Identifying the association between relationship hopelessness and relationship satisfaction and the moderating role of the therapeutic alliance

by

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Abstract

Relationship satisfaction is a variable highly focused on in relationship literature through attempts to understand its influences and influencers. This study hoped to further contribute to that research by analyzing the influence of hopelessness on relationship satisfaction and the moderating role of the therapeutic alliance for individuals in relationships receiving couples therapy treatment. Past studies established hopelessness as a risk for various negative factors and therapeutic alliance as a positive experience with the potential to intervene in negative factors' influence on the romantic relationship. Archival data collected from the Auburn University Marriage and Family Therapy Center (AUMFTC) was used to test a moderation model of the effects of the interaction of relationship hopelessness and therapeutic alliance on couples' satisfaction in the first four sessions of therapy, assuming that the male's alliance would present more significant in the result. The hierarchical multiple regression produced different results for men and women. For women, the most significant was that hopelessness negatively affected relationship satisfaction. No association existed for these variables with therapeutic alliance for women, nor did the alliance moderate the effects of hopelessness. The interaction of hopelessness and therapeutic alliance did have a significant impact on relationship satisfaction for males. These results demonstrate the critical roles hopelessness and alliance play in therapy and have implications for clinicians and researchers.

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List of Abbreviations

AUMFTC	Auburn University Marriage and Family Therapy Center
CSI	Couple Satisfaction Index
CT	Couples Therapy
CTAS-r	Couple Therapy Alliance Scale-revised
MDI	Major Depression Inventory

Chapter 1: Introduction

Nearly 60% of couples in the United States have experienced some level of distress and dissatisfaction (marital problems, feelings of discouragement and hopelessness about their relationship, experiences of disappointment, doubts about the relationship, etc.) in their romantic relationships, with 12% thinking about divorce regularly and 53% have thought about it at some point in their marriage (Hawkins et al., 2015). Researchers suggest that the most potent predictors of divorce are relationship disappointment and disillusionment encompassing feelings of hopelessness (Buehlman et al., 1992). The overall disillusionment and hopelessness can affect factors within the relationship, such as sexual desire (Brezsnyak & Whisman, 2004) and relationship satisfaction (Murtagh, 2020) as well as personal well-being (Proulx et al., 2007), and mental health, namely depression (Whisman, 2001).

The hopelessness experienced in a relationship may influence the dissatisfaction within the overall relationship. The limited clinical research suggests that hopelessness impacts the desire and the effort to improve the relationship or achieve satisfaction (Marques & Gallagher, 2017; Parker et al., 2015). The findings suggest that more research is needed to understand hopelessness in relationships. While research on relationship hopelessness is limited, there is extensive theory and research surrounding hopelessness in chronic long-term and terminal illness (Fischer et al., 2016; McLean et al., 2007; Nehir et al., 2019) and depression (Hack et al., 2004; McLean et al., 2011) offering supportive findings of the intrinsic nature of hopelessness. Research on terminal and long-term illnesses demonstrated that hopelessness negatively impacted the individual, their relationships, and their quality of life (Buursma et al., 2020; Hack et al., 2004; McLean et al., 2011). Likewise, research on terminal illness suggests that

hopelessness increases the risk for poor adjustment (Northouse et al., 2001) and hastens death (Buursma et al., 2020).

While there is limited research on hopelessness in the clinical literature, there is significant research in the area of hope. Hope, a concept that some believe to be the opposite of hopelessness (McLean, 2011), has received attention in couples therapy. What has been found provides a foundation for potentially understanding hopelessness research. Ward and Wampler (2010) found hope to be a significant component of the couples therapy process when they identified it as "a belief and a feeling that a desired outcome is possible'' (p. 223). The authors emphasized that hope exists on a continuum where that belief or feeling may range from strong to wavering to nonexistent. This definition reveals the importance of possessing hope in committed relationships in which believing in the possibility of seeing relationship improvement, even when previous relationship dynamics may offer a contrary assessment, may be what sustains change (Ward & Wampler, 2010).

However, hope might not be the therapeutic answer to hopelessness. In the case of terminal illness, loved ones using hope for their partner's recovery as a lifeline decreased intimacy. They limited the level of support offered to their dying partner, partially because of the chronicity of the problem (Kissane, 1994). Additionally, hopelessness in the terminally ill is associated with increased depression and suicidality (Pessin et al., 2002). Both symptoms impede hope (Silverman & Berman, 2014; Whisman, 2001). It might be that the chronic problems related to hopelessness require more than instilling hope for change. In couples where one partner has a cancer diagnosis, a sense of hopelessness interrupts the ability to cope with the illness for both partners. Still, marital satisfaction decreases hopelessness associated with the illness (Northouse et al., 2000). Although this research suggests that greater relationship

satisfaction can lessen hopelessness in the face of illness, a gap exists in the literature to know if a reverse effect exists between hopelessness and relationship dissatisfaction.

Long-term relationship dissatisfaction and disillusionment related to the deterioration of a committed relationship demonstrate similar hopelessness symptomology (Miller et al., 2014). Couples therapy (CT) is an effective treatment for those experiencing relationship distress exacerbated by hopelessness (Roddy et al., 2020). CT has improved overall relationship satisfaction, strengthened communication, increased emotional intimacy, and ameliorated partner behavior (Roddy et al., 2020). Within CT, Allan et al. (2019) found that hopelessness decreased for couples when therapists' reflections had a tone of caring that emphasized clients' strengths and positively highlighted their engagement in therapy.

While most couples benefit from participating in CT, research suggests that improvements in couple satisfaction vary, suggesting more attention needs to be given to processes of change that impact relationship improvement (Halford et al., 2016; Pinsof et al., 1996). Within CT, the alliance between the client and therapist is a unique process of change, offering a professional relationship that instills a sense of hope through collaborative efforts to improve the relationship; however, the alliance does more than instill hope (Johnson et al., 2002). The strength of the alliance as a process of change in couples therapy is the focus on collaborating with the couple to establish a professional relationship focused on implementing therapeutic goals and supportive tasks for relationship improvement (Principe et al., 2006). Additionally, developing a therapeutic bond that supports new couple interactions theoretically allows the couple to seek support during crises.

As a mechanism for change, the alliance accounts for 3-10% of the change in couples' relationships (Baldwin et al., 2007; Fluckiger et al., 2012), or 38 to 54% of variance accounted

for by treatment, which is five times greater impact than adherence to a specific model or technique (Duncan & Reese, 2012). The impact of the alliance could be a process of change powerful enough to alter the effects of hopelessness on the relationship. A professional collaborative relationship dedicated to client improvement suggests that the therapeutic alliance has the potential to moderate the negative impact of relationship hopelessness on relationship satisfaction (Ward & Wampler 2010). These correlations with alliance affect men and women differently in couples therapy. Males' alliance is frequently a more significant predictor of change and improved outcomes in therapy (Friedlander et al., 2018; Glebova et al., 2011). The current study seeks to add to the literature examining the association between the therapeutic alliance and relationship satisfaction for couples with varying levels of hopelessness after receiving couples therapy.

While the effects of hope on relationship satisfaction is a critical component of several therapeutic models (Minuchin & Fishman, 1981; Berg & Dolan, 2001), less is known about the role that relationship hopelessness plays with relationship satisfaction. Because the therapeutic alliance is a process of change that influences relationship dynamics, it could be assumed that this professional relationship could moderate changes in hopelessness and relationship satisfaction. Couple therapy is complicated when hope and motivation are low. Suppose a collaborative relationship with the couple is developed related to bonds, tasks, and goals. In that case, the professional relationship can help the couple set goals and work on tasks to improve their relationship satisfaction, moderate hopelessness, and instill emotional connection between the partners (Johnson, 2004), allowing relationship skills to be built (Jacobson & Christenson, 1996). There is a critical need to understand the connection between hopelessness and relationship satisfaction and the potential moderating quality of the therapeutic alliance in that

relationship. Increasing therapeutic attention to dissipating relationship hopelessness could improve relationship satisfaction in the early couple therapy processes.

Chapter 2: Literature Review

This review of current research will first assess what is understood about hopelessness as it relates to physical illness, depression, and suicide. A significant focus on hopelessness for people with a terminal diagnosis is found in the literature, citing that hopelessness can be an added stressor that contributes to morbidity but is buffered by relationship quality (Buursma et al., 2020). Likewise, researchers highlight that hopelessness is related to depression and suicidality, suggesting that poor support relationships and destructive peer relationships augment hopelessness along with depressive symptoms and suicidality. The literature shows that relationships decrease hopelessness with long-term illness, depression, and suicidality. However, research is limited to diminishing hopelessness when the relationship is deteriorating. The third aspect of the literature review will document the effectiveness of CT for improving couple satisfaction and potentially impacting hopelessness (Roddy et al. 2020). Finally, the authors connect the therapeutic alliance, a professional relationship used as a surrogate to heal the failing relationship and potentially moderate the effects of hopelessness on relationship satisfaction. (Halford et al., 2016).

Hopelessness and Physical Illness

Relationship hopelessness research has mainly focused on couples and long-term illness. While dealing with a terminal, long-term, or chronic illness is stressful for anyone; there is particular significance to the distress experienced by couples. One partner's diagnosis and deterioration can challenge the couple's relationship and reflect their hopelessness in the face of change (Kissane et al., 1994; Northouse et al., 2001). Distress in the diagnosed and the caregiving partner has been frequently linked to hopelessness in light of a terminal diagnosis

(Duggleby et al., 2015; McLean et al., 2007; McLean et al., 2011). The effects of this hopelessness are expounded in couples who already experience distress in their family (Kissane et al., 1994; McLean, 2007). Families who are rigid in relationship functioning are unlikely to be able to cope with the daily adjustments that come with a terminal illness and may lose hope more quickly. This is often displayed as anger or grief by loved ones of the dying, including partners (Kissane et al. 1994).

Considering illness from a systemic perspective, there is no doubt that the illness would affect a couple's relationship for better or worse. Research on relationship satisfaction and physical illness reveals a connection between how the patient feels about their illness and how they feel about their partner. This is further exasperated by the couple's uncertainty and unpredictability of physical illness. More than that, however, it was shown that perceptions of partner support were more influential over relationship satisfaction than feelings about the illness (Reich et al., 2006). Like hopelessness, a decreased quality of the marital relationship is detrimental to physical health. For women, relationship dissatisfaction was shown to worsen heart problems (Menchaca & Dehle, 2005) and increase the risk of cardiovascular disease (Gallo et al., 203). For men, higher marital distress led to a higher risk of heart problems (Matthews & Gump, 2002).

The hopelessness felt in couples with a terminal illness may reflect the despair they feel about the terminality of the relationship. Family members of dying patients have demonstrated hopelessness or "psychological morbidity" in their relationships as they face the stress of caregiving for a loved one (Kissane et al. 1994). Couples who feel hopeless about their relationship were more likely to respond to each other in more automated and less empathetic manners, furthering their despair in their relationship (McLean et al. 2007). For some, hope is

lost when partners realize their future together is limited and their partner will die from their illness (Duggleby et al., 2015).

The connection between relationships and hopelessness is significant in physical illness literature because an ill person's perception of social support has been shown to correlate with higher levels of hopelessness. The more someone believes they have support from their social circle (including their partners), the less hopelessness they will experience despite their illness (Buursma et al., 2020). Since higher hopelessness is linked to an increase in mortality, sooner death, and lower quality of life (Buursma et al., 2020; Nehir et al., 2019), the terminally ill partner's feelings of social support could extend the terminally ill partner's life and improve the quality of life (Buursma et al., 2020).

The literature clarifies that relationships matter when partners suffer from a long-term illness. Family members and partners are not spared in the diagnosis and progression of the illness of their loved one (Duggleby et al., 2015; Kissane et al., 1994; McLean et al., 2007; McLean et al., 2011). Moreover, the influence of other supports helps decrease hopelessness for people experiencing illness (Buursma et al., 2020).

McLean et al. (2011) found that hopelessness in patients with a terminal diagnosis led some individuals to develop thoughts of suicidality, whereas others found that those who felt hopeless about their impending death desired a quicker end (Hack et al., 2004; Lo et al., 2013; McLean et al., 2011). Depression, which is commonly correlated with suicidality (Abela, 2009), is linked in the illness literature with hopelessness, suicidality, and longing for death (Hack et al., 2004; Fischer et al., 2016; Mclean et al., 2007; McLean et al., 2001; Nehir et al., 2019).

Hopelessness and depression

Hopelessness and depression are extensively linked in the literature (Abramson et al., 1989; Breitbart et al., 2000; Haeffel et al., 2008; Marsiglia et al., 2011; Whisman, 2001), such that a theory of *hopelessness-depression* has been developed (Abramson et al., 1989; Abramson et al., 2000; Haeffel et al., 2008; Haeffel et al., 2017). Abramson et al. (1989) theorized hopelessness depression to be a subtype of depression caused by a negative outlook on the future combined with a sense of powerlessness in influencing said future. The theory of hopelessness depression has led to research establishing the significant impact of hopelessness on individuals' lives. This theory hypothesizes that hopeless individuals have a "negative outcome expectancy" (Abramson et al., 2000, p. 20)-- not expecting positively anticipated outcomes to occur -- and a "helplessness expectancy" (Abramson et al., 2000, p. 20)--assuming helplessness in the ability to influence change leading to the occurrence of said outcomes (Abramson et al., 2000).

Two more symptoms of this theory are derived from these expectancies. The "motivational symptom" (Abramson et al., 1989, p. 362) comes from feeling helpless, which leads a person to lose motivation to try to effect change in their own life. The "emotional symptom" (Abramson et al., 1989, p. 362) comes from having a negative outlook on the future and expecting that nothing will improve (Abramson et al., 1989). Hopelessness and depression were further connected by research that links both factors to social support. This is significant as social support has been identified as an alleviator of hopelessness (Buursma et al., 2020; Marsiglia et al., 2011), and hopelessness is significantly associated with depression (Marsiglia et al., 2011; Panzarella et al., 2006).

Literature linking hopelessness and depression is most evident in adolescent research. Hopelessness leads adolescents to assume the worst future results and be blinded to their potential for affecting these results (Hamilton et al., 2013). In light of this bleak outlook, it is not

surprising to see depression, anxiety, and suicidality connected to a loss of hope (Abela, 2009; Hamilton et al., 2013; Roeder & Cole, 2018).

For adolescents, these variables are influenced by relationships. Adolescents whose families did not believe in or support them found themselves struggling in their social relationships, which led to the development of social hopelessness (Ciarrochi & Heaven, 2008). Adolescents who experience peer victimization often develop suicide ideation (SI), may attempt suicide, and experience increased hopelessness (Bonanno & Hymel, 2010). Peer victimization becomes much more prevalent for adolescents, by default putting anyone in this stage at risk for suicide. With hopelessness as the leading predictor, when adolescents can no longer bear their suffering and see no pathway out of it, they are more likely to experience SI and attempt suicide (Roeder & Cole, 2018).

One study found that peer victimization is a crucial ingredient for adolescent suffering leading to feelings of social hopelessness and suicidal ideation. However, peer victimization alone did not strongly predict SI, demonstrating just how critical despair associated with hopelessness may be for these young people (Bonanno & Hymel, 2010). Chronic exposure to this negative experience eventually results in more hopeless thought processes (Gibb et al., 2012). Since hopelessness can lead to a low sense of agency in controlling future outcomes (Brozina & Abela, 2006), youth may believe their best will never be good enough, and their influence is meaningless. These negative cognitions will likely culminate in SI (Kashani et al., 1989). The literature on terminal illness or depression exhibits a common theme that hopelessness is linked to despair, poorer support systems, and a desire to end the life experience. All of this yet again shows how *positive* relationships could be lifesaving.

Hopelessness and Relationship disillusionment

The emphasis on relationship satisfaction playing a role in decreasing hopelessness is evident. However, the literature on romantic relationship deterioration and hopelessness needs attention. Limited research has been dedicated to evaluating the processes of change that moderates the effects of hopelessness on relationship deterioration in couples. The role of the therapeutic alliance is a professional relationship process that theoretically buffers hopelessness and increases satisfaction.

Similar to the despair felt with a terminal diagnosis, couples who perceive themselves to have little influence over their relationships demonstrate a decreased motivation to create change (Miller et al., 2014). Partners who have terminally diagnosed the relationship and no longer see a point in advocating for the relationship engage less in behaviors aimed at improving relationship dynamics while simultaneously engaging in harmful acts, such as avoiding and distancing. The partner experiences grief and despair for the relationship deterioration and death when they begin to appraise their relationship negatively. This "affective death" is characterized as an apathetic and fatigued response (Miller et al., 2014). This negative outlook, a central component of the hopelessness theory (Abramson et al., 2000), can be interpreted as a sense of hopelessness about the dying relationship.

Couples Therapy and the Therapeutic Alliance

With the research on the dangers of hopelessness in both physical and mental illness being so clear, it is essential to consider how to alleviate hopelessness and its effects when relationships deteriorate. It is first necessary to acknowledge that hopelessness could decrease motivation toward change (Nehir et al., 2019). Since distress is connected to a sense of hopelessness (Duggleby et al., 2015), if that distress can be challenged by shifting the couple's perception of the illness and its effects, it is possible to decrease their hopelessness and,

therefore, the risks that come along with it (Nehir et al., 2019). Couples therapy focusing on cognition, behaviors, and emotions is an effective tool in managing distress between partners. When therapeutic interventions targeting coping skills and social support are employed with these couples, it can lead to decreased distress and, as a result, decreased hopelessness (Fischer et al., 2016). However, more importantly, the therapeutic relationship is a necessary component in supporting the couple and transitioning clients to relationship-enhancing skills, which means the partners take action.

Scholars have called for theoretically grounded investigations to inform and enhance the effectiveness research (Rauer et al., 2014). Bordin (1979) suggests that the therapeutic alliance is the most effective process of change in therapy. Also known as a working alliance, this is a relationship between someone looking to change and someone who acts as a change agent, in this case, the client and the therapist. This relationship can be valuable in the early phase of therapy (Smith, 2021), as clients and therapists collaborate in developing their goals, objectives, and bonds for treatment (Bordin, 1979).

The therapy alliance is a process of change related to positive outcomes in therapy because the relationship qualities instill hope through a collaborative bond. Likewise, the therapists and clients partner to develop relationship tasks and goals to benefit the couple's relationship satisfaction. The collaborative effort to develop tasks and goals related to relationship improvement should decrease the disillusionment experienced within the couple's relationship and increase the hope for sustained positive behaviors within the relationship (Bordin, 1979). Clients who experience the therapist as a positive influence increase receptivity to the therapy process and the professional support (Bordin, 1979). The alliance influences the therapist's guiding each partner toward tasks and goals that establish relationship satisfaction.

This alliance quality could moderate the relationship between hopelessness at intake and change in relationship satisfaction in the early phase of treatment.

The therapeutic alliance between the therapist and the couple has improved how couples adjust to relationship changes resulting from therapy (Halford et al., 2015), impacting three to ten percent of client outcomes (Fluckiger et al., 2012). Knerr and Bartle-Haring (2010) found that the therapeutic alliance predicted improved relationship satisfaction and indicated that it has the potential to act as a buffer between satisfaction and the hostile relationship content clients bring to therapy (e.g., stress, communication, or emotional conflicts).

Finally, the alliance appears to impact male and female partners differently. Prior research suggests that the husband's perception of the therapeutic alliance was the determining factor for relationship satisfaction (Glebova et al., 2011). Another study showed that the male partner's deteriorating alliance with the therapist was correlated with early termination (Bartle-Herring et al., 2012). These findings suggest that there might be a gendered effect when evaluating the alliance and client outcomes, requiring further study to better understand these differences in CT.

Present Study

Based on the literature, there may be a connection between hopelessness and relationship satisfaction that the therapeutic alliance may moderate for couples. Hopelessness is shown to be correlated with relationships. In Buursma et al. (2020), it was found that improved social support was related to less hopelessness, while Fischer et al. (2016) advocated for bolstering relational strength in therapy to target feelings of hopelessness. Bordin (1979) found that the therapeutic relationship improved overall well-being in his foundational work on the therapeutic alliance. Knerr and Bartle-Haring (2010) continued this work to find that it can also improve relationship

satisfaction in therapy. The couple's connection with the therapist can influence their overall perception of the potential for change (Bordin, 1979), which should buffer hopelessness influence on relationship satisfaction. However, the alliance influence could have a gendered effect on how the alliance potentially relates to hopelessness and relationship satisfaction. The present study seeks to understand the moderating power of the therapeutic alliance on the relationship between hopelessness and relationship satisfaction.

Current study hypotheses

Hypothesis 1) Change in relationship hopelessness will be associated with a change in relationship satisfaction for both males and females.

Hypothesis 1a) Higher change in relationship hopelessness will be negatively correlated with lower change in relationship satisfaction for both males and females.

Hypothesis 2) The mean of therapeutic alliance across the first three sessions of therapy will be associated with a change in hopelessness and a change in relationship satisfaction.

Hypothesis 2a) Higher therapeutic alliance will negatively correlate with a change in hopelessness.

Hypothesis 2b) Higher therapeutic alliance will be positively correlated with change in relationship satisfaction more strongly for males than females.

Hypothesis 3) The therapeutic alliance will moderate the relationship between change in hopelessness and change in relationship satisfaction for males and females, controlling for client depression rates.

Hypothesis 3a) The negative impact of hopelessness on relationship satisfaction will decrease when accounting for the therapeutic alliance, with higher alliance moderating hopelessness to improve relationship satisfaction.

Chapter 3: Methods

The data in this study were collected through the Auburn University Marriage and Family Therapy Center (AUMFTC). AUMFTC offers individual, couple, and family therapy sessions to the community at a low cost using a sliding scale fee. Graduate students enrolled in the marriage and family therapy master's program at Auburn University provides these services under the supervision of Licensed Marriage and Family Therapy supervisors.

Participants

The study used longitudinal data from 355 clients who reported being in a coupled relationship, receiving couples treatment, and starting services between January 2016 and January 2020 at AUMFTC. All participants had to identify as married or in a coupled relationship (living together or living separately) to be included in the study. Slightly more participants identified as male (50.7%), but a similar amount of females were represented (49%). Participants ranged from ages 18 to 73, with a mean age of 32.4 years for men and 30.6 for women. A majority of participants identified their primary racial identity as White (84.2%); African American (8.8%); Hispanic/Hispanic American (2.9%); Asian (1.5%); Other (1.8%); and Native American (0.3%).

Approximately a quarter of participants earned a high school diploma or GED (27.9%), while only 1.1% did not graduate from school; and a smaller number of participants received an associate degree or 2-year degree (12%), a vocational or technical training degree (3.1%); more than a third of participants earned a bachelor's degree (33.9%), and about one-fifth of participants have obtained their graduate or professional degree. A little over 22% of participants lived close to the poverty line earning less than $16,000, another 21.6% earned between $16,000

to $34,999, and 14.7% earning between $35,000 to $49,999. The majority of the client population earned less than $50,000 (58.2%), While those earning more made up the rest of the participants; $50,000 to $69,999 (14.4%); $70,000 to $99,999 (14.4%); or $100,000 or more (11.4%).

Procedures

Auburn University's Institutional Review Board (IRB) approved AUMFTC's ability to collect data. These data were collected between January 2016 – January 2020. The clinic engages in various marketing strategies to the community to attract participants/clients, such as referral sampling, media, and fliers. The data used in this paper was gathered from "intake" and "follow-up" paperwork collected at the first and fourth session, respectively, from each client participating in therapy over 12 and contain the measures detailed below. All participants sign informed consent at the outset of therapy that details the clinic policies and their rights. At intake, additional demographic information is gathered from the participants as well. All questionnaires and paperwork packets are available in either English or Spanish.

Measures

This study utilized the following measures on couple satisfaction, hopelessness, and therapeutic alliance.

Change in Relationship Hopelessness (RH)

Relationship hopelessness is assessed using six statements (i.e., "All I see ahead of me are bad experiences within this relationship" and "I am about to give up because I don't expect this relationship to change") and a 4-point Likert scale (1 = Strongly disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree). This measures how the partner perceived the level of hopelessness in the relationship at T1 and T2, and the difference in each assessment shows the

change in hopelessness between sessions. The internal consistency was strong for the current population ($\alpha = .95$). The mean number of missing responses for each of the six questions was (0.9%), with most cases only exhibiting one missing item (55%). For this reason, the researcher chose to use the scale sum for the analysis instead of the mean.

Therapeutic Alliance

The therapeutic alliance was measured using the Couple Therapy Alliance Scale-revised (CTAS-r; Pinsof et al., 2008). This is a twelve-item questionnaire where items are scored using a 7-point Likert scale (1= … 7=), with greater alliance reflected in higher total scores.
The CTAS-r consists of three subscales: the self/group (between) therapeutic alliance, other (perception of partner between) therapeutic alliance, and the within-couple alliance, but only the overall scores were used for this study. The CTAS-r is administered at the end of each therapy session. The mean of the three sums was calculated for each of the first three sessions to create the moderating variable in this study. Therapeutic alliance after just one session is a significant predictor of outcomes in therapy, according to past research (Knobloch-Fedders, Pinsof, & Mann, 2004; Knobloch-Fedders et al., 2007; Kubricht, 2018; Thomas et al., 2005; Werner-Wilson et al., 2003). The Cronbach's alpha in this sample for the full scale is .97 for males and .94 for females, demonstrating high reliability (Kubricht, 2018). The mean number of missing responses for each of the 13 items on the scale was 1.6%. In 42% of these cases, there was only one missing data point for the 13 items. The researcher used the mean of the scale summation for each session because it was assumed that the response was purposefully left blank.

Change in Relationship Satisfaction

Couples attending therapy completed the Couple Satisfaction Index-16 (CSI-16; Funk & Rogge, 2007) to assess relationship satisfaction. This is a 16-item measure containing questions

(i.e., “How well does your partner meet your needs?”) and statements (i.e., “Our relationship is strong.”) that evaluate how the participants view their relationship. The measure is internally consistent with high Chronbach’s alpha (α = .92) for males and females. The participants rate their agreement using a 6-point Likert scale (0 = Never/Not true at all, 1 = A little true/rarely, 2 = Somewhat/occasionally, 3= Mostly/more than not, 4 = Almost completely true, 5 = All the time/Completely true). The first question of the measure uses a 7-point Likert scale, which asks about the overall Degree of happiness within the relationship (0 = Extremely unhappy… 6 =Perfect).

Data were collected in sessions one (1) and four (4), and the difference between sessions was used to measure the change in couple satisfaction at time one (T1) and time two (T2). The answers are summed to reach the total score, and higher scores represent more satisfaction within the relationship. Missing responses across the 16-item scale were assessed, and the number of missing responses averaged (0.6%) of the responses. Most respondents who left a response blank on the scale only did so once (59%). The researcher chose the most conservative decision to assume that the item was purposefully left blank.

Gender

At the intake, participants are asked to fill out demographic information, which includes asking the client to fill in the blank after the statement, “Your sex.”

Control

Depression

The Major Depression Inventory (MDI; Bech & Wermuth, 1998; Bech et al., 2001) is a 10-item Likert scale measuring clinical symptoms of depression with a high internal consistency of 0.90 using Cronbach’s coefficient alpha (Olsen et al., 2003). This assessment asks how often

the participants experienced symptoms of depression (0 = At no time…3 = More than half the time…5 = All of the time), with higher scores indicating higher levels of depression (20 – 24 = mild depressive symptoms, 25 – 29 moderate depressive symptoms, and 30 + = severe depressive symptoms). Some questions include "Have you felt lacking energy and strength?" and "Have you felt less self-confident?". The number of missing responses was assessed for the 10-item scale (0.6%). Most respondents who left a response blank on the scale only did so once (77%). The researcher chose the most conservative decision to assume that the item was purposefully left blank.

Data Analytic Plan

A regression model will be used to test the impact of hopelessness, therapeutic alliance, and depression on relationship satisfaction while measuring male and female partners separately (Figure 1). Missing data will be managed using Newman's (2014) guidelines, and all available data will be used to maintain statistical power and representative sample size. To investigate and describe missing data patterns, the researcher will use a Missing Value Analysis (MVA) using the expectation-maximization (EM) technique in SPSS (version 24.0). The male and female scores will be fit independently to avoid interdependence, maintaining the independent observations assumption (Kenny & Hoyt, 2009). Bivariate correlations will be examined, and a hierarchical multiple regression will be fit.

Bivariate correlations are examined, and a 4-stage hierarchical multiple regression is fit. The researcher begins by testing the significance of the control of depression. If it is not significant or does not add to the model fit, depression is left out to avoid potentially shared variance due to chance. Model 2 regresses the predictor, change in relationship hopelessness, onto relationship satisfaction at session 4, followed by adding the moderating variable, the mean

of therapeutic alliance in Model 3. For Model 4, an interaction term between change relationship hopelessness and the mean of the therapeutic alliance is created to test for a moderation effect.

Evidence for Supporting Hypotheses

Hypothesis 1) Relationship hopelessness is associated with relationship satisfaction for both males and females.

Hypothesis 1a) *Higher relationship hopelessness will negatively correlate with lower relationship satisfaction for both males and females.* Evidence supporting this hypothesis would include an increase in hopelessness having a negative relationship with relationship satisfaction.

Hypothesis 2) Therapeutic alliance will be associated with hopelessness and relationship satisfaction.

Hypothesis 2a) *Higher therapeutic alliance will be negatively correlated with lower hopelessness.* Evidence supporting this hypothesis would include an increase in the therapeutic alliance having a negative relationship with hopelessness.

Hypothesis 2b) *Higher therapeutic alliance will be positively correlated with higher relationship satisfaction more strongly for males than females.* Evidence supporting this hypothesis would include an increase in the therapeutic alliance having a positive relationship with relationship satisfaction for both males and females. Still, the relationship would be more significant for the male participants.

Hypothesis 3) The therapeutic alliance will moderate the relationship between hopelessness and relationship satisfaction for males and females, controlling for client depression rates.

Hypothesis 3a) *Higher therapeutic alliance will be positively correlated with higher relationship satisfaction even with higher levels of hopelessness.* Evidence supporting

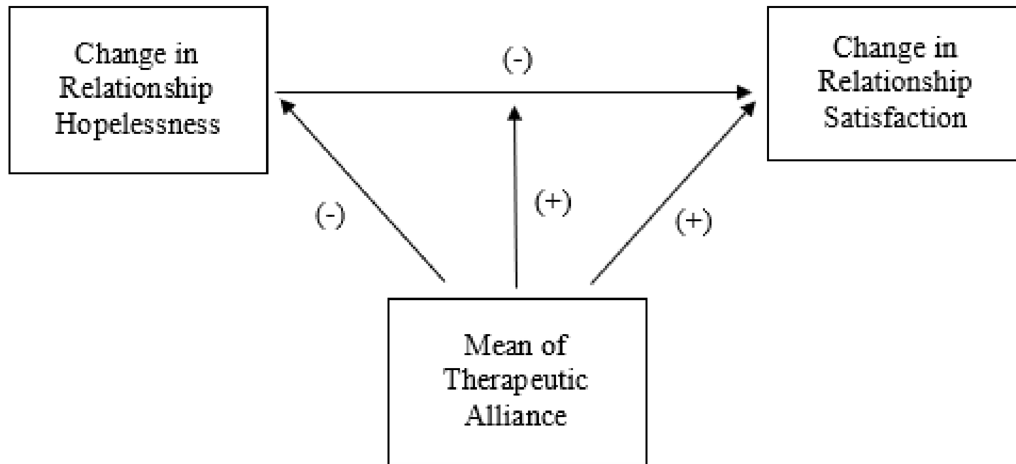
this hypothesis would include an increase in the therapeutic alliance having a positive relationship with relationship satisfaction despite an increase in hopelessness levels.

Conclusion

The current study aims to address the gap in the literature on hopelessness in couples' relationships and its effects on the satisfaction found therein while also seeking to understand the therapeutic alliance's role and if it acts as a moderator for hopelessness's influence on relationship satisfaction. Current research shows that relationships and hopelessness are correlated (Buursma et al., 2020; Fischer et al., 2016; Miller et al., 2014), while Knerr and Bartle-Haring (2010) show therapeutic alliance influences relationship satisfaction. The decrease or elimination of hopelessness has been shown to improve quantity and quality of life (Buursma et al., 2020; Nehir et al., 2019), and individuals in relationships benefit from the positive impact of higher relationship satisfaction (Brezsnyak & Whisman, 2004; Northouse et al., 2000). Given that all of the factors are influential in the lives of the individual and the couple, these variables should be addressed and considered in the initial stages of therapy. While this study is limited in that it does not have a control group or post-therapy follow-up, it should be beneficial to understand the immediate changes that may occur in therapy and the effects of hopelessness and the therapeutic alliance over time.

Figure 1

Simple Regression Moderation Model



Notes. Expected directions of significant main and interactive effects are indicated (i.e., +, -).

Chapter 4: Results

This study examines the impact exerted on a change in relationship satisfaction by a change in hopelessness across four therapy sessions. The assumption is that the therapeutic alliance will moderate the hopelessness and satisfaction of couples in therapy when evaluating this relationship. Demographic information is presented to understand the critical aspects of the client attending therapy at the AU MFT Center. Descriptive statistics are fit to improve understanding of sample distribution and characteristics. Information is provided concerning the participants, means, standard deviations, minimum and maximum scores, and correlations between the predictor, control, moderating, and outcome variables to better understand the scoring characteristics. Relationship hopelessness and relationship satisfaction are assessed in sessions one and four. The therapeutic alliance is measured at the end of each session. The change in relationship hopelessness and the mean of the first three therapeutic alliance scores are measured with change in relationship satisfaction, controlling for depression. The interaction between hopelessness and therapeutic alliance is assessed for moderation effects.

Preliminary Analyses

Means and standard deviations are assessed for the variables and are reported in Table 1. For females and males, scores improve from session one to session four, meaning scores increase for relationship satisfaction and therapeutic alliance and scores decrease for relationship hopelessness. Overall, scores are very similar when comparing males and females. Males report slightly higher relationship satisfaction than females and slightly lower relationship hopelessness in sessions one and four. Females were slightly higher for all three therapeutic alliance scores and showed a greater increase from session 1 (mean=78.32) to session 4 (mean=80.19).

Table 1
Sample Descriptive Statistics of Main Construct Variables

	Females					Males				
	N	Mean	SD	Skewness	Kurtosis	N	Mean	SD	Skewness	Kurtosis
AllyM	168	87.04	10.77	-1.25	1.76	167	85.07	10.98	-.61	4.34
Hope1	174	2.03	.82	.26	-1.01	175	1.90	.78	.71	-.06
Hope4	152	1.73	.71	.71	-.25	146	1.70	.67	.79	.15
CSI1	176	45.94	18.93	-.21	-.91	176	46.82	19.24	-.23	-.80
CSI4	152	49.96	18.92	-.58	-.47	146	50.73	18.71	-.44	-.78
MDI1	176	22.39	12.17	.23	-.89	176	19.18	12.06	.34	-.80

Note. AllyM (Therapeutic Alliance mean of session 1, 2, and 3 scores), Hope1 and Hope4 (Mean of Relationship Hopelessness at sessions one and four), CSI1 and CSI4 (Sum of Relationship Satisfaction at sessions one and four), and MDI1 (Sum of Depression at intake).

Early-Terminators and Completers

Completers are defined as couples that complete intake assessments and fourth session paperwork. At the same time, early terminators are couples who complete first session paperwork but attend less than four sessions and do not complete fourth session paperwork. Attrition is examined because early terminators may differ from couples attending four sessions and completing paperwork. Independent t-tests are conducted on the variables of interest and control variables reported in Table 2. The lack of significant male findings suggested no differences between completers and early-terminators on demographic and intake variables associated with the research. For females, there was a difference for early terminators versus those that continued therapy in their scores of relationship satisfaction ($p=.01$), with females who terminated therapy before four sessions scoring lower on relationship satisfaction than those that continued to attend. While the completers (45.93) and early-terminators (39.91) scored below the cut-off of 48, the early terminators scored significantly lower on relationship satisfaction at intake.

Table 2

Comparison of Means for Early Terminators and Completers at Time 1.

	Females (*N=176*)		Males (*N=175*)	
	t-score	Sig. (2-tailed)	*t-score*	Sig. (2-tailed)
Alliance	.59	.56	-.88	.38
Depression	1.4	.17	.63	.53
Hopelessness	1.6	.11	-.5	.62
Relationship Satisfaction	-2.5	.01*	-.15	.89

Note. $^{*}p < .05$, $^{**}p < .01$

Missing Values Analysis and Testing Regression Assumptions

Missing data is also a threat to research validity. A Missing Value Analysis with the expectation-maximization (EM) technique is implemented to identify and describe missing data patterns within this sample. Little's MCAR test yields a non-significant chi-square [$\chi 2(8) = 10.02$, p= .26] for females and [$\chi 2(8) = 12.02$, p= .15] and for males, indicating that data are missing completely at random for variables used in the subsequent analyses. Additionally, the predictor (e.g., change in relationship hopelessness) and moderator (e.g., mean of therapeutic alliance) variables are centered for the regression analyses to reduce potential multicollinearity (Dawson, 2014). None of the variables in the present study have a skewness of +/-three standard errors or kurtosis statistic of +/- six standard errors, which indicates that the data is normally distributed. Similarly, a visual inspection of the residual scatterplot also appears normally distributed, meeting the assumption of homoscedasticity. Thus, data appear to meet the assumptions of multiple regression.

Correlational Analyses

Bivariate correlations among study variables are examined (Table 3), with participants separated by gender. Additionally, demographic variables are listed in Table 4. Expected results are seen where lower relationship hopelessness and higher therapeutic alliance are associated with higher relationship satisfaction. The strongest correlations exist negatively between

Relationship Satisfaction at intake and session four and Relationship Hopelessness at intake and session four for males.

Table 4
Demographics of males and females in committed relationships

Demographics	Females (*N=177*)		Males (*N=177*)	
	N	Percent	N	Percent
Racial Group				
White	144	85.2%	141	79.7%
Black	14	8.3%	15	8.5%
Hispanic	4	2.4%	6	3.4%
Other	5	3%	6	3.4%
Missing	5	2.8%	9	5.1%
Income				
Under $20,000	48	27.1%	38	21.5%
$20,000 to $39,999	36	20.3%	38	21.5%
$40,000 to $59,999	26	14.7%	29	16.4%
$60,000 to $79,999	20	11.3%	24	13.5%
$80,000 to $99,999	14	7.9%	16	9.1%
Over $100,000	19	10.7%	19	10.7%
Missing	13	7.3%	13	7.3%
Education				
GED/High School or less	44	24.9%	57	32.2%
Vocational/Associates	28	15.8%	23	13%
Bachelor's Degree	62	35%	57	32.2%
Graduate/ Professional Degree	38	21.5%	36	20.3%
Missing	5	2.8%	4	2.3%
Relationship Type				
Married	104	58.8%	105	59.3%
Committed Relationship Heterosexual	31	17.5%	29	16.4%
Committed Relationship Homosexual	33	19.1%	33	18.6%
Separated	4	2.3%	6	3.4%
Widowed	1	0.6%	0	0%
Missing	4	2.3%	4	2.3%
	Females Mean (Range)		**Males Mean (Range)**	
Age	30.83 (18-65)		33 (19-73)	
Missing	5		4	
Relationship Length (Months)	66.2 (1-588)		66.6 (1-554)	
Missing	7		8	

Table 3
Summary of Correlations for Males (bottom diagonal) and Females (top diagonal)

	1.	2.	3.	4.	5.	6.	7.	8.
1. CSI1	-	-.777**	.-.184*	.244**	.238**	.346**	.749**	-.257**
2. Hopeless1	-.770**	-	.198**	-.136	-.112	-.191	-.628	.198*
3. Depress1	-.363**	.375**	-	.036	.-.28	-.006	-.262**	.044
4. Alliance1	.380**	-.233**	-.259**	-	.627**	.625**	.239**	-.312**
5. Alliance2	.311**	-.216**	-.191*	.765**	-	.800**	.297**	-.295**
6. Alliance3	.319**	-.251**	-.285**	.711**	.758**	-	-.330**	-.412**
7. CSI4	.777**	-.686**	-.373**	.408**	.317**	.402**	-	-.358**
8. Hopeless4	-.723**	.707**	.285**	-.304**	-.219*	-.317**	-.849	-

Note. Female scores were placed on the top/right, males on the bottom/left. CSI1 (Relationship Satisfaction at time 1). Hopeless1 (Relationship Hopelessness at time 1). Allaince1 (Therapeutic Alliance at time 1). Depress1 (Depression at time 1).
*p < .05, **p < .01

Hypothesis Testing using Hierarchical Multiple Regression

A 4-stage hierarchical multiple regression with change in relationship satisfaction from session 1 to 4 as the dependent variable is used to test both research questions for males (Table 5 and females (Table 6). The regression's first step is introducing the depression covariate into the model, which results in non-significant findings. Model 2 regresses the predictor, change in hopelessness, onto the change in relationship satisfaction, followed by adding the moderating variable, the mean of therapeutic alliance across three sessions, in Model 3. For Model 4, an interaction term between change in relationship hopelessness and the mean of the therapeutic alliance is introduced to test for a moderation effect.

Table 5

Summary of the Hierarchical Regression Analysis for Change in Relationship Satisfaction, Change in Relationship Hopelessness, the mean of Therapeutic Alliance, and the Interaction between Relationship Hopelessness and Therapeutic Alliance in Males.

	Model 2			Model 3			Model 4		
	B	*SE*	β	*B*	*SE*	β	*B*	*SE*	β
Intercept	-.12	.08	-	-.09	.28	-	.40	.26	-
Depression	-.02**	.01	-.23**	-.02**	.01	-.23**	-.01	.01	-.12
Δ in Hopelessness	-.13**	.03	-.42**	-.13**	.03	-.41**	-.10**	.02	-.32**
Mean of Alliance				.00	.01	-.01	-.01*	.01	-.15
Alliance × Δ Hopelessness							-.01**	.01	-.39**
ΔR^2	.21**			.21			.32**		
Adjusted R^2	.20**			.19			.30**		

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

Table 6

Summary of the Hierarchical Regression Analysis for Change in Relationship Satisfaction, Change in Relationship Hopelessness, the mean of Therapeutic Alliance, and the Interaction between Relationship Hopelessness and Therapeutic Alliance in Females.

	Model 2			Model 3			Model 4		
	B	*SE*	β	*B*	*SE*	β	*B*	*SE*	β
Intercept	-.27**	.08	-	-.27*	.15	-	-.32*	.13	-
Depression	-.02**	.01	-.18**	-.02**	.01	-.20**	-.02*	.01	-.12*
Δ in Hopelessness	-.15**	.02	-.55**	-.15**	.02	-.55**	-.12**	.02	-.41**
Mean of Alliance				.00	.00	.00	.00	.00	.07
Alliance × Δ Hopelessness							-.02**	.00	-.34**
ΔR^2	.35**			.35			.43**		
Adjusted R^2	.34**			.34			.41**		

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

The change in hopelessness in Model 2 is statistically significant for females [F(2, 143) = 37.85, p= <.001, R2 = .34] and males [F(2, 134) = 17.50, p= <.001, $R^2 = .21$]. Model 3 adds the alliance mean score to the regression, but the model was not statistically significant for males [F(3, 134) = 11.59, p= .895, $R^2 = .341$] or females [F(3, 143) = 25.05, p= .998, $R^2 = .35$]. For Model 4, an interaction term (Alliance mean score × change in relationship hopelessness) is added to test for a moderation effect. The fourth Model which included the hopelessness and alliance interaction was statistically significant for males [F(4, 134) = 15.46, p= <.001, $R^2 = .21$] and females [F(4, 143) = 26.24, p= <.001, $R^2 = .43$].

The therapeutic alliance moderates the relationship between relationship hopelessness and relationship satisfaction for males and females. In Model 4, 32% (ΔR^2=.32) of the variance in

relationship satisfaction is accounted for in males (β = -.39, p= .01), and 43% (ΔR^2=.43) of the variance in relationship satisfaction is accounted for in females (β = -.34, p= .01). In sum, Model 4 best fits the data for all participants, with a statistically significant main effect on relationship satisfaction for change in relationship hopelessness, therapeutic alliance, and the interaction between change in relationship hopelessness and therapeutic alliance. The moderation model is graphed in Figure 2 for males and Figure 3 for females.

Figure 2

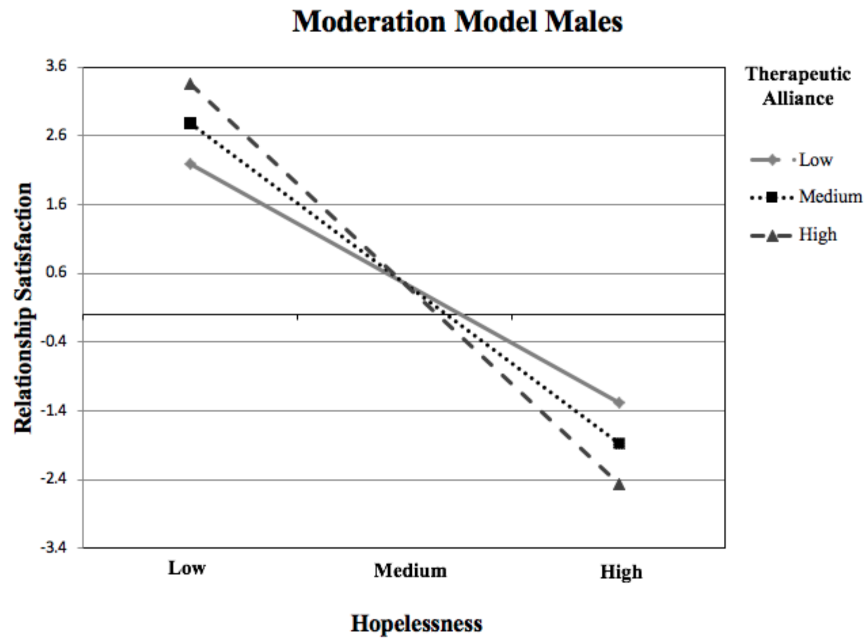
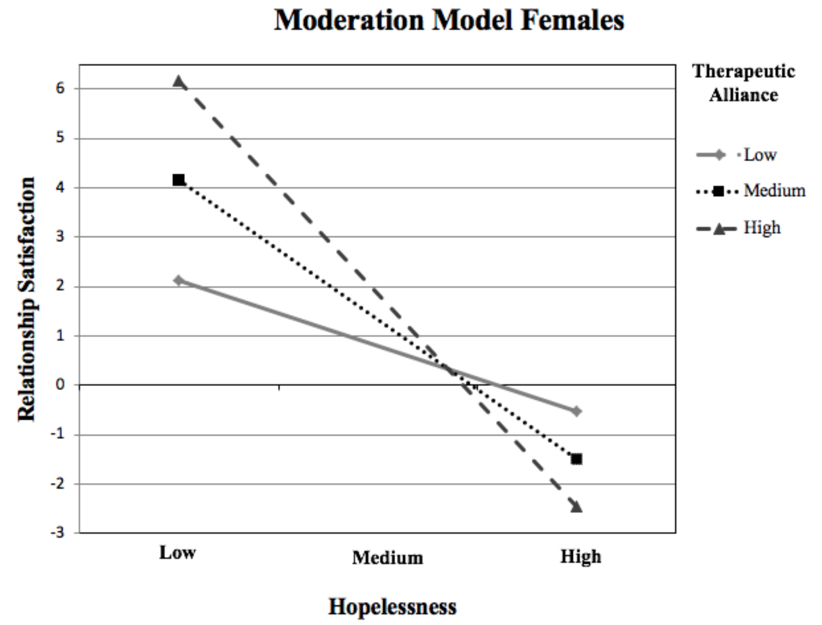


Figure 3



Chapter 5: Discussion

The importance of relationship satisfaction for well-being is supported in the literature; with a specific focus on improvements in sexual satisfaction (Brezsnyak & Whisman, 2004) and physical health (South & Krueger, 2013) and lower depression (Whisman, 2001), and suicidality (Till et al., 2016). In a meta-analytic study of marital quality and satisfaction, Proulx et al. (2007) found better marital quality leads to an increase in personal well-being, which encapsulated several factors, such as self-esteem, physical health, and a positive appraisal of one's current situation. Therefore, the current research results are impactful for the couple and the therapist. The purpose of this study was to further increase understanding of relationship satisfaction by examining how it may be influenced by hopelessness, therapeutic alliance, and gender. Previous research has suggested hope is linked to the therapeutic alliance (Bordin, 1979; Knerr & Bartle-Haring; 2010) and relationship satisfaction (Ward & Wampler, 2010), and alliance is linked to an improvement in relationship satisfaction and overall therapeutic outcomes (Halford et al. 2015; Knerr & Bartle-Haring; 2010). However, the effect of change in relationship hopelessness and therapeutic alliance on change in relationship satisfaction has yet to be studied. There was, therefore, a critical need to know how a change in hopelessness during the initial stage of CT impacts change in relationship satisfaction and how that relationship is moderated by the therapeutic alliance for males and females in a committed relationship.

The 4-stage hierarchical multiple regression moderation model showed significant results for both male and female participants, demonstrating that therapeutic alliance moderates the relationship between relationship hopelessness and relationship satisfaction. This interaction effect highlights the importance of alliance for couples in therapy, that hopelessness's influence

over their relationship satisfaction was altered when participants felt more aligned with and supported by their therapist. While these findings show that increased hopelessness results in decreased satisfaction in relationships for both men and women, the moderating aspect of the therapeutic alliance should be given special attention by the therapist. This study looked at the early impact of the alliance in the first three sessions, which other studies found to be related to premature termination of therapy (Bartle-Herring et al., 2012). To make progress and influence relationship satisfaction, it is of great importance that the therapist develops strong alliances with the couple.

The Impact of Relationship Hopelessness

This study first aimed to determine if relationship hopelessness impacted relationship satisfaction. Research has shown that relationships can alleviate hopelessness when researching long-term illness (Buursma et al., 2020). The prediction that hopelessness could also affect relationships was based on additional literature suggesting hopelessness plays an influential role in the lives of couples, namely studies of the emotional and mental impact of illness, which suggest hopelessness from a terminal diagnosis infiltrates the couple's relationship, increasing distress and strain on the partnership (Kissane et al., 1994; Northouse et al., 2001).

The first hypothesis is supported for both males and females, demonstrating that increased hopelessness is related to decreased relationship satisfaction. Previous literature looking at hopelessness and relationships demonstrates the positive impact of relationships in alleviating the effects of hopelessness. For example, Till et al. (2016) found romantic relationships to be a protective factor against suicidality, which was previously strongly tied to hopelessness. While little is known about how hopelessness affects the relationship, one study does emphasize that distress, which has been used interchangeably with hopelessness (Kissane et

al., 1994; McLean et al., 2011), in a couple's relationship can disillusion the partner to the relationship. The more hopeless they feel, the less likely they are to work to improve the relationship, leading to a deterioration of the partnership and the satisfaction found therein (Miller et al., 2014), which connects with the current findings that the more hopeless a couple becomes, the more unsatisfied they begin to feel in the relationship.

The Impact of Therapeutic Alliance

To test Hypothesis 2, the therapeutic alliance was next incorporated with hopelessness and relationship satisfaction. This factor has already been shown to play an essential role in therapy and therapeutic progress for couples. First, research demonstrates that greater therapeutic alliance is associated with improved relationship satisfaction for couples in therapy (Knerr & Bartle-Haring, 2010) and general progress in therapy overall (Bordin, 1979). Additionally, hopelessness literature emphasizes the importance of positive relationships (Buursma et al., 2020) and their impact on decreasing hopelessness within therapy (Fischer et al., 2016).

Hypothesis 2, however, was not found to be significant for participants. No correlations were identified when the alliance was incorporated into the model. This was not similar to previous findings, which show men's alliance related to improved outcomes for couples in therapy. The current hypothesis was based on the prior research that males' perception of the alliance is a greater predictor of therapeutic progress (Bartle-Herring et al., 2012; Glebova et al., 2011) and is more likely to lead to increased relationship satisfaction (Knerr & Bartle-Haring, 2010) than for females. Other researchers suggest that male and female alliance scores are related to more positive therapeutic outcomes (Hughes et al., 2021). A few studies on alliance had findings similar to the ones in the current study, showing that alliance alone is not always

predictive of better outcomes in relationship satisfaction (Glebova et al., 2011; Symonds & Horvath, 2004).

The Interaction of Hopelessness and Alliance on Relationship Satisfaction

The final hypothesis proposing that therapeutic alliance moderates the impact of hopelessness on the relationship was validated for male and female participants, demonstrating that alliance becomes significant when it interacts with hopelessness, though it is not significant alone. This shows that hopelessness's impact on relationship satisfaction changes based on the level of the therapeutic alliance and that greater alliance was associated with the highest level of relationship satisfaction, with low hopelessness. The alliance's strength is the interaction with other variables to impact relationship satisfaction. The interaction between alliance and hopelessness aligns with much of the literature that highlights the benefits of therapeutic alliance on outcomes in therapy.

Previous researchers have found a relationship between the alliance and increased relationship satisfaction, developing greater emotional intimacy, improving communication between partners, and displaying more positive behaviors in the relationship (Roddy et al., 2020). Additionally, therapeutic alliance alleviates other harmful factors in clients' lives, acting as a change agent for healing from stress, trauma, conflict, and other mental stressors (Briere & Scott, 2015). Some of the first works on alliance by Bordin (1979), who sees the alliance as vital for client change and progress, identifies the power of the therapeutic alliance to buffer these negative factors by using the therapeutic relationship as a vehicle for instilling hope in clients despite their adverse circumstances or symptoms. In the current research, it appears that alliance influences relationship satisfaction solely through the interaction with hopelessness. This finding adds a contextual factor to understanding the power of the alliance and therapy outcomes.

Studies investigating the moderating role of the therapeutic alliance also corroborate these findings. A recent conceptual study suggested that a therapist may use the alliance to intervene as a moderator in treatment to improve outcomes (Vilkin et al., 2022). Other studies show that therapeutic alliance as a moderator can lessen undesirable symptoms, such as depression and interpersonal problems (Dolev-Amit et al., 2021; Wu et al., 2020), or put progress at risk, with a lower alliance as a moderator leading to higher dropout rates. When researching therapeutic alliance in CT, Wu et al. (2020) found it to act as a moderator between depression and relationship satisfaction, with the male's alliance with the therapist being most important for the progress of both partners. These findings most closely reflect those of the current study, as depression and hopelessness have been linked repeatedly in the literature (Abramson et al., 2000; Marsiglia et al., 2011; Whisman, 2001).

A unique finding within the current research was that high hopelessness combined with a high alliance after three therapy sessions led to the lowest relationship satisfaction in our sample. The clients that scored high on hopelessness after three sessions but felt the least allied with their therapist had higher average relationship satisfaction than those who scored highly hopeless and were highly allied with the therapist. This finding was unexpected but made sense. The researcher initially hypothesized the high alliance would buffer the negative association between hopelessness and relationship satisfaction. However, not everyone who attends therapy changes. Some clients will attend therapy and join well with the therapist, but the relationship problems will not diminish. This finding suggests that more research is needed to understand these clients across a more extended timeframe in therapy and to understand the extenuating contextual factors related to hopelessness. While it is unclear why those who continue to score high on hopelessness but have a poor or moderate alliance exhibit higher relationship satisfaction, more

needs to be done to see specific therapist behaviors related to alliance. It might be that some therapists join well with clients but don't push effectively for relationship change. In contrast, other therapists join and then push the client, helping them dislodge from hopelessness to an uncomfortable change process.

Another explanation for the poor outcomes for clients who are highly hopeless about the relationship and, after three sessions, have a strong therapeutic alliance with a therapist may be that a highly hopeless client may feel even more disappointment and dissatisfaction in their relationship when they feel connected to their therapist, either because this acts as a model for a positive relationship which they don't currently have or because lack of progress cannot be blamed on disconnection with the therapist.

While these findings do not align with many other results showing that greater alliance leads to greater improvement in therapy (Anderson et al., 2015; Brier & Soctt, 2015; Bordin, 1979; Friedlander et al., 2018; Knerr & Bartle-Haring, 2010), these are not isolated findings. Glebova et al. (2011) studied alliance's influence on progress in CT and found the alliance to be an unreliable predictor for change, reflecting an earlier study in CT that similarly found an insignificant relationship between alliance and outcomes (Symonds & Horvath, 2004).

Clinical Implications

The present study affirms previous findings that hopelessness and relationship satisfaction play influential and related roles in the lives of couples (Buursma et al., 2020; Northouse et al., 2000; Roddy et al., 2020; Ward & Wampler, 2010). Hopelessness has already been shown to be detrimental to well-being (Lo et al., 2013; McLean & Jones, 2007; McLean et al., 2011; Till et al., 2016), whereas better relationships, in general, can improve mental and physical health (Buursma et al., 2020; Fischer et al., 2016; Marsiglia et al., 2011; Panzarella et

al., 2006). Current findings specifically show the importance of these variables in CT and how hopelessness can threaten relationship satisfaction, demonstrating that therapists and clients aiming to improve relationship satisfaction cannot ignore the existing hopelessness about the relationship's future. Otherwise, as pointed out in hopelessness literature, the clients may experience low motivation to work towards their goals if they believe improvement to be out of their reach (Haeffel et al., 2008; Marchetti, 2019; Miller et a., 2014). Therapists ought to be prepared to address hopelessness early in the therapeutic process to instill a greater possibility of progress towards goals and improved satisfaction for each partner.

This study could affirm previous works on therapeutic alliance and more clearly portray the critical role therapeutic alliance plays in therapy. The therapeutic alliance can be a moderator in CT and is especially important for the couple's relationship satisfaction. Alliance has been shown in other research to have a protective factor when it comes to negative stressors, either because it dissuades clients from early termination (Bartle-Haring et al., 2012; Winter et al., 2013) or because it balances those stressors with a positive relationship. Prior hopelessness research findings support that enhancing the relationship decreases hopelessness (Kissane et al., 1994; Marsiglia et al., 2011; McLean & Jones, 2007; Winter et al., 2013).

Giving clinicians a better understanding of the role alliance plays in therapeutic progress can help them give joining with clients the proper weight it needs in therapy. Therapeutic alliance needs to be valued highly from the start of therapy. The current findings show how important it can be within the first three sessions of therapy for client progress. Other studies have similarly emphasized the immediacy of the alliance at the start of therapy, finding that it may be established from the start with minimal change as therapy progresses (Glebova et al., 2011). If the therapist prioritizes the alliance with the couple, it is more likely that this will

improve their relationship satisfaction and lessen hopelessness. This timeline also reflects broader findings that most couples (70%) who do not demonstrate progress in the first four therapy sessions will not benefit from therapy (Pepping et al., 2015).

Limitations

This study is limited because it does not have a control group to compare results. A control group would offer the chance to differentiate causality versus correlations between these variables. It would also offer a more direct comparison, meeting a higher standard of experimentation than in the present study. A group showing what these variables look like in a sample of random couples may offer a better understanding of those components that influence couples' hopelessness, relationship satisfaction, and alliance in therapy.

The sample used in this study is 85% white, lacking racial and educational diversity. The data was collected only from couples who sought therapy services at the AUMFTC. This population may look different than those couples who do not seek treatment. The ethnic demographics of the sample do not reflect the population of this particular southern U.S. state. This could skew the results to reflect that population more than the general population.

Furthermore, the study is limited in not having posttherapy follow-up measures, only showing progress in the first four sessions. This limits the perspective of longitudinal change and the understanding of how likely the change will be maintained with time. Follow-up data would be able to solidify these findings or clarify if more needed to be done in therapy to decrease the risks of backsliding on progress.

The current study only evaluated alliance relating to the therapist and the client. The CTAS-r contains subscales that measure the clients' alliance based on how they perceived the alliance of the therapist with the couple as a unit and how they perceived their alliance within

their relationship (Pinsof et al., 2008). These subscales were not utilized in this current study. Previous research indicates that the alliance within the couple may affect therapy outcomes (Glebova et al., 2011; Hughes et al., 2021) and may be an essential factor to consider.

Implications for Future Research

The current study's findings offer several implications for future research. The unexpected finding of high hopelessness with the high therapeutic alliance as a moderator resulting in low relationship satisfaction warrants further investigation. Additional research to clarify these findings and better understand why high alliance did not change the impact of high hopelessness would benefit clinicians working with couples.

Further research into hopelessness should also be considered, such as comparing hopeful and hopeless couples to distinguish the unique roles hopelessness and hopefulness play in relationship satisfaction. The currently limited research on hopelessness, when not looking at physical illness, would be helpful to strengthen. It would be interesting to understand other factors affecting couples' feelings of hopelessness, such as income, children, religiosity, and gender roles and expectations.

A different angle in studying alliance could also bring about different results. The way partners feel connected to each other in therapy may be vastly different than how they perceive their connection with the therapist, especially considering the lower relationship satisfaction likely experienced at the outset of therapy. This could help clarify if the clinician focused on making themselves a positive source of connection or using themselves as a tool to unite the couple in their alliance.

Diversifying types of participants in the samples used in the study may also lead to new findings. An added direction for future study could be to compare clinical populations with

control groups to understand the differences between those who self-refer to therapy and those who do not receive treatment. Gathering a sample of participants with more varying racial-ethnic representation would also benefit the field by allowing findings to be more easily generalized to the diverse sets of couples existing in the United States. Most of the previous literature on relationship satisfaction has looked at heterosexual couples. While this current sample had a diverse representation of sexual orientations, much more work needs to be done to understand this population better and if and how they differ from the heteronormative population.

Conclusion

The present study addressed the gap in the literature on hopelessness in couples' relationships, and its effects on the satisfaction found therein while also seeking to understand the role the therapeutic alliance plays and if it moderates hopelessness's influence on relationship satisfaction. Growing understanding of what factors most influence relationship satisfaction in therapy provides direction for clinicians, researchers, and model developers. The role gender plays in all of this, too, has the potential to guide therapists' choices in how they relate to their clients. While lacking in long-term results, the short-term information provided in the findings of this study offer insight into the influence of relationship hopelessness and therapeutic alliance on couples' satisfaction in their committed relationship. Previous research backs up the dangers of hopelessness (Miller et al., 2014; Nehir et al., 2019), the importance of alliance (Bordin, 1979; Knerr and Bartle-Haring, 2010), and the value of relationship satisfaction (Buursma et al., 2020; Fischer et al., 2016; Northouse et al., 2000). These findings help us better understand preventative measures and points of intervention beneficial for couples in therapy.

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