an attempt to draw her out.” And lastly, “No one can know it all—omniscience is impossible.” The first two responses (66.7%) were considered part of the goodness of fit theme for this category, and the third response (33.3%) fell into the client’s belief about therapy theme for this category.

Three participants (50.0%) answered this question with a response that was labeled therapy technique. These responses included feedback about what therapists are doing in-session that clients would like to see change. One response was, “I like [my therapist] to be more questioning and analyzing.” Another participant was concerned that self-esteem issues were not being brought up in-session by the therapist that needed to be brought up. A third response to this question placed in the therapy technique category was about the participant’s spouse hearing from a third person “what the real solution is” even though it is difficult at times in-session to participate in couples counseling. This response was categorized as a therapy technique response due to the client’s description of the therapist offering solutions.

Three participants (50%) answered this question with a response that was labeled team. These responses were, “Here at [the university clinic], I have been somewhat aggravated by the team’s interruptions during some emotionally important sessions. Though additional guidance has been helpful,” “The ringing telephone by the observers was/is difficult to ignore or accept,” and “The buzzing from the observers is interruptive.” All three of these responses seem to fall toward the more negative side of the continuum for the team category.

One participant (17.7%) answered this question with a response that was labeled effect of therapy. This response is, “[The therapist] inadvertently alienated my husband to some extent. Now he understands that my anger is not to blame, but it was tense for a couple of weeks.”

One participant (17.7%) answered this question with a response that was labeled client change. This response is, “There haven’t been enough sessions to work on anything specific yet.” This response falls into the subcategory of no or little client change.

CHAPTER V

DISCUSSION

The purpose of this study was to investigate clients' perceptions of the therapeutic process from the theoretical standpoint of recent common factors research. The factors examined in this study include client change, therapy helpfulness, therapeutic relationship, extratherapeutic change, hope and expectancy, and therapeutic technique. To achieve this goal, the Client Perception Survey (CPS) was created to measure these factors in a single instrument. The survey contained 20 five-point scaling questions and three open-ended questions. The instrument was administered to 41 clients receiving mental health services at a university family therapy clinic in a large metropolitan area. A constructivist theoretical framework guided the study. Upon collection of the data, both quantitative and qualitative methods of data analysis were used. For the quantitative data, descriptive analyses and comparisons were made between demographic groups. Subscale scores were correlated and multiple regression analyses for the variables client change and therapy helpfulness were conducted. In analyzing the qualitative data, a cross-coding team was created with the purpose of categorizing client's responses into reoccurring themes. In the previous chapter, both quantitative and qualitative findings were presented. This chapter intends summarize the findings of the study, discusses possible limitations, and introduces both clinical and future research implications.

Summary of Findings

Clients in this study were asked to provide their perceptions of the process of family therapy by providing answers to 23 CPS items which were intended to encompass the areas of client change, therapy helpfulness, extratherapeutic factors, therapeutic relationship, hope and expectancy, and therapeutic technique. The inquiry was designed for the purpose of gathering information from the client's perspective that may be similar or different from the proposed common factors domains. The discussion of this investigation's findings is presented in four sections: demographic and descriptive analyses, relationship of common factors to clients' perceptions of outcome and change, qualitative findings, and a comparison between the quantitative and qualitative results.

Summary of Demographic and Descriptive Analyses

Demographics (or client factors) in general produced relatively few differences between groups in terms of the common factors measured in this study. Age groups produced no differences for any of the common factors, supporting some of the research that has found little differences between age and therapy outcome (Lambert & Asay, 1984). Between men and women, results indicate that women perceive themselves to be more motivated in therapy than men do. Findings also suggest that minority clients perceive themselves significantly more hopeful about the therapy process than non-minority clients, but that non-minority clients consider themselves to be more highly motivated in therapy than do minority clients. Although there is no evidence in the research that supports or refutes these findings, some possible explanations have been considered.

First, some possible explanations regarding the findings that indicate that women perceive themselves to be more motivated in therapy than men. Frequently in marriage and family therapy it seems that the female family member (the wife and/or mother) is the client who initiates the first visit to a family therapy session. At this particular clinic, for example, of all the people who called seeking mental health services in 1999, approximately 78% were female. Although this is a generalization based solely on this researcher's limited personal experience, it seems that time and again it is the mom who comes to therapy because she is worried about the kids' behavior or the wife who wants to involve a third party in her marital conflict with her husband. This may be due to stereotypical differences between the roles of men and women in relationships. Although gender roles are changing, women are still often the caretakers of the relationships in families (Carter & McGoldrick, 1988). Also, women may be more socialized to talk about what it is that is bothering them and may be more readily willing to discuss their problems with a therapist. Assuming that these speculations are true, it would make sense that women might perceive themselves to be more motivated in therapy, especially if they were the original initiators of the process.

Regarding the findings of differences between ethnic groups, it is interesting to learn that these results indicate minority clients perceive themselves as more hopeful

about the therapy process than non-minority clients and that non-minority clients consider themselves to be more motivated in the therapy process than minority clients. One possibility regarding minority clients feeling more hopeful about therapy may be that it is more difficult for minority clients to obtain mental health services, especially if they have a low socio-economic status. Perhaps by the time minority clients begin receiving help, it has taken some time and effort to get the needed services. This might explain their increased level of hope about the outcome of therapy. While findings regarding non-minority clients perceiving themselves as more motivated in therapy are significant and interesting, this researcher has no explanation of these differences. It may be noteworthy, however, for clinicians to keep these findings in mind when working with both minority and non-minority clients.

Interestingly, results revealed that number of sessions was the variable that produced the most significant difference between groups, suggesting that clients who have been in therapy for a longer amount of time (16 sessions or more) find themselves to be experiencing more positive change in their lives, to be perceiving therapy as more effective, and to be more hopeful about the therapy process than those clients who have been in therapy for fewer sessions (3-5 sessions). These findings support research that has investigated the impact that the length of treatment has on treatment outcome (Klee, Abeles, & Muller, 1998). Most surprising, however, is that significant differences were not found between number of sessions and therapeutic relationship. Individual psychotherapy studies have found that the therapeutic relationship strengthens as the length of therapy increases (Klee et al., 1998). The findings of this study may be explained by the possible differences between the clinical practice of individual therapies and marriage and family therapy. Some of the primary marriage and family therapy models consider the establishment of the therapeutic relationship to be the initial step in working with the client (Haley, 1976; Minuchin & Fishman, 1981), often occurring within the first few sessions. As many of the therapists in the present study reported the use of these types of models with their clients (almost 70%), the therapeutic relationship may have been well established within three to five sessions, resulting in little differences when compared to clients who had been in therapy for more than five sessions.

Quantitative CPS responses regarding this client sample's perceptions of their therapeutic experience produced findings indicating that (a) clients experience their therapists as generally trustworthy and respectful and consider themselves to have a positive relationship with their therapist; (b) clients perceive themselves as hopeful and expectant that therapy will help them; (c) clients consider themselves to be motivated in the therapeutic process; and (d) in general, clients find that therapy has helped them to deal more effectively with their problems. These findings suggest that overall, the clients at this outpatient marriage and family therapy training clinic are pleased with their therapeutic experience, including the quality of their relationship with their therapist and the eventual outcome of their treatment.

Relationship of Common Factors to Clients' Perceptions of Helpfulness and Change

Regression analyses found that overall, the common factors variables therapeutic relationship, client motivation, outside factors, and hope and expectancy accounted for around 49% of the variance for perceived client change and about 73% of the variance for perceived therapy helpfulness. These results are consistent with current research that supports the impact that the common factors have on positive client change and therapeutic outcome (Lambert, 1992; Lambert & Bergin, 1994; Miller, Duncan, & Hubble, 1997; Patterson, 1984).

Findings further suggest that the client's level of hopefulness and expectancy for positive change is the most significant predictor for both client change and therapy helpfulness. While the importance of hope and expectancy to therapeutic outcome is supported by the literature (Snyder, Irving, & Anderson, 1991), the level of importance found in the current study seems higher than most of the research reports (Lambert & Bergin, 1994). Lambert (1992) has found that hope and expectancy account for only 15% of the variance in therapeutic treatment outcome. Also, Lambert and Asay (1984) conclude that research has repeatedly found that clients who have positive expectations about therapy experience more successful therapeutic results. That figure is markedly lower than the findings for therapeutic relationship and extratherapeutic factors, which are believed to account for 30% and 40% of the variance in therapy outcome, respectively (Lambert, 1992).

It was, therefore, surprising to find that therapeutic relationship was not more of a significant indicator of perceived client change and therapy helpfulness. Although there are studies that have similar findings (Quinn, Dotson, and Jordan, 1997), the body of research suggesting that the therapeutic relationship is of major importance to therapy outcome is extensive (Dunkle & Friedlander, 1996; Horvath & Luborsky, 1993; Gaston, 1990; Klee, Abeles, & Muller; Luborsky, 1994; Rogers, 1957). One possible explanation for the current findings may be the lack of variance in clients' responses to the items contained in the therapeutic relationship subscale of the CPS. As reported, clients in this study tended to have a remarkably high level of agreement for items in the therapeutic relationship subscale (97.5%), with a mean response of 19.1 (out of a possible 20). In fact, for three items on this subscale, the majority of clients (75% or more) answered with a "strongly agree" response to all of the items. Because variance is an essential factor in the regression analysis equation (Elmore & Woehlke, 1997), an absence of variance could effectively skew regression results. This lack of variance may have affected the possible predictive significance between therapeutic relationship and the dependent variables client change and therapy helpfulness.

When considering an explanation for the lack of relationship between extratherapeutic factors and the dependent variables client change and therapy helpfulness, one possible explanation may be that the CPS was not an accurate measure for extratherapeutic factors. Upon consideration of the literature review, it is apparent that the research explains this factor as consisting of a large number of variables, including various demographic variables (e.g. age, ethnicity, marital status, socio-economic status, and gender), diagnosis, support networks, coping skills, life stressors, motivation level, and fortuitous events (Asay & Lambert, 1999). The measure created for this study obviously did not encompass all of these variables, or even the majority of them. While some client factors were considered (age, ethnicity, gender, and number of sessions), only two extratherapeutic variables (client motivation and outside factors) were examined in this instrument. And of those two subscales, the client motivation subscale did not significantly correlate with any of the other subscales in the measure. Therefore, it can be concluded that the extratherapeutic subscale items on this instrument did not

accurately measure nor did they actually tap into the breadth of variables that are considered to make up the extratherapeutic factors domain.

Summary of Qualitative Findings

The categorization of the qualitative CPS responses suggests that clients consider the therapeutic relationship to be the most helpful aspect of the therapeutic process (43.6% of respondents), followed by therapy technique (30.8% of respondents), extratherapeutic factors (25.6% of respondents), and hope and expectancy (17.9% of respondents). Finding that clients most frequently offered aspects of the therapeutic relationship as the most helpful part of their therapy indicates that therapy clients agree with the literature on this topic, that therapeutic relationship is essential to successful therapy (Dunkle & Friedlander, 1996; Horvath & Luborsky, 1993; Gaston, 1990; Klee, Abeles, & Muller; Luborsky, 1994; Rogers, 1957). Howe (1996) found similar results in his qualitative investigation about client's perceptions of the therapeutic experience, where clients identified being engaged with the therapist and being understood by the therapist as two core areas of importance in their experience of family therapy. The present study identifies the therapist's level of involvement, empathy, objectivity, active and patient listening, understanding, sincerity, honesty, and caring as important aspects of the therapeutic relationship in their therapeutic experience of family therapy.

It is interesting to note that second only to the therapeutic relationship category, clients consider therapeutic technique to be the next most helpful aspect of their therapeutic experience. These findings are not supported by the research that serves as the foundation for this study (Lambert, 1992; Miller, Duncan, & Hubble, 1997). In fact, Lambert (1992) reports that technique and hope and expectancy factors each contribute the least amount to therapeutic outcome (15%) and that extratherapeutic factors contribute the most (40%). In this study, clients identified such specific therapist actions as charting feelings, decision trees, recommending readings, assertiveness training, putting behavior plans into action, problem solving, complimenting, brainstorming, giving feedback, providing solutions, and normalizing as helpful to their therapeutic experience. These types of responses were indicated more frequently (30.8% of

respondents) than responses categorized as extratherapeutic (25.6% of respondents), although the differences in frequency were minimal (around 5%).

When specifically asked what they perceived their therapists to be doing that was most helpful, clients responded by far most often with a therapeutic technique answer (75.0% of respondents), followed by therapeutic relationship (40.0% of respondents), extratherapeutic factors (5.0% of respondents), and hope and expectancy (2.5% of respondents). This suggests that clients are able to identify the techniques that they consider helpful to their therapeutic experience. This question was intended to tap into the therapeutic technique aspect of the common factors, which Lambert (1992) suggests accounts for 15% of therapy outcome. In creating a question that asked about technique, an attempt was made to avoid clinical jargon that may not have been understood by clients. Their responses indicate that they are aware of the actions that therapists are taking in session. Specific examples of their responses include homework, encouragement, suggestions for improvement, the use of different media, goal-setting, giving feedback, asking questions, offering alternative options, providing new perspectives, remaining positive, searching for solutions, clarifying, discussion of the past, and complimenting.

Comparison of Quantitative vs. Qualitative Findings

The differences between the findings in the quantitative and qualitative portions of this study are noteworthy. The quantitative findings suggest that although all three common factors appear to play an important role in clients' perceptions of both client change and therapy helpfulness, only hope and expectancy contribute significantly to clients' perceptions of change and therapy helpfulness. Clients' qualitative responses, however, indicate that they find the therapeutic relationship to be the most helpful aspect of their therapeutic experience and that they are aware of the techniques that are used in therapy. A possible explanation for these differences may be that, while the questionnaire format attempted to account for all three of the factors (therapeutic relationship, hope and expectancy, and extratherapeutic factors), the open-ended questions were in no way suggestive of possible responses. Therefore, the questionnaire may have actually limited clients' responses and kept valuable information from

surfacing, while the open-ended questions allowed clients to respond in any number of ways. Another explanation could be that the therapeutic relationship may seem to clients to be a more tangible concept than hope and expectancy or extratherapeutic factors. For example, it may be more likely that a client would identify the relationship that they have with their therapist as most helpful, as it is something that they can more concretely observe and experience in session. The facilitation of hope or factors about themselves may actually have a large influence on the success a client experiences in therapy, but it may not be something that one might attribute to their own positive therapeutic change. More specifically, a client may not consider an important part of the reason that he or she is feeling better to be because they have the belief that therapy works or that they got a new job. The therapeutic relationship is a dynamic that occurs within the therapy process, perhaps more readily identifiable because it is not internal to the client.

Another explanation regarding the possible differences between the quantitative and qualitative results of this study may be related to the dynamic nature of the various common factors. As these variables are not independent of each other in clients' experiences, it could be assumed that one factor may have an impact on the importance of another factor in the process of therapy. Regarding these findings specifically, the techniques used in this training facility may be positive facilitators of hope and expectancy and therapeutic relationship, causing a systemic and dynamic interaction between technique and various common factors. This overlap between factors may increase the challenge in determining the importance that any one factor plays on the outcome of treatment. Quantitative and qualitative results may have been different due to this interaction and overlap.

Limitations

It is important to consider the limitations of the present study in interpreting the results. This sample was one of convenience and of limited size. It cannot be assumed, due to the non-randomness of the 41 clients in the sample, that the findings are generalizable to the entire population of clients receiving family therapy services at an on-site training clinic. The sample size is also relatively small when considering its use in regression analysis, therefore indicating a need for replication with a larger and more

random sample. Also, the demographic information available about the client participants and non-participants is limited. It would be premature to generalize these findings to a general population of marriage and family therapy clients without knowing more detailed information about the sample (e.g., marital status, socioeconomic status, or education level), or about those clients that opted not to participate. Upon replication of this study, this additional demographic information would be helpful in generalizing the results of the study.

Furthermore, the qualitative findings are also not generalizable in the traditional sense, as the data is very subjective to each individual client's experiences. Qualitative research is less determined to strive for generalizability than it is toward uncovering a discovery-oriented experiential process (Mahrer, 1988). Consequently, the results of the qualitative section of this study are unique in their representation and may or may not be replicated with additional administrations of the measure. Client's experiences vary from person to person and their descriptions could very well change from one period of time to the next. Therefore, the findings presented in this research are representative only of that particular group of clients at that particular place at that particular moment in time.

In addition, the scale used in the study was created with the intent to serve as a preliminary step in the direction of measuring clients' perceptions of the common factors. Although Cronbach alpha scores for the CPS subscales are relatively high, the creation of a measure is a detail-oriented and monumental task. Rigorous psychometric analyses, pilot tests, and expert panels are all stringent processes through which most established measures are eventually put. The validity of this instrument was not determined by using any of these methods. Therefore, this measure serves only as an initial avenue in the journey toward exploring clients' perceptions of a theory that has become a source of attention and controversy in the field of psychotherapy research and practice.

Also, the data collected from the CPS is further limited in that it is a single self-report measure that contains only 23 questions. As the common factors are conceptualized from an amalgamation of numerous research studies, it would be extremely premature to assume that this measure could sufficiently capture all of the various aspects of this theoretical framework. In fact, it became clear as the subscales were analyzed that extratherapeutic change is a domain that may very well be too vast

conceptually to measure easily in one instrument. Also, the questionnaire format may have limited clients' responses and kept valuable information from surfacing. As can be seen in the open-ended responses, many categories emerged from a more loosely based way of asking about client's experiences that were not reflected in the Likert-scale responses. And because the CPS is a self-report measure, the tendency for respondents to offer more desirable responses is also a consideration.

Lastly, the descriptions and conclusions found in this study should in no way imply that the complex and dynamic interactions of the therapeutic process are discrete and separate variables that each work individually. This interaction between variables may account for the difficulty that was found in attempting to measure these concepts independently, particularly the extratherapeutic factors domain. It should be pointed out that it was not the intent of this researcher to present these factors as disembodied parts of a whole, but instead as interactive and overlapping processes which all together play a vital role in the conducting of helpful therapeutic treatment.

This study is presented as a first step toward understanding clients' perceptions of the therapeutic process as explained by common factors research. Replication of this study with a larger sample, a random sample, and a stringently tested measure would further benefit this exciting realm of common factors research.

Implications for Clinical Practice

Despite the limitations of the study, there are several potential implications for the clinical application of the results. Primarily, the results of this study can assist clinicians in widening their view about what works in therapy according to the client's perception. As research regarding client's perceptions has proposed, the feedback that was received from the clients is useful in determining treatment quality and helpful when considering treatment improvement. In general, the clients who participated in this survey rated their overall experiences as positive and shared what they considered to be less helpful. Learning about clients' perceptions and experiences of the therapy that we practice as clinicians can help any program or agency provide quality services to their clients.

It could also be implied from the quantitative findings that facilitating hope and positive expectation in clinical practice is essential to providing clients with a positive

therapy experience. Some suggestions for facilitating hope and positive expectation for change in clinical practice are offered by Miller, Duncan, and Hubble (1997). A few of their recommendations include: therapists should believe in their procedure or therapeutic orientation and show interest in the results, the therapy must be credible and persuasive from the client's frame of reference, therapy should be oriented toward the future, therapists should have a possibility-focus, and therapy should enhance or highlight the client's feeling of personal control. They conclude that, "All therapists have ways of interacting with clients and conducting treatment that facilitate hope and positive expectations for change" (p. 160). Based on the findings of this study, we learned that hope and expectancy are important to clients and in turn may serve to be an important part of the therapist/client interaction.

From the qualitative results it was revealed that the therapeutic relationship was spontaneously indicated as the most helpful of the common factors for clients' experiences in therapy. Specifically, the theme of talk/listen was most prominent in the therapeutic relationship category. Although this conclusion seems basic to the therapeutic field, it appears that clients feel better when they are simply able to talk to someone and to be listened to by someone who cares. This may signify to clinicians that such a basic skill (being a good listener) may deserve more attention than it is granted in the practice of effective family therapy.

Clients suggest in both the quantitative and qualitative findings of this study that they perceive the therapeutic relationship, hope and expectancy, and therapy technique to be important parts of what makes therapy helpful for them. As mentioned in the previous limitations section, these domains are difficult to pull apart into separate and distinct phenomena. In the practice of family therapy at this particular university-based clinic, a systemic, competency-based approach is emphasized in clinical training and practice. Competency-based approaches span a number of models and strongly support the establishment of a positive therapeutic relationship and a hopeful, positive interaction between client and therapist. It would be difficult to discern, then, which came first: Does the facilitation of hope in the therapy interaction promote a positive therapeutic relationship, or does the establishment of a positive relationship facilitate hope and positive expectation for change? The indication as perceived by clients is that both are

vital regardless of the clinical approach that is used. The systemic methods used in this facility, however, make it difficult to determine the “separateness” of these factors, indicating that positive change and perceived therapy helpfulness are a product of their dynamic interaction and inter-relatedness. These findings imply that the use of a systemic, competency-based approach is important to clients in the practice of effective and helpful therapy.

Implications for Marriage and Family Therapy Training

The findings of this study suggest some implications for the training of marriage and family therapists. Three areas of training are considered as a result of these findings, including program course curriculum, clinical supervision, and trainee selection.

As mentioned in the previous section, it appears that clients find the therapeutic relationship and hope and expectancy to play important roles in their perceptions of therapy helpfulness and personal change. The current findings also suggest that clients are aware of the specific techniques that therapists are using in session. Traditionally, in training facilities, it is these techniques (or therapy models) that are the major focus in the first years of training for marriage and family therapists. Training practices of the past that focus solely on model may be overlooking the importance of both the therapeutic relationship and the facilitation of hope and positive expectation for change in the training of students. Many systemic models emphasize the importance of these factors, yet some fail to mention one or either of them. For example, structural therapy proposes that a strong therapeutic relationship, known as “joining,” should be established before the process of change can begin. Solution-focused therapy emphasizes the facilitation of hope and positive expectation through the use of compliments and positive presumptions. Neither combines both factors in their models, however. Perhaps professors who create marriage and family therapy curriculum should consider introducing the importance of these factors to effective therapy in addition to or in combination with the teaching of the major therapy models. And again, the cause-and-effect question arises: Are techniques and models the producers of positive relationships and expectations, or is the ability to form positive relationships and expectations an intrinsic characteristic of the therapist’s

personality? Could it be that you cannot teach a therapist to be warm, empathetic, genuine, and trustworthy?

This question leads to implications in the area of trainee selection. Since these factors may be an intrinsic characteristic of the therapist rather than something that can be taught in a classroom, considerations should be made about trainees that are accepted into marriage and family therapy training programs. For example, when considering the selection of an applicant into a program, the selectors may want to pay special attention to the applicant's ability to empathize and be warm and genuine in their interactions with others during the interview and/or application process. This attempt at congruence between trainee selection and classroom curriculum may be an important step in establishing a training facility that focuses not only on the model of therapy used, but also on the person of the therapist that is selected to use those models.

Lastly, clinical supervision may also be an area for which these findings hold future implications. Clinical supervisors of family therapy interns may want to include a focus on the intern's ability to facilitate hope and positive expectation for change in their clients. This may be done simply by modeling in their interactions with their student interns. For instance, if supervisors are able to form a working relationship with their students in a way that promotes positive expectations for learning, they are also, in turn, modeling this behavior for their students. This style of competency-based supervision may incorporate an increased focus on students' strengths and complimenting them in a warm and genuine way that then promotes these types of interactions in the students' interactions with their own clients. This type of supervision also seems systemic in approach, as it combines a concentration not only on the type of therapy that therapy interns are using, but also on how they are using it to establish a positive relationship with their clients through the facilitation of hope.

Implications for Future Research

There continues to be a call for research attempting to further understand clients' perceptions of the therapeutic process. This study emphasized clients' perceptions of therapy through the factors that have recently been proposed as the key ingredients for positive change. In comparison with other topic areas within marriage and family

therapy literature, as well as with the field of general psychotherapy, there are relatively few studies that focus on clients' perceptions of therapy or on the common factors.

The field of marriage and family therapy would not only benefit from more studies that examine clients' perceptions of the therapeutic process, but also from research that investigates the importance of factors not necessarily associated with therapy model and technique. Specifically, there appear to be some holes in the literature concerning studies about the efficacy of marriage and family therapy and its relationship with extratherapeutic factors and hope and expectancy factors. The lack of information about these relationships specific to the marriage and family therapy field indicates a need for these types of research in the future.

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APPENDIX A
CLIENT PERCEPTION SURVEY

Case # _____

Please help us to improve our program by answering some questions about your experiences in therapy. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* Thank you very much, we really appreciate your help.

Your: **Age** _____ **Gender** _____ **Race** _____

In general, as you think about what (if anything) has helped you to feel better about the situation that brought you to therapy, what comes to mind?

PLEASE CIRCLE YOUR ANSWERS

1. The therapy that I am receiving has helped me to deal more effectively with my problem(s). (Help)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

2. I have a positive relationship with my therapist. (Relate)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

3. When I came to therapy I was *not* motivated to make my life better. (Motive)*

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

5. My life seems better now than it was before the start of therapy. (Change)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

6. I do *not* feel hopeful that things will get better as a result of therapy. (Hope)*

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

7. Things have happened in my everyday life outside of therapy that have led me to make positive changes. (Outside)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

8. I do *not* have a positive expectation that therapy will help me. (Hope)*

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

9. The therapy that I am receiving has been helpful. (Help)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

10. When I came to therapy I was motivated to make my life better. (Motive)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

11. The problem that I came to therapy about has *not* improved since I started therapy. (Change)*

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

12. I trust my therapist. (Relate)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

13. The therapy that I am receiving has *not* been helpful. (Help)*

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

14. I feel hopeful that things will get better as a result of therapy. (Hope)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

15. I do *not* feel respected by my therapist. (Relate)*

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

16. My life does *not* seem better now than it was before the start of therapy. (Change)*

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

17. Things that are independent of my therapy have led me to make positive changes in my life. (Outside)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

18. The therapy that I am receiving has *not* helped me to deal more effectively with my problem(s). (Help)*

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

19. The problem that I came to therapy about has improved since I started therapy. (Change)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

20. I feel respected by my therapist. (Relate)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

21. I have a positive expectation that therapy will help me. (Hope)

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
strongly disagree	moderately disagree	neither agree nor disagree	moderately agree	strongly agree

Change = Client change item
Help = Therapy helpfulness item
Relate = Therapeutic relationship item
Hope = Hope and Expectancy item
Motive = Client motivation item
Outside = Outside factors item
* = Reverse code item

25. In what specific ways, if any, has your therapist been helpful?

26. In what specific ways, if any, has your therapist not been helpful?

Thank you.

Case # _____

Dear Center for Family Services Client:

Understanding that this survey is completely confidential, you do have the option of signing the bottom of the survey form to agree to be contacted by the researcher in order to participate in a thirty to forty-five minute interview here at the Center. Your signature would only be consenting to be contacted for an interview: **All the information that you provide, in both the survey and the interview (if you decide to participate in the interview), would still remain completely confidential.** Therapists will have no knowledge of which of the Center's clients are participating in the interview portion of the study. Upon signing the survey form, a complete explanation of the interview process would be offered and at that time participants would decide whether or not to continue with the interview process. If you decide to volunteer and are selected to be a participant in the interview portion of the study, The Center for Family Services will offer you **one free session of therapy** as a thank you for your time.

Please provide your name and phone number below if you approve of being contacted in the future by the researcher to provide further information about your experiences in therapy and your ideas about the therapeutic process. **Please separate this sheet from the survey and deposit it into the box along with the sealed survey envelope.**

Thank you again for your help.

Name: _____ Phone number: _____

APPENDIX B

THERAPIST QUESTIONNAIRE

Case # _____

Please help us to improve our program by answering some questions about your work with this case (as identified by the case number above). *Please answer all of the questions.* Thank you very much, we appreciate your help.

1. Gender of the client: M / F

2. Number of sessions you have had with this client: _____

3. Please identify the primary problem for which this client is seeking treatment:

4. Please select the primary family therapy theory model(s) you use with this case (choose all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Bowenian/Intergenerational | <input type="checkbox"/> Psychoanalytic |
| <input type="checkbox"/> Cognitive/Behavioral | <input type="checkbox"/> Solution-Focused |
| <input type="checkbox"/> Experiential | <input type="checkbox"/> Strategic |
| <input type="checkbox"/> Narrative | <input type="checkbox"/> Structural |
| <input type="checkbox"/> Other: _____
<i>(please specify)</i> | |

APPENDIX C

THERAPIST'S MEMO

To: All Clinic Therapists
From: Michelle R. Ward
Re: Client Survey Packets
Date: October 18, 1999

The Center for Family Services has approved my request to conduct a survey with the clinic's clients. The survey will be distributed with the purpose of examining the experiences of clients seeking therapy and will focus on what clients have found helpful or not helpful about the therapy process and about their relationship with their family therapist intern. Please be aware that this project is purely research oriented and **will not** be used to evaluate you or your work and will not be connected with your name in any way.

Beginning the week of November 1st, all therapists with clients who have attended therapy three or more sessions will find survey packets in their clinic boxes. These packets will include a therapist cover letter and therapist questionnaire, a client informed consent and client perception survey for each of the adult clients in that case, an envelope, and a pencil. Each form in the packet will have the case number in the right hand corner of the form.

At the end of each therapy session during this week, please give each of your adult clients (over 18 years-old) one informed consent form, one client survey, and one envelope. Please inform your client that there is a basket in the waiting room to deposit the signed informed consent form and another basket for the completed survey, which they should put into the envelope and seal.

Assure your clients that this information is completely anonymous and will not be disclosed to anyone, including you, their therapist. Please also thank them for their time in participating and let them know that it should take no more than 10-15 minutes to complete. All of these instructions will be provided again next week with the packets.

There is also a therapist questionnaire to be completed the same day. I will be contacting each therapist sometime this week before the survey distribution. If you agree to participate in the therapist portion of the research, at that time I will provide a detailed informed consent that describes the research process. Upon your agreement to participate, I will obtain your signature for consent to participate.

Thank you all very much for your support, help, and participation in this survey. If you have any questions before this process begins next week, please contact me at (703) 803-6476 or by email at mward@vt.edu.

APPENDIX D

THERAPIST'S INFORMED CONSENT

Title of the Study: Clients' Perceptions of the Therapeutic Process: A Mixed Methods Approach

Investigator: This study is being conducted by Michelle Ward, candidate for the master's degree in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. Michelle can be reached at (703) 803-6476. Faculty advisor, Dr. Karen Rosen, can be reached at (703) 538-8461.

Study Purpose

The purpose of this study is to examine the experiences of clients seeking therapy at the Center for Family Services at Virginia Tech's Northern Virginia Center. The study will focus on what clients have found helpful or not helpful about the therapy process and on their relationship with their family therapist intern. All of the clients in the clinic who have attended therapy three or more sessions will be asked to participate in the survey portion of the study. A total of four or five individuals are participating in the interview portion of this study.

Procedures

As participants of this study, you have agreed to complete a four-question questionnaire for each of your current clients at the Center for Family Services who have been seen by you for three or more sessions. The questionnaire will be concerned about four aspects of your work with each of your clients: the client's gender, the number of sessions they have attended with you as their therapist, the client's primary presenting problem, and the primary family therapy model(s) that you have used with this client.

Risks

Because of the nature of this project and the participants being selected, we do not anticipate any risks.

Benefits of the Project

Your participation in this project will give us information about what clients find helpful or not helpful about the therapy process and inform therapists about client perceptions of the relationship between therapy and client. This information will be very valuable to therapists to provide quality mental health care to their clients. A benefit for you may be the opportunity to better understand what clients consider helpful in their therapeutic experience. A summary of the findings will be available to you when the project is completed, but specific responses from your clients will not be available to you. *This is not an evaluation study of you and will not be used in connection with your name in anyway.*

Confidentiality

All information you provide will be treated with complete confidentiality. Your name will in no way be associated with the completed questionnaire, nor will the name of your client. During the interview, the therapists' identity will also be kept anonymous from the researcher to avoid any professional/co-worker concerns. A pseudonym will be created for both your name and the clients' name(s) for use during analysis and in the final written report. Only the researcher and her advisor will have access to the audiotapes of the interviews and other raw data. The expected completion date of this study is May, 2000. At that time, all tapes pertaining to the study will be destroyed.

Compensation

Other than our sincere appreciation, no guarantee of benefits is made to encourage you to participate in this study.

Freedom to Withdraw

If at any time you change your mind about participating in the study, you are encouraged to withdraw your consent and to cancel your participation.

Approval of Research

The Department of Family and Child Development have approved this research project, as required, by the Institutional Review Board for projects involving human subjects at the Virginia Polytechnic Institute and State University and.

Participant's Agreement and Responsibilities

I voluntarily agree to participate in this study. I have had all my questions answered and hereby give my consent for participation in this project.

I have read and understand the informed consent and conditions of this project. I hereby acknowledge the above and give my voluntary consent for participation in this project. I realize I have the right to withdraw at any time without penalty.

Should I have any questions about this research, I will contact:

Michelle Ward
Researcher/Interviewer
(703) 803-6476

Karen Rosen
Faculty Advisor
(703) 538-8461

Jerry Cline
IRB Reviewer
(540) 231-9359

Participant's Signature

Date

APPENDIX E

SURVEY PARTICIPANT'S INFORMED CONSENT

- **What is it?**

The Center for Family Services is distributing a survey with the purpose of examining the experiences of clients seeking therapy. The survey is part of a study that will focus on what clients have found helpful or not helpful about the therapy process and about their relationship with their family therapist intern. Please be aware that this project is for research purposes only and *will not* be used to evaluate the work of your therapist.

- **What Will I have to Do?**

If you agree to participate, please sign this form, separate it from the survey, and put it in the box marked "Informed Consent" in the waiting room area.

Complete the attached survey following your regularly scheduled session with your therapist intern. Filling out the survey should take about 10-15 minutes.

After completing the survey, put the survey form into the provided envelope, seal the envelope, and deposit it into the basket marked "Completed Client Surveys" in the waiting room area.

- **What are the Benefits and Risks?**

You will be helping us gather information that will help us to maintain and improve the quality of mental health care we provide to our clients.

There are no expected risks for you in completing the survey.

- **Is it Private?**

All of the information you give on the survey is confidential.

Neither the researchers nor your therapist will know the answers you give on this survey, as your name will in no way be attached to the completed forms.

- **Will I get Paid?**

Other than our sincere appreciation, no payment is offered to encourage you to participate in this study.

- **Can I quit if I want to?**

Completing the survey is voluntary and you can decline to fill it out at any time.

- **Approval of Research**

The Department of Family and Child Development have approved this research project, as required, by the Institutional Review Board for projects involving human subjects at the Virginia Polytechnic Institute and State University and.

- **Participant's Agreement and Responsibilities**

I voluntarily agree to participate in this study. I have had all my questions answered and I know of no reason that I cannot complete the survey.

Should I have any questions about this project or its conduct, I can contact any of the following: Ms. Michelle Ward, Researcher (703) 803-6476; Dr. Karen Rosen, Faculty Advisor (703) 538-8461; or Dr. Jerry Cline, Virginia Tech IRB Reviewer (703) 538-8492.

Signature

Date

APPENDIX F

THERAPIST'S SURVEY INSTRUCTION SHEET

Case # _____

1. At the end of your session today/tonight, please distribute (to each adult client) one consent form, one client survey, and an envelope, which are located within this packet. Pencils are available to clients in a basket in the waiting room. The client case number at the top of this sheet will determine which of your clients receive which packet.
2. Ask each adult client to take a few minutes in the waiting room to read and sign the informed consent and complete the survey. Let your clients know that once they have signed the consent form, it goes in the "Consent Form" box in the waiting room. Once they have completed the survey, ask clients to please put the survey in the envelope provided and seal the envelope. Then clients should deposit the pencil and the sealed envelope into the basket marked "Client Surveys" in the clinic waiting room.
3. Assure your clients that this information is completely confidential and will not be disclosed to anyone, including you, their therapist. Please also thank them for their time in participating and let them know that it should take no more than 10-15 minutes to complete.
4. Upon your approved consent, please complete the corresponding therapist questionnaire that is provided in the packet. Once the questionnaire is completed, please put the deposit it into the basket marked "Therapist Questionnaires" in the clinic office. *A therapist questionnaire should be completed for each individual client who was given a survey.*
5. Thank you again for your support, help, and participation in this survey.

Michelle Renee Ward

6854 Ridge Water Court
Centreville, VA 20121
(703) 803-6476
mrward@mindspring.com

EDUCATION:

M.S., Human Development, 2000
Virginia Polytechnic Institute and State University
Falls Church, Virginia

B.A., Psychology, 1995
George Mason University
Fairfax, Virginia

CLINICAL EXPERIENCE:

Family Therapy Intern (August 1998 - May 2000)

Center for Family Services, Virginia Tech, Falls Church, VA

Provided systemic outpatient therapy to individuals, couples, and families; developed case treatment plans, documented all forms of case management; coordinated therapeutic services; participated in co-therapy with other interns; observed/teamed with other's cases. Collected over 500 direct client contact hours and have received over 350 hours of supervision. Clientele included violent couples and individuals, children with behavior/anger management/anxiety problems, individuals with depression and/or substance abuse problems, couples with marital issues, and families seeking relationship enrichment and help with issues around divorce.

Therapist Intern (August 1999 - April 2000)

Abused Children's Treatment Services, INOVA Kellar Center, Fairfax, VA

Provided systemic outpatient play therapy to individual sexually abused children (ages 3-12) and group therapy to sexually abused female adolescents (ages 13-15) and sexually aggressive boys and girls (ages 5-8); developed case treatment plans and group therapy curriculum; documented all forms of case management; coordinated therapeutic services; participated in co-therapy with other licensed professionals. Utilized such play therapy interventions as sandtrays, artwork, family play genograms, family puppet shows, and various therapeutic games and activities while working under the direct supervision of Dr. Eliana Gil.

Group Facilitator (August 1998 - December 1998)

Men's Anger Management Group, Office For Women, Alexandria, VA

Co-facilitated a 16-week psycho-educational group for court ordered and self-referred male perpetrators of domestic violence.

Addiction and Mental Health Counselor (April 1996 - October 1997)

Montgomery General Hospital, Olney, MD

Served in a floating capacity in the hospital's Addiction and Mental Health Center,

utilizing skills in the following areas:

- Intensive Inpatient Addictions and Psychiatric Unit – Counseled patients with critical level mental illness and addictions diagnoses. Clientele included individuals experiencing depression or suicide attempt, schizophrenia, bipolar disorder and/or alcohol/drug detoxification and rehabilitation. Responsibilities included facilitating group and one-to-one counseling with patients, performing intake assessments, developing individual treatment plans, implementing activities of daily living, and securing a safe environment for entire intensive unit.
- Outpatient Addictions Treatment Center – Counseled individuals with substance dependence diagnoses to include all four families of substances (depressants, stimulants, narcotics and psychedelics). Responsibilities included facilitating small group counseling, developing individualized treatment plans and patient specific problem lists and assignments, performing diagnostic assessments and summaries. Educated patients on relapse prevention, Twelve Step recovery, disease process, co-dependence, stages of addiction, and defense mechanisms.
- Adolescent Intensive Outpatient Program – Counseled adolescents ages 13-18 years with behavioral and/or addiction issues. Responsibilities included performing intake assessments, developing individual treatment plans, utilizing diagnostic tool such as the SASSI, MAMSI, and POSIT, facilitating small group therapy and educational groups, exploring issues of peer pressure, self-esteem, relationships, school, anger management, and substance abuse.

Domestic Violence Court Advocate

(January 1995 - May 1995)

ACTS/Turning Points, Dumfries, VA

Counseled clients seeking protective orders involving domestic violence. Explained programs and options regarding client safety. Educated clients regarding cycle of violence and safety issues. Familiarized clients with court procedures. Provided advocate support to clients throughout legal proceedings.

PROFESSIONAL ORGANIZATIONS:

Student Member

(September 1997 - present)

American Association for Marriage and Family Therapy

Student Member

(September 1997 - present)

Virginia Association for Marriage and Family Therapy

PROFESSIONAL AWARDS:

Graduate Student Research Award, 2000

“Clients’ Perceptions of the Therapeutic Process: A Mixed Methods Approach”

American Association for Marriage and Family Therapy