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Pepperdine University

Graduate School of Education and Psychology

CLIENT PERCEPTIONS OF THE MOST AND LEAST HELPFUL ASPECTS OF COUPLE THERAPY

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Jessica Nelson

September, 2008

Kathleen Eldridge, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Jessica Nelson

Under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

September 15, 2008

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TABLE OF CONTENTS

LIST OF TABLES

Page

ACKNOWLEDGEMENTS

This dissertation has been a collaborative effort that has benefited from the generous support of many mentors, colleagues, friends, and family, all of whom have been a significant part of this process. I am particularly grateful and honored to have worked with my chair, Dr. Kathleen Eldridge, who mentored me through the exciting as well as more difficult times not only with my dissertation but also through my entire doctorate program. Her couple therapy interests and expertise inspired me to do this work, her compassion and thoughtfulness helped shape me as a budding researcher and clinician, and her patience and belief in me was invaluable. I would also like to express my gratitude toward the other members of my committee; to Dr. Joy Asamen for guiding me through the crucial, initial stages of the dissertation process and for her impeccable edits and expertise in research and statistical methods, and to Dr. Clarence Hibbs for dedicating himself to this project and for his kind and reflective feedback. I am also grateful to Dr. Mark Baker, who believed in me, encouraged me to pursue my graduate studies, gave me my first few couples to work with, and taught me to be myself both inside and outside of the therapy room. I am grateful to Dr. Aaron Aviera for his confidence and faith in me throughout my graduate studies and clinical experiences, and I am additionally thankful for the data analysis expertise of Dr. Yuying Tsong who helped immensely in the ending stages of the dissertation process. Thank you also to Victoria Koven Farber, my guardian angel, who graciously and unwaveringly devoted her time to listening to my experiences. This dissertation would not be possible without the permission of data use from Dr. Andrew Christensen as well, and to him I am grateful for sharing his incredibly amazing dataset with a student who admires him from a distance.

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EDUCATIONAL HISTORY

Doctoral Student in Clinical Psychology, APA-accredited Psy.D. program
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Master of Arts in Clinical Psychology with an emphasis in Marriage and Family Therapy
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Graduated May 2005, GPA 4.0/4.0

Bachelor of Arts in Psychology
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Graduated June 2003

- Dean's Honor List
- National Dean's Honor List
- Psi Chi National Honor Society
- President of the Beta Pi chapter of Kappa Kappa Gamma

CLINICAL TRAINING EXPERIENCE

Clinical Psychology Intern
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September 2008 – August 2009
Supervisor: Tamar Bourian, Psy.D., licensed psychologist

- Conduct intake interviews and brief and long-term individual psychotherapy for an adult, outpatient population in a community-based mental health setting, including diagnosis, assessment, and case management
- Provide group counseling to adults with varying mental health disorders, including topics such as anger management, relationship building, creative expressions, self-esteem, and healthy lifestyles
- Conduct psychological testing on adults with varying mental health disorders, involving cognitive, emotional, and personality assessment
- Conduct peer supervision with practicum-level students in order to gain experience in a supervisory role
- Participate in weekly individual and group supervised practical experience in order to enhance treatment planning, maintain legal and ethical requirements, and consult with other treatment team members
- Exposed to issues and skill development in community/clinical psychology such as community consultations, systems concerns, and indirect psychological services

Practicum Trainee
Long Beach Job Corps Health and Wellness Center
Long Beach, CA
September 2007 – August 2008
Supervisor: Joe Grillo, Ph.D., licensed psychologist

- Conducted intake interviews with disadvantaged youth ages 16-24 in order to assess for treatment, crisis issues, and need for intervention in cases of substance abuse
- Provided long-term, ongoing individual psychotherapy to address family histories of abuse, trauma, gang activity, and substance abuse
- Participated in weekly group and individual supervision to enhance treatment planning, assessment, and maintain legal and ethical requirements

Peer Supervisor
Pepperdine University Graduate School of Education and Psychology
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August 2007 – August 2008
Supervisor: Aaron Aviera, Ph.D., licensed psychologist

- Met weekly with two student supervisees for 1 hour each in order to discuss supervisees' cases, provide support and feedback, review chart notes, and discuss legal and ethical issues
- Throughout the year, met with three additional student supervisees for 1 hour each, also to discuss cases, provide support and feedback, review chart notes, and discuss legal and ethical issues
- Attended weekly case conference to support supervisees in their role as therapists and in supervision
- Attended supervision with the clinic director in order to review supervisees' cases and ensure legal and ethical guidelines were followed
- Participated in clinic outreach and networking activities, clinic program development projects, and quality assurance through chart reviews

Practicum Trainee
UCLA/NPI Medical Psychology Assessment Center
Los Angeles, CA
August 2006 – August 2007
Supervisor: Po Lu, Psy.D., licensed psychologist

- Administered, scored, and interpreted comprehensive neuropsychology assessment batteries for geriatric patients experiencing memory impairment in order to assess for cognitive decline
- Completed assessment reports for the patient's referring medical practitioner to provide feedback to the patients
- Participated in weekly group and individual supervision to ensure legal and ethical report writing occurs and that writing skills were developed and enhanced over time
- Attended weekly didactic trainings in infant and child development, and informal neuropsychology assessment

Practicum Trainee
Union Rescue Mission Counseling Center
Los Angeles, CA
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- Conducted intake interviews with homeless adult male and female clients with a history of drug and alcohol abuse in order to assess for treatment
- Provided ongoing individual therapy utilizing Cognitive-Behavioral and Psychodynamic therapies to increase coping skills and address past influences on current experiences and behavior
- Led one "Anger Management" group therapy for clients in the yearlong program at Union Rescue Mission
- Participated in weekly group and individual supervision for enhanced treatment planning

Graduate Assistant
Pepperdine University Graduate School of Education and Psychology
Los Angeles, CA
September 2005 – September 2006

- Created, maintained, and updated student placement files for master-degree level teachers resulting in an organized job application
- Assisted students through conducting workshops on file maintenance, resume, and cover letter writing in order to help them secure jobs
- Reviewed and edited graduate student resumes, cover letters, and curriculum vitas
- Created a database of local school districts and developed contacts in order to assist students in applying for teaching jobs

Practicum Trainee
La Vie Counseling Center
Pasadena, CA and Santa Monica, CA
January 2004 – May 2005
Supervisor: Mark Baker, Ph.D., licensed psychologist

- Conducted intake interviews and formulated treatment plans in order to evaluate the need for therapeutic services and referrals
- Provided weekly child, individual, family, and marital counseling using a long-term psychodynamically-oriented (object-relations theory) approach
- Administered Adult Attachment Interviews and Child History Questionnaires resulting in history gathering and treatment planning
- Led two eight-week "Anger Management" groups to provide treatment to clients
- Participated in weekly individual and group supervision in order to learn consistency and competency as a therapist-in-training

Activities Coordinator
Big Brothers Big Sisters of King County, Washington
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November 2002 – June 2003

- Designed and scheduled community activities for Big Brothers/Big Sisters ("Bigs") and Little Brothers/Little Sisters ("Littles") to foster togetherness and participation
- Created, updated, and distributed a monthly newsletter to all members describing activities to increase communication between the organization and its members
- Maintained a monthly budget through organization and careful monetary distribution consideration used to advertise and hold activities for the "Bigs" and "Littles"
- Established communication with several supporting community organizations
- Received and distributed all donated items to the "Littles"

Undergraduate Intern
Vision Creation, Inc.
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September 2002 – December 2002

- Managed the office of a licensed therapist by maintaining client contacts and reminding clients of scheduled appointments in order to learn the business aspects of private practice
- Gathered insurance reimbursement and filed client records resulting in an organized office

RESEARCH EXPERIENCE

Research Assistant
University of Washington, Department of Psychology
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Supervisor: Liliana Lengua, Ph.D.
Coordinated the data collection and recording for a research project examining the physiological and psychological development of three to four year olds

- Collected data from video tapes and recorded findings in order to maintain a database of observed behaviors
- Conducted phone interviews to recruit parents of the potential participants and maintained contact with families throughout their long-term participation
- Acted as a liaison between families and the principal investigator resulting in increased communication

Research Assistant
University of Washington, Department of Psychology
Seattle, WA
September 2000 to January 2001
Supervisor: John Gottman, Ph.D.
Participated in the coordination of a long-term research study of marriage and couples in long-term relationships

- Collected data from video tapes of couples in order to record behavioral observations and draw conclusions
- Helped design and record data on a computer program to eliminate non-relevant findings and create a database of recorded behaviors
- Reported initial findings to supervisor in order to establish baselines

TEACHING EXPERIENCE

Teaching Assistant
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August 2007 to December 2007
Supervisor: Kathleen Eldridge, Ph.D., Assistant Professor of Psychology

- Graded papers and provided feedback for Marriage Family Therapy I class
- Led one class on Integrative Behavioral Couple Therapy
- Helped design service learning project for class members to participate in, fostering community outreach related to class material
- Attended class in order to present and outline community service project to students
- Met with professor to increase collaboration and communication about class activities

Teaching Assistant
Pepperdine University, Graduate School of Education and Psychology
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September 2002 to December 2002
Supervisor: Susan Hall, J.D., Ph.D., Assistant Professor of Psychology

- Helped design class syllabus in order to be distributed to a family development class
- Researched articles and texts for professor to use in class
- Graded papers and provided feedback in collaboration with professor in order to maintain class continuity
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PROFESSIONAL ACTIVITIES

"Humanistic Theory Overview" presentation given to psychology masters students at Pepperdine University, Los Angeles, CA, March 4, 2008
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American Association for Marriage and Family Therapy Annual Conference, Long Beach, CA, October 11-14, 2007
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"Postpartum Depression" community outreach project presentation given to Lamaze class couples at Cedars-Sinai Medical Center, Beverly Hills, CA, May 16, 2006
California Psychological Association Annual Conference, Pasadena, CA, April 2005
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Los Angeles Professional Development Series, "Ten Things You Should Know About Eating Disorders," West Los Angeles, February 2004
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ABSTRACT

Couple therapy research has traditionally utilized either quantitative or qualitative methods to examine the mechanisms of change and outcomes in couple therapy. Also, while studies have examined couples' experiences in therapy, few have specifically examined the most and least helpful aspects of therapy according to the couple. The purpose of the present study was to utilize a mixed-methods design to examine couples' written responses about their experiences in therapy. Two hundred ten individual responses were obtained from a sample of 134 couples who sought Traditional Behavioral Couple Therapy (TBCT) or Integrative Behavioral Couple Therapy (IBCT) for marital distress as part of a larger research project (Christensen et al., 2004). Content analysis of the written responses resulted in five reliably-coded domains; most and least helpful aspects of therapy included therapy, therapist, outcome, client, and logistical factors. Chi-square tests demonstrated treatment group differences on most helpful therapy, therapist, and client factors; and differences between those who recovered and those who deteriorated by 2-year follow up on least helpful therapist and outcome factors. McNemar's tests (McNemar, 1947) also revealed just one significant difference between husbands and wives within IBCT on most helpful client factors. The results particularly suggest that couples in TBCT treatment report different most helpful factors than couples in IBCT treatment. Furthermore, the findings of the five domains found across treatments support the common factors research (e.g., Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004) and have several implications for the clinical treatment of couples.

Chapter 1

Introduction

Couples are likely to seek out therapy hesitantly, and often as a last resort (Doss, Simpson, & Christensen, 2004). Therefore, research has attempted to identify the most efficacious treatments available to couples presenting for therapy. As research regarding couple therapy continues to develop as a growing division within psychological literature, one way to discover and enhance what we know about efficacious treatments is to directly ask couples what they find most and least helpful in couple therapy. The focus of this dissertation is a qualitative and quantitative investigation of couples' experiences in therapy.

Couple Therapy Outcome Research

At this point in time, treatment for couples seeking therapy varies considerably, from behavioral, to cognitive-behavioral, to dynamic, to systemic approaches, among others. In a review of marital therapy studies spanning the previous 22 years, Baucom, Shoham, Mueser, Daiuto, and Stickle (1998) examined the efficacy status of various empirically supported couple and family interventions. Baucom et al. ultimately identified three forms of empirically supported treatments that inform couple therapy research, including efficacious and specific treatments, efficacious and possibly specific treatments, and possibly efficacious treatments. For example, Behavioral Marital Therapy (BMT), Emotion-Focused Therapy (EFT), Insight-Oriented Marital Therapy, Cognitive Therapy, and Group Analytic Therapy were all noted as efficacious and specific treatments. Additionally, Systematic Therapy was found to be an efficacious and possibly specific treatment, while the Cognitive Restructuring component of Cognitive Therapy

for couples was found to be a possibly efficacious treatment. Pinsof and Wynne (1995) echoed these findings in their empirical overview of the efficacy of marital and family therapy. Briefly, they demonstrated that marital and family therapy works, is more efficacious than no therapy at all, and is more efficacious than individual therapy for different types of problems, disorders, and patients.

While these standards of efficacy inform clinicians of superlative couple interventions, Snyder, Castellani, and Whisman (2006) more recently reviewed the current status of couple therapy, noting that a sizable percentage of individuals do not show significant posttreatment improvement, and even more individuals decline at follow up. They state that,

> Such findings have fostered two alternative lines of attack for treating couple distress: (*a*) distillation and emphasis of common factors hypothesized to contribute to beneficial effects across "singular" treatment approaches, and (*b*) pluralistic models incorporating multiple components of diverse treatment approaches. (p. 322)

One example of a pluralistic model is Integrative Behavioral Couple Therapy (IBCT), which incorporates elements of Traditional Behavioral Couple Therapy (TBCT; also referred to as BMT), with techniques designed to foster emotional acceptance (Jacobson & Christensen, 1996; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000). Previous research suggested that BMT is beneficial for couples seeking therapy, though it also indicates that researchers and clinicians need to better understand the differing strategies emphasized in this approach (Jacobson et al., 1984; Jacobson & Margolin, 1979). An in-depth evaluation reveals that the emphasis on change in TBCT

has limitations in its use with couples, including concerns about its durability and clinical significance (Jacobson et al., 2000). For example, one-third of couples have shown marital distress by the end of treatment (Jacobson & Addis, 1993), and of those who improve, the improvement is often not maintained at 2-year follow up (Jacobson, Schmaling, & Holtzworth-Munroe, 1987).

In contrast, IBCT is a pluralistic model in that it was designed to enhance some of the limitations of TBCT by combining the strategies for fostering change in TBCT with strategies for fostering emotional acceptance of previously unacceptable characteristics of one's partner. Preliminary reports comparing IBCT to TBCT were promising (Jacobson et al., 2000), leading Christensen et al. (2004) to conduct a clinical trial of acceptance techniques as applied in couple therapy by examining the use of IBCT for chronically distressed couples. The purpose of this experimental study was to examine the overall and comparative efficacy of TBCT versus IBCT. Using a sample of 134 married couples, this is the largest couple therapy study to date. Outcome measures included relationship satisfaction, stability, communication, and individual adjustment. Measures such as the Marital Adjustment Test, Marital Satisfaction Inventory, and Dyadic Adjustment Scale (DAS) were administered. Results showed that 65% of IBCT and 57% of TBCT couples evidenced reliable change or recovery after treatment. At 2-year posttreatment follow-up, 69% of IBCT and 60% TBCT couples showed clinically significant improvement (Christensen, Atkins, Yi, Baucom, & George, 2006). The authors ultimately conclude that the high rates of change and maintenance of improvement over time suggest that both IBCT and TBCT can be used with severely distressed couples, and that the long-term effect of behavioral couple therapy is encouraging.

In addition to examining the amount of change over time, these investigators also inspected the trajectories or patterns of change over time (Christensen et al., 2004). Interestingly, IBCT couples showed slow and steady improvement in marital satisfaction throughout the course of treatment. In contrast, the trajectory of change in TBCT showed rapid improvement early in treatment, followed by a plateau later in treatment where no additional gains were achieved. The authors postulated that the gradual change in IBCT may be due to the immediate focus on central themes and issues troubling couples, thus leading to slower but steady improvement. They also postulate that the behavior exchange assignments used in the beginning of TBCT to increase couples' positive behaviors toward one another may lead to early gains in satisfaction, but satisfaction levels off as therapy begins to focus on long-standing, enduring problems.

Couple Therapy Process Research

While data show that the application and outcome of TBCT and IBCT techniques are promising, it is important to understand which specific elements of treatment are therapeutic versus those that have little or no impact on couples in therapy. Process research provides a richer understanding of treatment efficacy beyond simplistic outcome investigations. It describes change and development in couples in order to determine a category of concepts or a narrative of how things change over time.

Researchers employ various methods for studying the processes or mechanisms of change in couple therapy. For example, a limited amount of research on couples has used direct observation of therapy sessions (providing information about therapy from the researcher's or an outsider's point of view; e.g., Garfield, 2004), whereas more researchers have asked therapists via questionnaires about their observations of couples

in treatment (providing information about therapy from the therapist's point of view; e.g., Allgood & Crane, 1991; Bourgeois, Sabourin, & Wright, 1990; Davis & Piercy, 2007a, 2007b; Geiss & O'Leary, 1981; Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989; Kelly & Iwamasa, 2005; Whisman, Dixon, & Johnson, 1997). However, the majority of researchers directly asked couples via questionnaires or interviews about their experiences of their relationships and/or in therapy (providing information about therapy and its effects on the relationship from the couples' point of view; e.g., Alexander, 1997; Bowman & Fine, 2000; Christensen et al., 2004; Christensen et al., 2006; Davidson & Horvath, 1997; Davis & Piercy, 2007a, 2007b; Doss, Simpson, & Christensen, 2004; Doss, Thum, Sevier, Atkins, & Christensen, 2005; Goldman & Greenberg, 1992; Greenberg, Ford, Alden, & Johnson, 1993; Helmeke & Sprenkle, 2000; O'Leary & Rathus, 1993; Olson, 2002; Worthington et al., 1995). This research has provided important information about effective elements of couple therapy and the processes of change during treatment. One way to summarize this information is to separate it into three categories: (a) the processes that are common to most or all approaches to couple therapy (common factors), (b) the processes that are directly related to a therapist's model (model-specific factors), and (c) the processes that are unhelpful in couple therapy (unhelpful factors).

Common factors across therapies. Common factors is the concept that the effectiveness of different therapies is more related to the common elements, rather than the specific differences, between them. It assumes that all types of psychotherapy, and in this case couple therapy, share basic components with one another. Sprenkle and Blow (2004) argue that the field of marital and family therapy has largely neglected the

research on common factors. They propose a moderate approach to researching common factors; they define moderate as a broad conception of the dimensions of the treatment setting. The components of their approach include the following treatment setting dimensions as common factors: The client, therapist effects, the therapeutic relationship, expectancy, and nonspecific treatment variables that include behavioral regulation, cognitive mastery, emotional experiencing, and a developmental sequence. The authors, viewing these components as vital to a common factors approach and to facilitating change in therapy, offer a unique method of studying common factors.

Of note, there is some debate about the common factors approach. For example, Sexton, Ridley, and Kleiner (2004) assert that common factors are insufficient and limited. In particular, they state that common factors overlook the multilevel nature of marital and family therapy practice, the diversity of clients and settings, and the complexity of therapeutic change.

Despite these conflicting views, the common factors approach has continued to evolve. Arguably the most important research on common factors in couple therapy has been conducted by Davis & Piercy (2007a, 2007b), who examined therapeutic change in three forms of couple therapy (Emotionally Focused Therapy, Cognitive-Behavioral Therapy, and Internal Family Systems Therapy) by using a framework that divided their findings into model-dependent and model-independent common factors. According to their results, model-dependent factors, or elements that are central to specific therapy approaches but also found across different therapies, include common conceptualizations of the therapy by both therapists and clients, common interventions such as use of metaphor, and common outcomes such as softening of behaviors and affects (2007a).

Model-independent factors, or general aspects of therapy that are not directly related to a particular therapeutic model, include client variables such as humility, therapist variables such as patience, therapeutic alliance such as mutual trust and respect, therapeutic process such as structure, and expectancy and motivational factors such as perception of the therapist as competent (2007b). This research on common factors seems to point toward aspects of couple therapy that clients may report to find most helpful.

Process research other than that conducted from a common factors viewpoint has revealed findings about the helpful processes of therapy regardless of which approach one is using. For example, Alexander (1997) explored clients' perceptions of successful and unsuccessful couple therapy (types of therapy unknown) by administering questionnaires and in-person interviews. In particular, 12 couples were interviewed and asked to complete a survey measuring therapeutic alliance, levels of distress, improvement, relationship satisfaction, and the overall helpfulness of therapy. Of note, 6 couples felt their experiences in couple therapy were unsuccessful and 6 couples considered their experiences successful. Interview responses were coded and analyzed into categories. The author subsequently identified and described the helpful aspects of therapy as including conflict management and improved communication, a coherent understanding of the underlying conflicts and causes of their problems, and the therapist's ability to refocus the tasks or goals of therapy sessions. The author concluded by hypothesizing that these categories conveniently describe the common components and natural progression of the therapeutic process in couple therapy, and that this developmental sequence may encourage maturation in a couple's relationship. Additional

findings from the couples who described their experience in couple therapy as unsuccessful are summarized below in the *Unhelpful Factors* section.

Bowman and Fine (2000) also examined client perceptions of the helpful aspects of couple therapy by asking couples in face-to-face interviews what was helpful. The therapists utilized social constructionist, narrative, feminist, and solution-focused therapies. Bowman and Fine identified some helpful aspects as trust in the therapist, safety in session structure, and the equal treatment of partners. Clients also mentioned that it was helpful when he or she felt like an expert in his or her own life. Interestingly, no gender differences were found in clients' perceptions of the therapy. The authors hypothesized that the therapist's relationship skills may produce successful therapy outcomes, and that homework assignments may have encouraged thinking about issues outside of sessions.

Model-specific factors. Other process studies have intentionally examined specific models of couple therapy to determine the processes of change within those particular approaches. The specific models reviewed here include Cognitive Behavioral Couple Therapy (CBCT), IBCT, TBCT, Emotionally Focused Therapy (EFT), Integrated Systemic Therapy (IST), cognitive marital therapy, systemically-based therapy, social learning-based therapy, and an eclectic family systems model. These studies provide information about the most helpful aspects of therapy within a specific model. All studies reviewed employ methodology that obtains information about therapy from the couple's point of view, a highly valuable method of evaluating the therapy. For example, Holtzworth-Munroe, Jacobson, DeKlyen, and Whisman (1989) examined the relationship between marital therapy outcome and process variables by administering questionnaires

to couples participating in a social learning-based couple therapy research project. According to couples, better therapy outcome was achieved when the therapist used less structuring behaviors. They further found that husbands associated therapist competence and emotional nurturance with better therapy outcome. Husbands and wives in this study viewed couples who make gains in therapy as those who believe they are actively and collaboratively participating in therapy and complying with homework assignments. For the purposes of the current study, these findings can be interpreted as helpful aspects of social learning-based couple therapy.

Researchers in another process study found that when therapists provided assessment and feedback to couples in CBCT, the couple's relationship was positively affected (Worthington et al., 1995). In other words, couples find assessment and feedback in the process of CBCT beneficial or helpful. The authors hypothesize that assessment and feedback may help couples to better understand and work toward improving their relationship.

Within the clinical trial described above which examined the efficacy of IBCT, Doss, Thum, Sevier, Atkins, and Christensen (2005) recently identified other processes that may be considered helpful in IBCT and TBCT. At pretreatment, 26 weeks into treatment, and posttreatment the researchers measured marital distress using the DAS, process variables using the Frequency and Acceptability of Partner Behavior Inventory, and communication variables using the Communication Patterns Questionnaire. As a result, they identified the following mechanisms of change: increased acceptance of partner problem behaviors and decreased demand-withdraw interactions. Moreover, behavior change was found to be associated with improvement earlier in treatment, and

acceptance of partner differences was found to be associated with improvement later in treatment. TBCT was specifically found to bring about greater changes in behavior, whereas IBCT was specifically found to bring about greater changes in acceptance of partner behavior. Furthermore, positive communication increased significantly in the IBCT treatment condition.

Greenberg, Ford, Alden, and Johnson (1993) examined in-session change using the Structural Analysis of Social Behavior (SASB) administered to couples in EFT. The SASB codes behavior from an interpersonal perspective, focusing on the behavior of one person toward another and the behavior of the individual toward him- or herself (Greenberg et al.). The researchers in this process study found that more affiliative behaviors between partners occurred in the latter stages of therapy, that certain sessions contained more self-focused positive statements such as disclosing, and that spouses are more likely to respond affiliatively after a therapist facilitates intimate self-disclosure by their partners. These findings of specific change that occurs in EFT contribute further information to some of the more helpful elements of successful couple therapy from the couple's point of view.

In another process study investigating EFT, Goldman and Greenberg (1992) briefly examined clients' perceptions of how change occurs in couple therapy via questionnaires and interviews. Forty-two couples seeking help in their relationships were randomly assigned to either an Integrated Systemic or an Emotionally Focused treatment condition. Familiar measures such as the DAS were administered. Of note, couples also responded to an open-ended question in a posttest interview about their experience of the effects of therapy. Among others, client responses included positive emotional response

to one's partner, increasing awareness of the partner's sensitivities and vulnerabilities, therapist neutrality (in the Integrated Systemic condition), and therapist empathy and caring (in the Emotionally Focused condition).

Processes or mechanisms of change in an eclectic family systems approach to couple therapy were identified by Helmeke and Sprenkle (2000) using questionnaires in addition to post-therapy interviews. The eclectic family systems approach, employed by a single therapist in the research project, incorporated elements of behavioral, communication, transgenerational, emotionally-focused, solution-focused, and narrative therapies. The authors report that couples who identified at least one pivotal moment felt that the pivotal moment led to change in the therapy. These moments were associated with specific discourses or events in sessions, and were always related to the couples' presenting problems. It is possible that the occurrence of a pivotal moment in therapy may be viewed as a helpful aspect within an eclectic approach to couple therapy.

Olson (2002) investigated the process of systemically-based couple therapy by administering questionnaires and a semi-structured interview to couples. Olson most notably found that couples reported experiencing gradual changes in affect, behavior, and cognition both in and out of session. Out of session facilitators of change included economic factors, upcoming marriage, the birth of a child, taking psychotropic medication, a life-threatening accident, and reliance on religion or spirituality. In-session facilitators of change originated with the therapist, the couple, and the individual, as well as the interaction created among all individuals in the session. In-session, the following factors also facilitated change: between-session directives given by the therapist, such as homework; the therapist acting as a mediator and facilitator of sessions; and the therapist

creating space for the clients to see things that could make a change in the couple's life. Finally, both in and out of session facilitators of change involved shifts in affect (such as less anger and defensiveness), behavior (such as development of communication skills and learning new ways of approaching one another), and cognition (such as recognizing relationship patterns and one's own role in maintaining the pattern).

Quite similarly, O'Leary and Rathus (1993) attempted to reveal what clients consider the most helpful components in another specific model of therapy. They examined client perceptions of cognitive marital therapy by asking 31 women who were seeking therapy for depression to write their responses to an open-ended question about the most helpful aspects of therapy. The responses were subsequently coded into 12 categories. As a result, this study demonstrated that cognitive marital therapy decreased depression and increased marital satisfaction. Couples reported that the most helpful content areas in the therapy were seeing positive change in one's spouse, improving overall communication, and putting in effort and engaging in the process to improve their marriage.

Unhelpful factors. Despite the growing research on the common and model-specific factors of couple therapy from the client's point of view, few researchers have specifically explored what is least helpful or unhelpful in addition to what is helpful by directly asking couples. In one of these studies, Bowman and Fine (2000) directly asked couples what was unhelpful in couple therapy. Their responses noted the unequal treatment of partners, the therapist talking too much, the use of the word "therapy," and the constraints of the 1-hour session.

Similarly, Alexander (1997) summarized findings from couples who described their therapy as unsuccessful. These couples reported that the following elements were missed or lacking: conflict management and improved communication, a coherent understanding of the underlying conflicts and causes of their problems, and the therapist's ability to refocus the tasks or goals of therapy sessions.

Ultimately, client identification of both helpful and unhelpful aspects of couple therapy provides an increased understanding of the specific elements that lead to successful couple therapy. In particular, open-ended questions prompt and allow couples the opportunity to share and verbally expand on their perspective of therapy. However, it appears that there is minimal research comparing one specific model of therapy to another, and there is even less research on what is least helpful compared to what is beneficial or most helpful.

Summary of Findings

Thus far, the mechanisms of change that have been elucidated by couple therapy process research are vast. In review, some identified mechanisms of change involve aspects of therapist behavior, including therapist neutrality, empathy, caring, nurturance, and competence; the therapist's relationship skills; the facilitation of intimate self-disclosure by each partner; therapist self-disclosure; the therapist's ability to refocus session goals; when the therapist used less structuring behaviors; and the therapist treating each partner equally. Other mechanisms of change involve aspects of the couple's behavior or experiences, including positive exchanges or communication; emotional acceptance of partner differences; active and collaborative participation of both partners; compliance with homework assignments; self-disclosure of each partner;

changes in affect, behavior, and cognition noticed both in and outside of session; a sense of trust and safety with the therapist; when the client felt like an expert in his or her own life; the perception of positive change in one's spouse; client identification of at least one pivotal moment in therapy; and an increased, coherent understanding of the underlying conflicts and causes of their problems. Finally, mechanisms of change also appear to involve aspects of the therapeutic process, including conflict management and communication skills training, behavior exchange assignments, the immediate focus of central themes and issues troubling the couple, the therapeutic alliance, and assessment and feedback. The factors that these authors have identified highlight aspects of couple therapy which clients may identify as the most helpful in the current dissertation.

Alternatively, the unhelpful aspects revealed in couple therapy process research thus far concentrate on therapist behavior, action, or inaction. These include the therapist's unequal treatment of partners and the therapist talking too much. Other unhelpful aspects include the therapist's failure or neglect to address conflict management, improve communication, facilitate the couple's understanding of underlying conflicts and causes of their problems, and refocus session tasks or goals. Despite several identified unhelpful elements of couple therapy, there appear to be considerably fewer unhelpful versus helpful aspects.

Within the literature on couple therapy research, the reports from therapists are similar and different from the reports of couples. Specifically, therapists have similarly reported that the therapeutic alliance in couple therapy is vitally important to treatment success (Bourgeois, Sabourin, & Wright, 1990). However, therapists have also identified areas that contribute to marital problems not identified by couples. These include

difficulty in successfully treating alcoholism or other addictive behaviors, lack of loving feelings, power struggles, value conflicts, physical abuse, unrealistic expectations of marriage or spouse, extra-marital affairs, and incest (Geiss & O'Leary, 1981). Therapists have also associated negative treatment outcome with partners' inability or unwillingness to change, and lack of commitment (Whisman, Dixon, & Johnson, 1997). Of note, there is minimal research on the couple therapist's point of view, and the existing research does not appear to have had therapists specifically report on their views of the helpful and unhelpful aspects of couple therapy.

Current Study

Many investigators have provided guidelines on conducting marital therapy outcome research (Christensen, Baucom, Vu, & Stanton, 2005; Jacobson & Addis, 1993; Snyder, Castellani, & Whisman, 2006) and enhancing the efficacy of marital therapy (Jacobson, 1991; Johnson & Greenberg, 1991). Currently, the literature that informs the practice and effectiveness of couple therapy predominantly utilizes either quantitative or qualitative procedures to examine one model within couple therapy (Alexander, 1997; Doss, Thum, Sevier, Atkins, & Christensen, 2005; Goldman & Greenberg, 1992; Greenberg, Ford, Alden, & Johnson, 1993; Helmeke & Sprenkle, 2000; Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989; O'Leary & Rathus, 1993; Olson, 2002; Worthington, McCullough, Shortz, Midnes, Sandage, & Chartrand, 1995). The future of couple therapy research clearly calls for more mixed-methods, process research on the common and model-specific mechanisms of change.

A mixed-methods examination of what couples specifically report to be the most and least helpful aspects within two models of therapy would inform the practice of

couple therapy for both researchers and clinicians. A mixed-methods study would further enhance clinician assessment, treatment planning, and goal setting when working with couples in clinical settings. Researcher and clinician understanding of the therapeutic process according to the client would also be sensitive to each partner's needs and the needs of the couple as a whole, especially when working with a population experiencing high levels of marital distress. Without couples who are willing to participate in research, there would be less-informed interventions in the clinical realm. Therefore, their feedback may be the most essential component of psychological research on couples.

Consequently, the current dissertation topic seeks additional information about clients' experiences of couple therapy. Using the original data from the Christensen et al. (2004) study, couples' written responses to an evaluation of their therapy experience (IBCT or TBCT) were analyzed qualitatively and quantitatively. The following research questions were proposed:

Qualitative research questions:

1. What themes emerge from clients' responses to a question about most and least helpful things about therapy?
2. What do IBCT and TBCT couples report as the most helpful and least helpful aspects of couple therapy?
3. What do wives report as most and least helpful, and what do husbands report as most and least helpful?
4. What do the couples who show clinically significant deterioration at 2-year follow up report as most and least helpful, and what do the couples who show

clinically significant recovery at 2-year follow up report as most and least helpful?

Quantitative research questions:

5. Do partners in IBCT and TBCT treatments differ significantly in their reports of the most and least helpful aspects of therapy?
6. Do husbands and wives differ significantly in their reports of the most and least helpful aspects of therapy?
7. Do husbands and wives within IBCT and within TBCT differ significantly in their reports of the most and least helpful aspects of therapy?
8. Do partners who show clinically significant deterioration at 2-year follow up differ significantly from partners who show clinically significant recovery at 2-year follow up in their reports of the most and least helpful aspects of therapy?

Chapter 2

Method

Participants

Participant data for the current study were obtained from an archive of data collected by Christensen et al. (2004). Participants included 134 heterosexual married couples who reported serious and chronic marital distress, with the first 26 couples designated as pilot cases. While the study was conducted simultaneously at two sites (in Los Angeles at the University of California or in Seattle at the University of Washington), participants attended sessions at their therapists' private offices. Participants consisted of wives with a mean age of 41.62 (*SD* = 8.59) and husbands with a mean age of 43.49 (*SD* = 8.74). Couples had been married for an average of 10.00 (*SD* = 7.60) years, with an average of 1.10 (*SD* = 1.03) children. Wives further had 16.97 (SD = 3.23) mean years of education, while husbands had 17.03 (*SD* = 3.17) mean years of education, including kindergarten. Participants were Caucasian (husbands: 79.1%, wives: 76.1%), African American (husbands: 6.7%, wives: 8.2%), Asian or Pacific Islander (husbands: 6.0%, wives: 4.5%), Latino or Latina (husbands: 5.2%, wives: 5.2%), and Native American or Alaskan Native (husbands: 0.7%). Finally, almost half of all couples disclosed that they had attended marital therapy together in the past.

To be included in the study, participants were required to voluntarily seek out couple therapy, be legally married, and in severe and chronic marital distress as assessed by a score at least one standard deviation below the population mean (<98) on the Dyadic Adjustment Scale and a T score of 59 or higher on the Global Distress Scale. Couples also had to be between the ages of 18 and 65, have a minimum high school education,

and be fluent in English. Participants who were currently diagnosed with any of the following *DSM-IV* Axis I disorders were excluded from the study: alcohol or drug dependence, bipolar disorder, and schizophrenia. Participants currently diagnosed with any of the following *DSM-IV* Axis II disorders were also excluded from the study: antisocial, borderline, and schizotypal personality disorders. Similarly, neither partner could be attending psychotherapy while participating in the marital therapy research study, and could only be currently taking psychotropic medication if they had been stabilized on the medication for at least 6 weeks and started taking the medication for at least 12 weeks prior to participating in the study. In addition, there could not be any changes made to the psychotropic medication dosage throughout the duration of their involvement in the study. Finally, information about relationship violence from the wives was used to exclude couples in which the husbands had been reportedly dangerously violent.

The therapists providing therapy during the research project were licensed clinical psychologists currently in practice in the Los Angeles and Seattle communities. They had between 7 and 15 years of experience post-licensure. They received training via treatment manuals and attendance at workshops led by Andrew Christensen or Neil Jacobson. In addition, therapists were provided with supervision from experts in IBCT and TBCT who had published extensively on these treatments, including Christensen and Jacobson; Peter Fehrenback, a therapist on the initial study of TBCT and IBCT (Jacobson et al., 2000); and Don Baucom, a published expert on TBCT. Supervision of therapists included weekly audio- and/or videotape reviews of sessions, with feedback provided to therapists prior to their next session. Supervisors talked via telephone with therapists in order to

provide feedback, though during the second half of the study feedback occurred via telephone and e-mail. Each supervisor observed videotaped sessions and provided feedback for most of the sessions.

Couples were randomly assigned to one of two treatment conditions, producing 68 TBCT couples and 66 IBCT couples. While a maximum of 26 sessions was offered to each couple at the outset of treatment, an average of 22.9 (*SD* = 5.35) sessions occurred over an average of 36 weeks. One hundred twenty-six of the 134 participants were considered "treatment completers," having attended over 10 sessions.

Procedures and Measures

Each couple was initially screened in a three-part process via telephone interview, questionnaires, and one in-person intake session. Screening measures included the Marital Adjustment Test, Marital Satisfaction Inventory—Revised, Dyadic Adjustment Scale, Conflict Tactics Scale—Revised, and the Structured Clinical Interview for DSM-IV. This process determined couples who met inclusion and exclusion criteria and were in severe marital distress. Couples were randomly assigned to treatment condition after the first appointment with the therapist was scheduled. Couples participated in free therapy and were paid to complete routine assessments. Outcome measures were administered at intake, 13 weeks after intake, 26 weeks after intake, post-treatment, and follow-ups. These measures assessed relationship satisfaction, relationship stability, communication, and individual functioning. The reader is directed to Christensen et al. (2004) for a more thorough description of the procedures of the clinical trial.

Specific to this study, a Client Evaluation of Services (CES) questionnaire was administered to the couples immediately following the last session. The CES was

developed based on a Client Satisfaction Questionnaire published by Nguyen, Attkisson, and Stegner (1983) to efficiently measure satisfaction of service. It included eight items on 4-point Likert scales asking each partner to rate, for example, the quality of the service they received. The scale has a Chronbach's alpha of .93 (Christensen et al., 2004). The data for this study come from an additional, open-ended question added by Christensen et al. (2004) to the end of the CES, querying, "What were the most helpful and least helpful things about the therapy?" Each partner was asked to write his or her response to this question directly on the questionnaire and to complete the measure independently. Couples were provided with materials and postage enabling them to complete the questionnaire at home and mail it back to the project investigators. Couples were also informed that their therapists would not have access to their responses. These measures were taken in order to optimize honesty in their responses. The principal investigator of the clinical trial and the university Institutional Review Boards at UCLA and Pepperdine University granted permission to the present researcher to utilize the de-identified responses for this study (see Appendix B).

Design

The design of this study contains both qualitative and quantitative approaches. The current research followed Creswell's (2003) description of mixed-methods data transformation utilizing a sequential exploratory strategy, in which the researcher quantifies the qualitative data through qualitative data collection and analysis first, followed by quantitative data collection and analysis second. To describe further, codes and themes are qualitatively extracted from the data, then counted for the number of

times they occur in the data. This allows the researcher to produce quantitative results with the qualitative data.

Qualitative design. The qualitative component involved a content analysis of written responses taken from an archival research database. Content analysis is a methodology that allows the researcher to extract information from written responses in a systematic and replicable manner (Smith, 2000). More specifically, it allows the researcher to examine large amounts of textual data by identifying key words, thereby reducing large amounts of information into small, more manageable material (Smith). For the purposes of the current study, a content analysis was performed in part due to the researcher's a priori assumptions, about what couples would report being most and least helpful, based on what was found in the literature review and is known about couple therapy. The content analysis procedures included determining and specifying units of analysis (such as key words), and determining coding categories based on patterns and evidence in the data (Flick, 2006). First, categories of information were generated by examining patterns of key words, and later the emerging data was divided into more specific categories and subcategories (Creswell, 2003). All qualitative coding and data analyses were done on Atlas.ti, a software program for basic content analysis and analyzing text.

*Quantitative design***.** The second step entailed the quantitative component of the research design. After the content analysis was complete, the codes assigned to the responses were examined for any statistical differences that existed between groups. The independent variables were treatment group (IBCT and TBCT) and gender (husbands and wives). In addition, clinical significance of couples' outcome at 2-year follow-up formed

a third independent variable (deteriorated or recovered at 2-year follow-up). These clinical significance groups were formed in the original dataset (Christensen et al., 2004) using DAS scores. These groups include 29 deteriorated (14 IBCT and 15 TBCT) and 52 recovered (30 IBCT and 22 TBCT) couples. These groups are hereafter referred to as "recovered" or "deteriorated."

The quantitative design included a statistical test for simple within-group design and a statistical test for simple between-group design. In all cases, the dependent variable was a frequency count measured at one point in time, with the question being, "How many people fall into a specific category?" Chi-square tests determined differences between the independent treatment (TBCT and IBCT) and outcome (recovered and deteriorated) groups. In addition, due to the categorical and dependent nature of couples' data within a research design, McNemar's test (McNemar, 1947) determined differences between genders. All quantitative data analyses were done on Statistical Package for the Social Sciences (SPSS).

Reliability and Validity

Due to the potential for researcher bias and subjectivity when examining and coding responses to an open-ended question, reliability and validity were addressed within the mixed-methods design of the study. The researcher addressed issues of credibility, trustworthiness, and transferability relevant to qualitative studies using methods similar to those used by Davis and Piercy (2007a). Steps to ensure credibility (how readers know if the results are consistent with the data collected; the equivalent of internal validity) and trustworthiness (how readers know if the researcher's findings can be trusted) included the use of rich, thick description, the presentation of negative or

discrepant information, the discussion of researcher bias, and the use of the constant comparative method of data analysis (Creswell, 2003). Triangulation, which heightens a qualitative study's credibility (Creswell), was also addressed by analyzing and cross-checking a variety of data from multiple perspectives in order to assign codes to difficult or unclear responses. This process included meetings with the chairperson and another psychology doctoral student in which difficult or unclear responses were examined, interpreted for meaning, and assigned the appropriate code after one was agreed upon by the entire group. Finally, steps to ensure transferability (how readers know if the study's findings relate to the experience of others; the equivalent of external validity; Creswell) included reporting unique client characteristics and the possible resulting effects on the data, and discussing researcher bias.

The researcher also assessed the reliability of the coding system that emerged during the content analysis of the data. This was established by recruiting and training coders to use the coding system, by meeting regularly with the coders in order to prevent rater drift, and by calculating inter-rater reliability. For example, after coders were recruited and trained to use the coding system, each coder independently coded the same responses; reliability among coders was checked by the researcher; and training during the meetings focused on areas of disagreement. Also, about 1/6 of the 210 responses were randomly selected for training purposes in weekly coding meetings. Each coder coded all of the data to increase precision of the coding. Reliability was regularly calculated throughout the coding process using the formula suggested by Miles and Huberman (1994): Reliability = Number of Agreements / (Total Number of Agreements + Disagreements). An inter-rater reliability of 80% to 90% was considered acceptable.

Chapter 3

Results

This section is divided into two parts, in order to address the mixed-methods nature of the study and the research questions. The qualitative results are presented first, followed by the quantitative results.

Qualitative Coding

Before the data coding and analysis occurred, Miles and Huberman's (1994) suggestion for creating a "start list" (p. 58) of codes was utilized. To generate the start list, the researcher developed descriptive categories that considered the conceptual framework, research questions, and hypotheses, in addition to knowledge of the two forms of therapy (IBCT and TBCT), clinical experience, previous research findings, and understanding of the therapeutic alliance, therapist factors, and client factors in couple therapy (see Appendix D). Some of the descriptive categories included therapist factors (such as warmth and competence), client factors (such as motivation and willingness to disclose), treatment strategies used (such as communication skills training) and mechanisms of change (such as improved communication). Other categories included a negative outcome or logistics of the therapy such as getting to the appointment on time. In creating the start list, some of the initial categories were also based on Davis and Piercy's (2007b) research on common factors in couple therapy. These factors included client variables (such as humility, commitment, and hard work); therapist variables (such as patience and cultural sensitivity); therapeutic alliance (such as mutual trust and respect); therapeutic process (such as structure and neutrality); and expectancy and

motivational factors (such as faith in the referral source and perception of the therapist as competent).

After the start list was created, the researcher began reviewing the responses. As recommended by Miles and Huberman (1994), categories within the start list were used lightly to allow revision of categories as the responses were examined by the researcher. Following content analysis methodology, the researcher first identified key words, statements, and phrases from several responses, and extracted and sorted these into broad categories (Smith, 2000). Distinct units of information in each response were identified to be coded (i.e., the phrases, sentences, etc. that represent distinct thought units, each to be coded separately within the response; Smith 2000). During the initial month of reviewing responses, this involved the researcher breaking down, examining, comparing, conceptualizing, and categorizing the data. The researcher coded the data in as many ways as possible through a line by line analysis (Miles & Huberman). In addition, thematic categories that emerged from the responses that were descriptive, as opposed to interpretative, were identified in order to most closely follow each individual's words and meanings (Miles & Huberman). The initial coding process also involved the constant comparative method, which is the process of constantly taking new information from data collection and comparing it to the emerging categories in order to establish and refine the categories (Orcher, 2005). This entailed a code-revise-code-revise process, in which several new codes were added to the list and others were eliminated as the themes emerged. Codes were eliminated from the list when they were not represented in the data. In addition, codes that began on the list and were added later on began with very detailed descriptions, and became more global categories over time, until reaching saturation.

Saturation, the point where no new categories or subcategories emerge from the data, occurred about one month into the process, after the entire response set had been reviewed by the researcher at least three separate times.

The next step in the content analysis process involved identifying a few thematic categories that could be attributed to several observations by several individuals (Miles & Huberman, 1994). The researcher also determined themes by identifying responses that were repetitive or that clients were expected to find relevant, with the overarching goal of identifying couples' views of meaningful aspects of therapy. Thematic categories of meaning that were distinct ideas remained separate, whereas multiple categories that represented one meaning set were clarified and combined, thereby minimizing overlap between categories. The categories of information that emerged were reviewed for relevancy to aspects of the therapy. At this point the entire response set had been reviewed a total of five separate times, and the original start list was no longer used but instead had morphed into a unique list of coding categories. Ultimately, a detailed coding system of the most helpful and least helpful aspects of couple therapy emerged.

After the coding system was developed by the researcher, the researcher coded the responses another time in order to match parts of responses to codes. Each response was coded as a whole, and could have multiple codes. However, any given code was only assigned to a response one time, even if several parts of or sentences in the response referred to that code. Also, one sentence could receive more than one code if multiple categories were included in that response. After coding the data this last time and having reached the point of saturation, the researcher met with the dissertation chairperson and another psychology doctoral student in order to review responses that were difficult or

unclear to code, thereby simultaneously establishing triangulation. Twenty-two (8%) of the responses were examined, interpreted for meaning, and assigned the appropriate code after it was agreed upon by the entire group. A total of 6 hours were spent reviewing the difficult responses, and approximately 20 hours were spent incorporating feedback from the meeting with the dissertation chairperson and psychology doctoral student, and reviewing the codes and responses an additional time. Following this last review of the codes and responses, the researcher generated the final list of codes and frequency counts within each code.

Inter-rater reliability. Inter-rater reliability was calculated to test the reliability of the coding system established during the qualitative data analysis. It is considered desirable to have two or more people code the data in qualitative research (Orcher, 2005). For this reason, once the coding system, final list of codes, and the frequency of codes in each response were established, four coders were recruited from a master's-level psychology program. They were all Caucasian females, aged 22-25. Over a two-week training period, the coders learned to discriminate between most and least helpful responses, identify the subject and most meaningful aspects of each response, and code each response using a list of 28 items provided by the researcher. Four additional weeks of independent coding occurred, during which weekly meetings were held in order to assess inter-rater reliability (calculated by the researcher) and discuss areas of disagreement. In order to calculate reliability, the equation suggested by Miles and Huberman (1994) for content analysis research was calculated throughout coding for all coders. Reliability of .80-.90 was considered acceptable inter-rater reliability. Thirty-three (16%) responses were used for training purposes and the coders independently rated

the remaining 177 (84%) responses. After independent coding, during weekly training meetings, the coders consulted with each other and the researcher on difficult responses. The coders and researcher then worked to establish agreement on the difficult response and arrive at consensus on the appropriate code(s). The occurrence of difficult responses suggested that the data are subject to more than one good interpretation (Orcher). The process of establishing agreement and group consensus is a component of Consensual Qualitative Research, which emphasizes reaching consensus between a team of researchers when studying a few cases intensively (Orcher). Difficult responses which required group consensus to code were not included in calculating inter-rater reliability.

Each response was rated by the coders for the occurrence of 28 potential codes (14 most helpful and 14 least helpful). The 28 codes fall under the five larger categories of therapist, client, therapy interventions and process, outcome, and logistical factors. Table 1 depicts the reliability for each of the five domains of most helpful and least helpful aspects of the therapy. As table 1 shows, the inter-rater reliability was above .80 for all most and least helpful factors across all coders, except for most helpful client factors, which was slightly below at .79. The reliability achieved in this study suggested that a consensus had been reached on the coding system developed by the researcher, giving evidence of the dependability of the results. Of note, there were no changes to the coding system and no new codes emerged during or following coding completed by the coders, suggesting that the coding system closely represented the data.

Table 1

Inter-rater Reliability among the Five Domains

Response domains	Most helpful	Least helpful
Therapy factors	0.92	0.92
Therapist factors	0.93	0.87
Logistical factors	0.90	0.90
Outcome factors	0.95	0.92
Client factors	0.79	0.88

Qualitative Results

Clients reported a wide variety of aspects that they found most and least helpful about couple therapy, with responses ranging from one-word answers given in a list format, to longer, more descriptive responses. Interestingly, the shortest response consisted of one word, and the longest response was 336 words long. Some clients responded that there were only most helpful, and no least helpful, aspects of the therapy. Others only responded to what was least helpful. A total of 210 individual responses emerged after accounting for 26 (14 male and 12 female) responses that were left blank (meaning the individual completed the Likert-scale portion of the Client Evaluation of Services questionnaire, but did not respond to the final, open-ended question about the most and least helpful things about the therapy).

Themes. After several examinations of the data, beginning on a micro-analytical level and later moving toward more conceptual categories, five domains emerged as the major themes of the findings. These five themes (presented in order from highest to lowest frequency) represented all responses about what was most and least helpful about the therapy: Therapy factors, therapist factors, therapy outcome factors, client factors, and logistical factors (see Appendix E for a descriptive list of all codes and frequencies within each domain). Overall, the fewest number of themes assigned to a single response was one, and the highest number of themes was six (out of ten possible most and least helpful codes). Below is a description of each theme or domain, followed by an examination of the qualitative research questions within each domain and most or least helpful category.

The first domain that emerged as a major theme in the responses was therapy factors. Two subcategories emerged describing couples' experiences about the therapy itself: Interventions and process. Combined together as two aspects of the therapy in which respondents did not reference the therapist or themselves, there were a total of 197 (152 most helpful and 45 least helpful) references to the interventions or process of the therapy. More specifically, there were 165 (133 most helpful and 32 least helpful) references to interventions in the therapy. Therapy interventions included specific methods, tasks, or techniques used in the therapy and/or assigned outside of the therapy as homework. The responses regarding therapy interventions fell into one of four areas: Communication skills training, problem solving training, other techniques used in the therapy, or other assignments. Examples of most helpful therapy interventions include, "The actual communication skills and suggestions were the most helpful"

(communication skills training), “Learning to discuss a problem and staying level headed; learning how not to fight at every disagreement” (problem solving training), “I like the "positives" list doing something nice for your spouse” (other techniques), and “The book is quite helpful; I realize others have similar problems and there are ways to cope, and deal with them” (other assignments). Examples of least helpful therapy interventions include, “Least helpful:-problem solving strategies (been there, done that)” (problem solving training), and “The readings were the least helpful” or “Written literature too wordy” (other assignments).

Therapy process included responses referring to the process of the therapy. In all, there were 32 (19 most helpful and 13 least helpful; see Table 2) references to aspects of the therapy process. This included responses that referred to what occurred in the therapy session or one’s overall experience of the therapy that was not a technique or assignment. The respondents named several things that described the process of the therapy. Some of these discussed safety and/or neutrality within the therapy (not attributed to the therapist), the therapy structure, or lack of therapy structure. An example of a most helpful therapy process factor includes, “The most helpful was being restricted to a process, and not really being allowed to just complain for an hour.” Examples of least helpful therapy process factors include, “Initially, first few sessions, lacked any structure. I was not sure where we were headed until after a few visits,” and “Occasionally I felt we didn't really get to the point and were discussing extraneous issues that weren't really helpful.”

Table 2

Frequency of Most and Least Helpful Therapy Factors Reported by Respondents

Response domain	Most helpful	Least helpful	Total
Therapy factors	152	45	197
Interventions	133	32	165
Process	19	13	32

The second domain that emerged as a major theme in the responses was therapist factors. Two subcategories emerged describing couples' experiences of the therapist: Qualities and behaviors. Therapist qualities evidenced as something about the therapist that described who the therapist was as a person as opposed to what the therapist did in the sessions. Their qualities may have been evident in their behavior, but a quality seemed to instead describe the therapist's relationship skills. In all, there were 83 total references to the therapist's qualities, 82 of which were most helpful and one that was least helpful. Therapist qualities that were identified as most helpful spanned a number of dimensions, such as therapist caring ("[The therapist] is an excellent therapist, as well as a caring human being."), understanding ("[The therapist] was most helpful. He was patient, understanding and neutral."), and sense of humor ("Also, the kindness, empathy and humor of the therapist made it easier to be open and honest."). In addition, eight respondents simply stated that "Our therapist was the most helpful," or some variation of this response, directly implicating the therapist as the most helpful aspect of the therapy.

In contrast, only one response indicated that the therapist's qualities were least helpful: "I feel [that the] therapist's style was not as effective as other therapists I have worked with." The remaining responses concerning the least helpful aspects of the therapist all referred to the therapist's behavior.

Therapist behavior evidenced as an action that the therapist did, such as "I felt that she worked to thoroughly understand us and worked to present other viewpoints." Responses referring to therapist behavior described observable things that the therapist did in the therapy. In all, there were 87 total references to the therapist's behavior in clients' responses, 78 of which were identified as most helpful and nine of which were least helpful. Similar to therapist qualities, the most and least helpful therapist behaviors covered a wide array of actions that the therapist took or failed to take. Most helpful therapist behaviors included, for example, the therapist giving feedback ("Most helpful was counselor feedback."), listening to the couple ("She listened to both of us, allowing us to speak both through her and directly to each other."), and identifying themes or patterns in the couple's behavior ("Therapist's insights about themes in our relationship were helpful."). In one response, the therapist was credited as reducing criticism ("He didn't let us get away with spending sessions just criticizing each other."). In contrast, least helpful therapist behavior seemed to refer to things that the therapist failed to do sufficiently or at all. One example is the therapist not treating the partners equally: "Least helpful: Wish therapist could perhaps not so much take sides, but rather be more assertive in recognizing mistakes made by myself and spouse." See Table 3 for a summary of frequencies with which therapist factors were reported.

Table 3

Frequency of Most and Least Helpful Therapist Factors Reported by Respondents

Response domain	Most helpful	Least helpful	Total
Therapist factors	160	10	170
Qualities	82	1	83
Behaviors	78	9	87

The third domain that emerged as a major theme in the responses was logistical factors. Logistical factors were referenced in 85 (21 most helpful and 64 least helpful; see Table 4) responses. Respondents commented on a number of logistical details, such as the planning, implementation, and coordination of the details of the therapy's operation. Three subcategories emerged describing couples' experiences of the logistics of the therapy: time, getting to the therapy sessions, and details of the research project itself. Comments about the time included the amount of time in each session or of the overall 26-week experience ("Getting together to talk one time weekly.") scheduling flexibility, or lack of scheduling flexibility. Getting to the therapy sessions included comments about the location of or parking at the therapist's office, or commuting to sessions:

> Truthfully, the least helpful aspect was the logistics. Due to no fault of (the therapist), it was difficult to arrive on time and have the benefit of full sessions. His office is a long distance from our home, and the meetings were during rush hour. This was frustrating to me. I would have liked more time.

Finally, comments about the research project itself included details to which couples would not normally be exposed in couple therapy, such as videotaping every session, completing questionnaires throughout the duration of the therapy, and the free services. A most helpful example is, “The questionnaires helped me to be clear about my feelings about the marriage.” Some least helpful examples are, “Some of the questionnaires are extremely repetitive in the types of questions asked and the quantity of questions is somewhat cumbersome,” and “Being very emotional for more sessions might have brought more things to light but having the video camera there kept the lid on for me.”

Table 4

Frequency of Most and Least Helpful Logistical Factors Reported by Respondents

Response domain	Most helpful	Least helpful	Total
Logistical factors	21	64	85
Amount of time	10	31	41
Getting to therapy	2	8	10
Research project details	9	25	34

The fourth domain that emerged as a major theme in the responses was outcome factors. In particular, several partners described most helpful aspects of the therapy as something that the couple achieved in therapy, or least helpful aspects of the therapy as something that the couple did not achieve in therapy. The participants discussed an outcome factor a total of 65 (37 most helpful and 28 least helpful; see Table 5) times.

Most helpful outcome factors included, for example, anything about the clients' ability to use any techniques learned in session, outside of session, or after therapy had ended. Most helpful outcome factors also discussed an improvement or increase in an aspect of the couple's relationship, such as improved communication and increased understanding of their differences or problems. For example, one partner wrote that, "This therapy helped us to communicate better." Some responses were described as phenomena that the respondent seemed to discover at a pivotal moment in the therapy, though this was not explicitly stated (for example, "I do feel that in the last few weeks something changed our relationship and what had been happening in here pulled together - a bigger shift seems to have occurred.") A least helpful outcome factor was coded when a response stated that an outcome had not been achieved, such as an issue that was not discussed in session that the client would like to have addressed, or not having enough tools or exercises to use at home after therapy ended. Some examples are individual needs that were not addressed or explored, an inability to find solutions to long-standing problems, and a lack of understanding of the couples' underlying conflicts and causes of their problems. For instance, one partner wrote that he "Probably did not get as much insight as I might have liked regarding understanding the causes of our problems."

Table 5

Frequency of Most and Least Helpful Outcome Factors Reported by Respondents

Response domain	Most helpful	Least helpful	Total
Outcome factors	37	28	65

The fifth and final domain that emerged as a major theme in the responses was client factors. Three subcategories emerged describing couples' experiences of themselves and their spouse in therapy: Self factors, spouse factors, and couple factors. In all, there were 59 references to one of these three subcategories (see Table 6). When examined more closely, there were 37 responses referring to oneself, 31 of which were most helpful and six that were least helpful. Self factors included anything the respondent noted about him or herself, including behaviors, feelings, and beliefs. This often occurred in the form of an I-statement, for example, "I felt very comfortable during our sessions" (most helpful) and "Some of the dialogue was not helpful, but mostly because I didn't listen at times. I was not ready to" (least helpful). One partner reported that the ability to self-disclose was most helpful: "Therapy helped me most by being able to express how I truly feel inside to my spouse." In the least helpful responses, self factors referred to aspects of the client's behavior such as difficulty incorporating skills learned in session, at home ("Attempting to incorporate skills at home environment.").

In eight responses, respondents referred to some aspect of his or her spouse's behavior as being most (two references) or least (six references) helpful in the therapy. Spouse factors were noted as most helpful in two separate responses, both referring to the spouse's disclosures. One of them stated, "My spouse did not really want to come to counseling and really came to enjoy (the therapist) and open up." On the other hand, least helpful spouse factors included things such as lack of openness or motivation in one's spouse ("The least helpful was when my spouse cancelled or didn't show up.") and

perceived traits or personal problems of the spouse (“The fact that I'm married to a totally sexless, affectionless, loveless spouse.”).

Finally, 14 responses referred to something about the couple’s behavior that was most (six references) or least (eight references) helpful. Couple factors were identified when “we” or “us” was the subject of the response. For example, one respondent noted that it was helpful that both partners did the reading assignments:

> The most helpful was actual practice of the exercises and working through them with our therapist. Both of us do a huge amount of reading, but actually doing the work and not shortcutting them to say “oh yeah, that's how it works” was very helpful.

On the other hand, a few respondents discussed failing to complete homework assignments or practice exercises, such as communication skills, at home (“Some suggested exercises weren't helpful because we didn't do them!”) or the couple arguing during sessions (“Sometimes we got into arguments, because of the issues that were raised during the sessions.”).

Table 6

Frequency of Most and Least Helpful Client Factors Reported by Respondents

Response domain	Most helpful	Least helpful	Total
Client factors	39	20	59

(*table continues*)

Response domain	Most helpful	Least helpful	Total
Self	31	6	37
Spouse	2	6	8
Couple	6	8	14

A comparison of frequencies across the five domains illustrates two main points. First, as shown in Table 7, the frequencies of the five domains in responses about the most helpful things about therapy, in order from highest to lowest frequency, are the therapist, therapy interventions and process, client, outcome, and logistical factors. Almost all groups of participants (husbands, wives, partners in TBCT, and partners in recovered marriages) reported the same order of domain frequency. The exceptions were partners in the IBCT treatment group and those whose marriages deteriorated by 2-year follow up, who noted therapy interventions and process factors more frequently than therapist factors.

Second, as shown in Table 8, the frequencies of the five domains in responses about the least helpful things about therapy, in order from highest to lowest frequency, are the logistical, therapy interventions and process, outcome, client, and therapist factors. Partners in the TBCT treatment group, husbands, and partners in the clinically significant recovery at 2-year follow up group stated the same order of domain frequency. However, partners in the IBCT treatment group, wives, and partners in the clinically significant deterioration at 2-year follow up group stated a higher frequency of outcome

factors than therapy interventions and process factors (see Appendix F for a more detailed table of the frequencies of codes within each domain and subdomain).

Table 7

Frequency of Each Domain in Responses about Most Helpful Aspects of Therapy

	Total	IBCT (*n* = 136)	TBCT (*n* = 132)	Husbands (*n* = 135)	Wives (*n* = 135)	Recovered (*n* = 104)	Deteriorated (*n* = 58)
Therapist factors	418	52	106	75	85	78	22
Therapy factors	405	102	52	73	78	72	28
Client factors	106	10	29	18	21	21	7
Outcome factors	82	6	21	15	21	15	4
Logistical factors	56	6	15	11	10	12	2

Table 8

Frequency of Each Domain in Responses about Least Helpful Aspects of Therapy

	Total	IBCT (*n* = 136)	TBCT (*n* = 132)	Husbands (*n* = 135)	Wives (*n* = 135)	Recovered (*n* = 104)	Deteriorated (*n* = 58)
Logistical factors	167	31	34	31	33	29	9

(*table continues*)

	Total	IBCT (*n* = 136)	TBCT (*n* = 132)	Husbands (*n* = 135)	Wives (*n* = 135)	Recovered (*n* = 104)	Deteriorated (*n* = 58)
Therapy factors	115	20	21	20	28	18	8
Outcome factors	112	31	18	13	33	8	9
Client factors	50	10	9	9	11	6	5
Therapist factors	27	3	7	4	6	3	4

Group Comparisons on Most Helpful Responses

Therapist factors. Perhaps not surprisingly, as it corresponds to literature stating the importance of the therapeutic alliance, all partners most frequently reported therapist factors that were most helpful. When the responses were examined by treatment group, partners who received Traditional Behavioral Couple Therapy (TBCT) provided more responses referencing therapist factors as most helpful than partners who received Integrative Behavioral Couple Therapy (IBCT). For example, TBCT partners stated that something about the therapist was most helpful 106 times, whereas IBCT partners stated that something about the therapist was most helpful 52 times. Specifically, TBCT partners reported a greater number of therapist qualities (57) than behaviors (49), and IBCT partners reported equal amounts of therapist qualities and behaviors (26 each). Among others, TBCT partners focused on therapist qualities such as sensitivity and competence (“I also respected [the therapist] for his ability and sensitivity to our

problems."), sense of humor ("The most helpful thing was [the therapist's] keen insight and sense of humor in teaching us new methods of communication."), and relationship skills ("Our therapist was helpful, warm, human and very approachable."). TBCT partners also reported therapist behaviors such as feedback ("The therapist's feedback and identification of our 'themes.'"), guidance ("[The therapist] brought us back to subject on hand quickly and gently when we drifted from it."), and listening ("The therapist used exceptional listening skills to capture our problems in action and invite us to redirect efforts - try something different."). TBCT partners referenced therapist factors as most helpful more frequently than any other domain. IBCT partners reported therapist qualities similar to TBCT partners, such as competence, patience, understanding, and warmth ("An excellent, understanding and warm therapist who explained things well and was patient and respectful of our needs."); relationship skills ("The therapist was wonderful - very good at his job and made you feel very much at ease."); and sensitivity ("The therapist was sensitive and professional - steady as a rock."). Therapist behaviors reported by IBCT partners included mediating ("He was a good referee when topics came up and we [my spouse and I] started getting mad and heated arguments arose."), affirming spouses ("I really appreciated the affirmations, been a long time for me!"), and suggestions for the couple ("[The therapist's] suggestion that we spend time just talking and that we set up a time to meet regularly to talk.").

Examining the responses by gender revealed that both husbands and wives reported that therapist factors were most helpful more frequently than in any other domain. However, they differed on how many times they referred to the therapist's behaviors versus qualities. Interestingly, further examination revealed that wives reported

a greater number of therapist qualities (49) than behaviors (36) whereas husbands reported a greater number of therapist behaviors (41) than qualities (34). Wives reported a number of therapist qualities, such as support and warmth ("Our therapist was helpful, warm, human, and very approachable."); sense of humor, caring, and empathy ("The kindness, empathy and humor of the therapist made it easier to be open and honest."); and cultural sensitivity ("The therapist was culturally sensitive which was an extremely important component for the success of the program."). Among others, wives reported that therapist behaviors included listening and making observations, summed up by one wife who reported,

> (The therapist) was relatively easy to communicate with. Often his observations were correct - even when you didn't want to believe it. There was never any pressure to feel a certain way, nor did he ever try to convince that his way was the only way. He was always willing to listen to whatever we had to say.

Husbands reported therapist behaviors that included defining the couple's problems ("The therapist defined the problem in our relationship."), checking in with the couple ("I felt the therapist was good about asking how things were going and how we felt about it."), and identifying the couple's patterns of behavior ("Therapist excellent at teasing out my issues in instances where I am focused on my spouse's issue."). Among others, husbands reported that therapist qualities included relationship skills ("For me the therapist got through to me [that] I could change me and that would help."), consistency ("Her manner and demeanor were consistent and so I felt I could rely on her and never had any doubt that she was providing consistent effort and thoughtfulness."), and cultural sensitivity ("Therapist was able to understand our cultural background and use it to

analyze our problems and provide concrete useful solutions based on our cultural way of living."). Of note, partners from both genders stated the importance of cultural considerations in the therapy.

Partners from the marriages that experienced clinically significant recovery at 2-year follow up (recovered) also reported a greater number of therapist factors than any other domain. They specifically reported a greater number of therapist qualities (46) than behaviors (32). Conversely, partners from the marriages that experienced clinically significant deterioration at 2-year follow up (deteriorated) reported a greater number of therapist behaviors (14) than qualities (8). Recovered partners specifically reported on qualities, among others, such as insightfulness ("[The therapist] is an insightful therapist.") and sincerity ("Therapist is also a very good person and a very sincere individual. It is very apparent that he enjoys doing what he is doing and most desires that individuals better their relationships."). They also reported on several behaviors referring to therapist identification of problems ("Was very perceptive in identifying problems that we could not pinpoint.") and assisting the couple to work as a team:

> Having (the therapist) assist us to find a way to become a team utilizing the readings and our conversations. She had a great memory which helped to remind us of where we have been and just how far we had progressed.

Deteriorated partners specifically reported on behaviors such as guidance ("He brought us back to subject on hand quickly and gently when we drifted from it."), restating what the couple said ("Most helpful was the synopsis and re-stating that the therapist used to help summarize and neutralize our different standpoints."), and treating each partner equally ("He saw both sides and was objective and reasonable."). They also reported on

several qualities referring to therapist neutrality ("The therapist's modeling of a neutral stance in emotional issues.").

Therapy interventions and process factors. The two different treatment groups varied on how frequently they referred to therapy interventions and process factors as being most helpful, as well as on the particular areas within the interventions and the process that they considered most helpful. For example, most groups found communication and problem solving training to be most helpful, although two groups interestingly found problem solving training to be less helpful than other interventions. Specifically, TBCT partners reported that therapy interventions and process factors were the second-most helpful aspect of the therapy (52; second only to therapist factors). They identified the most helpful aspects as communication skills training (20), therapy process (12), other assignments (10), other techniques (5), and problem solving training (5). TBCT partners reported several therapy interventions such as communication skills training, stating that, for example, the "Most helpful was learning techniques and skills in communication." Others reported problem solving techniques, such as "Most helpful was the confrontation of the problems and [to] try to solve together with calm." There were also references to the reading assignments, such as "The articles were a little helpful - mostly to realize that other couples have the same issues," and "I found the reading extremely helpful - even though I have not finished the book yet." TBCT partners mostly reported therapy process factors such as aspects of safety and neutrality in the therapeutic environment, such as "It also gave me a safe place to share some thoughts that I wouldn't have otherwise," and "Being in an unbiased environment." IBCT partners, however, identified therapy interventions and process factors as being most helpful more often than

any other domain (102). In a somewhat different order of code frequency from TBCT partners, IBCT partners identified the most helpful aspects as problem solving training (39), communication skills training (36), other techniques (13), other assignments (7), and therapy process (7). IBCT partners reported therapy interventions such as learning to communicate civilly ("Learning new communication skills and more civil way of discourse."), reflective listening ("What I found most helpful was [the] reflective listening technique."), and learning to problem solve ("Most helpful was how to approach an irritating problem and that was to start out with something positive."), as well as therapy process factors such as the structure and safety in the therapeutic environment ("Providing a place and time where we felt safe and could take risks.").

Husbands and wives referenced therapy interventions and process factors as most helpful a similar number of times. Wives reported 78 (problem solving training, 57; communication skills training, 34; other techniques, 9; other assignments 7; therapy process 7) and husbands reported 73 therapy interventions and process factors as most helpful (problem solving training, 24; communication skills training 22; therapy process, 11; other assignments, 8; other techniques, 8). Husbands and wives both reported that therapy interventions and process factors were most helpful the second-most often (second to therapist factors only). More specifically, wives reported several communication and problem solving techniques such as, "Most helpful was the work on listening and rephrasing to the other spouse and my being able to discuss my issues in our marriage that have been real problems for me," and "Most helpful was that we got to air some difficulties/problems in sessions that we were otherwise not able to constructively deal with on our own;" other techniques such as, "Taking time outs – realize

input/output;" and reading assignments. Wives also reported therapy process factors such as the structure and safety in the therapeutic environment ("The most helpful was having an opportunity to be in a therapeutic environment and discuss openly issues relating to our marriage."). Husbands also identified several problem solving and communication techniques such as, "The most helpful thing about our therapy was the problem solving format and learning how to state the problem, paraphrase, and good listening;" reading assignments; and other techniques such as labeling behaviors ("Attaching labels to behaviors."). One husband reported that the "Most helpful [thing] was the setting for both of us to have a discussion or air our feelings or concerns. No place to hide and avoid topics."

Similar to the TBCT and IBCT treatment groups, partners in the recovered and deteriorated groups reported that therapy interventions and process factors were the first- or second-most helpful aspect of the therapy. Specifically, partners in the recovered group reported that therapy interventions and process factors were second-most helpful (72; second only to therapist factors), with communication skills training (24), problem solving training (19), other assignments (12), therapy process (9), and other techniques (8) as the specific aspects of the therapy that were most helpful. Recovered partners specifically reported on therapy interventions such as communication and problem solving training ("Learning and practicing communication and problem solving was most helpful.") and other techniques ("Learning to communicate in new ways. Learning to check in with each other's feelings. Learning to accept our different ways of behaving and dealing with issues."); and on therapy process factors such as structure, neutrality ("Most helpful was resolving certain hot issues in a neutral arena."), and safety in the therapeutic

environment (“The most helpful aspect was having a safe place for communication between my spouse and I.”). Partners in the deteriorated group reported that therapy interventions and process factors were more helpful than any other domain, with communication skills training (14), therapy process (5), other techniques (4), problem solving training (3), and other assignments (2) as the specific aspects of the therapy that were most helpful. Deteriorated partners reported on therapy interventions such as communication techniques, evaluating strengths (“Evaluating strengths of relationship.”), goal setting (“Set goal to become more aware of intent versus impact.”), and role playing (“The most helpful thing in therapy was role playing. It gave me a chance to put myself in someone else's shoes and learn to communicate with my family.”); and on therapy process factors such as safety and neutrality in the therapeutic environment (“Non-confrontational environment.”).

Client factors. In response to the most helpful things about the therapy, TBCT partners reported 29 client factors. Of these, self factors were reported most often (22), followed by couple factors (5) and spouse factors (2). TBCT partners reported self factors such as learning to judge one’s spouse less (“The most helpful thing is not to judge the spouse by our own point of view.”), learning how to contribute to the marriage (“How I should help the marriage.”), and learning about one’s spouse (“Understanding what my spouse needs.”). They also reported how their spouse’s disclosures (“To see where we stand, how spouse thinks.”) and their openness with each other (“We were open with our feelings and got very clear on our problems and differences.”) were most helpful. IBCT partners reported 10 client factors. Of these, self factors were reported most often (9), followed by one comment about couple factors. IBCT partners reported self factors such

as learning about oneself ("Learning about myself."), self disclosure ("The first two sessions where I was able to vent my frustrations."), and learning about one's spouse ("Learned more about the person I married than I'd learned in the four years prior to our participation in this project."). Of note, IBCT partners did not identify any spouse factors as being most helpful.

There were very small differences between how many times husbands and wives reported that client factors were most helpful. Wives reported 21 (self factors, 17; spouse factors, 2; couple factors, 2) and husbands reported 18 (self factors, 14; couple factors, 4) client factors. Wives reported client factors such as learning about oneself ("Realization of experiences contribute to being who you are."), both partners noting patterns in their relationship ("For us to see the patterns in our disagreements was helpful."), and examining the value of one's relationship:

> Most helpful things about the therapy is that I believe we both learned to remember what brought us together to begin with, what attracted us to our spouses and even though each of us may not agree with the other person's feelings, it doesn't mean that we don't love each other or care about each other.

Husbands reported self factors such as self-disclosure ("I had the opportunity to express my feelings."), examining the value of the relationship ("Help me to see the value of my relationship."), learning about oneself ("Looking at my own defensiveness and taking a step back – my awareness of what is going on with me in a conflict."), and couple factors such as both spouses' disclosures ("Getting to know each others' thoughts and expressions about certain things."). Husbands notably did not identify any spouse factors as being most helpful.

Partners in the recovered group reported 21 client factors as most helpful (self factors, 15; couple factors, 5; spouse factors, 1) and partners in the deteriorated group reported seven client factors (self factors, 7). Recovered partners reported client factors such as a belief in the long-lasting effects of therapy ("I can't place a value on the therapy that we received and I will remember it for the rest of my life."), learning about each other ("Uncovering misconceptions about each other."), and disclosing to each other ("Most helpful was sharing our feelings, which we had previously been guessing about and not speaking about."). Deteriorated partners reported client factors such as understanding one's spouse better ("The most helpful would be understanding my spouse's position."). Notably, partners in the deteriorated group did not identify any spouse or couple factors as being most helpful. Of interest, several client factors that were most helpful seem to describe pivotal moments in the therapy. The descriptions in the current responses are, at times, quite similar to what is described in other research on pivotal moments in couple therapy.

Outcome factors. Partners in the two treatment groups identified a number of outcome factors as most helpful. As described below, all groups frequently reported an outcome of improved communication, which corresponds with numerous other research studies showing that couples' communication improves posttreatment. Within each treatment group, TBCT partners reported 21 outcome factors, and IBCT partners reported six. Partners in the TBCT treatment group reported that an outcome factor was the most helpful aspect of the therapy the second-fewest amount of times, second only to the logistical factors. TBCT partners mostly reported receiving tools to solve their own

problems (“Tools to help us communicate more effectively.”) and outcomes of improved communication:

> The most helpful thing about the therapy was that it enabled my spouse and I to actually talk about differences and not argue. Before the therapy we would argue about petty things that actually masked the main issues. We now feel as though we are a team and not just individual players.

IBCT partners also mostly reported outcomes of improved communication (“It taught us to communicate with each other.”) and tools they received to solve their own problems (“The most helpful thing was we have tools to use at home to analyze our problems. So, we can solve them ourselves.”).

Each gender reported that an outcome factor was the most helpful aspect of the therapy a similar number of times. Wives referred to 21 outcome factors and husbands referred to 15. Both genders reported that an outcome factor was the most helpful aspect of the therapy the second-fewest amount of times, second only to the logistical factors. While wives reported several outcomes related to improved communication, they also reported outcomes of increased acceptance of partner differences (“It has been helpful just thinking about what would make the other person happy and it has been helpful learning to accept differences.”), increased understanding of differences (“I think we both learned that we are very different by nature, but that doesn’t mean we have to only feel our way is right.”), and commitment to the marriage (“Getting us to understand that we were both committed to our marriage. That allowed us to build a foundation of trust that puts everything in perspective.”). Husbands also reported several outcomes related to improved communication, but they also reported outcomes related to improved problem

solving ("We were able to discuss problems more objectively than before.") and learning to get along better ("We have learned to get along better.").

Partners in the recovered group reported 15 outcome factors as most helpful and partners in the deteriorated group discussed four. Both groups reported that an outcome factor was the most helpful aspect of the therapy the second-fewest amount of times, second only to the logistical factors. Among other outcomes, recovered partners frequently reported outcomes of improved communication such as, "I learned how to listen to my spouse and address his needs," and improved problem solving such as, "Taught us how to solve our problems without hurting each other - taught us how to give more of ourselves to each other that started our relationship back on the road to happiness!" Deteriorated partners specifically reported outcomes of improved communication or receiving tools with which to solve their own problems.

Logistical factors. When examining the logistical factors reported as most helpful by each treatment group, TBCT partners reported 15 (amount of time, 7; research project details, 6; getting to the therapy, 2) and IBCT partners reported six (amount of time, 3; research project details, 3) logistical factors. TBCT partners specifically reported logistical factors such as the regularity of sessions ("Regular sessions over a reasonable duration."), parking at the session location ("Parking was good."), and videotaping ("The video-taped communications during the meetings were helpful – gave us an opportunity to discuss issues without demands [kids, phone, etc.]."). IBCT partners also reported logistical factors such as regularity of sessions ("Regular therapy sessions."), being treated with respect by the project staff ("We were treated with respect by all staff members."), and the free services ("No cost. Wouldn't have gotten therapy otherwise.").

Of note, IBCT partners did not identify any logistical factors related to getting to the therapy session. Also, both treatment groups reported a fewer number of logistical factors than any other domain.

There were very small differences between how frequently husbands and wives reported that logistical factors were most helpful. Wives reported 10 (research project details, 6; amount of time, 2; getting to the therapy, 2) and husbands reported 11 (amount of time, 8; research project details, 3) logistical factors. Wives reported logistical factors such as the amount of time, the free services, the location of the therapist's office ("It wasn't too far away."), and the therapy treatment delivered in the research project ("Program was entirely different form other therapy we had attempted. I feel much more optimistic."). Husbands mostly reported logistical factors related to the amount of time, but a few responses reported other logistical aspects like the questionnaires being helpful ("The questionnaires often represented problems that we do not experience [physically abusive spouse, etc.]. Although, that did help us to see that our own problems while deep were not as serious as those."). Husbands did not identify any logistical factors related to getting to the therapy session. Both husbands and wives reported a fewer number of logistical factors than any other domain.

Partners in the recovered group reported 12 logistical factors as most helpful (amount of time, 6; research project details, 6). Recovered partners reported logistical factors such as the time set aside to meet and talk with each other ("Time together to talk."), questionnaires, and videotaping. However, the recovered group of couples did not identify any logistical factors related to getting to the therapy session. Partners in the deteriorated group reported two logistical factors (amount of time, 2). Deteriorated

partners specifically referred to the regularity of sessions in their responses. Of note, the deteriorated group of couples did not identify any logistics related to the research project details or getting to the therapy session as most helpful. Also, couples in both groups reported a fewer number of logistical factors than any other domain.

Summary of most helpful factors. Several points can be summarized across all comparison groups. First, therapist factors were referenced as most helpful more times than any other domain by TBCT partners, by husbands and wives, and by recovered partners. All comparison groups reported therapist qualities such as sensitivity and competence, sense of humor, patience, understanding, and relationship skills; and therapist behaviors such as feedback, guidance, listening, and treating each partner equally. Second, all comparison groups frequently reported something about their own behavior, feelings, or beliefs that was most helpful in the therapy, and all groups except for the deteriorated group found something about the couples' behavior to be most helpful. Third, IBCT and deteriorated partners reported that therapy interventions and process factors were the most helpful aspect of the overall therapy experience, more than any other domain. All comparison groups reported that therapy interventions such as communication skills training, problem solving training, other techniques, and reading assignments were most helpful. They also reported that therapy process factors like safety and neutrality in the therapeutic environment were most helpful, although therapy process factors were reported less frequently than intervention factors. In addition, all groups except for TBCT partners found communication skills or problem solving training to be more helpful than other techniques, other assignments, and therapy process factors. Fourth, all comparison groups frequently reported outcomes of improved communication.

Both treatment groups and deteriorated partners frequently reported outcomes of receiving tools to solve their own problems at home, and recovered partners frequently reported outcomes of improved problem solving. Finally, logistical factors were reported as most helpful fewer times than any other domain. Wives were the only group not to report logistical factors related to the amount of time in the therapy more frequently than any other logistical factor. Time factors often included the regularity and duration of sessions. Also, considering that only a few logistical factors related to getting to the therapy session were reported, only wives and partners in the TBCT treatment group reported that this was most helpful. Logistical factors related to details concerning the research project itself were also mentioned by all comparison groups.

Group Comparisons on Least Helpful Responses

Logistical factors. Of interest, the high number of logistical factors reported as least helpful highlights how aspects such as the parking, fee, and time of each therapy session affect clients. When examining the logistical factors reported as least helpful by each treatment group, TBCT partners reported 34 (amount of time, 18; research project details, 10; getting to the therapy, 6) and IBCT partners reported 31 (research project details, 15; amount of time, 13; getting to the therapy, 3). TBCT partners frequently reported logistical factors related to the amount of time ("Wish the program were longer than six months."), as well as to scheduling sessions and the location of the therapist's office ("Distance and scheduling got in the way."). One TBCT partner specifically noted that,

> I think…that we could have still used a few more sessions because there are still bumpy spots in our relationship that could use some outside guidance. I wish we could have follow-up sessions that would take place after longer intervals of time.

IBCT partners also reported the amount of time ("Sessions were not long enough. We'd get into a problems and run out of time to deal with it to a good close."), a lack of individual sessions ("Not being able to talk to counselor alone."), and research project details such as the fit of the therapy model used for the research project ("Possibly more knowledge of family of origin issues would have helped."). Both treatment groups reported logistical factors as least helpful a greater number of times than any other domain.

There were very small differences between how many times husbands and wives reported that logistical factors were least helpful. Wives reported 33 (amount of time, 15; research project details, 14; getting to the therapy, 4) and husbands reported 31 (amount of time, 15; research project details, 11; getting to the therapy, 5) logistical factors. Wives reported logistical factors related to the amount of time ("Sometimes sessions seemed too short. We'd just get into the meat of the problem and time was up."), the videotaping ("I despise being videotaped."), and the questionnaires ("Can't say I care for the wording of the questionnaires in being able to get across my feelings effectively."). Husbands also reported on the amount of time ("It seems the standard one hour session is a little too brief for couples counseling," and "Not being able to continue with the same therapist.") and on the lack of individual sessions ("More independent therapy, I feel would have been more beneficial to us as a couple. Learning about oneself and about each other

would have added to our recovery!"). Both husbands and wives reported logistical factors as least helpful a greater number of times than any other domain.

Partners in the recovered group reported 29 logistical factors as least helpful (research project details, 12; amount of time, 10; getting to the therapy, 7). While several recovered partners reported logistical factors such as the limited time of the sessions, one partner specifically reported that the lack of individual sessions was least helpful:

> Although I understand and respect the fact that this is a Couples oriented therapy program, because certain issues are still extremely sensitive, I do wish that each of us (especially my spouse) could have had the opportunity to articulate certain concerns privately (perhaps 10-15 minutes – occasionally). One cannot always be ready and prepared to air concerns in a couple situation as they might prove too delicate or volatile. I found it most frustrating that this private time could not be made available and sincerely feel that it impaired the usefulness of the whole program and added to the frustration felt in the context of the couple situation.

Partners in the deteriorated group reported nine logistical factors (research project details, 6; amount of time, 3). Deteriorated partners reported logistical factors similar to those reported by recovered partners, such as the amount of time ("Least helpful is the amount of time it required to participate."). Of note, partners in this group did not identify any logistics related to getting to the therapy session as least helpful. Couples in both outcome groups reported logistical factors as least helpful a greater number of times than any other domain.

Therapy interventions and process factors. Interestingly, all groups frequently reported that reading assignments were least helpful. However, there were surprising

differences between the specific interventions that TBCT and IBCT partners reported. Both treatment groups identified a similar number of therapy interventions and process factors as least helpful. For example, TBCT partners reported 21 therapy interventions and process factors (other assignments, 9; therapy process, 6; other techniques, 4; communication skills training, 1; problem solving training, 1) and IBCT partners reported 20 (therapy process, 6; other assignments, 6; other techniques, 2; communication skills training, 3; problem solving training, 3). TBCT partners frequently reported therapy interventions such as reading assignments, but they also reported other techniques such as positive ideas exchanges ("The least helpful things about the therapy is that the positive ideas exchanges during the session don't translate into action.") and faking arguments ("Least helpful: Faking arguments. We weren't able to incorporate many into our daily lives."). Of note, while behavioral exchanges are a primary treatment strategy of TBCT, faking arguments is an intervention more typically used in IBCT. IBCT partners also reported other techniques such as formulaic feeling statements ("Least helpful: XYZ statements of how I feel in a situation. X when spouse does Y. Seems too canned."), the floor card technique ("Least helpful was the floor card [to be held by person speaking]."), and the therapy lacking structure.

Wives reported 28 therapy interventions and process factors as least helpful (other assignments, 14; other techniques, 7; therapy process, 7) and husbands reported 20 (other assignments, 9; therapy process, 6; problem solving training, 3; communication skills training, 2). Both genders frequently reported that reading assignments were least helpful. Wives also reported that "The therapy did not address our issues aggressively enough to encourage progress," and that "I did not feel safe to express what I really wanted to."

Husbands also reported on therapy interventions such as role playing ("Neither my spouse nor myself are comfortable with role playing.") and focusing on problems only ("The least helpful thing was you discussed problems only and that was your path."). Husbands and wives both reported therapy interventions and process factors the second-most amount of times (second to logistical factors only). Wives did not report any communication skills or problem solving training as least helpful, and husbands did not report any other techniques as helpful.

Similar to the TBCT and IBCT treatment groups, partners in the recovered and deteriorated groups reported therapy interventions and process factors to be first- or second-least helpful. Specifically, partners in the recovered group identified the following therapy interventions and process factors as least helpful (18): Other assignments (8), communication skills training (4), other techniques (3), therapy process (2), and problem solving training (1). Recovered partners specifically reported therapy interventions such as reading assignments ("The readings were not scheduled as sort of homework so they were not so helpful."), problem solving strategies ("Trying to structure problem-solving in a bit too rigid a fashion."), and communication exercises ("Least helpful was the communication exercises. They didn't translate well into real life."). Partners in the deteriorated group identified the following therapy interventions and process factors (8): Therapy process (4), other techniques (2), problem solving training (1), and other assignments (1). Deteriorated couples reported therapy interventions and process factors such as the structure ("Rigid structure – not allowing for more free-flowing expression of problems/feelings.") and discussing the couple's unhappiness ("The least helpful seemed to be many discussions about our unhappiness without a focus on resolving specific

problems."). Of note, partners in the deteriorated group did not report any communication skills training factors as least helpful.

Outcome factors. Perhaps not surprisingly, sexual issues not being addressed was one of the most frequently reported least helpful outcomes factors in all groups. Partners in both treatment groups identified several outcome factors as least helpful. Within each treatment group, TBCT partners reported that an outcome factor was least helpful 18 times, and IBCT partners reported that an outcome factor was least helpful 31 times. TBCT partners reported outcome factors such as lacking tools or exercises to use at home ("I think I was wanting more concrete exercises regarding values, agreements, trusting each other to follow through on those agreements and how to work out the 'fall out' from those."), too much individual focus or lack of couple focus in the therapy ("I felt like we were in each other's individual therapy. Did not really touch the issues as a couple…I don't feel the we were ever integrated in our views by the therapist."), and a lack of individual focus in the therapy ("Least helpful was that we were not challenged more to work on how we contribute individually to our problems together, and how to take more personal responsibility in making changes to improve the relationship."). Of interest, though stated above by a TBCT partner, taking personal responsibility for one's own needs in the relationship is a goal of IBCT treatment. IBCT partners reported outcome factors such as their sexual issues not being addressed ("Little or no focus on sex issues."), a lack of increased understanding of their problems ("It would be good to have more feedback sessions to be able to know our own contribution to impeding progress."), and a lack of behavioral modification ("Needed more behavior modification of the two of us.").

Wives reported that an outcome factor was least helpful 33 times, and husbands reported that an outcome factor was least helpful 13 times. Wives reported feeling like the couple's sexual issues were not addressed ("Ending treatment before [actually way before] we could address our sexual issues - that's the scariest topic for us - and the one I feel least confident we can address on our own.") and that there was not enough problem solving ("Dealt with communication tool more than we dealt with problems."). Husbands also reported feeling like the couple's sexual issues were not addressed ("Not being able to address all of the issues that cause our internal problems, such as my spouse's sexual inhibitions."), a lack of increased understanding of the couple's problems ("Not digging into issues deeper."), and a lack of individual focus in the therapy ("Lack of enough emphasis or focus on individual patterns and their sources [us as individuals] to further reinforce self-reflection and aid in dissipating conflicts early on.").

Partners in the recovered group reported an outcome factor as least helpful eight times, and partners in the deteriorated group reported outcome factors nine times. Recovered partners reported outcome factors such as their sexual issues not being addressed ("Did not discuss sexual relationships at all."), not enough tools or exercises to use at home ("I probably wanted more tools or exercises that my spouse and I could share together at home."), and not enough problem solving ("Didn't seem to be making any clear or definite progress. Problems were clearly identified but little or nothing in the way of solutions was forthcoming."). Deteriorated partners reported outcome factors such as individual needs not being explored or addressed ("The relationship issues stayed stuck for a long time. Individual needs, hopes, desires, strengths/weaknesses were not explored much."), and an inability to find solutions to old problems ("The least helpful is how to

deal with old problems and find solutions accepted by both of us."). In the deteriorated group, a greater number of outcome factors were reported than any other domain (except for logistical factors, with which it tied for the most responses).

Client factors. In response to the least helpful things about the therapy, both TBCT and IBCT partners reported client factors the second-fewest amount of times (therapist factors were stated fewer times). TBCT partners reported nine total client factors, including three statements each about self factors, spouse factors, and couple factors. They reported client factors such as not completing homework assignments ("We didn't really read the book.") and difficulty learning to accept one's spouse ("The least helpful thing is to learn to accept the character of the spouse."). Similarly, IBCT partners reported 10 client factors, including five references to couple factors, three references to spouse factors, and two references to self factors. They reported client factors such as lack of motivation in one's spouse ("My spouse did not want to be in the program.") and not completing homework assignments ("Sometimes difficult to find the time to do the homework.").

Wives reported 11 (self factors, 4; couple factors, 4; spouse factors, 3) and husbands reported nine client factors as least helpful (couple factors, 4; spouse factors, 4; self factors, 1). Whereas both genders reported client factors such as not completing homework assignments and other aspects of their behavior, one wife reported that a "Lack of self-esteem or other personal problems about the individual may contribute to the marriage problems." Husbands reported more frequently about their spouse's behavior, such as "Less helpful to motivate spouse to success." Both husbands and wives

reported client factors as least helpful the second-least amount of times (therapist factors were stated less times).

Partners in the recovered group reported six client factors as least helpful (self factors, 3; couple factors, 3) and partners in the deteriorated group reported five (couple factors, 2; spouse factors, 2; self factors, 1). Recovered partners frequently reported failing to complete homework assignments, such as "My spouse is often reluctant to do homework…This impaired the effectiveness of the program – our fault, definitely not yours!" However, spouse factors were not identified as least helpful by partners in the recovered group. Deteriorated partners reported client factors such as their commitment level ("Commitment level – ours.") and a lack of openness in one's spouse ("My spouse has much difficulty compromising and forgiving."). Partners in both outcome groups reported client factors the second-fewest amount of times (therapist factors were stated fewer times).

Therapist factors. When examining the responses about what was least helpful about the therapy by treatment group, both TBCT and IBCT partners referred to therapist factors the fewest amount of times. Specifically, TBCT partners reported seven therapist factors and IBCT partners reported three therapist factors. Of note, the therapist factors all referred to therapist behavior, except for one comment about a therapist quality from an individual in the TBCT treatment group (the same comment noted above; it is the only statement identified that was coded as a least helpful therapist quality: "I feel [that the] therapist's style was not as effective as other therapists I have worked with."). TBCT partners reported therapist behaviors such as not treating the partners equally ("Occasionally feeling bias towards my spouse from the therapist.") and IBCT partners

reported therapist behaviors such as not self-disclosing ("The therapist does not offer much of how she thinks, or [what] she thinks is right or not right.").

Similarly, both husbands and wives referred to therapist factors as least helpful the fewest amount of times. Wives reported six therapist factors and husbands reported four. As in the treatment group comparison, the therapist factors all referred to therapist behavior, except for the comment about a therapist quality by one of the wives. Wives reported therapist behaviors such as an inability to refocus session goals ("Counselor failed to refocus spouses to get each to focus on feelings behind problems.") and husbands reported therapist behaviors such as ineffective instruction ("Direction of explorations often very controlled and directed, many times far afield from where we needed to go.").

Partners in both outcome groups (clinically significant recovery and deterioration at 2-year follow up) reported therapist factors as least helpful fewer times than any other domain. Partners in the recovered group reported three therapist factors and partners in the deteriorated group reported four. The therapist factors all referred to therapist behavior, except for one comment about a therapist quality by an individual in the recovered group. Recovered and deteriorated partners reported therapist behaviors such as lack of assistance (recovered: "Therapist didn't really assist in resolution of problems;" deteriorated: "The materials that were given were not dealt with in our therapy.").

Summary of least helpful factors. Several points can be summarized across all comparison groups. First, the therapist was found to be the least helpful aspect of the therapy fewer times than any other domain across all comparison groups. All comparison groups reported a variety of therapist behaviors that were least helpful, such as not

treating the partners equally, a lack of therapist assistance, and the therapist's inability to refocus session goals. However, there was only one therapist quality reported, in a response from a wife who was in the TBCT treatment group and was considered recovered at 2-year follow up, that was considered least helpful. Second, while all comparison groups reported client factors as being least helpful, most groups focused more on spouse or couple factors than self factors. Spouse factors that were least helpful were often a lack of motivation or openness in therapy, and couple factors were often a lack of completing homework assignments. Wives were more likely to report something about their own behavior that was least helpful than were husbands, and husbands more frequently reported aspects of their spouse's behavior that was least helpful. Third, all comparison groups except for deteriorated partners frequently reported reading assignments (therapy intervention) as least helpful. Deteriorated partners and wives were also the only groups not to find some aspect of communication skills training to be least helpful, and wives were the only group not to find the problem solving training to be least helpful. Fourth, all comparison groups reported that their sexual issues were not addressed in the therapy, or felt that this was lacking in the treatment (outcome factor). They also all reported lacking enough tools or exercises to use at home after the therapy ended. In addition, TBCT partners, husbands, and deteriorated partners more frequently reported a lack of individual focus in the therapy than did IBCT partners, wives, and recovered partners.

Finally, a summary of both treatment groups, genders, and outcome groups revealed that there were a greater number of logistical factors identified as least helpful than any other domain. All comparison groups frequently reported that the limited time of

the sessions (logistical factor) was least helpful, with only the deteriorated partners reporting that this was least helpful just a few times. Although logistical factors related to getting to the therapy session was reported by all comparison groups except for the deteriorated partners, this was reported infrequently. More often logistics related to the research project were reported, especially by IBCT partners and recovered and deteriorated partners. However, wives more frequently reported research project details such as the videotaping and questionnaires, whereas husbands more frequently reported the lack of individual sessions.

Quantitative Results

Group comparisons on most helpful responses. The quantitative analyses involved two separate tests for significance: Chi-square and McNemar's tests (McNemar, 1947). Chi-square tests were performed to determine differences between treatment (TBCT and IBCT) and outcome (recovered and deteriorated) groups and to account for dichotomous dependent variables. Due to the dependent nature of couple data, McNemar's tests were performed to determine differences between genders and between genders within each treatment group, and to account for dichotomous dependent variables.

The first aim of the quantitative results was to assess for TBCT and IBCT treatment group differences in their reports of the most helpful aspects of therapy. The chi-square tests showed significant differences between the two treatment groups on the following most helpful aspects of therapy: Therapy ($\chi^2 = 8.35$; $df = 1$; $p = .004$), therapist ($\chi^2 = 8.37$; $df = 1$; $p = .004$), and client factors ($\chi^2 = 6.73$; $df = 1$; $p = .010$). Table 4 depicts a summary of the treatment group differences on the most helpful aspects of therapy.

Table 9

Treatment Group Differences on the Most Helpful Aspects of Therapy

	Treatment group		Most helpful	
Response domains	IBCT (n = 136)	TBCT (n = 132)	Chi-square	p
Therapy factors	102	52	8.35	.004
Therapist factors	52	75	8.37	.004
Logistical factors	6	15	1.31	.253
Outcome factors	6	21	.17	.681
Client factors	10	29	6.73	.010

The second aim of the quantitative results was to assess for gender differences in their reports of the most helpful aspects of therapy. The McNemar tests using binomial distribution did not show any differences between husbands and wives on most helpful aspects of therapy.

The third aim of the quantitative results was to assess for gender differences within each treatment group in their reports of the most helpful aspects of therapy. While there were no differences between husbands and wives within TBCT, the McNemar tests using binomial distribution showed just one significant difference between husbands and wives within IBCT, in the identification of client factors as the most helpful aspect of therapy, (n = 102, p = .008).

The fourth aim of the quantitative results was to assess for differences between the two outcome groups (recovered and deteriorated at 2-year follow up) in their reports of the most helpful aspects of therapy. The chi-square tests did not show any significant differences between the two outcome groups on the most helpful aspects of therapy.

Group comparisons on least helpful responses. The analyses parallel those used for the most helpful responses. First, the chi-square tests did not show any significant differences between the two treatment groups on the least helpful aspects of therapy. Also, the McNemar's tests showed no significant gender differences on the least helpful aspects of therapy. Similarly, no significant gender differences within each treatment group were found on the least helpful aspects of therapy.

Finally, the chi-square tests showed significant differences between the two outcome groups on the following least helpful aspects of therapy: Therapist ($\chi^2 = 4.08$; $df = 1$; $p = .043$) and outcomes ($\chi^2 = 5.63$; $df = 1$; $p = .018$). Table 5 depicts a summary of the outcome group differences on the least helpful aspects of therapy.

Table 10

Outcome Group Differences on the Least Helpful Aspects of Therapy

	Outcome group			
	Recovered	Deteriorated	Least helpful	
Response domains	(n = 104)	(n = 58)	Chi-square	p
Therapy factors	18	8	.16	.691

(*table continues*)

	Outcome group			
	Recovered	Deteriorated	Least helpful	
Response domains	(*n* = 104)	(*n* = 58)	Chi-square	*p*
Therapist factors	3	4	4.08	.043
Logistical factors	29	9	1.22	.269
Outcome factors	8	9	5.63	.018
Client factors	6	5	2.34	.126

Summary of quantitative results. Three comments can be made about the quantitative results. In summary, although there were no significant treatment group differences on the least helpful aspects of therapy, there were significant differences on the following most helpful aspects of therapy: Therapy, therapist, and client factors. In addition, there were no significant gender differences or gender differences within each treatment group on the most and least helpful aspects of therapy, with the exception of husbands and wives within IBCT, who differed significantly on most helpful client factors. Finally, although there were no significant differences between outcome groups on the most helpful aspects of therapy, there were significant differences on the following least helpful aspects of therapy: Outcome and therapist factors.

Chapter 4

Discussion

The current study was a mixed-methods investigation of couples' written responses about their experiences in therapy. Typically, researchers have measured how clients experience couple therapy via quantitative or qualitative studies, within one model of couple therapy. Few studies have utilized mixed-methods, process research to examine the common and model-specific mechanisms of change. Qualitative examination of data allows for examination of what clients actually experience in couple therapy, and a mixed-methods examination of what couples specifically report to be the most and least helpful aspects within two models of therapy informs the practice of couple therapy for both researchers and clinicians. The purpose of this section is to first provide a discussion of the codes as well as the themes that were observed across participants. Second, methodological limitations will be discussed. Third and lastly, implications and future directions of research will be proposed.

Codes and Themes

The primary finding emerging from this study that impacts research and practice with couples was the five domains (therapy, therapist, logistical, outcome, and client factors) that clients find most and least helpful about couple therapy. Notably, each domain was found to be both most and least helpful by different individuals, so that one person may have described the therapist as most helpful whereas another person described the therapist as least helpful, for example. Also, some individuals described aspects within one domain that were both most and least helpful, such as describing therapy factors as most and least helpful. The five domains, found in the responses of

both treatment groups and genders, complement the research on common factors that highlight the importance of the common elements among all types of therapy (Blow, Sprenkle, & Davis, 2007; Davis & Piercy 2007a, 2007b; Sprenkle & Blow, 2004). Briefly, Davis and Piercy's (2007b) model-independent variables, including client variables, therapist variables, and therapeutic process factors, closely compare to the client, therapist, and therapy factors that emerged in the current study. Davis and Piercy also include expectancy and motivational factors with the subcategories of faith in the referral source and fit of the model, two subcategories of the logistical factors that emerged in the current study. However, in contrast, the therapeutic alliance variable in Davis and Piercy's study did not emerge as a separate theme in the current study, and was instead incorporated into therapist factors. Blow, Sprenkle, and Davis's (2007) examination of the role of the therapist in common factors resulted in therapist variables including observable traits and states, and inferred traits and states that also resemble the two therapist factors subcategories of behaviors and qualities that emerged in the current study. This research provides further confirmation and replication of the findings from common factors research.

The overall high frequency of responses referring to the therapist as most helpful complements the myriad research on the importance of the therapeutic relationship (i.e., Garfield, 2004; Sprenkle & Blow, 2004; Sprenkle et al., 2007). Similarly, therapist factors are less important than other least helpful aspects of the therapy, implying that the therapist is not often considered a least helpful factor by couples in therapy. Despite nonsignificant statistical differences on therapist factors between genders, there were clear qualitative differences between husbands and wives when looking more closely at

their responses. For example, husbands and wives differed on whether they found the therapist's behaviors or qualities to be more helpful. The qualitative results suggested that wives find qualities of the therapist more helpful, and husbands find the therapist's behaviors more helpful. These gender differences implicate that couple therapists will have to balance things like how they direct, mediate, or listen to the couple with their natural qualities of warmth, caring, patience, openness, and honesty (to name a few) in order to meet the needs of both partners in a heterosexual marriage. In addition, the gender differences implicated that couple therapists will benefit from understanding the different needs of husbands versus wives when forming and maintaining the therapeutic alliance.

The qualitative differences between genders also illustrate some of the ways that males and females may differ in the way that they describe things about the therapy. In review, husbands were more likely to report what behaviors they saw from the therapist (therapist behaviors), and wives were more likely to report what they saw from the therapist from a quality rather than a behavioral standpoint (therapist qualities). In fact, males and females may be socialized to perceive, express, and communicate their observations differently. It should be noted here that both genders also reported the importance of cultural considerations in the therapy, suggesting that this is an integral component of couple therapy for therapists to address. However, considering that the quantitative results did not indicate any significant gender differences, this study does not mean to imply that partners in couple therapy should be treated differently by the therapist. In fact, in support of treating partners equally, several partners in this study

noted that therapist neutrality was most helpful, and therapist's unequal treatment of partners was least helpful.

A second notable finding emerging from this study was significant treatment group differences on three most helpful domains: Therapy, therapist, and client factors. This seems to imply that the therapy interventions, the therapists, and the clients' own experiences of themselves were experienced as most helpful to a different extent in TBCT and IBCT. Specifically, partners in TBCT noted therapist and client factors more than partners in IBCT, while IBCT partners noted therapy factors more than partners in TBCT. Interestingly, examination of the qualitative findings revealed more specific comparisons within treatment groups across the domains. First, frequency counts showed that therapist factors were more frequently reported by TBCT partners than therapy factors, and of the therapist factors, TBCT partners reported more therapist qualities than behaviors. This difference may be driven by the structured interventions and directive nature of the TBCT therapist, who may have acted in a more visible way, which TBCT partners then noted in their written responses. Second, frequency counts showed that therapy factors were more frequently reported by IBCT partners than therapist factors, and of the therapy factors, IBCT partners reported more interventions than processes. This suggested that while TBCT partners value the therapist more than strategies, IBCT partners value more interventions in the therapy. Third, frequency counts showed that client factors were more frequently reported by TBCT partners than IBCT partners, and of the client factors, TBCT partners reported more self factors. This suggested that TBCT partners value aspects of their own behavior more, as they reported more self factors than did IBCT partners.

Some of the treatment group differences fit with previous literature and our understanding of the two different models, and others do not. One example is that communication and problem solving training are components of both TBCT and IBCT therapies, although they tend to be more extensively done in TBCT than IBCT treatment. However, in the current study, only the IBCT group reported that communication and problem solving training were more helpful than other interventions. While two of the three primary treatment strategies of TBCT include communication and problem solving training, the TBCT couples in this study found the communication training more helpful than problem solving training. The final primary TBCT treatment strategy is behavioral exchange. However, some TBCT partners reported that the positive ideas exchanges (a structured, direct effort to increase mutual, positive behavior exchange) were least helpful. This suggests that the behavioral exchange strategy used in this study was less helpful than communication and problem solving training in TBCT, and that of the three primary TBCT treatment strategies, communication training was the most helpful.

A few other qualitative differences between treatment groups emerged with regard to interventions. First, some TBCT partners reported aspects of the therapy that were least helpful that are often found in IBCT treatment. These included difficulties learning to accept the spouse's character and faking arguments. Acceptance and faking arguments are interventions in IBCT, which raises curiosity about how these interventions were used in TBCT and if the interventions were used correctly or incorrectly. Also, the least helpful responses about acceptance in TBCT may reflect the difficulty effectively utilizing acceptance interventions in the context of a treatment focused on changing (TBCT) rather than accepting (IBCT).

Also, IBCT partners reported a few instances of desiring "more behavioral modification" between them. Behavioral modification is typically an intervention in behavioral forms of therapy, and unfortunately, there is no further information on what those participants meant by behavioral modification. The safe assumption is that these partners were hoping to achieve individual and/or couple behavioral changes, and that this need was not met in the therapy. It begs the question of whether another model of therapy or the TBCT treatment condition would have solved the behavioral problems for those individuals. It also highlights the delicate balance between behavior change and acceptance that must be reached with each unique couple. Lastly, reading assignments were reported by both treatment groups as least helpful, suggesting that homework or reading outside of therapy was less helpful than other interventions in this study.

A third notable finding emerging from this study was the outcome group differences on two least helpful domains: Therapist and outcome factors. This seems to imply that the therapists and the outcomes the couple achieved or failed to achieve were noted to a different extent by partners depending on how their relationships fared 2 years after treatment ended. Interestingly, examination of the qualitative findings revealed more specific comparisons between outcome groups within the domains. First, although couples who were considered recovered or deteriorated at 2-year follow up both infrequently reported that the therapist was least helpful, it is important to note that the deteriorated couples specifically reported only least helpful therapist behaviors, while the recovered couples reported similar amounts of least helpful therapist behaviors and qualities. For the deteriorated couples in this study, it seemed that aspects of the therapist that were least helpful were all attributed to the therapist's behavior or something the

therapist did or did not do. Upon reflection, couple therapists and couple therapist researchers should pay attention to the factors that deteriorated couples say are least helpful, particularly when it comes to therapist behaviors.

Second, couples who were considered deteriorated at 2-year follow up reported more least helpful outcome factors than any other domain, whereas recovered couples reported least helpful outcome factors less frequently. Of note, the most frequently reported least helpful outcome factor was sexual issues not being addressed. For some couples, this may have contributed to significant differences on least helpful outcome factors between the recovered and deteriorated partners. It suggests that couples' sexual relationship is an important area for couple therapists to assess. It further suggests that many couples who enter therapy are unsatisfied with their sexual relationship, as indicated in other research (Doss et al., 2004). On the same note, researchers and clinicians alike should be curious about both the couples' and the therapists' reluctance to address sexual issues in therapy. The couple's sexual relationship may be an issue the couple is uncomfortable discussing, or which the therapist is uncomfortable discussing and the couple, sensing this from the therapist, stays away from that topic. In any case, therapists would benefit from more frequently acknowledging that sex is not always an easy topic to discuss in therapy.

On a side note, although the researcher found that several responses could have potentially been coded as an outcome factor, it was only coded if this was explicitly stated, which was defined by the respondent's use of past tense. Not surprisingly, perhaps, both treatment groups frequently reported outcomes of improved communication. It is a known fact that couples often seek therapy as a last resort, and that

they commonly report seeking therapy due to problematic communication (Doss, Simpson, & Christensen, 2004). Prior research has identified the development of communication skills as an important in-session facilitator of change (Olson, 2002). It also demonstrated that an increase in positive communication and increased acceptance of partner problem behaviors are important mechanisms of change (Doss et al., 2005). This last study highlights for the current study the difference between outcomes of improved communication that are behavioral and visible to others versus outcomes of improved acceptance that is an individual inner-experience and therefore may not be reported as often. The current study's finding that couples frequently report outcomes of improved communication demonstrates that a change of communication very likely occurred in the therapy.

The logistical factors are noteworthy in suggesting that aspects of the therapy such as commuting to, parking at, and time of sessions are noticed by and affect couple therapy clients. This is especially interesting for couple therapists because it adds to the challenge of working with two as opposed to one client. Factors that influence the couple prior to entering the therapy room, such as both arriving on time and together or separately, are a part of the couple's entire therapy experience. Couples in this study specifically and frequently reported logistical factors related to the amount of time, often suggesting that the standard one-hour therapy session was not enough time. Couple therapists may consider the benefit of 90-minute sessions instead, and couple therapy researchers may be interested in examining the differences between 60- and 90-minute sessions for couples.

Overall, for the most helpful aspects in this study, more was said about the people in the room (therapist and couple) and the interventions in the therapy and less about the logistics. For the least helpful aspects, less was said about the people in the room and more was said about the logistics and interventions used. Though it seems straight forward or perhaps elementary, this study seems to indicate that the most important factors of couple therapy were who was in the room, what was done in the room, and how well the two factors work together, which seems to fit extremely well with the common factors research highlighting the therapist, common interventions, and the therapeutic alliance as some of the common elements found across distinct types of therapy.

Methodological Limitations

There are some limitations to the current study's methodology worth noting. First, a specific sample was obtained that may be considered difficult to generalize. For example, the diversity of the sample is limited; about 20% of the sample included ethnic minorities. It was also a highly educated sample, with the average partner having graduated from college. Second, couples had to be willing to be video taped every session of their therapy. This may have compromised their ability to honestly share information in session. Third, participation was paid for and offered by highly reputable schools in the Los Angeles and Seattle areas. Fourth, the sample can only be generalized to the mean number of sessions (23) given to couples. Perhaps a final limitation is the fact that the therapists who administered the treatments were highly trained and closely supervised, which may not represent the "typical" marital therapy situation.

On a similar note, the characteristics of the individuals in the study sample may have influenced one's perceptions of the most and least helpful aspects of therapy and/or one's willingness to share his or her perspective. For example, considering that the diversity of the sample is limited, one's culture may have influenced how a person responded and his or her desire to please the researchers by providing positive feedback. Others may have felt pressured by the request to provide feedback that was unstructured and open-ended in nature. Couples' willingness to share their perspectives is integral to increasing our understanding of couple therapy. However, it can be expected that participant characteristics such as culture, age, education, and gender influenced their perceptions of therapy and willingness to share them.

Two limitations of the Client Evaluation of Services questionnaire may have included recency effects between the last Likert scale question asked before the open-ended question, and between the termination of therapy and the administration of the questionnaire. First, the question immediately preceding the open-ended question states, "How helpful were the materials the therapist gave you to read about communication and conflict?" which may have cued participants' responses to the next question that asks for the most helpful and least helpful things about the therapy. Second, the questionnaire was administered immediately after the therapist had just worked toward leaving the therapeutic issues addressed and the process of termination on a positive note. However, couples were informed that their therapist would not be able to view their responses, with the hope that each partner would respond honestly. Thus, an advantage of administering the questionnaire at termination was that the couples would perhaps have been able to reflect on the whole course of their therapy.

Although there is some overlap between IBCT and TBCT, research has also demonstrated that they are distinct in important ways (Christensen et al., 2004; Doss et al., 2005). However, another limitation of the study may include the overlap between the two treatment approaches, which were both behavioral but to a greater (TBCT) or lesser (IBCT) degree. Considering that IBCT was developed and expanded from TBCT, and that there were thus common elements among the treatments that couples received, couples may have provided similar types of responses about what was most and least helpful in the therapy. It is possible that examining two types of couple therapy that differed more greatly from each other may have evoked responses that differed more greatly from each other, thus lending less support to common factors.

It is important to note the limitations of a mixed-methods study that employs a content analysis followed by statistical tests. Within a mixed-methods study, the sequential exploratory model requires that the researcher spend a great deal of time within each phase (qualitative and quantitative) of data collection (Creswell, 2003). Without describing in further detail, Creswell also states that building the theory from first the qualitative to then the quantitative data collection may be difficult for the researcher. As noted by Davis and Piercy (2007b), another challenge the qualitative researcher faces is reducing the effects of her preferences on reporting data. In other words, the data should reflect what the couples say as closely as possible. It is hoped that the nature of responding to an open-ended question in writing minimized this effect.

In qualitative studies, it is particularly important to address issues of researcher bias (Creswell, 2003). This study was mostly conducted by one researcher, who quickly noticed that bias played into her interpretation of the written responses when coding the

data. Steps were taken to minimize bias, such as de-identifying the gender of each partner's response and eliminating therapist names. Despite this, some responses were difficult to interpret and at times the researcher felt the need to make assumptions about what a participant was trying to convey in his or her written response. When a number of difficult-to-interpret responses were identified, the researcher met with a team of other individuals including the chairperson who was familiar with the project, and another psychology graduate student who was less familiar with the project. The researcher acknowledged her assumptions and questions with the team, who worked together to interpret the responses. In some cases, due to incomplete sentences or punctuation for example, responses or parts of responses were not coded.

Finally, this study was at risk for increasing the chance of Type I error, which is caused by conducting several quantitative analyses. Type I error is a type of statistical error that is caused by random fluctuations in measurement and is the error of rejecting a null hypothesis when it is actually true. Therefore, an increase in random fluctuations that is caused by conducting several quantitative analyses (i.e., in the current study, chi-square and McNemar's tests) increased the chance of Type I error occurring.

Implications and Potential Contributions

Considering the relatively new introduction of Integrative Behavioral Couples Therapy to the field of clinical psychology, as well as the shortage of in-depth literature on clients' perceptions of unhelpful or least helpful aspects in marital therapy, there is much to contribute. The original study from which the current study evolved is the largest study of marital therapy ever, the first to be done at two sites (University of California, Los Angeles and University of Washington), and the first to investigate the IBCT

approach. Therefore, the data set is unique and has potential to offer new information to the field. The current study was the first to evolve from the original dataset that was conducted as a mixed-methods study, and it potentially contributes to two overarching areas: couple therapy research and couple therapy clinical practice. It contributes to research with couples by illustrating the importance of understanding the therapeutic process from the couple's point of view. It also demonstrates that when asked, couples are forthcoming about their experiences and often have much to say. This study contributes to clinical practice with couples by highlighting the importance of everything from the therapeutic relationship, to the interventions used, to the logistics. This study particularly seems to imply that couples consider five main factors (the therapy, therapist, couple, outcomes, and logistics) to be the helpful therapeutic elements in couple therapy, adding weight to the research on common factors (Blow, Sprenkle, & Davis, 2007; Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004).

This study is unique to the field in that it is one of just a few to examine what is least helpful (or "un-helpful"; Bowman & Fine, 2000) about couple therapy from the couple's point of view. Furthermore, it is the first study to examine both most and least helpful factors within a traditional behavioral couple therapy model and within a newer, promising model called IBCT. This work potentially provides further information about the therapeutic relationship and its importance in couple therapy, as well as some of the common factors that previous research has demonstrated across therapy types (i.e., Blow, Sprenkle, & Davis, 2007; Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004). In other words, the five factors discussed in this dissertation were found to be common elements reported by partners in both treatment groups, supporting common factors

research stating that it is the common elements among therapies that lead to positive client outcomes (Davis & Piercy; Sprenkle & Blow).

More specifically, the coding system that evolved from the current study contributes to process research by offering a unique, systematic conceptualization of the way that clients view therapy. It is not meant to be the only categorization of most and least helpful elements of couple therapy; however, it is clearly distinct from other categorizations found in the common factors research on a number of accounts. First, the current study did not divide categorizations of responses into model-dependent or model-independent factors. Rather, elements that were both model-dependent and model-independent were incorporated into the coding system. Second, logistical factors were a separate, distinct set of responses found in the current study not found in the common factors research. While the logistical factors theme incorporated the motivational and expectancy factors that are found in common factors research (Davis & Piercy, 2007b) it also included additional factors such as time, the couples' experiences related to getting to the therapy sessions, and the couples' experiences with things like completing questionnaires. Third, whereas therapist factors were divided into categorizations of observable traits and states, and inferred traits and states in other research (Blow, Sprenkle, & Davis, 2007), therapist factors were simplified into behaviors and qualities in the current study. The simplification allows therapists to examine themselves within two domains, and may aid in educating future mental health practitioners on the need for certain actions as well as certain personality characteristics or attributes when conducting therapy. Fourth, the current study also paid greater attention to the depth and variety of outcome factors, beyond the "softening" and "making space for the other" subcategories

found in Davis and Piercy's (2007a) research. In fact, the current researcher did not further categorize the outcome factors theme, finding that this theme was better represented within its own domain.

The coding system is also unique in that it could be used in ways other than for examining couples' experiences of therapy. For example, it could be used to code the experiences of those in individual therapy and those in group therapy. In other words, it is not limited to use with couples only. Additionally, it could easily be used with models of therapy other than TBCT and IBCT, as one cannot tell from the coding system what type of therapy was used. This widens the application of the coding system to all types of therapy, making its use easily transferable to future clinical research. Although the coding system would benefit from refinement through its use in future research, it is a clearly distinctive way of examining one's experiences in therapy as well as the common factors of therapy.

Finally, this study also contributes greater awareness to the importance of and our understanding of what couples think about the therapist in couple therapy. The fact that couples are very aware of the therapist and the therapist's qualities in particular, is encouraging. Furthermore, the high frequency of responses referring to the therapist's qualities highlights the misconception of behavioral types of therapy as not humanistic. In the current study, couples focused on aspects of the therapeutic relationship regardless of the treatment approach, lending further support to the claim that it is the common factors among all types of therapy that contribute to the effectiveness of therapy (i.e., Blow, Sprenkle, & Davis, 2007; Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004).

Future Directions of Research

There are a number of suggestions for future directions of research. For one, future research would benefit from a more in-depth investigation of couples' most and least helpful experiences in therapy beyond an open-ended question, such as in the form of an interview. Through interviewing couples, a qualitative researcher would be able to check in with participants throughout data collection and analysis and perform member checks where the couple gives feedback on the researcher's developing themes and theories, a common method of validating the accuracy of findings in qualitative research (Creswell, 2003). The current researcher found some written responses to the open-ended question difficult to understand, and an interview method of data collection would also allow the researcher to request elaboration from participants on responses that are unclear or open for interpretation.

Future investigations should also consider asking follow up questions to the one asked in this study ("What are the most and least helpful things about the therapy?"). In particular, it may be helpful to find out why couples respond certain ways. Considering that some responses were given in a list format in the current study, there were often responses that begged follow up questions such as, "What about the therapist was most helpful?" In particular, future studies may want to address the current study's finding of significant outcome group differences on least helpful therapist factors. Examining the specific therapist behaviors that are least helpful would be especially beneficial to practicing couple therapists, and could be used to further clinicians' understanding of fostering the therapeutic relationship by paying attention to our behavior in the room.

Consistent with another couple therapy study (Helmeke & Sprenkle, 2000), some of the most helpful client factors reported in this study seemed to indicate pivotal moments in the therapy. Although there were a few responses that would have fit under an additional domain of pivotal moments ("Uncovering misconceptions about each other," "Help[ing] me to see the value of my relationship," "Realizing [that your] experiences contribute to being who you are."), this question was not specifically asked and likewise not specifically stated by any participants. Thus it was difficult to consider whether something reported as most helpful was also a pivotal moment. However, this study does not intend to imply that pivotal moments did not occur in the therapy, and future studies could further examine pivotal moments via an interview method of data collection by asking participants to elaborate on responses that seem to imply that a pivotal moment occurred.

Another suggestion for future research is to compile what therapists also believe is most and least helpful about couple therapy and compare and contrast the responses to those of couples. Ultimately it would be interesting to see what therapy elements therapists and couples agree are most and least helpful, and even further, if these are elements of change or aspects of therapy that contribute to better outcomes. It may be first beneficial to explore the literature on both therapists' and clients' assessments of couple therapy in order to follow up with how best to assess the helpfulness phenomenon going on for all three individuals in the room.

It may also be helpful to assess the therapy's helpfulness throughout the therapy, assessed at different times over the course of treatment. In other literature, researchers have even discussed therapists' needs to assess clients at the beginning of every therapy

session (Asay & Lambert, 1999). Perhaps a three-part assessment, including asking couples after the first two to three sessions, in the middle sessions, and after the last session (as in the current study), would enable researchers to examine if couples' responses change over time, remain consistent, and/or become more clear or specific. Multiple measurements are often administered over the duration of a quantitative research study, and though this may seem easier with quantitative scales, future research will benefit from knowing that the question asked in this study was short and elicited response despite being open-ended in nature.

Another important area for future research would be to conduct a study that asks couples who received treatment other than TBCT or IBCT the same question asked in the current study. Considering the wide variety of couple therapy techniques and theories, the field would be enhanced by examining if the five factors found in the current study would also be found in other therapy models. The current study found similar responses across gender, treatment condition, and outcome group, suggesting similar helpful processes occurred in both TBCT and IBCT. This implicates that there may be common factors among what couples find most and least helpful about therapy, despite the therapy model used, and future studies should examine this with couple therapy models such as Emotion-Focused Therapy, Cognitive Behavioral Couple Therapy, Solution-Focused Therapy, and Narrative Therapy, just to name a few. In addition, future research would benefit from examining this study using models of couple therapy that differ more greatly from each other. The current study involved two types of treatment that were behavioral in nature, which may have contributed to this study's support of common factors. Future research calls for continued examination of common factors, especially between

treatment approaches that appear to differ to a greater extent. This would help determine whether the common factors model would still be supported, or if model-specific factors would emerge more strongly.

A more in-depth look at each couple's answer, comparing one partner within a couple to the other, at the helpfulness question is another suggestion for future research. Couple therapy researchers may find the extent to which partners within one couple agree with each other extremely informative, especially if it was compared related to outcome. In other words, an area for examination includes the potential correlation between partners' agreements about the helpfulness of therapy and their status at the end of therapy. It would be interesting to assess if partner agreement was related to their relationship satisfaction at the end of therapy, their relationship satisfaction at follow up, how well they perceived the therapeutic relationship, and many other areas.

An important point about this study is that participants were married couples. Future research should examine the most and least helpful aspects of couple therapy according to couples other than those that are legally married, including gay and lesbian couples, unmarried couples, cohabitating couples, and perhaps even families. Follow up research should then consider if the myriad responses form a pattern that would inform the practice of all couple therapists regardless of whether or not the clients are married.

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Appendix A

Literature Review Table

Author, Year, Title	Publication Type	Objectives	Sample	Variables/ Instruments	Research Design	Results/ Statistics	Major Findings
I. Couple Therapy Outcome Research							
Baucom, Shoham, Mueser, Daiuto, Stickle (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems	Journal article	Purpose: to focus on the efficacy status of various, empirically supported couple and family interventions, and to discuss findings related to effectiveness and clinical significance	n/a	n/a	Review study	Empirically supported treatments were divided into three forms: Efficacious and specific treatments (Behavioral Marital Therapy [BMT]), efficacious and possibly specific treatments (Emotion-Focused Therapy [EFT]), and possibly efficacious treatments (Cognitive Therapy, Cognitive-Behavioral Therapy [CBT], Insight- Oriented Therapy [IOT], and Systemic Therapy).	A number of couple- and family-based treatments appear to be beneficial for marital distress. The most efficacious appears, in the research, to be BMT.
Pinsof, Wynne (1995). The efficacy of marital and family therapy: An empirical overview, conclusions, and recommend-ations	Journal article	Purpose: to provide an overview of the state of scientific knowledge about the efficacy of marital and family therapy (MFT) for a variety of mental disorders and problems	n/a	n/a	Review study	Several findings emerged in this review: MFT works; it is not harmful; it is more helpful for specific patients, disorders, or problems; one MFT model is not superior to another; it may be more cost effective for certain diagnoses; and MFT is not sufficient in itself to treat certain severe disorders and problems.	Methodological and conceptual recommendations are made for the field. Overall, there is a vast amount of scientific research supporting the efficacy of MFT.
Snyder, Castellani, Whisman (2006). Current status and future directions in couple therapy	Journal article	Purpose: to examine the effectiveness of couple-based interventions, discuss methods for evaluating processes of change and predictors of outcome, and make recommenda tions for future research	n/a	n/a	Review study	In this review, it is noted that a sizable percentage of individuals do not show significant improvement posttreatment, and even more individuals deteriorate in gains at follow up. These findings have led to two different research paradigms: common factors that contribute to	Research and training implications are noted. Couple therapy is effective at reducing distress, but studies on the processes of change are needed. The authors suggest several directions for future research, including outcome research that benefits from smaller-level or

						beneficial effects across "singular" treatment approaches, and pluralistic models that incorporate multiple components of diverse treatment approaches.	single-case designs; research that identifies individual, relationship, and treatment factors that contribute to relapse and means of reducing or eliminating these effects; examines integrative approaches; explores specific individual and relationship problems for intermediate and long-term effectiveness; focuses on the generalizability of research findings across potential moderators such as age, family life stage, gender, culture and ethnicity, and nontraditional relationships; assesses the costs, benefits, and cost-effectiveness of couple-based interventions; researches change processes; and incorporates research on emotion regulation processes.
Jacobson, Follette, Revenstorf, Baucom, Hahlweg, Margolin (1984). Variability in outcome and clinical significance of behavioral marital therapy: A reanalysis of outcome data	Journal article	Purpose: to reanalyze data from previous BMT outcome investigations, to answer two questions; one, what proportion of couples improve during the course of BMT? Two, how likely is it that couples treated in the BMT studies really became non-distressed?	N=148 couples	Locke-Wallace Marital Adjustment Test, Dyadic Adjustment Scale, Partnership Question-naire	Re-analysis of outcome data	More than half of couples improved and deterioration was rare. In 40% of improved couples, positive changes in marital satisfaction occurred in one spouse. More than one third of couples changed from distressed to nondistressed by the end of therapy. At six-month follow-up, 60% of couples had maintained gains. Improvement was rare without treatment.	The success rate of BMT is "more modest" than previous estimates have predicted. Previous estimates have been "grossly inflated," at 90%. This is the first study to be less objective, basing improvement percentages on criteria that are psychometrically sound, clinically meaningful, and objective. Jacobson's data shows the most positive results; they remained superior even after removing the least distressed couples from his data set.
Jacobson, Margolin	Book					Behavior Marital Therapy is	Comparative studies at that time

(1979). Marital therapy: Strategies based on social learning and behavior exchange principles						significantly more effective than no treatment. Communication training can be necessary and sometimes sufficient for couples. However, different couples respond to different emphases in BMT, such as communication training versus positive exchanges.	were inconclusive, though behavior therapy was said to be "demonstrably effective" in treating relationship problems, when compared to other approaches. The book calls for approaches to marital therapy that are held accountable by couples seeking therapy and that meet ethical standards of evaluation.
Jacobson, Christensen (1996). Acceptance and change in couple therapy	Book chapter	Chapter title: from change to acceptance				Two-thirds of couples receiving TBCT improved, and of those, one-third relapsed within two years post-treatment. Five couple factors discriminating between success and failure with TBCT include commitment, age, emotional engagement, traditionality, and convergent goals for the marriage. Initial pilot data on the efficacy of IBCT shows significantly increased couple satisfaction when compared to TBCT.	Traditional behavior therapy is not enough. The authors point out that only half of the couples were being helped. Acceptance of incompatibilities, differences, or marital problems is viewed as the missing link in TBCT.
Jacobson, Christensen, Eldridge, Prince, Cordova (2000). Integrative behavioral couple therapy: An acceptance-based, promising new treatment for couple discord	Journal article	Purpose: to provide data on IBCT treating marital distress	N=21 couples seeking therapy for marital distress	Marital satisfaction. Global Distress Scale, Marital Satisfaction Inventory, Dyadic Adjustment Scale	Experi-mental	Ratings and means used; Naïve raters and global codes of instigate change and acceptance used; Therapist adherence to TBCT and IBCT; TBCT was competently given based on a rating scale and rated by an expert; pre- and post-test scores on GDS and DAS: effect sizes moderate to large favoring IBCT; 80% of IBCT couples improved or recovered.	IBCT may be more effective than TBCT. Acceptance may be the element supporting greater change in couples treated with IBCT.
Jacobson,	Journal	Purpose: to	N=34	Global	Mixed-	The majority of	As therapy

Schmaling, Holtzworth-Munroe (1987). Component analysis of behavioral marital therapy: 2-year follow-up and prediction of relapse	article	provide 2-year follow up data for a comparison between a complete behavioral marital therapy treatment package and two of its major components, behavior exchange and communication/problem-solving training	couples	measure of marital satisfaction (Dyadic Adjustment Scale) and a checklist of presenting marital problems (Areas of Change Question-naire)	methods	couples showed reduced marital satisfaction at follow up. Any initial change did not appear to be enduring. Differences between 3 versions of BMT that emerged at 6-month follow up had disappeared by 1-year follow up, and did not reappear at 2-year follow up. For many couples, marital satisfaction was declining. 30% of couples who had shown clinically significant improvement had relapsed by 2-year follow up.	becomes more temporally removed from couples' current life experiences, it loses its impact on their marriages. Follow up or booster sessions may counteract this.
Jacobson, Addis (1993). Research on couples and couple therapy: What do we know? Where are we going?	Journal article	Purpose: to discuss the outcome and process research on couple therapy. Which treatments work, how do they work, and what factors predict outcome?	n/a	Questions: Which treatments work? When do they work and why? What methods have proved useful in studying couple therapy?	Qualita-tive	n/a	Brief enrichment and prevention programs and existing therapies for distressed couples showed, at the time, that it may be easier to prevent relationship problems than to treat them once they emerge. Couples more severely distressed are less likely to be "happily married" at end of treatment; younger couples respond better to treatment; emotional disengagement is a bad prognostic sign; couples with polarized gender role preferences are less likely to benefit. More emotional involvement and self-description n sessions, and more acceptance and less hostility and coercion represent more successful couples in therapy. Taking responsibility for one's own experiences and receiving

							validation from the partner also leads to successful couple therapy. Finally, comparative clinical trials and intramodel comparisons are the primary methods that have been used to study couple therapy. Priorities for research on couples include research on gender issues and domestic violence.
Christensen, Atkins, Berns, Wheeler, Baucom, Simpson (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed married couples	Journal article	Purpose: examine overall and comparative efficacy of TBCT v. IBCT	N=134 seriously and chronic-ally distressed married couples	Outcome measures include relationship satisfaction, stability, communicati on, and individual adjustment. Marital Adjustment Test, Marital Satisfaction Inventory, Dyadic Adjustment Scale; Conflict Tactics Scale-Revised, Structured Clinical Interview for DSM-IV.	Experi-mental	Therapists were adherent and competent using alpha reliabilities across coders. Couple therapy does not have its impact early in treatment. TBCT couples improve more quickly and then plateau; IBCT couples slowly and steadily improve throughout treatment. Husbands progress more quickly in treatment. 65% of IBCT couples showed reliable change or recovery.	The high rates of change suggest that IBCT and TBCT can be used with very severely distressed couples. The effects indicating improved relationship satisfaction, stability, and communication may be due to the increased number of sessions. The gradual change in IBCT may be due to the immediate focus on central themes and issues troubling the couple, compared to the immediate focus on problem behaviors in TBCT. Greater change in husbands may be due to their fears of entering therapy being dispelled by an even-handed stance taken by the therapist.
Christensen, Atkins, Yi, Baucom, George (2006). Couple and individual adjustment for 2 years following a randomized clinical trial comparing traditional versus integrative behavioral	Journal article	Objectives: to overcome limitations of past research on the outcome of Behavioral Couple Therapy by investigating 2 years later (1, trajectory of marital satisfaction; 2, change over time in	N=130 of 134 couples originally part of clinical trial compar-ing TBCT and IBCT	Dyadic Adjustment Scale, Marital Status Inventory, Mental Health Index from the Compass Outpatient Treatment Assessment System, and the MAQ, and a therapy	Quantita-tive	There appeared to an initial, rapid period of deterioration in satisfaction that later turned into a slow period of increasing satisfaction later in follow up. Initial deterioration was shorter for IBCT than TBCT. Couples in both conditions show a sharp, initial	2/3 of couples reliably improved or recovered at 2 year follow up. There was an initial drop in marital satisfaction immediately following therapy, followed by a gradual increase in satisfaction over the course of the 2 years. Those who were the most satisfied with

couple therapy		other couple behaviors; 3, effect of treatment condition and other covariates; 4, association of individual functioning and marital satisfaction over time; 5, clinical significance of change in marital satisfaction; 6, impact of additional therapy during follow-up.		information sheet		decline in marital satisfaction. At 22 weeks, IBCT couples were more satisfied than TBCT couples.	treatment reported greater marital satisfaction at therapy's end, sharper drop in satisfaction following therapy, and more rapid improvement at the end of follow up.
II. Couple Therapy Process Research							
A. The Common Factors Debate							
Sexton, Ridley, Kleiner (2004). Beyond common factors: Multilevel-process models of therapeutic change in marriage and family therapy	Journal article	Purpose: to consider the limitations of the common factors perspective and propose necessary components and processes that might comprise comprehensive, multilevel, process-based therapeutic change models in MFT	n/a	n/a	Response article	n/a	Common factors are viewed as an inadequate foundation for MFT practice, as the research on common factors is premature in drawing confident conclusions, this research is not integrated into practice, change mechanisms do not explain or are the same as common factors, common factors have not yet advanced theory development, they do not provide guidelines for successful clinical work, and they do not serve as the basis of clinical training. An alternative to the limitations of common factors is a comprehensive process-based change model that is heuristic, metatheoretical, systematic, practical, simplistic, and

							clear. A "modest multilevel-process model" is suggested.
B. Common Factors Across Therapies							
Sprenkle, Blow (2004). Common factors and our sacred models	Journal article	Purpose: to argue for common factors as the causes of change in family therapy	n/a	n/a	n/a	n/a	The components of a moderate view of a common factors approach would include the follow as common factors: The client, therapist effects, the therapeutic relationship, expectancy, and nonspecific treatment variables such as behavioral regulation, cognitive mastery, emotional experiencing, and developmental sequence. Unique to MFT practice are the following common factors: Relational conceptualization, the expanded direct treatment system, and the expanded therapeutic alliance.
Davis, Piercy (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 article	Purpose: to investigate common factors in couple therapy	N=3 different MFT model develop-ers, 2 former students of the MFT model develop-ers, and 3 couples and 2 individ-uals working on relation-ship issues who were clients of the model develop-ers or former students	30-60 minutes open-ended audiotaped telephone interview (generally using the same questions for therapists and clients)	Qualita-tive	Model-dependent common factors, or common elements found across three distinct therapies, include common conceptualizations , common interventions, and common outcomes.	These variables are directly informed by the therapist's model. Across these models, the common factors were identified, and the authors discuss the clinical, research, and training implications of their findings.
Davis, Piercy (2007b). What	Journal article	Purpose: to investigate	N=3 different	30-60 minutes	Qualita-tive	Model-independent	A conceptual framework

clients of couple therapy model developers and their former students say about change, part II: Model-independent common factors and an integrative framework		common factors in couple therapy	MFT model developers, 2 former students of the MFT model developers, and 3 couples and 2 individuals working on relationship issues who were clients of the model developers or former students	open-ended audiotaped telephone interview (generally using the same questions for therapists and clients)		common factors were determined to fall into one of five categories: client variables, therapist variables, therapeutic alliance, therapeutic process, and expectancy and motivational factors.	outlines how these common factors may interact to produce change.
C. Model-Specific Factors							
Olson (2002). Clients' perceptions of the process of couple therapy: A qualitative and quantitative investigation	Dissertation abstract	Purpose: to investigate clients' perceptions of the process of couples therapy and identify pertinent areas of change	N=56 individuals receiving couples therapy	Outcome Questionnaire, Revised Dyadic Adjustment Scale, Broderick Commitment Scale, semi-structured qualitative interview	Mixed-methods	There were identifiable facilitators of change both in and out of session. Client experienced changes in affect, behavior, and cognition. Change was experienced as gradual by the individuals.	Pertinent areas of change in couple therapy could be identified.
Doss, Thum, Sevier, Atkins, Christensen (2005). Improving relationships: Mechanisms of change in couple therapy	Journal article	Purpose: to reveal mechanisms of change in couples therapy	N=134 married couples	Dependent variable: Change in relationship satisfaction during treatment; independent variable: Change in the mechanisms during treatment. Dyadic Adjustment Scale, Frequency and Acceptability of Partner Behavior Inventory, Communication Patterns Questionnaire. Measures	Quantitative	Both partners demonstrated significant change over therapy. Husbands show change earlier in therapy. Both partners became more accepting of the partner's problem behaviors. Positive communication increased significantly in the IBCT condition. Also, demand-withdraw interactions decreased. Behavior change is associated with early improvement in therapy, and acceptance is associated with later improvement in therapy. TBCT	Results suggest that increased acceptance for each spouse is related to increases in feeling satisfied in therapy during the first half of therapy. However, the immediate changes shown early in therapy may not be enough to help the couple, shown by relapse of negative behaviors during the second half of therapy.

				administered pretreatment, 13 weeks after pretreatment assessment, 26 weeks after pretreatment assessment, and after the final therapy session.		brings about greater changes in behavior; IBCT brings about greater changes in acceptance.	
Greenberg, Ford, Alden, Johnson (1993). In-session change in emotionally focused therapy	Journal article	Three different marital studies of in-session change are examined in order to compare change and no-change performance to identify components of competence in change.	N=22 couples	Dyadic Adjustment Scale, Structural Analysis of Social Behavior, Experiencing Scale, Self-Disclosure Coding System.	Experi-mental	It was found that more affiliative behaviors between partners occurred in the latter stages of therapy, that sessions contained more self-focused positive statements such as disclosing, and that spouses are more likely to respond affiliatively after a therapist facilitates intimate self-disclosure by their partners.	It is suggested that intrapsychic experience is deepened in "good" sessions and that interaction is more affiliative over the course of therapy. The reason that intimate disclosures are followed by more affiliative behavior suggests that revealing experience in intimate ways leads to change in the way couples interact with each other.
Helmeke, Sprenkle (2000). Clients' perceptions of pivotal moments in couples therapy: A qualitative study of change in therapy	Journal article	Purpose: to identify key themes and patterns of pivotal moments based on client's experiences and perceptions in couples therapy, and to guide the emergent process of generating hypotheses or assertions regarding pivotal moments	N=3 couples	Transcripts of therapy sessions, post-session question-naires, two post-therapy interviews	Qualita-tive	Clients identified specific events in therapy as pivotal. These occurred once per session on average. Spouses did not necessarily agree on pivotal moments, and the therapist did not necessarily identify the same pivotal moments. The pivotal moments often occurred during discussion of presenting problems. Pivotal moments tended to be cognitive in nature, rather than behavioral or emotional.	Clients are the key to unraveling insight into the change process that occurs in couple therapy.
Holtzworth-Munroe, Jacobson, DeKlyen, Whisman (1989). Relationship between behavioral marital	Journal article	Purpose: to examine specific therapist and client behaviors hypothesized as necessary for positive therapy	N=32 Caucasian couples receiving social learning-based marital therapy at the	Therapist process rating scales, Client process rating scales, Dyadic Adjustment Scale	Quantita-tive	Facilitative client behavior was positively related to therapy outcome. The more structuring behaviors a therapist used, the poorer the therapy outcome.	Couples who respond positively to social learning-based behavioral marital therapy have therapists who view their clients as behaving in a facilitative manner in and out

therapy outcome and process variables		outcome	University of Washing-ton			Husbands view increasing therapist competence and emotional nurturance as related to better outcome.	of sessions, and therapists who rate themselves as being effective in encouraging collaboration in therapy. Clients view couples who make gains in therapy as those who believe they are actively and collaboratively participating in therapy, and complying with homework assignments. Patient involvement may be conceptualized as therapeutic alliance.
Alexander (1997). Successful and unsuccessful couples therapy: A grounded theory study of client perspectives	Dissertation abstract	The investigation of client views of successful and unsuccessful couple therapy.	N=12 couples; Six who considere d therapy successful and six who consider-ed therapy un-successful	Hour-long individual interviews 1-12 months after termination. Therapeutic alliance measure and survey rating levels of distress, improvement , relationship satisfaction, and overall helpfulness of therapy.	Qualita-tive	Clients report learning to manage conflict and improve communication, developing a coherent understanding of underlying conflicts and causes of problems, and specification of the goals and tasks of therapy sessions as helpful. Clients report failing to meet these areas/needs as unsuccessful.	The results indicate the normal developmental progression of couple therapy that may influence the maturation in the life of the couple.
Goldman, Greenberg (1992). Comparison of integrated systemic and emotionally focused approaches to couples therapy	Journal article	Purpose: to compare the effects of emotionally focused couples therapy (EFT) with the effect of integrated systemic marital therapy (IST)	N=42 couples seeking help for problems in conflict-ual relation-ships	Three treatment groups (control, IST, and EFT), and three occasions (pretest, posttest, and follow-up). The Couples Therapy Alliance Scale, The Dyadic Adjustment Scale, Target Complaints, Goal Attainment Scaling, Conflict Resolution Scale, post-treatment interview.	Repeated measures design	Responses to an open-ended question about the effects of therapy included positive emotional response to one's partner, increasing awareness of the partner's sensitivities and vulnerabilities, therapist neutrality (in the IST condition), and therapist empathy and caring (in the EFT condition).	IST may be more self-sustaining than EFT at follow-up. Both therapies are helpful in alleviating marital distress and resolving conflict. Clients' perceptions of how change occurred are suggested to have been influenced by a team of observers in the IST condition who devoted time and effort toward discussing each couple's relationship and interactional patterns.

				The couple's average score on the four dependent measures (DAS, CRS, TC, and GAS) was the unit of measurement			
O'Leary, Rathus (1993). Clients' perceptions of therapeutic helpfulness in cognitive and marital therapy for depression	Journal article	Why individual cognitive therapy and conjoint marital therapy for the treatment of depressed, martially discordant women were successful from the client's perspective	N=20 depressed women who received marital therapy; N=11 women receiving individual cognitive therapy for depress-ion and marital discord	Open-ended question: what has helped you feel better over the course of therapy?	Quantita-tive and qualitative	Reliabilities of content domain calculated using kappa. Kappa ranged from .63-.92. Marital therapy was shown to decrease depression and increase marital satisfaction (Covariances of analyses of post-therapy scores with pre- scores.) Chi square analyses show seeing positive change in spouse, better communication, and both partners putting in effort and engaged in process to save marriage as most helpful content in marital therapy.	Communication improvement and seeing a positive change in the spouse are most helpful elements of marital therapy. Marital therapy not as helpful in gaining control over thoughts and feelings as in cognitive therapy.
Worthington, McCullough, Shortz, Mindes, Sandage, Chartrand (1995). Can couples assessment and feedback improve relationships? Assessment as a brief relationship enrichment procedure	Journal article	Purpose: to investigate whether relationship assessment and feedback, such as in CBCT, has a beneficial effect for couples who are not self-identified couples therapy clients	N=48 couples with one partner from an introduct-ory psych-ology class; N=26 married couples, N=15 cohabitat-ing couples, and N=7 engaged couples	Dyadic Adjustment Scale, Commitment Inventory, Client's rating form, Assessor's self-report of experience, Couples Pre-Counseling Inventory, Personal Assessment of Intimacy in Relatio-nships	Experi-mental	Dyadic satisfaction improved for couples between pre-assessment and post-assessment, and also between post-assessment and follow-up. Assessment-feedback participants gained in dyadic satisfaction between pre- and post-assessment. These participants also felt more dedication between pre- and post-assessment.	The main finding is that small positive effects on dyadic satisfaction and commitment are seen for individuals who participate in face-to-face couple assessment. This involves two assessment interviews, completion of inventories, and receipt of written and oral feedback. The results also suggest that assessment alone may influence positive effects of interventions. Assessment of and feedback given to couples affected their relationship positively. These elements may help couples to understand their

							relationship better and work toward improving their relationship.
D. Unhelpful Factors							
Bowman, Fine (2000). Client perceptions of couples therapy: Helpful and unhelpful aspects	Journal article	How do clients view what was helpful and unhelpful about their therapy experiences?	N=5 hetero-sexual couples	Face-to-face interviews of partners, after therapy. Interviews were coded for emerging themes.	Qualita-tive	Therapeutic atmosphere is related to satisfaction in therapy. Developing new ways of looking at and doing things had the most impact for couples. Helpful aspects include trust in therapist, safety in session structure, client choice, and equal treatment of partners, therapist refocusing sessions, and time to focus on the relationship. Also: new understandings about relationship, seeing partner in new light, understanding issues, seeing self in new light, new ideas about gender, and making links between sessions. Unhelpful aspects include unequal treatment of partners, too much therapist talking, using the word "therapy," too-short of session time.	Relationship skills of therapist may produce successful therapy outcomes. Also helpful is the client feeling like an expert in their own life. Homework may have encouraged thinking about issues outside of session. In terms of safety in session structure, the authors think there may be a trend towards therapist increased sensitivity toward clients and how they affect clients. No gender differences were found in client perceptions.
III. Summary of Findings							
The Therapist's Point of View							
Kelly, Iwamasa (2005). Enhancing behavioral couple therapy: Addressing the therapeutic alliance, hope, and diversity	Journal article	Purpose: to provide practical ways to enhance the ability of Behavioral Couples Therapy to address the therapeutic alliance, hope, and diversity throughout treatment	N=1 case example	n/a	Qualita-tive	n/a	Current behaviorally based approaches are enhanced by the use of integration in addressing the therapeutic alliance, hope, and diversity.

Whisman, Dixon, Johnson (1997). Therapists' perspectives of couple problems and treatment issues in couple therapy	Journal article	Purpose: to survey a national sample of couple therapists regarding the frequency, difficulty, and severity of problems encountered in couple therapy	N=122 members of APA and AAMFT who claimed to actively practice couples therapy	Survey modeled after one used by Geiss and O'Leary (1981), consisting of questions about the therapist, general questions about couples therapy, and problems encountered in couples therapy, and an open-ended question about topics for future clinical research	Qualita-tive/ Survey	Results suggested that communication and power struggles were the most frequent problems, a lack of loving feelings and alcoholism were the most difficult problems, and abuse and affairs were the most damaging problems. Also, problems that were difficult to treat were also rated as most damaging to the relationship.	Some of these problems and characteristics may be good variables to use in future studies of couple therapy. Also, the efficacy of couple therapy will improve with the development in the assessment and treatment of these problem areas.
Geiss, O'Leary (1981). Therapist ratings of frequency and severity of marital problems: Implications for research	Journal article	Purpose: to ascertain fruitful directions for marital therapy research	N=116 members of the American Associa-tion of Marriage and Family Therapists treating at least five couples in their practice	A structured questionnaire asking the therapists to rate the frequency, severity, and treatment difficulty for 29 problems commonly experienced by distressed couples	Survey	Communication and alcoholism were most strongly endorsed as priority research areas. Communication, unrealistic expectations of marriage or spouse, power struggles, serious individual problems, role conflict, lack of loving feelings, demonstration of affection, alcoholism, extra-marital affairs, and sex (in that order) were the ten areas rated by therapists as having the most damaging effect on a marital relationship. Alcoholism, lack of loving feelings, serious individual problems, power struggles, addictive behavior other than alcoholism, value conflicts, physical abuse, unrealistic expectations of marriage or spouse, extra-marital affairs, and incest (in that order) were the ten	Communication emerged as the highest priority topic of future marital therapy research as it ranked as having the most damaging effect on a relationship, as the most frequently occurring problem in distressed marriage, and as the most desired topic for future research. This suggests that therapists view communication as central to well-functioning marriages.

						areas rated as being the most difficult to deal with or treat successfully.	
Garfield (2004). The therapeutic alliance in couples therapy: Clinical considerations	Journal article	Purpose: to introduce clinically relevant issues for therapists when establishing the therapeutic alliance with couples	N=1 hetero-sexual couple	Therapist identification of destructive assumptions and patterns of behavior within a loyalty dimension, defined as the couple's allegiance in their relationship	Qualita-tive	The therapeutic relationship, initiated by the therapist, can positively influence the loyalty dimension of a couple's relationship.	The positive impact of the therapeutic alliance is accomplished by highlighting the healthy aspects of a relationship and noting aspects that need change. Clinical considerations include establishing a "meta-alliance," avoiding loyalty conflicts, prioritizing marital issues, establishing guidelines for emotional engagement in treatment, anticipating early family-related issues, establishing balanced relational power in the therapeutic alliance, and addressing clients' reactions to the therapist's gender.
Davidson, Horvath (1997). Three sessions of brief couples therapy: A clinical trial	Journal article	Objective: to evaluate the efficacy of paradoxical interventions in couples therapy in a time-limited naturalistic context	N=40 couples	Dyadic Adjustment Scale, Conflict Resolution Scale, Target Complaints, Marital Attitude Survey, Relationship Belief Inventory, Homework report form, Implementati on checklist	Quantita-tive	Couples receiving treatment improved significantly more than those on a wait-list in terms of increased marital satisfaction. 75% of the treated couples rated themselves as having improved at least slightly on the Target Complaints.	Improvement in behavior was seen as a result of a cognitive intervention focusing on attributions and relationship beliefs.
Allgood, Crane (1991). Predicting marital therapy dropouts	Journal article	Purpose: to predict therapy dropouts using data gathered at marital therapy intake	N=474 marital therapy seeking couples	Marital Adjustment Test, Marital Status Inventory, Symptom Check List	Quantita-tive	72 couples met dropout criteria. Three variables, including having less than two children, having a male intake clinician, and a presenting problem relating only to one spouse, were significant	These three predictor variables provide insight into possible reasons people may find it easier to drop out of therapy. The following are examples. 82% of the couples who dropped out of therapy had male

						predictors in accounting for couples who would drop out of therapy. High phobic anxiety for husbands and a presenting problem related to parenting also accurately classified 82% of couples who dropped out of therapy.	intake clinicians. This may be due to the fact that several clinicians had been doing therapy for less than a year. Also, having more children would suggest a longer length of time being married, which may contribute to commitment to marriage and therapy. Finally, marital therapy is focused on a systemic view of problems, making problems seem manageable if focused on the couple as a team, making the couple less likely to drop out of therapy.
Bourgeois, Sabourin, Wright (1990). Predictive validity of therapeutic alliance in group marital therapy	Journal article	The first objective was to determine if couple distress is a stable predictor of therapeutic alliance formation. The second objective was to assess if the quality of the alliance is a precursor of outcome in group marital therapy. This was assessed by the couples and the therapists.	N=63 couples in a group marital skills training program; Nine weekly three-hour sessions occurred	The Couples Survival Program (CSP) as the treatment intervention; Instruments include the Couple Alliance Scale, Therapist Alliance Scale, Dyadic Adjustment Scale, Potential Problem Checklist, Marital Happiness Scale, Problem Solving Inventory	Quantita-tive	Perceptual change occurred over the course of the treatment program; marital distress (DAS) level was not a consistent predictor of therapeutic alliance; and therapeutic alliance was a precursor of treatment outcome as viewed by subjects, though this was more consistent among male subjects.	Levels of marital distress did not hurt or improve alliance formation. In addition, early development and maintenance of a productive therapeutic alliance is predictive of positive outcome. That the alliance strength is a more powerful determinant of therapeutic success for men left the authors surprised and unable to interpret these results.
IV. Current Study							
Christensen, Baucom, Vu, Stanton (2005). Methodologically sound, cost-effective research on the outcome of couple therapy	Journal article	Purpose: to provide guidelines on conducting outcome research of marital therapy	n/a	Treatment efficacy, control and comparison groups, and statistical analyses were some of the topics addressed	Literature review	n/a	Single-case designs, analysis of treatment components, and open clinical trials of couples can provide valuable information to the field. The authors challenge practitioners and researchers to join efforts on

							methodologically sound treatment development, efficacy, and effectiveness studies for distressed couples.
Johnson, Greenberg (1991). There are more things in heaven and earth than are dreamed of in BMT: A response to Jacobson	Journal article	Purpose: to address points of agreement and disagreement with Jacobson's (1991) article and then give an alternative perspective on enhancing the efficacy of marital therapy	n/a	n/a	Response article	n/a	The authors suggest that future marital therapy research need not focus on therapist competence and that manuals must include more than simple therapist behaviors. The focus must be on the process of change in marital therapy. It is crucial to accept the person rather than the problem in explaining a person's behavior. They agree with Jacobson that studies need to match client to treatment and identify the active components of therapy using task analysis.
Jacobson (1991). Toward enhancing the efficacy of marital therapy and marital therapy research	Journal article	Purpose: to suggest directions for future research in marital therapy and marital therapy research	n/a	n/a	Discus-sion article	n/a	Research strategies most likely to advance the theory, research, and practice of marital therapy include assessment of therapist competence, intramodel comparisons, matching studies, and intensive analyses of the therapy process.
Doss, Simpson, Christensen (2004). Why do couples seek marital therapy?	Journal article	Purpose: to improve therapists' understand-ing of the reasons why couples seek marital therapy	N=147 heterosex ual married couples	Reasons for seeking marital therapy questionnaire , Marital Satisfaction Inventory—Revised	Mixed-methods	Gender differences were found in that women report communication as a reason for seeking therapy more than do men. However, they were consistent in their motivations for marital therapy. Wives reported more reasons for seeking therapy, and rated themselves as expressing more negative	The gender differences found indicate that each partner in a couple likely presents for therapy for very different reasons. The fact that only sexual problems/dissatisf action overlapped for the couple, indicates that asking about reasons for seeking therapy provides information different from

						emotionality, more partner responsibility for problems, and greater self-responsibility for problems. Despite this, partners did not differ in their level of distress and their reasons for seeking therapy (most commonly interpersonal difficulties, communication problems, and lack of emotional affection) were very similar. Finally, of the areas assessed for reasons for seeking therapy, only sexual problems/dissatisf action overlapped for both partners.	standardized questionnaires. It is suggested that attention given to the reasons couples seek therapy is critical to the success of therapy. The use of this data and why couples seek therapy can help therapists present and advertise their practice and aid in helping more couples seek treatment and benefit from therapy. Finally, the study suggests that spouses' reasons for seeking therapy may be very different from psychologists' impressions of couples' problems (also in Whisman et al., 1997).
V. Additional Couple Therapy Research of Relevance							
Atkins, Yi, Baucom, Christensen (2005). Infidelity in couples seeking marital therapy	Journal article	Purpose: to examine the qualities of individuals and couples that differentiate couples with and without infidelity	N=134 heterosex ual married couples who sought therapy for marital problems	Dyadic Adjustment Scale, Marital Satisfaction Inventory—Revised, Marital Status Inventory, Problem Areas Question-naire, NEO-Five Factor Inventory	Quantita-tive	Couples with infidelity showed more instability, dishonesty, arguments about trust, narcissism, and time spent apart in their marriage. Men who had had an affair showed greater substance use, were older, and were more sexually dissatisfied.	These findings support past research showing that men are more likely to have affairs for sexual reasons, and are more upset about a partner's sexual affair whereas women are more upset by the partner's emotional connectedness to another. This data is useful for therapists seeing couples who have had an affair in assisting their awareness of factors that might increase the likelihood that affairs are occurring. Both individual and relationship factors are related to infidelity.
Atkins, Berns, George, Doss, Gattis,	Journal article	Purpose: to explain changes in	N=134 distressed married	Dyadic Adjustment Scale as	Experi-mental	Results showed that greater desired closeness	The authors find that these qualities of the relationship

Christensen (2005). Prediction of response to treatment in a randomized clinical trial of marital therapy		marital satisfaction over time using pretreatment variables, when comparing IBCT to TBCT	couples	criterion variable		and better communication were associated with less initial marital distress, whereas poor communication and any movement toward divorce or separation were associated with greater initial distress.	help explain overall relationship satisfaction prior to treatment.
Gattis, Berns, Simpson, Christensen (2004). Birds of a feather or strange birds? Ties among personality dimensions, similarity, and marital quality	Journal article	Purpose: to examine the relationship between six personality dimensions (Big Five personality factors and positive expressivity) and marital satisfaction	N=132 distressed, treatment-seeking couples and 48 non-distressed couples	The Marital Adjustment Test, The Marital Satisfaction Inventory—Revised (including The Global Distress Scale), The Dyadic Adjustment Scale, NEO Five-Factor Inventory, NEO Personality Inventory, Personal Attributes Questionnaire	Quantita-tive	Higher neuroticism, lower agreeableness, lower conscientiousness, and less positive expressivity are tied to marital dissatisfaction. Partner similarity did not predict relationship satisfaction.	Results suggest that nonpathological variations in these personality dimensions do not contribute to marital satisfaction. Also, similarity between partners' personalities may not be closely tied to marital happiness.
Atkins, Eldridge, Baucom, Christensen (2005). Infidelity and behavioral couples therapy: Optimism in the face of betrayal	Journal article	Purpose: to examine the initial level of distress and course of treatment in couple therapy for infidelity couples compared with distressed couples who had no affair	N=134 hetero-sexual, married couples who sought therapy for marital problems	Dyadic Adjustment Scale, Infidelity questionnaire, therapist report on any couples involved in a sexual and/or emotional affair in order to identify affairs	Quantita-tive	Infidelity couples began treatment more distressed than noninfidelity couples; however, if the affair was revealed prior to or during therapy the couple showed greater improvement in satisfaction than noninfidelity couples.	The authors find that the results of their study are optimistic, in that infidelity is not necessarily the end of a relationship. Though these couples are highly distressed at the beginning of treatment, they improve in therapy at a greater rate than their noninfidelity peers. Focusing on the relationship as a whole may be especially helpful for the spouse involved in an affair. If the infidelity is addressed during treatment, IBCT and TBCT can be effective.
Riggs, Jacobvitz, Hazen (2002). Adult attachment and history of	Journal article	Purpose: to empirically explore the theoretical association of internal	N=120 females in the third trimester of a first-time	The Mental Health Survey; Adult Attachment Interview	Quantita-tive	Security of attachment is linked to history of psychotherapy. "Secure" adults reported the	Secure adults report past experiences of couple therapy because they have a positive view of

psychotherapy in a normative sample		working models of attachment, measured by the AAI and history of psycho-therapy	pregnancy	(AAI)		highest rates of couple therapy.	relationships and are able to access and utilize social support during times of stress. These adults may also be more open to therapy when distressed.
Srivastava, McGonigal, Richards, Butler, Gross (2006). Optimism in close relationships: How seeing things in a positive light makes them so	Journal article	Is optimism associated with happier and longer lasting romantic relationships ?	N=108 couples	Part I. The Life Orientation Test, Maintenance Question-naire, Couple Satisfaction Scale, Investment Scale, Big Five Inventory; Part II. Couple Problem Inventory, Couple Satisfaction Scale, report of positive engagement in conflict, rating of conflict resolution	Quantita-tive	Part I. Optimists reported greater relationship satisfaction, as did their partners. Optimists perceived greater support from their partners and had more satisfied partners; Part II. Optimists and partners report disagreements as somewhat less intense. Those who saw disagreements as intense reported poorer conflict resolution. Those with high perceived support saw themselves as engaging more positively in the conflict, and their partners shared this perception. Those with high perceived support saw partners as also engaging more positively in the conflict, and their partners shared this perception. Those who positively engaged in conflict conversation reported better conflict resolution one week later.	Part I. The effects of an individual's optimism on the individual's relationship satisfaction and on the partner's satisfaction could b explained by the optimist's perceived support. Optimists and partners experienced great overall relationship satisfaction. The reason for this could be that optimists hold positive illusions about their relationships; Part II. Both optimists and partners agree that conflicts had reached a more satisfactory resolution one week later. Optimists and partners saw themselves and each other as engaging more positively in conflict and as reaching a better resolution. The reason for this could be that the positive illusions that optimists hold about their relationship drive them to practice and elicit better conflict-related behavior.

Appendix B

Request for Use of Data from the Original Study

Date of Request 9/12/07

Request for Use of Data from the Study
"Acceptance and Change in Marital Therapy"

1. Name and degree — Jessica Nelson, M.A. (Psy.D. doctoral student)
2. Professional affiliation — Pepperdine University
3. Address — 6100 Center Dr., Los Angeles, CA 90045
4. E-mail and phone number
5. Advisor (if a student) — Kathleen Eldridge, Ph.D.
6. Advisor's contact information — Kathleen.Eldridge@pepperdine.edu 310-506-8559
7. Type of Project (Students only)
   a. _X_ Dissertation
   b. _____ Master's Thesis
   c. _____ Undergraduate Honor's Thesis
   d. _____ Other (describe)

8. Brief Description of Research Project

TITLE: Client Perceptions of the Most and Least Helpful Aspects of Couple Therapy
The current dissertation topic seeks additional information about clients' experiences of couple therapy. Using the original data from the Christensen et al. (2004) study, couples' written responses to an evaluation of their therapy (IBCT or TBCT) experience will be analyzed qualitatively and quantitatively. The following research questions are proposed:

Qualitative research questions:

1. What do IBCT and TBCT couples report as the most helpful and least helpful aspects of couple therapy?
2. What do wives report as most and least helpful, and what do husbands report as most and least helpful?
3. What do the couples who show clinically significant deterioration at the end of therapy report as most and least helpful, and what do the couples who show clinically significant recovery at the end of therapy report as most and least helpful?

Quantitative research questions:

4. Do IBCT and TBCT couples differ significantly in their experiences of IBCT or TBCT?
5. Do husbands and wives differ significantly in their reports of the most and least helpful aspects of therapy?
6. Are there significant gender differences within IBCT and within TBCT?
7. Do couples who show clinically significant deterioration or clinically significant recovery at the end of therapy differ significantly in their reports of the most and least helpful aspects of therapy?

9. Description of Data Needed for Research Project

Couples' written responses to the open-ended question that read, "What were the most helpful and least helpful things about the therapy?" on question 10 of the CLIENT EVALUATION OF SERVICES questionnaire.

10. Approximate Time Line for Research Project

October 2007: dissertation preliminary exam

November 2007: data coding and analysis begins
July 2008: dissertation final oral exam

11. Proposed authorship
Dissertation: sole author Jessica Nelson
If published: Eldridge, Nelson and Christensen

Decision
✓ Request Approved Contingent on approval fr
Pepperdine IRB.
____ Request Denied Because _____

Signature [signature] Date 10/12/07

Appendix C

Start List

Therapist variables/factors

Client variables/factors

Therapeutic process factors

Expectancy factors

Logistics of the therapy factors

Appendix D

Complete List of Codes

MOST HELPFUL

Therapist Factors

Qualities

The therapist
Therapist caring
Therapist competence
Therapist consistency
Therapist cultural sensitivity
Therapist empathy
Therapist honesty
Therapist (sense of) humor
Therapist neutrality
Therapist patience
Therapist relationship skills
Therapist sensitivity
Therapist sincerity/genuineness
Therapist support
Therapist understanding
Therapist warmth

Behavior

Therapist explained my spouse's point of view
Therapist facilitated client learning
Therapist feedback
Therapist flexibility
Therapist guidance
Therapist helped us deal constructively with problems
Therapist helped us examine our own actions
Therapist helped us to work as a team
Therapist helped us understand one another
Therapist identification of couple's themes/patterns
Therapist listened to us
Therapist as mediator
Therapist reduced criticism
Therapist referred to reading assignments in session
Therapist suggestions and paraphrasing feelings
Therapist treating each partner equally
Therapist validation
Therapist was active/proactive
Therapist's affirmations of spouses
Therapist's restatement of the problem/situation
Therapist's use of hope

Client Factors

Self Behavior, Feelings, or Beliefs

Client commitment
Client compliance with homework

Client grew close to spouse
Client learning about self
Client learning about spouse
Client learning how to contribute to the marriage
Client learning to judge spouse less
Client self-disclosure
Client's active and collaborative participation
Client's belief in long-lasting effects
Client's identification of patterns in couple's behavior
Client's sense of trust and safety with therapist
Examining the value of my relationship
Understanding my spouse's point of view
Spouse Behavior
Spouse's disclosures
Couple Behavior, Feelings, or Beliefs
Both spouses' disclosures
Spouses complying with homework
Uncovering misconceptions about each other

Therapy Factors
Interventions
(Communication Skills Training)
Communication skills training
Learning to listen and respond to spouse
Listen-summarize technique
Paraphrasing
Reflective listening technique
Role playing
(Problem Solving Training)
Brainstorming
Discussing problem areas
Learning to problem solve (by starting with something positive)
Problem definition and solution
Problem recognition/identification
Problem solution/problem solving
Problem solving exercises/strategies
(Other Techniques Used in the Therapy)
Assessment and feedback
Evaluating strengths
Finding new ideas
Focus on central themes and issues
Goal setting
Lists
Labeling behaviors
Learning about satisfaction erosion and destructive frame of mind
Reinforcement

Reviewing difficult/pleasant incidents over the past week
Time outs
(Other Assignments)
Assignments/assigned work
Exercises
Reading assignments
Process
Neutrality in the therapeutic process
Safety in the therapeutic environment
Structure

Outcome Factors
Outcome of improved communication
Outcome of improved problem-solving
Outcome of increased acceptance/tolerance of problems or partner
Outcome of increased understanding of differences/problems
Outcome of personal responsibility
Outcome of softening
Solutions for future conflicts
Something shifted/changed in the relationship
Tools to solve our own problems
We learned to get along better

Logistical Factors
Amount of Time
Amount of time
Scheduling flexibility
The timing was right for the relationship
Getting to Therapy
Location of therapist's office
Parking at session location
Research Project Details
Fit of the model
Free services
Questionnaires
The therapy was different from others the couple had tried before
Videotaping
We were treated with respect by project staff

LEAST HELPFUL

Therapist Factors

Qualities

Therapist's style not as effective as others couple has seen

Behavior

Ineffective instruction by therapist
Therapist did not assist in problem resolution
Therapist did not assist with materials given in session
Therapist did not self-disclose
Therapist did not treat partners equally
Therapist's inability to refocus session goals

Client Factors

Self Behavior, Feelings, or Beliefs

Client did not do homework or readings
Client difficulty incorporating skills at home
Client self-disclosure
Lack of client readiness
Learning to accept spouse's character
Personal problems contributing to marriage problems

Spouse Behavior

Lack of motivation in my spouse
Lack of openness by my spouse
Spouse's personal problems

Couple Behavior, Feelings, or Beliefs

Spouses arguing during sessions
Spouses' commitment level
Spouses did not do homework assignments

Therapy Factors

Interventions

(Communication Skills Training)
Communication exercises
Faking arguments
Floor card technique
Role playing
XYZ feeling statements
(Problem Solving Training)
Focusing on problems only
Not enough problem solving
Problem solving exercises/strategies
(Other Techniques Used in the Therapy)
Cookie jar
Determining motivations behind behaviors/statements/actions
Discussing our unhappiness
Lists

Positive ideas exchanges
(Other Assignments)
Homework assignments
Reading assignments
Workbook
Process
Lack of "couple" focus/too much individual focus
Lack of safety in the therapeutic environment
Lack of structure
Personal expression was inhibited
Structure
Therapy not confrontational/aggressive enough
Therapy proceeded slowly
Valuing process over content

Outcome Factors
Important underlying issues were not addressed
Inability to find solutions to old problems
Individual needs were not explored/addressed
Lack of impact on relationship
Lack of increased understanding of underlying conflicts and causes of problems
Lack of individual focus/emphasis
Not enough behavioral changes/modification
Not enough tools/exercises to use at home
Outcome of personal responsibility lacking
Relationship worsened
Sexual issues not addressed

Logistical Factors
Amount of Time
Amount of time
Getting to session on time
Lack of scheduling flexibility
There is no quick fix
Getting to Therapy
Commuting to the therapist's office
Going to sessions
Location of the therapist's office
Parking at session location
Research Project Details
Fit of the model
No individual sessions/appointments
Questionnaires
The couple felt limited by the research project
Videotaping

Appendix E

Frequencies of Most and Least Helpful Codes within each Domain and Subdomain

Frequency of Most Helpful Codes within each Domain and Subdomain

	Total	IBCT (*n* = 136)	TBCT (*n* = 132)	Husbands (*n* = 135)	Wives (*n* = 135)	Recovered (*n* = 104)	Deteriorated (*n* = 58)
Therapist factors	418	52	106	75	85	78	22
Qualities	220	26	57	34	49	46	8
Behavior	198	26	49	41	36	32	14
Client factors	106	10	29	18	21	21	7
Self	84	9	22	14	17	15	7
Spouse	5	0	2	0	2	1	0
Couple	17	1	5	4	2	5	0
Therapy factors	405	102	52	73	78	72	28
Interventions	354	95	40	62	71	63	23
Process	51	7	12	11	7	9	5
Outcome factors	82	6	21	15	21	15	4
Logistical factors	56	6	15	11	10	12	2
Amount of time	28	3	7	8	2	6	2

(*table continues*)

	Total	IBCT (*n* = 136)	TBCT (*n* = 132)	Husbands (*n* = 135)	Wives (*n* = 135)	Recovered (*n* = 104)	Deteriorated (*n* = 58)
Getting to therapy	4	0	2	0	2	0	0
Research project details	24	3	6	3	6	6	0

Frequency of Least Helpful Codes within each Domain and Subdomain

	Total	IBCT (*n* = 136)	TBCT (*n* = 132)	Husbands (*n* = 135)	Wives (*n* = 135)	Recovered (*n* = 104)	Deteriorated (*n* = 58)
Therapist factors	27	3	7	4	6	3	4
Qualities	3	0	1	0	1	1	0
Behavior	24	3	6	4	5	2	4
Client factors	50	10	9	9	11	6	5
Self	14	2	3	1	4	3	1
Spouse	15	3	3	4	3	0	2
Couple	21	5	3	4	4	3	2
Therapy factors	115	20	21	20	28	18	8

(*table continues*)

	Total	IBCT (*n* = 136)	TBCT (*n* = 132)	Husbands (*n* = 135)	Wives (*n* = 135)	Recovered (*n* = 104)	Deteriorated (*n* = 58)
Interventions	84	14	15	14	21	16	4
Process	31	6	6	6	7	2	4
Outcome factors	112	31	18	13	33	8	9
Logistical factors	167	31	34	31	33	29	9
Amount of time	74	13	18	15	15	10	3
Getting to therapy	25	3	6	5	4	7	0
Research project details	68	15	10	11	14	12	6