AN INVESTIGATION OF THE RELATIONSHIP BETWEEN THE STAGES OF CHANGE AND CLIENT OUTCOMES IN COUPLES THERAPY

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Paty Pruet

Certificate of Approval:

Alexander T. Vazsonyi
Professor
Human Development and
Family Studies

Thomas A. Smith, Chair
Associate Professor
Human Development and
Family Studies

Scott A. Ketring
Associate Professor
Human Development and
Family Studies

Joe F. Pittman
Interim Dean
Graduate School

AN INVESTIGATION OF THE RELATIONSHIP BETWEEN THE STAGES OF CHANGE AND CLIENT OUTCOMES IN COUPLES THERAPY

Paty Pruet

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Signature of Author

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Date of Graduation

THESIS ABSTRACT

AN INVESTIGATION OF THE RELATIONSHIP BETWEEN THE STAGES OF CHANGE AND CLIENT OUTCOMES IN COUPLES THERAPY

Paty Pruet

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While research exists concerning the stages of change and outcomes for individuals in specified treatments, there is currently a lack of research on the stages of change and client outcomes in couples therapy. This study examined a possible relationship between the two constructs in addition to the relationship between the therapeutic alliance and client outcomes. The sample was composed of couples attending therapy at a southern university marriage and family therapy training clinic. A significant negative relationship existed between therapy alliance and client outcomes. When the stages of change was added into the equation this relationship remained significant and an additional significant positive relationship was found between the stages of change and client outcomes. Neither of these relationships was in the expected direction.

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INTRODUCTION

The stages of change may serve as a lens through which therapeutic outcome can be studied. Surprisingly, there is little research that exists in this area. While there is an abundance of literature on the stages of change and addictions treatment (Petry, 2005; Henderson, Saules, & Galen, 2004; Ledgerwood, & Petry, 2006; Blancherd, Morganstern, Morgan, Labouvie, & Bux, 2003), research on the stages of change and other psychotherapy outcomes is lacking, especially in regards to couple therapy. The proposed study seeks to contribute to filling this gap.

Prochaska and Norcross (2001) posit that the stage of change model includes six different stages through which people proceed when changing their behavior. Precontemplation occurs when people are unaware that they have a problem. When a person recognizes the need to change and is seriously thinking about changing he or she is deemed to be in the contemplation stage. Preparation exists when a person is planning to change within the next month and has taken action, although without success, within the last year. A person in the action stage has changed the behavior for a time of one day to six months. Maintenance occurs when a person strives to avert relapse and merge the benefits achieved in the action stage. The problem behavior is not present and a new contrary behavior is carried out for more than six months. The final stage, termination, transpires when a person has finished the process of change and does not have to labor to avoid relapse.

These stages of change are an integral part of the trans-theoretical model in which effective therapy is viewed as requiring two attributes: using different change processes for different stages of change and adjusting the therapist's role according to the client's stage of change (Prochaska & Norcross, 2001). Experiential, cognitive, and psychoanalytic change processes tend to be effective in the precontemplation and contemplation stages. Existential and behavioral change processes work well for the action and maintenance stages. The therapist's role fluctuates according to the client's stage of change. For clients in the precontemplation stage, a therapist can be seen as a "nurturing parent joining with a resistant and defensive youngster who is both drawn to and repelled by the prospects of becoming more independent" (Prochaska & Norcross, 2001, p. 444). Therapists guide clients in the contemplative stage in obtaining their own understanding of their problems. When clients are in the preparation stage therapists lead them in defining ways to overcome their difficulties. For clients who are entering the action and maintenance stages, therapists provide assistance when problems are not being overcome as easily as hoped (Prochaska & Norcross, 2001).

A review of studies that specifically addressed the stages and process of change in relation to treatment outcome revealed that outcome largely depends upon clients' pretreatment stage of change (Prochaska, & Norcross, 2001). A study conducted by Franko (1997) supported the findings of the study review. This study investigated if readiness for change was related to cognitive behavioral group therapy outcome for bulimic women. Results indicated that patients who were further along in the stages of change, as determined by their higher pre-treatment action scores, showed the most clinical improvement in frequency of binging.

Scott and Wolfe (2003) examined the stages of change in relation to batterer treatment outcome. They found that men who are in the contemplation and action stages of change at the start of treatment show greater gains than those in the precontemplation stage. The stage-related differences in improvement occurred from the start to midpoint of treatment. Interestingly, however, these stage-related differences did not continue to occur towards the end of treatment. Therefore, the men appeared to become more similar over treatment time. The researchers suggest this could be explained by precontemplative men acknowledging less abuse and greater communication and empathy skills at intake than men in other stages. When this aspect of denial is considered, these stage-related differences probably depict actual differences in progress even though the end results are similar.

Research exploring the stages of change in relation to cognitive behavioral therapy outcome for clients with panic disorder found that CBT responders scored significantly higher on the contemplation subscale than did CBT nonresponders and marginally significantly higher than partial responders (Dozois, Westra, Collins, Fung, & Garry, 2004). The study also evaluated the predictive ability of the URICA (University of Rhode Island Change Assessment) for treatment outcome. Partial predictive value in the treatment of anxiety was indicated.

An encouraging study found that those who enter therapy in the precontemplation stage are not doomed to poor outcomes. Schechtman and Ben-David (1999) examined the stages of change and therapy outcome for children attending therapy aimed at reducing their aggressive behavior. Results indicated that children moved along the continuum of change as therapy progressed. Thus, it could be assumed that it may be quite possible that

despite the stage of change clients could obtain similar outcomes, although, this might entail those entering therapy in the beginning stages attending therapy for a longer period of time than those entering in a stage further along the change continuum.

The lack of research on the stages of change and psychotherapy outcome promotes the need for the proposed study. However, other predictors of outcome must be taken into consideration to avoid overemphasizing the significance of the single construct. There are obviously many factors that can and do influence therapy outcome. An exhaustive examination of every such factor is beyond the scope of this study. However, a few general predictors have been identified by several meta-analyses. One meta-analysis found that therapist training and experience influenced outcome (Stein & Lambert, 1995). Two meta-analyses of play therapy outcome predictors found that parent involvement in therapy was related to treatment effectiveness (Leblanc & Ritchie, 2001; Bratton, Ray, Rhine, & Jones, 2005). Another meta-analysis established that empathy accounted for nearly 10% of outcome variance (Greenberg, Watson, & Elliot, 2001). Youth and parents' willingness to engage in therapy and counselor interpersonal skills were found to be predictors of outcome in a meta-analysis on therapeutic relationship variables as predictors of therapeutic outcome for youth and family therapy (Karver, Handelsman, Fields, & Bickmen, 2006).

In addition to the information obtained from these meta-analyses, there is one other area that requires specific focus: the therapeutic alliance. The therapist-client relationship entails "(a) the collaborative nature of the relationship, (b) the affective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks" (Martin, Garske, & Davis, 2000, p. 438). Also termed the

working alliance, it includes “an agreement on goals, an assignment of task or a series of tasks, and the development of bonds” (Bordin, 1979, p. 253).

Martin, Garske, and Davis (2000) aggregated 79 studies and found a statistically significant correlation between therapeutic alliance and outcome. A meta-analysis of alliance and outcome also found an association between the two (Horvath & Symonds, 1991). In a study by Johnson and Ketring (2006) involving therapy for families that have experienced child abuse and neglect, a significant association was found between tasks, bonds, and goals (subscales of alliance) and levels of symptom distress at post-treatment. Another study on alliance and home-based family therapy found that alliance was a statistically significant, positive influencing factor in symptom distress changes (Johnson, Wright, and Ketring, 2002). Due to the well established influence of the therapeutic alliance on therapy outcome, this variable will also be included in the proposed study.

While there is a plethora of information readily available on various therapy outcome predictors, the primary variable of interest in this study is the stages of change. There are a number of studies on the stages of change and addictions treatment. However, there is a deficit of studies on the stages of change in relation to therapy outcome in therapies that do not just target specific issues, but rather address a wide variety of presenting problems. Of specific surprise was the fact that no study was located in the review of literature that addressed the stages of change in relation to any couple or marital therapy.

Thus, this study seeks to further investigate what kind of influence the stages of change has on psychotherapy outcome in couple therapy. In the few studies that do exist, the general trend appears to be that the two constructs are related, but more research on

the trend is desirable to confirm the preliminary findings. In fact, there is a general lack of research on readiness for change in mental health (Dozois, Westra, Collins, Fung & Garry, 2004). Thus, the proposed study is warranted.

Based upon the existing literature of the stages of change and therapy outcome that asserts that the two constructs are related (Prochaska, & Norcross, 2001; Franko, 1997; Scott and Wolfe, 2003; and Dozois, Westra, Collins, Fung, & Garry, 2004), it is hypothesized that:

Hypothesis 1: Clients who begin therapy in a stage of change that is further along the change continuum will be associated with more positive therapy outcome scores at the fourth therapy session when compared to the scores of clients who begin therapy in a stage of change that is not as far along on the change continuum.

Hypothesis 2: There is an independent and/or additive relationship between stage of change and therapy outcome, in addition to the relationship between therapeutic alliance and therapy outcome.

LITERATURE REVIEW

The proposed study seeks to determine the possible contribution of the stages of change to therapeutic outcome. A review of the literature substantiates the need for this study. First, general predictors of therapy outcome are briefly discussed. Next, the stages of change are described. Then, literature analyzing the stages of change in relation to therapy outcome is examined. Finally, the hypotheses are introduced.

Predictors of Therapy Outcome

There are numerous predictors of the outcome of therapy. These include both therapist variables and client variables. Stein and Lambert (1995) conducted a meta-analysis of therapy outcome studies and found that client outcomes were better for those who had therapists that were more trained and experienced compared to those whose therapists were less trained and experienced. Two meta-analyses of play therapy outcome predictors found that the involvement of parents in the therapy and treatment effectiveness were related (Leblanc & Ritchie, 2001; Bratton, Ray, Rhine, & Jones, 2005). Furthermore, the length of therapy and therapy outcomes was found to be related, with the most effective therapy lasting 30 sessions (Leblanc & Ritchie, 2001). Play therapy seemed to be as effective as non-play therapy for children with emotional hardship (Leblanc & Ritchie, 2001). A meta-analysis on empathy and therapy outcome established that empathy accounted for nearly 10% of outcome variance (Greenberg, Watson, & Elliot, 2001). Karver, Handelsman, Fields, and Bickmen (2006) conducted a

meta-analysis on therapeutic relationship variables as predictors of therapeutic outcome for youth and family therapy. Some of the paramount predictors included the youth and parents' willingness to engage in therapy and counselor interpersonal skills.

In addition to meta-analyses, many other studies have examined specific predictors that could be related to therapy outcome. Two factors found to affect treatment outcome include length of treatment and attrition (Ward & McCollum, 2005). A review of the literature on treating depression found that participants that are high-functioning (i.e. have less specific deficits, such as dysfunctional attitudes, that are focused on within cognitive and behavioral therapies) appear to have better therapeutic outcomes (Rude & Rehm, 1991). Comorbidity of personality disorders with other disorders has also been examined as a predictor of outcome. However, results are conflicting (Sato, Sakado, & Sato, 1993; Leibbrand, Hiller, & Fitcher; 1999; Leibbrand, Hiller, & Fitcher; 1999). Examining every predictor of therapy outcome is beyond the goal of this study. Nevertheless, the therapeutic alliance is a particular variable related to therapy outcome that requires more detailed inspection.

Therapeutic Alliance

The working alliance, one of several terms used to refer to different aspects of the therapist-client relationship (Martin, Garske, & Davis, 2000) is defined by Bordin (1979) as including three different aspects: "an agreement on goals, an assignment of task or a series of tasks, and the development of bonds" (p. 253). It is vital for therapists and clients to work towards a shared goal. When the goals of the therapist and client conflict, then the goals facet of the therapeutic alliance will be low (Pinsof, 1994). It is critical for clients to understand the connection between the tasks that the therapist assigns to them

in relation to their desire to change. When clients understand how tasks will enable the change process the therapeutic alliance will be enhanced (Bordin, 1979). If the client and therapist are at odds concerning the anticipated tasks, the alliance will be hindered (Pinsof, 1994). Therapists are also expected to carry out certain tasks according to their theoretical framework, such as empathizing with clients (Bordin, 1979).

Other researchers have defined the alliance in various ways. However, among the different definitions, several commonalities evolved. These entail "(a) the collaborative nature of the relationship, (b) the affective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks" (Martin, Garske, & Davis, 2000, p. 438).

Johnson, Wright, and Ketring (2002) conducted a study on the relationship between the alliance in family therapy and changes in symptom distress, interpersonal relationships, and family coping. Participants in this study included families in which at least one child or adolescent was at risk of being removed from the home because of child abuse or neglect or juvenile offenses. Typically, therapy was provided by teams of doctoral level therapists who were in their third year of the Marital and Family Therapy (MFT) program and case managers who were master's level MFT students. Three different measures were used in order to assess the therapy alliance, therapy progress, and behavioral and problem-solving tactics families engage in during stressful times. Specific issues such as child abuse and neglect, depression, and family structural problems were addressed (Johnson, Wright, & Ketring, 2002).

Upon analysis of the data, the researchers found that the alliance plays an important factor in the outcome of therapy. Although a significant association between the alliance and interpersonal relationships and family coping was not found, the alliance was associated with changes in symptom distress. Results indicated that the alliance accounted for 19% of the variance in mothers' symptom distress changes, 55% in fathers' symptom distress changes, and 39% in adolescents' symptom distress changes (Johnson, Wright, & Ketring, 2002).

Johnson and Ketring (2006) noted that research on the link between therapeutic alliance and outcome using the family, not just individual members of the family, as the unit of analysis was not available. Seeking to fill this gap, the researchers examined the relationship between symptom level at intake, alliance, and therapy outcome with the family serving as the unit of analysis. The families came to therapy after having been reported to the state social service agency for child abuse or neglect. The agency referred the families to therapy; families in which a child had been removed from the home were not referred to therapy. Therapists provided home-based ecosystemic therapy (Johnson & Ketring, 2000) to the families (Johnson & Ketring, 2006).

The researchers found that the tasks, bonds, and goals of the therapy alliance were significantly associated with levels of symptom distress at posttreatment. Additionally, posttreatment level of violence and the goals subscale were significantly related. Furthermore, the interaction between the bonds subscale and the pretest level of violence was significant, suggesting that when higher levels of violence were reported at intake, a stronger therapist-client bond was necessary to promote change (Johnson & Ketring, 2006).

The association of alliance and therapy outcome of these two recent studies is in line with two previously conducted meta-analyses. Horvath and Symonds (1991) conducted a meta-analysis of the working alliance and psychotherapy outcome in which they reviewed 24 studies. The working alliance and positive therapy outcome was found to have a moderate association (weighted effect size for all of the combined data = .26). Similarly, in another meta-analysis, Martin, Garske, and Davis (2000) aggregated 79 studies and found a moderate weighted correlation between therapeutic alliance and outcome (r =.22).

Stage of Change Model

Prochaska and Norcross (2001) explicate that the stage of change model includes six different stages through which people proceed in order when they are changing behaviorally. The stages include precontemplation, contemplation, preparation, action, maintenance, and termination. Each stage has unique characteristics.

The first stage, precontemplation, is characterized by a lack of awareness of a problem. Clients in this stage generally attend therapy at the request of another. Those in the precontemplation stage of change do not plan to change within the next six months, even if they may like to change. Contemplation, the second stage of change, occurs when a person recognizes the need to change and is really thinking about changing within the next six months but has not yet decided to change (Prochaska & Norcross, 2001).

The third stage is preparation. This stage includes both intention and behavioral aspects. A person in this stage is planning to change within the next month and has taken action without success within the last year. Small behavioral changes have been made. A lessening of the problem has occurred, but the person is not yet in the full action stage.

For example, the person may not be abstaining completely from the problem, but has diminished it (Prochaska & Norcross, 2001).

Action is the fourth stage. In this stage, a person changes his or her behavior, environment, and experiences so as to conquer the problem. This stage includes the most obvious behavioral changes. A person is considered to be in the action stage if he or she has changed the behavior for a time of one day to six months (Prochaska & Norcross, 2001).

The fifth stage is maintenance. In this stage, a person strives to avert relapse and merge the benefits achieved in the action stage. A person is considered to be in the maintenance stage if he or she does not carry out the problem behavior and participates in a new contrary behavior for more than six months (Prochaska & Norcross, 2001).

The final stage is termination. A person enters this stage when he or she has finished the process of change and does not have to labor to avoid relapse. This stage is characterized by a complete lack of temptation to relapse and surety in high-risk situations (Prochaska & Norcross, 2001).

Stage of Change and Therapy Outcome

Prochaska and Norcross (2001) conducted a review of studies published that specifically addressed the stages and process of change in relation to outcome of treatment. From their review, the authors concluded that the outcome of therapy largely depends upon the clients' pretreatment stage of change. Moving from one stage to the next in the first month of treatment, however, leads to clients being twice as likely to take action in the next six months. Treatment aimed at helping clients move to the next stage in one month might lead to clients being twice as likely to take action in the near future.

Franko (1997) conducted a pilot study in which she sought to determine if readiness for change was related to outcome in cognitive behavioral group therapy for bulimic women. The study involved sixteen patients who met the DSM-III-R criteria for bulimia nervosa. Each patient received a questionnaire packet before beginning after completing twelve weeks of group therapy. The group therapy entailed psychoeducation, behavioral strategies, and cognitive restructuring.

Three different measures were used in the study. The Change Assessment Scale (McConnaughy et al., 1983; McConnaughy et al., 1989) was used to determine the patient's stage of change. Bulimic symptoms were measured by the Binge Eating Questionnaire (Halmi, 1985). Finally, thoughts that bulimic women often have were measured by the Bulimic Automatic Thoughts Test (Franko & Zuroff, 1992). An alpha level of .10 was used as an indication that the results might represent true findings, but would need to be confirmed by studies utilizing a larger sample size.

After treatment, the sample was split into those who no longer met the DSM-III-R criteria for bulimia nervosa and those who cut their binge frequency by half and no longer met the DSM-III-R criteria of two binges per week. This led to two groups: ten "positive outcome" patients and six "negative outcome" patients. The two groups did not have differences of binge frequency before beginning treatment (positive outcome group mean = 6.1 binges per week; negative outcome group mean = 5.8 binges per week, $t(1, 15) = .22$, $p = .71$).

The small sample size resulted in a non-normal distribution. Therefore, nonparametric tests were utilized to establish if pretreatment scores on the Change Assessment Scale delineated the positive outcome from the negative outcome group.

Only the Action subscale was analyzed due to the hypothesis that more positive outcome would be related to higher Action scores. The Wilcoxon Rank Sum Test was implemented and a significant difference between the positive and negative groups on the pretreatment Action scores was found (exact 2-tailed $p = .0312$). The Action subscale pretreatment scores were higher in the positive outcome group ($M = 54.0$, S.D. = 5.6) than the negative outcome group ($M = 47.5$, S.D. = 4.1).

Furthermore, the patients were divided into Contemplators and Action Takers, determined by their highest subscale score on the Change Assessment Scale (Prochaska, Norcross, Fowler, Follick, & Abrams, 1992). Those whose highest subscale score were on Precontemplation or Contemplation were deemed "Contemplators" while those whose highest subscale scores were on Action or Maintenance were deemed "Action Takers." Four Contemplators and twelve Action Takers were determined based upon this delineation. Nine Action Takers, but only one Contemplator, reduced binge frequency by half. This led to a trend toward significance using the test of proportions ($z = 1.78$, $p < .08$; Ferguson, 1981). This suggests that more of the Action Takers than Contemplators decreased binge frequency during the time of group therapy. Yet, more studies with larger sample sizes are warranted before any determination can be made. The scores after treatment on the Bulimic Automatic Thoughts Tests were not significantly different between the positive outcome group and negative outcome group ($p = .75$).

This study revealed some important information in regards to stage of change and therapeutic outcome. It was found that the patients who were further along in the stages of change, as determined by their high Action scores, showed the most clinical improvement in frequency of binging. However, there were some significant limitations.

The sample size was small and there was no follow-up data to determine if changes remained over time. There was also no assessment conducted during treatment which would have depicted the influence of the process of change during therapy.

Dozois, Westra, Collins, Fung, and Garry (2004) examined the stages of change in relation to cognitive behavioral therapy outcome for clients with panic disorder. The participants included 81 patients (52 females and 29 males) who were in a CBT group program for managing anxiety. The patients were recruited from an anxiety and affective disorders clinic of a Canadian teaching hospital. Of the 81 patients, 53 met DSM IV criteria for panic disorder with agoraphobia and 28 met DSM IV criteria for panic disorder without agoraphobia. Half of the patients had some post-secondary education, 19 % did not graduate high school, and 30% finished high school. The patients' ages ranged from 17 to 62 years. The mean age was 38 years (SD = 10.38). Eighty-six percent of the patients were taking anxiolytic medicine.

Five different measures were used in the study. The URICA (McConnaughy, Prochaska, & Velicer, 1983) was used to measure the stage of change. Somatic anxiety symptoms were measured by the BAI (Beck & Steer, 1990). The Panic Attack Questionnaire Revised (Cox, Norton, & Swinson, 1992) was used to measure the frequency of panic attacks. Fear of physical sensations related to anxiety was measured by the Anxiety Sensitivity Index (Peterson & Reiss, 1992). The final measure used was the Agoraphobic Avoidance subscale of the Fear Questionnaire (Marks & Matthews, 1979). This subscale assessed for the participants' degree of avoidance.

The URICA was administered prior to treatment and other measures of anxiety symptomatology were used prior to and following CBT group treatment. The CBT group

treatment lasted eight sessions. The sessions were held bi-weekly for 2.5 hours. Various CBT techniques such as cognitive restructuring, anxiety psychoeducation, and exposure were employed.

Cronbach's coefficient alpha for the whole URICA was excellent ($\alpha = .83$). Each of the four subscales had good internal reliability (Precontemplation $\alpha = .73$; Contemplation $\alpha = .79$; Action $\alpha = .90$; and Maintenance $\alpha = .81$). However, a maximum-likelihood confirmatory factor analysis, used to determine the fit of the data from the clinical sample to the intended subscale item loadings of the URICA, found inadequate fit indices (GFI = .64; AGFI = .58; RMS = .12).

The study also examined whether the URICA was able to predict treatment outcome. No significant effects were found between the URICA subscales and pre- to post-CBT change on anxiety symptomatology outcome measures when zero-order correlations were conducted. However, a significant multivariate group effect, F (8, 106) = 2.53, $p < .05$, was found when a MANOVA with group (responder, partial responder, nonresponders) as the independent variable and URICA subscales as the dependent variables was conducted. The Contemplation subscale was found to be significant, F (2. 56) = 5.60, $p < .05$, according to univariate F-tests. Scheffe's test of post-hoc comparisons found that CBT responders ($n = 25$) scored significantly higher on the Contemplation subscale ($M = 37.28$, SD = 1.9) than did CBT nonresponders ($n = 18$, $M = 34.44$, SD = 3.4, $p < .05$) and marginally significantly higher than partial responders ($n = 16$, $M = 35.06$, SD = 3.6, $p = 0.054$). However, a relationship between Precontemplation and Action subscale scores and CBT response was not found, a finding that the authors state is consistent with other research involving the URICA and anxiety disorders. These

overall results indicate that the URICA has partial predictive value in the treatment of anxiety.

Shechtman and Ben-David (1999) also examined the stages of change and therapy outcome. In this study, children attended therapy aimed at reducing their aggressive behaviors. Participants included 101 students ranging from first to ninth grades. Ninety percent of the participants were boys, which is consistent with other research (Pettit, 1997). Teachers nominated aggressive students for the study. Half of these students were randomly assigned to either treatment or control groups. The treatment groups consisted of individual or group therapy determined by the therapists' access to the participants. The treatment was based upon affective bibliotherapy that focused on emotions, experiencing, insight development, and interaction. Sessions were 45 minutes long and occurred weekly for 10 weeks.

Aggression was assessed by the Child Behavior Checklist (Achenbach, 1991a) and the Teacher Report Form (Achenbach, 1991b). The process of change was measured by Prochaska's (1995) change process and Hill's (1986) counselor and client verbal response modes system. While Prochaska's stages of change are generally measured by the distribution of questionnaires, this study employed content analysis of transcripts. Rater agreement was high (ks = .70, .88, .85, and .88 for Stages 1, 2, 3, and 4, respectively).

A significant univariate interaction for group type (treatment versus control) and time found that the treatment groups had more of a reduction in aggression over time than did the control group. In regards to Prochaska's process of change, the process did not appear to be linear. The researchers posit that this could be due to the child's inner

struggle. Overall, the undesirable statements that indicated lack of awareness or desire to change decreased over time and desirable statement that indicated desire and attempts to change increased during treatment. A Person correlation analysis was implemented to test this pattern. The results found a significant relationship between the expected process of change and length of treatment, especially for Stages 1 (unawareness of problem) and 4 (attempts to change aggression). In both the individual and group treatments the pattern was alike, but there were differences noticed between the treatment types in the second stage.

These results indicate that over the duration of treatment the children became more aware of their aggression and tried to modify their behavior. This was verified by the significant correlation between session and stage of change (Schechtman, & Ben-David, 1999). Thus, the children moved along the continuum of change as therapy progressed. From this data, it could be assumed that entering therapy in the Precontemplation stage does not necessarily mean that success in therapy is not possible. If clients move along the continuum in therapy, it may very well be that despite the stage of change, clients could obtain similar outcomes; although, this might entail those entering therapy in the beginning stages attending therapy for a longer period of time than those entering in a stage further along the change continuum.

Another study, conducted by Scott and Wolfe (2003) investigated the stages of change in relation to batterer treatment outcome. After excluding those who dropped out of treatment, participants included 119 men that finished treatment at an agency in Ontario that focuses on preventing and stopping men's abuse towards women. Treatment included 10 weekly sessions of psychoeducational counseling that entailed each section

of the Minnesota Power and Control Wheel (Pence & Paymar, 1986). After this part of treatment, the men were invited to engage in a 7 week closed group where group process, insight-oriented interventions, and confrontations were more of the focus. Almost all men were white (90) and the age range was 23-70 years.

Several different areas were assessed. Demographics were completed via self-report questionnaires. Two questions adapted from the National Family Violence Survey were used to inquire about a history of victimization (NFVS; Straus & Gelles, 1990). Alcohol problems were measured by the Short Michigan Alcoholism Screening Test (Selzer, Vinokur, & van Rooijen, 1975). The stage of change was assessed by the URICA (McConnaughy, DiClemente, Prochaska, & Velicer, 1989). The 8 physical abuse items from the Conflict Tactics Scale and 15 items from an early version of the Psychological Maltreatment of Women Inventory, Short Version were used to assess for emotionally and physically abusive behaviors (Straus, 1979; Tolman, 1999). Four other items, drawn from several scales, were added to measure participants' threatening and sexually abusive behaviors. At initial intake the participants reported the incidence and frequency of their abusive behaviors. Following intake, the participants answered in a yes/no fashion. This scale was normally distributed and internally consistent on each follow-up (α = .89, .90, and .90, respective of follow-up times). Participants' partners were requested to give responses regarding the participants' abuse. The same scale was used with word changing to reflect victimization instead of perpetration. Participants' level of responsibility taking was measured by requesting them to rate agreement with three different sentences regarding responsibility. The Self Dyadic Perspective-Taking Scale was used to evaluate

empathy (Long, 1990). Communication skills were measured by an adjusted version of the Interpersonal Competence Scale (Buhrmester, Furman, Wittenberg, & Reis, 1988).

"Hierarchical linear modeling (Bryk & Raudenbush, 1992) was used to represent change through a two-level hierarchical model, multiple observations nested within persons" (Scott and Wolfe, 2003; p. 882). To see if stage of change could predict growth variability, or change over time, the beginning covariate-adjusted growth model was examined, with only the outcomes that represented enough interindividual variability studied ($p < .30$). So, only change between the first and second assessments in participant- and partner-reported abuse, empathy, and communication was examined.

Significant values of contrast coefficients (precontemplation versus contemplation, precontemplation versus action, and contemplation versus action) provided support for stage of change as a predictor of individual change over time. At least one contrast between stages of change was significant for 5 of the 7 measures. The two measures that were not significant, partner-reported victimization and empathetic awareness, did approach significance ($p< .10$). No measures were significant for the contrast between contemplation and action, but there was a great reduction in self-reported abusive behaviors in both of these stages. Almost no change in self- or partner-reported abuse was found for men in the precontemplation stage. Men who were in the action stage of change improved perspective taking over the first two assessment times. Self-reported communication skills were improved for men in the action stage and, although not as strong of an improvement, men in the contemplation stage. Almost no improvement in communication skill was made by men in the precontemplation stage.

Overall, these results provide support that men who are in the contemplation and action stages of change at the start of treatment show greater gains in outcome than men are in the precontemplation stage. Stage-related differences in improvement over time were found from the start to midpoint of treatment. However, changes in outcome towards the end of treatment did not have enough variability to indicate individual differences.

Interestingly, the men seemed to become more similar over treatment. This could be due to the fact that precontemplative men acknowledged less abuse and greater communication and empathy skills at intake than men in other stages. Thus, the criticalness of the stages of change needs to be viewed in terms of whether more importance is placed on the amount of improvement over the course of time, which changes according to the stage, or the end result at the final assessment, which seems to be similar for men regardless of stage of change. Scott and Wolfe note that "the stage-related differences in men's rates of change over treatment likely reflect actual differences in men's progress, despite apparent similarity in men's scores at final assessment" (p. 887), especially when the influence that denial may have upon a precontemplative man's self-report information is considered.

In addition to therapy, the predictive ability of stages of change on addictive treatment outcome has been studied. Results are conflicting. Some research has found support for the predictive usefulness of the stages of change (Petry, 2005; Henderson, Saules, & Galen, 2004). Others have not found much support (Ledgerwood, & Petry, 2006; Blancherd, Morganstern, Morgan, Labouvie, & Bux, 2003). All of these studies utilized the URICA as a measure of stage of change.

Introduction to the Research Question

In their review of the literature, Prochaska and Norcross (2001) note that there is a lack of studies that involve psychotherapy for various neurotic disorders. Most of the available literature examines self-help treatments for addictions. Furthermore, Dozois, Westra, Collins, Fung, and Garry (2004) stated that there is a lack of research on readiness for change in mental health.

While there is a plethora of information available on the stages of change, therapeutic outcomes, and even a fair amount on the stages of change with various treatments, there is a lack of research examining the link between the stages of change and psychotherapy outcomes, especially in regards to couples therapy. The proposed study seeks to contribute to filling this gap and determine if there is a relationship between the two constructs of stages of change and client outcomes in couple therapy. Determining the significance of the therapeutic alliance will be necessary since it is a known predictor of therapy outcome, and a construct on which we have accessible data.

Hypotheses:

1. Clients who begin therapy in a stage of change that is further along the change continuum will be associated with more positive therapy outcome scores at the fourth therapy session when compared to the scores of clients who begin therapy in a stage of change that is not as far along on the change continuum.

2. There is an independent and/or additive relationship between stage of change and therapy outcome, in addition to the relationship between therapeutic alliance and therapy outcome.

METHODS

The purpose of this study is to determine the relationship between clients' stage of change and therapy outcome. The data was analyzed retrospectively from data obtained from the Marriage and Family Therapy (MFT) Clinic at Auburn University. The independent variables included the stage of change and therapy alliance. The dependent variable was therapy outcome.

Participants

The original nonrepresentative, convenience sample of participants in this study included clients who attended therapy at the MFT clinic between January 2004 and March 2008. In order to be included in the sample, participants must have attended at least four sessions, participated in couple therapy, and completed the necessary first and fourth session paperwork. The original sample included 335 cases. Due to client drop-outs prior to the fourth session, missing all data on the required scales, or attending therapy that was not couple therapy (such as individual therapy), the final sample size was composed of 122 participants (61 males and 61 females).

Participants ranged in age from 21-59 and more than half were white (66%). The proportion of males to females was 50% and approximately half were married (48%). Available demographics are presented in Table 1.

Table 1. Available demographics of clients.

Demographics	N	Percent
Age Group		
21-29	55	45.0
30-39	46	37.6
40-49	13	10.6
50 or above	5	4.1
Racial Group		
White	81	66.4
Black	25	20.5
Hispanic	2	1.6
Native American	1	.8
Asian	3	2.5
Multi	1	.8
Household Income		
Less than $10,001	16	13.1
$10,001 to $20,000	17	14.0
$20,001 to $30,000	23	18.8
$30,001 to $40,000	20	16.4
$40,001 or above	28	23.0
Client Education		
GED/High School	28	23.0
Vocational/Technical	7	5.7
Associate's Degree	12	9.8
Bachelor's Degree	39	32.0
Master's Degree	16	13.1
Other	12	9.8
Marital Status		
Married	59	48.4
Separated	21	17.2
Other	36	29.5

Measures of the Independent Variables

University of Rhode Island Change Assessment (URICA). (Appendix A) Each participant completed the URICA at every first and fourth sessions (McConnaughy, Prochaska, & Velicer, 1983). The scale utilizes 32 items, based upon a 5-point Likert scale, to determine the participant's stage of change. It is divided into four subscales including precontemplation, contemplation, action, and maintenance. The Cronbach's coefficient alpha for each subscale has been found to be as follows: precontemplation = .79, contemplation = .84, action = .84, and maintenance = .82 (McConnaughy, DiClemente, Prochaska, & Velicer, 1989). In regards to the stages of change, there is "no agreed protocol" for scoring (Derisley & Reynolds, 2002, p. 218). In this study, items on the precontemplation scale were reversed scored so as to facilitate the use of the URICA as a continuous measure of clients' stage of change. For this sample, internal consistency of the scale was found to have an overall α =.91.

Therapeutic Alliance. (Appendix B) The Couple Therapy Alliance Scale was designed to measure the therapy alliance between clients and the therapist and assess the tasks, bonds, and goals of the alliance, constructs originally devised by Bordin (1979) (Pinsof, 1994). Since the development of the CTAS, a revised version has been created (CTAS-R). This revised version was utilized in this study. The CTAS-R provides statements about the alliance to which clients rank on a 7-point Likert type scale according to their level of agreement with the statement (1 = completely disagree, 7 = completely agree). Statements are worded both positively and negatively. Reverse scoring was also utilized on this scale to ensure accuracy. Clients complete the scale every fourth session. Cronbach's alpha for the CTAS-R for this sample was .90.

Measure of the Dependant Variable

Outcome Questionnaire (OQ). (Appendix C) The OQ is a 45-item questionnaire created to assess psychological functioning and symptomatic distress. Three subscales comprise the OQ and include Symptom Distress, Interpersonal Relations, and Social Role Performance. Subscale scores can be combined to produce a total score. Higher scores indicate higher client distress (Lambert et al., 1996). Clients complete the OQ at every first and fourth sessions.

The OQ has been found to be sensitive to change by identifying significantly more improvements in clients obtaining psychotherapy than in clients who are not being treated (Vermeersch et al, 2004). Reliability for the questionnaire was reported with an internal consistency of α = .93. For this sample, internal consistency was calculated as α = .95.

RESULTS

The purpose of this study was to determine if a link between clients' stage of change and client outcomes in couple therapy existed independently of and/or additionally to therapy alliance. Client outcomes were measured by the OQ (Lambert et al., 1996). Stage of change was measured by the URICA (McConnaughy, Prochaska, & Velicer, 1983) and therapy alliance was measured by the CTAS-R (TA) (Pinsof, 1994).

Procedure

In order to determine if there were statistically significant independent relationships between the independent and dependent variables, the URICA, and the CTAS-R were correlated with the OQ. Hierarchical linear regression was employed to examine the amount of variance of the dependent variable (client outcomes as measured by the OQ) explained by the independent variables, stage of change (as measured by the URICA), and therapeutic alliance (as measured by TA). For this study the level of statistical significance was set at $p<.05$.

Univariate Statistics

The univariate statistics for all variables (URICA, TA, OQ) were examined and the data appeared normal. The univariate statistics are outlined in Table 2 and include the number of participants that completed each scale, the mean, the standard deviation, and the skewness of each scale.

Table 2. Descriptive Statistics of All Variables

Variables	N	Mean	Std. Deviation	Skewness
URICA	122	117.43	15.68	-.48
TA	122	219.95	36.89	-.58
OQ	122	56.73	23.08	.04

Examining Extreme Outliers

The data was first analyzed for extreme outliers. Due to the small sample size, extreme outliers have the potential to greatly alter the results. No extreme outliers were found. Therefore, elimination of outlying cases was not necessary.

Correlation Analyses

Correlations were conducted of all the predictors and outcome variables to determine if there were any statistically significant relationships. Correlations were also conducted to determine if the sex of clients was related to the different variables. The correlation table is presented in Table 3.

Table 3. Correlations between predictor and outcome variables

	OQ	URICA	TA	Sex
OQ	1.00			
URICA	.30**	1.00		
TA	-.43**	-.04	1.00	
Sex	.12	.15	.01	1.00

**p<.01

Hypothesis One asserts that clients who begin therapy in a stage of change that is further along the change continuum will be associated with more positive therapy outcome scores at the fourth therapy session when compared to the scores of clients who begin therapy in a stage of change that is not as far along on the change continuum. A correlation analysis was completed to determine if any statistically significant relationships existed between stage of change and/or therapy alliance, and client outcomes.

URICA scores were significantly correlated with OQ scores (p<.01) but not in the expected direction. Therefore, Hypothesis One was not supported. TA was significantly correlated with OQ (p<.01) but was also not in the expected direction. Sex was not correlated with the other variables indicating that it likely does not influence the relationships between variables.

Linear Regression Analyses

Hypothesis Two posits that there is an independent and/or additive relationship between stage of change and therapy outcome, in addition to the relationship between

therapeutic alliance and therapy outcome. A linear regression analysis was implemented to test Hypothesis Two. TA was found to have a significant negative relationship with OQ. This was not in the expected direction. For every one unit difference in OQ there was a .27 decrease in TA. When URICA was added into the equation, TA maintained a statistically significant negative relationship with OQ, and the URICA significantly predicted variance in the OQ beyond what the TA predicted, but this was also not in the expected direction. For every one unit difference in OQ there was a .26 decrease in TA and a .40 increase in URICA. It was expected that as clients' stage of change at intake increased client outcomes at the fourth therapy session would become more positive. However, as the stage of change increased, client outcomes actually became more negative. Therefore, results indicated that Hypothesis Two was not supported. Furthermore, the sex of clients was included in the linear regression analyses to ensure that it was not influencing results. The sex of clients was not found to significantly account for variance in client outcomes. Results are listed in the Table 4.

Table 4. Linear Regression of Sex on OQ, Sex and TA on OQ, and Sex, TA, and URICA on OQ.

		Unstandardized Coefficients B	t	*p*
Model 1	Sex	5.56	1.33	.19
Model 2	Sex	5.80	1.54	.13
	TA	-.27	-5.25	.00**
Model 3	Sex	3.89	1.07	.29
	TA	-.26	-5.32	.00**
	URICA	.40	3.44	.00**

**p<.01

DISCUSSION

This study examined the possibility that a relationship between clients' stage of change and client outcomes in couple therapy existed. It was hypothesized that clients who began therapy in a stage of change that was further along the change continuum would be associated with more positive client outcome scores at the fourth therapy session when compared to the scores of clients who began therapy in a stage of change that was not as far along the change continuum. It was also hypothesized that there would be an independent and/or additive relationship between stage of change and client outcomes, in addition to the relationship between therapeutic alliance and client outcomes. A summary of the findings, limitations of the study, and possible future research areas are discussed.

Summary

While the literature on clients' stage of change and client outcomes in couple therapy does not exist, literature is available on clients' stage of change and other types of treatments or specific types of therapies that indicate a connection between the two constructs (Prochaska, & Norcross, 2001; Franko, 1997). This study attempted to provide information concerning the possible link between clients' stage of change and client outcomes in couple therapy.

Based upon the existing literature surrounding the stages of change and treatment outcomes, two hypotheses were asserted. It was first hypothesized that clients who began

therapy in a stage of change that was further along the change continuum would be associated with more positive client outcome scores at the fourth therapy session when compared to the scores of clients who began therapy in a stage of change that was not as further along on the change continuum. It was also hypothesized that there would be an independent and/or additive relationship between stage of change and client outcomes, in addition to the relationship between therapeutic alliance and client outcomes. It was necessary to account for the therapy alliance as it is known to be a predictor of client outcomes in therapy (Horvath & Symonds, 1991; Johnson & Ketring, 2006; Johnson, Wright, & Ketring, 2002; Martin, Garske, & Davis, 2000).

Results from the correlations indicated a statistically significant negative relationship between therapy alliance and client outcomes ($p<.01$) and a statistically significant positive relationship between the stages of change and client outcomes ($p<.01$). Neither of these correlations was in the expected direction. A statistically significant relationship was not found between clients' sex and client outcomes.

Linear regression analyses supported the findings of the correlations. Clients' sex was again not significantly related to client outcomes, indicating no differences in clients' outcome of therapy depending on whether clients are male or female. Therapy alliance was found to be negatively related to client outcomes. This was surprising, but could suggest that on average those who report higher distress at the fourth session of therapy have a more difficult time forming a positive therapy alliance and vice versa. When clients' stage of change was added to the model, the relationship between therapy alliance and client outcomes remained significant, and an additional statistically significant relationship was found between clients' stage of change and client outcomes ($p<.01$).

However, this finding was also not in the expected direction and indicated that on average clients who were further along on the change continuum at intake reported more negative outcomes than those who were not as far along the change continuum and vice versa.

This unexpected finding could be due to a number of different reasons. For instance, this study solely focused on participants who were attending couple therapy. The existing literature concerning the stages of change and client outcomes points towards a link between the two constructs but involves individual clients – not couples. Perhaps different dynamics between the two types of clients account for the different findings. In couple therapy, for example, in the first session one partner may announce that he/she is leaving the relationship if change does not occur. The other partner who may have begun therapy in the precontemplation stage may find himself or herself suddenly very motivated to change and following through with all that is required in therapy to quickly bring about this change in the couple relationship. With positive change underway, this partner may report positive outcomes by the fourth session, especially if the partner's threat of leaving has subsided. The partner who was threatening to leave the relationship may have entered therapy highly motivated to change but may still be dealing with years of feeling hurt and isolated from the partner. As a result, this highly motivated partner may report more negative outcomes by the fourth session.

Another reason that the findings were not in the expected direction could be that clients who are further along the change continuum may be working harder towards change because they are experiencing more distress than those who are not as far along the stages of change. Those who are experiencing more severe problems are probably

more likely to be motivated to change than those who are not experiencing the same amount of distress. This idea fits well with those who are entering therapy, but it was expected that at the time of outcome, clients who were very motivated to change would report fewer problems than those who were not motivated to change. Yet, the fact could remain that those who were unmotivated to change could truly be experiencing fewer difficulties than those who were highly motivated to change. Keeping in mind that client outcomes were measured at the fourth session, clients who experience more severe problems and are therefore highly motivated to change may require more therapy sessions to resolve their problems than those who present to therapy with less severe problems and, therefore, less motivation to change.

The results of this study could also be related to the findings of one particular study that examined the stages of change and therapy outcome for children attending therapy aimed at reducing their aggressive behavior (Schechtman & Ben-David 1999). Results indicated that children moved along the continuum of change as therapy progressed. Some clients may begin therapy in the precontemplative stage due to denial that a problem exists, as opposed to actually having fewer problems, and therefore report positive outcomes at the fourth session. However, by a later session, these clients may admit problems exist and become motivated to change. Then, an opposite pattern could be found in which these clients suddenly report high distress. Meanwhile, the clients who presented to therapy with high motivation may have since resolved their problems. The formerly precontemplative clients may work through their newly admitted problems but after additional therapy sessions beyond what those who began therapy motivated to change required. Thus, in this study, it may have been quite possible that despite the stage

of change in which clients began therapy similar outcomes could have occurred at sessions beyond the fourth therapy session.

A variety of reasons have been proposed to explain why the findings were contrary to what was expected. However, final conclusions must not yet be supposed. More replicate studies need to be implemented before drawing such final conclusions.

Limitations

One of the most apparent limitations of this study is the small sample size. Due to client drop-outs prior to the fourth session, missing all data on the required scales, and attending therapy that was not couple therapy, only 122 participants of the original 335 cases were utilized. In addition to the small sample size, most of the participants were white and between the ages of 21 and 39. Data that included more participants of diverse races and older or younger generations could have greatly influenced the study's findings.

Additionally, data was obtained from a convenience sample of clients attending therapy at a southern university setting. Therefore, the applicability of the results is hindered for other regions of the country and even non-university settings. Additionally, data is collected from self-report questionnaires. Assuming that those completing the questionnaires are answering with complete truth can be misleading considering clients may limit the amount of personal information that they are willing to reveal.

Future Research

A fair amount of research exists between stage of change and specific treatment outcomes, but little exists on stage of change and client outcomes of therapy that is not limited to one therapy model or one specific client issue. Research examining stage of

change and outcomes in a variety of therapy approaches would be beneficial. Additionally, it would be pertinent to study the relationship within a broad spectrum of client issues.

Furthermore, no prior research was found that focused upon stage of change and client outcomes in couple therapy. This study sought to more specifically tap into this domain, but more research on the two constructs in couple therapy is needed. This is especially important considering that the results of this study differed from the previous findings that utilized data obtained from individuals.

Future research that does not have the limitations of this study would be of great use. Employing a larger sample size and a more varied sample, including those of different ages and races, would add a wealth of information to this field. Information collected from measures other than self-report and locations other than university settings are also merited.

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APPENDICES

APPENDIX A

University of Rhode Island Change Assessment (URICA)

This questionnaire is to help us improve services. Each statement describes how a person might feel when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. “Here” refers to the place of treatment or the problem.

1 = Strongly Disagree
2 = Disagree
3 = Undecided
4 = Agree
5 = Strongly Agree

1.	As far as I’m concerned, I don’t have any problems that need changing.	1	2	3	4	5
2.	I think I might be ready for some self-improvement.	1	2	3	4	5
3.	I am doing something about the problems that have been bothering me.	1	2	3	4	5
4.	It might be worthwhile to work on my problem.	1	2	3	4	5
5.	I’m not the one with a problem. It doesn’t make much sense for me to be here.	1	2	3	4	5
6.	It worries me that I might slip back into a problem that I have already changed, so I am here to seek help.	1	2	3	4	5
7.	I am finally doing some work on my problem.	1	2	3	4	5
8.	I’ve been thinking that I might want to change something about myself.	1	2	3	4	5
9.	I have been successful in working on my problem but I’m not sure I can keep up the effort on my own.	1	2	3	4	5
10.	At times my problem is difficult, but I’m working on it.	1	2	3	4	5
11.	Being here is pretty much a waste of time for me because the problem doesn’t have to do with me.	1	2	3	4	5
12.	I’m hoping that this place will help me to better understand myself.	1	2	3	4	5
13.	I guess I have faults, but there’s nothing that I really need to change.	1	2	3	4	5
14.	I am really working hard to change.	1	2	3	4	5
15.	I have a problem and I really think I should work at it.	1	2	3	4	5
16.	I’m not following through with what I have already changed as well as I had hoped, and I’m here to prevent a relapse of the problem.	1	2	3	4	5
17.	Even though I’m not always successful in changing, I am at least working on my problems.	1	2	3	4	5
18.	I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
19.	I wish I had more ideas on how to solve the problem.	1	2	3	4	5
20.	I have started working on my problems but I would like help.	1	2	3	4	5
21.	Maybe this place will be able to help me.	1	2	3	4	5
22.	I may need a boost right now to help me maintain the changes I’ve already made.	1	2	3	4	5
23.	I may be part of the problems, but I don’t really think I am.	1	2	3	4	5

24.	I hope that someone here will have some good advice for me.	1	2	3	4	5
25.	Anyone can talk about changing; I’m actually doing something about it.	1	2	3	4	5
26.	All this talk about psychology is boring. Why can’t people just forget about their problems?	1	2	3	4	5
27.	I’m here to prevent myself from having a relapse of my problem.	1	2	3	4	5
28.	It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
29.	I have worries but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
30.	I am actively working on my problem.	1	2	3	4	5
31.	I would rather cope with my faults than try to change them.	1	2	3	4	5
32.	After all I had done to try to change my problem, every now and again it comes back to haunt me.	1	2	3	4	5

APPENDIX B

Couple Therapy Alliance Scale

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

Statement							
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

Item	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

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