

A Common-Factors Informed Mixed Methods Investigation of Clients of MFTs' Perception of
Therapy Productiveness

Carissa D'Aniello

Dissertation submitted to the faculty of the Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy
In
Human Development

Fred. P. Piercy (Chair)
Megan. L. Dolbin-MacNab
Peggy. S. Meszaros
Susan. N. Perkins

May 1, 2015
Blacksburg, Virginia

Keywords: change processes, retention, common factors

Copyright © 2015 Carissa D'Aniello

A Common-Factors Informed Mixed Methods Investigation of Clients of MFTs' Perception of
Therapy Productiveness

Carissa D'Aniello

ABSTRACT

Many clients drop out of therapy before reaching their goals, (Bohart & Wade, 2013) though research shows that being in therapy is more effective in producing change than not being in therapy, (Lambert, 1992). Little is known about what makes therapy effective (Davis & Piercy, 2007a, b; Pinsof & Wynne, 2000). The purpose of the present study was to understand what clients believe is productive about therapy, and how clients' assessment of therapy productiveness impacts their decision to remain in therapy or to drop out of therapy. For the qualitative strand of this simultaneous convergent mixed methods study, grounded theory was used to inductively develop a common-factors informed model describing how productive change processes influence intended retention. The convenience sample consisted of 19 current clients in therapy with a marriage and family therapist. For the quantitative strand, participation involved completing a semi-structured interview and quantitative survey. Direct, binary logistic regression analyses were conducted to determine whether perceived productiveness, goal attainment and therapeutic alliance, predicted intended treatment retention or intended dropout. The convenience sample for quantitative analysis included the 19 qualitative participants, and continued sampling until adequate statistical power was reached with 72 participants. Mixed analysis strategy was data comparison for the purpose of triangulation. Qualitative results span three categories emerged from qualitative: client factors, therapy process factors and evaluation of progress. Client factors, including presenting problem factors, expectations and motivation were considered when participants made decisions about staying in therapy or dropping out of

therapy. Therapy process factors, including therapists' understanding of the presenting problem, therapeutic alliance, therapists interventions and the pacing and timing of those interventions were also considered when participants made decisions about staying in therapy or dropping out of therapy. When participants evaluated the progress made because of therapy, they evaluated changes in the presenting problem, symptom reduction, and noticed this progress took place outside of therapy. Quantitative results showed that goal attainment, therapeutic alliance and productiveness significantly predicted intended retention when each was tested as an individual predictor. When tested in a full model, containing goal attainment, therapeutic alliance and productiveness; only the task domain of therapeutic alliance emerged as significant. Results confirm the importance of therapeutic tasks to clients' decision to stay in therapy or to drop out of therapy. Results contribute to the importance of common factors in keeping clients in therapy until they reach their goals. Further, results inform research, clinical practice and training in the MFT field.

Keywords: change processes, retention, common factors

ACKNOWLEDGEMENT

This project would not have been possible without the participants who generously gave their time. I would also like to thank my colleagues at UNLV, Fairfield University, Virginia Tech and Kayenta Family Therapy Centers who supported my research and helped make this project feasible.

My parents provided tremendous support that made this possible. My parents, David and Cathy D'Aniello have been teaching me about the value and importance of education since I can remember. This dissertation wouldn't have been possible without their continued support. Thank you for the many sacrifices you have made over the years that made it possible for me to reach for my dreams.

I would like to thank my committee for their investment in mentoring me throughout my time at Virginia Tech. Peggy Meszaros, Susan Perkins and Megan Dolbin-MacNab invested their time in training me to be a better scholar, researcher and writer. I have learned more from each of you than I can say. Susan, I have really valued your mentorship and collaboration on this, and other projects. Megan, thank you for continually pushing me to reach my potential. I recognize and appreciate your generous contributions to my professional development.

Fred Piercy, my chair, continually supported and mentored me. Through this project, and others, you gave me the space to develop and refine my ideas. Your mentorship gave me confidence while also grounding me and I will always appreciate your impact on my development. Academically and professionally, you have given me roots and wings.

Table of Contents

Chapter 1. Introduction	1
Statement of the Research Problem	1
Purpose.....	4
Chapter 2. Literature Review	5
Common Factors: A Theoretical Basis	5
Common Factors and Change Processes	6
Change Processes.....	7
Premature Dropout.....	10
Therapy Dosage	12
Problems Defining Premature Dropout	12
Intended Retention	15
Goal Attainment.....	15
Therapeutic Alliance	16
History of Therapeutic Alliance.....	18
Importance of Therapeutic Alliance	19
Expectations.....	21
Purpose.....	22
Research Questions	23
Chapter 3. Methodology	25
Research Design Overview.....	25
Qualitative Strand	26
Participants.....	26
Collecting Data from Clients	27
Sampling	27
Recruitment	28
Procedures.....	29
Data Analysis	31
Instrument	32
Trustworthiness.....	36
Quantitative Strand	37
Survey Research.....	37
Sample.....	39
Procedures.....	40
Measures	41
Principle Components Analysis	43
Reliability Analysis of the PCPI.....	46
Data Analysis	49
Mixed Data Analysis	54
Chapter 4: Findings.....	56
Qualitative Findings.....	56
Demographic Data	56
Overview of Qualitative Findings.....	60
Client Factors	61
Therapy Process Factors	68
Summary of Qualitative Findings.....	85

Quantitative Findings.....	85
Demographic Data	86
Correlations.....	88
Chi Square.....	91
Binary Logistic Regression.....	93
Mixed Results	97
Chapter 5: Discussion	103
Client Factors Interact with Therapy Process Factors	104
Expressing Dissatisfaction with Therapy to The Therapist	110
Participants Evaluate Therapy Progress.....	112
Discussion Summary	116
Implications	117
Research.....	117
Clinical Practice.....	119
Training.....	120
Limitations.....	123
Future Research	124
Conclusion	125
References.....	127
Appendix A: IRB Approval Letter (Qualitative Strand)	154
Appendix B: IRB Approval Letter (Quantitative Strand).....	155
Appendix C: Qualitative Recruitment Flyer.....	156
Appendix D: Qualitative Consent Form	157
Appendix E: Qualitative Interview Prompts.....	159
Appendix F: Quantitative Survey	160
Appendix G: Quantitative Recruitment Flyer.....	163
Appendix H: Consent form (Quantitative Strand).....	164
Appendix I: Productive Change Processes Inventory Construct Map.....	166
Appendix J: Productive Change Processes Inventory Content Validity Check	167
Appendix K: PCA Scree Plot Results.....	168
Appendix L: Permission to use Scales.....	169
Appendix M: Chi Square Tests for Dropout Status by PCPI Component.....	171

List of Figures

Figure 1. Overall study procedure.....	26
Figure 2. Photo of recruitment display.....	29
Figure 3. Process Model of Deciding-Making About Therapy.....	105

List of Tables

Table 1. Component Loadings for PCA Components.....	45
Table 2. Eigenvalues for PCA Components.....	46
Table 3. Demographic Characteristics of Therapy Client Participants.....	57
Table 4. Demographic data relevant to decision to drop out or stay in therapy.....	59
Table 5. Frequency Table of Most Saturated Open Codes.....	60
Table 6. Summary of Qualitative Categories and Supporting Themes.....	85
Table 7. Therapeutic Alliance Scores for the Working Alliance Inventory (WAI- SF).....	87
Table 8. Productive Change Processes Inventory (PCPI) Measures of Central Tendency.....	88
Table 9. Correlations Among Demographic Variables.....	90
Table 10. Correlations Among Predictor and Outcome Variables.....	91

Chapter 1. Introduction

Statement of the Research Problem

Though empirical research indicates that therapy is more effective than no therapy for producing change (Lambert, 1992), many clients drop out of therapy before they reach their goals (Bohart & Wade, 2013). Dropout may signal dissatisfaction with treatment, or alternatively, a sign that the client achieved his or her goals after few sessions (Reis & Brown, 1999). Little is known about what makes therapy effective, (Davis & Piercy, 2007a, 2007b; Pinsof & Wynne, 2000) and comparisons between marriage and family therapy (MFT) models consistently show few differences in effectiveness (Davis & Butler, 2004). The same is true in identifying the unique elements of specific therapeutic models that contribute to therapeutic effectiveness (Davis & Piercy, 2007a, b; Pinsof & Wynne, 2000; Sprenkle & Blow, 2004a). This issue has lead theorists and researchers to apply a common factors-approach to MFT. Lambert (1992) identifies common factors as "...variables that contribute to therapeutic change that are not the province of any particular approach or model." Common factors are hypothesized to account for 30% of variation in therapeutic outcome (Lambert, 1992). Broadly, common factors can be grouped into: client factors, therapist factors, therapeutic alliance factors, hope and expectancy factors, and motivation factors (Sprenkle & Blow, 2004a). Common factors are not specific to any single treatment model; rather, they are imbedded and inherent elements of most models and most psychotherapy. While the majority of empirical support for common factors as contributors to successful therapeutic outcome arises from meta-analytic studies, qualitative studies of client perception of change processes have also found support for common factors (Shadish & Baldwin, 1995, 2003).

A limited body of research on change processes, or the in-session, emotional processes that occur during therapy that clients identify as helping to produce change (Greenberg, James & Conry, 1988, p. 6) has contributed to the explanation of how change occurs through the therapeutic process (Blow, Morrison, Tamaren, Wright, Schaafsma & Nadaud, 2009; Christensen, Russell, Miller & Peterson, 1998; Wark, 1994). There have been four qualitative studies investigating clients' perceptions of helpful change processes in couple and family therapy (Blow et al., 2009; Christensen et al., 1998; Helmeke & Sprenkle; 2000; Wark, 1994). In each of these studies, couple and family therapy clients were asked to describe the events that occurred in therapy sessions that they believe were most important in helping them change. Participants identified change processes that are consistent with common factors as productive in leading to therapeutic change. These findings highlight one way that change processes research supports the importance of common factors as proponents of change. While common factors demonstrate contributions to successful therapy and improved therapeutic outcomes, researchers have yet to investigate the relationship between common factors and staying in therapy until therapeutic goals are met.

Premature dropout poses a problem for mental health practitioners and their clients (Hamilton, Moore, Crane & Payne, 2011). Clients who end treatment prematurely are less likely to experience therapy benefits, more likely to experience poor outcomes and report dissatisfaction with treatment (Hamilton et al., 2011; Pekarik, 1992). Retaining clients in therapy is of critical importance to helping clients change, as continued therapy yields a higher possibility (in comparison to no therapy) that clients will attain their therapeutic goals (Marchionda & Slesnick, 2013). Little is known about the change processes that maintain clients in treatment (Marchionda & Slesnick, 2013). Identifying the common factors that predict

therapy dropout may help therapists target triggers of dropout early in the therapy process, and to increase the likelihood that clients will remain in therapy (Marchionda & Slesnick, 2013). The majority of empirical inquiry into premature dropout is devoted to identifying client characteristics and demographic factors associated with premature dropout, the results of which have been inconclusive (Allgood & Crane, 1991; Bohart & Wade, 2013; Hamilton et al., 2011; Masi, Miller & Olson, 2003; Wang et al., 2006; Werner-Wilson & Winter, 2010). Over-emphasis on client variables at the expense of therapeutic process variables may contribute to the limited understanding of how therapeutic process variables impact retention and goal attainment (Allgood & Crane, 1991; Bohart & Wade, 2013; Hamilton et al., 2011; Masi, Miller & Olson, 2003; Werner-Wilson & Winter, 2010). Therapeutic process variables are arguably more important in determining outcome than client or therapist variables (Bischoff & Sprenkle, 1993; Davis & Dhillon, 1989). Examining process variables provides unique and rich information for understanding the process of treatment retention (Beyebach & Carranza, 1997; Marchionda & Slesnick, 2013).

In the majority of studies, premature dropout was not researched until the client had dropped out of therapy, which presented the challenge of understanding the event by gathering information retrospectively (Bischoff & Sprenkle, 1993; Shadish, Hu, Glaser, Kownacki & Wong, 1998). Ambivalence about continuing therapy is likely to precede the client dropping out of therapy. Many clients exhibit ambivalence when they are in the process of weighing the costs and benefits of continuing treatment versus living with their problems (Walitzer, Dermen & Connors, 1999). But when ambivalent, what attributes of therapy do clients consider? Do clients consider progress they have made? Or lack of progress? Relationship with their therapist? How long do they think about dropping out before they actually do it? Further, if

clients have never thought about dropping out of therapy, what kept them from considering dropping out? Investigating current clients' decision-making processes about staying in therapy or dropping out of therapy, leads to new insight about therapy retention.

Purpose

The purpose of the present study was to explore the process by which current clients of marriage and family therapists decided to stay in therapy or to drop out of therapy. Specifically, I aimed to investigate how therapy clients assess therapy productiveness. I investigated therapy clients' assessment of therapy productiveness by current therapy clients of MFTs about whether they believed therapy was productive and how they knew so. The common-factors approach informs the present study (Sprenkle & Blow, 2004a). Participants were asked to describe their therapy experiences in interviews, and answer survey questions about their therapy experience. This mixed-method research design allowed me to obtain a more complete understanding of the phenomenon than either individual method.

Chapter 2. Literature Review

Common Factors: A Theoretical Basis

Couple and family therapy is effective for resolving a variety of problems (Blow et al., 2009; Lambert, 1992; Shadish & Baldwin, 2003; Sprenkle, Davis & Lebow, 2009). What happens in couple and family therapy that contributes to this effectiveness is not well understood (Blow et al., 2009; Sprenkle & Blow, 2004a). The common-factors perspective is an approach to understanding the factors that are responsible for therapeutic change, specifically, the factors that are more general, and not the hallmark of a particular model (Lambert, 1992; Sprenkle et al., 2009, p. 9). Empirical evidence supporting the assertion that common factors are therapeutic change agents is derived from meta-analyses of couple and family therapy (Lambert & Ogles, 2004; Shadish, Ragsdale, Glaser & Montgomery, 1995; Shadish, Montgomery, Wilson, Wilson, Bright & Okwumabua, 1993; Smith & Glass, 1979). Meta-analyses by Smith and Glass (1979), Shadish and Baldwin (2002; 2003), Shadish, Ragsdale, Glaser & Montgomery (1995) and Lambert and Ogles (2004) found no difference in effectiveness across treatment models when controlling mediating and moderating factors. This empirical evidence provides strong support for common factors' contributions to therapeutic change, suggesting that psychotherapy works, not because of the unique contributions of any particular therapeutic model, but rather, because of a set of common change processes (also called mechanisms of change) that cut across all effective therapies (Sprenkle et al., 2009). In other words, the common-factors approach postulates that common factors, or elements of therapy, are the primary contributors to therapeutic change (Sprenkle & Blow 2004a, b).

The common-factors approach is a particularly useful theoretical lens for guiding process research for several reasons. Among practicing therapists, use of integrative models is most

common, more so than singular models. The acceptance of integrative models is widespread, and use of integrated models has been described as a paradigmatic shift away from definitive schools of thought or models (Lebow, 1984, 1987, 1997). Due to the shift toward integrative practice, researching the process of therapy from a purist, model-specific perspective may present challenges in ensuring that the outcome of that research accurately informs clinical practice. Research that informs and enhances clinical practice is of great importance to the MFT field, as it is an important step in narrowing the research practice gap (Oka & Whiting, 2013). Thus, the common-factors approach aligns well with the aim of the present study, which is to investigate the process of therapy as it is practiced in real world settings.

Common Factors and Change Processes

Common factors inform understanding of change processes, as change processes often contain elements of common factors that are present in many effective therapy models (Sprengle et al., 2009). Research on change processes that is informed by common factors is an important area of research that may further the explanation of *how* effective therapy leads to change. There has been one study, by Blow and colleagues (2009) to apply a common-factors lens to a study of change process. This qualitative single-case analysis of couple therapy identified change processes from the perspective of client, therapist, and observers in a natural therapeutic setting for the purpose of understanding and describing how change occurs (Blow et al., 2009). Common-factors theory was particularly suited to guide this study because the researchers did not aim to test elements of a specific therapeutic approach; rather, they were concerned with general change processes embedded in most forms of psychotherapy (Blow et al., 2009). Key change processes related to the therapeutic alliance factors, hopefulness that therapy would be

successful and goal clarity emerged as salient findings (Blow et al., 2009). This study is an example of how common factors can effectively guide and structure change processes research.

Change Processes

Change processes is the term used in the MFT literature to describe what occurred in therapy sessions that is believed to be important for bringing about change (Blow et al., 2009; Wark, 1994). The term change processes refers to “...micromechanisms of therapeutic gain and the links of these microprocesses with each other and with overall treatment goals” (Heatherington et al., 2005, p. 19). Change processes are the things that happen in therapy sessions that clients perceive as leading to change (Greenberg, James & Conry, 1988). Research on change processes is particularly important for beginning to answer the long standing question of *how* change occurs in the therapy room (Blow et al., 2009; Christensen et al., 1998; Wark, 1994). The focus on general change processes is consistent with common-factors theory in claiming that similar mechanisms of change are common across therapeutic models, although they may be described using different language (Sprenkle et al., 2009). For example, emotionally focused therapists (Johnson, 2004) would say that fostering a secure attachment improves the quality and functionality of a couple’s relationship, whereas a solution focused therapist (deShazer, 1988) may say that couples are able to improve their relationship when they re-discover their strengths, while a Bowenian therapist (Kerr & Bowen, 1988) may say that couples who reach higher levels of differentiation enjoy improved relationship quality (Sprenkle et al., 2009). From this example, it is clear that different models use different language to explain the process by which change occurs.

Wark (1994) investigated clients’ accounts of the most critical events of therapy associated with change using critical incident technique. In a sample of five couples and five

therapists, she found that clients' positive views of therapy were associated with the therapists' ability to provide routine and structure, ability to offer alternative perspectives, assume a directive or non-directive style when needed and ability to focus on positives (Wark, 1994). Most notably, Wark's (1994) findings are focused on therapeutic alliance variables and the therapists' actions.

Christensen and colleagues (1998) were influenced by Wark's (1994) research of critical change incidents over the course of therapy and designed a qualitative investigation of 24 couple therapy clients and nine therapists aimed to understand turning points over the course of therapy that left them thinking or feeling differently about the presenting problem. In contrast to Wark (1994), this study does not assume that therapeutic change occurs in few noteworthy events, rather, change is assumed to occur as a subtle gradual process, sometimes even without significant markers (Christensen et al., 1998). Christensen and colleagues (1998) found changes occurred in cognition, affect and communication patterns. Five contextual factors, safety, fairness, normalization, hope and pacing, were identified as contributing to this perceived change. Similar to Wark's (1994) findings, Christensen and colleagues' (1998) findings related to what happened in therapy that brought about change are inextricably linked to things the therapist did to facilitate changes in cognition, affect and communication.

Helmeke and Sprenkle (2000) were influenced by Wark's (1994) and Christensen and colleagues' (1998) studies of change processes, and aimed to focus on specific change processes they called pivotal moments, as opposed to more general aspects of therapeutic change. Helmeke and Sprenkle's (2000) sample consisted of three couples (six clients) and one therapist. This study was the first to establish that clients of couple therapy could in fact identify something from therapy as a pivotal moment (Helmeke & Sprenkle, 2000). Clients reported just about one

pivotal moment per session. Partners of different genders, therapists, and clients often identified different events as pivotal. Consistent with Wark's (1994) and Christensen and colleagues' (1998) findings, Helmeke and Sprenkle (2000) found support for things the therapist did that were identified as allowing a pivotal moment to occur. Pivotal moments were found to occur around discussions of the presenting problem, and occur after a topic had been discussed repeatedly in sessions (repetition). Other findings related to pivotal moments were centered upon things that the therapist did to facilitate such moments, including use of illustration or metaphor, therapist characteristics, use of practical suggestions, positive reinforcement, willingness to offer alternative solutions, ability to be in tune with the moment and ability to foster client trust (Helmeke & Sprenkle, 2000). Further, one participant stated, "I feel it is up to the therapist to create pivotal moments" (Helmeke & Sprenkle, 2000, p. 479). Findings of this study and preceding studies continually find that the therapist is inextricably linked to change processes.

Though methodologically and conceptually rigorous, the small body of research of change processes has not been replicated in several years, warranting new research aimed to continue and expand this research. A notable limitation of these qualitative studies is that they do not identify an outcome that is impacted by these change processes and the importance of this research is not clear to its' consumers (Greenberg & Pinsof, 1986; Helmeke & Sprenkle, 2000).

Productive change processes. One way to expand on change processes research is to clarify the language used to identify those processes that contribute to successful outcomes. While studies use words such as "productive," "critical" and "pivotal" interchangeably, I propose that *productive* is the most accurate and specific way to identify and describe these processes. Productive is defined as giving rise to a significant event or result (Merriam-Webster's Collegiate

Dictionary, 1993). Change processes can be defined as productive when they are identified as the process (an event, behavior, cognition or action) that gave rise to the goal for therapy. This conceptualization of *productive change processes* is more specific than *helpful*, as productive is defined as useful, a definition that does not indicate giving rise to a significant event or movement toward change. The definition of *productive change processes* is inextricably linked with clients' perceived progress toward their therapeutic goals.

Premature Dropout

A way to continue the body of research on change processes is to identify their role in bringing about a therapeutic outcome. Premature dropout (also called premature termination, attrition, and the antonym, retention) is a frequent and problematic occurrence in mental health care treatment (Marchionda & Slesnick, 2013). Hamilton and colleges (2011) found that family therapy clients are 33.2% more likely to drop out of treatment than clients of individual therapy, possibly because couple and family therapy clients face more barriers to treatment than individual therapy clients (Masi, Miller & Olson, 2003). Between 40% and 60% of couple and family therapy clients end therapy without discussing this decision with their therapist (Hamilton et al., 2011; Marchionda & Slesnick, 2013; Mueller & Pekarik, 2000; Wierzbicki & Pekarik, 1993). The majority of clients who drop out of therapy do so after one session (Odell & Quinn, 1998; Phillips, 1987). Taube, Burns, and Kessler (1984) found about one-third of private practice clients terminated within two visits and about two-thirds did so by the 10th visit (Mueller & Pekarik, 2000).

Clients who drop out of therapy before their goals have been reached are less likely to experience therapy's benefits (Kazdin, 1990), less likely to seek therapy with another practitioner (Garfield, 1963) and less likely to report satisfaction with their therapy experience (Pekarik,

1992). Perhaps the most problematic result of premature dropout is the loss of potential for therapeutic change (Hamilton et al., 2011). Few studies have investigated the processes responsible for keeping (retaining) couples and families in treatment (Marchionda & Slesnick, 2013; Masi, Miller & Olson, 2003). Few studies have examined the relationship between therapeutic process variables and premature termination (Bischoff and Sprenkle, 1993). Therefore, researchers recommend process research that examines the impact of therapy process variables on premature dropout (Bischoff and Sprenkle, 1993). Several issues contribute to difficulty in the empirical investigation of retention. The effects of premature dropout are often difficult to investigate, as the status (*e.g.* satisfied or unsatisfied) of the dropout client is usually unknown (Shadish, Hu, Glaser, Kownacki & Wong, 1998), which leads to errors of reporting (Bischoff & Sprenkle, 1993).

A notable limitation of retention research is that many studies rely on data collected as a subset of larger randomized clinical trials. This limitation is problematic, as these studies are aimed to investigate other factors, and their samples are not collected for the purpose of understanding dropout. For example, many studies of dropouts use a substance-abusing sample (Shadish, Ragsdale, Glaser & Montgomery, 1995; Stanton & Shadish, 1997) and these results may not be generalizable to non-substance abusing clients. Among the most problematic issues are how premature dropout is defined (Bischoff & Sprenkle, 1993; Marchionda & Slesnick, 2013) and when dropout constitutes a treatment failure (Marchionda & Slesnick, 2013). Issues inherent in defining and identifying premature dropout lend themselves to questions about therapy dosage, or the amount of therapy necessary to achieve the desired outcome.

Therapy Dosage

Although brief treatment can be as effective as long-term treatment, (Koss & Shiang, 1994) very early treatment termination is associated with poor treatment outcome and is considered a major service-delivery obstacle, contributing to fiscal, administrative, clinical, and personnel problems (Pekarik, 1986). Early research of therapy dosage, or treatment length, showed that the amount of therapeutic benefit is often positively correlated with amount of treatment (Howard, Kopta, Krause & Orlinsky, 1986; Orlinsky & Howard, 1978). In other words, generally, more therapy yielded better results. However, meta-analysis results suggest that about 15% of patients will feel and show measurable improvement before attending the first session of psychotherapy (Howard et al., 1986). Howard and colleagues (1986) found that between 29% and 38% of clients improved within the first three sessions, regardless of the ultimate duration of treatment. Similarly, 48% to 58% improved within four to seven sessions. Fifty three percent of clients improved following eight weekly sessions, 75% by 26 sessions, and 83% by 52 sessions (Howard et al., 1986). These results reflect a drop off in the percentage of clients that improved after seven weeks of therapy, further indicating that more sessions do not necessarily equate to more change. These findings yield tentative support for the idea that therapists are not always the best judges of how much therapy is necessary. Rather, the amount of therapy necessary may best be determined in collaboration with clients. Therapy dosage is an important consideration when determining criteria used to identify and define premature dropout.

Problems Defining Premature Dropout

Problems arise with how premature dropout is defined, and who should define dropout (Bischoff & Sprenkle, 1993). There are four commonly used methods for defining premature dropout (Hamilton et al., 2011). The first method uses the criteria of a predetermined number of

sessions; clients who terminate therapy before reaching the predetermined number of sessions are identified as having dropped out of therapy (Bischoff & Sprenkle, 1993; Hamilton et al., 2011). The second method relies on the therapists' definition of a proper termination point, and clients who end therapy before this point are considered dropouts (Bischoff & Sprenkle, 1993; Hamilton et al., 2011; Sledge, Moras, Hartley & Levine, 1990). The third method combines a set number of sessions with the therapists assessment of the treatment case, while the fourth method involves identifying dropout as clients who present for a single session and fail to return (Bischoff & Sprenkle, 1993; Garfield, 1986; Hamilton et al., 2011).

While each of these methods of defining premature dropout poses unique benefits, each also poses unique challenges. Determining dropout based on a predetermined number of sessions as a cutoff is likely an arbitrary choice (Bischoff & Sprenkle, 1993; Hamilton et al., 2011; Reis & Brown, 1999) that does not accurately reflect the clients' goals and experience of treatment. Therapist defined premature termination is likely to be subjective, because it omits the clients' perspective of the treatment. Therapists' ideas about the number of sessions necessary to reach the goal may differ from their clients' ideas (Bischoff & Sprenkle, 1993). A common problem with these methods of defining premature termination is the omission of the clients' perspective of the treatment. Client perception of therapeutic process is often the most reliable (Horvath & Symonds, 1991). The client holds complete control over whether he or she continues therapy, therefore, the client perception is the most important perspective in research on premature dropout. One way for clients to judge when treatment is over is based on goal attainment.

Using goal to define premature dropout. Establishing goals for therapy is crucial for providing an organizational structure to the topics discussed, interventions used, and client

motivation (Werner-Wilson, & Winter, 2010). Researchers have identified goals as useful indicators by which to measure therapeutic progress (Woodward, Santa-Barbara, Levin & Epstein, 1978). Some researchers believe that dropout occurs when clients end therapy before fulfilling their therapeutic goals (Allgood & Crane, 1991; Werner-Wilson & Winter, 2010). The degree to which the therapist and client agree about the presenting problem influences treatment retention (Bischoff & Sprenkle, 1993). An early study of family casework found that clients who reject the therapist's identification of the presenting problem and corresponding goals were more likely to drop out of treatment than those who agreed with the therapist's identification of their problem (Blenker, 1954). A study conducted at a child guidance clinic several years later confirmed these results (Blenker, 1954). For the purpose of the present study, intended premature dropout will be defined as occurring when participants indicate that they will stop attending therapy sessions before meeting their therapeutic goal for the current treatment course (Adams, Piercy & Jurich, 1991).

Some researchers oppose the idea of assessing premature dropout using client perception of goal attainment because a) it does not distinguish between long-term therapy clients who terminated after improvement, those who saw no improvement, and those who failed to return after the first session, b) therapists and clients may have different perceptions of the therapeutic goals, and c) the client may feel helped after few sessions and stop therapy, while the therapist perceives that client as needing more therapy (Werner-Wilson & Winter, 2010). These problems identified in using goal attainment in defining premature dropout appear to be outweighed by the benefits. Specifically, perceived progress makes intuitive sense. Further, research on client and therapist goal consensus supports the importance of clients and therapist agreement on treatment goals (Gurman, 2008; Monder, Sabourin, Wright, Poitras-Wright, McDuff, Lussier, 2013).

Intended Retention

An inherent problem in research studies of premature dropout is that clients who terminate prematurely are rarely available research participants. Identifying and defining the construct of *intended retention* in studies of retention with current clients is a unique perspective on the topic. In the present study, intended retention is defined as the intention to remain in therapy until the therapeutic goal(s) are attained. Research shows that clients' anticipated attendance is an accurate predictor of actual attendance patterns (Garfield, 1986; Goin, Yamamoto, & Silverman, 1965; Pekarik & Wierzbicki, 1986).

Clients likely experience ambivalence, a time when they may weigh the costs and benefits of continuing therapy versus living with their presenting problem (Walitzer et al., 1999). I hypothesize ambivalence toward therapy precedes the dropout event. During a period of ambivalence, I hypothesize that clients evaluate the therapeutic process, perceived benefits of therapy, and the therapeutic relationship before deciding if they will stop therapy or remain in therapy.

Goal Attainment

The overarching purpose of therapy is to bring about change for clients (Wark, 1994). Therefore, clients should be the ones to define change, rather than their therapists or researchers (Wynne, 1988). Goals, or the desired end result of therapy, are important contributor to therapeutic effectiveness, (Bohart & Wade, 2013) and a useful measure of change. Clients become dissatisfied with therapy progress when they are unable to formulate clear goals and mobilize themselves toward those goals (Blow et al., 2009; Snyder, Michael & Cheavens, 1997).

Historically, the treatment model and the therapist often defined the treatment goal and the path to change. Currently, the importance of collaboratively developed goals is recognized

as a crucial step in tailoring treatment to clients (Bohart & Wade, 2013). Empirical evidence supports the association between therapists' explanation of the rationale behind the proposed plan for treatment, and how it fits with clients presenting concerns and improved therapeutic outcome (Bohart & Wade, 2013). When clients agree with the therapist about the therapeutic goals and how they will be reached, clients are likely to have an increased understanding of the therapeutic process (Bohart & Wade, 2013). Further, clearly defined goals serve as important indicators for determining whether change occurred, and can help determine when therapy should be terminated (Adams et al., 1991). Client and therapist agreement on the treatment goals are considered important elements of therapeutic alliance (Bordin, 1979).

Therapeutic Alliance

Therapeutic alliance is an important common factor in all MFT theories, (Blow & Sprenkle, 2001) and has been closely linked to positive client change and retention in therapy (Horvath, 2006). Above all, therapy is a human endeavor (Blow et al., 2009). Therapeutic alliance is defined as a conscious, collaborative relationship between the client and therapist along the dimensions of bond, task and goal (Bordin, 1975, 1979, 1980; Horvath & Greenberg, 1989; Kneer et al., 2011). Therapeutic bond refers to a mutual fondness and trust between therapist and client, while task refers to agreement between therapist and client on the activities that clients engage in during the therapeutic process (Bordin, 1979). Goal refers to the agreement between therapist and client on the outcome of therapy (Bordin, 1979). This definition is used to guide the use of therapeutic alliance in the present study. Early therapeutic alliance is hypothesized to account for 22% of variance in therapy outcome (Knobloch-Fedders, Pinsof, & Mann, 2004). Further, poor early treatment alliance is highly predictive of premature dropout from treatment (Horvath, 2006). Therapeutic alliance is crucial in clients' decisions

about ending therapy, as those who perceive a strong alliance are less likely to end therapy before it is completed (Horvath, 2006; Sprenkle et al., 2009).

Clients also identify the therapeutic alliance as a productive change process (Blow et al., 2009; Christensen et al., 1998; Helmeke & Sprenkle, 2000; Sundet, 2011; Wark, 1994). Blow and colleagues (2009) found support for therapeutic alliance as a key component of change in their intense case analysis of one couple in couple therapy. Therapeutic alliance factors identified by clients as productive in producing change are therapists' ability to enhance client comfort and the ability to balance each member of the couples' goals (Blow et al., 2009). Similarly, Christensen and colleagues' (1998) asked clients in couple therapy about the change process that were most productive in creating change. Emergent findings included therapists' ability to create a safe environment, the therapists' ability to balance the needs of each partner and the therapists' ability to normalize the presenting problems. Helmeke and Sprenkle (2000) asked clients of couple therapy about pivotal change moments, and also found support for the importance of therapeutic alliance as a change process. Participants identified therapist factors as non-pivotal events that were believed to have allowed a pivotal moment. Clients identify the following events as pivotal change moments: the therapists' use of practical suggestions, engendering hopefulness, the ability to be relatable, willingness to offer an opinion or take a stand, and to provide positive feedback (Helmeke & Sprenkle, 2000). Wark (1994) also asked clients and therapists to describe critical change incidents and found support for therapeutic alliance as a productive change process. Clients identified the therapists' ability to focus on strengths, know when to be directive and when to be non-directive, ability to offer an alternative perspective, and willingness to provide structure in therapy as instrumental in helping them change (Wark, 1994).

History of Therapeutic Alliance

Therapeutic alliance is one of the oldest bodies of empirical research in the MFT field, and psychotherapy in general. Carl Rogers' (1951; 1957) continuation of this work on the therapeutic relationship has been one of the most influential. Rogers (1951; 1957) defined the critical components of the therapeutic relationship as empathy, unconditional positive regard, and congruence. Rogers' conceptualization of therapeutic alliance identified important components, though his theory was not generalizable to all therapeutic models (Horvath & Greenberg, 1989). Later, Strong (1968) attempted to conceptualize therapeutic alliance as a construct that would be applicable to many therapeutic approaches. The definitive feature of Strong's (1968) theory is that the therapeutic alliance is based on the therapists' ability to offer the client mutual trust, acceptance and confidence. Strong (1968) was influential in shifting the locus of control over the therapeutic alliance to the therapist, rather than the client's perception (Horvath & Greenberg, 1989). Strong's (1968) theory formed the basis for Bordin's (1975, 1979, 1980) conceptualization of therapeutic alliance, which is one of the most widely, accepted conceptualizations of therapeutic alliance.

Bordin's (1975, 1979, 1980) seminal works on therapeutic alliance incorporated and expanded upon previous psychoanalytic understanding of therapeutic alliance (Horvath & Greenberg, 1989). Bordin (1975, 1979, 1980; Horvath & Greenberg, 1989) defines the alliance as a conscious, collaborative relationship between the client and therapist along the dimensions of bond, task and goal (Bordin, 1975, 1979, 1980; Horvath & Greenberg, 1989). Tasks are the behaviors and cognitions that form the basic elements of the therapeutic process (Horvath & Greenberg, 1989). Primarily, tasks are the actions, experiences and relatedness of client and therapist in session when they are physically together (Orlinsky, Ronnestad & Willuzki, 2004).

Importance of Therapeutic Alliance

The relationship between therapist and client, also called therapeutic alliance or rapport, is a central aspect of psychotherapy treatment (Bordin, 1979, 1994; Mahaffey & Granello, 2007). Therapeutic alliance is the basis for the client to accept and follow the therapists' treatment (Bordin, 1979). Research points to the importance of the therapeutic alliance in successful treatment outcome and preventing premature dropout (Beutler & Harwood, 2002; Bischoff & Sprenkle, 1993; Horvath, 2001; Horvath, 2006; Horvath & Symonds, 1991; Kneer et al., 2011). Though rapport is critical to successful therapeutic progress, how rapport is developed and maintained is not thoroughly understood, (Taft, Murphy, Musser & Remington, 2004) particularly in the case of relational treatment constellations (Porter & Ketting, 2011).

The rationale for attuning to therapeutic alliance is garnered from the link to therapeutic outcome (Horvath, 2011; Horvath, Del Re, Fluckiger & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000). In their meta-analysis of 24 studies linking therapeutic alliance to therapeutic outcome, researchers found strong support for therapeutic alliance as a predictor of therapeutic outcome. An overall effect size of $r = .26$, $p < .05$, is believed to be conservative, though establishes therapeutic alliance as a robust predictor of outcome (Horvath & Symonds, 1991). Therapeutic alliance best predicted therapy outcome when information about the therapeutic alliance was collected from clients (Horvath & Symonds, 1991). This finding demonstrates unintended empirical support for relying on client report (Horvath & Symonds, 1991).

In a follow up study, Horvath (2001) examined the empirical literature on therapeutic alliance from previous meta-analytic studies by Horvath and Symonds (1991) and Martin and colleagues (2000) and also added findings from ten recent studies. Through analyzing the

relationship between therapeutic alliance and therapeutic outcome, this data showed an overall effect size of .21 (range = .06 to .89) (Horvath, 2001). The overall effect size for psychotherapy treatment in general is .39 (Horvath, 2001; Smith & Glass, 1977). By comparison, the effect size of .21 for therapeutic alliance is rather large (Horvath, 2001).

In 2000, researchers Martin and colleagues conducted a meta-analysis focusing on patterns in therapeutic alliance literature. The focus of the analysis is data from 79 studies that measured therapeutic alliance using a variety of measurement scales (Martin et al., 2000). Results show minimal difference in each scales' ability to predict successful therapeutic outcome, and an overall effect size of .22 ($n=68$, $SD = .12$) (Martin et al., 2000). This moderate effect size is consistent with previous meta-analyses by Horvath and Symonds (1991) and Horvath (2001). The results found by Martin and colleagues (2000) support the extant literature by showing a significant relationship between therapeutic outcome and therapeutic alliance.

In 2011, Horvath and colleagues conducted a fourth meta-analysis examining the relationship between therapeutic alliance and therapeutic outcome; building upon the work of Horvath and Symonds (1991), Martin and colleges (2000) and Horvath and Bedi (2002). This analysis included 190 independent alliance to outcome relationships, yielding an aggregate effect size of $r = .275$, $p < .0001$ with a 95% confidence interval of .24 - .301 (Horvath et al., 2011). This effect size indicates a moderate but highly reliable relationship between therapeutic alliance and therapeutic outcome. This aggregated value was adjusted for sample size and intercorrelation among outcome measurements. This effect size value is consistent with the current literature, though slightly larger than previous meta-analytic research (Horvath et al., 2011).

Expectations

Expectancy factors are client expectations for therapeutic gains and psychotherapy processes (Arnkoff et al., 2002; Garfield, 1986). Expectations are hypothesized to account for 15% of variance in psychotherapy (Anderson et al., 2013; Lambert & Barley, 2002). Expectations are a key common factor embedded in all psychotherapy approaches, and non-specific to any treatment modality (Arnkoff, Glass & Shapiro, 2002; Lambert, 1992). Bischoff and Sprenkle (1993) recommend that future research on premature dropout incorporate client expectations into their designs, the present study fills this gap. Client expectations about therapy play an important role in client willingness to derive benefits from therapy (Arnkoff et al., 2002; Joyce et al., 2000). When clients view therapy as relevant to their problem, they are likely to remain in treatment, rather than dropping out prematurely (MacNair-Semands, 2002; Tambling, 2012). It is essential for therapists to inquire about client expectations, as positive expectations are associated with continuing therapy, and making therapeutic changes (Frank et al., 1963; Gladstein, 1969; Tambling, 2012).

Arnkoff and colleagues (2002) found that mismatch between client expectations and experience in treatment often results in premature dropout. Three studies have investigated the relationship between clients' outcome expectations and premature dropout (Arnkoff et al., 2002). Gunzberger, Henggeler and Watson (1985) asked clients to rate the degree to which their session met their expectations. Results showed that clients' expectation rating at the end of the first session was a significant predictor of premature dropout. When examining the relationship between role expectations and premature dropout, 14 out of 22 studies discussed by Arnkoff and colleagues (2002, p. 342) showed a significant relationship. These results show support for the importance of role expectations.

Expectations are delineated into role, process and outcome expectations. Clients begin therapy with expectations about the therapist's role, therapeutic relationship and treatment length (Garfield, 1986). Client expectations influence decisions to begin therapy treatment (Meyer et al., 2002; Norberg et al., 2011) and motivation for change (Arnkoff et al., 2002; Joyce, McCallum, Piper & Ograniczuk, 2000; Tinsley et al., 1984). Clients expect the therapist to be an experienced expert helper, warm, empathic, active and able to create a comfortable environment (Joyce & Piper; 1998; Tinsley & Harris, 1976; Tinsley et al., 1980). Process expectations significantly influence therapeutic outcome (Tambling, 2012). Clients who feel therapy meets their expectations are more likely to perceive therapy as productive and report positive outcomes as compared with those who do not feel therapy met their expectations (Wilkins, 1973a, b). Early studies of therapy expectations suggest clients will be most satisfied when positive expectations are confirmed by therapeutic gains (Arnkoff et al., 2002).

Alternatively, discrepancies between expectations and therapeutic reality are associated with negative therapy outcomes (Tambling, 2012). A study by MacNair-Semands (2002) found a relationship between poor attendance and incongruence between expectations and reality. A more recent study by Joyce and colleagues (2000) found that clients expected therapeutic tasks to include discussions about their symptoms, childhood memories, the here-and-now relationship, and the relationship between past experiences and current difficulties. Clients expect their therapist to be encouraging and reassuring, and expect to have the opportunity to talk about the treatment they will receive before changing (Arnkoff et al., 2002).

Purpose

The purpose of the present study is to begin to understand how productive change processes influence intended retention for clients of marriage and family therapists. These

results inform marriage and family therapists refine their therapeutic techniques to attune to intended retention, and possibly demonstrate empirical support for common-factors informed training and supervision. Using a grounded theory approach, I interviewed couple and family therapy clients' about their experience of making the decision to remain in therapy or to drop out. The common-factors approach explains that productive change processes, goal and alliance are predictors of successful therapy outcome. I tested to what extent productiveness, therapeutic alliance and goal attainment predict membership in the intended retention group or intended dropout group for current therapy clients using binary logistic regression analysis. The purpose for collecting both qualitative interview data and quantitative survey data was to triangulate or compare the results of the two forms of data to develop an increased understanding of the process by which clients decided whether they would remain in treatment or drop out. This multi-informed model brings a richer understanding of this phenomena than would be obtained by either method independently.

Research Questions

Qualitative

1. What is the process by which productive change processes impact intended retention for therapy clients.

Quantitative

2. What components of the productive change processes inventory (PCPI) account for the most variance in change processes productiveness?
3. To what extent do therapeutic alliance, productiveness and goal attainment predict intended retention or intended dropout?

H_0 : A positive therapeutic alliance, high perceived productiveness and positive goal attainment will predict membership to intention to stay in therapy.

Mixed

4. How does the qualitative model of the process by which productive change processes impact intended retention or intended dropout converge or contrast with the results of the logistic regression model assessing productive change processes, goal attainment and therapeutic alliance as predictors of intended retention (or intended dropout)?

Chapter 3. Methodology

Research Design Overview

This simultaneous, convergent (Creswell & Plano Clark, 2011) mixed-methods study was conducted to investigate the process of intended treatment retention by examining the influence of productive change processes, goal attainment and therapeutic alliance on retention.

Qualitative interview data and quantitative survey data were collected from the same participants simultaneously for the purpose of converging or comparing the results of the two data forms to develop an increased understanding of the process by which clients decide to stay in or drop out of therapy. Semi-structured interview data, analyzed using grounded theory, were used to inductively develop a common-factors theory based model describing the process by which productive change processes positively influence intended retention. An instrument was designed to measure productiveness. The Productive Change Processes Inventory (PCPI) was designed for the present study, and tested for reliability and validity. Quantitative survey data were used to determine whether productiveness, goal attainment and therapeutic alliance predicted membership in the categories of intended treatment retention or intended dropout. The overall study procedure is depicted in Figure 1.

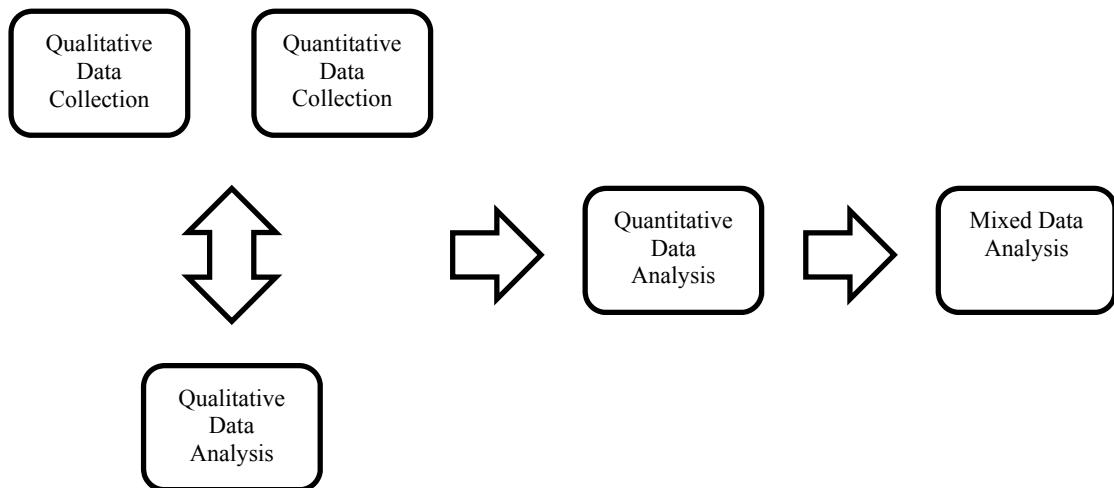


Figure 1. Overall study procedure

Qualitative Strand

Participants

The population for the present study was adult (over age 18) current clients of marriage and family therapists (MFT) being seen for individual, couple and family therapy in a community or university clinic. A convenience sample of 19 participants ($N=19$) was recruited from Kayenta Therapy Centers, a conglomerate of three community agencies in Las Vegas, Nevada between October 1, 2014 and December 20, 2014. These therapy centers are owned and staffed by MFTs. Kayenta therapy centers provided an access point to reach clients of outpatient community mental health treatment settings, commonly known as a general clinical population. Therapists of clients in the sample were trained as MFTs, and vary in experience level from student interns, to experienced therapists with over 10 years in practice. Student therapists were supervised by American Association for Marriage and Family Therapy (AAMFT) approved supervisors. Therapists practiced a variety of therapeutic models. No specific practice information was collected from therapists. Since participants were disclosing sensitive details about the therapist and the therapy, no information linking the participant to a specific therapist

was collected. This decision enhanced participants' willingness to disclose without fear of their therapist finding out their responses, and it also enhanced agency directors' comfort with my study.

Collecting Data from Clients

Data source is an important consideration in process research (Horvath & Symonds, 1991). Through effect size comparison, Horvath and Symonds (1991) found that client-rated outcome is a better predictor of outcome than therapist-reported outcome, and while observer report was found to be the least reliable predictor. Client self-reports were useful for assessing client perceptions for a variety of things, such as their behaviors, thoughts, feelings, or symptoms of individual and relational functioning (Oka & Whiting, 2013). Research showed that therapists' perceptions of therapy are often incongruent with clients' perceptions (Oka & Whiting, 2013). These findings from previous research serve as justification for using client report as the data source in the present study.

Sampling

Convenience sampling was the primary sampling strategy used to recruit current therapy clients (Patton, 1990). As sampling progressed, maximum variation sampling strategies were employed to ensure diversity in the sample regarding stage of therapy and treatment constellation. I aimed to obtain an evenly varied sample of participants in individual, couple and family therapy, as well as variation among participants in early, middle and late therapy. As sampling progressed, I increased screening of potential participants by phone or email by asking participants to disclose their therapy constellation, stage of therapy, and a general statement about the problem for which they sought therapy. Enhanced screening procedures allowed me to include participants who possessed characteristics that needed more representation in the sample.

Grounded theory researchers aim to reach theoretical saturation with a small sample (Charmaz, 2006, Strauss & Corbin, 1998). I reached theoretical saturation with a sample of 19 (N=19) participants. A total of 22 interviews were conducted (N= 22), and three cases were removed from the analysis because it was discovered that they were partners of other participants.

Recruitment

After obtaining IRB approval, (see Appendix A and Appendix B for documentation) recruitment displays were established in the waiting rooms of each Kayenta Therapy Center. Potential participants were informed of the study, the requirements and the incentive through recruitment posters and flyers (found in Appendix C). In addition to these recruitment materials, a small locked box with a drop slot, blank note cards and pens were displayed. An instruction sheet explained that potential participants could leave their first name and either a phone number or email address if they were interested in being contacted by the researcher to possibly schedule an interview. The researchers' business card was also left, and some participants opted to email the researcher directly. Of the total 22 participants who expressed interest in participating, 13 potential participants chose to leave their contact information in the lock box, while nine participants opted to email the researcher directly. Eight participants expressed initial interest in the study, but chose not participate. Additionally, four participants expressed interest, but after further screening during the initial phone call, did not meet the inclusion criteria. Of the 34 people who expressed interest in the study, 22 participated. A photo of the full recruitment display can be found in Figure 2.



Figure 2. Photo of qualitative recruitment display

Procedures

Upon receiving contact information for potential participants in the locked boxes, the researcher contacted each person via the phone or email information provided. During the initial phone call or email the researcher gave a brief synopsis of the study including the requirements of the participant and the incentive before scheduling the interview. The researcher also used the initial phone contact to confirm the participant met the stated inclusion criteria (currently in therapy with an MFT and over age 18). A maximum of two attempts to contact each potential participant were made. If the participant failed to show for the scheduled interview, one follow up contact attempt (via phone or email) was made. The researcher pursued no additional contact with the potential participant beyond the one follow up phone call or email. Two participants failed to show for their scheduled interview, and did not respond to the one follow up phone call.

All interviews were conducted individually, meaning with one participant and the researcher. Interviews took place in a private room within Kayenta Therapy Centers. Prior to

beginning data collection, the researcher reviewed the purpose of the interview, timeframe of the interview, and the audio recording. Participants were informed that they are able to stop the interview at any time, for any reason without consequence. No participants asked to stop the interview. The researcher reviewed the informed consent form (found in Appendix D) and answered questions. Once any questions were clarified, the participant was asked to sign the consent document. Recording, via a handheld digital audio recording device, began after the informed consent document was signed. The audio recording contained no identifying information and identifies the participant by a pseudonym and a study code.

Following the conclusion of the interview, the researcher administered a paper and pencil version of the quantitative survey (found in Appendix F). The researcher was available to the participant for any questions about the survey and collected it upon completion. At the conclusion of the survey, a \$20 grocery store gift card was given to the participant. Participants were informed that a de-identified copy of the findings would be available upon request.

Piloting. Piloting was essential for ensuring that both the interview protocol and measurement instrument function as intended. Piloting procedures discussed here were intended to pilot the overall procedures, and specific piloting procedures used in the instrument development phase of the present study were discussed in the measurement section. The first interview and the first three surveys were considered a pilot. Participants were informed they were part of a pilot study, and asked to provide feedback on the clarity of interview prompts and survey items as well as overall length. Pilot surveys were scored and reviewed for length of time participants take to complete it, missing data and the pattern of missing data. Pilot data were analyzed as if they were actual data. Piloting is important for ensuring the researcher is able to

practice coding according to the predetermined procedures. Results of this pilot did not indicate that any significant changes needed to be made to the interview protocol or quantitative survey.

Data Analysis

The method of analysis for the qualitative phase of the present study was Strauss and Corbin's (1990) grounded theory. This interpretation of grounded theory is rooted in positivism, which postulates that empirical observation and experimentation are the only means to knowledge, while other methods are limited to speculation (Sandelowski, 2000). Grounded theory analysis involves a specific set of procedures whereby the researcher inductively develops theory about a phenomenon (Strauss & Corbin, 1990). Specifically, the process of Strauss and Corbin's (1990) grounded theory involves systematic coding with the intention of validation rather than interpretation. A theory that is grounded meets four criteria: fit, understanding, generality and control (Glasser, Strauss & Anselm, 1967; Strauss & Corbin, 1990). The theory should be understandable to participants as well as those not sampled (Strauss & Corbin, 1990). The theory should also be abstract enough to include variation, enhancing applicability in a variety of contexts (Strauss & Corbin, 1990).

Grounded theory research is indicated when the nature of the research problem calls for a deeper understanding of a new slant on a phenomenon that quite a bit is known about, or an initial understanding of a phenomenon that is not yet well understood (Strauss & Corbin, 1990). Grounded theory is particularly suited for use in mixed methods research (Strauss, Bucher, Enrlich, Schatzman, & Sabshin, 1964). Consistent with triangulation, quantitative data can be used to validate prior qualitative analysis (Denzin, 1970; Strauss & Corbin, 1990). Grounded theory is particularly suited for developing new theory. Further, grounded theory is well suited

for incorporation in a mixed methods study, as it is predicated on ideals of social inquiry, and understanding the social world from multiple perspectives (Green, 2008).

Strauss and Corbin's (1990) grounded theory was selected as the qualitative methodology for the present study because it is consistent with the study's purpose "...to develop a well integrated set of concepts that provide a thorough theoretical explanation of social phenomena under study" (Strauss & Corbin, 1990, p. 5). Grounded theory is particularly applicable to questions about the therapeutic process because these questions usually refer to client meaning, perception, and understanding of therapy (Echevarria-Doan & Tubbs, 2005, p.55). Couple and family therapy clients are experts in their experience of participating in therapy, and my role is to describe their perception of their participation related to their intention to remain in therapy until their therapy goals had been met. Grounded theory is also particularly suited for use in mixed methods research and shares an overarching pragmatist theoretical underpinning (Strauss et al., 1964; Strauss & Corbin, 1990).

Instrument

An interview protocol, (found in Appendix E) was used to guide the interview toward the overarching aim of gathering information about participants' experience of productive change processes and their decision to remain in therapy. Probing questions are designed to elicit indicators of the process by which client participants decided to remain in therapy or to drop out. Questions are intended to be open ended enough to allow for rich description of many different facets of the participants' experiences to emerge, while being focused enough to keep the interview on topic.

The interview protocol was divided into six topic areas: goals and progress, therapists' understanding of the goals and progress, most helpful about therapy, lack of progress, considered

ending therapy, and never considered ending therapy. Each topic area contained between two and four supporting prompts. For topic one, goal and progress, a prompt was “Thinking about the problem that brought you to therapy, what was it about this problem that made you decide to go to therapy?” A prompting question in the second topic area, therapists’ understanding of goals and progress was “How would you know if your therapist understands your problem and the progress you want to make?” The third topic area involved questions about what was most helpful about therapy. Participants were asked “What happened in therapy that helped you make the most progress on this problem?” Topic area four addressed lack of progress, or “feeling stuck”. Participants were asked, “How did you know that you were not making change?” and “Did you find therapy beneficial even if you didn’t see change happening?” Participants who considered ending therapy were asked, “What things did you consider when you thought about stopping therapy?” Alternatively, participants who never considered ending therapy were asked, “Why do you think you never considered ending therapy?” Participants were always asked if there were additional things the researcher did not ask that would be important to their experience.

Data Preparation. The researcher and four research assistants transcribed all interviews. Research assistants were trained at the master’s degree level and had specific training in ethical research practices. Transcripts were stored and prepared in Microsoft Excel[©]. I crosschecked all transcripts for accuracy and to ensure all potentially identifying information had been properly redacted. Digital audio recordings were stored on a password-protected computer. Consent forms and paper copies of completed surveys were stored in a locked file cabinet within the researchers’ locked office. Prior to beginning coding, the researcher read each transcript in its entirety. Once prepared, interview data were analyzed using Strauss & Corbin’s (1990)

grounded theory triadic coding scheme. This coding procedure has become the most widely accepted coding procedure in grounded theory research. I used the constant comparative method of data analysis, in which data were simultaneously collected and analyzed (Strauss & Corbin, 1998).

Open coding. Open coding focused on developing categories, or dimensions, which become conceptual, stand-alone elements of the theory (Glaser & Strauss, 1967). Line-by-line coding allowed the data to be broken apart for the purpose of examining each part (Charmaz, 2006). During the first round of open coding, I first read each transcript, and wrote notes about my initial thoughts about the data. I open coded transcripts on a computer screen, in Microsoft Excel. Initial thoughts were noted in a column to the right of the textual data. After reading the entire transcript, I returned to the start of the transcript and focused on each textual passage. As I examined each piece of text, I examined each line with the question in mind; “What is the participants’ experience?” “What are they saying?” This process is consistent with Strauss and Corbin’s (1998) description of open coding in which data are broken apart. During open coding, I refined my initial thoughts into an open code.

After each transcript had been initially open coded, these open codes were refined and specified in a second round of open coding in which the research question, the phenomenon and the study purpose were used as a guiding lens. This procedure is consistent with Straus and Corbin’s (1990) approach to grounded theory, in that it is acceptable practice to have a guiding theory in mind, as opposed to constructivist grounded theory where the codes are emergent. During this round of open coding, I re-examined the textual data, and re-examined the original open code assigned. In the second round of open coding, I maintained focus on the research question. As I read each textual excerpt, I focused on how the ideas conveyed impacted the

decision to stay in therapy or to stop therapy. I refined the original open codes in a second round of coding, focusing on how the textual data answered the research question. During the second round of coding, a codebook of all open codes assigned was continually updated and maintained during coding. I did this by copying and pasting each open code assigned into a separate Microsoft Excel[®] document. In the column to the right of each open code, I recorded the frequency of each code assigned. Transcripts were open coded in the order in which they were collected. When open coding did not result in developing new categories and subcategories, I concluded saturation had been reached when continued sampling fails to result in new facets of the phenomenon emerging (Strauss & Corbin, 1998). Saturation was reached after sampling 19 participants.

Axial coding. After breaking the data apart during open coding, the purpose of axial coding is to put fractured data together in new ways by making connections (Strauss & Corbin, 1990). Connections among the data involve conditions in which the phenomenon occurs, actions or inactions of the people in response to what is happening and/or, the consequences or results of the action or inaction (Strauss & Corbin, 1998). Axial coding involves refining broad categories, which allows for the emergence of subcategories. Categories are related to their subcategories, and to other categories through relational statements (Strauss & Corbin, 1998). Relational statements are hypotheses about how concepts relate to one another. For each transcript, relational statements were inserted in a column to the right of the open code. During axial coding, I identified exemplary quotations that illustrated each category and subcategory.

Selective coding. In Strauss and Corbin's (1990, 1998) grounded theory, selective coding involves selecting a tentative core category, and coding the data with that core category in mind. Throughout open and axial coding, I noticed that all participants made mention to the idea

of the “right therapist” and this being a critical factor in the decision to remain in therapy or to stop therapy. The open code “*the right therapist is the key to therapy (P016)*” was the hypothesized core category that seemed to tie all categories together (Strauss & Corbin, 1998). After axial coding was complete, I analyzed each transcript with the core category in mind. In this final round of coding, I examined categories and subcategories, and the relationships among them in search of selective categories that had the most conceptual connections to other categories. Core categories are theoretically saturated and pull all other variables together to form an explanatory whole (Strauss & Corbin, 1998; Larossa, 2005).

Trustworthiness

Guba’s (1981) criteria for demonstrating trustworthiness (credibility, transferability, dependability) were considered in the qualitative analysis. Though inherently, qualitative research is predicated on the assumption that there is no single version of reality, (Denzin & Lincoln, 2000) qualitative researchers take steps to ensure their research is trustworthy and their procedures can be replicated. I consulted with a peer debriefer on a weekly basis during the period of data collection and analysis (October 2014-December 2014). Using a peer-debriefer ensured credibility by ensuring that the primary researcher maintains a balanced level of closeness and distance in relationship to the data (Guba & Lincoln, 1981).

Second coders ensured credibility, trustworthiness and transferability. The 19 transcripts were divided among four researchers, with three researchers reading five transcripts and one researcher reading four transcripts. Researchers who were trained at the master’s level coded each transcript using open, axial and selective coding procedures. I compared my open and axial codes to the second coder’s open and axial codes, respectively. The codes assigned by the second coders were consistent with my codes. I noticed that I assigned more codes than the

second coders. This additional perspective of a second coder supported credibility and trustworthiness by ensuring that my bias did not unduly influence the data analysis.

A rich, thick description was used to ensure trustworthiness, credibility and transferability (Strauss & Corbin, 1990). I used numerous quotations from participants in the final write up of my results to ensure that I accurately represented the participants' experience. Providing several quotations from participants allows the reader to experience the data first hand, and clarifies the connection between the data and the categories and themes.

Triangulating qualitative data with quantitative data also ensured trustworthiness, credibility and transferability by allowing me to draw conclusions from more than one data source. Triangulation involves drawing multiple data sources together and is ensured through the use of a mixed methods design, bringing together interviews and surveys (Guba, 1981). Analytic triangulation is ensured through the use of grounded theory analysis and quantitative logistic regression analysis.

Quantitative Strand

Survey Research

Survey research is intended to describe, explain and explore unique facets of participants' experience (Nelson & Allred, 2005). Further, survey methodology is well suited for use in mixed methods studies. The tailored design method was used to guide the development and implementation of the survey in the present study (Dillman, 2007). The tailored design "is the development of survey procedures that create respondent trust and perceptions of increased rewards and reduced cost for being a respondent, which take into account features of the survey situation and have as their goal the overall reduction of survey error" (Dillman, 2007, p. 27). The intended outcome of using the tailored design is to obtain high quality data with high

response rates and reduced survey error (Dillman, 2007). Tailored design procedures were used in item writing, developing a questionnaire, and implementation of the instrument (Dillman, 2007). The following design considerations were used in the development of this survey to facilitate collection of accurate, valid data and willingness and ease of participation. Brief and simple instructions were carefully crafted to provide a clear understanding of the requirements of participants (Dillman, 2007). Items were clearly worded to ensure interpretability (Dillman, 2007). The formatting of the survey is intentionally simple, and questions are designed to be clear and easily followed (Dillman, 2007).

Web-based survey research. A web-based survey instrument was well suited for the present study in several ways. Web-based surveys allow researchers to collect information from more participants at a lower cost than paper and pencil format (Fowler, 2009). I noticed, during qualitative data collection, that the majority of participants were hesitant to disclose negative therapy experiences and dissatisfaction with their therapist. Participants qualified these statements with phrases like, “I’m not talking bad about her” or “she was a nice lady”. I also noticed the majority of participants reported satisfaction with the current therapy and current therapist. In the quantitative phase of the analysis, I hoped for more even variation in participant experience. Specifically, I hoped more people who were dissatisfied with therapy and their therapist would volunteer to participate. A web-based quantitative survey allowed participants to remain anonymous, which increases the likelihood of disclosing a wide range of therapy experiences. Additionally, an Internet-based survey platform, (QuestionPro[©]) allowed me to give incentives without collecting identifying information (email, address, phone number) (Fowler, 2009).

A potential concern about using web-based surveys is the potential for sampling bias. Using the Internet for survey research limits the participants to those who have access to computers and the Internet. Given the increasing availability of the Internet, this was not enough of a concern to warrant using paper and pencil methods. I was confident that enough elements of the population I aimed to sample had access to the Internet and that using the Internet would not limit data collection.

Sample

The population for the quantitative strand was also adults (over age 18) who are current clients of MFTs being seen in a general therapy clinic. A convenience sample of 72 (N= 72) participants was recruited from community and university based therapy centers. The sample was obtained from the following university and community-based therapy centers: The Family Therapy Center at Virginia Tech, the Koslow Center at Fairfield University, The Center for Individual, Couple and Family Therapy at the University of Nevada Las Vegas and Kayenta Family Therapy Centers. All university based therapy centers are formally affiliated with Commission on Accreditation in Marriage and Family Therapy Education (COMFTE) accredited training programs.

I also collected quantitative data from the qualitative interview participants. After reaching theoretical saturation with 19 participants, I continued quantitative sampling until achieving sufficient statistical power. Achieving sufficient statistical power is an important component in avoiding Type II errors, and is more important than sample size (Tambling & Anderson, 2014). A preliminary G* power analysis for a logistic regression, with an odds ratio of 2.33, alpha of .05, suggested a sample of 67 participants to achieve a statistical power of .80 (Faul et al., 2007). Manual calculation of sample size using an effect size of .33, alpha level of

.05 suggests a sample of 72 participants to achieve a statistical power of .80 (Howell, 2010). It was necessary to continue sampling qualitative participants beyond the amount of participants needed for the qualitative strand. Quantitative survey data were collected between October 1, 2014 and February 20, 2015. Though the survey was administered in a web-based format, participants were recruited through community and university based treatment centers. Maintaining similar recruitment strategies for the qualitative to the quantitative strands ensured that the samples were comparable.

Potential participants were informed of the study, the requirement of participants and the incentive through recruitment posters and flyers in the waiting rooms of therapy centers. A small poster was displayed next to a table holding a stack of small flyers for distribution. Recruitment flyers (see Appendix G) contained the Internet link to the survey, the purpose of the study, instructions, and the incentive. The flyer stated that participation was confidential, there were no consequences for choosing not to participate, and also included the researcher's contact information if potential participants wanted further information. The recruitment flyer also advertised an incentive, a \$5 Amazon[©] gift card.

Procedures

The Internet-based version of the survey was administered using the survey portal, QuestionPro[©]. An Internet-based survey allowed for data collection from a wider variety of participants, in a way that was less intrusive to the therapeutic process, and more confidential than completing the survey in the center. Further, collecting information about participant perception of therapy productiveness using a web-based method provided increased anonymity, necessary for participants to disclose positive, and less-than-positive perceptions. This decision resulted from observations made during qualitative sampling, in which participants who

volunteered felt overwhelmingly positive about their therapist; those who had less-than-positive perceptions of their therapist were reluctant to disclose.

The first page of the survey was the study consent form, which participants were required to sign before continuing to the survey (See Appendix H). The gift card was given directly through the survey platform, QuestionPro[©] and no identifying data were gathered in order to give the \$5 Amazon[©] gift card. Sixteen potential participants viewed the survey, but did not answer any questions.

Measures

Productiveness. This instrument was designed specifically for the present study to quantitatively measure clients' perceptions of the productiveness of change processes and the degree to which these change processes influenced their decision to remain in therapy. The instrument can be found in Appendix F. The root question was "Therapy is most productive for me when." Response categories along a five point Likert scale are: 1= Does Not Apply 2= Not Productive, 3= Somewhat Unproductive, 4= Somewhat Productive, 5= Very Productive. A neutral response category is intentionally not included, as I aimed to encourage participants to make a decision between productive or unproductive responses (Dillman, 2007). The instructions stated that the "does not apply" response should be used when the given change process did not occur. An example of an item is "our therapist helps us clarify our therapy goals". A score of two or three indicated change processes were unproductive and a score of four or five indicated change processes were productive. A higher overall score means a higher level of perceived productiveness.

Design procedures for the Productive Change Processes Inventory (PCPI). The purpose of the PCPI was to measure clients' perception of how productive change processes

impacted their decision to continue therapy. I reviewed and analyzed qualitative findings of studies of helpful and pivotal change processes in couple and family therapy for common or recurring themes. Studies reviewed were Blow and colleagues (2009), Christensen and colleagues, (1998) Helmeke and Sprenkle, (2000) and Wark (1994). Reoccurring themes, those found in two or more study results were flagged for use in construct development. Once the researcher had identified reoccurring themes (six themes were identified), the researcher determined that these themes could be collapsed into four constructs that could be used to classify all results. Constructs were: therapeutic alliance factors, process factors, locus of control and therapeutic timeframe factors. A construct map can be found in Appendix I. Items were then created that are aimed to operationalize and measure the constructs identified. Items intended to measure the same construct were written in several different ways. Multiple versions of each item were included in the initial item pool.

I used the following procedures to ensure face, content and construct validity. Obtaining feedback from both laypersons and experts supported validity. Expert reviewers were a university professor and a doctoral candidate in marriage and family therapy who have designed measurements and conducted independent research. Expert reviewers are familiar with the topic area. Layperson reviewers are seven adults intended to represent individuals who may seek services in a community mental health clinic.

Face validity refers to the degree to which the PCPI looks like it is appropriate for measuring what it intends to measure. Having the words “productive change processes” and “staying in therapy” in the title, address face validity. Both expert reviewers reported the PCPI looks like it measures perceived productiveness of change processes and the decision to stay in therapy. Both expert reviewers reported that the PCPI looks like it measures productive change

processes. Further, all seven layperson reviewers agreed that the PCPI looks like its purpose is to measure productive change process and the decision to stay in therapy.

Content validity refers to the extent to which the PCPI truly represents the abstract construct of productiveness of change processes (Pedhazur & Schmelkin, 1991). To address content validity, I have operationalized constructs represented in the extant literature into variables through writing items. A strong connection to existing literature is an important step in demonstrating content validity. The items change processes identified in each item, as well as the language used to talk about these change processes are directly from the findings of qualitative studies on productive change processes (*e.g.* Christensen et al., 1998; Blow et al., 2009; Helmeke & Sprenkle, 2000; Wark, 1994). I asked two experts in MFT to assess content validity. I created a spreadsheet, in which column one contained the construct and appropriate citation from the literature, in the second column, the item intended to measure that construct (See Appendix J). In column three, I asked reviewers to indicate their assessment of the degree to which the item represents the construct. Resulting from the expert review, I re-worded one item that the expert believed did not accurately reflect the intended construct, and I removed one item that was determined to be qualitatively different than the others. Further, I solicited feedback from colleagues and lay people who have been to therapy. I also asked for feedback on item clarity and length. Survey reviewers were asked to comment on content validity in addition to face validity.

Principle Components Analysis

After the data were gathered, a principle component analysis (PCA) was conducted. Though a PCA must be conducted post hoc, the results are useful for researchers who may use the PCPI in future research studies. PCA is a useful data reduction technique for reducing a

large number of factors down to a smaller number of components that describe the relationships among observed variables, or to test the underlying process (Tabachnick & Fidell, 2013). In other words, PCA reveals the data's internal structure that best explains the variance. PCA is particularly suited for use as an exploratory analysis to support construct validity by showing the components being measured by items (Tabachnick & Fidell, 2013).

The PCA was guided by the research question, what components of the productive change processes inventory (PCPI) account for the most variance in change processes productiveness? Seventy-two cases were analyzed in the PCA. I first examined the scree plot (see Appendix K) to determine the number of components contributing unique variance. The number of components extracted was based on the eigenvalues, and consistent with scree plot results, SPSS extracted three components. Component loadings are presented in table 1.

Tabachnick and Fidell (2013) recommend using varimax rotation when the solution is hypothesized to be orthogonal and when the goal is to simplify the number of factors by maximizing variance of the loadings within factors and across variables (Tabachnick & Fidell, 2013). Varimax rotation is the most commonly used rotation type of all rotations available (Tabachnick & Fidell, 2013). Kaiser-Meyer Olkin measure of sampling adequacy was conducted and sampling adequacy was determined to be .769 with 16 variables and 72 participants. A score over .4 is generally accepted as adequate, indicating the present sample is acceptable for PCA (Tabachnick & Fidell, 2013). Bartlett's test of sphericity was conducted to determine if there is at least one meaningful correlation among the dataset. Bartlett's test of sphericity ($\chi^2 (120) = 653.57$, $p < .001$) indicates these data were adequate to conduct PCA.

Table 1.

Component Loadings for PCA Components

Item	Component 1 Productive Interpersonal Processes	Component 2 Relational Change Processes	Component 3 Therapeutic Progress Markers
PCPI 7*	.872**	-.013	.181
PCPI 9	.836	.099	.227
PCPI 8	.794	.231	.016
PCPI 11	.621	.307	.413
PCPI 10	.581	.521	.116
PCPI 12	.564	.533	.254
PCPI 16	.511	.405	.374
PCPI 17	.060	.904	-.082
PCPI 13	.074	.745	.225
PCPI 14	.171	.742	.017
PCPI 15	.308	.706	-.049
PCPI 6	.494	.528	-.172
PCPI 2	.111	.495	.417
PCPI 3	.090	.075	.805
PCPI 5	.100	-.109	.724
PCPI 1	.215	.080	.722

* Items (questions) are found in Appendix F

**Values highlighted in grey indicate these items load onto the same component.

Three components are evident in these data, as three components have an eigenvalue greater than one, indicating that this component structure fits these data. The three components explained 63.1% of overall variance (see Table 2). The first component explained 39.9% of variance and included items related to therapeutic alliance, for example “our therapist makes us feel safe and comfortable”, “the therapist’s pace is comfortable”, and “the therapist makes us feel hopeful we can reach our goal”. The second component accounted for 13.9% variance, and included items related to relational change processes. For example, talking to one another in session instead of only talking to the therapist, talking about the problem together after session, and individual changes lead to relational changes. The third component accounted for 9.3%

variance and included items related to evaluating therapeutic progress. For example “something productive happens each session”, “subtle changes happen gradually” and “small changes happen early in therapy”.

Table 2.

Eigenvalues for PCA Components

Component	Total	% Variance	Cumulative % Variance
1. Productive Interpersonal Processes	6.40	39.9%	39.9%
2. Relational Change Processes	2.26	13.9%	53.8%
3. Therapeutic Progress Markers	1.48	9.3%	63.1%

Reliability Analysis of the PCPI

Reliability of the instrument was measured using internal-consistency reliability, Chronbach's alpha (Pehauzur & Smelkin, 1991). Internal-consistency reliability was used because it is most sensitive to the degree to which items on a measure are representative of the domain of the construct being measured (Pehauzur & Smelkin, 1991). Further, Chronbach's alpha yields the highest reliability estimate of all methods, is closest to actual reliability and is appropriate for use with Likert response scales. The standard cutoff score for acceptable reliability of .70 will be applied (Nunally, 1978). Chronbach's alpha was $\alpha = .89$, indicating high internal consistency reliability, as $\alpha = .7$ is a generally accepted cutoff score (Nunally, 1978). Item four, “we revisit an important topic several times” was removed from the scale, as it did not contribute to reliably measuring the intended construct. All other items in the scale contributed to increasing internal consistency reliability of the PCPI.

Goal Attainment. Progress toward goal attainment was measured using a single item measure, modified from the *Immediate Outcome Rating Scale (IORS)* (Adams et al., 1991). Permission to use and modify the IORs is found in Appendix L. The IORS is intended to assess

improvement in the presenting problem and overall functioning. Adams and colleagues (1991) adapted this measure from an earlier measure created by Sprenkle, Piercy, Constantine and Denton (1983). The item used in the present study asks clients to rate change in the status of the presenting problem since beginning therapy. The item asks, "Since beginning therapy, the problem is". The five-point Likert responses are; 1= Much Better, 2= Somewhat Better, 3=About the Same, 4=Slightly Worse and 5=Much Worse (Adams et al., 1991). Response categories one and two are considered positive perception of progress toward goal, while four and five are considered negative progress toward goal and response category three is considered neutral.

Intended retention. Participants' intentions toward the future of therapy are measured using an item written for the purpose of the present study. The first item asks participants to choose the response that best described how they feel about continuing therapy. Response categories are: 1 = I will stop therapy because I have made my desired change, 2 = I will continue coming to therapy because I am making good progress toward change, 3 = I continue coming to therapy but I am not making progress toward change, 4= I will stop therapy because I am not making progress toward change and 5 = None of these apply to me. Responses two and three are modified from the *Termination Status Form (TSF)* (Adams et al., 1991). Permission to use and modify the TSF is found in Appendix L. Responses one and two are considered positive intentions to remain in treatment, indicating that the participant has made the desired changes, or will remain in therapy until making the desired changes. The later two responses are considered negative intentions to remain in treatment, as they indicate lack of perceived progress because of therapy. For the purpose of conducting a binary logistic regression analysis, responses one and two were coded as, "intention to stay in therapy" = 1 while responses three and four were coded

as, “intention to drop out of therapy” = 0. These response categories intentionally include indicators of participants’ perceived therapeutic progress. As previously described, for the present study, retention is defined as intention to remain in therapy until participants have made progress toward attaining their goals. Premature dropout is defined as intention to end therapy before participants have met their goals (made progress toward change).

Therapeutic alliance. Therapeutic alliance will be measured using the *Working Alliance Inventory, Short Revised (WAI – SR)* (Hatcher, & Gillaspy, 2006; Horvath, 1981, 1982). Permission to use the WAI is found in Appendix L. This revision of the WAI short form appears to have superior psychometric properties to the original short form (Hatcher, & Gillaspy, 2006). This 12-item self-report measure assesses client perception of the therapeutic alliance along a 5-point Likert scale (1=Always, 2= Very Often, 3=Fairly Often, 4=Sometimes and 5=Seldom), on the dimensions (subscales), of bond, task and goal (Bordin, 1979, 1994). This shortened form of the inventory maintains acceptable internal consistency ranging from $\alpha = .90$ to $\alpha=.92$, while reducing participant burden (Horvath & Greenberg, 1994; Kneer et al., 2011). Test-retest reliability yielded a score of .83 (Horvath & Greenberg, 1994; Kneer et al., 2011). Horvath and Greenberg (1989) found initial support for convergent and discriminant validity of the WAI. All items are positively worded, and no items require reverse coding. Items 4, 6, 8 and 11 measure goal, items 1, 2, 10 and 12 measure task, and items 3, 5, 7 and 9 measure bond. A higher score (closer to five) indicates a positive perception of therapeutic alliance, while a lower score indicates lower perceived therapeutic alliance. The WAI scale score is the mean for the total scale, therefore, the WAI scale score is obtained by calculating the mean. Subscale scores were obtained by calculating the mean of the items that load onto the particular subscale. For example, the task subscale mean was calculated by taking the mean of items 1, 2, 10 and 12. For the total

scale, Chronbach's alpha was $\alpha = .93$, indicating high internal consistency reliability, as $\alpha = .7$ is a generally accepted cutoff score (Nunally, 1978).

Data Analysis

Logistic regression was best suited for use in the present study because it predicted membership to one of the two categories (intention to stay in therapy or intend to drop out of therapy) of the outcome variable (Tabachnick & Fidell, 2013). It was necessary to conduct preliminary data analyses to ensure that predictor variables used showed a relationship to the dependent variable. All analyses were conducted using the Statistical Package for the Social Sciences (SPSS) version 22 (IBM Corp., 2013).

SPSS Missing Values Analysis (MVA) was used to identify the frequency of missing data and to test the pattern of missing data (IBM Corp., 2013). Results of missing data analysis show that out of 72 cases, 11 cases had missing data. Missing data accounted for 15.3% of the total dataset. Pattern analysis of missing data showed that data were missing completely at random (MCAR), with no discernable pattern. The Markov Chain Monte Carlo (MCMC) multiple imputation method was used to estimate and impute missing values (Gilks, Richardson, & Spiegelhalter, 1995). The MCMC algorithm was an acceptable estimation method for use in the present study because the missing data had no pattern (Gilks et al., 1995). Regression was used to estimate missing data, where cases with complete data generate the regression equation, and the equation predicts missing values for incomplete cases. Regression is a more sophisticated method for estimating missing data than deletion (Tabachnick & Fidell, 2013).

Tests of skewness and kurtosis were conducted on the continuous independent variables, therapeutic alliance (measured by the WAI) and productiveness (measured by the PCPI). The PCPI distribution is unimodal and positively skewed, as the mean falls to the right of the median,

with the majority of values falling on the left tail, and fewer cases in the right tail. The skewness value for the PCPI is 1.11, meaning the distribution is not symmetrical. Skewness for the WAI is 1.12, also indicates the distribution is not symmetrical. It is noteworthy that the skewness for the PCPI and WAI are almost identical.

Kurtosis value for the PCPI is $1.37 > 0$, meaning the distribution is positive, and too peaked, or leptokurtotic. Kurtosis value for the WAI is $.596 > 0$, meaning the distribution is positive. Though the distribution for the WAI is less dramatically peaked than the PCPI, it is still considered leptokurtotic. Though the PCPI and WAI showed similar skewness patterns, they differ in kurtosis. The WAI has a kurtosis value that is closer to zero, therefore, closer to normal kurtosis, while the PCPI shows a positive kurtosis. Given that I sampled current therapy clients, positively skewed data makes conceptual sense, that more participants perceived their current therapy as productive, therefore, the data are skewed to reflect a higher concentration of scores in values that correspond to high productiveness.

When performing an analysis with grouped data, such as logistic regression, outliers were tested separately within each group (Tabachnick & Fidell, 2013). Since these data were being prepared to conduct logistic regression, they were screened for the presence of univariate and multivariate outliers. Univariate outliers were identified by calculating z scores against the absolute value of among continuous independent variables (the WAI mean and the PCPI mean), cases with a standardized score greater than 3.29 ($p < .001$) are potential outliers (Tabachnick & Fidell, 2013). There are no outliers on the WAI total scale mean, WAI bond subscale, the WAI task subscale, or the PCPI mean because no cases had a standardized score greater than the cutoff score for significance, 3.29 ($p < .001$). One univariate outlier was present on the WAI goal subscale with a standardized z score of 3.46, which is greater than 3.29. The corresponding scale

score to this standardized score was a goal subscale score of 5, which is the lowest possible score on the WAI goal subscale. This low subscale score indicates that one participant felt complete disagreement with his or her therapist on the treatment goals. This was not common in this dataset, as the mean score was 1.82, indicating that many participants in the dataset perceived higher alignment with their therapist on the treatment goals. I decided to include this outlier in the dataset because this data point was collected from a member of the target population sampled and I believe this represents a unique facet of the phenomenon (Tabachnick & Fidell, 2013).

Multivariate outliers were screened using Mahalanobis distance test, which Tabachnick and Fidell (2013) identify as a recommended method for identifying multivariate outliers. “Mahalanobis distance is the distance from a case from the centroid of the remaining cases where the centroid is the point created at the intersection of the means of all variables” (Tabachnick & Fidell, 2013, p. 74). Mahalanobis values were calculated using linear regression in SPSS, which calculates values for Mahalanobis, Cook’s and leverage (IBM Corp., 2013). Once the Mahalanobis value was obtained, Mahalanobis distance could be calculated. Mahalanobis distance is calculated as chi squared with degrees of freedom equal to the number of variables being tested, in this case, two variables (PCPI and WAI were tested) (Tabachnick & Fidell, 2013). Through this calculation, one case (P010) emerged as a possible outlier, because it had a Mahalanobis distance value of .00117 is $< .001$. Cases with a Mahalanobis distance probability $p < .001$ are considered outliers (Tabachnick & Fidell, 2013). Upon close calculation of this value, examining extended decimal places I determined that this case is only extremely slightly more influential than other cases. Since this data point was collected from a member of the target population sampled, I decided not to reduce the slightly increased influence of this one case using a logarithmic transformation. As outliers were sampled from the intended population

(current therapy clients), but these data are positively skewed, (too many cases in the tail), the distribution from which the outliers are sampled has kurtosis that departs from the normal (Tabachnick & Fidell, 2013). Meaning, that the distribution of the population I sampled is different from a normal distribution.

The three main predictors in this analysis (goal attainment, therapeutic alliance and productiveness) were screened for multicollinearity. Variance inflation factor (VIF) and tolerance (T) were calculated in SPSS for the purpose of testing multicollinearity (IBM Corp, 2013; Tabachnick & Fidell, 2013). When goal attainment (as measured by the IORS) was tested with productiveness (as measured by the PCPI), results showed an absence of multicollinearity (VIF =1, Tolerance = 1). The same result emerged when therapeutic alliance (as measured by the WAI) was tested with goal attainment; there was an absence of multicollinearity (VIF =1, Tolerance = 1). Productiveness and each of the three therapeutic alliance subscales (WAI bond, WAI goal and WAI task) were tested for multicollinearity, VIF = 6.60; since this observed score exceeds the cutoff score of three, multicollinearity is likely present (Tabachnick & Fidell, 2013). Logistic regression is sensitive to high correlations among independent variables (Hosmer & Lemeshow, 1989).

Prior to conducting the primary data analysis (logistic regression), preliminary analyses were conducted to determine the relationship between each predictor variable and the outcome variable (Tabachnick & Fidell, 2013). Since the predictor variables are categorical, and measured on a likert scale, cross tabulation and chi square analyses were conducted to determine the strength and direction of the relationship among dependent variables and predictor variables.

Primary data analysis. The primary analysis method was direct logistic regression for the purpose of predicting membership in the categories of intended treatment retention or

intended dropout as a function of predictor variables, productive change processes, therapeutic alliance and goal attainment (Tabachnick & Fidell, 2013). Direct logistic regression is the method of choice if there are no hypotheses about the order of importance of the predictor variables, meaning that no single predictor is more important than others (Tabachnick & Fidell, 2013).

Univariate and multivariate binary logistic regression analyses were conducted to test the relationship between goal attainment, therapeutic alliance, productiveness and intended retention. Intended retention was independently regressed on goal attainment, therapeutic alliance and productiveness for the purpose of determining the effect of each variable on intended retention. Multivariate binary logistic regression analyses were conducted for the purpose of constructing and testing a model that best predicts intended retention based on these variables. A full model, containing the therapeutic alliance subscales of bond, task and goal (each was entered separately), goal attainment and productiveness (measured by a mean score of the PCPI component 1 and 3) was tested.

To ensure the best model fit possible, several goodness of fit tests were used to evaluate logistic regression models conducted. Goodness of fit for logistic regression analyses were assessed using Nagelkerke's R^2 statistic was used to assess the amount of variance accounted for by each regression model. The optimal range of Nagelkerke's R^2 value is between .20 and .50, which indicates that predictors in the model being tested account for 20%-50% of variance in the dependent variable (Tabachnick & Fidell, 2013). The Hosmer-Lemeshow test (Hosmer & Lemeshow, 1980; 1989) was used as an additional test of goodness of fit, as it is specifically designed for use in logistic regression models. The Hosmer-Lemeshow test is similar to a chi square test, as it tests whether the model being tested fits better than the constant. Therefore, a

favorable fit is indicated by a non-significant result of the Hosmer-Lemeshow test (Hosmer & Lemeshow, 1980; 1989). The ideal model is one in which individual predictor variables as well as the overall model account for significant variance. The *b* coefficients for each predictor variable were used to assess the variance each variable contributes to the model. Ideally, the variables that contribute to the significance of the overall model will be independently significant as well. According to the Wald criterion, variables with a significance value that is less than .05 do not make a significant contribution to the overall model (Burns & Burns, 2008).

Mixed Data Analysis

The final phase of this study was conducted for the purpose of determining the extent to which, and in what ways, results from quantitative and qualitative data strands converge or diverge. The mixed data analysis strategy was data comparison for the purpose of triangulation (Green et al., 1989; Onwuegbuzie & Teddlie, 2003). Data comparison produces a more complete understanding of the role of productive change processes in predicting intention to remain in therapy or intention to drop out (Creswell & Plano Clark, 2011). Data comparison involves comparing and contrasting quantitative and qualitative findings for the purpose of triangulating data sources (Green et al., 1989; Onwuegbuzie & Teddlie, 2003). Triangulating data sources involves drawing conclusions from more than one strand of data, (i.e. quantitative and qualitative) for the purpose of obtaining richer conclusions than would be possible by analyzing one data strand.

I triangulated data sources by examining common findings present in the quantitative and qualitative strands. I organized the mixed data analysis around the three main quantitative predictors (productiveness, therapeutic alliance and goal attainment) and examined areas of convergence and divergence with the qualitative findings. Examining the ways in which the

qualitative themes further explain the quantitative findings explain participants' experience of these factors in action.

Chapter 4: Findings

The purpose of this chapter is to present findings from the qualitative and quantitative strands of the present study. Results are presented by strand. Qualitative findings are presented first, followed by quantitative, and ending with mixed data analysis.

Qualitative Findings

The purpose of the qualitative strand of the present study was to understand the attributes of therapy that clients consider when making decisions about staying in therapy or dropping out. The research question that guided this strand of the present study was: What is the process by which change processes impact intended retention for individual, couple and family therapy clients? In the first half of this chapter, results of qualitative interviews will be presented. Quotes and excerpts from the interviews will be presented to both describe and enrich the findings. First, I will present demographic and descriptive information related to participants' assessment of therapy productiveness and the decision to stay in therapy or to drop out of therapy.

Demographic Data

Ten men (53%) and nine women (47%) ranging in age from 20 to 77 years old ($M = 41.3$, Mode = 50 and 53, $SD = 15.62$) comprised the qualitative sample. Thirty-seven percent ($n = 7$) of participants were married, while 26% ($n = 5$) were single, 16% ($n = 3$) were divorced and 16% ($n = 3$) lived with their partner, 5% ($n = 1$) was widowed. Of the 19 participants sampled, eight (42%) were in individual therapy, eight (42%) were in couple therapy, while one participant (5%) was in both individual and couple therapy, and two participants (11%) were in family therapy with their children and partner. Most participants who volunteered for the present study had completed more than nine sessions ($n = 11$, 58%). Six participants (31%) had completed

between five and eight sessions, while two participants (11%) had completed less than four sessions ($M = 2.23$, $SD = .87$, $R = 2$). See Table 3 for demographic data including age, gender, ethnicity, constellation, stage of therapy and participant description of the presenting problem.

Table 3.

Demographic Characteristics of Therapy Client Participants

ID	Age	Gender	Race	Constellation	Stage*	Presenting Problem
P001	29	F	White	Individual	Early	Anxiety
P002	25	F	White	Couple	Late	Anxiety
						Couple Issues
P005	31	M	Hispanic	Couple	Middle	Couple Issues
						Infidelity
P006	77	M	White	Individual	Late	Grief
P008	53	F	White	Couple	Late	Couple issues
						Bipolar Disorder
P009	31	M	White	Individual	Middle	Couple Issues
P010	43	F	White	Individual	Early	Family of origin issues
						Anxiety
P011	34	F	White	Couple	Late	Couple Issues
P012	23	M	White	Individual	Late	Addiction
P013	34	F	White	Family	Late	Depression
						Family of origin issues
P014	50	M	White	Family	Middle	Family of origin issues
P015	34	M	White	Couple	Late	Couple Issues
P016	50	F	White	Couple	Late	Domestic violence
						Couple issues
P017	53	Trans	White	Individual	Late	Gender Issues
						Addiction
P018	50	M	Hispanic	Individual and Couple	Late	Anger
						Couple Issues
P019	53	F	White	Couple	Late	Couple Issues
P020	20	M	White	Individual	Middle	Career problems
P021	31	F	White	Individual	Middle	Eating Disorder
						Couple issues
P022	32	M	White	Couple	Middle	Couple issues

*Stage of therapy is defined as: Early therapy (session 1-4), Middle therapy (session 5-8) and Late therapy, 9 or more sessions.

*Categories for Race are those used in the US census.

Prior to beginning the current course of therapy, 14 of 19 (74%) had a previous therapist, and stopped therapy because it was not productive. During interviews, participants explained their decision making process about how they arrived at the decision to stop therapy with one therapist, and re-start therapy with another therapist. The majority of participants reported satisfaction with the current therapist/course of therapy. Fifteen participants (79%) felt the problem was “much better” or “somewhat better” since beginning therapy with the current provider. The majority of participants also perceived a strong alliance with their current therapist ($M = 4.38$, $SD = .719$, $Min = 2.00$ $Max = 5.00$). Participants also perceived the current course of therapy as productive ($M = 4.31$, $SD = .638$, $Min = 2.35$, $Max=5.00$). Fourteen (74%) participants intend to continue therapy with the current provider until making the desired changes. Two participants intend to stop because they have not made change, one participant was ready to end therapy because change had occurred, while two participants selected “not applicable”. These data are presented in Table 4.

Table 4.

Demographic data relevant to decision to drop out or stay in therapy

ID	Previous Dropout	Goal Attainment (Since starting therapy the problem is:)	Intended Retention
P001	Yes	Somewhat better	N/A
P002	No	Much better	Continue, making progress
P005	No	Much better	Continue, making progress
P006	Yes	Much better	Continue, making progress
P008	Yes	Much better	Continue, making progress
P009	Yes	Much better	Stop, I've made change
P010	Yes	Somewhat better	Continue, making progress
P011	No	Much worse	Continue, making progress
P012	Yes	Much better	Continue, making progress
P013	No	Much better	Continue, making progress
P014	Yes	Somewhat better	Continue, making progress
P015	Yes	Somewhat better	Stop, not making progress
P016	No	Much better	Continue, making progress
P017	Yes	Much better	Continue, making progress
P018	Yes	Much better	Continue, making progress
P019	Yes	Same	Stop, not making progress
P020	Yes	Same	Continue, making progress
P021	Yes	Much better	Continue, making progress
P022	Yes	Much worse	Stop, not making progress

*P001 selected N/A and explained that her decision would depend on finances

I tabulated the number of times each code was assigned and the number of participants who endorsed a given code. A frequency tabulation of the codes assigned is helpful for uncovering general trends across the entire dataset (see Table 5). The most salient themes that emerged from the qualitative data analysis were inextricably linked to the therapist. The environment the therapist creates, therapeutic relationship and interventions initiated emerged as salient elements of therapy considered when participants evaluated overall therapy productiveness.

Table 5.

Frequency Table of Saturated Open Codes

	Number of Participants who Endorsed Code	Frequency of Code Assignment
Client Factors		
1. It is of critical importance that the therapist understands the clients' desired changes	19	25
2. The problem being extremely important to resolve brings people to therapy	15	18
3. Severity of the problem brings people to therapy	13	17
4. Not being able to resolve the problem on one's own brings people to therapy	8	12
5. Expected therapy to take a long time	11	11
6. Opinions of friends and family members about an agency or a therapist influenced participants' opinions	5	10
7. Therapist is a guide in resolving the problem	4	4
8. Dropping out of therapy tells the therapist they don't get it	3	4
Therapy Process Factors		
1. The right therapist is the key to therapy	19	34
2. Participant felt comfortable and connected with the therapist	11	34
3. Therapists' interventions related to the participants' understanding of the problem and how to resolve it	12	20
4. Previous therapist did not understand what the participant needed from therapy, which lead to dropout	8	18
5. Being able to talk openly in therapy sessions leads to progress	9	10
6. Participant would be willing to correct the therapist	6	8
7. Participant would not tell a therapist they didn't think therapy was going well	5	7
8. Telling the therapist when therapy is not going well is intimidating	5	7
9. Lack of connection and comfort with the therapist lead to dropping out	4	7
10. Therapy was not productive when the therapist sided with one member of a couple over another	3	4
Evaluation of Progress		
1. Stopped therapy with a previous therapist because they were not making change	14	20
2. Noticing change means progress is happening	12	16
3. Recognizing progress between sessions	10	16
4. Change in an individual lead to change in the couple	7	7
5. Therapy is a process	5	7
6. Therapy can be beneficial even if stuck	5	5

Overview of Qualitative Findings

The process of deciding to stay in therapy or deciding to drop out of therapy was explained by the relationships among three key domains: (1) client factors, (2) therapy process

factors, and (3) evaluation of progress because of therapy. Participants' decision to remain in therapy or to drop out of therapy was the result of their evaluation of therapy progress. This evaluation of therapy progress began prior to starting therapy, and continued throughout the therapy process. Client factors had considerable influence over *how* participants evaluated progress because of therapy. Client factors (including expectations about therapy, motivation for change, and clients' assessment of the presenting problem and how to resolve it) play a crucial role in participants' evaluation of therapy, and thus, the decision to remain in therapy or to drop out of therapy. Once therapy had begun, participants immediately began evaluating therapy process factors (including; therapeutic relationship, the therapists' interventions, the therapists' pacing and timing and therapists understanding of the presenting problem and how to resolve it) for alignment with their expectations about therapy and their own understanding of the presenting problem and how to resolve it. The intersection of client factors and therapy process factors are important considerations during participants' evaluation of the progress made because of therapy. When therapy process factors align with client factors, participants perceived progress because of therapy, and were more likely to remain in therapy. When therapy process factors did not align well with client factors, participants perceived little or no progress because of therapy, and were increasingly vulnerable to dropping out of therapy. The qualitative results are organized according to these three domains. Within each domain, the relationships among each domain's subcategories will be presented and discussed.

Client Factors

Client factors emerged as a critical finding. Though client factors were in place before even beginning therapy, they contributed to clients' decision making about staying in therapy.

Client factors that contributed to clients' decision to stay in therapy or to drop out of therapy were: (1) presenting problem factors, (2) motivation and (3) expectations about therapy.

Presenting problem factors. Participants were asked what about the presenting problem influenced their decision to seek therapy. The most common response, endorsed by 15 participants, was the severity of the problem brought participants to therapy. Seeking therapy because of a severe problem was a theme that emerged for participants in individual therapy and relational therapy. Severe problems were described as causing a marked disturbance in participants' lives because of their high intensity and frequency. In other words, severe problems caused dire consequences that often lead to increased motivation to resolve that problem. For example, one said, "*I felt like I was going crazy. Like I couldn't control my thoughts and I couldn't control scenarios that go through my head*" (P010). Participants described seeking therapy when problems felt overwhelming or threatening to overall functioning and well-being. One, for example, stated, "*I had a very bad situation in my life where everything came together at once; everything went wrong in my life. And so I decided okay now I need to come to therapy*" (P001).

Severe problems carried severe consequences, thus making them highly important to resolve. When problems were severe and highly important to resolve, participants' approached resolving the problem with high motivation. Thirteen participants expressed that the severity of the problem and the consequences made it critically important to resolve. For example, one participant stated, "*I knew I needed to fix my problem or I wasn't going to be able to have a normal life* (P012) and *{the problem} was destroying my life*" (P018). This excerpt above demonstrates the importance of an urgent need to resolve the presenting problem. Another participant described seeking therapy because of severe depression and suicidal ideation. She

explained, *that specific problem was pretty important because I wouldn't have been here anymore* (P013). Quite literally, this participant felt that her life depended on solving the presenting problem.

Problem severity emerged as a theme across therapy constellations, equally important for participants of individual therapy and couple therapy. Relational problems were also identified as severe and carrying severe consequences. For example, one participant explained, “*My husband and I were arguing. That really causes me to just go insane and I snapped. Then I got placed in {hospital}*” (P008). When describing severe relational problems, the most commonly discussed severe consequence was ending the relationship. For example, one participant explained, “*{Resolving the problem} was extremely important because if not, me and my wife might not be together*” (P005). Another participant described that she and her partner were not willing to consider ending the relationship, therefore, resolving the presenting problem was of paramount importance. She said, “*divorce is not an option so we have to figure out a way to work everything out*” (P011).

Severe problems with severe consequences were of high priority to resolve. Many participants explained that resolving the presenting problem was their first priority. For example, a participant explained,

I got myself in a position where solving my problem is the #1 priority rather than a side thing. At the very beginning my therapist was asking me if I was committed to staying in therapy, and I said "I'd stay in therapy forever". I would do whatever it took (P012).

Participants explained that solving the presenting problem was their first priority at the time of beginning the current course of therapy. The above participant explained that solving the problem is currently a most critical priority, and everything in his life has become reorganized

because of that. The importance of prioritizing the presenting problem emerged among those in individual therapy and relational therapy. Participants in couple therapy explained that the problem was both members' first priority. One participant said, "*That was basically our number one priority and that's what we talk about {with the therapist} on day one*" (P011).

Motivation. Motivation to resolve the presenting problem emerged as an influential theme in the decision to remain in therapy or to drop out of therapy. Many participants described motivation as a state of readiness for change. For example, one participant said, *I think it was up to me actually. I think I had to be ready* (P001). One participant described feeling that until she decided she wanted change to happen, a therapist would most likely not be able to help her. She explained, "*Until I was ready to really let someone in, a therapist could have tried everything and I would of just said forget it*" (P001). This excerpt exemplifies the importance of participant readiness to accept responsibility for change.

Motivation to resolve the presenting problem was evident when participants discussed their own attempts to resolve the presenting problem. Almost all participants described attempts to resolve the problem independently, without therapy. Participants sought therapy when their own attempts to resolve the problem were unsuccessful. Failed attempts to resolve the problem without therapy emerged as a central theme when participants discussed the presenting problem that brought them to therapy. Participants' entry into therapy came after all personal resources had been exhausted, therefore, beginning therapy was similar to the admission that they were unable to resolve the problem. For example, one participant said,

The problem had gotten so out of control. I had tried so many other things- well I thought that I was trying other things and I like hit rock bottom and that made me realize that I was just out of control in who I was and the person I was (P002).

Another theme that emerged was who participants believed was responsible for change. The overwhelming majority of participants in the present sample believed they were responsible for change, not the therapist. In other words, participants recognized that it was not the therapist's job to "make them change", rather it was their task to do the changing. For example, one participant said,

In the first session I expected someone who would help me help myself, I guess. I've always understood it's not just them fixing you. Sometimes people come in and think, "my therapist is going to fix me" I never really felt that. I just knew I needed someone who understood what I was going through (P011).

The above excerpt illustrates the idea that even though participants believed change was their responsibility, they expected the therapist to guide them toward their desired change. When participants began therapy after being unable to resolve the problem, they were dependent on the therapists' ability to guide them in resolving the presenting problem. One participant described the moment she and her partner decided to begin therapy; *we looked at each other we said well, we can't seem to work this out so let's get a therapist involved (P011)*. The above excerpt illustrates the theme that participants begin therapy hoping that a therapist will be able to do something above and beyond what participants could do independently.

Expectations. Participants began therapy with expectations about the role the therapist would play, how the process of therapy would unfold and the outcome of therapy. Expectations contributed to participants' decisions to drop out of therapy or to continue therapy until reaching their goals. Participants were asked about their expectations about how long they would be in therapy before noticing results. One stated,

I didn't really have expectations, I think if I had an expectation it was that it would be a longer road as opposed to a shorter road or solution. I knew it would be several months rather than "oh we will sit down and in a couple weeks we will hash this sucker out and then we will walk out". I expected it to be several months' worth of work to be able to begin to work through the issues and I figured it was going to be pretty complex (P015).

This excerpt illustrates how this participant initially stated he had no expectations, and then went on to state his expectation that therapy would take more time than less time. This theme emerged in 11 of the 19 participants.

In addition to expectations about therapy timeframe, participants began therapy with expectations about the therapist. One participant described expecting the therapist to fit stereotypical characteristics, “*When we came I expected this old dude or old lady because of all the movies and programs. You have the guy looking at you with the glasses, writing notes*” (P005). Another participant explained that she expected her therapist to be judgmental, “*I think I expected a lot of judgment and a lot of "how does that make you feel", not really listening*” (P013). Another participant expected that the therapist would be a guide through the process of change. *In the first session I just expected someone who would help me help myself I guess* (P012). This theme fits with the theme discussed above about participant motivation, and recognizing change was the responsibility of the client, not the therapist. Participants expect a therapist will be able to guide them through the process of helping themselves. Expectations are a critical factor in the decision to stay in therapy or to drop out of therapy. One participant explained that with her first therapist, she dropped out of therapy after about four sessions, “*...it wasn't a terrible experience. It just didn't meet... it wasn't the right match*” (P010).

Eleven participants began therapy with expectations about how long they would be in therapy. One participant explained, “*Well no I had expectations. I wouldn't have done it if I didn't. I had expectations that I could work through some issues. And hopefully get a start on fixing the problem*” (P006). This participant explained that therapy would be a platform for her to work through the presenting problem.

Choice of therapist. Once participants decided that therapy was necessary in order to resolve the presenting problem, choosing the therapist became a salient consideration. Five participants identified family and friends’ endorsement of a therapist or an agency as important in their decision to stay in therapy. Participants were more hopeful that therapy would be helpful in resolving the presenting problem when someone they knew has had a positive experience. For instance one explained, “*I know a friend who goes to counseling here, and she also said, "Oh my therapist is amazing". So I will give therapy the benefit of the doubt*” (P001). Participants felt more confident about going to therapy when someone they trust endorsed a therapist or an agency. Just as participants accepted recommendations or referrals from friends, participants were also willing to provide referrals to friends. One participant explained, “*I have talked to people and told them to go to {agency}...I said they have helped my husband and I tremendously and saved our marriage*” (P008). Participants seemed to understand how important it was when someone they trust endorsed a therapist or an agency, therefore, they were willing to endorse their therapist or agency to friends and family. Receiving an endorsement from a trusted friend or family member raised participants’ expectations that therapy would be productive.

Presenting problem factors, motivation and expectations about therapy are client factors that contribute to participants’ decision to stay in therapy or to drop out of therapy. Participants evaluate therapy process factors in relationship to their understanding of the presenting problem,

motivation and expectations for therapy. From this perspective, client factors are instrumental because they set the stage for therapy.

Therapy Process Factors

Once therapy begins, participants almost immediately evaluate therapy to determine whether they want to stay in therapy until meeting their goals, or drop out of therapy before meeting their goals. The evaluation process is iterative and continuous throughout the therapy process. Emergent therapy process factors are (1) therapists understanding of the problem, (2) therapeutic relationship (3) therapist's interventions, and (4) pacing and timing of interventions. These factors were most often identified when participants were asked to describe what happened in therapy that lead to the most change. Alternatively, when participants described the factors they considered when deciding to drop out of therapy, they often mentioned a problem in one of these areas.

Therapists' understanding of the problem. Participants assessed therapy process factors at the outset of treatment, sometimes, even before the first session. One participant describes her ambivalence about attending her first scheduled therapy session because of her first interaction with her therapist on the telephone,

Before my first session I considered dropping out of therapy. I don't like to say it because I feel bad for {the therapist}, but I could not understand her on the telephone. Her accent was very thick and it was very difficult for me to understand what she was saying and I thought, if I can't understand her on the telephone how would I be able to understand her in a clinical setting (P001).

During the initial phone call, in which scheduling the first session was the goal, this participant was assessing her therapists' ability to be helpful to her. The above excerpt illustrates that

participants begin evaluating therapy productiveness before the first session even occurs. This participant also explained that her concern was related to the therapists' ability to understand her, and the presenting problem.

All 19 participants found it critically important that the therapist understands the presenting problem and the therapy goals. When asked how important it is that her therapist understands her presenting problem and goals, one participant said,

Oh it's very important. {Therapy} would be a waste of my time if they didn't understand}. If they don't understand the problem, it would be like talking to one of my friends...I'm going to see somebody who has been educated to see through the words that I'm telling them to see what is really underlying (P010).

This quotation exemplifies the major theme of the importance of the therapists' understanding of the problem. This participant explained that therapy would not be effective if the therapist didn't convey an understanding of the presenting problem.

How participants assessed therapists' understanding of the problem. When evaluating the therapists' understanding of the problem, the clients consider things the therapist does in session. For example, one participant described feeling understood by the way her therapist reflects what she says,

Sometimes patience, just being patient. Sometimes it is reflecting and talking. She doesn't just repeat back what I say. It's the way it's repeated that lets me know I was really heard (P013).

Another participant explained that he knows his therapist understands the presenting problem when the therapist is active in structuring the session. This participant said, “{The therapist}

repeats it back - then he let me {talk} for a little bit, and then he stop me and we think about certain parts (P012).

When assessing the therapists' understanding of the presenting problem, participants considered their own responses to things the therapist said. One participant explained that he knew his therapist understood the changes he wanted to make when he noticed himself expressing things he never had before. He said,

She hit the right points in my life and she dragged things out of me that I probably, if they didn't understand what I was going through, I would never have been able to answer those questions (P018).

Another participant noticed that the therapists' questions made him feel like he was making progress, and also that he was able to be open and truthful with the therapist.

It's just the line of questioning, the way the therapy session goes you get the feeling that you're working towards something it's like you're not arguing or you're not I'm not always trying to justify myself per say I'm not always trying to hide stuff (P017).

Therapeutic alliance. Eleven participants endorsed the importance of the therapeutic alliance to their decision to stay in therapy or to stop therapy. The therapist's understanding of the problem is so important because it allowed participants to form a stronger connection with the therapist. For example, one participant said,

I feel like I could connect with them better if they understand {the problem and the goals}. If I were to say something, I would feel like they really understood and not just say that they did. I like that they understand what I'm talking about (P012).

The therapists' understanding of the presenting problem and the therapy goals form the basis for the therapeutic relationship. Participants explained that the relationship between therapist and

client is forged over the therapist's ability to convey an understanding of the presenting problem. Participants described the process of building an alliance with their therapist as similar to building relationships with friends. One participant said:

You need to look at it as how you would go about building a friend relationship. There's a lot of times you meet somebody 1-2 times you know we're not going to ever be buds and hang out. There are other people that have that feel you can comfortably talk to. Build it as you're looking at or determining if that person can be your friend. You don't have to be friends but you have to have that feel. That's how I would best describe how to determine if you're getting anything from your therapist (P014).

Though participants were clear about the idea that the therapist is not a friend, they wanted the same level of comfort as exists in a friendship.

The importance of therapists remaining non-judgmental emerged as a theme. Nine participants endorsed the importance of being able to talk openly in session as critical to their decision to stay in therapy or to stop therapy. One participant said, “*When I'm in my sessions I feel validated. Someone was listening to me without judgment*” (P010). Another participant said, “*I was comfortable with her and I knew she wasn't going to judge me on the way I look or the way I was raised. She was just going to take it in and be like okay, this is how this guy was*” (P005). These two excerpts exemplify how non-judgmental listening lead to participants’ feelings of comfort and connection with the therapist.

Three participants in relational therapy felt comfort and connection with the therapist when the therapist remained neutral. When participants perceived the therapist siding with their partner over them, the participant felt that change was not happening, and considered stopping therapy. For example, one participant said,

There were times where I felt {the therapist} was making excuses for {my husband's} behavior and my issues weren't being addressed (P016).

This participant felt that her point of view was not being heard or addressed, which lead her to consider stopping therapy. Also, participants noticed and appreciated the therapists' balanced approach:

I like this therapist because she seems to be much more neutral and will state how we both need to handle a situation. So she'll tell my wife and I this is how you guys need to deal with this. But she'll also go to my wife and say you're a key critical component and you need to do x y and z (P014).

Comfort and connection is a critically important therapy process factor because it is connected to therapy progress. Four participants endorsed this theme. One participant expressed that family therapy did not yield progress until her daughter felt comfortable with her therapist.

She seemed depressed from when she was a little girl and I didn't know why. I kept bringing her to different therapists and it just never seemed to get anywhere. We have gone through a few therapists with my daughter. But this therapist has a disease my daughter has, and they have similar backgrounds, so they really connected. It's interesting because the therapist is so much older than my daughter is but they just have this connection (P013).

Though a connected and comfortable therapeutic relationship is necessary for change to happen, it was not the sole factor identified as important in contributing to change. Eight participants expressed that a therapeutic alliance alone is not enough to produce change. One participant explained,

I have said that many times because we've been through 3-4 different {therapists}. It's something I don't feel so comfortable with because it doesn't ever truly help. The last lady was a little more empathetic to the situation and tried to work through it but change never seemed to truly happen (P014).

This participant articulated feeling comfortable with a previous therapist, however, change never happened. This participant ultimately dropped out of therapy with this particular provider because change was not happening. Another participant explained her experience of beginning therapy with a therapist whom she felt connected to and comfortable with, however, change did not happen.

She was a very nice lady. She was probably too nice. She was very passive. Didn't really talk much. I needed some direction. She wouldn't take very many notes. I have a tendency to go off on tangents and I need someone to hone me back in. She didn't do that. There were times where I was like what was my point again? And she would say, "I'm not sure." She wasn't there with me. She wasn't there in my conversation (P010).

This participant stopped therapy with this therapist because she did not provide enough structure to the therapy process. This excerpt explains how the therapist did not understand that the participant was looking for direction and structure from the therapist.

Therapists' interventions. When evaluating therapy productiveness, participants evaluated the therapists' interventions. Twelve participants endorsed the importance of the degree to which interventions reflect therapist's understanding of the presenting problem and the therapeutic relationship. I asked participants what happened in therapy that they believe lead to therapeutic change. Most all responses contained an intervention initiated by the therapist. Participants identified interventions as effective in leading to therapeutic change when the

intervention fits with the clients' understanding of the problem, and fits with how the client changes. Additionally, participants explained their perceptions of interventions that were not effective in leading to therapeutic change.

Interventions that were identified as effective in leading to change were perceived as specially devised to fit the participant's presenting problem and personhood. For example, one participant explained how she perceived her therapists' approach and why it was effective. She said,

I really liked her approach. {The therapist} let me tell her what I was looking for. That was good for someone like me who is controlling. She asked me to write down what I thought were my problems, and then she also had me do homework after each session. Most therapists would just say, 'oh, I see your dealing with anxiety, so what's on your mind right now?' rather than saying, 'What's your history? (P001)

This excerpt illustrates how this participant noticed that her therapist understood her anxiety, and devised a collaborative treatment approach and interventions that fit with her personhood and presenting problem. Participants appreciated when therapists conveyed an understanding of the presenting problem, and provided a course of action for how to begin resolving the problem. In other words, participants appreciated therapists who provided their formulation. For example, one participant explained her experience,

Day one {the therapist} listened. {my husband} would talk, then I would talk and then she said alright well I have some ideas and she kind of at the end she talked for maybe five minutes and just said well you know here's what you can do right now to calm things down. Then after three or four sessions she met with each of us individually and she

spent time and again just listening. Then when we got back together as a couple she had a laundry list. She just nailed it. She pinpointed okay a, b, c, and d (P011).

This participant explained that her therapist listened to each person's understanding of the problem and provided feedback on how to begin the change process. The therapists' formulation fit with the client's understanding of the problem. Participants often expressed their appreciation for therapists who could provide a revolutionary understanding of the problem. One participant explained,

She pin pointed my problem and I never saw it the way she saw it and brought it to my attention. And that sealed the deal. I want to come back and I want to see this woman again (P010).

Although this participant explains that the therapist introduced a new way of looking at the problem, he says she "pin-pointed" the problem. This excerpt explains how the therapist introduced a new way of looking at the presenting problem that was still consistent with the participants' understanding of the problem.

Participants in relational therapy identified interventions as productive when they targeted the relational processes that contributed to the presenting problem. For example, one participant sought couple therapy because of communication problems. When asked what lead to the most change, he said,

I think it's when she got us practicing reflective listening and talking, when the focus was taken off of a triangle, where we were talking us to her and her to us. And then it became a focus of the two of us talking to each other. Taking what we heard and absorbed from the session and then took that and bounced those thoughts and that information back to each other (P015).

This example illustrates how the intervention of reflective listening fit with the participants' presenting problem, and their understanding of how to resolve it. Participants also explained that interventions that did not fit with client factors were not helpful in leading them to change. Specifically, when interventions did not fit with the participants' understanding of the problem, they were not helpful in leading to change. For many participants, this disconnect lead to the participant feeling that change was not occurring, and deciding to drop out of therapy. For example, one participant explained his decision to drop out of therapy in relationship to the therapists' interventions. He explained,

I just felt like the therapist was making broad generalizations a lot of the time. Was like jumping to a conclusion that she had believed was right and was running with it. Like it really didn't identify with us at all. But it's like you almost couldn't get her off of that track (P009).

Another participant described an unproductive therapist as having her own agenda. He explained, "You know they seem to be trotting the path that other ones had trotted and it lead nowhere" (P006). It was also unproductive when therapists attempted to give solutions that were incongruent with the participants' understanding of the problem.

I felt like she just wanted to have an answer, she just wanted to solve it. She just wanted to be the one to fix it. My problem isn't really fixable like that. Its not like I can take a pill and fix it (P012).

Timing and pacing of interventions. In addition to evaluating the interventions, participants evaluated the pacing and timing of interventions initiated by the therapist. Participants were particularly sensitive to interventions that seemed inappropriate for their current stage of therapy. In other words, participants wanted therapy to move at a gradual pace,

and often described feeling that therapy was moving too quickly. For example, one participant said, “*We only did like 2 or 3 sessions but it felt like we were doing things that probably should have been done in session 5 or 6*” (P009).

Pacing and timing was important to participants because it was a cue that the therapist had an accurate understanding of the presenting problem, and the participants’ needs. Another participant described his experience of dropping out of therapy because the therapist jumped to a conclusion too quickly about the nature of the problem. The therapists’ understanding of the problem and how to make progress toward it did not fit with the clients’ understanding of the problem.

The second session escalated very quickly. We weren't having sex and it was that session our homework assignment was to go home and uh lay in bed naked together and kind of explore each other's bodies. That just seemed to escalate so quickly. With us, it was like uh awkward and stupid (P009).

The above excerpt illustrates how an intervention is perceived as ineffective in leading to change when it is implemented at an inappropriate time in the therapy process. When therapy pacing and timing do not make sense to participants, they were more apt to describe therapy as chaotic, confusing or disjointed. Further, errors in pacing and timing often reflect missed opportunities to implement a productive intervention.

Therapy process factors including the therapists’ understanding of the presenting problem, therapeutic alliance, interventions and timing and pacing of interventions contribute to the decision to stay in therapy or to drop out of therapy. Participants explained that when therapists understand the presenting problem, they know how to effectively intervene, making therapy productive. Participants believe that the relationship with the therapist should be

characterized by comfort and safety, giving them the ability to feel comfortable to disclose sensitive issues. When the therapist devised interventions that fit with the participants' understanding of the presenting problem, it increased therapy productiveness. It was also of critical importance that interventions were implemented in a comfortable pace. As a result of each of these factors, participants look for evidence of progress in their daily lives, that is, times in between therapy sessions. Participants evaluate therapy these factors when making the decision to drop out or to continue therapy.

Evaluation of Therapy Progress

I asked participants how they knew they were making progress toward their desired changes. Participants evaluated therapy progress along three domains, (1) changes in the presenting problem, (2) symptom reduction and (3) change happens outside of therapy. Participants' evaluation of therapy progress was directly related to their decision to drop out or remain in therapy. Once therapy progress was evaluated, three possible outcomes emerged from this evaluation. Participants either decided to (1) remain in therapy with the current therapist ($n=14$), (2) drop out of therapy due to lack of progress ($n=3$), or (3) stop therapy because change has been made ($n=1$). One participant selected "not applicable" and further explained that her decision to remain in therapy would depend on finances.

Change in the presenting problem. Twelve participants noticed that progress had occurred when they recognized positive changes in the presenting problem. Even if participants did not feel the problem had resolved, noticing any change in the presenting problem was recognized as progress. For example, a participant described his experience of finding better ways to manage anger. He said,

I'm dealing with problems better. I had anger issues where I could just fly off the handle. I still get mad. I'm much more calm. I'm able to deal with my problems better and stop and think, then act (P009).

Symptom reduction. Participants also identified symptom reduction as a key marker of progress. Participants believed progress had been made when they noticed a reduction in the frequency or intensity of symptoms. For example, one participant explained,

Within the first couple of sessions I got over my anxiety attacks. That was the big thing. And I stopped getting frustrated over someone else's issues (P018).

Change outside of therapy. I asked participants where they notice progress. Ten participants said they know progress has been made when they are living their daily lives outside of therapy sessions. This theme emerged as a fully saturated category. Participants explained that progress is not recognized during or shortly after therapy sessions, rather, progress is recognized in daily life. For example, one participant explained,

I can feel a difference not necessarily the session. The session itself doesn't make me feel good but if I go throughout the next week before I have my next therapy session I think about {the therapist}, or think about a topic that I want to talk to her about. Or I utilize one of the comments she makes then I think that it is productive (P001).

This excerpt illustrates that even though the actual sessions do not yield an immediate result, therapy is considered productive because something done in therapy was helpful later in the week. Another participant explained that therapy sessions are similar to a class, or a time to learn, after session is a time to practice what you have learned.

Its like working on a car after you went to a class on how to fix an engine. You go home and fix your engine after the class. You can fix it because you went to that class. There

isn't a lot that's going to happen in the session to change you, its really the rest of the week. It makes it hard because you are like "I just paid whatever amount for this hour" and it didn't do anything (P012).

Seven participants in relational therapy noticed progress when they noticed changes in their interactions. For relational clients, noticing change in the presenting problem often included improved communication, reduction in intensity and frequency of conflict, and increased closeness. For example, a participant said, “*Arguments that used to become full blown fights would be diffused so there was less fighting*” (P011).

Participants generally indicated that the most dramatic change happened at the beginning of the therapy process, and the changes become more gradual over time.

Sometimes it feels like peaks and valleys, I've been successful over time, I've gotten a Bachelors {degree} and a Masters {degree}, got out of an abusive relationship. I couldn't do that when I first started. I couldn't have handled that (P013).

This participant had been in therapy for 10 years with the same therapist. During that time, she had experienced times of dramatic change, and also times where little change happened. The above excerpt exemplifies that noticing change over the course of the therapy process lead this participant to evaluate therapy as effective in leading to change.

Stuckness. Though the majority of participants report making progress in the presenting problem because of therapy, there were times when little or no change occurred. Participants explained that they feel stuck when they feel that therapy is not working. One participant indicated that when he is feeling stuck, he talks about it with his therapist. He explained,

My therapist always tells me I'm making change while I'm down, I'm still progressing.

He reminds me I'm still progressing. I know I'm doing good when I'm not feeling it (P012).

During times of little or no change, five participants found it helpful to reflect on progress made. Short-term goals emerged as an effective gauge by which to measure progress. Goals were useful for keeping participants accountable to working on the problem outside of session. For example, one participant explained,

We made a promise of what we would do over the short term - the next few days or week. That was good because it gave us something concrete to do for the next time period (P015).

Twelve participants said it was critically important that participants noticed progress because of therapy, as it lead to staying in therapy. One participant explained that he never considered stopping therapy because he saw so much progress happening in his life. He explained, “*I felt better every time I came, like I accomplished something*” (P018).

Just as the decision to remain in therapy was related to noticing progress because of therapy, the decision to drop out of therapy was often related to lack of progress because of therapy. For example, one participant explained, “*I have done therapy before but have only gone for maybe I don't know two or three session each time and thought this was a waste, it's not going to do anything*” (P001). By “a waste” this participant expressed that therapy did not lead to progress, which caused her to drop out. Another participant explained that his lack of progress was due to not having a connection to the therapist.

I have said that many times because we've been through 3-4 different ones. It's something I don't feel so comfortable with because it doesn't ever truly help (P014).

The above excerpt exemplifies the commonly described experience of testing several therapists, and feeling that therapy will not lead to progress.

Expressing dissatisfaction with therapy to the therapist. I asked participants if they felt they could tell their therapist if therapy wasn't helpful. While some participants indicated that they could discuss their evaluation of therapy with the therapists, five indicated they could not. All participants said that it was difficult to tell the therapist when they were dissatisfied with therapy. When participants explained an unhelpful event that occurred in their therapy, or they felt that therapy was unhelpful in general, I always asked "Did you express that feeling to your therapist?" Almost all participants said that they could not tell the therapist when something about therapy was unhelpful. For example, one participant responded, "*At the time no, because it was my first time coming to therapy and I was intimidated*" (P022). The aspects of therapy that participants found unproductive were always related to something about the therapist, or an activity initiated by the therapist. When discussing this topic in interviews, participants often used words like "confrontation" and "intimidating."

There were factors identified that lead to participants being willing to talk with their therapist when they were dissatisfied. Participants who had been to therapy in the past explained when they were in therapy for the second time, with a second therapist, they were able to tell the therapist if something about therapy was not helpful. One participant explained,

I still feel {therapists} think of something and try to latch on to it. They want to make an assumption about what's going on with you. If it doesn't sit right with me, this time I'm much more prone to saying "no that's not it" (P009).

Participants were more likely to tell their therapist that something wasn't helpful when they had an established therapeutic relationship. For example, a participant explained,

I couldn't always say something that day; I would say it the next time. It's still hard. I'll say, "it felt like you weren't paying attention" or "it felt like you didn't understand." Sometimes I'll say I feel frustrated, you aren't getting what I'm saying, you are just assuming. I think it's because we have worked together for so long that it's a little easier now (P013).

How to Drop Out of Therapy

Since the majority of participants had dropped out of therapy with previous therapists, I asked them *how* they ended therapy. I also asked participants to explain how they chose their method of ending therapy. I found that the way participants chose to end therapy was related to the therapeutic relationship and the reason the participant wanted to end therapy. Participants ended therapy face to face when they had a long-standing, comfortable relationship with their therapist. Participants also ended therapy face-to-face when they respected their therapist as a competent therapist. For example, one participant explained,

I just told her in one session, I was like hey I think I'm going to try this type of therapy, I asked her if she could do it, it was more about a type of therapy rather than a person, because I have a high level of comfort with her, so I really didn't want to leave, but I mean stylistically I got to the point where I was going in and I knew what she was going to say you know what I mean? (P021).

Participants used impersonal forms of communication, such as email, to end therapy when their goal was to avoid confrontation. Participants often avoided the confrontation of telling the therapist that an aspect of the therapy was not effective in leading them to change. For example, one participant described her experience of being in therapy with a therapist who did not structure therapy sessions as much as the participant wanted. She explained,

I just emailed her and told her I didn't think it was working out with me going to see her. It was a very short email but essentially it said that I was not going to come back. I didn't want to go through a confrontation with her and hurt her feelings. I was kind of afraid to just tell her to her face so that's why I went through the platform of email. When you break up with someone you are supposed to do it to their face (laughs) but I just did it through email (P010).

This excerpt shows that participants may be concerned that their decision to stop therapy may hurt the therapist's feelings. Other participants explained that they ended therapy without communicating this to the therapist in any way. When asked how she ended therapy with her previous provider, one participant stated, "*I'm just the one that leaves*" (P008). Another participant elaborated that leaving therapy "...tells the therapist 'you don't get it'" (P010).

In some instances, participants described severe problems, motivation to resolve that problem, only to begin therapy with a therapist that was not helpful. Many of the participants who had previously stopped therapy with a past therapist described this feeling. As one participant described this feeling, he explained,

I didn't feel it from the beginning, well now I look at it like 'why didn't I just switch therapists?' But you're going through that embarrassment factor of having to go to therapy so you have to break down that wall to do it and when that doesn't work it's like well I don't want to go through it all again (P009).

This passage shows that beginning therapy is a vulnerable time. Further, this passage shows how changing therapist poses additional anxiety, and remaining in therapy with an unhelpful therapist placed the participant between two difficult choices.

Summary of Qualitative Findings

The intersection of client factors, therapy process factors, and evaluation of progress because of therapy describe the complex process by which therapy clients decide to remain in therapy or decide to drop out of therapy. A summary of categories and main themes is presented in Table 6. The therapist's personhood and treatment approach were influential in many aspects of therapy that participants evaluated when making decisions about staying in or dropping out of therapy. Rather than evaluating therapy productiveness, it can almost be said that clients evaluate the productiveness of the therapist. The therapist was synonymous with the therapy.

Table 6.

Summary of Qualitative Categories and Supporting Themes

Main Categories	Supporting Themes
Client Factors	Presenting Problem Factors Expectations Motivation
Therapy Process Factors	Therapist's understanding of the presenting problem Therapeutic alliance Therapists' interventions Pacing and timing
Evaluation of Progress	Changes in the presenting problem Symptom reduction Noticing progress outside of therapy sessions Making a decision to drop out or stay in therapy How to end therapy

Quantitative Findings

Quantitative survey data were used to determine whether productiveness, goal attainment and therapeutic alliance predicted group membership to the categories of intended treatment retention or intended dropout. The quantitative sample included the qualitative participants, and

continued sampling until reaching adequate statistical power. After data preparation, the final quantitative sample size was 72 cases (N= 72).

Demographic Data

The mean age of participants was 34 years old, SD = 14.24, a range of 18–77 years old. Sixty nine percent of participants (n = 50) were white, 3% (n= 2) were native Hawaiian, 6% (n= 4) were Middle-Eastern, 10% (n= 7) were Black, 7% (n= 5) were Hispanic, 3% (n= 2) were Asian, and 3% (n=2) identified as mixed race. Sixty-three percent (65%, n=47) of participants were female while 32% (n = 23) were male, and one participant identified as transgender. Thirty-two percent (32%) of participants were single, while 51% were either in a committed relationship, living with their partner or married, 10% of participants were divorced.

Participants were asked to select the category that describes the approximate number of sessions attended (Sessions 1-4, Sessions 5-8 and 9 or more). Fifty-one percent of participants had attended more than nine sessions, while 28% were in sessions one and four and the remaining 20% were between sessions five and eight. Sixty-four percent of participants (n=46) were clients of individual therapy while 24% (n=17) were in couple therapy and 12% (n=9) were in family therapy. This variation appears to mirror the reality of a community based treatment clinic, where the majority of clients are in individual therapy, and family therapy is less common. Collecting data on therapy dosage using a categorical variable with three levels posed advantages and disadvantages. A disadvantage is the lost nuance, as the third level of this variable has a wide range. In other words, participants who completed 10 sessions would indicate the same answer choice as those who completed 50 sessions. Participants who completed 10 sessions are different from those who completed 50, and this item cannot account for those differences. An advantage posed by measuring therapy dosage in this way is that participants who do not

remember the exact number of sessions they have completed were less likely to skip this question. Using three answer categories allowed me to collect information about participants' stage in therapy in a way that resulted in minimal missing data.

Goal attainment. The majority of participants, 83% (n = 60), reported improvement in the presenting problem since starting therapy. Fourteen percent (14%, n = 10) of participants reported the problem was about the same as when they began therapy, while two participants (3%) reported that the problem was much worse since beginning therapy. When asked how productive therapy has been in resolving the presenting problem, 95% of participants reported that therapy has been productive or somewhat productive.

Therapeutic Alliance. The majority of participants reported a strong alliance with their therapist along the dimensions of bond, task and goal. These dimensions of the alliance also form the subscales of the Working Alliance Inventory (WAI). Means and standard deviations are reported in table 7.

Table 7.

Therapeutic Alliance Scores for the Working Alliance Inventory (WAI- SF)

Variable	M	SD	N	Range
WAI Bond Mean	1.65	.74	72	1-5
WAI Task Mean	2.01	.94	72	1-5
WAI Goal Mean	1.82	.92	72	1-5
WAI Mean	1.84	.78	72	1-5

*A score closer to one indicates a stronger therapeutic alliance, where a higher score, closer to five indicates a weaker therapeutic alliance.

Productiveness. The PCPI measures participants' perception of productiveness of therapy. Each item of the PCPI describes a change process identified in the extant literature. Measures of central tendency, means, standard deviations, sample size and range are presented for each item and component of the PCPI in Table 8.

Intended retention. Participants were asked to select the category that best describes their intention toward the future of therapy. Participants were asked if they intend to continue therapy until reaching their goals, or if they intend to drop out of therapy before reaching their goals. Seventy-six percent (76%) of participants (n=55) intend to stay in therapy until they reach their goals. Twenty-four percent (24%) of participants (n = 17) intend to drop out of therapy before reaching their goals.

Table 8.

Productive Change Processes Inventory (PCPI) Measures of Central Tendency

PCPI Item	Mean	SD	N	Range
1. Notice small changes early	1.90	1.01	72	1-5
2. Therapist clarifies goals	1.74	.97	71	1-5
3. Something productive each session	1.83	.93	72	1-5
5. Subtle, gradual changes	1.63	.72	72	1-5
6. Therapist is fair	2.00	1.44	72	1-5
7. Therapist makes me safe & comfortable	1.44	.99	72	1-5
8. Therapists pace is comfortable	1.55	.94	70	1-5
9. Hopeful we can reach goal	1.69	1.04	72	1-5
10. Therapist slows down when necessary	1.78	1.19	72	1-5
11. Therapist knows when to challenge and when not	1.85	1.21	72	1-5
12. We can tell therapist if therapy isn't working	1.90	1.26	72	1-5
13. We talk about the problem after session	2.74	1.70	72	1-5
14. Individual change leads to relational change	2.21	1.62	72	1-5
15. We talk about presenting problem.	2.11	1.35	72	1-5
16. Life events challenge us	1.79	1.21	71	1-5
17. We talk to each other in session, not only therapist	2.29	1.62	72	1-5
Component 1: Interpersonal Change Processes	1.74	.88	72	1-5
Component 2: Relational Change Processes	2.26	1.20	72	1-5
Component 3: Measures of Progress	1.77	.65	72	1-5

*A score closer to one indicates higher productiveness, where a higher score, closer to five indicates lower productiveness.

Correlations

Correlations among quantitative variables are presented in Tables 9 and 10, as there were too many data points to include in a single table. Demographic variables (described in Table 9) showed few significant correlations. Age and relationship status were significantly correlated, as

older participants are more likely to be in relationships. A related correlation showed that age and therapy constellation was significantly negatively correlated. Number of sessions was significantly, positively correlated with age. This means that when participant age increases, the number of sessions increases. Number of sessions was also significantly, positively correlated to relationship status.

Table 10 shows correlations among predictor variables in the present study. Goal attainment significantly positively correlated with the PCPI component 1 and 3, the WAI, and all subscales of the WAI. This finding shows that when goal attainment increases, productiveness and therapeutic alliance also increase. The PCPI mean (containing all subscales) did not significantly correlate with goal attainment. As anticipated, all subscales of the WAI correlated with one another. The WAI mean, and each subscale mean (bond, task and goal) significantly, positively correlated with the PCPI Comp 1 and 3 mean. This finding shows that productiveness varies in the same direction as therapeutic alliance. For example, when productiveness increases, therapeutic alliance increases also. The PCPI mean (including component 2) significantly, positively correlated with the WAI total mean, and the goal and task subscales only; the bond subscale did not significantly correlate with the PCPI overall mean. Intended retention significantly, negatively correlated with goal attainment, therapeutic alliance (and all subscales, bond, task and goal) and productiveness. Meaning that when goal attainment, therapeutic alliance and productiveness increase, intention to drop out of therapy decreases.

In strong measurement instruments, the overall mean correlates with each component or subscale, and each subscale should correlate with the other subscales. All three PCPI components significantly, positively correlated with the overall PCPI mean score. Component one significantly correlated with components 2 and 3. An unexpected finding of the correlations

among PCPI subscales was that component 2 and component 3 did not significantly correlate with one another. Component 2, relational change processes and component 3, therapeutic progress markers did not significantly correlate with one another, which may indicate that relational therapy clients identify progress markers differently than clients of individual therapy. This result may indicate that component three should be a separate version of the PCPI, specifically for participants in relational therapy.

Table 9.

Correlations Among Demographic Variables

		1	2	3	4	5	6
1. Age	Pearson Correlation	1					
	Sig. (2-tailed)						
	N	72					
2. Ethnicity	Pearson Correlation	.09	1				
	Sig. (2-tailed)	.41					
	N	72	72				
3. Gender	Pearson Correlation	-.17	.04	1			
	Sig. (2-tailed)	.16	.73				
	N	71	71	71			
4. Relationship Status	Pearson Correlation	.57**	.01	-.08	1		
	Sig. (2-tailed)	.00	.95	.51			
	N	71	71	70	71		
5. Number of Sessions	Pearson Correlation	.35**	.01	-.03	.33**	1	
	Sig. (2-tailed)	.001	.93	.83	.01		
	N	70	70	69	69	70	
6. Therapy Constellation	Pearson Correlation	-.24*	.12	.14	-.19	-.16	1
	Sig. (2-tailed)	.04	.31	.25	.11	.19	
	N	72	72	71	71	70	72

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Table 10.

Correlations Among Predictor and Outcome Variables

		1	2	3	4	5	6	7	8	9
1. WAI	Pearson Correlation	1								
	Sig. (2-tailed)									
	N	72								
2. WAI Task	Pearson Correlation	.92**	1							
	Sig. (2-tailed)	.00								
	N	72	72							
3. WAI Bond	Pearson Correlation	.80**	.59**	1						
	Sig. (2-tailed)	.00	.00							
	N	72	72	72						
4. WAI Goal	Pearson Correlation	.93**	.82**	.61**	1					
	Sig. (2-tailed)	.00	.00	.00						
	N	72	72	72	72					
5. PCPI	Pearson Correlation	.42**	.47**	.16	.46**	1				
	Sig. (2-tailed)	.00	.00	.17	.00					
	N	72	72	72	72	72				
6. PCPI Component 1	Pearson Correlation	.43**	.45**	.24*	.43**	.88**	1			
	Sig. (2-tailed)	.00	.00	.04	.00	.00				
	N	72	72	72	72	72	72			
7. PCPI Component 2	Pearson Correlation	.14	.19	-.07	.22	.84**	.55**	1		
	Sig. (2-tailed)	.25	.09	.52	.07	.00	.00			
	N	72	72	72	72	72	72	72		
8. PCPI Component 3	Pearson Correlation	.67**	.73**	.39**	.61**	.59**	.51**	.23	1	
	Sig. (2-tailed)	.00	.00	.00	.00	.00	.00	.05		
	N	72	72	72	72	72	72	72	72	
9. Intended Retention	Pearson Correlation	-.59**	-.58**	-.46**	-.52**	-.29*	-.32**	-.07	-.46**	1
	Sig. (2-tailed)	.00	.00	.00	.00	.02	.01	.52	.00	
	N	72	72	72	72	72	72	72	72	

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Chi Square

In preparation for logistic regression analysis, it is essential to determine whether a relationship exists between the independent and dependent variables. Cross tabulations and chi

square tests were conducted for the purpose of determining the relationship between each predictor variable and the outcome variable, intended retention.

Chi square tests showed no relationship between intended retention and age, ($\chi^2 = 30.602$, $df = 29$, $p > .05$) ethnicity, ($\chi^2 = 8.358$, $df = 6$, $p > .005$) gender, ($\chi^2 = 4.723$, $df = 4$, $p > .005$) and relationship status ($\chi^2 = 4.112$, $df=7$, $p > .005$). No demographic characteristics had a significant relationship to the outcome variable. Chi square tests also showed no relationship between number of sessions and intended retention ($\chi^2 = .501$, $df=2$, $p > .005$). This result was surprising, as participants in early therapy are typically more likely to drop out of therapy before reaching their goals. Chi square tests also show no relationship between therapy constellation and intended retention ($\chi^2 = 1.71$, $df=2$, $p > .005$).

Chi square tests showed a significant relationship between goal attainment (as measured by the IORS) and intended retention ($\chi^2= 17.769$, $df=3$, $p< .001$). Therapeutic alliance (as measured by the WAI) showed a significant relationship to intended retention ($\chi^2 = 44.155$, $df=26$, $p < .005$). All three of the WAI subscales (task, ($\chi^2 = 33.57$, $df=15$, $p < .05$), goal, ($\chi^2 = 23. 56$, $df = 14$, $p < .05$) and bond ($\chi^2 = 22.03$, $df=11$, $p < .05$)) had significant relationships to intended retention. Intended retention is a new construct, therefore, I conducted several tests to explain the relationship between intended retention and the predictor variables. In order to obtain a nuanced and thorough understanding of the WAI's ability to predict intended retention, I examined each item. All individual items of the WAI showed a significant relationship to intended retention with the exception of item number seven, "My therapist appreciates me" ($\chi^2 = 5.56$, $df=3$, $p > .05$).

Since the PCPI is a new measure, I examined each item using chi square tests to test the relationship between productiveness and intended retention. The results of each test are

presented in a table in Appendix M. Many items of the PCPI had a significant relationship to intended retention. When tested as individual predictors, items one, ten and fourteen did not have a significant relationship to intended retention.

Binary Logistic Regression

Several logistic regression analyses were conducted to test the variables hypothesized to predict group membership to the categories of intended retention and intended dropout. Intended retention was regressed on the individual predictors, therapeutic alliance, goal attainment and productiveness. Finally, a full model was fit in which multiple predictors were tested together.

Therapeutic Alliance. Intended retention was regressed on therapeutic alliance as measured by the WAI mean score and was statistically significant ($\chi^2 = 24.74$, $df = 1$, $p < .001$). Therapeutic alliance predicted intended retention with 83% prediction accuracy (47% intention to dropout and 95% for intention to continue). Nagelkerke's R^2 of .437 indicates a strong relationship of 43.7% between therapeutic alliance and intended retention. The H-L goodness of fit test statistic was greater than .05, ($\chi^2 = 6.03$, $df = 7$, $p > .05$) which indicates the model fits well. This result means that therapeutic alliance has a significant impact on intention to continue or to drop out of therapy. Therapeutic alliance made a significant contribution to predicting intended retention or intended dropout ($b = -2.03$ (exp)B = .131, $df = 1$, $p < .001$, [.048, .358]).

A second regression analysis was conducted in which intended retention was regressed on the mean scores of each WAI subscale, bond, task and goal. This model significantly predicted intended retention ($\chi^2 = 25.82$, $df = 3$, $p < .001$). Nagelkerke's R^2 of .45 indicated that this model accounted for 45% variance in intended retention. The Hosmer –Lemeshow test of goodness of fit also indicated this model fits these data well ($\chi^2 = 5.80$, $df = 8$, $p > .05$). The WAI subscales predicted intended retention with 84.7% accuracy (93% for intention to continue

therapy and 59% for intention to drop out of therapy). Examining the beta coefficients showed each variable's contribution to the model. The task subscale of the WAI made the only statistically significant contribution to this model, ($b = -1.23$, $(exp)B = .29$, $df = 1$, $p < .05$, [.095, .884]) suggesting that the task domain of therapeutic alliance has more influence over intended retention than the bond and goal domains of alliance. Bond ($b = -.662$, $(exp)B = .516$, $df = 1$, $p > .05$ [.178, 1.49]) and goal ($b = -.15$, $(exp)B = .85$, $df = 1$, $p > .05$ [.277, 2.673]) did not contribute significantly to this model.

Goal. A binary logistic regression analysis was conducted to test goal attainment as a predictor of intended retention. The modified IORS item, “since starting therapy the problem is: 1= Much better, 2= somewhat better, 3 = about the same, 4 = somewhat worse and 5 = much worse” was used as a predictor. To control for the influence of number of sessions, I included this variable in the model by measuring it. Number of sessions did not make a statistically significant contribution, and thus was removed from the model ($\text{Wald } \chi^2 = .305$, $df = 2$, $p > .05$). Goal attainment was then tested as an independent predictor and was statistically significant ($\chi^2 = 16.82$, $df = 3$, $p < .01$). Goal attainment predicted intended retention with 81.9% accuracy (95% for intended retention, and 41% for intended dropout). Nagelkerke’s R^2 of .313 indicated a moderately strong relationship of 31.3% between goal attainment and intended retention. The Hosmer and Lemshow test was used to provide an additional estimate of goodness of fit. The H-L goodness of fit test statistic was greater than .05, ($\chi^2 = .00$, $df = 2$, $p > .05$) indicating the model fits well. The Wald criterion was used to assess the significance of each predictor variable in the equation. According to the Wald criterion, variables with a significance value that is less than .05 do not make a significant contribution to the overall model (Burns & Burns, 2008). Goal

attainment contributed significantly to the model, ($\text{Wald } \chi^2 = 12.99$, $\text{df} = 3$, $p < .05$). This result shows that goal attainment predicts intended retention.

Productiveness. The mean score of the PCPI was used as a measure of productiveness. Intended retention was regressed on productiveness and was statistically significant ($\chi^2 = 5.52$, $\text{df} = 1$, $p < .05$). Nagelkerke's R^2 of .111 indicates that productiveness accounts for 11% of variance in intended retention. The overall prediction success of productiveness was 73.6% (94% for intention to continue therapy and 6% for intended dropout). Productiveness was a statistically significant predictor ($b = -.837$, $(\exp)B = .433$, $\text{df} = 1$, $p < .05$, [.210, .892]) of intended retention.

I regressed intended retention on each of the three PCPI components (identified in the PCA analysis) individually in order to determine their individual ability to predict PCPI. This step allowed me to determine which components, if any, do not significantly predict intended retention so it could be removed from further analysis. Component 1, interpersonal change processes, significantly predicted intended retention ($b = -.761$, $(\exp)B = .467$, $\text{df}=1$, $p < .05$ [.250, .873]). Component 3, therapy progress markers, also significantly predicted intended retention ($b = -1.76$, $(\exp)B = .172$, $\text{df}=1$, $p < .05$, [.062, .481]). Component 2, relational change processes, did not significantly predict intended retention ($b = -.146$, $(\exp)B = .864$, $\text{df}=1$, $p > .05$ [.557, 1.34]) and was removed from future models. This result may indicate that component 2, describing relational change processes, may be a separate version of the PCPI rather than a subscale. Component 2 may be a separate version, of the PCPI, suitable for use with participants in relational therapy. It is possible that component 2 produced a non-significant result because 64% of participants in the present sample are in individual therapy.

The mean score of PCPI component 1 and 3 was calculated in a variable named “PCPI_Comp1and3mean”. Productiveness significantly predicted intended retention ($\chi^2 = 12.65$, $df = 1$, $p < .001$). Productiveness, as measured by components 1 and 3 was a statistically significant predictor of intended retention ($b = -1.53$, $(exp)B = .216$, $df = 1$, $p < .01$ [.081, .576]). Nagelkerke's R^2 of .242 indicates that these components accounted for 24% of variance in intended retention. The overall prediction success of productiveness was 80.6% (96% for intention to continue therapy and 29% for intended dropout). Nagelkerke's R^2 changed from .11 in the initial test of the mean of all three PCPI components, to .24, when I tested the mean of PCPI components 1 and 3. This result shows that PCPI components 1 and 3 predict more variance in intended retention than components 1, 2 and 3. This evidence supporting PCPI components 1 and 3 as better predictors of intended retention lead me to remove component 2 from future analysis. In tests of model fit, productiveness was measured by the variable, PCPI_Comp1and3mean, which is defined by the mean of component 1 and 3 only. When tested in the full model, PCPI_Comp1and3mean was used to measure productiveness.

Full model. Predictors: PCPI_Comp1and3mean (productiveness), goal attainment (IORS), and therapeutic alliance (WAI Bond, WAI Task and WAI goal), formed a model that significantly predicted intended retention ($\chi^2 = 23.915$, $df = 1$, $p < .001$). Nagelkerke's R^2 indicated this model accounted for 42.5% variance in intended retention. The only predictor that significantly contributed to this model was the WAI Task mean ($b = -1.59$, $(exp)B = .20$, $df = 1$, $p < .001$ [.09, .44]. All other predictors were removed from the model because they did not contribute significant variance.

Mixed Results

Mixed findings are organized according to the three main quantitative predictors: therapeutic alliance, goal and productiveness. I will discuss how the qualitative findings support the quantitative findings related to each of these predictor variables. Mixed data analysis showed three key areas of convergence among qualitative and quantitative data. Results of each analysis show that therapy clients assess therapy for, (1) a strong therapeutic alliance, (2) productive therapy sessions (3) and progress toward their therapeutic goals. When these three key elements were present, participants intended to continue therapy until reaching their goals.

Goal Attainment

Goal attainment, or perception of progress toward resolving the presenting problem was measured quantitatively and qualitatively. Goal attainment was measured quantitatively by a single item measure, which was a modified version of the *IORS* (Adams et al., 1991). Goal attainment significantly predicted intended retention as a single predictor. Qualitatively, goal attainment was measured by asking participants to describe how they knew progress was happening (or not happening). Nearly all participants perceived therapy as leading to progress when they noticed changes in the frequency and intensity of the presenting problem or symptom reduction. For example, participants in couple therapy described reduction in frequency and intensity of arguments, while an individual participant in therapy to manage anxiety noticed progress when his panic attacks stopped occurring.

Therapeutic Alliance

The therapeutic relationship emerged as a significant predictor of intended retention in the quantitative and qualitative analysis. Therapeutic alliance was quantitatively measured using the working alliance inventory, (WAI) which measures alliance along the dimensions of bond,

task and goal. Therapeutic alliance significantly predicted intended retention both as an individual predictor. The task domain of therapeutic alliance emerged as the only significant predictor in a regression model containing the goal and bond domains of therapeutic alliance, goal attainment, and productiveness. In the qualitative strand, themes related to the bond, task and goal dimensions of therapeutic alliance emerged. When participants were asked what influenced their decisions about continuing therapy or dropping out of therapy, their responses always related to the therapist. Therapists were regarded as responsible for creating and maintaining a safe and comfortable therapeutic environment. Participants wanted a therapist to listen without judgment, be present and attentive, and develop an understanding of the clients' unique presenting problem. When participants felt safe and comfortable with their therapist, they were able to disclose vulnerable and sensitive information about the presenting problem, resulting in more opportunities for change to occur.

Nearly all participants in the qualitative analysis explained that they began to feel connected to their therapist when the therapist conveyed an understanding of the presenting problem. Particularly at the outset of therapy, participants were sensitive to cues that the therapist understood the presenting problem, and the participants' desired changes. The therapists' understanding of the participants' desired changes in the presenting problem was measured quantitatively as the goal dimension of therapeutic alliance. Bond and goal dimensions of therapeutic alliance emerged as intricately connected. The therapist's understanding of the goals deepened and enhanced the therapeutic bond. Once the therapeutic bond had been forged and the therapist conveyed his or her understanding of the therapeutic goals, participants wanted the therapist to initiate a plan of action that would lead to resolving the presenting problem.

The therapist is responsible for initiating therapeutic activities or interventions. In the quantitative analysis, therapeutic tasks emerged as a significant predictor. In the qualitative analysis, therapeutic tasks emerged as an important way in which participants' assessed therapy productiveness, and also their intention to remain in therapy or stop therapy. Participants were able to identify specific activities, or things that happened in session that they felt were productive in leading to therapeutic change. These activities were always initiated by the therapist, or involved the therapist. For example, one participant identified that change happened when the therapist asked questions that were important for him to answer. Another participant explained that when the therapist initiated reflective listening activities, it helped him and his partner practice their communication. Another participant explained that a productive intervention was having someone who would listen to him talk about the presenting problem without judgment. Each of these therapy activities or interventions were identified as productive, and were inextricably linked to the therapist.

Productiveness

Productiveness is a concept that had yet to be applied to MFT prior to the present study. Therefore, I awarded a great deal of consideration to how I would ask participants about this construct in the qualitative strand. I asked participants what happened in therapy sessions that they felt contributed most to their progress. When describing aspects of therapy that most contributed to change, participants identified the therapeutic relationship, the therapists' interventions and the pacing and timing of those interventions. Participants identified bond, task and goal domains of the therapeutic alliance when asked what was most productive about therapy. In the qualitative strand, one participant said, "*the right therapist is the key to therapy*"

(P016). Since the therapist is so closely tied to the therapy, when participants evaluate therapy productiveness, they are assessing productiveness of the therapist.

In order to be able to measure productiveness as a quantitative construct, I needed to devise the PCPI. The PCPI showed that it was a viable measure of therapy productiveness. A principle components analysis was conducted to begin to establish construct validity, the results of which showed the PCPI has three components: (1) productive interpersonal processes, (2) relational change processes and (3) therapeutic progress markers. Perhaps the most encouraging finding suggesting that productiveness is an important concept in MFT practice, is that productiveness (as measured by the PCPI) significantly predicted intended retention. When participants perceive the therapist as productive, they are more likely to stay in therapy.

Participants in the qualitative analysis explained that a safe and comfortable relationship with their therapist was not sufficient to lead to change. Participants needed the therapist to devise and implement productive therapy activities or interventions. Participants needed to believe that therapeutic activities and interventions would lead to therapeutic progress. For that to happen, participants needed therapeutic activities or interventions to align with their understanding of the presenting problem. Understanding of the presenting problem refers to participants' impression of the ideology of the problem and how to begin taking steps to resolve it. Participants needed to understand how therapeutic activities could lead to therapeutic progress. For example, one participant in the present qualitative sample sought couple therapy because he and his partner were not sexually active. The therapist initiated an intervention that was similar to sensate focus (Fichter, Libman, Brender, 1983). The participant believed that their problem (of not being sexually active) could resolve through deepening their communication, not through non-goal oriented touching, as prescribed in sensate focus. This

particular participant stopped therapy because he did not feel the therapist was able to help him resolve this particular problem, and he and his partner ended their relationship. This example shows a scenario in which an effective intervention could be perceived as unproductive when it does not fit with the clients' understanding of the problem and how to resolve it. This example further illustrates the connection between productiveness and staying in therapy or dropping out of therapy.

Distinctions Among Productiveness and Therapeutic Alliance

The therapist is the key area of overlap between therapeutic alliance and productiveness, though these concepts are fundamentally distinct. Therapeutic alliance is defined as a collaborative relationship between the client and therapist along the dimensions of bond, task and goal (Bordin, 1975, 1979, 1980; Horvath & Greenberg, 1989). The most fundamental distinction between therapeutic alliance and productiveness is that therapeutic alliance is a relationship, where productiveness is not a relationship. Productive change processes, or productiveness, are therapeutic activities that clients identify as leading to therapeutic change. Overlap between therapeutic alliance and productiveness emerged qualitatively and quantitatively. When participants were asked what things happened in therapy sessions that were most helpful in leading them toward change, they often identified things that related closely to the therapist. The way the therapist conveys his or her understanding of the problem, the comfort level in the therapeutic environment, and the interventions the therapist initiates emerged as productive features of therapy. These aspects of therapy are heavily dependent on the therapist.

Though many of the change processes identified in this instrument overlap with items on therapeutic alliance measurements, there are noteworthy conceptual distinctions. Where therapeutic alliance scales measure the clients' perception of agreement between therapist and

client, the PCPI is intended to measure client perception of therapy productiveness. Where therapeutic alliance scales intend to measure the strength of the alliance along the dimensions of bond, task and goal, the PCPI aims to measure the elements of therapy that are most responsible for facilitating client change, therefore, the most productive. The PCPI measures clients' perception of therapy productiveness. This instrument is based on the extant literature on change processes (e.g. Christensen et al., 1998; Helmeke & Sprenkle, 2000; Wark, 1994). Though the PCPI contains constructs and items that are related to alliance, they are measured for a fundamentally different purpose than in alliance scales.

Chapter 5: Discussion

The present study contributes to the process research on change processes and common factors that contribute to change in MFT (e.g. Blow et al., 2007, Eisler, 2006; Sprenkle & Blow 2004a, b). This study examined MFT clients' perceptions of productive or unproductive change processes that influenced their decision to stay in therapy until reaching their goal or to drop out of therapy before reaching their goal. Participants of the present study used their perspective of therapy as a basis for decision making about staying in therapy or dropping out of therapy. This result aligns with common-factors theorists, Blow and colleagues (2007) who said, "What the therapist thinks about the alliance becomes irrelevant if the client isn't thinking the same as the therapist" (p. 307). Additionally, researchers identify the importance of measuring client perception in studies of retention, as many clients end therapy without discussing their decision with the therapist (Bischoff & Sprenkle, 1993). One way of obtaining the clients' perspective is using therapy clients as the data source, as in the present study. The following research questions guided the present study:

1. Describe the process by which productive change processes impact intended retention for therapy clients.
2. What components of the productive change processes inventory (PCPI) account for the most variance in change processes productiveness?
3. Are therapeutic alliance, productiveness and goal attainment significant predictors of intended retention or intended dropout?

H_0 : A positive therapeutic alliance, high perceived productiveness and positive goal attainment will significantly predict membership to the intended retention category.

4. How does the qualitative model of the process by which productive change processes impact intended retention or intended dropout converge or contrast with the results of the logistic regression model assessing productive change processes, goal attainment and therapeutic alliance as predictors of intended retention (or intended dropout)?

This discussion will address how the findings presented in chapter four contribute to the understanding of how therapy clients decide to stay in therapy or to drop out of therapy. Findings provide initial support for the conclusion that therapy clients assess the productiveness of their therapy experience. This assessment of therapy productiveness is a consideration in the decision to stay in therapy or to drop out of therapy.

Client Factors Interact with Therapy Process Factors

The decision to drop out of therapy or to remain in therapy was the result of clients' ongoing assessment of the therapist and the therapy. This is an iterative process, rather than a linear process. Participants continually assessed productiveness of the therapy and the therapist. Participants evaluated therapy process factors in coordination with the client factors they bring to therapy. For example, one participant considered dropping out of therapy before the first session or early in therapy. This finding confirms findings of previous research showing that dropout is common around the first session (Marchionda & Slesnick, 2013).

Client factors, including assessment of the presenting problem, motivation and expectations were influential therapy process factors in the decision to begin therapy, and also the decision to stay in therapy. Client factors interact with therapy process factors: therapists' understanding of the problem, therapeutic relationship, therapists' interventions, and pacing and timing of interventions. As depicted in Figure 3, the intersection client factors and therapy process factors contributes to decision making about staying in therapy or dropping out of

therapy. Participants want the therapist to join them in their understanding of the presenting problem and share their understanding of how to resolve it. Participants want a therapist who creates and maintains an environment of safety and comfort, allowing for vulnerability. Further, participants continually assessed therapy process factors for alignment with client factors (see Figure 3). Participants want a therapist who has an accurate understanding of the presenting problem, and who devises interventions that align with the clients' idea of how to work toward resolving the presenting problem. Additionally, participants want interventions to be delivered and implemented in a pace and timeline that feels comfortable and logical to them. When these features were in place, participants wanted to notice progress in their daily life, or they wanted to sense the potential for progress to occur.

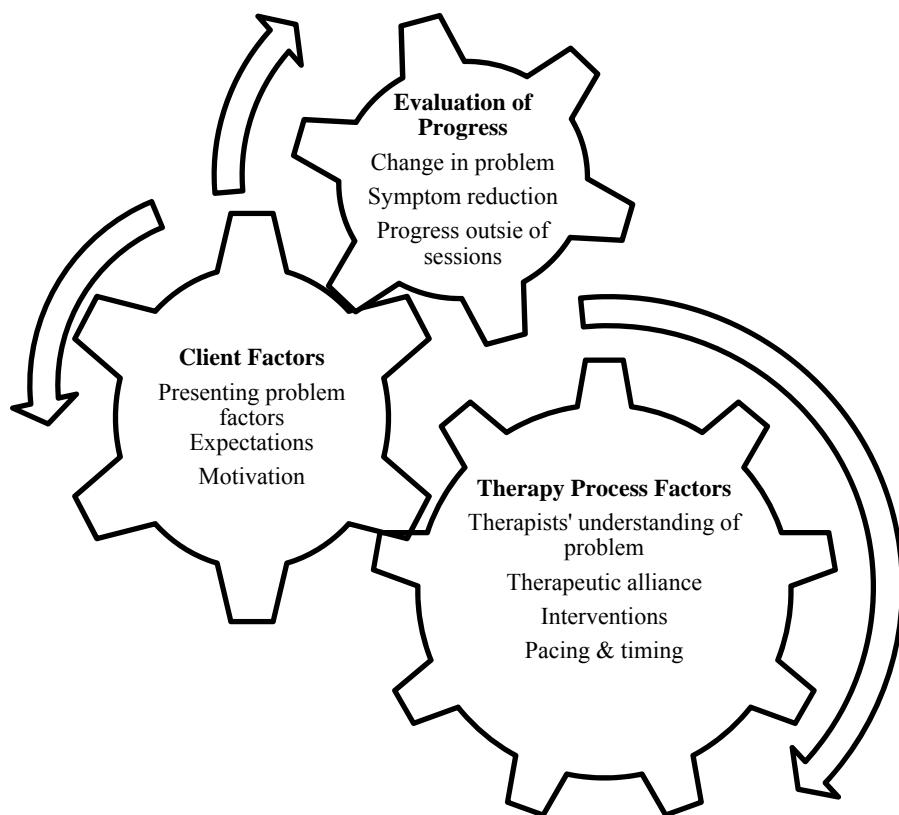


Figure 3. Process Model of Decision-Making About Therapy

Participants Did Not Expect Brief Therapy

Findings of the present study confirm the importance of role, process and outcome expectations (Arnkoff et al., 2002; Garfield, 1986; Lambert & Barley, 2002). Participants entered therapy with expectations about the role of the therapist, the therapy process, and therapy outcome. A surprising finding that emerged in the present study related to therapy process expectations, particularly about therapy timeframe. Nearly all participants did not expect to reap the benefits of therapy immediately. Rather, participants expected therapy to be a long and complex process. Many participants explained that they understood their presenting problem as complex and difficult to resolve, therefore, they did not expect a quick and simple solution. Further, participants were not bothered or deterred by the expectation that they would be in therapy for a long time. Participants' responses reflected tolerance of the idea that therapy is a process. This was a surprising finding, as I anticipated participants would expect their problem to resolve quickly once beginning therapy.

Participants Were Motivated

Participants in the present study almost always reported that solving the presenting problem was their first priority. This finding may explain why many participants in the present study chose to switch therapists rather than stopping therapy completely after a negative experience. Perhaps, when resolving the problem wasn't a high priority, and the therapy was not perceived as productive, participants were increasingly vulnerable to dropout. Some participants acknowledged that solving the problem was not their first priority when they previously dropped out of therapy. These participants identified problem priority as a contributor to the decision to drop out of therapy.

An unexpected finding that emerged was that an overwhelming number of participants viewed themselves as responsible for change, not the therapist. This finding is connected to the idea that almost all participants expressed some understanding that therapy is a process, rather than few key change moments (Christensen et al., 1998). Even though participants believed that they were responsible for their own change, this was not a protective factor against dropout. Participants who believe change is their responsibility dropped out of therapy when they did not feel the therapist was an effective guide toward that change. This finding suggests that even though participants are motivated, they want a therapist who is an effective guide in the change process. Participants want a therapist to provide tools, or resources to help them change, while the therapist was considered the facilitator. It was important that the therapist is able to serve as the right coach or guide in the change process.

The Therapist is Critically Important

Many previous studies found that therapeutic alliance significantly predicts retention (e.g. Beutler & Harwood, 2002; Bischoff & Sprenkle, 1993; Horvath, 2001; Horvath, 2006; Horvath & Symonds, 1991; Kneer et al., 2011). In the quantitative phase of the present study, when each of the three WAI subscales of bond, task and goal, were entered into a direct regression analysis, only the task subscale significantly predicted intended retention. Further, when the full model was tested, containing the predictors productiveness, goal attainment, task domain of therapeutic alliance, goal domain of therapeutic alliance and bond domain of therapeutic alliance, the only variable that contributed significant variation to this model was the task domain of alliance. This finding confirms that of previous studies that found the task dimension of alliance is the most important predictor of retention (Johnson & Greenberg, 1985). This finding highlights the importance of *how* therapy is conducted, specifically, what is done during therapy sessions

(Eisler, 2006). This result supports the importance of continued investigation and understanding of therapeutic tasks as suggested in previous studies (e.g. Johnson & Greenberg, 1985).

A guide in resolving the presenting problem. Throughout the data collection interviews, participants stated in various ways that they want the therapist to have and demonstrate specialized knowledge of the presenting problem and how to resolve it. Participants' desire for their therapist to demonstrate specialized knowledge or ability to resolve the presenting problem, above and beyond what the participant could do independently is consistent with previous literature. Pinsof and Catheral (1986) broadened Bordin's (1979) conceptualization of the task dimension of alliance to include the client's belief in the therapist's power and therapy approach. Frank (1973) conceptualized hope as an elemental healing property. Therapeutic tasks that aligned with participants' understanding of the presenting problem, and understanding of how to resolve it were viewed as productive. Further, when therapists explained their rationale for therapeutic tasks, participants were more likely to view the task as productive. Common-factors theorists acknowledge the importance of understanding what therapist qualities lead clients to perceive the therapist as skilled and effective (Blow et al., 2007).

Therapist recommendations. An unexpected finding was the importance participants' placed on therapist recommendations from friends and family. Also, participants who had positive therapy experiences were eager to share their recommendations of treatment provider with family and friends. Word of mouth among significant others emerged as an important factor in the decision to stay in therapy or to drop out of therapy. This may have occurred because participants who pursued treatment with a therapist or agency identified as credible expected therapy to be productive. This finding is consistent with the idea of hope, or placebo

effect (Kirsch, 1999; Rosenthal, 1994). This finding is also consistent with research on therapist credibility, suggesting that therapist reputation as credible is a factor that influences client perception of the therapist as credible (Hoyt, 1996).

Therapists' understanding of the presenting problem. Participants noticed and appreciated therapists' efforts to understand the presenting problem. As participants described what the therapist *did* that indicated their understanding of the presenting problem, I recognized how much it meant to them that the therapist put time and effort into understanding the problem. The therapists' understanding of the presenting problem formed the basis for the therapeutic alliance, particularly the bond dimension. When participants felt their therapist had a firm understanding of the presenting problem, participants felt a deeper connection and bond with that therapist. Participants also believed that a firm understanding of the presenting problem was a critical pre-requisite for devising productive interventions. Participants explained that previous therapy dropout was often related to a therapist having an inaccurate or incomplete understanding of the presenting problem.

Comfort and connection with the therapist. A safe relationship between therapist and client, characterized by connection and comfort emerged as a saturated category. This finding confirmed findings of change processes studies by Wark (1994), Christensen and colleagues (1998) and Blow and colleagues (2009), which found that therapeutic alliance is of central importance to client change. The present study built upon these findings by linking the importance of the therapeutic relationship as a change process, to the outcome therapy retention.

Therapeutic interventions. Interventions that were not productive were often those that did not fit with the clients' understanding of the problem. In the majority of participants, this lead to premature dropout. This finding is consistent with Wark's (1994) finding that therapists'

actions are of critical importance, as Blow and colleagues (2007) explain, the therapist is nearly synonymous with the therapy.” In addition to the therapists’ interventions, participants evaluated the pacing and timing of the therapists’ interventions. Participants identified the therapist as intervening too quickly when they did not have an understanding of the problem that fit with their own. These therapists were perceived as having jumped to a conclusion, made an assumption, or operating on their own agenda. Participants were also as likely to drop out of therapy when the therapist was not active in sessions. Therapists who simply allowed clients to speak, generally were considered too passive, or lacking the expertise necessary to help resolve the problem. This finding is consistent with Wark’s (1994) finding about the importance of knowing when to be direct and when not to be direct. Additionally, Christensen and colleagues (1998) found that pacing was of critical importance to perceived therapy change. The findings of the present study find that pacing is also of critical importance to the issue of premature dropout. Participants were more likely to drop out of therapy when the interventions did not fit with their understanding of the presenting problem, and when those interventions were not initiated in a comfortable and logical pace.

Expressing Dissatisfaction with Therapy to The Therapist

A particularly interesting finding that emerged was participants’ reluctance to tell therapists when they are dissatisfied with an aspect of therapy. When participants expressed dissatisfaction with an aspect of therapy, I always asked, “Did you express that to your therapist?” The most common response I received was that participants had not informed their therapist of their dissatisfaction. Many participants were more willing to stop therapy with their therapist than they were willing to discuss an aspect of therapy that dissatisfied them. Nearly all participants expressed that it is awkward, intimidating or uncomfortable to talk with their

therapist about their concerns about the therapy process. Participants believed the therapist wouldn't "hear" their critiques, or believed the therapist would view this discussion as a challenge to their expertise. This reluctance to discuss the approach to therapy with the therapist may be evidence of clients' awareness that the therapist holds more power than the client in the therapeutic relationship (Hecker & Wetchler, 2014). Connection with the therapist, course of therapy, and amount of time in therapy emerged as moderating factors. Participants who reported a stronger connection and higher level of safety with their therapist were more likely to be direct in expressing feelings of dissatisfaction with the therapist. Participants who had been in therapy for an extended length of time, and participants who had previous therapists were more likely to discuss concerns directly with their therapist. An interesting and unanticipated finding related to participants' reticence about discussing concerns with their therapist was that the mode in which participants decided to end therapy seemed to relate to their reason for ending therapy. Participants ended therapy face to face when they had a longstanding, comfortable and connected relationship to their therapist. Participants used a more impersonal method to end therapy when they were upset with something the therapist did or felt that therapy was unproductive.

Productiveness

Productiveness was also a significant predictor of intended retention. Therapy clients who find therapy productive are more likely to stay in therapy than those who do not find their therapy productive. This result indicates that productiveness may be an important aspect of the therapy process that has an impact on premature dropout. Participants were able to identify the things that happened in their therapy that they believe were most responsible for their therapeutic progress. These results confirm and expand those of Helmeke and Sprenkle (2000), Christensen and colleagues (1998) and Wark (1994). Participants in the present study identified similar

processes identified as helpful in these previous studies, but also connect their productiveness to the outcome of intended retention.

Participants Evaluate Therapy Progress

Goal attainment significantly predicted intended retention, which supports previous research on the importance of goals as a useful way to recognize therapy progress (Bohart & Wade, 2013). Previous research found that clients are more likely to become dissatisfied with therapy when goals are not clearly delineated (Bohart & Wade, 2013; Tryon & Winograd, 2011). Findings of the present study confirm previous findings. In the present study, participants were more likely to intend to drop out of therapy when they perceived less goal attainment. Conversely, when participants perceived higher levels of goal attainment, they were more likely to intend to continue therapy.

Participants evaluate the progress they made because of therapy. Issues evaluated were “feeling better” or noticing reduction in the presenting problem. I noticed that participants were less concerned with noticing progress quickly. Participants in the early stages of therapy said that they did not expect to notice concrete progress early on. Rather, participants wanted to feel that what happens in therapy sessions would lead to progress. Specifically, if participants felt that they could be vulnerable with their therapist, if their therapist has a strong and accurate understanding of the problem, and the therapist devises interventions that fit their understanding of the presenting problem, progress would occur. Participants were increasingly vulnerable to dropout when they perceived one or more process factors as unproductive or inaccurate. When participants never considered dropping out of therapy, it was usually related to feeling the therapist had an accurate understanding of the problem and the desired changes, the therapist devised interventions that were perceived as helpful in working toward resolving the presenting

problem, and progress was beginning to be noticed in the participants' daily life (or the client felt that eventually progress would be made).

Re-Starting Therapy After a Negative Therapy Experience

Fourteen of 19 participants in the qualitative strand had a negative therapy experience, and subsequently re-started therapy with their current provider. Therefore, the current sample is comprised of people who are motivated and committed to solving the problem. It is likely there is another population of therapy clients who do not return to therapy with another provider after a negative experience. Research identifies that people who drop out of therapy are less likely to seek therapy with another provider (Bischoff & Sprenkle, 1993) yet, the present sample contains many participants who have done so. Therefore, the present sample represents a unique facet of the experience of dropping out of therapy. For inclusion in the present study, I asked that participants were adult, current therapy clients, in therapy with an MFT. Many participants told me they had experience with multiple therapists, both positive and negative, and felt they would be a good source of information for my study. Several participants who previously dropped out of therapy said that they never anticipated returning to therapy after their initial negative experience. While it is encouraging that so many participants in the present study returned to therapy in hopes of finding a treatment provider that provided a better fit, they reported that returning was terrifying. Participants who returned to therapy did so because of escalating problem severity, or at the insistence of significant others in their lives. It is likely that another population exists of individuals who never return to therapy after an initial negative experience.

Contributions to Common Factors

Findings of the present study contribute to the argument for common factors as influential contributors to therapy retention. The present study provides empirical support for

common factors as agents that contribute to therapy retention. In asking clients what they found productive about therapy, emergent findings contained many elements of common factors. Particularly, the present study supports the important role of the broad conceptualization of common factors, including client factors, therapist factors, and therapeutic alliance factors (Hubble et al., 1999; Sprenkle & Blow, 2004a).

Therapeutic alliance. The common factor that has received the most empirical attention is therapeutic alliance (Sprenkle & Blow, 2004a). Therapeutic alliance, particularly the task domain, emerged as a salient finding in the qualitative and quantitative strand of the present study. In the present study, therapeutic alliance emerged as therapy factor that participants considered in their decision to drop out of therapy or to stay in therapy. This is unique from previous studies that have investigated therapeutic alliance as important in contributing to therapeutic outcome, or therapy satisfaction (e.g. Lambert, 1992; Johnson & Talitman, 1997).

Client factors. Client factors emerged as an important finding in the qualitative strand of the present study. Client factors are defined as characteristics or qualities of the client (Lambert, 1992; Sprenkle & Blow, 2004a). The client is a key factor in therapy, as the client is the person who does the work of change (Miller et al., 1997). Studies by Helmeke and Sprenkle (2000) and Tallman and Bohart (1999) have found that clients use what the therapist presents in unique ways. For example, clients take what they find useful or productive about what the therapist offers, and this may be different for each client. Miller and colleagues (1997) identify the client as the single most important contributor to therapy outcome. In the present study, the client was an important contributor to therapy retention, as the client is in control of whether he or she continues therapy or drops out of therapy.

Expectations. Client expectations are examples of client factors, which also emerged in the qualitative strand of the present study. Participants commonly discussed their expectations for what would happen in therapy, what the therapist would be like, and the expected therapy outcome. Lambert (1992) hypothesized that expectancy, or placebo effects account for about 15% of therapy outcome variation. In the present study, participants identified expectations as important contributors to their decision to remain in therapy or to drop out of therapy. Similarly to Johnson and Talitman (1997), in the present study, the therapists' ability to present therapy in a way that was consistent with client expectations contributed to therapy retention (Sprenkle & Blow, 2004a).

Therapist factors. The therapist is one of the most crucial, yet most under researched aspects of therapy (Beutler et al., 2004; Blow et al., 2007; Lebow, 2006). Findings of the qualitative and quantitative strands of the present study support the critical influence the therapist has on the therapy process (Lambert, 2006; Blow et al., 2007; Wampold, 2001). The MFT field knows little about how therapist variables intersect with therapy approaches, clients and presenting problems (Davis and Piercy (2007a, b). In qualitative interviews, when participants described aspects of therapy that made them decide to stay in therapy or drop out of therapy, it was always related to something the therapist had done. This finding confirms the idea that models work through therapists (Blow et al., 2007). Further, many participants in the present study had previously dropped out of therapy and subsequently re-started further confirms that these participants left therapy because of the therapist. In most cases, participants who had previously dropped out reported that the first therapist was not a "fit", and also reported that their current therapy has been a positive and productive experience. This finding illustrates that

participants did not feel that therapy was unproductive, rather, they felt their previous therapist was unproductive.

Fit between therapists' approach and client factors. Participants in the present study were attuned to the how well their therapists' approach fit with their ideas about how to resolve the problem, and their expectations of therapy. Participants also noticed when their therapist adhered to a particular idea. These therapists were described by their clients as "having their own agenda" or "pushing their ideas on me", and also identified this disconnect between the therapists' ideas about what would be productive and their own as a primary reason for stopping therapy. This finding may have emerged because our clients want an individualized approach, tailored to meet their needs. This finding supports previous research suggesting that it is critical for therapists to accommodate to their clients, rather than clients accommodating to their therapist (Blow et al., 2012, Eisler, 2006, Johnson & Talitman, 1997).

Discussion Summary

Findings confirm the importance of the therapists' role in treatment. Participants' overall evaluations of therapy productiveness were intricately connected to the therapist. These findings confirm the importance of the therapist's role in treatment (Blow et al., 2007). The therapists' actions were not only assessed for interpersonal warmth and comfort, but they were also assessed for productiveness. Further, the fact that the majority of qualitative participants had previously dropped out of therapy, and re-started with the current provider may suggest that participants evaluate the productiveness of the therapist.

Implications

Findings of the present study provide initial support for the idea that clients consider therapy productiveness when making decisions about staying in therapy or dropping out of therapy. These findings also further discussions about common factors, the role of the therapist, and emphasis on common factors in training. Use of the construct, intended retention makes a unique contribution to premature dropout research. Finally, the present study introduces the construct of therapy productiveness. These key unique findings carry important implications for research, clinical practice and training.

Research

The methodology used in the present study is an example of process research. This empirical study uses current clients of MFTs as the data source, and is focused on gathering information about the process of therapy itself, rather than specific elements (Oka & Whiting, 2013; Pinsof & Wynne, 2000). Process research in the MFT field is a relevant and timely way to begin narrowing the research practice gap (Oka & Whiting, 2013). Eisler (2006) believes that the MFT field needs to ask how therapy works rather than asking what works. The present study is an example of process research performed with minimal controlled variables. Therapist variables vary in the present sample as they do in actual real-world therapy practice. The data source in this study is exclusively therapy clients. Many researchers in the MFT field are hesitant to sample clients for several important reasons. The present study illustrates that therapy clients may be more willing and able research participants than we once believed. Current therapy clients were willing to participate in qualitative interviews and complete a web-based survey. Steps taken in the present study to increase the convenience of participating can be used in other studies. Interviews were conducted in the same location in which participants received

therapy. This increased convenience, and reduced no-show rate in several key ways. Participants were already familiar with the location, which eased the burden of needing to find an unfamiliar location. Also, participants were willing to schedule their interviews with me either directly before, or after session. I also reached more potential participants by using a drop slot in the waiting room to collect inquiries. I originally planned to leave my contact information available for interested participants to contact me. I found that participants were more likely to engage when I reached out to them. These results offer a promising example for how to collect qualitative and quantitative responses from current therapy clients.

Productiveness is an important component of therapy. Several areas of couple and family therapy research would benefit from including productiveness components. For example, when testing new models or interventions, it would be beneficial to include and measure client perception of their productiveness. Additionally, managed care companies are continually interested in efficacious treatment. Research that investigates client perception of productiveness may be of interest to managed care companies who seek to understand the change producing elements of therapy treatment.

The present study also contributes to premature dropout research. Prior to the present study, premature dropout was investigated retrospectively, and qualitative data from clients who had dropped out was rarely available. At the outset of the study, I did not anticipate that by sampling current therapy clients, such a large majority of participants would have had the experience of previously dropping out of therapy. Gaining access to this population allowed me to understand the lived experience of dropping out of therapy. Other researchers aiming to study therapy retention may benefit from sampling current clients, and asking specifically for those who have previously dropped out of therapy.

The construct of intended retention, involved measuring the likelihood that therapy clients would remain in therapy until meeting their goals. Research shows that clients' anticipated attendance is an accurate predictor of actual attendance patterns (Garfield, 1986; Goin, Yamamoto, & Silverman, 1965; Pekarik & Wierzbicki, 1986). Findings of the present study show that intended retention may be a promising way to investigate therapy retention. Future research using the construct of intended retention would be useful in continuing to understand this construct.

Clinical Practice

The results of the present study serve as a guide for clinicians to consider, particularly when beginning therapy with new clients. It benefits therapists to ask clients about their feelings about beginning therapy, previous therapy and their expectations. Further, therapists would be best served to devote more time to assessing and understanding clients' perception of the problem and how to begin working to resolve it. Therapists should be mindful of the therapy process variables (therapist's understanding of the problem, therapeutic relationship, interventions, pacing and timing and perceived progress) evaluated by clients when deciding to stay in therapy or to stop therapy.

Many clients do not tell their therapist when they are dissatisfied with therapy. Therefore, therapists should devote extended session time to conducting a thorough assessment of the presenting problem, maybe even more thorough than the therapist believes is necessary, would be beneficial. It is also essential to ask clients about their expectations, and past therapy experiences. These conversations would provide the therapist with important information about therapy approaches that the client did not consider productive. Clients are more likely to tell the

therapist what they want from therapy before treatment begins, than they are likely to tell the therapist that his or her approach is not working mid-treatment.

This result shows the importance, for both clients and therapists, to use client feedback scales. Many valuable client feedback scales have been developed; (Pinsof & Lebow, 2006; Pinsof & Wynne, 2000) perhaps the best known and most widely used is the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) (Johnson, Miller, & Duncan, 2000).

Soliciting client feedback through a standard scale provides a forum for clients to provide feedback on their progress and each session. For example, therapists can review feedback scores prior to session, and inquire about a particularly low rating, and also, therapists can review a client's feedback scores and immediately address feedback indicating the client felt a session did not go well.

Training

The present study carries implications for training MFT therapists. Results provide support for the importance of assessment and information gathering. Clients are unique, and therefore, present the therapist with unique needs. Therapists must be attuned to those needs and be able to respond to them. For example, participants in the present study described dropping out of therapy because the therapist was too passive, and did not structure therapeutic conversations enough. Alternatively, participants in the present study described dropping out of therapy because the therapist moved too quickly, made assumptions or jumped to conclusions. This example highlights the uniqueness of each client system and their needs.

Results show that different clients find different aspects of therapy productive. In other words, therapy productiveness cannot be reduced to a set of one-size-fits-all criteria. This finding supports the importance of therapy as a craft (Doherty, 2012). The practice of therapy

has been described as a science, based on the scientist-practitioner model, beginning with the Boulder Model of Clinical Psychology (1949) and the therapist as an artist; however, Doherty (2012) postulates that therapy is more accurately described as a craft. Doherty (2012) describes a craft as “a skill set used for producing useful things” (p. 58). This aligns well with productiveness, as strong therapeutic skills on the part of the therapist contribute to productive therapy. The therapeutic tools of the craft are considered questions, listening, pausing, and pacing, raising intensity or reducing intensity, focusing on a particular subject or shifting focus (Doherty, 2012).

Focus on General Therapy Skills. Therapeutic models and common factors provide the therapist with a roadmap, but it is the therapists’ in-the-moment clinical decision making that translates therapeutic models into meaningful therapeutic conversations. In addition to the focus on therapy models in training, emphasizing strong general therapy skills would enhance training therapists’ ability to conduct productive therapy. General therapy skills include things like, session pacing and timing, reflective listening, knowing when to use questions and statements and use of silence. Training is the forum to develop strong therapy skills from the outset, with the understanding that these skills will be practiced throughout the course of one’s career.

In Master’s level training, a strong emphasis on therapeutic models and general therapy skills is important for training productive therapists. General therapy skills can be emphasized in a variety of ways. In addition to demonstrating the practice of a therapeutic model, training tapes can be used to facilitate discussion about the conversational craft of therapy, or the therapists’ clinical decision-making (Doherty, 2012). Encouraging students to consider how the therapist decided what to do in a given moment can help students develop intentionality about their own practice. In addition to training tapes, role-plays can be used in a way that isolates and

emphasizes general therapy skills. As in medical training, where skills are isolated and practiced, through the use of simulated patients, (e.g., Humphris & Kaney, 2001) MFT training programs can tailor this approach to the needs of training therapists. This approach aligns with the competency-based training standards used in our field, which focus on the mastery of general therapy skills (Nelson, Chenail, Alexander, Crane, Johnson, & Schwallie, 2007). For example, the general therapy skill of reframing can be isolated and practiced. Students can focus on how to use reframing techniques in a variety of clinical scenarios.

Using Client Feedback During Training. The simplest way to begin to understand client impression of therapy productiveness is to ask for client feedback. Many training programs emphasize the importance of asking clients about their goals for therapy, and their presenting problem. Typically, we do not ask clients how they would know if therapy was productive. Another way is to use brief feedback gathering instruments such as the Session Rating Scale (SRS) after each session (Johnson et al., 2000). Creating a culture of gathering and using client feedback in training programs ensures that trainees form desirable habits early in their career. Another way to increase our understanding of client productiveness is to become further adept at deciphering clients' non-verbal cues. For example, if clients continually come to session reporting they have not completed their homework, it may be important to consider whether the client perceived the homework as productive. Also, if an intervention initiated by the therapist does not fit with the clients' understanding of the problem, the client may make a confused facial expression, or ask questions about the intervention. Therapists in training must be taught to evaluate these cues in order to ensure clients perceive their therapy as productive.

Limitations

The present study contributes to the premature dropout literature in MFT. This is one of few studies to collect qualitative data from therapy clients who have dropped out of therapy, which is unique, because those who have dropped out of therapy are rarely available research participants. This study is also one of the first to apply the concept of productiveness to couple and family therapy. Though the present study makes unique contributions to the MFT literature, it is not without limitations.

Sampling limitations impacted the qualitative and quantitative analysis. Since generalizability is not an aim of qualitative research, the qualitative findings are not generalizable to all clients of MFTs in a general treatment setting. Rigorous qualitative research involves procedures to ensure trustworthiness, such as cross-coders and peer debriefing. This sample does not contain a nearly equal number of participants of couple, family and individual therapy; many more were in individual therapy. Additionally, the number of sessions completed was not balanced. Most participants completed between sessions 1-4 and more than 9. Fewer participants had completed between sessions 5 and 8. It would have been ideal to have a more even balance among these characteristics. Participants at different stages of therapy represent different facets of therapy experience, and may be more vulnerable to dropout at certain stages. The sampling strategy used also carries some limitations. The sampling criteria I used were that participants must be: (1) current clients and (2) in therapy with an MFT. These broad criteria allowed me to obtain a representative sample of a general clinic population. The majority of participants intended to continue therapy. Critical case sampling would have allowed me to recruit participants who possess a unique aspect of the phenomenon (Patton, 1990). For example, recruiting participants who have had a strongly positive experience in therapy, and

recruiting participants who have had a strongly negative experience in therapy would have allowed me to obtain an even number of participants in each experience.

As I did not recruit directly for positive or negative therapy experiences in the quantitative strand, the majority of participants ($N = 55$) reported they intended to stay in therapy, and only seventeen ($N=17$) intended to drop out of therapy, which may suggest that clients who intend to stay in therapy are more likely to volunteer to participate in research. An unbalanced amount of responses in these categories of the dependent variable (intended retention) may have been a limitation to the quantitative analysis, as logistic regression models tested more accurately predicted intention to stay in therapy than intention to drop out of therapy. King and Zeng (2001) research the use of binary logistic regression in the study of rare events. A rare event is defined as an outcome that is only present in less than 1% of the sample. Since intention to drop out of therapy accounted for 23% of the dataset, it was not considered a rare event. Though I achieved adequate statistical power, with a large enough sample size, it would have been ideal to have a more even distribution in responses categories. In social science research, it is sometimes difficult to obtain balance among responses. It would be useful to examine situations in which there is an uneven balance among response categories that is not marked enough to qualify as a rare event. It would be useful to analyze how, if at all, this distribution in responses impacts the analysis.

Future Research

Though the present study contributes to understanding the process by which couple, family and individual therapy clients decide to stay in therapy or to drop out of therapy, there are useful ways to continue this research. Additional research that addresses the limitations of the

present study would be useful in filling gaps in our understanding of how clients evaluate productiveness, and how clients decide to stay in therapy or drop out of therapy.

Though the present study sampled clients of MFTs, many participants were individual therapy clients. Sampling clients of relational therapy would allow for sophisticated relational data analysis. Dyadic data analysis, perhaps using the actor partner interdependence model (APIM) would allow researchers to examine differences within and between client dyads (Cook & Kenny, 2005). This research would enhance our understanding of how relational clients decide to stay in therapy or to stop therapy. In the present study, some participants mentioned that their decisions to begin therapy, to switch therapists or to drop out of therapy were influenced by a partner or family member. Dyadic analysis methods that account for the relational aspect of decision making about therapy would be beneficial. The present study was conducted using a sample of clients who were in therapy voluntarily. Investigating how mandated clients determine what is productive about therapy would be an important area for future research.

The PCPI was developed for use in the present study. It would be useful for the PCPI to be used in other studies with different populations in order to test and understand its psychometric properties. Further investigation is necessary to understand and clarify the factor structure further of this instrument.

Conclusion

The present study contributes to marriage and family therapy literature on change processes, productiveness, premature dropout and common factors. In the present study, I sought to tell the story of MFT clients' decision-making process of deciding to stay in therapy until reaching their goals or deciding to drop out of therapy before reaching their goals. I wanted

to understand the impact of therapeutic alliance, goal attainment, and therapy productiveness on the decision to remain in therapy or to drop out. These factors showed to be important predictors of intended retention, which emerged in qualitative and quantitative strands. Findings support and confirm several areas of common-factors theory including the importance of the therapist, the importance of client factors and the importance of accommodating to clients' views.

Researchers and theorists in couple and family therapy have often debated the question of whether every therapist can be the right therapist for every client. While most would agree that every therapist might not be the best therapist for every client, every therapist can certainly be a productive therapist for every client. Findings support the importance of process-oriented research, a client-centered approach to clinical practice and support the role of common factors in MFT training.

References

- Adams, J.F., Piercy, F.P., & Jurich, J.A. (1991). Effects of solution focused therapy's "formula first session task" on compliance and outcome in family therapy. *Journal of Marital and Family Therapy, 17*, 277-290. Doi: 10.1111/j.1752-0606.1991.tb00895.x.
- Alexander, J., Barton, C., Schiavo, R., & Parsons, B. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology, 44*, 656-664. Doi:10.1037/0022-006X.44.4.656.
- Alexander, J., & Parsons, B. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*, 219-225. Doi: 10.1037/h0034537.
- Allgood, S. M., Crane, D. R. (1991). Predicting marital therapy dropouts. *Journal of Marital and Family Therapy, 17*, 73-79. Doi: 10.1111/j.1752-0606.1991.tb00866.x.
- Anderson, T., Patterson, C. L., McClincock, A.S., Song, X. (2013). Factorial and predictive validity of the expectations about counseling-brief (EAC-B) with clients seeking counseling. *Journal of Counseling Psychology, 60*, 496-507. Doi: 10.1037/a003422.
- Arnkoff, D. B., Glass, C. R., & Shapiro, S. J. (2002). Expectations and preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 335–356). New York: Oxford University Press.
- Attkisson, C., Larson, D., Hargreaves, W. A., LeVois, M., Nguyen, T., Roberts, R., & Stegner, B. (1989). *Client satisfaction questionnaire (CSQ-8)*. San Francisco, CA: University of California.

- Barber, J. P., Luborsky, L., Crits-Christoph, P., Thase M. E., Weiss R., Frank A., Onken, L., & Gallop, R. (1999). Therapeutic alliance as predictor of outcome in treatment of cocaine dependence. *Psychotherapy Research*, 9, 54-73. Doi: 10.1037//0022-006x.69.U19.
- Bergin, A. E., & Garfield, S. L. (1994). *Handbook of psychotherapy and behavior change*. New York: J. Wiley.
- Beutler, L. E., & Harwood, T. M. (2002). What is and can be attributed to the therapeutic relationship? *Journal of Contemporary Psychotherapy*, 32, 25–33. Doi: 10.1023/A:1015579111666.
- Beyebach, M., & Carranza, V. E. (1997). Therapeutic interaction and dropout: Measuring relational communication in solution-focused therapy. *Journal of Family Therapy*, 19, 173–212. Doi: 10.1111/1467-6427.00047.
- Bischoff, R.J., & Sprenkle, D.H. (1993). Dropping out of marriage and family therapy: A critical review of research, *Family Process*, 32, 353-375. Doi: 10.1111/j.1545-5300.1993.00353.x.
- Blenker, M. (1954). Predictive factors in the initial interview in family casework. *Social Service Review*, 28, 65-73. Doi: 10.1086/639511.
- Blow, A.J., Davis, S.D., Sprenkle, D.H. (2012). Therapist-worldview matching: Not as important as matching to clients. *Journal of Marital and Family Therapy*, 38, 13-17. Doi: 10.1111/j.1752-0606.2012.00311.x.
- Blow, A., Morrison, N., Tamaren, K., Wright, K., Schaafsma, M., & Nadaud, A. (2009). Change processes in couple therapy: An intensive case analysis of one couple using a common factors lens. *Journal of Marital and Family Therapy*, 35, 350-368. Doi: 10.1111/j.1752-0606.2009.00122.x.

- Blow, A.J. & Sprenkle, D.H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital and Family Therapy*, 27, 385-401. Doi: 10.1111/j.1752-0606.2001.tb00333.x.
- Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, 33, 298-317. Doi: 10.1111/j.1752-0606.2007.00029.x.
- Bohart, A.C. & Wade, A.M. (2013). The client variables in psychotherapy. In M. Lambert (Ed.) Bergin & Garfield's *Handbook of psychotherapy and behavior change*. (p. 219-257). New York: Wiley.
- Bordin, E. S. (1975). The working alliance: Basis for a general theory of psychotherapy. Paper presented at a symposium of the American Psychological Association, Washington, DC.
- Bordin, E. (1979). The generalizability of the psychoanalytic concept of the alliance. *Psychotherapy: Theory, research and practice*, 16, 252-260. Doi:10.1037/h0085885.
- Bordin, E. S. (1980, June). *Of human bonds that bind or free*. Presidential address delivered at the meeting of the Society for Psychotherapy Research, Pacific Grove, CA.
- Bordin, E.S. (1983). A working alliance based model of supervision, *The Counseling Psychologist*, 11, 35-42. Doi: 10.1177/0011000083111007.
- Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13-37). New York: Wiley.
- Burns, R.P. & Burns, R.A. (2008). *Business research methods and statistics using SPSS*. London: Sage.

- Calvert, S. C. & Johnston, C. (1990). Acceptability of treatments for child behavior problems: Issues and implications for future research. *Journal of Clinical Child Psychology*, 19, 61-74. Doi: 10.1207/s15374424jccp1901_8.
- Christensen, L. L., Russell, C.S., Miller, R. B., Peterson, C. M. (1998). The process of change in couples therapy: A qualitative investigation. *Journal of Marital and Family Therapy*, 24, 177-188. Doi: 10.1111/j.1752-0606.1998.tb01074.x.
- Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment*, 7, 309-319. Doi: 10.1037/1040-3590.7.3.309.
- Collins, K. M. T., Onwuegbuzie, A. J., & Sutton, I. L. (2006). A model incorporating the rationale and purpose for conducting mixed methods research in special education and beyond. *Learning Disabilities: A Contemporary Journal*, 4, 67-100. Doi: 10.1177/1558689807299526.
- Comrey, A. L. (1988). Factor-analytic methods of scale development in personality and clinical psychology. *Journal of Consulting and Clinical Psychology*, 56, 754-761. Doi: 10.1037/0022-006X.56.5.754.
- Corbin, J.M., & Strauss, J.M. (2007). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.
- Corrigan, P.W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 614-625. Doi: 10.1037/0003-066X.59.7.614.
- Creswell, J.W. (2007). *Research Design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.
- Creswell, J. W., & Plano Clark, V. (2011). *Designing and conducting mixed methods research*. (2nd Ed). Thousand Oaks, CA: Sage.

- Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209-240). Thousand Oaks, CA: Sage.
- Crits-Christoph, P., Connolly Gibbons, M., & Mukherjee, D. (2013). Process-outcome research. In M. J. Lambert (Ed.). Bergin and Garfield's *Handbook of psychotherapy and behavioral change* (6th ed.) pp. 298–340). New York, NY: Wiley.
- Cronbach, L.J. & Meehl, P.E. (1955). Construct validity in psychological tests. *Psychological Bulletin, 52*, 281-302. Doi: 10.1037/h0040957.
- Davis, S. D., & Butler, M. H. (2004). Enacting relationships in MFT: A conceptual and operational definition of an enactment. *Journal of Marital and Family Therapy, 30*, 319-333. Doi: 10.1111/j.1752-0606.2004.tb01243.x.
- Davis, H. and Dhillon, A. M. (1989). Prediction of early attrition from couple therapy. *Psychological Reports, 65*, 899-902. Doi:10.2466/pr0.1989.65.3.899.
- Davis, S.D., Lebow, J.L., & Sprenkle, D.H. (2011). Common factors of change in couple therapy. *Behavior Therapy, 43*, 36-48. Doi:10.1111/1467-6427.12033.
- Davis, S D., & Piercy, F.P. (2007a). What clients of couple therapy model developers and their former students say about change, part I: Model-dependent common factors across three models. *Journal of Marital and Family Therapy, 33*, 318-343. Doi: 0.1111/j.1752-0606.2007.00030.x.
- Davis, S.D., & Piercy, F.P. (2007b). What clients of couple therapy model developers and their former students say about change, part II: Model-dependent common factors across three models. *Journal of Marital and Family Therapy, 33*, 344-363. Doi: 10.1111/j.1752-0606.2007.00030.x.

- De Haene, L. (2010). Beyond division: Convergences between postmodern qualitative research and family therapy. *Journal of Marital and Family Therapy*, 36, 1-12. Doi: 10.1111/j.1752-0606.2009.00174.x.
- Denzin, N. (1970). *The research act*. Chicago: Aldine.
- de Shazer, S. (1988). Clues: Investigating solutions in brief therapy. New York, New York: W. Norton & Company.
- Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (1999). Alliance-building interventions with adolescents in family therapy: A process study. *Psychotherapy: Theory, Research, Practice, Training*, 36, 355– 368. Doi: 10.1037/h0087729.
- Dillman, D.A. (2007). *Mail and internet surveys: the tailored design method*. New Jersey: John Wiley & Sons, Inc.
- Doherty, W. J. (2012). One brick at a time: Therapy is more than art or science. *Psychotherapy Networker*, September/October, 2012, 23-29, 58, 60.
- Echevarria-Doan, S. & Tubbs, C. (2005). Let's get grounded: Family therapy research and grounded theory. In Sprenkle, D. & Piercy, F., *Research Methods in Family Therapy (2nd Ed.)* (41-62). New York: Guilford.
- Fife, S.T., Whiting, J.B., Bradford, K. & Davis, S.D. (2013). The therapeutic pyramid: A common factors synthesis of techniques, alliance and way of being. *Journal of Marital and Family Therapy*, 40, 20-33. Doi: 10.1111/jmft.12041.
- Fichter, C.S.; Libman, E.; Brender, W. (1983). Methodological issues in the study of sex therapy: effective components in the treatment of secondary orgasmic dysfunction. *Journal of Sex and Marital Therapy*, 9, 191-202. Doi: 10.1080/00926238308405847.
- Frank, J. (1973). Persuasion and healing. Baltimore: Johns Hopkins University Press.

- Frank, J.D., Gliedman, L.H., Imber, S.D., Stone, A.R. (1959). Patients' expectancies and relearning as factors in determining improvement in psychotherapy. *American Journal of Psychiatry, 115*, 961-968. Doi: 10.1176/ajp/115.11.961.
- Frank, J. D., Nash, E. H., Stone, A. R., & Imber, S. D. (1963). Immediate and long-term symptomatic course of psychiatric outpatients. *American Journal of Psychiatry, 120*, 429–439. Doi: 10.1176/ajp/120.5.429.
- Garfield, S. L. (1986). Research on client variables in psychotherapy. In A. E. Bergin, & S. L. Garfield (Eds.). *Handbook of Psychotherapy and Behavior Change* (3rd Edition) (pp. 213–256). New York: John Wiley & Sons.
- Gilks, W. R., Richardson, S., and Spiegelhalter, D. (1995). *Markov Chain Monte Carlo in Practice*. Boca Raton, Florida: Chapman & Hall/CRC Interdisciplinary Statistics.
- Fowler, F.J. (2009). Survey research methods, 4th edition. California: Sage Publications.
- Gladstein, G. A. (1969). Client expectations, counseling experience, and satisfaction. *Journal of Counseling Psychology, 16*, 476–481. Doi: 10.1037/h0028487.
- Glaser, W. (1998). *The Quality School*. New York. Harper Collins.
- Glaser, Barney G & Strauss, Anselm L., 1967. *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.
- Glebova, T. Bartle-Haring, S., Gangamma, R., Knerr, M., Delaney, R. O., Meyer, K., Silverthorn, B., McDowell, T., Adkins, K. & Grafsky, E (2011). Therapeutic Alliance and progress in couple therapy: Multiple Perspectives. *Journal of Family Therapy, 33*, 42-65. Doi: 10.1111/j.1467-6427.2010.00503.x.

- Goin, M., Yamamoto, J., Silverman, J. (1965). Therapy congruent with class-linked expectations. *Archives of General Psychiatry*, 13, 133-137.
Doi:10.1001/archpsyc.1965.01730020035004.
- Goldstein, A.P. (1960). Therapist and client expectation of personality change in psychotherapy. *Journal of Counseling Psychology*, 3, 180-184. Doi: 10.1037/h0043489.
- Greenberg, L.S., James, P.S., Conry, R.F. (1988). Perceived change processes in emotionally focused couples therapy. *Journal of Family Psychology*, 2, 5-23. Doi:10.1037/0893-3200.2.1.5
- Greenberg, L., & Pinsof, W. (1986). Process research Current trends and future prospects. In L. S. Greenberg & W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook*, (pp. 3-20). New York Guilford.
- Greene, J. C. (2008). Is mixed methods social inquiry a distinctive methodology? *Journal of Mixed Methods Research*, 2, 7–22. Doi: 10.1177/1558689807309969.
- Greene, J.C., Caracelli, V.J., & Graham, W.F. (1989). Toward a conceptual framework for mixed-methods evaluation designs. *Educational Evaluation and Policy Analysis*, 11, 255-274. Doi: 10.3102/01623737011003255.
- Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco, CA: Jossey-Bass.
- Guba, E.G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal*, 29, 75–91. Doi: 10.1007/BF02766777.

- Gunzberger, D.W., Henggeler, S.W., & Watson, S.M. (1985). Factors related to premature termination of counseling relationships. *Journal of College student Personnel, 26*, 456-460. Doi: 10.1016/j.cpr.2011.03.006.
- Gurman, A.S. (2008). *Clinical handbook of couple therapy (4th edition)*. New York: The Guilford Press.
- Hamilton, S., Moore, A.M., Crane, R.D., Payne, S.H. (2011). Psychotherapy dropouts: Differences by modality, license and DSM-IV diagnosis. *Journal of Marital and Family Therapy, 37*, 333-343. doi: 10.1111/j.1752-0606.2010.00204.x
- Hatcher, R. L. and Barends, A. W. (2006) How a return to theory could help alliance research. *Psychotherapy: Theory, research, practice, training, 43*, 292–299. Doi: 10.1037/0033-3204.43.3.292.
- Hatcher, R.L., & Gillaspy, J.A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16*, 12–25. Doi: 10.1080/10503300500352500.
- Heatherington, L., & Friedlander, M. L. (1990). Couple and family therapy alliance scales: Empirical considerations. *Journal of Marital and Family Therapy, 16*, 299–306. Doi: 10.1111/j.1752-0606.1990.tb00851.x.
- Heatherington, L., Friedlander, M.L., Greenberg, L. (2005). Change Process Research in Couple and Family Therapy: Methodological Challenges and Opportunities. *Journal of Family Psychology, 19*, 18-27. Doi: 10.1037/0893-3200.19.1.18.
- Hecker, L.L. & Wetchler, J.L. (2014). *An introduction to marriage and family therapy*. New York: Routledge

- Helmeke, K. B. & Sprenkle, D.H. (2000). Clients' perceptions of pivotal moments in couples therapy: A qualitative study of change in therapy. *Journal of Marital and Family Therapy, 26*, 469-483. Doi: 10.1111/j.1752-0606.2000.tb00317.x.
- Hodgson, J. L., Johnson, L. N., Ketring, S. A., Wampler, R. S., & Lamson, A. L. (2005). Integrating research and clinical training in MFT training programs. *Journal of Marital and Family Therapy, 31*, 75-86. Doi: 10.1111/j.1752-0606.2005.tb01544.x.
- Horvath, A. O. (2001). The alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*, 365–372. Doi: 10.1108/1525383X201000001.
- Horvath, A.O. (2006). The alliance in context: Accomplishments, challenges, and future directions. *Psychotherapy: Theory, practice, training, 43*, 258-263. Doi: 10.1037/0033-3204.43.3.258.
- Horvath A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.). *Psychotherapy relationships that work* (pp. 37–70). New York: Oxford University Press.
- Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*, 9–16. Doi: 10.1037/a0022186.
- Horvath, A.O. & Greenberg, L. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology, 36*, 223-233. Doi: 10.1037/0022-0167.45.1.30.
- Horvath, A. O. and Luborsky, L. (1993). The role of therapeutic alliance in psychotherapy. *Journal of Consulting Psychology, 61*, 561-573. Doi: 10.1176/foc.4.2.269.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139–149. Doi: 10.1037/0022-0167.38.2.139.

- Hosmer D.W. & Lemeshow S. (1980). A goodness-of-fit test for the multiple logistic regression model. *Communications in Statistics*, 1043-1069. Doi: 10.1080/03610928008827941.
- Hosmer D.W. & Lemeshow S. (1989). *Applied logistic regression*. New York: John Wiley & Sons.
- Howard, K. I., Kopta, S. M., Krause, M. S. & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist*, 41, 159-164. Doi: 10.1037/a0033589.
- Hoyt, W.T. (1996). Antecedents and effects of perceived therapist credibility: A met analysis. *Journal of Counseling Psychology*, 43, 430-447. Doi: 10.1037/0022-0167.43.4.430.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). *The heart and soul of change: What works in therapy* (pp. 33–56). Washington, DC: American Psychological Association.
- Humphris, G., & Kaney, S. (2001). Examiner fatigue in communication skills objective structured clinical examinations. *Medical Education*, 35, 444-449.
- IBM Corp. Released 2012. IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp.
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connection*. New York: Brunner-Routledge.
- Johnson, L.D., Miller, S.D., & Duncan, B.L. (2000). *The Session Rating Scale 3.0*. Chicago, IL: Authors.
- Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy*, 23, 135–152. Doi: 10.1111/j.1752-0606.1997.tb00239.x.

- Johnson, L. N., & Wright, D. W. (2002). Revising Bordin's theory on the therapeutic alliance. *Contemporary Family Therapy, 24*, 257–269. Doi: 10.3389/fpsyg.2011.00270.
- Joyce, A. S., McCallum, M., Piper, W. E., & Ograniczuk, J. S. (2000). Role behavior expectations and alliance change in short-term individual psychotherapy. *Journal of Psychotherapy Practice & Research, 9*, 213–225. Doi: 10.1037/a0029440.
- Joyce, A. S., & Piper, W. E. (1998). Expectancy, the therapeutic alliance, and treatment outcome in short- term individual psychotherapy. *Journal of Psychotherapy Practice & Research, 7*, 236–248. Doi: 10.1016/j.jpec.2010.08.005.
- Kazdin, A. E. (1990). Premature termination from treatment among children referred for antisocial behavior. *Journal of Child Psychology and Psychiatry, 31*, 415–425. Doi: 10.1111/j.1469-7610.1990.tb01578.x.
- Keith, T.Z. (2006). *Multiple regression and beyond*, Boston MA: Pearson.
- Kenny, D. A., & La Voie, L. (1984). The social relations model. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (pp. 142-182). Orlando, FL: Academic Press.
- Kerr, M. E., & Bowen, M. (1988). *Family evaluation: An approach based on Bowen theory*. New York: Norton.
- King, G. & Zeng, L. (2001). Logistic regression in rare events data. *Political Analysis, 9*, 137-13.
- Kinney, J., & Dittmar, K. (1995). Homebuilders: Helping families help themselves. In I. M. Schwartz & P. AuClaire (Eds.). *Home- based services for troubled children* (pp. 29–54). Lincoln: University of Nebraska Press.
- Kirsch, I. (1999). How expectations shape experience. Washington, DC: American Psychological Association Press.

- Kneer, M., Bartle-Hering, S., McDowell, T., Adkins, K., Delaney, R.O., Gangamma, R.,...Meyer, K. (2011). The impact of initial factors on therapeutic alliance in individual and couples therapy. *Journal of Marriage and Family Therapy*, 37, 182-199. Doi: 10.1111/j.1752-0606.2009.00176.x.
- Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2004). The formation of the therapeutic alliance in couple therapy. *Family Process*, 43, 425–442. Doi: 10.1111/j.1545-5300.2004.00032.x.
- Koss, M. P., & Shiang, J. (1994). *Research on brief psychotherapy*. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 664–700). New York: Wiley.
- Lake, M., & Levinger, G. (1960). Continuance beyond application interviews at a child guidance clinic. *Social Casework*, 41, 303-309. Doi: 10.1037/h0087951.
- Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.
- Lambert, M. J., & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 17–32). Oxford, England: Oxford University Press.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139-193). New York: Wiley.

- LaRossa, R. (2005). Grounded theory methods and qualitative family research. *Journal of Marriage and Family, 67*, 837-857. Doi:10.1111/j.1741-3737.2005.00179.x.
- Lebow, J. L. (1987). Developing a personal integration in family therapy: Principles for model construction and practice. *Journal of Marital and Family Therapy, 13*, 1-14. DOI: 10.1111/j.1752-0606.1987.tb00678.x.
- Lebow, J. L. (1984). On the value of integrating approaches to family therapy. *Journal of Marital and Family Therapy, 10*, 127-138. Doi: 10.1111/j.1752-0606.1984.tb00003.x.
- Lebow, J. (1997). The integrative revolution in couple and family therapy. *Family Process, 36*, 1-17. Doi: 10.1111/j.1545-5300.1997.00001.
- Levine, S., & Herron, W. (1990). Changes during the course of the psychotherapeutic relationship. *Psychological Reports, 66*, 883-897. Doi: 10.1080/10503307.2013.765998.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park: Sage.
- Luborsky, L. (1995). Are common factors across different psychotherapies the main explanation for the Dodo Bird verdict that 'Everyone has won so all shall have prizes'? *Clinical Psychology: Science and Practice, 2*, 106-109. Doi: 10.1111/j.1468-2850.1995.tb00033.x.
- MacNair-Semands, R. R. (2002). Predicting attendance and expectations for group therapy. *Group Dynamics: Theory, Research, and Practice, 6*, 219–228. Doi: 10.1037/1089-2699.6.3.219.
- Mahaffey, B.A., & Granello, P. F. (2007). Therapeutic alliance: A review of sampling strategies reported in marital and family therapy studies. *The Family Journal, 15*, 207-216. Doi: 10.1177/1066480707301314.

- Marchionda, D.M. & Slesnick, N. (2013). Family therapy retention: An observation of first-session communication. *Journal of Marital and Family Therapy*, 39, 87-97. Doi: 10.1111/j.1752-0606.2011.00279.x.
- Martin, D. J., Garske, J. P., & Davis, K. M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438–450. Doi: IO.I037//0022-006X.68.3.438.
- Masi, M.V., Miller, R.B., & Olson M.M., (2003). Differences in dropout rate among individual, couple and family therapy clients. *Contemporary Family Therapy*, 25, 63-75. Doi: 10.1023/A:1022558021512.
- McConaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research & Practice*, 20, 368–375. Doi: 10.1037/h0090198.
- Merriam-Webster's collegiate dictionary* (10th ed.). (1993). Springfield, MA: Merriam-Webster.
- Meyer, B., Pilkonis, P. A., Krupnick, J. L., Egan, M. K., Simmens, S. J., & Sotsky, S. M. (2002). Treatment expectations, patient alliance and outcome: Further analyses from the national institute of mental health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology*, 70, 1051–1055. Doi: 10.2174/157340010790596571.
- Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, 2, 91–100. Doi: 100.1080/13284200802676391.

- Miller, S.D., Duncan, B.L., & Hubble, M.A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice*. New York: Norton.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York: Guilford.
- Miller, J.K., Todahl, J.L., & Platt, J.J. (2010). The core competency movement in marriage and family therapy: Key considerations from other disciplines. *Journal of Marital and Family Therapy*, 36, 59-70. doi: 10.1111/j.1752-0606.2009.00183.x
- Mohl, P.C., Martinez, D., Ticknor, C., Huang, M. & Cordell, L. (1991). Early dropouts from psychotherapy. *Journal of Nervous and Mental Disease*, 179, 478-481. Doi: 10.1176/appi.ps.61.7.684.
- Mondor, J., McDuff, P. Lussier, Y., & Wright, J. (2011). Couples in therapy: Actor-partner analyses of the relationships between adult attachment and marital satisfaction. *The American Journal of Family Therapy*, 39, 112-123. Doi:10.1080/01926187.2010.530163.
- Morgan, D. L. (1998). Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative Health Research*, 8, 362-376. Doi: 10.1177/104973239800800307.
- Mueller, M., & Pekarik, G. (2000). Treatment duration prediction: Client accuracy and its relationship to dropout, outcome and satisfaction. *Psychotherapy: Theory, Research, Practice, Training*. 37, 117-123. Doi:10.1037/0033-3204.37.2.117.
- Nelson, T. (1996). Survey research in marriage and family therapy. In D. H. Sprenkle & S. M. Moon (Eds.) *Research methods in family therapy* (pp. 447-468). New York: Guilford Press.

- Nelson, T., & Allred, D. (2005). Survey research in marriage and family therapy. In D. H. Sprenkle & F. P. Piercy (Eds.), *Research methods in family therapy* (2nd ed) (pp. 211-237). New York: Guilford Press.
- Nelson, T., Chenail, R., Alexander, J., Crane, D., Johnson, S., & Schwallie, L. (2007). The development of core competencies for the practice of marriage and family therapy. *Journal of Marital and Family Therapy*, 33, 417-438.
- Norberg, M. M., Wetterneck, C. T., Sass, D. A., & Kanter, J. W. (2011). Development and psychometric evaluation of the Milwaukee Psychotherapy Expectations Questionnaire. *Journal of Clinical Psychology*, 67, 574-590. Doi: 10.1002/jclp.20781.
- Norcross, J.S. (Ed.) (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.
- Norcross, J. S., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.) New York: Oxford University Press.
- Nunnally, J. C. (1978). *Psychometric theory* (2nd ed.). New York: McGraw-Hill.
- Odell, M. & Quinn, W.H. (1998). Therapist and client behaviors in the first interview: Effects on session impact and treatment duration. *Journal of Marital and Family Therapy*, 3, 369-388. Doi: 10.1111/j.1752-0606.1998.tb01091.x.
- Oka, M. & Whiting, J. (2013). Bridging the clinician/researcher gap with systemic research: The case for process research, dyadic and sequential analysis. *Journal of Marital and Family Therapy*, 39, 17-27. Doi: 10.1111/j.1752-0606.2012.00339.x
- Onwuegbuzie, A. J., & Teddlie, C. (2003). A framework for analyzing data in mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 351-383). Thousand Oaks, CA: Sage.

- Orlinsky, D.E. & Howard, K.I. (1978). The relation of process to outcome in psychotherapy. In S.L. Garfield and A.E. Bergin (Eds.), *Handbook of Psychotherapy and Behavior Change* (2nd ed.). New York: John Wiley, 283-330.
- Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy* (pp. 307–365). New York: John Wiley & Sons.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (pp. 169-186). Beverly Hills, CA: Sage.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Pedhazur, E.J., Schmelkin, L.P. (1991). *Measurement, design and analysis: An integrated approach*. New Jersey: Lawrence Erlbaum Associates.
- Pekarik, G. (1986). The use of termination status and treatment duration patterns as an indicator of clinical improvement. *Evaluation and Program Planning*, 9, 25-30. Doi:10.1016/0149-7189(86)90004-2.
- Pekarik G, Wierzbicki M. (1986). The relationship between clients' expected and actual treatment duration. *Psychotherapy: Research, Practice, & Training*. 23, 532–534, Doi: 10.1207/s15374424jccp2002_2.
- Phillips, E. (1987). Ubiquitous decay curve: Service delivery similarities in psychotherapy, medicine and addiction. *Professional Psychology: Research and Practice*, 18, 650-652. Doi: 10.1037/0735-7028.18.6.650.

- Pinsof, W.M. & Catherall, D.R. (1986). The integrative psychotherapy alliance: Family, couple and individual therapy scales. *Journal of Marital and Family Therapy*, 12, 137-151. Doi:10.1111/j.1752-0606.1986.tb01631.x.
- Pinsof, W. M., & Wynne, L. C. (1995a). The effectiveness and efficacy of marital and family therapy: Introduction to the special issue. *Journal of Marital and Family Therapy*, 21, 341-343. Doi:10.1111/j.1752-0606.1995.tb00169.x.
- Pinsof, W. M., & Wynne, L. C. (1995b). The efficacy of marital and family therapy: An empirical overview, conclusions, and recommendations. *Journal of Marital and Family Therapy*, 21, 585-613. Doi: 10.1111/j.1752-0606.1995.tb00179.x.
- Pinsof, W.M., & Wynne, L.C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy*, 26, 1-8. Doi: 10.1111/j.1752-0606.2000.tb00270.x.
- Plano Clark, V.L., Huddleston-Casas, C.A., Churchill, S.L., O'Neil Green, D., Garrett, A.L. (2008). Mixed methods approaches in family science research. *Journal of Family Issues*. 29, 1543-1566. Doi 10.1177/0192513X08318251.
- Plotnicov, K.H., (1990). Early termination from counseling: The client's perspective. Unpublished doctoral dissertation, University of Pittsburg, PA.
- Porter, R. & Ketring, S. (2011). Contributing factors in the therapeutic alliance. *Journal of Couple & Relationship Therapy*, 10, 201-214. Doi: 10.1080/15332691.2011.588095.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102-1114. Doi: 10.1037/0003-066X.47.11.1102

- Prochaska, J.O. (1994). Strong and weak principles for progressing from precontemplation to action on the basis of twelve problem behaviors. *Health Psychology, 13*, 47-51. Doi: 10.1111/j.1475-6773.2006.00547.x.
- Prochaska, J.O. (1999). How do people change, and how can we change to help many more people? In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change* (pp. 227-255). Washington, DC: American Psychological Association.
- Prochaska, J. Q., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 20*, 161-173. Doi:10.1080/13549839.2014.968841.
- Prochaska, J.O., DiClemente, C.C. & Norcross, J.O. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114. Doi:10.1037/0003-066X.47.9.1102.
- Prochaska, J. O., Velicer, W. F., Fava, J. L., Rossi, J. S., & Tsoh, J. Y. (2001). Evaluating a population-based recruitment approach and a stage-based expert system intervention for smoking cessation. *Addictive Behaviors, 26*, 583–602. Doi: 10.1016/j.ijmedinf.2008.03.001.
- Reis, B.F., & Brown, L.G. (1999). Reducing psychotherapy dropout: Maximizing perspective convergence in the psychotherapy dyad. *Psychotherapy: Theory, Research, Practice, Training, 36*, 123–136. Doi: 10.1111/j.1752-0606.2010.00204.x.
- Reisner, A. D. (2005). The common factors, empirically validated treatments, and recovery models of therapeutic change. *Psychological Record, 55*, 377–399. Doi:10.1007/s10591-013-9260-8.

- Rice, L. & Greenberg, L. (Eds.) (1984). *Patterns of change: An intensive analysis of psychotherapeutic process*. New York: Guilford Press.
- Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton-Mifflin.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103. Doi: 10.1037/0033-3204.44.3.240.
- Rosenthal, R. (1994). Interpersonal expectancy effects: A 30-year perspective. *Current Directions in Psychological Science*, 3, 176–179.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6, 412-415. Doi: 10.1111/j.1939-0025.1936.tb05248.x
- Safren, S.A., Heimberg, R.G., & Juster, H.R. (1997). Clients' expectancies and their relationship to pretreatment symptomology and outcome of cognitive-behavioral group treatment for social phobia. *Journal of Consulting and Clinical Psychology*, 65, 694-698. Doi: 10.1037/0022-006x.65.4.694.
- Sexton, T.L., Alexander, J. F., Mease, A.L. (2004). Levels of evidence for the models and mechanisms of therapeutic change in family and couple therapy. In Lambert, M.J. (Ed.) Bergin and Garfield's *Handbook of Psychotherapy and Behavior Change* (pp.590-646). New York: Wiley.
- Sexton, T., Gordon, K.C., Gurman, A., Lebow, J., Holtzworth-Munroe, A. & Johnson, S. (2011). Guidelines for classifying evidence-based treatments in couple and family therapy. *Family Process*, 50, 377-392. Doi: 10.1111/j.1545-5300.2011.01363.x.

Sexton, T. L., & Ridley, C. R. (2004). Implications of a moderated common factors approach:

Does it move the field forward? *Journal of Marital and Family Therapy*, 30, 159-163.

Doi: 10.1111/j.1752-0606.2004.tb01231.x

Sexton, T. L., Ridley, C. R., & Kleiner, A. J. (2004). Beyond common factors: Multilevel-

process models of therapeutic change in MFT. *Journal of Marital and Family Therapy*,

30, 131-150. Doi: 10.1111/j.1752-0606.2004.tb01229.x.

Shadish, W.R., & Baldwin, A.S. (2003). Meta-analysis of MFT interventions. *Journal of Marital*

and Family Therapy, 29, 547-570. Doi: 10.1111/j.1752-0606.2003.tb01694.x.

Shadish, W.R., Hu, X., Glaser, R.R., Kownacki, R., & Wong, S. (1998). A method for exploring

the effects of attrition in randomized experiments with dichotomous outcomes.

Psychological Methods, 3, 3-22. Doi:10.3102/10769986029004421.

Shadish, W.R., Ragsdale, K., Glaser, R. R., & Montgomery, L. M. (1995). The efficacy and

effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of*

Marital and Family Therapy, 21, 345-360. Doi: 10.1111/j.1752-0606.1995.tb00170.x

Shadish, W. R., Montgomery, L. M., Wilson, P., Wilson, M. R., Bright, I. and Okwumabua, T.

(1993). The effects of family and marital psychotherapies: a meta-analysis. *Journal of*

Consulting and Clinical Psychology, 61, 992–1002. Doi: 10.1037/0003-066x

Shields, C. G., Sprenkle, D. H., & Constantine, J. A. (1991). Anatomy of an initial interview:

The importance of joining and structuring skills. *American Journal of Family Therapy*,

19, 3–18. Doi: 10.1080/01926189108250829.

Skovholt, T. M., & Ronnestad, M.H. (1995). *The evolving professional self: Stages and themes*

in therapist and counselor development. Chichester, United Kingdom: Wiley.

- Skovholt, T. M., & Ronnestad, M.H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development, 13*, 45-58. Doi: 10.1177/089484530303000103.
- Sledge, W. H., Moras, K., Hartley, D. and Levine, M. (1990). Effect of time-limited psychotherapy on patient dropout rates. *The American Journal of Psychiatry, 147*, 1341-1347. Doi: 10.1176/ajp.147.10.1341.
- Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*, 752–760. Doi: 10.1037/0003-066X.32.9.752.
- Snell-Johns, J., Mendez, J.L. & Smith, B.H. (2004). Evidence based solutions for overcoming access barriers, decreasing attrition and promoting change with underserved families. *Journal of Family Psychology, 18*, 19-35. Doi: 10.1037/0893-3200.18.1.19.
- Snow, M. G., Prochaska, J. O., & Rossi, J. S. (1992). Stages of change for smoking cessation among former problem drinkers: A cross-sectional analysis. *Journal of Substance Abuse, 4*, 107-116. Doi: 10.1177/0145445502026002006.
- Snyder, C. R., Cheavens, J., & Sympson, S. C. (1997). Hope: An individual motive for social commerce. *Group Dynamics: Theory, Research, and Practice, 1*, 107-118.
- Sprenkle, D.H. (2012). Intervention research in couple and family therapy: A methodological and substantive review and an introduction to the special issue. *Journal of Marital and Family Therapy, 38*, 3-19. Doi: 10.1111/j.1752-0606.2011.00271.x.
- Sprenkle, D.H., & Blow, A.J. (2004a). Common factors and our sacred models. *Journal of Marital and Family Therapy, 30*, 113-129. Doi: 10.1111/j.1752-0606.2004.tb01228.x.

Sprengle, D.H., & Blow, A. J. (2007). The role of the therapist as the bridge between common factors and therapeutic change: more complex than congruency with a worldview.

Journal of Marital and Family Therapy, 30, 109-113. Doi: 10.1111/j.1467-6427.2007.00375.x.

Sprengle, D.H., Davis, S.D. & Lebow, J.L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York: The Guilford Press.

Sprengle, D., Piercy, F., Constantine, J., & Denton, W. (1983). Family Goal Attainment Scale. Mimeographed instrument, Department of Child Development and Family Studies, Purdue University, West Lafayette, IN.

Stanton, D. & Shadish, W.R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin*, 122, 170-191. Doi:10.1136/ebmh.1.3.81.

Strauss, A. (1987). *Qualitative analysis*. New York: Cambridge University Press.

Strauss, A., Bucher, R., Enrlich, D., Schatzman, L., & Sabshin, M. (1964). Psychiatric ideologies and institutions. Glencoe, IL: Free Press.

Strauss, E. S., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

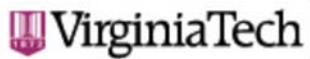
Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.)*. Thousand Oaks, CA: Sage.

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, 15, 215-224. Doi: 10.1002/j.2164-4918.1981.tb00613.x.

- Sundet, R. (2011). Collaboration: Family and therapists' perspectives of helpful therapy. *Journal of Marital and Family Therapy*, 37, 236-249. Doi: 10.1111/j.1752-0606.2009.00157.x.
- Tabachnick, B. G., & Fidell, L. S. (2013). *Using multivariate statistics* (6th ed.). Boston, MA: Pearson.
- Taft, C.T., Murphy, C, M. Musser, P.H., & Remington, N.A. (2004). Personality, interpersonal and motivational predictors of the working alliance in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology*, 72, 349-354. Doi: 10.1037/0022-006X.72.2.349.
- Tambling, R.B. (2012). A literature review of therapeutic expectancy variables. *Contemporary Family Therapy*, 34, 402-415. Doi: 10.1007/s10591-012-9201-y.
- Tambling, R. B., & Johnson, L. N. (2008). The relationship between stages of change and outcome in couple therapy. *The American Journal of Family Therapy*, 36, 229-241. Doi: 10.1080/01926180701290941.
- Tambling, R. B. & Ketring, S. A. (2013). The R-URICA: A confirmatory factor analysis of a revision of the University of Rhode Island Change Assessment. *Contemporary Family Therapy*, 36, 108-119. Doi:10.1007/s10591-013-9279-x.
- Taube, C. A., Burns, B. J., & Kessler, L. G. (1984). Patients of psychiatrists and psychologists in office-based practice: 1980. *American Psychologist*, 39, 1435-1447. Doi:10.1037/0003-066X.39.12.1435.
- Tashakkori, A. and Teddlie, C. (2003). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: Sage.
- Tinsley, H. E. (1980). The expectations about Psychotherapy Questionnaire. Unpublished test manual. Southern Illinois University.

- Tinsley, H. E., Brown, M. T., de St. Aubin, T. M., & Lucek, J. (1984). Relationship between expectations for a helping relationship and tendency to seek help from a campus help provider. *Journal of Counseling Psychology, 31*, 149–160. Doi: 10.1037/0022-0167.31.2.149.
- Tinsley, H. E., & Harris, D. J. (1976). Client expectations for counseling. *Journal of Counseling Psychology, 23*, 173–177. Doi: 10.1007/BF00121519.
- Tinsley, H. E., Workman, K. R., & Kass, R. A. (1980). Factor analysis of the domain of client expectations about counseling. *Journal of Counseling Psychology, 27*, 561–570. Doi:10.1037/0022-0167.27.6.561
- Tryon, G.S. & Winograd, G. (2011). Goal consensus and collaboration. *Psychotherapy, 48*, 50-57. Doi.org/10.1037/a0022061.
- Walitzer, K.S., Dermen, K.H., & Connors, G.J. (1999). Strategies for preparing clients for treatment: A review. *Behavior Modification, 23*, 129-151. Doi: 10.1177/0145445599231006.
- Walker, D. & Myrick, F. (2006). Grounded theory: An exploration of process and procedure. *Qualitative Health Research, 16*, 547-599. Doi: 10.1177/1049732305285972.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum Associates.
- Wang, M., Sandberg, J., Zavada, A., Mittal, M., Gosling, A., Rosenberg, T., Jeffrey, A., McPheters, J. (2006). "Almost there"...Why clients fail to engage in family therapy: An exploratory study. *Contemporary Family Therapy, 28*, 211-224. Doi: 10.1007/s10591-006-9001-3.

- Wark, L. (1994). Therapeutic change in couples' therapy: Critical change incidents perceived by therapists and clients. *Contemporary Family Therapy, 16*, 39-52. Doi: 10.1007/BF02197601.
- Werner-Wilson, R.J. & Winter, A. (2010). What factors influence therapy dropout? *Contemporary Family Therapy, 32*, 375-382. Doi: 10:1007/s10591-010-9131-5.
- Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*, 190-195. doi.org/10.1037/0735-7028.24.2.190.
- Wilkins, W. (1973a). Client's expectancy of therapeutic gain: Evidence for the active role of the therapist. *Psychiatry: Journal for the Study of Interpersonal Processes, 36*, 184–190. Doi: 10.1521/00332747.1973.11023755.
- Wilkins, W. (1973b). Expectancy of therapeutic gain: An empirical and conceptual critique. *Journal of Consulting and Clinical Psychology, 40*, 69–77. Doi: 10.1027/h0034065.
- Williams, E.N. & Morrow, S.L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research Methods, 19*, 576-582. doi: 10.1080/10503300802702113.
- Woodward, C.A, Santa-Barbara, J., Levin, S., Epstein, N.B. (1978). The role of goal attainment scaling in evaluating family therapy outcome. *American Journal of Orthopsychiatry, 48*, 464-476. DOI: 10.1111/j.1939-0025.1978.tb01335.x
- Wynne, L.C. (1988). *The state of the art in family therapy research: Controversies & recommendations*. New York, New York: Family Process Press.

Appendix A: IRB Approval Letter (Qualitative Strand)

Office of Research Compliance
Institutional Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website <http://www.irb.vt.edu>

MEMORANDUM

DATE: September 19, 2014
TO: Fred Piercy, Megan Leigh Dolbin-MacNab, Carissa A Daniello
FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)
PROTOCOL TITLE: Couple and family therapy clients' perspective of how productive change processes impact intended retention: A common factors informed mixed method analysis
IRB NUMBER: 14-538

Effective September 19, 2014, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the Amendment request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<http://www.irb.vt.edu/pages/responsibilities.htm>

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As: Expedited, under 45 CFR 46.110 category(ies) 6,7
Protocol Approval Date: June 2, 2014
Protocol Expiration Date: June 1, 2015
Continuing Review Due Date*: May 18, 2015

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Invent the Future

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
An equal opportunity, affirmative action institution

Appendix B: IRB Approval Letter (Quantitative Strand)

Office of Research Compliance
Institutional Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website <http://www.irb.vt.edu>

MEMORANDUM

DATE: December 8, 2014
TO: Fred Piercy, Carissa A Daniello, Megan Leigh Dolbin-MacNab
FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)
PROTOCOL TITLE: Couple and Family Therapy Clients perspective of how productive change processes impact intended retention: A common factors informed mixed method analysis
IRB NUMBER: 14-1119

Effective December 8, 2014, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the Amendment request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<http://www.irb.vt.edu/pages/responsibilities.htm>

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As: **Exempt, under 45 CFR 46.110 category(ies) 2**
Protocol Approval Date: **November 10, 2014**
Protocol Expiration Date: **N/A**
Continuing Review Due Date*: **N/A**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Invent the Future

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
An equal opportunity, affirmative action institution

Appendix C: Qualitative Recruitment Flyer

**What was helpful about therapy?
What helped you decide to stay in therapy?**

**Participate in a research study
Complete an interview and questionnaire.**

The purpose of this research study is to hear clients' perspectives about what influenced them to stay in therapy until they reach their therapy goals, and whether they ever thought about stopping therapy before reaching their goals. Also, this research aims to understand what clients find most helpful about therapy.

You may volunteer to participate if you are over 18 years old, currently in couple or family therapy, though participating in this study is individual.

- Interviews and questionnaires will be conducted at the Family Therapy Center or a location of your choice.
- Participating in this study will take about one hour.
- Participation is voluntary and there are no consequences for not participating. Choosing to participate, or choosing not to participate will not impact the treatment you receive at the Family Therapy Center at Virginia Tech.
- Your responses are confidential.
- Your therapist will not be informed of your participation or your responses.
- Your participation would be a valuable research contribution for marriage and family therapists and students.

For more information about this research study, contact:

**Carissa D'Aniello
Phone: 203-605-0390
Email: Cariad4@vt.edu**

**To thank you for the time and effort involved in participating
you will receive a \$20 grocery store gift card.**

This research study is being conducted by a doctoral candidate in the marriage and family therapy program, Human Development Department at Virginia Tech as part of a doctoral dissertation under the direction of Fred Piercy Ph.D.

Appendix D: Qualitative Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Couple and family therapy clients' perspectives of how productive change processes impact intended retention: A common factors informed mixed method analysis

Investigators: Carissa D'Aniello, M.A., Fred Piercy, Ph.D., Megan Dolbin-MacNab, Ph.D., Department of Human Development, Virginia Tech.

I. Purpose of this research

The purpose of this research study is to hear clients' perspectives about what influences them to consider staying in therapy until they reach their therapy goals, or to consider stopping therapy before they reach their goals. This research also aims to understand what clients find most helpful for meeting their therapy goals. Almost half the clients who begin therapy stop therapy before they meet their goals. Little is known about how helpful change processes (things that happen in therapy sessions that contribute to change) help people meet their therapy goals and continue with therapy. The purpose for collecting both interview responses and questionnaire responses is to compare the results to develop a detailed understanding of the process by which clients decide stay in therapy until their goals are met, or to stop therapy. The results of this research study will be presented as a doctoral dissertation, and possibly publication and conference presentations.

II. Procedures

Participants will be asked to participate in an interview and complete a brief questionnaire about what was most helpful about therapy and what has influenced them to continue therapy, or to consider stopping therapy. Interviews will be scheduled, and will last about 45 minutes, and the questionnaire will take approximately 15 minutes to complete. The interview and questionnaire will be completed in a private room in the Family Therapy Center at Virginia Tech or a convenient location of your choice.

III. Risks

A potential risk of participating is that you may feel unduly influenced by your therapist to participate. Your participation is voluntary, you may choose not to participate, or you may stop participating at any time without impact on your therapy treatment. Another risk is that you may feel concerned about the confidentiality of your responses, specifically that your therapist will see your responses. You have been informed that your interview and questionnaire responses are confidential, and no information linking your identity to your responses will be collected, nor will it be shared with your therapist.

IV. Benefits

A potential benefit of participation in the study is the positive feelings associated with sharing your therapy experience. A potential indirect benefit of your participation is helping therapists increase their understanding of what helps clients stay in therapy and meet their therapy goals. No promise or guarantee of benefits has been made to encourage you to participate. Results are available after data analysis is complete upon your request.

V. Extent of Anonymity and Confidentiality

Interviews will be audio-recorded. Participants and therapists will be identified by a false name, chosen by you, the participant. Do not reveal the name of your therapist to the researcher. Audio recordings will be treated as confidential at all times, and destroyed after they are transcribed.

Responses to questionnaires will be collected using hard copy (pencil and paper) questionnaire. Individual questionnaires will not contain identifying information. Study codes will be used to protect participant

confidentiality. That is, participants' interview and survey responses will be linked using a separate, confidential data file linking participants' name to a unique study ID. The unique study ID will be written at top of each completed questionnaire and attached to the interview transcript.

Limits to Confidentiality

There are times when the researcher may be legally or ethically required to divulge information against your wishes. The researcher is required by professional ethics and law to report evidence or suspicion of child or adult abuse or neglect, with or without your consent. The researcher is also required by professional ethics and law to report threats of physical harm to self or others, regardless of your wishes.

VI. Compensation

To thank you for the time and effort involved in participating, you will receive a \$20 Kroger © gift card.

VII. Freedom to Withdraw

Participation is voluntary and you may choose to stop participation at any time without penalty or impact on your therapy treatment.

VIII. Subject's Responsibilities

You voluntarily agree to participate in this study. You have the following responsibilities: (a) scheduling with the researcher an interview; (b) signing consent forms; (c) participating in a 45 minute interview and (d) completing a 15 minute questionnaire.

IX. Subject's Permission

I have read the Consent Form and the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

Participant Signature _____ Date _____

Researcher's Signature _____ Date _____

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

Carissa D'Aniello, M.A.
Ph.D. Candidate
Virginia Tech
203-605-0390
cariad4@vt.edu

Megan Dolbin-MacNab, Ph.D.
Associate Professor, Marriage and Family Therapy
Clinical Training Director, Family Therapy Center
540-231-6807
mdolbinm@vt.edu

Fred P. Piercy, Ph.D.
Professor, Marriage and Family Therapy
Virginia Tech
piercy@exchange.vt.edu

David M. Moore
Chair, Virginia Tech institutional Review
Board for the Protection of Human Subjects
540-231-4991
Moored@vt.edu

Appendix E: Qualitative Interview Prompts

Qualitative Interview Prompts

The purpose of these questions is to conduct research about the helpful things that happened in therapy, and how you decided to continue therapy or stop therapy. If at any time you no longer wish to participate in the study you may quit at any time without penalty. You may choose not to answer any questions without penalty. As we talk about you and your therapist, we will choose a false name to identify you and your therapist. Please do not reveal the actual name of your therapist to me. Lets choose false names now.

Topic 1: Goal & Progress

1. Thinking about the problem that brought you to therapy, what was it about this problem made you decide to go to therapy?
2. How important is resolving this problem in your decision to stay in therapy?
3. What about this problem did you think would change because you came to therapy?
4. How many sessions (or how long) did you think it would take to make these changes?

Topic 2: Therapists' Understanding of Goal & Progress

1. How important is it that your therapist understands the changes you want to make? Why?
 - a. How would you know if your therapist understands your problem and the progress you want to make?
2. How many times would you be willing to explain it to your therapist before you started thinking they really don't understand?

Topic 3: Most helpful about therapy

1. What happened in therapy that helped you make the most progress on this problem?
2. Describe a time when you felt you were making good progress in therapy.
 - a. How did you know you were making progress toward your goal?
3. Do you think this progress is because of therapy?

Topic 4: Lack of progress (feeling stuck).

1. Was there a time during therapy when you felt stuck? (Making little or no change) Describe.
2. How did you know you were not making change?
3. Did you find therapy beneficial even if you didn't see any change happening?
4. During this time, how did you feel your next appointment?

Topic 5: For Participants Who Considered Ending Therapy

1. Describe a time you considered stopping therapy? (*If no, move to topic 6 immediately*)
 - a. What things did you consider?
 - b. What would it have taken for you to quit?
 - c. What impacted your decision?
2. What kind of things influenced your decision to stay in or drop out?

Topic 6: For Participants Who Didn't Consider Ending Therapy:

Many clients drop out of therapy, or at least think about it.

1. Why do you think you never considered stopping therapy?
2. If you did get frustrated with therapy, and you decided to quit, is there anything that could change your mind?

Appendix F: Quantitative Survey

Helpful Change Processes and Staying In Therapy

Directions: The purpose of this survey is to conduct research that will help therapists understand what you think is helpful about therapy and how you decided to continue or stop therapy. Please answer all questions thinking about your current therapy and mark the first answer that comes to your mind.

SECTION ONE: Basic Information					
Age:	Ethnicity:		American Indian/Alaska Native	White	
	Native Hawaiian/Pacific Islander	Middle Eastern	Hispanic or Latino	Mixed Race	Asian
Gender:	Male	Female	Transgender	Other: _____	
	<input type="checkbox"/> Prefer Not To Answer				
1. What is your current relationship status: <input type="checkbox"/> Single <input type="checkbox"/> Committed Relationship <input type="checkbox"/> Live with my partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other: _____					
2. How many sessions have you had with your current therapist? Between 1 & 4 Sessions Between 5 & 8 Sessions 9 or more sessions					
3. What type of therapy are you currently receiving: <input type="checkbox"/> Couple Therapy <input type="checkbox"/> Family Therapy					
4. Since starting therapy with your current therapist, the problem you came here for is: Much Better(1) Somewhat better (2) About the same (3) Somewhat worse Much worse					
5. Overall, how helpful has your current therapy been in achieving the change you want to make? Very Helpful Somewhat Helpful Somewhat Unhelpful Very Unhelpful					
6. Considering your responses to the questions above, are you most likely to: Continue therapy until you make the change you want to make Stop therapy before you make the change you want to make Does not apply. Please explain: _____					
7. Select the category that best describes how you feel about continuing therapy: I will stop therapy because I've made change I will continue coming to therapy because I am making good progress toward change I will continue coming to therapy, but I am not making progress toward change I will stop therapy because I am not making progress toward change None of these apply to me. Explain: _____					
SECTION TWO: Relationship With Your Therapist					
Directions: Choose the response that describes the way you feel about your therapist most of the time.					
	Always	Very Often	Fairly Often	Sometimes	Seldom
1. Because of therapy sessions, I am clearer as to how I can change.	5	4	3	2	1
2. Therapy gives me new ways of looking at my problem.	5	4	3	2	1
3. I believe my therapist likes me.	5	4	3	2	1
4. My therapist and I collaborate on setting goals for my therapy.	5	4	3	2	1
5. My therapist and I respect each other.	5	4	3	2	1
6. My therapist and I agree on the goals we are working on.	5	4	3	2	1
7. I feel that my therapist appreciates me.	5	4	3	2	1
8. We agree on what is important for me to work on.	5	4	3	2	1
9. My therapist cares about me even when I make mistakes.	5	4	3	2	1
10. The things I do in therapy help me accomplish the things that I want.	5	4	3	2	1
11. My therapist and I understand of the changes I want to make.	5	4	3	2	1
12. I believe the way we are working with my problem is correct.	5	4	3	2	1

13. How important is your relationship with your therapist in your decision to continue therapy?	4	3	2	1	
SECTION Three: Helpful Change Events					
Directions: Select the response that best describes how helpful the event was in contributing to the overall change you made so far in therapy. If the event described did not happen in the course of your therapy, please select "Does not apply". Response categories in gray correspond to the items in gray.					
Therapy is most helpful for me when:	Very Helpful / Important	Somewhat Helpful / Important	Somewhat Unhelpful / Unimportant	Not helpful / Important	Does Not Apply
1. I notice small changes early in therapy.	5	4	3	2	1
1a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
2. our therapist helps us clarify our therapy goals	5	4	3	2	1
2a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
3. something helpful happens in each session.	5	4	3	2	1
3a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
4. we revisit an important topic several times.	5	4	3	2	1
4a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
5. subtle changes happen gradually.	5	4	3	2	1
5a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
6. our therapist is fair to both of us.	5	4	3	2	1
6a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
7. our therapist makes us feel safe and comfortable.	5	4	3	2	1
7a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
8. our therapists' pace is comfortable for us.	5	4	3	2	1
8a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
9. our therapist helps us feel hopeful that we can reach our goals.	5	4	3	2	1
9a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
10. our therapist slows down when we need to.	5	4	3	2	1
10a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
11. our therapist senses when to challenge us and when not to.	5	4	3	2	1
11a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
12. we can talk to our therapist if therapy isn't working.	5	4	3	2	1
12a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
13. we talk about the problem after therapy sessions.	5	4	3	2	1
13a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1

14. Changes in me lead to changes in our relationship.	5	4	3	2	1
14a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
15. we talk about the problem that brought us to therapy in sessions.	5	4	3	2	1
15a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
16. life events challenge us to use the skills we learn in therapy.	5	4	3	2	1
16a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1
17. our therapist encourages us to talk to each other, not only to him/her.	5	4	3	2	1
17a. How important was this in your decision to continue or to stop therapy?	5	4	3	2	1

Appendix G: Quantitative Recruitment Flyer

Take a Brief Online Survey

The purpose of this research survey is to hear your positive and not as positive experiences in therapy.

To participate you must be over 18 years old, currently in individual, couple or family therapy with a marriage and family therapist.

- Type this link into your internet browser:
<http://questionpro.com/t/ALIdzZRrBy>

- The survey takes about 10 minutes
- Participation is voluntary and there are no consequences for not participating.
- Choosing to participate, not to participate will not impact your therapy treatment.
- Your responses are confidential.
- Your responses will not be shared with your therapist or therapy agency.

Participants receive a \$5 Amazon gift card.

(Gift card pops up on your screen when the survey is completed)

For more information, please contact:

Carissa D'Aniello
Phone: 203-605-0390
Email: Cariad4@vt.edu

Appendix H: Consent form (Quantitative Strand)

Couple and family therapy clients' perspectives of how productive change processes impact intended retention: A common factors informed mixed methods analysis

6%

[Exit Survey](#)

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Couple and family therapy clients' perspectives of how productive change processes impact intended retention: A common factors informed mixed method analysis.

Investigators: Carissa D'Aniello, M.A., Fred Piercy, Ph.D., Megan Dolbin-MacNab, Ph.D., Department of Human Development, Virginia Tech, Jeana Rae Alvarado, Ericka Hulbert, Sarah Elashmawy, Sean Miller.

I. Purpose of this research
The purpose of this research study is to obtain survey responses from current therapy clients about what was helpful or unhelpful about therapy, and what influenced them to stay in therapy, or to stop therapy before reaching their goals. Almost half the clients who begin therapy stop therapy before they meet their goals. Little is known about how helpful change processes (things that happen in therapy sessions that contribute to change) help people stay in therapy and meet their goals. The purpose for collecting survey responses is to develop a detailed understanding of the process by which clients decide stay in therapy until their goals are met, or to stop therapy. The results of this research study will be presented as a doctoral dissertation, publication and conference presentations.

II. Procedures
Participants will be asked complete a 15 minute online survey about what was helpful or unhelpful about therapy, and what influenced them to stay in therapy, or to stop therapy before reaching their goals.

III. Risks
A potential risk of participating is that you may feel unduly influenced by your agency or therapist to participate. Your participation is voluntary, you may choose not to participate without impact on your therapy treatment. Another risk is that you may feel concerned about the confidentiality of your responses. Your responses are confidential, and no information linking your identity to your responses will be collected.

IV. Benefits
A potential benefit of participation in the study is the positive feelings associated with sharing your therapy experience, and helping therapists increase their understanding of what helps clients stay in therapy and meet their therapy goals. No promise or guarantee of benefits has been made to encourage you to participate. Results are available after data analysis is complete upon your request.

V. Extent of Anonymity and Confidentiality
Survey responses are collected using a web-based format and contain no identifying information.

VI. Compensation

To thank you for the time and effort involved in participating, you will receive a \$5 Amazon gift card.

VII. Freedom to Withdraw

Participation is voluntary and you may choose to stop participation at any time without penalty or impact on your therapy treatment.

VIII. Subject's Responsibilities

You voluntarily agree to participate in this study. You have the following responsibilities: (a) sign consent form presented; (b) complete a 15-minute questionnaire.

IX. Subject's Permission

I have read the Consent Form and the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

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

Carissa D'Aniello, M.A.

Ph.D. Candidate

Virginia Tech

203-605-0390

cariad4@vt.edu

Megan Dolbin-MacNab, Ph.D.

Associate Professor, Marriage and Family Therapy

Clinical Training Director, Family Therapy Center

540-231-6807

mdolbinm@vt.edu

Fred P. Piercy, Ph.D.

Professor, Marriage and Family Therapy

Virginia Tech

piercy@exchange.vt.edu

David M. Moore

Chair, Virginia Tech institutional Review

Board for the Protection of Human Subjects

540-231-4991

Moored@vt.edu

I Agree

Continue

Appendix I: Productive Change Processes Inventory Construct Map

Construct Map for Helpful Change Processes Inventory

Construct 1: Therapeutic Alliance Factors

- Safety / comfort / vulnerability
- Therapist was direct when necessary and non-direct when necessary
 - In other words – the therapist knew when to take a stand and offer a suggestion and when to listen and collaborate
- Therapist pacing worked for clients
- Therapist focused/guided and structured sessions

Construct 2: Processes

- Encourage and facilitate interaction between clients
- Co-construct clear goals and a plan to meet those goals
- Repetition of topics
- Focus on the presenting problem (keep it a conversation topic, always connect to it)
- Change occurs in:
 - Communication: How clients talk to each other
 - Emotion: How clients feel
 - Cognition: How clients think
 - Action: What clients do

Construct 3: Timeframe

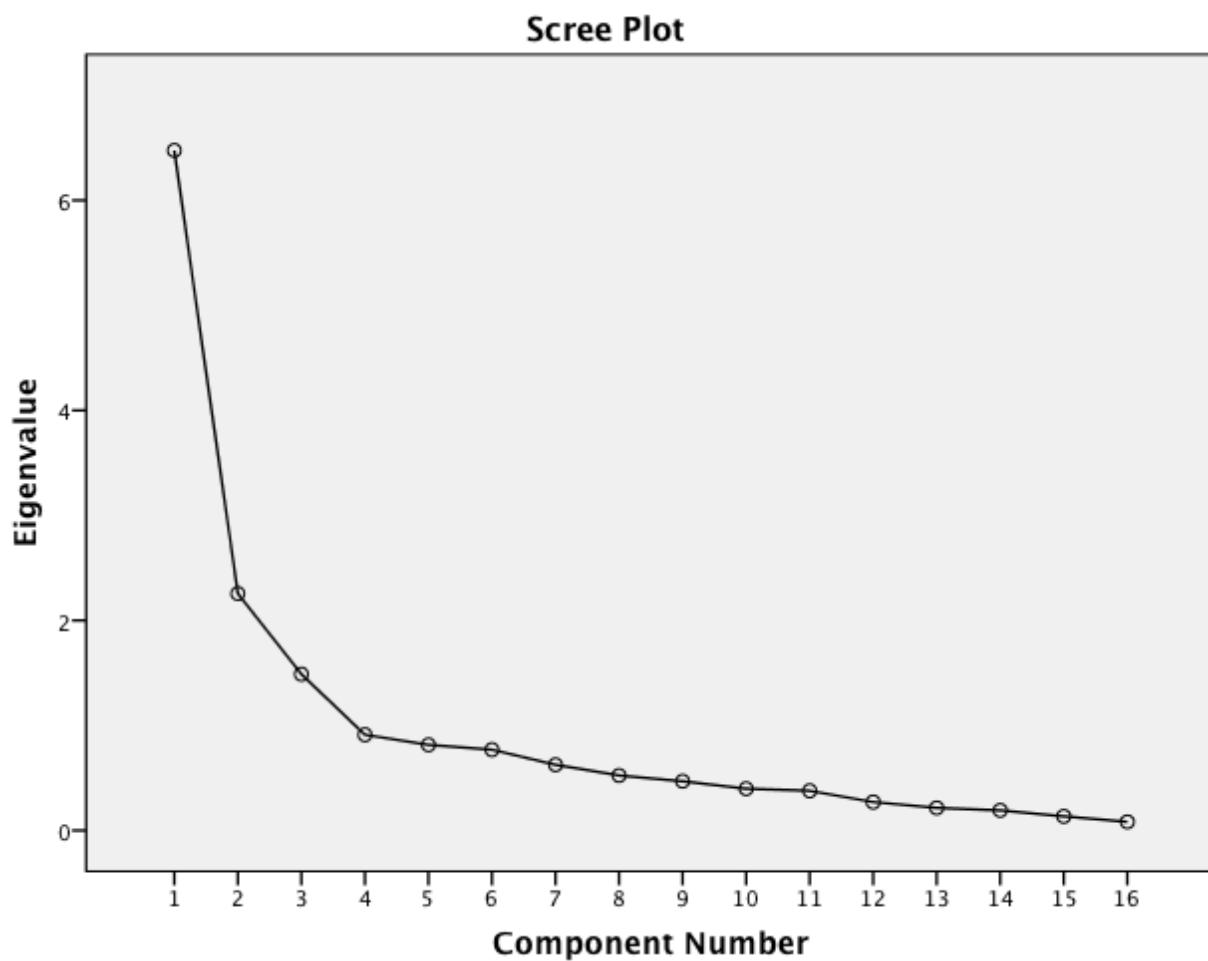
- Early change moments are important contributors to retention
 - Foster hope that therapy will work
- Something helpful should happen each session
- Change happens gradually, sometimes so subtly that there are no markers

Construct 4: Locus of Control

- Most believe that change happens on the individual level (67%) not the relationship level (29%) (Helmeke & Sprenkle, 2000).

Appendix J: Productive Change Processes Inventory Content Validity Check

Construct & Citation	Item	Degree to which the item captures the concept
The majority of pivotal moments identified occurred in the first 3 sessions of therapy (Helmke & Sprenkle, 2000).	<i>Therapy is most helpful for me when:</i>	
Early changes help clients believe that change can occur (Blow, Morrison, Tamaren, Wright, 2009).	1. I notice small changes early in therapy.	
The therapist helped clients uncover or clarify what the true problem was (Helmke & Sprenkle, 2000).	2. our therapist helps us clarify our therapy goals	
Clients feel stuck when they do not have clear goals and a clear plan (Blow et al., 2009).	3. something helpful happens in each session.	
An average of one pivotal moment per session was identified (Helmke & Sprenkle, 2000).	4. we revisit an important topic several times.	
Repetition of a topic lead to a pivotal moment (Helmke & Sprenkle, 2000).		
Pivotal moments usually have a gradual build-up of events preceding them (Helmke & Sprenkle, 2000).		
Change happened in a gradual, incremental process rather than one pivotal moment (Christensen, 2000).	5. subtle changes happen gradually.	
Couples identified discussions outside of therapy as contributing to pivotal moments (Helmke & Sprenkle, 2000).	6. we discuss the problem after therapy sessions.	
<i>Contextual factors frequently mentioned by participants as contributing to the perceived change were safety and fairness (Helmke & Sprenkle, 2000).</i>		
Clients reported that feeling comfortable with the therapist made a big difference in helping them change (Blow et al., 2009).		
Clients feel that they have a trusting connection with their therapist (Christensen et al., 1998).	7. our therapist makes us feel safe and comfortable.	
<i>Therapy works best when therapists do not push their agendas aggressively, but fold them into the process (Blow et al., 2009).</i>		
Clients appreciate the therapists pace of sessions (Christensen et al., 1998).	8. our therapists' pace is comfortable for us.	
Early moments in therapy may set the tone for therapy and established hope (Helmke & Sprenkle, 2000).		
The therapist created a sense of optimism and encouragement (Wark, 1994).	9. our therapist helps us feel hopeful that we can reach our goals.	
If clients felt confident that things were improving, they perceived change was occurring.		
Slowing communication so participants hear and understand the content of messages was a vital factor in change (Helmke & Sprenkle, 2000).		
Therapists occasionally slow the process of a discussion (Christensen et al., 1998).	10. our therapist slows down when we are angry.	
Both non-directive and directive styles of the therapist were important to clients (Wark, 1994).	11. our therapist senses when to be direct and when not to be.	
The therapist does not become permanently aligned with one spouse, but understands each spouse's perspective (Christensen et al., 1998).	12. our therapist is fair to both of us.	
Locus of control was often on the self as opposed to the relationship (Helmke & Sprenkle, 2000).	13. changes in me lead to changes in our relationship.	
Clients who experienced change were motivated to change in spite of a history of difficulties (Blow et al., 2009).	14. I stayed motivated to change the problem throughout therapy.	
When a pivotal moment occurred, the topic being discussed at the time was highly likely to be related to the presenting problem (Helmke & Sprenkle, 2000).	15. we talk about the problem that brought us to therapy during sessions.	
Extratherapeutic events can be used as effective mechanisms to identify change (Blow et al., 2009).	16. life events challenge us to use the skills we learn in therapy.	
Therapists encouraged relating between clients rather than between therapist and clients (Wark, 1994).	17. our therapist encouraged us to talk to each other rather than only to her.	

Appendix K: PCA Scree Plot Results

Appendix L: Permission to use Scales

Permission to use IORS and TSF

From: Jerome Adams jadams@uri.edu
Subject: RE: Permission to use modified version of IORS
Date: June 24, 2014 at 9:41 AM
To: Carissa D'Aniello cariad4@vt.edu

Hi Carissa,

Absolutely you can't use it. Sounds like an interesting study! Say hi to Fred for me.

Jerome

From: Carissa D'Aniello [mailto:cariad4@vt.edu]
Sent: Monday, June 23, 2014 9:16 PM
To: Jerome Adams
Subject: Permission to use modified version of ORS

Dear Dr. Adams,

My name is Carissa and I am one of Dr. Piercy's doctoral students in marriage and family therapy at Virginia Tech. I am in the process of planning my dissertation. I am studying client's perceptions of helpfulness of therapy and intention to continue therapy. I am writing to request your permission to use a modified version of your Immediate Outcome Rating Scale as part of my dissertation research. I have included my modification of the question and response categories below.

Thank you in advance for your time and consideration,
Carissa

Carissa D'Aniello, M.A.
Doctoral Candidate
Virginia Tech

7. Select the category that best describes how you feel about continuing therapy:
- I will stop therapy because I've made change
 - I will continue coming to therapy because I am making good progress toward change
 - I will continue coming to therapy, but I am not making progress toward change
 - I will stop therapy because I am not making progress toward change
 - None of these apply to me. Explain:

Permission to use WAI

From: Adam Horvath <prof.aoh@gmail.com>
Subject: Re: Permission to use the WAI
Date: August 7, 2014 at 11:24:08 PM PDT
To: "Carissa D'Aniello" <cariad4@vt.edu>

Dear Carissa

NO payment required!

You can obtain copies of the Working Alliance Inventory (in a variety of forms) from my web site <http://wai.profhovrath.com>

The WAI is copyright, not in the public domain. You may download a copy of the instrument from the web for review purposes. If you wish to obtain permission to USE the instrument for research or clinical work, you need a Limited Copyright Release (LCR). To get an LCR you can activate the link posted on the web page OR use this link: <http://websurvey.sfu.ca/survey/33238145> to jump there directly.

I do not charge for copyright release of the WAI if it is used in non-funded/not-for-profit research. If you have funding for purchasing material, or plan to use it in a commercial environment, please contact me by e-mail and give me some details about how you planning to use the instrument. I do not permit the distribution or publication of the instruments to which I hold copyright to be published electronically or in other form without my express written permission.

I no longer maintain a "User Manual" for the WAI --it is easy to administer-- however, if you need some information on the use and interpretation either go to <http://wai.profhovrath.com> or, for a more detailed discussion, read my chapter in: Horvath, A. O. (1994). Empirical validation of Bordin's pan theoretical model of the alliance: The Working Alliance Inventory perspective. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* New York: Wiley .

I would appreciate if you inform me the results of your study (or the references where such results may be located) as I keep a database of such material both for the refinement of the instrument and as a resource for myself and others who are exploring this field.

Please do not hesitate to contact me if I can be of further assistance.

Sincerely;

Adam O. Horvath Professor Emeritus
Faculty of Education and Dept. of Psychology

Appendix M: Chi Square Tests for Dropout Status by PCPI Component

Results of Chi-square Test and Descriptive Statistics for Dropout Status by PCPI Component

PCPI 1	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	5	23
Somewhat Helpful	6	26
Somewhat Unhelpful	4	2
Not Helpful	1	2
Does Not Apply	1	2

Note. $\chi^2 = 7.415$, df = 4, Asymp. Sig., .116, $p < .05$

PCPI 2	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	3	31
Somewhat Helpful	8	20
Somewhat Unhelpful	2	1
Not Helpful	1	0
Does Not Apply	1	2

Note. $\chi^2 = 14.518$, df = 4, Asymp. Sig., .006, $p < .05$

PCPI 3	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	2	29
Somewhat Helpful	7	20
Somewhat Unhelpful	6	5
Not Helpful	0	1
Does Not Apply	2	0

Note. $\chi^2 = 17.757$, df = 4, Asymp. Sig., .001, $p < .05$

PCPI 4	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	5	34
Somewhat Helpful	9	16
Somewhat Unhelpful	0	0
Not Helpful	3	4
Does Not Apply	0	0

Note. $\chi^2 = 6.392$, df = 4, Asymp. Sig., .094, $p < .05$

PCPI 5	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	5	36
Somewhat Helpful	7	28
Somewhat Unhelpful	5	7
Not Helpful	0	1
Does Not Apply	0	0

Note. $\chi^2 = 11.100$, df = 3, Asymp. Sig., .011, $p < .05$

PCPI 6	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	6	38
Somewhat Helpful	8	20
Somewhat Unhelpful	2	2
Not Helpful	0	0
Does Not Apply	1	11

Note. $\chi^2 = 12.291$, df = 3, Asymp. Sig., .006, $p < .05$

PCPI 7	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	10	44
Somewhat Helpful	4	8
Somewhat Unhelpful	2	0
Not Helpful	0	0
Does Not Apply	1	3

Note. $\chi^2 = 7.880$, df = 3, Asymp. Sig., .049, .p < .05

PCPI 8	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	7	38
Somewhat Helpful	4	12
Somewhat Unhelpful	4	1
Not Helpful	0	0
Does Not Apply	1	2

Note. $\chi^2 = 10.737$, df = 3, Asymp. Sig., .013, .p < .05

PCPI 9	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	3	37
Somewhat Helpful	9	13
Somewhat Unhelpful	3	1
Not Helpful	1	0
Does Not Apply	1	3

Note. $\chi^2 = 18.321$, df = 4, Asymp. Sig., .001, .p < .05

PCPI 10	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	7	32
Somewhat Helpful	7	17
Somewhat Unhelpful	1	1
Not Helpful	0	0
Does Not Apply	2	5

Note. $\chi^2 = 1.972$, df = 3, Asymp. Sig., .578, .p < .05

PCPI 11	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	5	31
Somewhat Helpful	6	20
Somewhat Unhelpful	2	0
Not Helpful	1	0
Does Not Apply	3	4

Note. $\chi^2 = 13.034$, df = 4, Asymp. Sig., .011, .p < .05

PCPI 12	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	6	32
Somewhat Helpful	4	15
Somewhat Unhelpful	3	2
Not Helpful	3	1
Does Not Apply	1	5

Note. $\chi^2 = 11.046$, df = 4, Asymp. Sig., .026, .p < .05

PCPI 13	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	3	23
Somewhat Helpful	2	13
Somewhat Unhelpful	4	1
Not Helpful	3	1
Does Not Apply	5	17

Note. $\chi^2 = 17.661$, df = 4, Asymp. Sig., .001, $p < .05$

PCPI 14	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	8	30
Somewhat Helpful	5	9
Somewhat Unhelpful	1	2
Not Helpful	0	1
Does Not Apply	3	13

Note. $\chi^2 = 1.951$, df = 4, Asymp. Sig., .745, $p < .05$

PCPI 15	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	6	26
Somewhat Helpful	1	19
Somewhat Unhelpful	8	1
Not Helpful	1	1
Does Not Apply	1	8

Note. $\chi^2 = 27.075$, df = 4, Asymp. Sig., .000, $p < .05$

PCPI 16	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	4	29
Somewhat Helpful	5	18
Somewhat Unhelpful	3	1
Not Helpful	1	0
Does Not Apply	3	3

Note. $\chi^2 = 15.112$, df = 4, Asymp. Sig., .010, $p < .05$

PCPI 17	Dropout Status	
	Intend to drop out	Intend to stay in
Very Helpful	5	28
Somewhat Helpful	5	11
Somewhat Unhelpful	4	0
Not Helpful	1	1
Does Not Apply	2	14

Note. $\chi^2 = 16.945$, df = 4, Asymp. Sig., .005, $p < .05$