

CLIENT ATTACHMENT, SYMPTOM DISTRESS, MARITAL ADJUSTMENT,
AND THERAPEUTIC ALLIANCE IN COUPLE'S THERAPY

Except where reference is made to the work of others, the work described in this thesis is my own or was done in collaboration with my advisory committee. This thesis does not include proprietary or classified information.

Jacob B. Nishida

Certificate of Approval:

Scott A. Ketring
Associate Professor
Human Development and Family
Studies

Margaret K. Keiley, Chair
Associate Professor
Human Development and Family
Studies

Ellen Abell
Associate Professor
Human Development and Family
Studies

George T. Flowers
Interim Dean
Graduate School

CLIENT ATTACHMENT, SYMPTOM DISTRESS, MARITAL ADJUSTMENT,
AND THERAPEUTIC ALLIANCE IN COUPLE'S THERAPY

Jacob B. Nishida

A Thesis

Submitted to

the Graduate Faculty of

Auburn University

in Partial Fulfillment of the

Requirements for the

Degree of

Master of Science

Auburn, Alabama
December 17, 2007

CLIENT ATTACHMENT, SYMPTOM DISTRESS, MARITAL ADJUSTMENT,
AND THERAPEUTIC ALLIANCE IN COUPLE'S THERAPY

Jacob B. Nishida

Permission is granted to Auburn University to make copies of this thesis at its discretion, upon request of individuals or institutions and at their expense. The author reserves all publication rights.

Signature of Author

Date of Graduation

VITA

Jacob B. Nishida, son of Leslie and Kathryn Nishida, was born on January 15, 1980, in Columbus, Georgia. He graduated with a Bachelor of Science degree in Marriage, Family, and Human Development from Brigham Young University in August, 2005. In August, 2005, Jacob entered graduate studies at Auburn University to complete a Master of Science in Human Development and Family Studies, with an emphasis in Marriage and Family Therapy. Jacob was married to his wife, Michelle Miller, daughter of J. Clare and Eileen Miller, on August 22, 2003. Jacob and Michelle's daughter, Miya Mae, was born on April 26, 2007.

THESIS ABSTRACT

CLIENT ATTACHMENT, SYMPTOM DISTRESS, MARITAL ADJUSTMENT, AND THERAPEUTIC ALLIANCE IN COUPLE'S THERAPY

Jacob B. Nishida

Master of Science, December 17, 2007
(B.S., Brigham Young University, 2005)

89 Typed Pages

Directed by Margaret K. Keiley

The purpose of this thesis was to examine the relationship between client anxiety, avoidance, symptom distress, marital adjustment and the therapeutic alliance in couple's therapy. Sample for this study was composed of 188 couples attending therapy at a marriage and family therapy training clinic at a public, Southeastern university. A significant negative relationship was found between male symptom distress and therapeutic alliance. Similarly, a significant negative relationship was also found between male marital adjustment and therapeutic alliance. No significant relationships were found between male attachment anxiety, avoidance and the therapeutic alliance. A significant negative relationship was found between female avoidance and therapeutic alliance when controlling for all symptom distress and marital adjustment. No significant

relationships were found between female anxiety, symptom distress, and marital adjustment and the therapeutic alliance.

ACKNOWLEDGEMENTS

I would like to express my sincerest gratitude to my Heavenly Father for the educational opportunities that I have been blessed. I want to thank my wife Michelle for her patience, love, and constant encouragement throughout this time-consuming process. I would also like to thank my daughter Miya, for finally sleeping through the night. I wish to thank Dr. Margaret Keiley for the time and energy that she devoted in mentoring me throughout this project. I wish to also thank the other members of my committee, Dr. Scott Ketring and Dr. Ellen Abell, for their valuable insights throughout the review process.

Style manual used: Publication Manual of the American Psychological Association, Fifth Edition.

Computer software used: Microsoft Office Word 2007, SAS, Mplus

TABLE OF CONTENTS

LIST OF TABLES	x
LIST OF FIGURES	xi
INTRODUCTION	1
REVIEW OF LITERATURE	6
METHODS	25
RESULTS	36
DISCUSSION	46
REFERENCES	60
APPENDIX A	69
APPENDIX B	70
APPENDIX C	73
APPENDIX D	75
APPENDIX E	77

LIST OF TABLES

Table 1: Categorical Demographics for Males and Females	26
Table 2: Continuous Demographics for Males and Females	27
Table 3: Univariates and T-test for Demographic Variables	28
Table 4: Univariates and Chi-square for Demographic Variable	29
Table 5: Univariates and T-test for Predictor Variables	37
Table 6: Fit Statistics for Study Models	39

LIST OF FIGURES

Figure 1: Hypothesized Path Diagram.....	34
Figure 2: Path Diagram for Model 1.....	40
Figure 3: Path Diagram for Model 2.....	42
Figure 4: Path Diagram for Model 3.....	45

INTRODUCTION

Therapeutic alliance, the relationship between client and therapist, has consistently been shown to be an important aspect of outcome in psychotherapy. Despite the fact that alliance appears to be an important factor of therapy, research is just beginning to understand both the pretreatment and treatment factors that contribute to a strong alliance. Alliance research is moving beyond linking alliance to therapeutic outcome to understanding how the alliance is constructed and developed through the process of therapy.

The therapist-client relationship has been identified as one of the oldest themes in research regarding psychotherapy outcomes (Horvath & Symonds, 1991). Growing evidence exists that the therapeutic alliance is one of the strongest predictors of outcome and treatment completion in both individual (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) and couples therapy (Brown & O'Leary, 2000; Rait, 2000; Raytec, McCrady, Epstein, & Hirsch, 1999). Two meta-analyses, by Horvath and Symonds (1991) and Martin et al. (2000), have reinforced the significance of the therapy alliance in outcome in psychotherapy.

Horvath and Symonds (1991) asked the questions; "How strong is the relation between the working alliance and therapy outcome?" and "Are there measurements or therapy variables related to the strength of the alliance-outcome relation?" (Horvath & Symonds, 1991, p. 140). To answer their research questions they conducted a meta-analysis. In order to obtain the most complete sampling of research articles possible they

searched for relevant literature using PsychInfo, MedLine, Dissertation Abstracts, the Educational Resource Center (ERIC). Additionally they cross-tabulated the references of all the material that were yielded by their primary search. Inclusion criteria for their sample were: in the study a) the alliance had to be identified by the author(s) as working, helping, or therapeutic alliance; b) the investigation had to report a quantifiable relationship between the alliance and outcome; c) the research included had to be clinical. d) a minimum of five study subjects was required; e) only research involving individual treatment was examined. Their search combined with their inclusion criteria yielded a sample of 24 studies based upon 20 distinct data sets. Horvath and Symonds (1991) concluded that “the working alliance is a relatively robust variable linking therapy process to outcome” (p. 146), independent of modality of therapy ($r=.26$).

Martin et al. (2000) completed a meta-analysis similar to the one conducted by Horvath and Symonds. In their study, Martin et al. examined the underlying patterns between therapeutic alliance and therapy outcome in the therapy research. Using similar sampling procedures and inclusion criteria applied by Horvath and Symonds (1991), Martin et al. reported a final sample of 79 studies (58 published, 21 unpublished). Of the 24 studies included in Horvath and Symonds’ (1991) meta-analysis, 23 of the same studies were used in Marten et al.’s (2000) meta-analysis. Overall, they found that most alliance measures were moderately related to outcome ($r=.22$). They also found the relationship between alliance and outcome to be stable across studies, regardless of the many variables that have been posited to affect this relationship such as type of outcome measure used in the study, the type of outcome rater, the time of alliance assessment, the

type of alliance rater, the type of treatment provided, or the publication status of the study.

Findings by Martin et al. (2000) as well as Horvath and Symonds (2004) clearly indicate that the therapeutic alliance is positively related to outcome in therapy. The work of Pinsof and Catherall (1986), was a catalyst that shifted researcher's focus from the relationship between the therapeutic alliance and outcome in individual therapy to the relationship between the therapeutic alliance and outcome in conjoint therapy.

Despite the fact that the therapeutic alliance is understood to be an important factor of psychotherapy outcome (Horvath & Symonds, 1991), relatively little is known about the factors that contribute to a good alliance. Constantino, Arnou, Blasey, and Agras (2005) reiterated the importance of research examining predictors of the therapeutic alliance when he said, "Without a greater understanding of (factors contributing to the development of a quality alliance), findings relating alliance to outcome will be of limited use to the practitioner" (p.203).

Recently, therapy alliance research has moved in a new direction; determining what contributes to its development. Research has found that individual pretreatment symptom distress does not have a significant impact on the therapeutic alliance in conjoint therapy (Knobloch-Fedders, Pinsof, & Mann, 2004; Mamodhousen, Wright, Tremblay, & Poitras-Wright, 2005). These findings are different from those found for individual therapy, in which a majority of the findings suggest that a significant relationship does exist between individual symptom distress and the alliance (Constantino et al., 2005; Eaton, Abeles, & Gutfreund, 1988; Raue, Castonguay, & Goldfried, 1993). Little is known about why such a difference might exist between individual symptom

distress in conjoint and individual therapy and therapeutic alliance. The research examining the relationship between marital adjustment and the therapeutic alliance in couple's therapy is also divided. Some studies have found no significant relationship between marital adjustment and the therapeutic alliance (Bourgeois et al., 1990; Johnson & Talitman, 1997; Knobloch-Fedders et al., 2004), but a recent study by Mamodhousen et al. (2005) indicates that marital adjustment is positively related to therapy alliance.

Since the predictors that contribute to the therapeutic alliance are presently not well understood, and studies that have examined predictors of the therapy alliance have yielded inconclusive results, this study will examine the relationships between anxiety, avoidance, symptom distress, and marital adjustment at intake with the therapeutic alliance at session four. While building upon the work of previous research, this study will be the first to examine the relationship between attachment anxiety and avoidance, symptom distress, marital adjustment, and therapeutic alliance. The data will be fit to a path model using Mplus. The utilization of Mplus will be a strength of this study as it will allow the data for males and females in each couple to be analyzed simultaneously in the same model. Past research on therapeutic alliance with couples has not done this, thus violating the assumption of independence necessary for results to be valid. Mplus also utilizes full information maximum likelihood (FIML) estimation (Muthen & Muthen, 1998), allowing for estimation of robust parameter estimates even with some missing data.

Hypotheses

Hypothesis 1: Client attachment, as measured by avoidance and anxiety, will be negatively related to the therapeutic alliance in couple's therapy, controlling for all else in the model.

Hypothesis 2: Client symptom distress, as measured by the Outcome Questionnaire, will be negatively related to the therapeutic alliance, controlling for all else in the model.

Hypothesis 3: Client marital adjustment, as measured by the Revised Dyadic Adjustment Scale, will be positively related to the therapeutic alliance, controlling for all else in the model.

REVIEW OF LITERATURE

Therapy Alliance

The therapeutic alliance has been defined broadly as “the collaborative and affective bond between therapist and patient” (Martin, Garske, & Davis, 2000, p. 438). In a meta-analysis of the relationship between the therapeutic alliance and outcome, Martin, Garske, and Davis (2000) found that most definitions of the therapeutic alliance had three things in common: the collaborative nature of the relationship, the affective bond between patient and therapist, and patient’s and therapist’s ability to agree on treatment goals and tasks. Over the years, as researchers have sought to describe this relationship, different terms have been used. The relationship between a therapist and client has been conceptualized as therapeutic alliance, working alliance, therapeutic bond, and helping alliance (Martin, Garske, & Davis, 2000). This relationship will be referred to as the “therapeutic alliance” in this study.

Although therapeutic alliance has traditionally been studied within the context of individual psychotherapy, each family member and partner may also establish a strong working alliance and emotional bond with a therapist in conjoint therapy. To account for the systemic nature of the therapeutic alliance in couples and family therapy, Pinsof and Catherall (1986) developed a tri-partite model consisting of the individual alliance, the subsystem alliance, and the whole system alliance. Based upon their conceptual model they developed both the Couple Therapy Alliance Scale (CTAS) and the Family Therapy Alliance Scale (FTAS) to measure therapeutic alliance. Later, Pinsof revised the CTAS

scale and added an additional dimension that included a measure of the alliance between partners. These advances in alliance measurement have allowed researchers a greater look into the construct of alliance from a systemic point of view.

Attachment Theory

Attachment theory has its foundation in the work of John Bowlby. Attachment has been defined as an enduring emotional bond of a child with his/her parent over the life span (Rice, FitzGerald, Whaley, & Gibbs, 1995). The term attachment has historically been used to refer to the affectional bond of an infant with his/her primary caretakers. Over the years, however, this definition of attachment has broadened to include other developmental periods and attachment figures (Buist, Dekivic, Meeus, & van Aken, 2002).

Attachment theory provides a useful framework from which to understand the development of emotional attachments from infancy through adulthood (Ainsworth, 1989; Bowlby, 1969, 1973, 1980). Bowlby reinforced the lifelong importance of the attachment system, developed within the infant's earliest relationships, for normative development. The necessity of secure parental ties for successful development later in life is a fundamental extension of Bowlby's original formulations, in which the infant's ability to explore the world is predicated on the use of the parent as a "secure base." Bowlby's attachment theory "...has provided a theoretical paradigm from which to investigate the complexities of development throughout life" (Vivona, 2000, p.316) and is an important theory from which to view the relationship between therapist and client. According to attachment theory, early attachment-related experiences of the infant become internalized and consequently become the internal working models of self and

the world (Arbona & Power, 2003). These working models include beliefs about one's competence and expectations regarding the availability and responsiveness of others. Internal working models, or beliefs about oneself and others, tend to be stable over time and can greatly affect the extent to which the individual will be able to engage in close relationships later in life. Applying the idea of a secure base to therapeutic relationships, Bowlby (1988) suggested that in psychotherapy, the therapist should assume the role of an attachment figure, who by inspiring trust can provide a secure base from which the patient may confidently explore and reassess his working models of attachment figures and of himself.

The attachment established while in childhood continues to have a major influence on intimate relationships later in life (Hazan & Shaver, 1994; Mallinckrodt et al., 1995). These attachment systems, created early in life, may be activated by a close relationship that invokes the potential for love, security, and comfort, including friendship, kinship, romantic partnership, and the therapeutic alliance (Ainsworth, 1989).

Traditionally, attachment has been viewed as a categorical variable; however, a growing consensus among researchers is that adult attachment is best understood through its continuous dimensions. A factor analysis of over 1,000 participants, who completed more than 300 items drawn from every English language self-report adult attachment measure available at the time, suggested that two orthogonal dimensions provide a good description of the data: Anxiety and Avoidance. (Brennan, Clark & Shaver, 1998). The Anxiety dimension involves fear of rejection, preoccupation with abandonment, and negative feelings prompted by a partner's perceived lack of responsiveness. The Avoidance dimension involves fear of intimacy and discomfort associated with getting

close to others.

Attachment and Therapeutic Alliance

The literature has consistently shown that a significant relationship exists between adult attachment style and ratings of therapeutic alliance. While studies have found that attachment anxiety and/or avoidance is positively associated with an insecure attachment to therapist or negatively associated with a lower therapeutic alliance (Satterfield & Lyddon, 1998; Mallinckrodt, Porter, & Kivlighan, 2005; Eames & Roth, 2000), others have found no significant relationship between adult attachment and therapeutic alliance (Satterfield & Lyddon, 1998).

Associations between attachment and the therapeutic alliance were examined by Satterfield and Lyddon (1998). In their study, they sought to obtain a greater understanding of how different client attachment styles influence the therapeutic alliance. Similar to other studies, Satterfield and Lyddon used a construct of the therapeutic alliance built upon Bordin's definition of the therapeutic alliance including goals, bonds, and tasks (Bordin, 1979). Goals refer "to the extent to which the therapist and patient systems agree about and invest in the goals or outcomes of the therapy" (Pinsof, 1994, p. 182). Bonds relates to the affective aspects of the relationship between and within the therapist and client. It deals with the extent to which clients trust, respect, care about, and feel cared about by the therapist. Finally tasks relates to the extent "to which the system and subsystems expect and agree about their respective tasks" as well as "the degree of comfort or anxiety that the systems and their members experience when they engage in their respective tasks" (Pinsof, 1994, p. 181). They hypothesized that secure attachment would be positively associated with the subscales (goals, bonds, tasks) as well as the

global rating of the Working Alliance Inventory (Horvath & Greenberg, 1986). Satterfield and Lyddon also hypothesized that insecure attachment would be negatively associated with both the Working Alliance Inventory subscales and global rating. Sixty-three first-time clients seeking counseling services from a university counseling services center were included in the study. In this study, attachment was measured using Bartholomew and Horowitz's (1991) Relationship Questionnaire (RQ). Therapeutic alliance was measured using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986). The RQ was administered to study participants at intake, while the WAI was completed between the third and sixth session.

Satterfield and Lyddon's (1998) findings lend partial support to the idea that client attachment style is related to the development of the therapeutic alliance. Significant positive correlations were found between client-reported secure attachment and the bond subscale of the WAI. A negative correlation between client reported fearful attachment and the bond subscale was also found to be significant. In addition to these findings, attachment security was significantly correlated with the goals subscale as well as the global WAI rating. Preoccupied and the dismissing dimensions of the RQ were found not to be correlated significantly with the WAI subscales.

In a more recent study, Mallinckrodt et al. (2005) examined how client attachment style contributes to the therapeutic alliance. Their study sought to understand how closely the attachment relationship between client and therapist mirrored aspects of the client's other close attachment relationships. They also wanted to know whether or not the quality of the security of a client's attachment to his or her therapist was related to greater in-session exploration and/or depth. In their study, 38 participants were recruited

from a counseling center of a large, Midwestern, public university. Participants had already completed 4-8 sessions of 12-session time-limited therapy, thus representing the middle phase of counseling for clients. The authors focused on the middle third of 12-session time-limited therapy, because they reasoned that in “the first 3 sessions, a secure attachment to the therapist would not have sufficient time to develop, whereas by the 9th-12th sessions, clients with poor attachment or working alliance might no longer be in treatment” (p. 95).

Clients who volunteered for the study completed surveys that contained measures of adult attachment (Experiences in Close Relationships Scale; Brennan, Clark & Shaver, 1998), client attachment to therapist (Client Attachment to Therapist Scale; Mallinckrodt, Gantt & Coble, 1995), therapeutic alliance (Working Alliance Inventory; Horvath & Greenberg, 1989), session depth and smoothness (Session Evaluation Questionnaire, Stiles & Snow 1984a, 1984b), as well as client post-session positivity and arousal (Session Evaluation Questionnaire, Stiles & Snow 1984a, 1984b).

Mallinckrodt et al. (2005) found that adult attachment Anxiety and Avoidance were positively associated with Avoidant-Fearful attachment to therapist. Adult attachment anxiety was significantly negatively associated with the Tasks and Goals subscales, but not the Bond subscale. It may be implied that highly anxious clients may find it more difficult to agree on the direction of therapy with their therapist than forming an emotional bond with their therapist. Mallinckrodt et al. also found that secure attachment to therapist was strongly associated with ratings of positive working alliance. Due to their small sample size they found that correlations of anxiety and avoidance with secure attachment to therapist were not statistically significant. Findings in this study are

similar to those found by Satterfield and Lyddon (1998); clients with high levels of avoidance or anxiety in their romantic relationships also tend to be highly avoidant in their therapeutic attachments. Overall, these studies suggest that clients who exhibit high levels of attachment security report more positive therapeutic alliances and vice-versa.

More recently researchers have begun to inquire about the effect of client attachment on therapeutic alliance over time (Eames & Roth, 2000; Goldman & Anderson, 2007; Kanninen, Salo & Punamäki, 2000). Eames and Roth investigated the relationship between clients' self-reported attachment orientation and the quality and development of the therapeutic alliance over time. They also sought to investigate the relationship between clients' attachment style and frequency of ruptures in therapy. Their sample consisted of 30 clinical outpatients. Data were collected from sessions 1 through 5. After the first session, study participants completed the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994), which is a measure of adult attachment. At the conclusion of each subsequent session, through session five, participants completed the Working Alliance Inventory (WAI; shortened version, Tracey & Kokotovic, 1989) measure of therapeutic alliance. Therapists also completed a corresponding version of the WAI at the end of sessions 2 through 5.

As predicted, Eames and Roth (2000) found that fearful attachment was associated with lower alliance ratings (significantly with patient ratings at sessions 3 and 5 and therapist ratings at session 2). Additionally, security in attachment was significantly associated with alliance ratings (significantly with therapist ratings at session 5). Their results suggest that attachment concerns may have more of an effect on the therapeutic alliance over time. They concluded that therapist knowledge regarding

the association of client attachment style and alliance, may allow therapists to be “more alert to threats to the alliance, more sensitive to the form that these threats might take, and less likely to respond in a countertherapeutic manner which confirms client expectancies” (p. 431). Despite study limitations such as convenience sampling, small sample size and self-report methodology, Eames and Roth’s results lend support to previous findings that client attachment styles are significantly associated with therapeutic alliance.

Kanninen, Salo, and Punamäki (2000), sought to further investigate alliance development by examining the effects of client attachment on the development of the therapeutic alliance in a sample of 36 Palestinian political ex-prisoners. Their study objectives were: to examine the relationship between attachment patterns and early working alliance, investigate how alliance develops over time in different attachment patterns, and examine the relationship between attachment and therapy outcome. The study included 50 Palestinian political ex-prisoners who had been exposed to torture and who suffered from symptoms of posttraumatic stress. They were self-referred clients who sought individual ($n=25$) and group ($n=25$) therapy from mental health centers in Gaza. Nine participants were missing either attachment or alliance data and five more were in an unclassified attachment group, and were thus left out of the final sample, resulting in a sample size of 36.

A paper and pencil version of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) was used. Cluster analysis was conducted to identify different groups of participants with similar attachment patterns. The resultant clusters from their analysis were autonomous individuals ($n=18$), dismissing individuals ($n=12$), and preoccupied individuals ($n=6$), with remaining participants placed into a fourth group

called “unclassifiable” ($n=5$) due to missing data. Working alliance was measured using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Participants completed the WAI at three time points; after the third session (beginning of therapy), during the fifth or sixth month (middle of therapy), and between the 10th or 11th month (after the second to last session of therapy). Outcome was measured using the Harvard Trauma Questionnaire (HTQ; Mollica & Caspi-Yavin, 1991), which measured symptoms of Post Traumatic Stress Disorder as found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R).

Kanninen et al. (2000) found that there was not a difference between attachment patterns in the levels of early alliance. However, when examining ratings of alliance over time, significant group differences were evident. At the beginning of therapy, levels of alliance were found to be approximately the same across clusters, but the pattern of development was different for each one. The level of alliance dropped in the middle of therapy for the autonomous group, but returned to the initial level at the end of therapy. Preoccupied individuals also reported a drop in alliance in the middle of therapy, but increased to a level higher than the initial by the end. The pattern was different for the dismissing group. The level of alliance was about the same for the beginning and middle of therapy, but unlike the other two groups, alliance levels dropped by the end. In addition to their findings regarding attachment and the development of the alliance, Kanninen et al. (2000) also found that attachment was not related to outcome.

Symptom Distress and Therapeutic Alliance

Just as attachment has been an important aspect in the study of therapeutic alliance, client symptom distress has also been an area of study as researchers continue to

determine the key factors that contribute to the development of the therapeutic alliance. Studies examining the relationship between client symptom distress and therapeutic alliance have been few and have yielded mixed results. Research that has examined the relationship between symptom distress and therapeutic alliance in individual therapy has found either a negative relationship between symptom distress and therapeutic alliance (Constantino et al., 2005; Eaton et al., 1988; Raue et al., 1993) or no significant relationship at all (Connolly Gibbons, Crits-Christoph, de la Cruz, Barber, Siqueland, & Gladis, 2003; Santiago, Klein, Vivian, Vocisano, Dowling, Arnow, Manber, Markowitz, McCullough, Riso, Rothbaum, Rush, Thase, & Keller, 2002).

The relationship between symptom distress and the therapeutic alliance was examined by Eaton et al. (1988). Data were collected from the Michigan State University Psychotherapy Research Project. Their sample was composed of cases that resulted in termination between 1978 and 1982. Inclusion criteria included the completion of at least 10 sessions, completion of intake and post-therapy measures, and completion of audiotape of selected sessions. A final sample size of 40 cases was selected based upon the compliance with inclusion criteria. The 40 cases were then grouped into three groups based upon the number of completed sessions. The high group (over 40 sessions) consisted of 12 cases, the moderate group (20-40 sessions) consisted of 15 cases, and the low group (20 sessions or less) consisted of 13 cases.

Client pretreatment symptom distress was measured using the Hopkins Symptom Checklist (SCL-90; Derogatis, 1977). Therapeutic alliance was measured using the Therapeutic Alliance Rating Scale (TARS; Marziali, 1984). Therapeutic alliance was also measured by both a male and female graduate student in clinical psychology. These

two graduate students listened to randomly selected audio captured during therapy sessions from the beginning, middle and end of treatment. The students were also trained to rate the therapeutic alliance by reading the manual for the rating system, rating practice segments, and participating in group meetings to discuss items and practice transcripts to achieve consensus in their ratings. The student raters also participated in 16 hours of additional meetings during the 20 weeks of the research ratings to promote inter-rater consistency.

Eaton et al. (1988) found that clients' pretreatment symptom distress was negatively related to therapy alliance. Thus, high levels of pretreatment symptom distress were related to low levels of therapy alliance and vice versa. They also found that clients entering therapy with high levels of symptom distress had low levels of positive contribution to the alliance and had high levels of negative contribution to the alliance.

Findings by Raue et al. (1993) were similar to those found by Eaton et al (1988). In their study, they investigated the relationship between client symptom distress and the therapy alliance by conducting a comparative analysis of alliance formation within therapy approaches. Researchers selected 30 cognitive-behavioral and 30 psychodynamic-interpersonal therapists to identify other therapists within their orientation to whom they would refer to a friend or relative. Therapists who received at least two nominations were invited to participate in the study. This selection process yielded 13 cognitive-behavioral and 18 psychodynamic-interpersonal therapists, who each worked with one client throughout the duration of the study. Clients participating in the study presented with either anxiety or depression. Clients taking psychoactive

medication, possessing psychotic or borderline symptoms, or presenting with problems associated with life stress were excluded from the study.

Symptom distress was measured using the Global Symptom Severity Index of the Symptom Checklist (SCL-90; Derogatis, Lipman, Rickets, Uhlenhuth, & Covi, 1974). Therapeutic alliance was measured using the Working Alliance Inventory-Observer Form (WAI-O; Horvath & Greenberg, 1989). The therapeutic alliance was measured by coding of a therapist-identified session during the middle course of therapy. Criteria for the selection of this session was a large amount of therapeutic change in-session (from the therapist's perspective), the primary issue that was dealt with in the session had to reflect a theme that was central to the client's problem, and the therapist had to identify an effect on the client in that session and in subsequent sessions.

The findings of Raue et al. (1993) reflect similar findings by Eaton et al. (1988); a significant negative relationship between client symptom distress. This was true solely in the psychodynamic therapy group, as a significant negative relationship between symptom distress and therapeutic alliance was not found in the cognitive-behavioral therapy group.

Despite the evidence supporting a negative relationship between symptom distress and therapeutic alliance in individual therapy, emerging research examining the relationship between symptom distress and the therapeutic alliance in conjoint therapy suggests that a significant relationship might not exist between the two variables. In studies by both Knobloch-Fedders et al. (2004) and Mamodhoussen et al. (2005), symptom distress was not found to be significantly related to symptom distress in conjoint treatment. However, in both of these studies, the linked couples data were

analyzed separately, not in a path model in which male and female partners' data are modeled simultaneously as required by the assumption of independence of the general linear model. Couple data are non-independent, thus must be modeled simultaneously in one model.

Despite the fact that clinical knowledge suggests that individuals' symptom distress may affect their ability to form an alliance with a therapist, findings are mixed. A greater understanding of the relationship between client symptom distress and the therapeutic alliance would be important to both clinicians as well as researchers. More research needs to be done in this area to add to the knowledge gleaned from the handful of studies that have been completed thus far.

Marital Adjustment and Therapeutic Alliance

While much of the research has focused on individual symptom distress, recent research has begun to examine symptom distress and therapeutic alliance in couple's therapy (Bourgeois et al., 1990; Johnson & Talitman, 1997; Knobloch-Fedders et al., 2004; Mamodhousen et al., 2005). One of the first studies to explore the relationship between marital adjustment and the therapeutic alliance in couple's therapy was by Bourgeois et al. (1990). In their study they sought to determine whether couple distress represented a stable predictor of alliance formation and whether alliance predicted outcome in a group marital skills training program. Their study included 63 self-nominated, Caucasian, French-speaking couples from the Province of Québec, Canada. Participants participated in the Couples Survival Program (CSP; Wright, 1985) based upon social learning and humanistic theories. CSP was a nine week program that consisted of weekly 3 hour sessions.

Marital adjustment was measured using the Dyadic Adjustment Scale (DAS; Spanier, 1976) and was administered along with three other measures (Potential Problem Checklist; Patterson, 1976; Marital Happiness Scale; Azrin, Naster, & Jones, 1973; Problem Solving Inventory; Heppner & Peterson, 1982) at two time points; before the first session and a week after the last session. Client-reported therapy alliance was measured by self-report after the third therapy session using the Couples Therapy Alliance Scale (CTAS; Pinsof & Catherall, 1986). Couples were divided into multiple couple treatment groups, consisting of 2 distressed couples and 2 nondistressed couples per group, as measured by the DAS. Couples participated in 3-hour, weekly group treatment over 9 weeks.

Bourgeois et al. (1990) found that the couple pre-therapy level of marital adjustment was not found to be related to the quality of the alliance. Based upon their study data, they concluded that “marital distress neither impaired nor facilitated alliance formation” (p. 611). Their findings must be considered with caution, however, due to the sample’s homogeneity and the fact that the sample may not be representative of a clinical population. However, once again, these data were not modeled simultaneously.

Johnson and Talitman (1997) obtained similar results to those found by Bourgeois et al. (1990) when they studied the predictors of success in Emotionally Focused Therapy (EFT; Greenberg & Johnson, 1988; Johnson, 1996). Couples were recruited from newspaper advertisements which resulted in a sample of 36 couples. Since two couples dropped out during the course of therapy, the final sample size was 34 couples. All couples had cohabited for at least one year, were free of alcohol or drug-related problems, received no psychiatric or psychological treatment in the previous year, and scored less

than 97 (which was the cutoff for marital distress) on the Dyadic Adjustment Scale (DAS; Spanier, 1976). Treatment occurred over 12 sessions. Again, data were not modeled simultaneously, but were instead modeled through separate, multiple regression models.

Marital adjustment was measured using the Dyadic Adjustment Scale (DAS; Spanier, 1976) and was assessed at intake, at the end of treatment, and at a 3-month follow-up. Therapy alliance was measured at the end of the third session using the Couples Therapy Alliance Scale (CTAS; Pinsof & Catherall, 1986). Other variables such as attachment, intimacy, relationship trust, and emotional self-disclosure were also assessed during intake. Johnson and Talitman (1997) found that alliance was significantly related to outcome. They reported that “initial level of marital satisfaction was not significantly related to the couples’ alliance level” (p. 145). They also found that “the level of symptom distress did not hinder or facilitate the quality of the alliance made with the therapist” (p. 145).

Strong evidence suggests that pre-therapy marital adjustment is not related to therapeutic alliance (Bourgeois et al., 1990; Johnson & Talitman, 1997). Similar to the findings regarding symptom distress, the handful of studies that have examined the relationship between marital adjustment and the therapeutic alliance offer conflicting results. Such results necessitate further examination by future research studies.

Symptom Distress, Marital Adjustment, and Therapeutic Alliance

Two recent studies examined the relationship of symptom distress, marital adjustment, and the therapeutic alliance (Knobloch-Fedders et al., 2004; Mamodhousen et al., 2005). They found similar results in the relationship between symptom distress

and the therapeutic alliance, but found different results in their examination of the relationship between marital adjustment and the therapeutic alliance.

Knobloch-Fedders et al. (2004) examined both the predictive validity of marital distress and individual symptomatology on the formation of the therapeutic alliance in couples therapy. Their study included 35 couples as well as an additional 10 individuals whose partners were not included in the final sample due to missing data. Therapy was conducted at a large outpatient clinic specializing in couple and family therapy. Couples presented with a variety of problems including difficulties with communication, conflict, intimacy, problem solving, and parenting. They received Integrative Problem-Centered Therapy (IPCT; Pinsof, 1995) over an average span of 18.26 sessions.

At intake, couples completed three measures assessing family-of-origin functioning, individual functioning, and couple functioning. Family-of-origin functioning was measured using the Family Assessment Device-family of origin (FAD; Epstein, Baldwin, & Bishop, 1983; Miller, Epstein, Bishop, & Keitner, 1985). Individual functioning was measured using the COMPASS Treatment Assessment System (COMPASS; Howard, Brill, Lueger, O'Mahoney, & Grissom, 1995). The COMPASS is a 68-item questionnaire containing three subscales: Current Well-Being, Current Symptoms, and Current Life Functioning. The Current Well-Being subscale assesses energy and health, distress, emotional and psychological adjustment, and current life satisfaction. The Current Symptoms subscale is designed to assess the frequency of symptoms characteristic of seven diagnoses represented in the Diagnostic and Statistical Manual of Mental Disorders – IV (DSM – IV; American Psychiatric Association, 1994): depression, anxiety, obsessive-compulsive, adjustment, bipolar, phobia, and substance

abuse disorders. The Current Life Functioning subscale measures six areas of life functioning: self-management, work/school/homemaker, social/leisure, intimacy, family, and health. Couple functioning was measured using the Marital Satisfaction Inventory – Revised (MSI – R; Snyder, 1997). The MSI – R is a self-report measure of relationship distress that includes a global distress scale, as well as 10 additional scales assessing various relationship dimensions: affective communication, problem-solving communication, aggression, time together, disagreement about finances, sexual dissatisfaction, role orientation, family history of distress, dissatisfaction with children, and child rearing. Therapy alliance was then measured after the first session and again after the eighth using Pinsof's (1994) Couple Therapeutic Alliance Scale-Revised (CTAS-R). While Knobloch-Fedders et al.'s (2004) considered a data analytic strategy utilizing a series of simultaneous regression equations, they ultimately used bivariate correlations to analyze their data. Bivariate correlations were analyzed separately for males and females.

Knobloch-Fedders et al.'s (2004) found that individual symptomatology was not a good predictor of the formation of the therapeutic alliance in couple's therapy. Global marital distress at intake was not significantly related to early therapeutic alliance for both males and females. At session eight, a significant relationship between global marital distress and therapeutic alliance did exist for males, but not for females. These findings suggest that at high levels of marital distress after session eight, men reported low levels of therapeutic alliance and vice versa. From their study results, Knobloch-Fedders et al. (2004) posited that gender differences may have obscured the relationship between marital distress and the development of the alliance. They recommended that

future research look at gender differences in the relationship between marital distress and the development of the therapeutic alliance.

In another study that examined the relationship between individual symptom distress, marital adjustment, and the therapeutic alliance in couple's therapy by Mamodhousen et al. (2005), findings were both similar and different to those of Knobloch-Fedders et al. (2004). In their study, 79 French-speaking couples from Quebec, Canada completed at least three sessions of couple's therapy. Couples were recruited through a group of couple's therapists from a large French-speaking university in Quebec. Study participants completed a French version of the Dyadic Adjustment Scale (DAS; Spanier, 1976) as well as the Psychiatric Symptoms Index (PSI; Ilfeld, 1976) after the first session. Upon completion of the third session participants completed a French-version of the Couples Therapy Alliance Scale-Revised (CTAS-R; Pinsof, 1995). Data for their study were fit through a series of multivariate regressions. Similar to the study by Knobloch-Fedders et al. (2004), models were not fit simultaneously for males and females, but were examined separately, violating the assumption of independence.

Similar to results found by Knobloch-Fedders et al. (2004), Mamodhousen et al. (2005) found that psychiatric symptoms were not found to be related to formation of the alliance for both males and females in conjoint treatment. However, reporting results contrary to those of Knobloch-Fedders et al. (2004), Mamodhousen et al. (2005) found that marital adjustment at intake predicted the quality of the therapeutic alliance at session three for both men and women. According to their study, on average, at high

levels of marital adjustment, there are high levels of therapeutic alliance for men and women, and vice versa.

Over the years many clinicians and researchers have focused on the therapeutic alliance due to its documented impact on the outcome in therapy (Mamodhousen et al., 2005). Currently little empirical evidence exists to guide clinicians as they strive to foster a good therapeutic alliance with their clients, leaving them to their own hypotheses of what cultivates and what damages the therapeutic alliance in conjoint therapy. This study will examine the relationship between client pretreatment factors of anxiety, avoidance, symptom distress, marital adjustment and the therapeutic alliance at session 4.

METHODS

Data for this study were collected from the Auburn University Marriage and Family Therapy Center (AUMFT Center) in Auburn, Alabama. The AUMFT Center is a training facility for master's level marriage and family therapists and is accredited by the Commission on Accreditation for Marriage and Family Therapy Education. Therapists in training are supervised by Auburn University professors in the Department of Human Development and Family Studies, who are Licensed Marriage and Family Therapists, and are approved supervisors by the American Association for Marriage and Family Therapy. The center provides services for affiliates of the university community and for residents of eastern Alabama.

Participants

Participants for this study were clients who received treatment at the AUMFT Center. The sample is a convenience sample composed of 195 couples who received therapeutic services at the AUMFT Center in Auburn, Alabama between March 1, 2002 and April 30, 2006. Of the 195 couples who received services, 7 couples were missing all data on all variables included in this study, resulting in a final analytic sample of 188 couples.

The mean age for male partners included in this study was 31 years, while the mean age for females was 30 years. Approximately 80% of both male and female participants identified themselves as European-American. Composing approximately

14% of the sample for men and women, African-American was the next highest ethnicity identified among study participants (see Table 1 and Table 2).

Table 1
Categorical demographic variables for males and females in committed relationships (N=188)

Demographic	Male		Female	
	N	Percent	N	Percent
Ethnicity				
White	133	80	134	80
African American	24	14	24	14
Hispanic/Non-White	7	4	5	3
Asian	2	1	5	3
Income				
\$10,000 or less	31	20	35	22
\$10,001 to \$20,000	35	22	30	19
\$20,001 to \$30,000	28	21	28	18
\$30,001 to \$40,000	24	18	27	17
Over \$40,000	41	26	39	25
Client Education				
GED/High School	66	40	66	40
Technical/Associate	32	19	27	16
Bachelor's Degree	41	25	43	26
Master's Degree	12	7	22	13
Other	14	9	9	5

Table 2
Continuous demographic variables for males and females in committed relationships (N=188)

Demographic	Male	Female
Age		
Mean	31.44	29.56
SD	8.59	8.07
Range	18-59	17-59

Chi-square and t- tests were conducted to determine whether or not significant differences existed between participants who completed fourth session paperwork and those who did not. Reasons for clients not completing fourth session paperwork include discontinuance of therapy or therapist/client non-compliance with of fourth session paperwork protocol. Results showed that there were no significant differences by gender, age, race, income, or education for those who completed first and fourth session paperwork and those who did not (Table 3 and Table 4).

Table 3

N, mean, standard deviation and t-test values comparing those who completed fourth session paperwork and those who did not (attriters or drop-outs)

Demographic	Male	Female
Age (attrited)		
N	110	105
Mean	31.16	29.42
SD	8.42	8.18
Age (non-attrited)		
N	64	69
Mean	31.91	29.75
SD	8.92	7.95
T-test	-.55 ^{NS}	-.27 ^{NS}

NS = not significant

Table 4

N and chi-square values comparing those who completed fourth session paperwork and those who did not (attriters or drop outs)

Demographic	Male		Female	
	attrited	non-attrited	attrited	non-attrited
Race				
N	104	60	102	68
χ^2	7.18 ^{NS}		3.33 ^{NS}	
Income				
N	99	60	96	64
χ^2	6.63 ^{NS}		3.81 ^{NS}	
Education				
N	109	62	105	67
χ^2	12.09 ^{NS}		11.00 ^{NS}	

NS = not significant

Procedure

Data for this study were obtained by way of self-report measures completed by clients of the AUMFT Center at intake and after the fourth session. Participants completed intake paperwork consisting of informed consent for treatment, the Experiences in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998), the Outcome Questionnaire (OQ-45.2; Lambert, Hansen, Umphress, Lunnen, Okiishi, Burlingame, Huefner, & Reisinger, 1996), and the Revised Dyadic Adjustment Scale (RDAS; Busby, Crane, Larson, & Christiansen, 1995) before their first session at the AUMFT Center. Following every fourth session, study participants completed the

Experiences in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998), Outcome Questionnaire (OQ-45.2; Lambert et al., 1996), Revised Dyadic Adjustment Scale (RDAS; Busby, Crane, Larson, & Christiansen, 1995), as well as the Couple Therapeutic Alliance Scale-Revised (CTAS-R; Pinsof & Catheral, 1986).

Measures

Experiences in Close Relationships (ECR). The Experience in Close Relationships (ECR, Brennan, Clark, & Shaver, 1998) was developed to measure attachment in adult relationships. The authors developed two 18-item sub-scales using factor analysis of all the known assessments measuring attachment. Each of the items is rated on a 7-point scale. The ECR is composed of two subscales; Anxiety and Avoidance. The Anxiety subscale assesses the fear of rejection, degree of jealousy/ fear of abandonment, and preoccupation. The Avoidance subscale measures discomfort with closeness, the avoidance of intimacy, and self-reliance. Scores for each of the sub-scales are calculated by reverse-scoring certain items, and calculating the mean of each sub-scale. Individuals that score high on the Anxiety subscale are characterized as experiencing a fear of interpersonal rejection, fear of abandonment, an excessive need for approval from others, and/or distress when one's partner is unavailable (Wei, Russell, Mallinckrodt & Vogel, 2007). Individuals scoring high on the Avoidance subscale experience a fear of interpersonal intimacy, a reluctance to self-disclose, and an excessive need for self-reliance. Secure individuals score low on the anxiety and the avoidance sub-scales. Preoccupied individuals score high on anxiety and low on avoidance. Dismissing individuals score low on anxiety and high on avoidance. Fearful individuals score high on both sub-scales. The Cronbach's alpha for the avoidance subscale, in the

current study, was .90 for males and .91 for females at Time 1 (intake). The Cronbach's alpha for the anxiety subscale was .93 for males and .90 for females at Time 1 (intake) in the current study.

Outcome Questionnaire-45.2 (OQ). The OQ (Lambert et al., 1996) is designed to measure client's progress in mental health services. The three sub-scales of the OQ-45.2 are Symptom Distress, Interpersonal Relations, and Social Role. For this study, only the Symptom Distress subscale will be used. The Symptom Distress subscale is composed of 25 items and is a measure of the most common intra-psychic problems of anxiety and depression (e.g. "I tire quickly." "I feel nervous." "I have thoughts of ending my life.>"). High scores indicate that the client is experiencing symptoms of anxiety and depression while low scores indicated either an absence or denial of these symptoms. The scale has reported good test-retest reliability (.84) (Lambert et al., 1996) and the internal consistency reliability at intake for this measure in this study was .91 for males and .92 for females.

Revised Dyadic Adjustment Scale (RDAS). The Revised Dyadic Adjustment Scale (RDAS; Busby, Crane, Larson, & Christiansen, 1995) is an updated version of the Dyadic Adjustment Scale developed by Spanier (1976). The RDAS is a 14-item questionnaire that measures adjustment in relationships. It consists of three sub-scales: Consensus (items 1-6), Satisfaction (items 7-10), and Cohesion (items 11-14). Scores for the Consensus subscale may range from 0-30, scores for the Satisfaction subscale range from 0-20, and scores for the Cohesion subscale can range from 0-19 with higher score indicates more consensus, greater satisfaction, or better cohesion that a couple displays, respectively. For this study, an average scale score of the whole scale will be used. The

Consensus scale as well as item 11 from the Cohesion scale were reversed scored, all item scores summed, and divided by 14 to obtain an average scale score. High scores indicate high levels of marital satisfaction, while low scores indicate marital distress.

Construct validity and criterion validity has been established for the updated RDAS. The reliability coefficients demonstrate that the RDAS has internal consistency and split-half reliability. Cronbach's alpha was found to be .90 for the total scale score. Chronbach's alpha for the consensus, satisfaction, and cohesion sub-scale are .81, .85, and .80, respectively (Busby, Christensen, Crane, & Larson, 1995). Cronbach's alpha for the total scale was .87 for males and .86 for females at intake in the current study

Couple Therapy Alliance Scale-Revised (CTAS-R). The CTAS-R (Pinsof, 1994) is a 40-item questionnaire that measures the therapeutic alliance in conjoint therapy. The CTAS-R measures three components of the alliance as defined by Bordin (1979): Goals, Tasks, and Bonds. These three components are measured for each of the four possible alliance subsystems in conjoint therapy: self-therapist (the "Self" subscale), partner-therapist (the "Other" subscale), couple-therapist (the "Group" subscale), and self-partner (the "Within" subscale). The four subscales can be summed for a total scale score. For this study, an average scale score of the whole scale will be used. High scores reflect an individual's positive perception of the therapeutic alliance while low scores reflect a negative perception. Reliability of this instrument has been reported at .83 (Pinsof, 1994). In the current study, Cronbach's alpha was .96 for males and .95 for females at intake.

Plan of Analysis

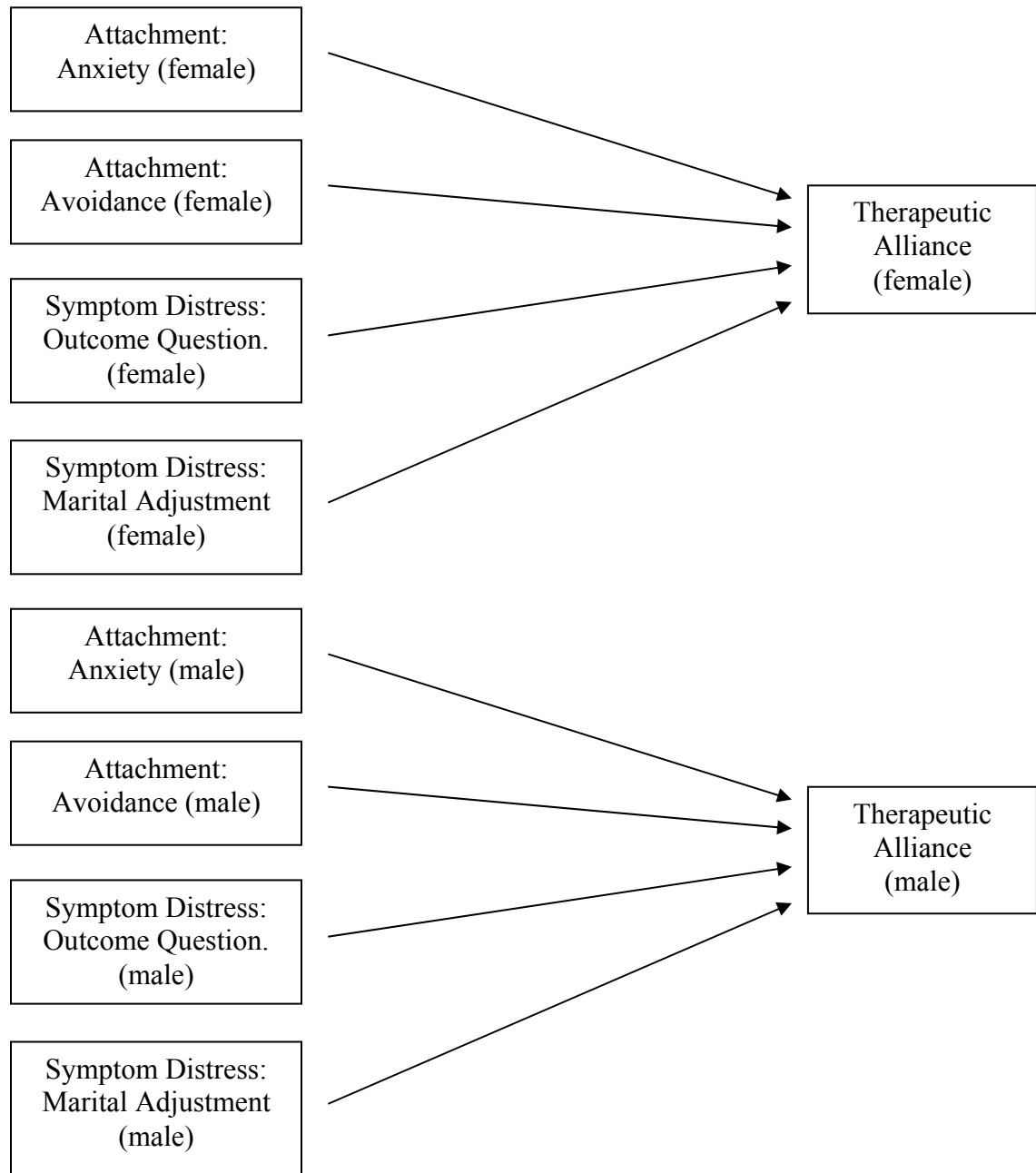
Three hypotheses were tested. The hypotheses of this study were:

1. Client attachment anxiety and avoidance will be significantly negatively associated with therapeutic alliance for both males and females.
2. Client individual symptom distress will not be significantly negatively related to therapeutic alliance for both males and females controlling for client attachment anxiety and avoidance.
3. Client marital adjustment will be significantly positively related to therapeutic alliance for both males and females controlling for client attachment anxiety and avoidance and client individual symptom distress.

To test the first hypothesis, therapeutic alliance (CTAS-R) was regressed on client attachment anxiety/avoidance (ECR) simultaneously for males and their female partners.

To test the second hypothesis, therapeutic alliance (CTAS-R) was regressed on client attachment anxiety/avoidance (ECR) and individual client symptom distress (OQ) simultaneously for males and females. Finally, the third hypothesis was tested by regressing therapeutic alliance (CTAS-R) on client attachment anxiety/avoidance (ECR), individual symptom distress (OQ), and marital adjustment (RDAS) for males and females simultaneously (Figure 1).

Figure 1: Hypothesized path model of attachment, symptom distress, marital adjustment, and the therapeutic alliance for females and males in couple's therapy



In order to assess the linearity of the relationships among the predictors and outcomes, the statistical software, SAS, was used. The data were then fit to three different path models using the statistical software, Mplus. Mplus was selected to fit

these models because of its ability to include participants with missing data, by using full information maximum likelihood (FIML) estimation (Muthen & Muthen, 1998), as well as its ability to fit models containing linked data. In FIML estimation of missing data, observations are sorted into missing data patterns from which parameters are estimated using all available data for that particular parameter (Keiley, 2007).

RESULTS

Univariate Analysis

SAS statistical software was used to analyze participant intake and fourth session data. A univariate analysis was completed to determine both the mean and the standard deviation for all variables used in the study (for both males and females): Anxious, Avoidant, Symptom Distress, Marital Adjustment, and Therapeutic Alliance. It was determined from analyzing the stem-and-leaf displays as well as the normal probability plots that all variables included in the study appear to exhibit symmetric distributions.

T-tests were conducted to determine whether or not there were significant differences between participants who completed fourth session paperwork and those who did not on Time 1 (intake) predictors (Table 5). T-tests indicated that the Anxiety and Avoidant Scales for females as well as the Avoidant Scale for males were not significantly different for those who completed fourth session paperwork and those who did not. T-tests indicated that the Anxiety Scale, OQ, and RDAS for males as well as the OQ and RDAS for females were significantly different for those who completed fourth session paperwork and those who did not. T-test results for both the OQ and RDAS indicated that both males and female who dropped out of the study were significantly more distressed (individual and marital) than those who stayed.

Table 5

N, Mean, standard deviation, and t-test (p-value) values comparing those who completed fourth session paperwork and drop outs

Variable	Male		Female	
	Attrited	Non-attrited	Attrited	Non-attrited
Anxious				
N	105	64	102	69
Mean	3.91	3.54	4.14	4.09
SD	1.37	1.33	1.30	1.12
T-test	1.77 [~] (<i>p</i> =.08)		.29(<i>p</i> =.77)	
Avoidant				
N	105	64	102	69
Mean	2.76	2.64	2.89	2.71
SD	1.01	1.05	1.02	1.07
T-test	.74(<i>p</i> =.46)		1.13(<i>p</i> =.26)	
OQ				
N	101	63	99	69
Mean	1.37	1.18	1.62	1.43
SD	.62	.47	.61	.60
T-test	2.05*(<i>p</i> =.04)		2.01*(<i>p</i> =.05)	
RDAS				
N	103	63	100	69
Mean	3.90	4.09	3.65	3.91
SD	.74	.65	.75	.69
T-test	-1.64 [~] (<i>p</i> =.10)		-2.31*(<i>p</i> =.02)	

[~]*p*<.10, * *p*<.05
Path Analysis

A series of path models were fit in Mplus to address the hypotheses of this study. In the first model, therapeutic alliance was regressed on attachment anxiety and avoidance simultaneously for both males and females. In the second model, therapeutic alliance was regressed on individual symptom distress controlling for attachment anxiety and avoidance for males and females simultaneously. In the third model, therapeutic alliance was regressed on marital adjustment controlling for individual symptom distress, anxiety, and avoidance simultaneously for males and females.

Before model results were examined, fit indices were inspected for the three models to determine model fitness. The fit indices examined were the Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), Chi-square (χ^2) with its degrees of freedom (df) and p-value, as well as the Root Mean Square Error of Approximation (RMSEA) and its associated p-value. The CFI, TLI, and RMSEA were 1.00, 1.19, and 0.00($p=.81$) respectively for model one and indicate a good model fit. Model two also exhibits good model fit with a CFI, TLI, and RMSEA of 1.00, 1.27, and 0.00($p=.93$) respectively. Results of the CFI, TLI, and RMSEA (1.00, 1.03, 0.00($p=.77$)) for model three also indicate a good model fit. All of the examined fit indices for the three models can be found in Table 4.

Table 6
Fit statistics for models of regressions fit in Mplus (N=188)

Model	N	CFI	TLI	χ^2	df (p-value)	RMSEA (p-value)
1. Therapeutic Alliance on Anxiety and Avoidance	184	1.00	1.19	2.45	4 (p=.65)	0.00 (p=.81)
2. Therapeutic Alliance on Anxiety, Avoidance, and Individual Symptom Distress	188	1.00	1.27	2.97	6 (p=.81)	0.00 (p=.93)
3. Therapeutic Alliance on Anxiety, Avoidance, Individuals Symptom Distress, and Marital Adjustment	188	1.00	1.03	7.40	8 (p=.49)	0.00 (p=.77)

* $p < .05$

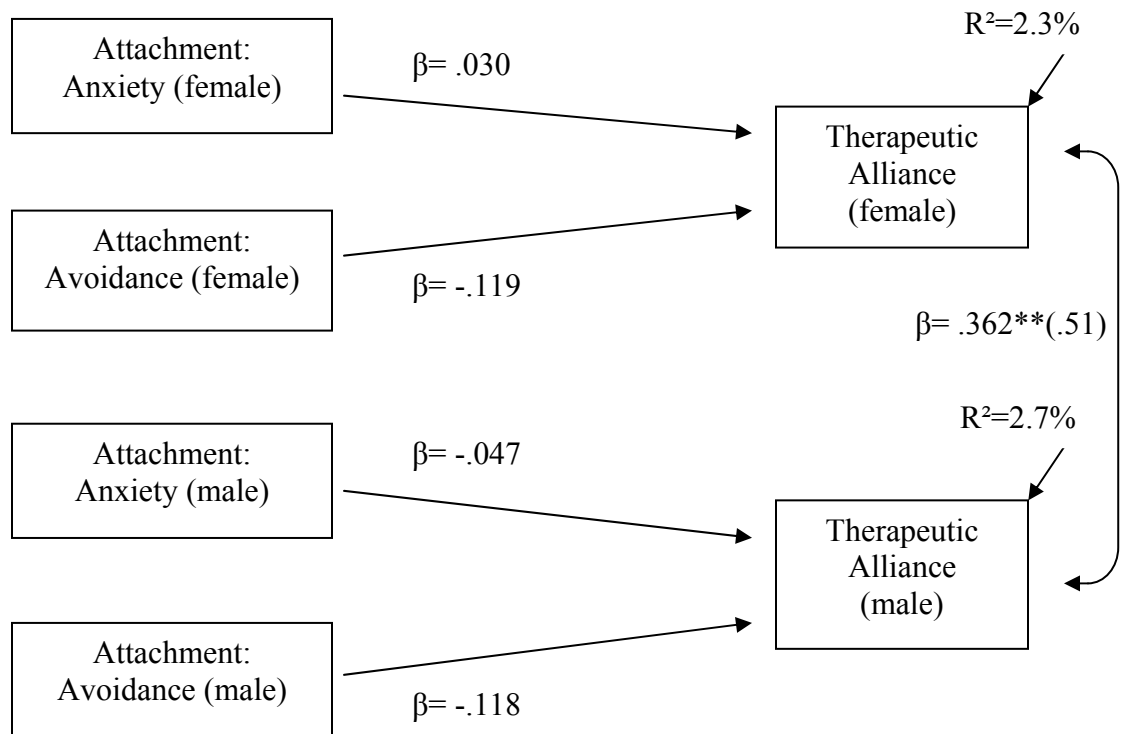
Hypothesis 1

The first hypothesis posited that client attachment anxiety and avoidance would be significantly negatively associated with therapeutic alliance for both males and females. To test this hypothesis therapeutic alliance was regressed on attachment anxiety and avoidance simultaneously for both males and females (Figure 3). Results from this model indicate that a significant relationship does not exist between attachment anxiety and therapeutic alliance for males and females. Similarly the relationship between attachment avoidance and therapeutic alliance was found to be non-significant for both males and females.

Female attachment anxiety and avoidance accounted for 2.3 percent of the variance in female reported therapeutic alliance. Male attachment anxiety and avoidance accounted for 2.7 percent of the variance in male reported therapeutic alliance. Female

and male therapeutic alliance were found to be highly significantly related ($\beta = .362$, $p < .01$). Thus, at high levels of male therapeutic alliance, there are high levels of female therapeutic alliance and vice versa, controlling for all else in the model.

Figure 2: Path model of non-standardized parameter estimates of attachment anxiety and avoidance and the therapeutic alliance for females and males in couple's therapy (Model 1)



** $p < .01$

Note: Estimates in parenthesis are correlations

Hypothesis 2

The second hypothesis posited that client individual symptom distress would not be significantly negatively related to therapeutic alliance for both males and females controlling for client attachment anxiety and avoidance. To test this hypothesis therapeutic alliance was regressed on anxiety, avoidance, and individual symptom distress simultaneously for both males and females (Figure 4). The inclusion of

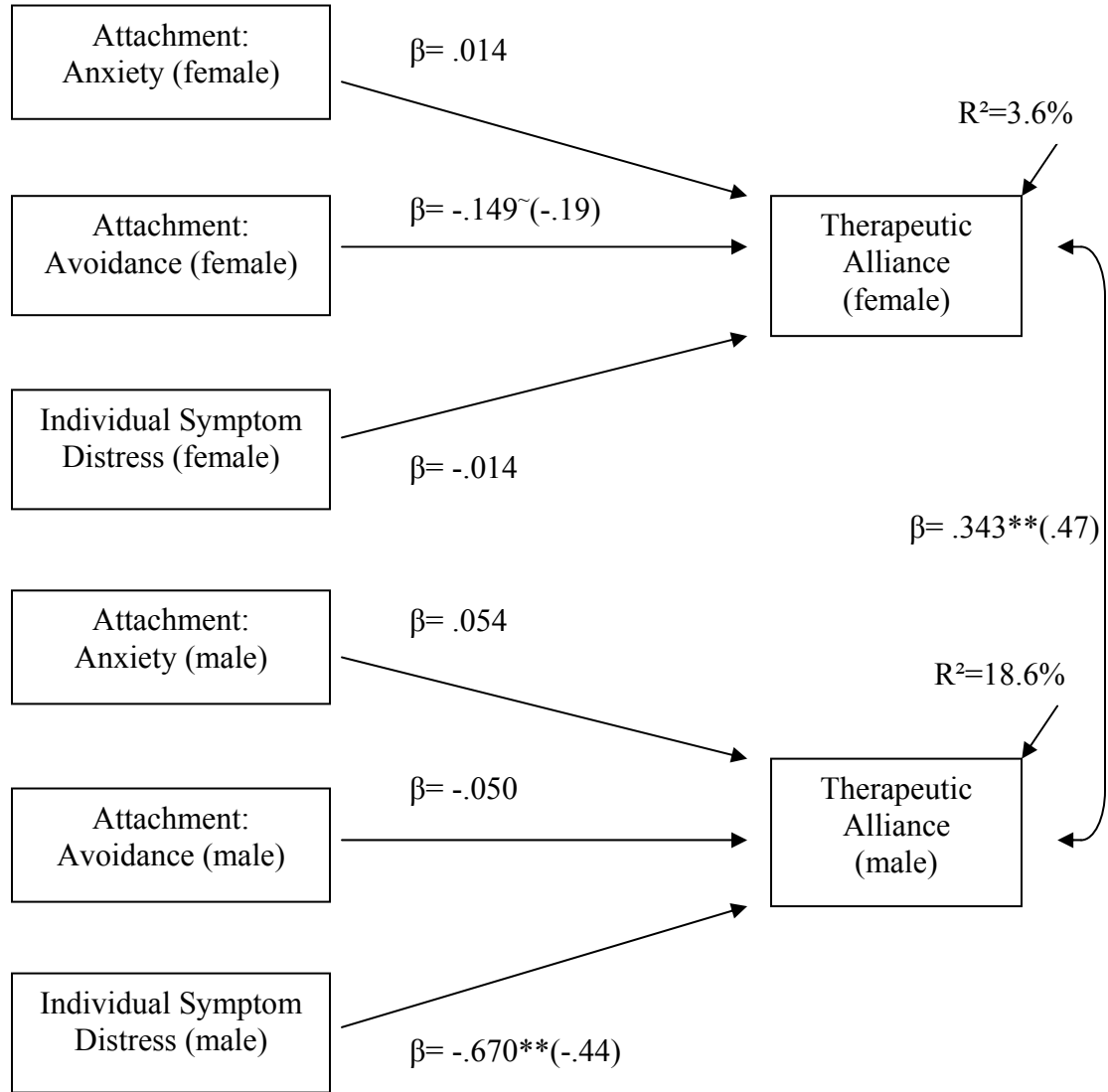
individual symptom distress as a predictor variable in the model yielded different results for females and males. Individual symptom distress was not significantly related to therapeutic alliance for females, controlling for anxiety and avoidance and all else in the model. In contrast, a significant negative relationship existed between individual symptom distress and therapeutic alliance for males ($\beta = -.670, p < .01$), controlling for male attachment anxiety and avoidance and all else in the model. On average, high levels of male symptom distress, are associated with low levels of therapeutic alliance for males and vice versa. Thus, for a one unit difference in male symptom distress, there is a $-.67$ difference in male therapeutic alliance controlling for all else in the model.

The inclusion of symptom distress in the model resulted in a marginally significant negative relationship between female attachment avoidance and therapeutic alliance ($\beta = -.149, p < .10$), controlling for female anxiety and individual symptom distress. On average, high levels of female avoidance, are associated with low levels of therapy alliance for females and vice versa. For a one unit difference in female avoidance, there is a $-.149$ difference in female therapeutic alliance, controlling for all else in the model. Female anxiety was not significantly related to therapeutic alliance. Male anxiety and avoidance were also found not to be significantly related to therapeutic alliance, controlling for all else in the model.

Female attachment anxiety, avoidance, and individual symptom distress accounted for 3.6 percent of the variance in female reported therapeutic alliance. Male attachment anxiety, avoidance, and individual symptom distress accounted for 18.6 percent of the variance in male reported therapeutic alliance. Female and male therapeutic alliance were found to be highly significantly related ($\beta = .343, p < .01$). Thus,

at high levels of male therapeutic alliance, there are high levels of female therapeutic alliance and vice versa, controlling for all else in the model.

Figure 3: Path model of non-standardized parameter estimates of attachment anxiety and avoidance, individual symptom distress, and the therapeutic alliance for females and males in couple's therapy (Model 2)



$\sim p < .10$, $**p < .01$

Note: Estimates in parenthesis are correlations

Hypothesis 3

The third hypothesis stated that client marital adjustment will be significantly positively related to therapeutic alliance simultaneously for both males and females

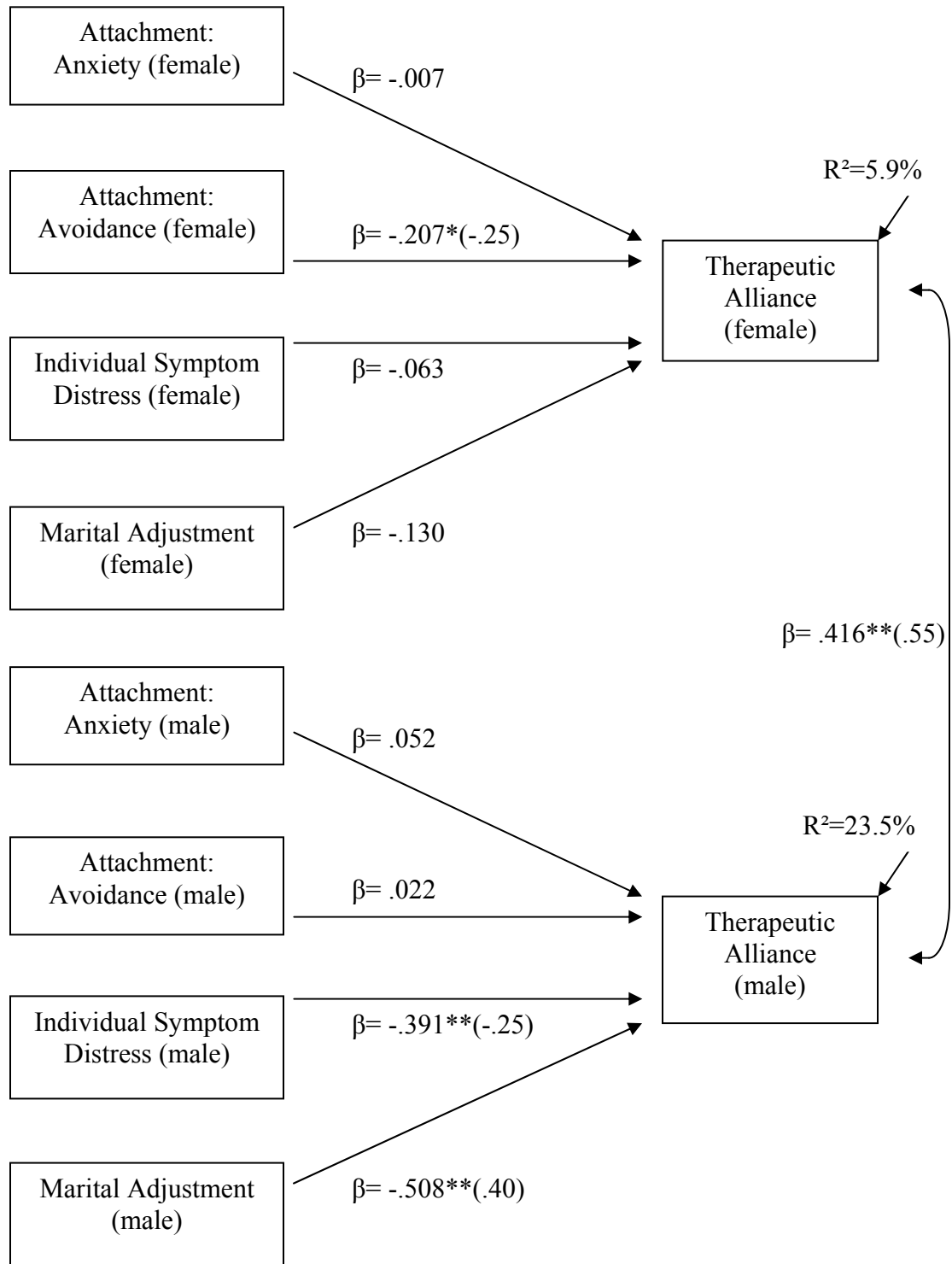
controlling for client attachment anxiety and avoidance and client individual symptom distress. A model regressing therapeutic alliance on anxiety, avoidance, individual symptom distress, and marital adjustment for both males and females simultaneously was fit to test this hypothesis. Similar to the differential effect that the inclusion of individual symptom distress had for males and females in model two, the inclusion of marital adjustment in model three also had different effects for males and females. Marital adjustment was not significantly related to therapeutic alliance for females. In contrast, there was a significant negative relationship between marital adjustment and therapeutic alliance for males ($\beta = -.508, p < .01$), controlling for all else in the model. On average, high levels of marital adjustment, are related to low levels of therapeutic alliance for males and vice versa, controlling for all else in the model. Thus, for a one unit difference in male marital adjustment, there is a $-.508$ difference in male therapeutic alliance controlling for all else in the model.

The inclusion of marital adjustment in the model resulted in a significant negative relationship between female attachment avoidance and therapeutic alliance ($\beta = -.207, p < .05$), controlling for all else in the model. On average, at high levels of female avoidance, there are low levels of therapeutic alliance and vice versa. For a one unit difference in female avoidance, there is a $-.207$ difference in female therapeutic alliance, controlling for all else in the model. Female anxiety, female individual symptom distress, and female marital adjustment were not found to be significantly related to female therapeutic alliance, controlling for all else in the model. A significant negative relationship was found to exist between individual symptom distress and therapeutic alliance for males ($\beta = -.391, p < .01$), controlling for all else in the model. On average, at

high levels of male individual symptom distress, are associated with low levels of therapeutic alliance and vice versa. Thus for a one unit difference in male individual symptom distress, there is a -.391 difference in male therapeutic alliance, controlling for all else in the model. Male anxiety and avoidance were not found to be significantly related to male therapeutic alliance, controlling for all else in the model.

Female anxiety, avoidance, individual symptom distress, and marital adjustment accounted for 5.9 percent of the variance in female reported therapeutic alliance. Male attachment anxiety, avoidance, individual symptom distress, and marital adjustment accounted for 18.6 percent of the variance in male reported therapeutic alliance. Female and male therapeutic alliance were found to be highly significantly related ($\beta = .416$, $p < .01$). Thus, at high levels of male therapeutic alliance, there are high levels of female therapeutic alliance and vice versa, controlling for all else in the model.

Figure 4: Path model of non-standardized parameter estimates of attachment anxiety and avoidance, individual symptom distress, marital adjustment and the therapeutic alliance for females and males in couple's therapy (Model 3)



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

Note: Estimates in parenthesis are correlations

DISCUSSION

This study examined the relationship between anxiety, avoidance, symptom distress, and marital adjustment and the therapeutic alliance in couple's therapy. Based on existing research and recommendations to examine more fully the precursors to the therapy alliance it was hypothesized that: 1. Client attachment, as measured by avoidance and anxiety, will be negatively related to the therapeutic alliance in couple's therapy, controlling for all else in the model. 2. Client symptom distress will be negatively related to the therapeutic alliance, controlling for all else in the model. 3. Client marital adjustment will be positively related to the therapeutic alliance, controlling for all else in the model.

Summary of Results

Hypothesis 1: Client attachment, as measured by avoidance and anxiety, will be negatively related to the therapeutic alliance in couple's therapy, controlling for all else in the model. Results from model 1 indicate that the first hypothesis was not supported; however, model 2 and model 3 results lend partial support to this hypothesis. Neither anxiety nor avoidance were significantly related to therapeutic alliance for men and women, controlling for all else in the model. In other words, client's pretreatment level of anxiety and/or avoidance was not significantly related to therapy alliance at session 4. This was surprising, due to multiple findings that suggest that individuals with high anxiety or avoidance tend to have a lower therapeutic alliance (Satterfield & Lyddon, 1998; Mallinckrodt, Porter, & Kivlighan, 2005; Eames & Roth, 2000). It may be

possible that the relationship between male and female anxiety and avoidance and the therapeutic alliance is moderated by some other variable. Perhaps client attachment is not directly related to therapeutic alliance but its effect may be moderated by some other variable such as individual or marital symptoms.

In support of the first hypothesis female avoidance was significantly, negatively associated with therapeutic alliance, when controlling for symptom distress (Model 2) or symptom distress and marital adjustment (Model 3). In other words, when the relationship between symptom distress and therapeutic alliance as well as the relationship between symptom distress, marital adjustment, and therapeutic alliance are held constant there is a significant, negative relationship between female avoidance and therapeutic alliance. When removing the effect of pre-therapy symptoms, female avoidance is significantly, negatively related to therapeutic alliance. Over and above symptom distress, females who are avoidant have low therapy alliance and vice versa.

Examination of the univariate statistics indicate that males and females that attrited from the study had higher levels of both anxiety and avoidance than those who did not attrit. T-tests were conducted to determine whether there were significant differences between those that attrited and those that did not. T-tests results indicated that male and female avoidance as well as female anxiety did not differ significantly. The t-test for male anxiety was marginally significant, indicating that males who dropped out were significantly more anxious than those who did not attrit.

As mentioned earlier in the review of literature, Mallinckrodt et al. (2005) found that adult attachment Anxiety and Avoidance were positively associated with Avoidant-Fearful attachment to therapist. Adult attachment anxiety was significantly negatively

associated with the Tasks and Goals subscales, but not the Bond subscale. These results led them to hypothesize that highly anxious clients may find it more difficult to agree on the direction of therapy than forming an emotional bond with the therapist. The use of various measures of the therapeutic alliance, observational methods, and multiple measurements of the alliance over the course of therapy may aid in gaining a greater understanding of the alliance and its precursors in futures studies.

Hypothesis 2: Client symptom distress will be negatively related to the therapeutic alliance, controlling for all else in the model. Results from models 2 and 3 lend partial support to the second hypothesis. There was a significant negative relationship between symptom distress and the therapeutic alliance for males, but no significant relationship was found for females, controlling for attachment. Males entering therapy at high levels of symptom distress at intake, have low levels of therapy alliance at session 4 and vice versa. For females, level of symptom distress at intake is not related to therapeutic alliance at session 4, controlling for attachment. These results reflect findings within the individual psychotherapy literature, in which some have found that symptom distress is negatively related to therapeutic alliance (Constantino et al., 2005; Eaton et al., 1988; Raue et al., 1993), while others have found that there is not a significant relationship at all (Connolly Gibbons, et al., 2003; Santiago et al., 2002).

Interestingly, the current study found a significant, negative relationship between male symptom distress and therapeutic alliance, controlling for attachment, while two previous studies examining the same relationship in couple's therapy, did not find a significant relationship (Knobloch-Fedders et al., 2004; Mamodhousen et al., 2005). These findings do not support Knobloch-Fedders et al.'s (2004) hypothesis that, "Perhaps

because individual symptoms may not be the specific focus of treatment in conjoint therapy, they are not relevant predictors of alliance formation in this treatment context” (p.438). If Knobloch-Fedders et al.’s (2004) hypothesis does not hold true for males in couple’s therapy, what may account for the reason why male symptom distress is negatively related to therapeutic alliance, controlling for attachment? It may be that males who come to therapy with high levels of anxiety and depression (symptom distress) are not very willing to accept help and join with a therapist. It may mean that males with low levels of anxiety and depression at intake are more willing to open up and join with a therapist in couple’s therapy. Limitations of the statistical analysis used by both Knobloch-Fedders et al. (2004) and Mamodhousen et al. (2005), may also be a reason for the difference in findings. According to the assumption of independence, couple’s, or linked data, requires simultaneous analysis in the same model. This study fit data to a path model, allowing for the data for males and females in each couple to be analyzed simultaneously in the same model, thus not violating the assumption of independence.

Study results indicating that female symptom distress is not related to therapeutic alliance, controlling for all else in model 2 and 3, is confirmatory of prior studies that have found that symptom distress was not related to therapeutic alliance in couple’s therapy (Knobloch-Fedders et al., 2004; Mamodhousen et al., 2005). For some reason pre-treatment symptomatology is not a significant predictor of therapeutic alliance for females. Females clients may be more motivated for change in conjoint treatment. Perhaps females’ desire to engage in the therapeutic process mediates the relationship between pre-treatment symptoms and the therapeutic alliance.

Examination of the univariate statistics indicate that males and females that attrited from the study had higher levels of symptom distress than those who did not attrit. T-tests results indicated that males and females who attrited were significantly more distressed than those who did not. Results of the study should be interpreted with caution as both men and women who did not continue through session 4, and therefore did not complete the therapeutic alliance measure, experienced significantly higher levels of symptom distress than those who completed fourth session measures.

Model 1 (which includes anxiety and avoidance) explains 2.3% of the variance in therapeutic alliance for females and 2.7% of the variance for males. With the addition of symptom distress in model 2 (which includes anxiety, avoidance, and symptom distress), 3.6% of the variance in therapeutic alliance is explained for females while 18.6% of the variance is explained for males. This indicates that anxiety, avoidance, and symptom distress are poor predictors of therapeutic alliance for females, while the addition of symptom distress greatly increased the amount of variance in therapeutic alliance explained for males.

Hypothesis 3: Client marital adjustment will be positively related to the therapeutic alliance, controlling for all else in the model. Results from this study do not support hypothesis 3. A significant, positive relationship was found between male marital adjustment and therapeutic alliance, while no significant relationship was found for females, controlling for attachment and individual distress. Males who enter therapy with high levels of marital adjustment (marital satisfaction), have high levels of therapeutic alliance at session 4 and vice versa, controlling for attachment and individual

distress. Level of marital adjustment at intake is not significantly related to therapeutic alliance for females, controlling for attachment and individual distress.

Previous studies have found that marital adjustment is not significantly related to symptom distress, but a recent study by Mamodhousen et al. (2005) found that there is a significant, negative relationship between marital adjustment and therapeutic alliance for both males and females. While finding a significant relationship between marital adjustment and therapeutic alliance for males, results are contrary to those found by Mamodhousen et al. (2005). One explanation for the results found in the current study is that males who are satisfied with their marital relationship at intake, may not be customers for change, thus may have less motivation to form a good alliance with their therapists. Another explanation may be that males who experience high levels of marital satisfaction are resistant to receiving outside help (e.g. therapist), leading to lower quality of therapeutic alliance. In addition, the differences in methodology may be yet another reason why findings were not similar. This study was fit to a single path model, allowing for both male and female couple's data to be analyzed simultaneously in the same model.

Consistent with prior findings by Knobloch-Fedders et al. (2004), female marital adjustment at intake was not significantly related to early therapeutic alliance controlling for all else in model 3. Despite not finding a significant relationship between marital adjustment at intake and therapy alliance after session 1, Knobloch-Fedders et al. (2004) reported a significant negative relationship between male's marital distress at intake and therapy alliance after session 8. Knobloch-Fedders et al. (2004) suggested that the influence of client marital distress at intake may be significant in mid-treatment. Future studies including multiple measures of the therapeutic alliance over the course of therapy

may be able to test this hypothesis. Why is marital adjustment a significant predictor for males and not for females? As was stated in the discussion of why female symptom distress was not significantly related to therapeutic alliance, females may enter therapy with a higher motivation for change than do males. This higher motivation may mediate the relationship between female marital adjustment and therapeutic alliance.

Examination of the univariate statistics indicate that males and females that attrited from the study had lower levels of marital adjustment than those who did not attrit. T-tests results indicated that males and females who attrited had significantly lower levels of marital adjustment than those who did not. Results of this study should be interpreted with caution as both men and women who did not continue through session 4, and therefore did not complete the therapeutic alliance measure, experienced significantly lower levels of marital adjustment than those who completed fourth session measures. This significant difference between attriters and non-attriters may not allow for an accurate examination of the relationship between individuals with low levels of marital adjustment and their associated therapeutic alliance.

While model 2 (which includes anxiety, avoidance, and symptom distress) explains 3.6% of the variance in therapeutic alliance for females and 18.6% of the variance for males, model 3, with the addition of marital adjustment, explains 5.9% of the variance in therapeutic alliance for females and 23.5% of the variance for males. It is clear from these results that these predictors are not predicting much of the variance in therapeutic alliance for females.

One of the most interesting findings of this study is the relationship between male symptom distress and therapeutic alliance as well as the relationship between male

marital adjustment and therapeutic alliance. The results found in the final model (Model 3) illustrate the incongruous relationship between individual symptoms, marital adjustment, and therapeutic alliance for males. Both well adjusted males and males with high levels of individual symptoms report low levels of therapeutic alliance. In examining the Pearson Correlation Coefficients (Appendix A), there appears to be a negative correlation between male symptom distress and male marital adjustment. Since correlations were not included in the final model (Model 3), definitive conclusions cannot be made, however future studies should examine the intra-gender as well as the inter-gender correlations between predictor variables included in this model. An examination of predictor correlations may allow researchers to answer such questions as: Are males who report high levels of individual symptoms more or less likely to have high levels of marital adjustment, and vice versa? An understanding of how male symptom distress and male marital adjustment interact would aid therapists as they seek to understand the effect that these pre-treatment client variables have on the therapeutic alliance. Greater understanding would hopefully help therapists devise strategies to better foster the therapeutic alliance with clients identified as higher risk for as poor therapeutic alliance.

Another interesting finding is that the only predictor for female therapeutic alliance was avoidant tendencies, controlling for all else in the model. And, avoidance only predicted 6% of the variance of therapeutic alliance. This indicates that more research needs to be done exploring the predictors of female therapeutic alliance. An examination of other pre-treatment client characteristics such as female expressivity, investment in marriage, as well as motivation to change may yield more significant findings in the pursuit of understanding predictors to female therapeutic alliance. It is

also possible that variables, such individual symptoms or marital adjustment, may mediate the relationship between female attachment and therapeutic alliance. As was suggested previously, future studies should examine correlations between predictors to gain a greater understanding of their interactions.

Limitations

One major limitation of this study was its reliance on self-report measures. Previous studies have shown that the CTAS-R has yielded fairly high alliance ratings (Bourgeois et al., 1990; Pinsof & Catherall, 1986), which makes it hard to differentiate between individuals with low alliance and those with high alliance ratings. The self-report measures used in this study are susceptible to center paperwork non-compliance. Participants may not complete measures and therapists may not administer measures conforming to paperwork protocol. Additionally, at any time clients may decide to discontinue therapy, resulting in a smaller sample size. Measures were also administered at two different time points. The ECR, OQ, and RDAS were administered at intake, while the CTAS-R was administered after the fourth therapy session. The difference in time of measurement may influence data through client responses as well as increased number of study attriters.

Another limitation was the study's sampling technique. The sample was a convenience sample taken from a university marriage and family therapy clinic at a large Southeastern university. Since random sampling was not employed, it is not possible to generalize study findings to a larger population. The sample was also constrained by its relatively small sample size, which may limit its ability to detect significant relationships among variables. The sample was fairly homogenous with regard to ethnicity with

European-American representing 80% of the sample for both male and female participants, and therefore may not represent the experience of other ethnic groups. This study only included heterosexual couples, which may not reflect the experiences of homosexual couples.

Study Strengths

Despite the limitations previously discussed, the study also exhibited many strengths. Unlike two previous studies that investigated the relationship between individual symptom distress, marital adjustment, and therapeutic alliance (Knobloch-Fedders et al., 2004; Mamodhoussen et al., 2005) this study fit male and female linked couple data in a simultaneously fit path model. Data across gender were able to be examined and trusted since male and female data were fit in the same model.

Another strength of this study was its utilization of FIML estimation. Since a clinical sample was used in this study, there was a rather high rate of attrition between the first and fourth sessions for couples who began treatment. Applying FIML estimation of missing data to this study's sample, observations were sorted into missing data patterns from which parameters were estimated using all available data for that particular parameter (Keiley, 2007). Of the 195 potential couples to be included in this study, only 7 couples were excluded from the final sample because they were missing all data on all variables included in this study.

Implications and Benefits of Research Findings

This study builds on previous studies that have looked at the relationship between client pre-treatment variables and the therapeutic alliance for both males in females in couples' therapy. The results of this study suggest that only a small amount of the

variance in the early therapeutic alliance is actually predicted by anxiety, avoidance, symptom distress, and marital adjustment for females in couples' therapy (5.9%). While only explaining minimal variance in therapeutic alliance for females, these predictors account for nearly a quarter (23.5%) of the variance in therapy alliance for males. Males with high levels of pre-treatment symptom distress at intake have low levels of therapy alliance at session 4 and vice versa. Males that report high pre-treatment levels of marital adjustment (marital satisfaction), have high levels of therapeutic alliance at session 4 and vice versa.

With the exception of a marginally significant relationship between female anxiety and therapeutic alliance (when controlling for male and female avoidance, symptom distress, and marital adjustment), this study's findings suggests that there is not a significant relationship between attachment anxiety and avoidance and therapeutic alliance. Additionally this study also found that female symptom distress, as well as female marital adjustment, was not significantly related to therapeutic alliance.

Regardless of this lack of significant findings, attachment, female symptom distress, and female marital adjustment may still play an important role in the development of the therapeutic alliance, and must not be ignored. The identification of these and other predictors that are associated with a poor therapeutic alliance early in therapy may help clinicians to better identify individuals at risk of forming a poor alliance and allow them to adjust therapy to help maximize the potential of having a good alliance with clients.

Results from this study indicate that males with high levels of symptom distress have low levels of therapeutic alliance. In a related finding, males with high levels of symptom distress are also more likely to discontinue therapy. Study results also indicate

that males with high marital adjustment have low levels of therapeutic alliance. Males with low levels of marital satisfaction are also more likely to drop out of therapy. A knowledge of these relationship may allow clinicians the opportunity to adjust early intervention strategies to build a strong therapeutic alliance with these clients. Therapists should be mindful of the risk that symptomatic males have to the therapeutic alliance. Therapists may need to devote additional time and energy to understanding the experience of their male clients and to engage them in the therapeutic process. While the examination of interventions was not included within the scope of this study, clinicians would benefit from future studies investigating the effects of specific interventions with clients exhibiting high levels of marital satisfaction, symptom distress, and anxiety.

Future Research

Factors that contribute to females' therapeutic alliance are largely unknown. Pre-treatment anxiety, avoidance, symptom distress, and marital adjustment explain only 5.9% of the variance in female therapeutic alliance, while the same pre-treatment variables account for 23.5% of the variance in therapeutic alliance for males. Are there other pre-treatment client characteristics that better predict therapeutic alliance for females, or is it some aspect of the therapeutic relationship between the first and fourth session that accounts for the residual variance? Some pre-treatment female characteristics that may be better predictors of the therapeutic alliance may include expressivity, investment in marriage, and motivation to change. Future studies examining the relationship between the aforementioned pre-treatment variables and therapeutic alliance may provide greater insight into predictors that contribute to the therapeutic alliance for females. On the other hand, it could be that pre-treatment client

factors are not very important in the development of the therapeutic alliance for females, but that aspects of the process of therapy between session 1 and 4 may be more predictive of the alliance.

It would be beneficial for future studies to measure therapy alliance over time. Eames and Roth (2000) found that client pre-treatment attachment may have more of an effect on the therapeutic alliance over time. Especially since this study found only one significant relationship between client attachment and therapeutic alliance at session four (female avoidance was negatively related to therapeutic alliance controlling for symptom distress and marital adjustment), the inclusion of measurements of alliance over time would enhance clinicians understanding of client attachment so that they could be “more alert to threats to the alliance, more sensitive to the form that these threats might take, and less likely to respond in a countertherapeutic manner which confirms client expectancies” (Eames & Roth, 2000; p. 431). Multiple data points would be helpful in determining the stability of the alliance and the influence of client pre-treatment variables over time.

Since one of the major limitations of this study was its reliance on client self-report measures, future studies should consider using observational methods of data collection of the therapeutic alliance. Therapist and/or observer rated measures of the therapeutic alliance would also help to gain a more complete understanding of the multifaceted aspects of the therapeutic alliance.

Conclusion

Notwithstanding the emergence of studies that have examined the relationships between client attachment, symptom distress, and marital adjustment and the therapeutic alliance, this study was the first to include these predictors in a single path model. By

fitting these predictors into a single model for both males and females, it allowed us to examine the relationship between individual predictors (anxiety, avoidance, symptom distress, and marital adjustment), controlling for all else in the model. The findings from this study have significant application to therapists working with couples. Findings suggest that males that enter therapy with high level of individual symptoms tend to have low levels of therapeutic alliance. Interestingly, males who are well adjusted in their relationship also report low levels of therapeutic alliance. The identification of these client attributes in males may be essential for therapists, in their attempts to both retain males as clients and strengthen the therapeutic alliance. Explaining a total of 5.9% of the variance in the final model, female anxiety, symptom distress, and marital adjustment were not good predictors of the therapeutic alliance. Future studies should examine other predictors such as expressivity, investment in marriage, and motivation to change to attempt to explain more of the variance in female therapeutic alliance. Moderating variables may also account for non-significant findings of this study.

REFERENCES

- Ainsworth, M. D. S. (1989). Attachment beyond infancy. *American Psychologist, 44*, 709-716.
- American Psychiatric Association, (1987). *Diagnostic and Statistical Manual of Mental Disorders* (Rev. 3rd ed.). Washington, DC: Author.
- American Psychiatric Association, (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Arbona, C., & Power, T. G. (2003). Parental attachment, self-esteem, and antisocial behaviors among African-American, European-American, and Mexican-American adolescents. *Journal of Counseling Psychology, 50*, 40-51.
- Azrin, N., Naster, B., & Jones, R. (1973). Reciprocity counseling: A rapid learning based procedure for marital counseling. *Behavior Research and Therapy, 11*, 365-382.
- Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226-244.
- Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182.
- Bedi, R. B., Davis, M. D., & Williams, M. (2005). Critical incidents in the formation of the therapeutic alliance from the client's perspective. *Psychotherapy: Theory, Research, Practice, Training, 42*, 311-323.

- Bourgeois, L., Sabourin, S., & Wright, J. (1990). Predictive validity of therapeutic alliance in group marital therapy. *Journal of Consulting and Clinical Psychology*, 58, 608-613.
- Bowlby, J. (1969). *Attachment and Loss: Vol. I. Attachment*. New York: Basic Books.
- Bowlby, J. (1973). *Attachment and Loss: Vol. II. Separation-anxiety and anger*. London: Hogarth Press.
- Bowlby, J. (1980). *Loss, sadness & depression: Vol. III. Attachment and loss*. London: Hogarth Press.
- Bowlby, J. (1988). 'Attachment, communication, and the therapeutic process,' in Bowlby, J. *A Secure Base: Clinical Applications of Attachment Theory* (pp. 137-157), London: Routledge, and New York: Basic Books.
- Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York, NY, US: Guilford Press.
- Brown, P. D., & O'Leary, K. D. (2000). Therapeutic alliance: predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology*, 58, 608-613.
- Buist, Dekovic, Meeus, van Aken, M. (2002). Developmental patterns in adolescent attachment to mother, father and sibling. *Journal of Youth and Adolescence*, 31, 167-176.
- Busby, D. M., Crane, D. R., Larson, J. H., & Christensen, C. (1995). A revision of the

- Dyadic Adjustment Scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy*, 21(3), 289–308.
- Connolly Gibbons, M. B., Crits-Christoph, P., de la Cruz, C., Barber, J. P., Siqueland, L., & Gladis, M., (2003). Pretreatment expectations, interpersonal functioning, and symptoms in the prediction of the therapeutic alliance across supportive-expressive psychotherapy and cognitive therapy. *Psychotherapy Research*, 13, 59-76.
- Constantino, M. J., Arnow, B. A., Blasey, C., & Agras, W. S. (2005). The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. *Journal of Consulting and Clinical Psychology*, 73, 203-211.
- Daniel, S. (2006). Adult attachment patterns in individual psychotherapy: A review. *Clinical Psychology Review*, 26, 968-984.
- Derogatis, L. R. (1977). *The SCL-90R Manual I: Scoring, administration, and procedures for the revised version*. Baltimore, MD: Clinical Psychometrics Unit, Johns Hopkins University School of Medicine.
- Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. R., & Covi, I. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science*, 19, 1-15.
- Dew, S. E., & Bickman, L. (2005). Client expectancies about therapy. *Mental Health Services Research*, 7, 21-33.

- Eames, V., & Roth, A. (2000). Patient attachment orientation and the early working alliance—a study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10*, 421-434.
- Eaton, T. T., Abeles, N., & Gutfreud, M. J. (1988). Therapeutic alliance and outcome: Impact of treatment length and pretreatment symptomatology. *Psychotherapy, 25*, 536-542.
- Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. *Journal of Marital and Family Therapy, 9*, 171-180.
- George, C., Kaplan, N., & Main, M. (1985). *An adult attachment interview*. Unpublished manuscript, University of California at Berkeley.
- Goldman, G. A. & Anderson, T. (2007). Quality of object relations and security of attachment as predictors of early therapeutic alliance. *Journal of Counseling Psychology, 54*, 111-117.
- Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples*. New York: Guilford.
- Griffin, D., & Bartholomew, K. (1994). The meta-physics of measurement: The case of adult attachment. In K. Bartholomew & D. Perlman (Eds.), *Advances in personal relationships, attachment processes in adulthood* (Vol. 5, pp. 17-52).
- Hazan, C. & Shaver, P. R. (1994). Attachment as an organizational framework for research on close relationships. *Psychological Inquiry, 5*, 1-27.
- Heppner, P. P., & Peterson, C. H. (1982). The development and implications of a personal problem-solving inventory. *Journal of Counseling Psychology, 29*, 66-75.

- Horvath, A. O., & Greenberg, L. S. (1986). The development of the working alliance inventory. In L. Greenberg & W. Pinsoff (Eds.), *The psychotherapeutic process: A resource handbook* (pp. 529-556). New York: Guilford Press.
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.
- Howard, K. I., Brill, P. L., Lueger, R. J., O'Mahoney, M. T., & Grissom, G. R. (1995). *Integra outpatient tracking assessment*. Philadelphia: Compass Information Services.
- Ilfeld, F. W. (1976). Methodological issues in relating psychiatric symptoms to social stressors. *Psychological Reports, 39*, 1251-1258.
- Johnson, S. M. (1996). *The practice of emotionally focused marital therapy: Creating connection*. New York: Brunner/Mazel.
- Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy, 23*, 135-152.
- Kanninen, K., Salo, J., & Punamaki, R. (2000). Attachment patterns and working alliance in trauma therapy for victims of political violence. *Psychotherapy Research, 10*, 435-449.
- Keiley, M. K. (2007). Multiple-family group intervention for incarcerated adolescents and their families: A pilot project. *Journal of Marital and Family Therapy, 33*, 106-124.

- Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2004). The formation of the therapeutic alliance in couple therapy. *Family Process, 43*(4), 425-442.
- Lambert, M.J., Hansen, N.B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G., Huefner, J.C., & Reisinger, C.W. (1996). *Administration and scoring manual for the Outcome Questionnaire (OQ-45.2)*. Wilmington, DL: American Professional Credentialing Services.
- Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the client attachment to therapist scale. *Journal of Counseling Psychology, 42*, 307-317.
- Mallinckrodt, B., Porter, M. J., & Kivlighan, D. M., Jr. (2005). Client attachment to therapist, depth of in-session exploration, and object relations in brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 42*, 85-100.
- Mamodhousen, S., Wright, J., Tremblay, N., & Poitras-Wright, H. (2005). Impact of marital and psychological distress on therapeutic alliance in couples undergoing couple therapy. *Journal of Marital and Family Therapy, 31*, 159-169.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Counseling Psychology, 68*, 438-450.
- Marziali, E. (1984). Three viewpoints on the therapeutic alliance. *Journal of Nervous and Mental Disease, 172*, 417-423.
- Miller, I. W., Epstein, N. B., Bishop, D. S., & Keitner, G. I. (1985). The McMaster Family Assessment Device: Reliability and validity. *Journal of Marital and Family Therapy, 11*, 345-356.

- Mollica, R., & Caspi-Yavin, Y. (1991). Measuring torture and torture-related symptoms. *Journal of Consulting and Clinical Psychology, 4*, 581-587.
- Muthen, L. K., & Muthen, B. O. (1998). *Mplus user's guide*. Los Angeles: Muthen & Muthen (Website: <http://www.statmodel.com>).
- Patterson, G. R. (1976). Some procedures for assessing changes in marital interaction patterns. *Oregon Research Institute Research Bulletin, 16*(7).
- Pinsof, W. M. (1994). An integrative systems perspective on the therapeutic alliance: Theoretical, clinical, and research implications. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 174-195). New York: Wiley.
- Pinsof, W. M. (1995). *Integrative problem-centered therapy: A synthesis of family, individual, and biological therapies*. New York: Basic Books.
- Pinsof, W. M. (1994). An integrative systems perspective on the therapeutic alliance: Theoretical, clinical, and research implications. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 174-195). New York: Wiley.
- Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple and individual therapy scales. *Journal of Marital and Family Therapy, 12*(2), 137-151.
- Rait, D. S. (2000). The therapeutic alliance in couples and family therapy. *Journal of Clinical Psychology, 56*, 211-224.
- Raue, P. J., Castonguay, L. G., & Goldfried, M. R. (1993). The working alliance: A comparison of two therapies. *Psychotherapy Research, 3*, 197-207.

- Raytec, H. S., McCrady, B. S., Epstein, E. E., & Hirsch, L. S. (1999). Therapeutic alliance and the retention of couples in conjoint alcoholism treatment. *Addictive Behaviors, 24*, 317-330.
- Rice, K. G., FitzGerald, D. P., Whaley, T. J., & Gibbs, C. L. (1995). Cross-sectional and longitudinal examination of attachment, separation-individuation, and college student adjustment. *Journal of Counseling & Development, 73*, 463-474.
- Santiago, N. J., Klein, D. N., Vivian, D., Vocisano, C., Dowling, F., Arnow, B. A., Manber, R., Markowitz, J. C., McCullough, J. P., Riso, L. P. L., Rothbaum, B. O., Rush, A. J., Thase, M. E., & Keller, M. B., (2002). Pretreatment correlates of the therapeutic alliance in the chronically depressed. *Journal of Contemporary Psychotherapy, 32*, 281-289.
- Satterfield, W. A., & Lyddon, W. J. (1998). Client attachment and the working alliance. *Counseling Psychology Quarterly, 11*, 407-415.
- Snyder, K. K. (1997). *Manual for the Marital Satisfaction Inventory—Revised*. Los Angeles: Western Psychological Services.
- Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38*, 15-28.
- Stiles, W. B., & Snow, J. S. (1984a). Counseling session impact as viewed by novice counselors and their clients. *Journal of Counseling Psychology, 31*, 3-12.
- Stiles, W. B., & Snow J. S. (1984b). Dimensions of psychotherapy session impact across sessions and across clients. *British Journal of Clinical Psychology, 23*, 59-63.
- Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment, 1*, 207-210.

Wei, M., Russell, D. W., Mallinckrodt, B., & Vogel, D. L. (2007). The experience in close relationship scale (ecr)-short form: Reliability, validity, and factor structure.

Journal of Personality Assessment, 88(2), 187-204.

Wright, J. (1985). *Survival strategies for couples*. Rochester, NY: Prometheus Press.

APPENDIX A

Pearson Correlation Coefficients for Male and Female Anxiety, Avoidance, Symptom Distress, and Marital Adjustment (Model 3)

Variable	1	2	3	4	5	6	7	8	9	10
1. TA female	1.00									
2. TA male	.54 ^{***}	1.00								
3. Anx female.	-.01	-.11	1.00							
4. Anx male	-.15	-.17	.01	1.00						
5. Avoid female	-.19	-.08	.10	.33 ^{***}	1.00					
6. Avoid male	-.10	-.22 [~]	.45 ^{***}	.08	-.01	1.00				
7. SD female	-.17	-.19	.45 ^{***}	.14	.42 ^{***}	.20 [*]	1.00			
8. SD male	-.22	-.39 [*]	.24 ^{**}	.47 ^{***}	.29 ^{***}	.29 ^{***}	.36 ^{***}	1.00		
9. RDAS female	.06	.36 ^{**}	-.29 ^{***}	-.38 ^{***}	-.46 ^{***}	-.25 ^{***}	-.37 ^{***}	-.30 ^{***}	1.00	
10. RDAS male	-.10	.38 ^{**}	-.21 ^{**}	-.24 ^{**}	-.26 ^{**}	-.31 ^{***}	-.20 [*]	-.23 ^{**}	.60 ^{***}	1.00

[~] $p < .10$, ^{*} $p < .05$, ^{**} $p < .01$, ^{***} $p < .001$

TA=Therapeutic Alliance, Anx=Anxiety, Avoid=Avoidance, SD=Symptom Distress

APPENDIX B

Couple Therapy Alliance Scale (CTAS)

Instructions: The following statements refer to your feelings and thoughts about your therapist and your therapy right NOW. Please work quickly. We are interested in your FIRST impressions. Your ratings are CONFIDENTIAL. They will not be shown to your therapist or other family members and will only be used for research purposes. Although some of the statements appear to be similar or identical, each statement is unique. PLEASE BE SURE TO RATE EACH STATEMENT.

Each statement is followed by a seven-point scale. Please rate the extent to which you agree or disagree with each statement AT THIS TIME. If you completely agree with the statement, circle number 7. If you completely disagree with the statement, circle number 1. Use the numbers in-between to describe variations between the extremes.

	Completely Agree 7	Strongly Agree 6	Agree 5	Neutral 4	Disagree 3	Strongly Disagree 2	Completely Disagree 1
1. The therapist cares about me as a person	7	6	5	4	3	2	1
2. The therapist and I are not in agreement about the goals for this therapy.	7	6	5	4	3	2	1
3. My partner and I help each other in this therapy.	7	6	5	4	3	2	1
4. My partner and I do not feel the same ways about what we want to get out of this therapy.	7	6	5	4	3	2	1
5. I trust the therapist.	7	6	5	4	3	2	1
6. The therapist lacks the skills and ability to help my partner and myself with our relationship.	7	6	5	4	3	2	1
7. My partner feels accepted by the therapist.	7	6	5	4	3	2	1
8. The therapist does not understand the relationship between my partner and myself.	7	6	5	4	3	2	1

- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| 9. The therapist understands my goals in therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 10. The therapist and my partner are not in agreement about the about the goals for this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 11. My partner cares about the therapist as a person. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 12. My partner and I do not feel safe with each other in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 13. My partner and I understand each other's goals for this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 14. The therapist does not understand the goals that my partner and I have for ourselves in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 15. My partner and the therapists are in agreement about the way the therapy is being conducted. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 16. The therapist does not understand me. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 17. The therapist is helping my partner and me with our relationship. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 18. I am not satisfied with the therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 19. My partner and I understand what each of us is doing in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 20. My partner and I do not accept each other in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 21. The therapist understands my partner's goals for this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 22. I do not feel accepted by the therapist. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 23. The therapist and I are in agreement about the way the therapy is being conducted. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 24. The therapist is not helping me. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 25. The therapist is in agreement with the goals that my partner and I have for ourselves as a couple in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 26. The therapist does not care about my partner as a person. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 27. My partner and I are in agreement with each other about the goals of this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |

- | | | | | | | | |
|---|---|---|---|---|---|---|---|
| 28. My partner and I are not in agreement about the things that each of us needs to do in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 29. The therapist has the skills and ability to help me. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 30. The therapist is not helping my partner. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 31. My partner is satisfied with the therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 32. I do not care about the therapist as a person. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 33. The therapist has the skills and ability to help my partner. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 34. My partner and I are not pleased with the things that each of us does in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 35. My partner and I trust each other in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 36. My partner and I distrust the therapist. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 37. The therapist cares about the relationship between my partner and myself. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 38. The therapist does not understand my partner. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 39. My partner and I care about each other in this therapy. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 40. The therapist does not appreciate how important my relationship between my partner and myself is to me. | 7 | 6 | 5 | 4 | 3 | 2 | 1 |

APPENDIX C

Revised Dyadic Adjustment Scale (RDAS)

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occasional Agreement	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Religious matters	5	4	3	2	1	0
2. Demonstrations of affection	5	4	3	2	1	0
3. Making major decisions	5	4	3	2	1	0
4. Sex relations	5	4	3	2	1	0
5. Conventionality (correct or proper behavior)	5	4	3	2	1	0
6. Career decisions	5	4	3	2	1	0
	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
8. How often do you are your partner quarrel?	0	1	2	3	4	5
9. Do you ever regret that you married (or live together)?	0	1	2	3	4	5
10. How often do you and your mate "get	0	1	2	3	4	5

of each other's
nerves”?

	Every Day	Almost Every Day	Occasionally	Rarely	Never
11. Do you and your mate engage in outside interests together?	4	3	2	1	0

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
12. Have a stimulating exchange of ideas	0	1	2	3	4	5
13. Work together on a project	0	1	2	3	4	5
14. Calmly discuss something	0	1	2	3	4	5

APPENDIX D

Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

Never Rarely Sometimes Frequently Almost Always

1. I get along well with others
2. I tire quickly
3. I feel no interest in things
4. I feel stressed at work/school
5. I blame myself for things
6. I feel irritated
7. I feel unhappy in my marriage/significant relationship
8. I have thoughts of ending my life
9. I feel weak.
10. I feel fearful
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”)
12. I find my work/school satisfying
13. I am a happy person.
14. I work/study too much
15. I feel worthless.
16. I am concerned about family troubles
17. I have an unfulfilling sex life.
18. I feel lonely
19. I have frequent arguments.
20. I feel loved and wanted
21. I enjoy my spare time
22. I have difficulty concentrating
23. I feel hopeless about the future
24. I like myself
25. Disturbing thoughts come into my mind that I cannot get rid of
26. I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark “never”)
27. I have an upset stomach
28. I am not working/studying as well as I used to

29. My heart pounds too much
30. I have trouble getting along with friends and close acquaintances
31. I am satisfied with my life

32. I have trouble at work/school because of drinking or drug use (If not applicable, mark never)
33. I feel that something bad is going to happen
34. I have sore muscles
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
36. I feel nervous
37. I feel my love relationships are frill and complete
38. I feel that I am not doing well at work/school
39. I have too many disagreements at work/school
40. I feel something is wrong with my mind
41. I have trouble falling asleep or staying asleep
42. I feel blue
43. I am satisfied with my relationships with others.
44. I feel angry enough at work/school to do something I might regret
45. I have headaches

- _____ 19. I find it relatively easy to get close to my partner.
- _____ 20. Sometimes I feel that I force my partner to show more feeling, more commitment.
- _____ 21. I find it difficult to allow myself to depend on romantic partners.
- _____ 22. I do not often worry about being abandoned.
- _____ 23. I prefer not to be too close to romantic partners.
- _____ 24. If I can't get my partner to show an interest in me, I get upset or angry.
- _____ 25. I tell my partner just about everything.
- _____ 26. I find that my partner(s) don't want to get as close as I would like.
- _____ 27. I usually discuss my problems and concerns with my partner.
- _____ 28. When I'm not involved in a relationship, I feel somewhat anxious and insecure.
- _____ 29. I feel comfortable depending on romantic partners.
- _____ 30. I get frustrated when my partner is not around as much as I would like.
- _____ 31. I don't mind asking romantic partners for comfort, advice, or help.
- _____ 32. I get frustrated if romantic partners are not available when I need them.
- _____ 33. It helps to turn to my romantic partner in times of need.
- _____ 34. When romantic partners disapprove of me, I feel really bad about myself.
- _____ 35. I turn to my partner for many things, including comfort and reassurance.
- _____ 36. I resent it when my partner spends time away from me.