

**Couple Satisfaction and Individual Symptom Distress: Forming an Alliance in Couples  
Therapy**

by

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## Abstract

In this study, the relationship between dyadic adjustment ratings, individual symptom distress ratings and the therapeutic alliance for males and females was explored. Likewise, the interaction between individual symptom distress and dyadic adjustment predicting fourth session therapy alliance formation was analyzed. Sample data were collected from previous therapy clients at a marriage and family therapy training clinic at a southeastern university. Overall findings revealed the interaction of male symptom distress and dyadic adjustment ratings at intake, significantly and negatively predicted fourth session alliance ratings. Female (married and non-married) findings suggested a significant negative relationship between symptom distress ratings at intake and fourth session alliance.

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## **Introduction**

Researchers suggested therapists' treatment models are merely vehicles through which important change-facilitating factors emerge (Sprenkle & Blow, 2004). One of these factors is a relationship called the therapy alliance. This relationship ranks as one of the most critical challenges therapists are concerned with early in the therapy process (Garfield, 2004).

Researchers have found that as much as 5-22% of the variance in therapeutic outcomes was attributable to the therapeutic alliance (Bourgeois, Sabourin, & Wright, 1990; Johnson & Talitman, 1997; Knobloch-Fedders, Pinsof, & Mann, 2007). The therapeutic alliance is much more than a subjective measure of the therapist's "niceness," rather; it is a genuine interest, empathy, and concentration on the client in session (Horvath, 2000). This relationship between the client(s) and therapist is therapeutic in and of itself (Bordin, 1979); such that the formation of a strong alliance creates a therapeutic maneuverability by which interventions are accepted, goals are made, and change can take place.

The therapy alliance has typically been defined as the working relationship between the therapist and the client, which produces workable treatment goals, assigned tasks, and the development of bonds. These are established through empathy, warmth, and sincerity (Bordin, 1979; Eaton, Abbles, & Gutfreund, 1988; Eckert, Abeles, & Graham, 1988). However, forming a strong, yet flexible alliance with each person can be very challenging (Symonds, 2004).

One challenge that affects the alliance, which is frequently assessed in couple's therapy, is the level of distress within the couple relationship (Knobloch-Fedders, Pinsoff, Mann, 2004; Mamodhousen, Wright, Tremblay, & Poitras-Wright, 2005). The degree to which the couple experiences this relational distress is called dyadic adjustment (Busby, Crane, Larson, & Christensen, 1995). It is measured by the degree of relationship troubles, interpersonal or



personal anxiety, and categorized through relationship satisfaction, cohesion, and consensus (Symonds & Horvath, 2004). Dyadic adjustment is rated along a continuum, from well adjusted to poorly adjusted (Spanier 1979). Spanier (1979) described dyadic adjustment as a process, but also as a qualitative evaluation of a state of being, suggesting that the process of dyadic adjustment can be observed over time (longitudinal), or as a snapshot in time.

In an article looking at how dyadic adjustment impacts the therapeutic alliance in couple's therapy, Mamodhousen, et al. (2005) found that dyadic adjustment predicts the therapeutic alliance. In other words, when dyadic adjustment is poor, on average, it is likely the therapeutic relationship will be weak. Knobloch-Fedders, et al. (2004) cited similar findings, suggesting individual symptoms of depression or anxiety (symptom distress) were not as powerful in predicting alliance compared to dyadic adjustment in couple's therapy. Knobloch-Fedders et al. indicated that symptom distress may influence the alliance, but dyadic adjustment is a more distinct indicator of the alliance formation in couples therapy.

However, in individual therapy it is suggested that the more serious the client's pretreatment symptoms of depression or anxiety upon entering therapy, the lower the client's positive involvement in therapy will be experienced. Furthermore, serious pretreatment symptoms are related to negative client contributions to the therapeutic alliance as well (Eaton et al., 1988; Raue et al., 1993). In other words, the therapeutic alliance, within individual treatment, can be adversely affected by individual pretreatment symptom distress.

The literature states that dyadic adjustment predicts alliance over and above symptom distress in couple's therapy (Knobloch-Fedders et al., 2004; Mamodhousen et al., 2005). Additionally, within individual therapy literature serious symptoms, on average, contribute to a negative alliance (Eaton et al., 1988; Raue et al., 1993). However, according to Fincham, Beach,

Harold, and Osborne (1997) there is an interaction between symptoms and relationship distress for gender. They identified a causal path for females between depression and marital distress over time. They report that females with lower marital satisfaction ratings, demonstrated greater depressive symptoms one year later, and males with greater symptoms had lower marital satisfaction one year later. In a longitudinal study, it was revealed at each wave (8-wave data collection) that higher marital satisfaction was related to fewer depressive symptoms as well. Furthermore, lower marital satisfaction and greater depressive symptoms were related between each wave (Davila, Karney, Hall, & Bradbury, 2003). These findings suggest that merely assuming relationship satisfaction as the most important factor affecting couples may be misguided. Rather, a bi-directional relationship between individual symptoms and relationship satisfaction seems more realistic (Davila, et al., 2003). For example, relationship satisfaction might vary at different levels of depression or anxiety, and vice-versa.

Although research indicates the bi-directional relationship between depressive symptoms and relationship satisfaction is a relevant assumption (Davila et al., 2003; Fincham et al. 1997), no present research has observed how an interaction between these variables might affect the alliance formation process. The only known study investigating client symptom distress as a moderator was an unpublished thesis (Wimbish, 2004). This study found that symptom distress did moderate the relationship between male attachment anxiety at intake and alliance ratings. Furthermore, Wimbish suggested males with an anxious attachment quality with greater levels of symptom distress ratings reported increased alliance scores. Without considering this moderating effect, strong attachment anxiety negatively influenced the alliance formation. However, the therapeutic alliance was stronger, in general, at fourth session for anxious males reporting greater

symptom distress. In order for clinicians to understand what factors affect the alliance formation process, more research must be done regarding symptom distress as a moderator.

This study sought to understand the relationships between individual symptom distress ratings at intake and fourth session alliance ratings, dyadic adjustment ratings at intake and the fourth session alliance ratings, as well the interaction of symptom distress and dyadic adjustment ratings at intake in relation to fourth session alliance ratings. This was performed for males and females separately.

## **Review of Literature**

This review explored the literature concerning what is understood about particular client factors affecting the formation of the therapeutic alliance. Specifically, the relationship between symptom distress, dyadic adjustment, and the therapy alliance was reviewed. The literature concerning the therapeutic alliance and outcomes, as well as the formation of the alliance was discussed. Research revealing the interaction of dyadic adjustment and symptom distress is also presented. Furthermore, literature exploring client characteristics affecting the formation of the alliance, specifically individual symptom distress and relationship satisfaction (dyadic adjustment) is reviewed. Finally, the research questions pertaining to this study are presented.

### **Therapeutic Alliance and Therapy Outcomes**

Horvath and Symonds (1991) stated that therapeutic alliance is collaboration between the therapist and the client, which allows client and therapist to negotiate a therapeutic agreement fitting to the range and depth of therapy. Bordin (1979) described the alliance as the level or intensity at which clients and therapists are working together. He then suggested a successful therapeutic alliance includes an emotional bond based on mutual trust and positive regard, shared goals, and clearly defined tasks.

Much attention has been given regarding how these bonds, goals, and tasks affect the alliance and therapeutic outcomes (Sprenkle & Blow, 2004), even to the point that many regard the alliance as a possible common factor across all therapy models, theories, and strategies (Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996; Horvath, 2001; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Carl Rogers (1951) suggested the therapist's most significant influence on the clients' progress is interpersonal, rather than cognitive or model driven, and that the responsibility for such a relationship lies with the therapist. Furthermore,

Horvath (2000) found that a positive therapy alliance was predictive of therapeutic outcomes, indicating, that the client's perception of the alliance with the therapist is more important than the therapist's actual focused behavior towards therapeutic outcomes.

Throughout the literature the therapeutic alliance is a major contributor to many positive therapeutic outcomes (Bordin, 1979; Castonguay et al., 1996; Johnson & Taliman, 1997). Due to these positive findings, the therapeutic alliance research has initiated four meta-analyses examining the relationship between the alliance and therapy outcomes (Horvath & Bedi, 2002; Horvath, Del Re, Flueckiger, & Symonds, 2011a, 2011b; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Horvath and Symonds (1991) conducted the first meta-analysis concerning alliance literature and found a relationship between alliance and therapy outcomes. Their meta-analysis was composed of 24 studies involving therapeutic alliance. Twenty distinct data sets were used in the 24 studies and were sampled from 1980-1991. They were found using PsycInfo, Medline, Dissertation Abstracts, and Educational Resources Information Center (ERIC). Overall, Horvath and Symonds (1991) found that quality of alliance is a relatively robust predictor of therapy outcomes. Furthermore, they concluded therapists' ratings of the alliance did not correlate as much with therapeutic outcomes as the clients' ratings of alliance. In other words, clients' opinions count the most concerning the therapeutic relationship.

Martin et al. (2000) conducted another meta-analysis in an attempt to understand how alliance relates to therapeutic outcomes in individual psychotherapy as well. These authors conducted their analysis using 18-years of data from 79 total studies (58 published, 21 unpublished). The authors found that on average, when the quality of the therapeutic alliance was high, therapy outcomes were better or more positive, and vice-versa. Martin et al. found the

alliance is therapeutic in and of itself. In other words, part of client change can be accounted for through the relationship formed with the therapist.

Other researchers sought to determine how predictive the alliance is towards therapy outcomes. Barber, Connolly, Crits-Cristoph, Gladis, and Siqueland (2000) explored the causal link between the alliance and therapy outcomes within individual therapy. They hypothesized that alliance predicts change in depression. In this study, prior change in depression was partialled out, because they thought it could influence clients' ratings of the therapeutic alliance.

The authors discussed that process variables, such as the therapy alliance, make it difficult to examine causal inferences. Thus, in order to determine causality, Barber et al. took into account three conditions: nonspuriousness, covariation between alliance and the outcome measure, and temporal precedence (Feeley, DeRubeis, & Gelfand, 1999). They measured the amount of symptom change from the beginning of therapy (intake) to the time of first alliance measurement (week 2). They also assessed for change in symptoms after the alliance had been measured and the role of how early symptom improvement actually affects subsequent outcomes.

This study included 86 clients with generalized anxiety disorders, chronic depression, or avoidant or obsessive-compulsive personality disorder. The 46 women and 42 men were divided into three groups of treatment: behavioral, cognitive, or short-term dynamic therapy. Client symptomatology was measured using the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988). The strength of the alliance was measured using the California Psychotherapy Alliance Scale (CALPAS; Barber, et., 2000; Hatcher & Barends, 1996). At the end of sessions 2, 5, and 10 the alliance was measured, and when prior change in depression was ruled out, alliance at all sessions significantly predicted a decrease in depression.

Although, the research findings build a strong argument that the alliance is predictive of outcomes in individual therapy, the alliance literature in couples therapy is just beginning to grow (Horvath & Symonds, 1991; Martin et al., 2000). A recent couple therapy study by Anker, Owen, Duncan, and Sparks (2010) explored the relationship between partner alliances and therapy outcomes, and whether the alliance predicted outcomes over and above early change. They also looked at gender and partner influences concerning the alliance. The sample consisted of 250 white Euro-Scandinavian heterosexual couples. The Outcome Rating Scale (ORS) was used to assess psychological functioning and distress at the beginning of each session (Miller & Duncan, 2004), however the ORS ratings were only used at pre-treatment, session 3, and post-treatment. Post-treatment rating varied according to timing of termination. The Locke-Wallace Marital Adjustment Test was used to measure self-reported perceptions of marital functioning (Locke & Wallace, 1959). The client's perspective of their alliance with the therapist was measured using the Session Rating Scale (SRS; Duncan, et al., 2003). The SRS ratings were administered at first and last sessions in the total sample.

After testing their first hypothesis, that individual and partner alliance scores after the first and last sessions would be positively related to therapy outcomes at post-treatment and follow-up ( $n=250$ ), Anker et al. found a relationship existed between relationship satisfaction and alliance scores, such that outcomes were better for clients who reported better alliances at the end of therapy. Furthermore, when the partner had higher alliance scores with the therapist when therapy finished, client outcomes were also better. In regard to outcomes over and above early change, the third- and last-session alliances were established as predictions of outcomes. Regarding gender, men's alliance at last session more strongly predicted outcomes than women.

These findings concerning partner alliances and outcomes validate previous research reported that the interplay between partner alliances can influence therapy outcomes (Anderson & Johnson, 2010; Pinsof & Catherall, 1986). Pinsof and Catherall (1986) described two different alliances—a between and within system alliance. The within system consists of the relationships between all three individuals (couple and therapist), whereas the between system relationship is just between the couple.

In an attempt to observe within-system alliances, researchers Johnson, Wright, and Ketring (2002) investigated two questions do mothers,' fathers,' and adolescents' perceptions of family alliance (measured in bonds, tasks, and goals) predict an increase in individuals' relationship functioning, a decrease in symptom distress, and an increase in coping skills? The researchers continued on to determine if perceptual differences existed for mothers, fathers, and adolescents concerning the family alliance in their domains (goals, tasks, bonds), and if these domains have a greater influence in predicting outcome variable scores.

In this study, clients' ( $n=81$ ) perceptions of their therapeutic progress, specifically concerning symptom distress and family relationships functioning were measured using the Outcome Questionnaire (OQ-45.2; Lambert et al., 1996). The Therapy Alliance Scale (Pinsof & Catherall, 1986) was used to measure therapy alliance, which assesses the agreement between client and therapist regarding bonds, tasks, and goals. Lastly, to assess family problem-solving and behavior strategies, the Family Crisis Oriented Personal Evaluation Scales (F-COPES) was utilized (McCubbin, Olsen, & Larsen, 1981).

Findings suggested the domains of bonds, goals, and tasks predict change in symptom distress for mothers, fathers, and adolescents. Therapeutic alliance explained 19% of the variance in symptom distress changes in mothers, 55% in fathers, and 39% in adolescents. Furthermore,



the tasks domain of the alliance appeared to be the most significant correlate in symptom distress change for mothers and adolescents, and the goals domain correlated more for the father symptom distress change (Johnson, Wright, & Ketring, 2002). Thus, it appears reported levels of depression and anxiety decrease as people feel they have someone (i.e. therapist) to help them create goals and discover ways of achieving those goals.

Overall, these findings, and previously reviewed findings create clear evidence that the alliance correlates positively with therapeutic outcomes in couple's therapy (Castonguay & Butler, 2005a; Constantino, Castonguay, & Schut, 2002). Because research finds a positive relationship between alliance and outcomes, one of the salient tasks is to explore which specific client characteristics influence the alliance formation. Two common client characteristics pertinent to couples therapy are individual levels of depression and anxiety and couple relationship satisfaction. Couple relationship satisfaction, known as dyadic adjustment, is one couple characteristic often assessed before therapy begins. Individual levels of depression and anxiety, known as symptom distress, are also key clinical elements clinicians must acknowledge. It seems logical that at different levels of either of these factors, the ability to form a therapeutic relationship could be affected. However, before these constructs are reviewed regarding their impact on the alliance, research will be presented concerning their bidirectional relationship.

### **Interaction of Depression and Relationship Satisfaction Literature**

A question must be asked when assessing dyadic adjustment and individual depression as factors of therapy—does individual partner depression affect the degree of relationship satisfaction or does poor relationship satisfaction affect later depression? According to Fincham, Beach, Harold, and Osborne (1997) the answer is yes. Fincham et al. explored whether different causal effects could be expected due to gender. They used a predominantly European American

sample consisting of 150 newlyweds (married 3-8 months). Marital satisfaction was measured using the Marital Adjustment Test (MAT; Lock & Wallace, 1959), and the Beck Depression Inventory (BDI) was used to assess depressive symptoms. On average, couples reported being satisfied in their marriages at baseline 1 and 18 months later. Overall, participant depressive symptoms remained stable. Results indicated for women, that a significant causal path between marital satisfaction and later depressive symptoms existed, specifically lower marital satisfaction at time 1 led to higher depressive symptoms at time 2. Researchers identified a causal path for men as well, such that higher symptoms at time 1 were related to later relationship dissatisfaction. In other words, when the relationship quality is poor, later depressive symptoms for women often follow, and for men, depressive symptoms often lead to later marital dissatisfaction.

Proulx, Helms, & Buehler (2007) published a meta-analysis similar to the study conducted by Fincham et al. (1997), however, rather than solely looking at depression, they also constructed multiple measures of personal well-being (self-esteem, life satisfaction, physical health). Included in the analysis were longitudinal ( $k = 78$ ) and cross-sectional studies ( $k = 137$ ), containing personal well-being and marital quality as the dependent variables. Overall, findings from the longitudinal studies revealed when personal well-being was the dependent variable, the association between marital quality and personal well-being was stronger, rather than marital quality as the dependent variable. Furthermore, cross-sectional findings indicated that a positive association exists between marital quality and personal well-being. In sum, Proulx et al. (2007) reported some evidence that marital quality precedes depressive symptoms. However, results of Proulx et al. (2007) were not conclusive. They assumed the lack of well-being measured

depression, which they assessed using multiple measures of well-being instead of assessing depression independently.

Overall, Proulx et al. (2007) suggested that despite the significant impact of marital quality on well-being, personal well-being had a stronger association on marital quality. However, Davila, Karney, Hall, & Bradbury (2003) had already discovered that a two-way or bi-directional relationship existed between relationship satisfaction and depressive symptoms. Data were collected over a 4-year period at 6-month increments. Assessment began at baseline, which created an 8-wave analysis. Researchers used the BDI to measure depressive symptoms. Relationship satisfaction was assessed using the MAT, as well as a version of the semantic differential (SMD; Osgood, Suci, & Tannenbaum, 1957). At each wave of assessment, researchers found a correlation between relationship satisfaction and depressive symptoms ranging from .23 to .53. Methodological analysis included hierarchical linear growth modeling to examine the effects of time-varying relationship satisfaction on changes in depressive symptoms, as well as time-varying depressive symptoms on changes in relationship satisfaction.

As relationship satisfaction changed overtime, Davila et al. found higher depressive symptoms between waves were associated with lower relationship satisfaction, and lower depressive symptoms were associated with higher relationship satisfaction. Although each wave in this relationship was significant for both partners, it was stronger for women. Furthermore, as depressive symptoms changed overtime, Davila et al. found that higher relationship satisfaction was associated with lower averages of depressive symptoms for which there were no gender differences.

Davila et al. (2003) provided evidence that a bidirectional relationship between depressive symptoms and relationship satisfaction exists. Furthermore, it lends insight that

clinicians might approach therapy with different strategies depending on which partner demonstrates certain levels of depression or relational dissatisfaction. However, the present study focuses on the possible interaction of depression and anxiety and relationship adjustment on the alliance. Davila et al. (2003) and Fincham et al. (1997) provided a strong rationale that these constructs are related, and that at different levels of each construct for each partner, therapeutic outcomes may change. Although literature concerning individual depressive and anxious symptoms and alliance is scant, as well as literature discussing relationship satisfaction and alliance formation, the literature does suggest symptom distress and dyadic adjustment are viable constructs pertaining to the therapeutic alliance.

### **Dyadic Adjustment and Therapeutic Alliance Formation**

Symonds and Horvath (2004) explored levels of relationship distress as it affects the alliance. They stated an important allegiance existed within the couple relationship called the “loyalty dimension.” It is defined by the couple’s unique strength and relationship connection quality. It allows for a sense of security and safety, which helps each partner trust and be trusted in stressful situations. Symonds and Horvath (2004) suggested the quality of the partner allegiance is an important influence on the formation of the therapeutic alliance, which subsequently contributes to successful therapeutic outcomes.

Knobloch-Fedders et al. (2004) analyzed marital distress, individual client symptomatology, family of origin functioning, and alliance formation. The total number of participants in the study was 80, derived from 35 couples and 10 individuals (partner data missing). All were treated at a Midwestern outpatient clinic for couple and family therapy. Most of the presenting problems were cited as issues with communication, intimacy, conflict, and parenting.

Client symptomatology and responses to psychotherapy were assessed using the COMPASS Treatment Assessment System. This 68-item questionnaire contains three subscales: Current Well-Being, Current Symptoms, and Current Life Functioning, which are all rated on a 5-point Likert type scale. The six-item Current Well-Being scale included items assessing distress, energy and health, emotional and psychological adjustment, and current life-satisfaction. Greater well-being is considered, at higher scores of that subscale. In order to assess for the frequency of symptoms common with depression, anxiety, obsessive-compulsive, adjustment, bipolar, phobia, and substance abuse disorders, a 40-item Current Symptoms scale was used. A 24-item Current Life Functioning scale was administered to measure six areas of functioning: self-management, work/school/homemaker, social/leisure, intimacy, family, and health.

The Marital Satisfaction Inventory--Revised (MSI-R; Snyder, 1997) assessed for marital distress, whereas current family of origin functioning was assessed using the Family Assessment Device--family of origin (FAD; Epstein, Baldwin, & Bishop, 1983; Miller Epstein, Bishop, & Keitner, 1985). The COMPASS, MSI-R, and FAD were completed at initial intake. Lastly, the Couple Therapy Alliance Scale--Revised was used as a self-report questionnaire measuring the therapy alliance in conjoint therapy (CTAS-R; Pinsof, 1994). The CTAS-R was administered immediately following session one and session eight.

Findings from Knobloch-Fedders et al. (2004) revealed marital adjustment predicted alliance formation, such that greater levels of marital distress predicted a weaker alliance at either stage of treatment. In other words, the more distressed the couple relationship was at intake, on average, the poorer the alliance ratings at session eight. In this sample, individual symptomatology did not predict alliance in conjoint therapy. They suggested that alliance is perhaps not predicted by individual symptomatology because it is not the focus during conjoint

therapy. In other words, even though serious levels of client well-being may exist for each spouse, within this treatment sample, the formation of an alliance in conjoint therapy is more significantly related to relational distress.

Mamodhoussen et al. (2005) revealed similar results to Knobloch-Fedders et al. (2004). The purpose of their study was to examine the impact of marital distress and psychiatric symptoms on the quality of the alliance. Data were obtained from 79-French speaking couples living the province of Quebec, who accomplished at least three sessions of couple's therapy. Couples were recruited through a large French-language university in Quebec. All participants completed a French version of the dyadic adjustment scale, (DAS; Spanier, 1976) and a Psychiatric Symptoms Index (PSI; Ilfeld, 1976), which is a self-report questionnaire identifying symptoms of psychological distress (depression, anxiety, cognitive disturbances, and hostility) of the last seven days.

Mamodhoussen et al. (2005) indicated that first session men and women's DAS scores predicted alliance scores at session 3, even after controlling for education, number of children, and psychiatric symptoms. Furthermore, first session psychiatric symptoms did not predict total alliance scores for men or women at session 3. They suggested that spouses who reported similar alliance ratings, tended to have more positive alliance ratings. Overall, first session marital adjustment predicted the quality of the alliance at session three. Furthermore, first session psychiatric symptoms were significantly related to third session alliance formation.

Mamodhoussen et al. (2005) discussed that perhaps the formation of a good alliance was influenced not just by how many difficulties clients present to begin therapy, but specifically which difficulties or challenges affected them.

Together, these findings form an argument that dyadic adjustment should be a viable client factor when assessing which characteristics are important in creating a relationship with clients in couple therapy. However, in 1990 Bourgeois, Sabourin and Wright contradicted Knobloch-Fedders et al. (2004) and Mamodhoussen et al. (2005) in a study that focused on the relationship between therapeutic alliance formation and marital distress in a marital skills treatment group. The group had 63 couples. All met for nine, three-hour weekly trainings. The goal of the study was to explore marital distress as a stable predictor of alliance formation and the quality of the alliance as an indication of outcome in-group marital skills training.

All 63 couples were married or cohabiting, and were French speaking residents of Quebec, Canada. Six senior therapists and seven co-therapists facilitated the program, all of who were licensed psychologists. The program (CPS-Couple Survival Program) centered on communication skills, such as active listening, expressing positive and negative feelings, and problem solving. Each group consisted of one therapist, one co-therapist, and four couples (two distressed/two non-distressed).

Before the first session training, all couples completed four assessment measures. Bourgeois et al. used the dyadic adjustment scale (DAS; Spanier 1976), which assesses the degree of marital satisfaction using 31 aspects of interaction, and an overall global happiness measure. Participants completed the Potential Problem Checklist (PPCL; Patterson, 1976), which is a self-report questionnaire assessing themes in the marriage that lead to conflict. The Marital Happiness Scale (MHS; Azrin, Naster, & Jones, 1973) was also used to assess nine different aspects of the marriage, which then creates a level of happiness value. Lastly, researchers administered the Problem Solving Inventory (PSI; Hepner & Patterson, 1982), which evaluates personal problem solving behaviors. After the third session, participants completed the Couple

Alliance Scale (CAS; Pinosof & Catherall, 1986), which assessed therapist and client observations' of the alliance. A week after treatment was completed, all couples were administered the four pre-treatment assessments.

Overall, Bourgeois et al. (1990) suggested that serious levels of distress at intake were not a significant predictor of alliance formation or successful completion of treatment goals. Levels of relationship distress did not negatively or positively affect the alliance formation. A limitation to this study is sample bias. The couples were recruited and given similar goals to work towards as a group, rather than personal treatment goals like usual therapy. Additionally, in order for couples to be taught the skills training, only non-conflictual issues were used in-group discussion and processing, which is very different than the usual conflict centered discussions in therapy. This suggests that this sample, overall, is not similar to the sample we find in most other alliance studies, and especially because this sample experienced relationship education rather than therapy.

Research concerning dyadic adjustment has created a relevant case, that it does influence later alliance formation processes. However, clients rarely attend therapy only discussing the relationship, rather, there are individual components within the couple relationship that might influence the alliance process. One common component is individual depression and anxiety, or individual levels of symptom distress.

### **Symptom Distress and Therapeutic Alliance Formation**

Surprisingly, throughout the research investigating alliance and outcomes, very little explores individual levels of client depression and anxiety influencing alliance formation in individual therapy—a common factor many clients experience (Constantino, Arnow, Blasey, & Agres, 2005). There are mixed findings within symptom distress studies; however some studies



find a negative relationship, such that at greater reported levels of symptom distress there are lower ratings of therapeutic alliance in individual therapy (Constantino et al., 2005; Eaton, et al., 1988; Raue et al., 1993).

Eaton et al. (1988) produced one of the first studies spotlighting the relationship between therapy alliance and individual pre-treatment symptoms. The authors gathered data from the Michigan State University Psychotherapy Research Project at the MSU Psychological Clinic. Researchers selected 40 cases, all of which had a minimum of 10 treatment sessions and had completed pre- and post-treatment written measures as well as treatment audio recordings. The 40 cases were then grouped into three groups: high (over 40 sessions,  $n=12$ ), moderate (20-40 sessions,  $n=15$ ), and low (20 sessions or less,  $n=13$ ).

The Hopkins Symptom Checklist (SCL-90; Derogatis, 1977) was used to measure pretreatment individual symptomatology and the Therapeutic Alliance Rating Scale (TARS; Marzilli, 1984) was used to measure therapeutic alliance. Using randomly selected audio recordings two judges randomly selected segments from the beginning, middle, and end of treatment and rated the therapeutic alliance. One male and one female graduate student in clinical psychology judged the alliance. Both judges were trained how to rate the alliance by reading a manual for the rating system, rating practice sessions, and in order to have consensus they participated in group meetings to discuss transcripts from audio tapes. Furthermore, judges spent time (16 hours) during the 20-week rating process to prevent rater drift.

Eaton et al. found a negative relationship, suggesting the alliance was adversely influenced when client's pre-treatment symptoms were high. Furthermore, when a client began therapy reporting greater levels of depression, they had lower levels of positive contribution to the alliance and high negative contribution to the alliance.

In 1993, Raue et al. produced a similar study, which explored individual client symptom distress and alliance within specific therapeutic approaches. The sample size for this study was 31 clients. All participants had a diagnosis of either generalized anxiety disorder or major depression. All participants ranged between 20 and 55 in age. Their findings were similar to Eaton et al. (1988) that a negative relationship existed between client symptomatology and the alliance. This means, the greater the reported individual rating of depression and/or anxiety at intake, on average, the lower the alliance rating later in therapy.

Researchers from a Stanford University Medical Center reported findings conflicting with Eaton et al. (1988) and Raue et al. (1993). They looked at the relation between specific patient characteristics and the development of the alliance during treatment of bulimia nervosa. They found client symptom distress at baseline, negatively related to middle treatment alliance in cognitive-behavioral therapy, but failed to find significance between symptoms and alliance for bulimic clients receiving interpersonal therapy (Constantino et al., 2005). Other studies provide evidence that alliance ratings and individual symptomatology are not significantly correlated (Principe, et al., 2006).

Individual therapy literature is more definitive concerning alliance formation than couple's therapy research around alliance formation processes. Few studies on the subject of symptom distress and alliance formation exist within couples therapy, and from what has been investigated, findings appear conflicting (Johnson & Taliman, 1997; Knobloch-Fedders et al., 2004; Mamodhousen, et al., 2005). As reviewed earlier, Knobloch-Fedders et al. (2004) found symptom distress not as useful a predictor of alliance as marital adjustment. Such that, no significant relationship between the alliance and symptom distress in conjoint therapy existed. Furthermore, they concluded that any previous significant relationship that existed in individual

therapy no longer existed within couple therapy. The authors highlight that these findings are similar to the only other study that observed client symptom distress not significantly predicting alliance in couple therapy (Mamodhoussen et al., 2005).

Of note however, is an unpublished thesis conducted by Stephens in 2006. In her study, 106 couples provided data for analysis. She explored the relationship between male and female symptom distress, as well as differences in symptom distress and how this affected the formation of the alliance. Treatment was received at a southeastern university marriage and family therapy clinic. Clients included in the data analysis all received at least four sessions, completing pre-treatment assessments at session one and post-treatment assessments at session four.

The Outcome Questionnaire (OQ-45.2; Lambert et al., 1996) was used to assess client symptom distress. Marital adjustment was assessed using the Revised Dyadic Adjustment Scale (RDAS; Spanier, 1979). After the fourth session assessments, both the OQ and RDAS assessments were completed, as well as the Couple Therapy Alliance Scale--Revised (CTAS-R; Pinsof, 1994), which assesses the therapeutic alliance.

Stephens (2006) revealed that a negative relationship between male symptom distress and therapeutic alliance in the sample. This suggested, on average, when males reported greater levels of symptom distress alliance scores are lower. Furthermore, male marital adjustment was mediated by male symptom distress at greater levels of symptom distress, which contradicts previous research that symptom distress at the onset of therapy does not influence conjoint treatment. Overall, Stephens suggested that males might play a key role in alliance formation, because no such relationship was found between female symptom distress and alliance scores (Stephens, 2006).

## **Gender and a Case for Symptom Distress Moderating Dyadic Adjustment**

Unfortunately, research is scarce concerning gender and alliance formation. Most research has focused on therapeutic outcomes as predicted by gender, rather than how gender affects alliance. Researchers have found that the male alliance score is a powerful predictor of outcomes in therapy (Bourgeois et al., 1990, Brown & O'Leary, 2000, Garfield, 2004; Symonds & Horvath, 2004). For example, Symonds and Horvath (2004) found when men have a stronger alliance than women at the beginning of therapy, and as the couple progresses together in a positive therapeutic alliance, a positive outcome in treatment is more likely. However, Stephens (2006) reported in an unpublished thesis that male symptom distress negatively affecting alliance formation, such that at greater reported levels of distress, alliance ratings are low. This may lend insight into how a therapist attempts to begin the alliance process between the spouses.

Knobloch-Fedders (2004) suggested engaging the male partner more frequently at the beginning of the therapeutic process. They added that keeping rapport with the female partner throughout the session must occur, but that specific focus on the male might help the therapist create a positive alliance with the couple. It was suggested that attempting the opposite may undermine the individual partners (i.e. the male) emotional needs when beginning therapy. In other words, when the male feels safe and understood, he is more likely to engage in therapy and believe that therapy is not one-sided. Garfield (2004) suggested that men carry the "positional power," which corresponds to control and status, and that women carry the "relational power," which corresponds with the emotional needs and intimacy of the relationship. As such, joining early with the man and allowing him time in the beginning of therapy to be expressive, can allow him to become invested in the process and learn more about emotional expression. If this does

not happen, it is possible the man could feel left out, resulting in what researchers call a split alliance (Mamodhoussen et al., 2005)

Mamodhoussen et al. (2005) examined the split alliance (or when couples differ in their opinion about the therapeutic relationship). It was established that when men rated dyadic adjustment low (negative), they are more likely to rate a low alliance as well, or have a split alliance with their spouse. In other words, dyadic adjustment is also a powerful predictor of a split alliance and low alliance scores for men. Women, however, when entering therapy reporting fewer psychiatric symptoms (i.e. depression and anxiety), they often exhibited a split alliance in couple's therapy. Thus, it seems how each person perceives the marriage, could alter the alliance process differently depending on gender.

In sum, Stephens (2006) found when individual male symptom distress is greater, meaning they are very depressed or anxious, alliance ratings are low, and Mamodhoussen et al. (2005) found when male marital adjustment ratings are high, meaning low marital quality or happiness, the alliance will be rated lower as well. The only other study to consider symptom distress moderating the alliance formation is an unpublished thesis. It was discussed whether symptom distress moderated the relationship between male and female attachment qualities and the therapy alliance (Wimbish, 2004).

Overall, 48 married couples and 20 individuals in a committed relationship participated in this study. All were clients at a southeastern university marriage and family therapy clinic. The Outcome Questionnaire (OQ-45.2; Lambert et al., 1996) was used to assess client symptom distress. The Experiences in Close Relationships scale (ECR; Brennan, Clark, & Shaver, 1998) was used to measure attachment in adult relationships. The two subscales of the ECR are anxiety and avoidance. After the fourth session assessments, both the OQ and ECR assessments were

completed, as well as the Couple Therapy Alliance Scale--Revised (CTAS-R; Pinsof, 1994), which assesses the therapeutic alliance within three sub-scales--goals, tasks, and bonds.

The interaction between symptom distress, male attachment anxiety and alliance was not significant at intake. After assessing the interaction of male attachment anxiety and symptom distress at intake, it was established that the interaction significantly related to the tasks and bonds scales of the therapeutic alliance at the fourth session. Wimbish (2004) found there is a difference between the interaction of symptom distress and male attachment anxiety from intake to fourth session reports. Perhaps there is reluctance for males to automatically accept help from a new resource (therapist), and that it takes a few sessions for the impact of their symptoms to be exposed. For females, no significant interaction existed between attachment anxiety and symptom distress and the therapeutic alliance at fourth session. In other words, symptoms distress did not moderate attachment anxiety. Wimbish (2004) suggested this might be explained by female's ability to experience an overall more positive alliance regardless of outside influences, such as symptoms or attachment.

### **Research Questions**

**Question 1:** What is the relationship between dyadic adjustment at intake and 4th session therapy alliance ratings?

- a) for males
- b) for females

**Question 2:** What is the relationship between individual symptom distress ratings at intake and 4<sup>th</sup> session therapy alliance ratings?

- a) for males
- b) for females

**Question 3:** Do individual symptom distress ratings at intake moderate the relationship between dyadic adjustment ratings at intake and 4<sup>th</sup> session therapy alliance ratings?

- a) for males
- b) for females

## Methods

Overall, the alliance is a powerful factor in therapeutic change, and is formed differently depending on who is in session, what kinds of pre-treatment characteristics are experienced, and how and when the therapist attempts to join with each person. As reviewed, dyadic adjustment lends insight that dyadic adjustment could be a significant predictor of alliance (Knobloch-Fedders et al., 2004; Mamodhoussen et al., 2005). Additionally, Eaton et al. (1988) and Raue et al. (1993) found symptom distress to be a relevant factor affecting the alliance formation. Furthermore, numerous studies have found that depressive symptoms and relationship adjustment were bidirectionally related (Beach et al., 2003; Whisman et al., 2004), which suggested that when one spouse has depression and/or anxiety, it is likely that marital distress will also exist. In other words, a stressful marriage can be depressing.

Therefore, the purpose of this study was to explore whether dyadic adjustment ratings at intake related to fourth session ratings of the therapeutic alliance for males and females in conjoint therapy, whether individual ratings of symptom distress at intake related with the therapy alliance for both males and females, and whether a relationship between couples' dyadic adjustment and alliance changed due to the interaction of symptom distress.

This methods section introduces and describes the mechanisms by which the research questions were answered. It discusses the data collected, the sample, the measures used to assess and create the quantitative data, and whether symptom distress moderates the relationship between marital adjustment and the therapeutic alliance.

Data for this study were collected and completed at the Auburn University Marriage and Family Therapy Center (AUMFTC) in Auburn, Alabama. This center is an on-campus training clinic for the Commission on Accreditation for Marriage and Family Therapy Education



(COAMFTE) accredited Marriage and Family Therapy Master's program at Auburn University, providing services to residents of east Alabama. Therapy at the Center is conducted by Master's level student therapists in training and supervised primarily by Ph.D. level licensed marriage and family therapists who are AAMFT approved supervisors.

## **Participants**

Participants for this study were clients who attended therapy at the AUMFTC. This sample consisted of couples married and non-married in heterosexual partnerships. Clients sought therapy for many therapeutic reasons, including couple relationship counseling, behavior problems, anxiety and depression, infidelity, and many other difficult challenges. During the sample time frame, 288 couples began therapy at the center. From the 288 couples, 164 couples failed to fill either attend at least four sessions of therapy, or did not fill out 4<sup>th</sup> session paperwork, eliminating them from the sample (69.3%). These couples were considered non-completers. In the end, 124 total couples (248 participants) attended at least 4 sessions of therapy, and completed all required paperwork (intake and 4<sup>th</sup> session). These couples were considered completers. Overall, a 44% retention rate existed for all couples attending at least 4 sessions of therapy from the original sample frame.

Age ranges for the 248 completers in this study were 18-61 years of age ( $M =$  male/female) ( $M = 31.8/29.9$ ). Approximately 71% of males and 73% of females reported their race as White, while 10% of males and 11% of females were African American. On average, the reported annual income for this sample ranged from \$20,000 to \$40,000 ( $M = \$26,000/\$24,000$ ). Educational attainment was also assessed. In this sample 49 males (39.5%) and 24 females (23.6%) reported graduating from high school, and 24 males (19.4%) and 45 females (36.3%) reported receiving Bachelor's degrees (See Table 1).

This study also included 37 Master's level therapists, all completing training at the Auburn University Marriage and Family Therapy program. There were also three full-time AAMFT Approved supervisors and four supervisors-in-training who individually supervised the therapists during their training.

Table 1

*Demographics of males and females in committed relationships (N= 248)*

Demographics (% chose not to provide)	Males		Females	
	N	Percent	N	Percent
<b>Marital Status (0.8%)</b>				
Married	83	66.9%	80	64.5%
Non-married	39	31.5%	44	35.5%
<b>Age Group (1.6%)</b>				
18-29	58	47.5%	74	62.7%
30-39	41	33.6%	28	23.7%
40-49	18	14.8%	12	10.2%
50 or above	5	5.7%	4	3.4%
<b>Racial Group (10%)</b>				
White	88	71.0%	91	73.4%
African American	12	9.7%	14	11.3%
Hispanic/Non-White	2	1.6%	2	1.6%
Asian/Pacific Islander	4	3.2%	2	1.6%
<b>Income (4.8%)</b>				
Less than \$10,000	15	12.1%	16	12.9%
\$10,001 to \$20,000	17	13.7%	16	12.9%
\$20,001 to \$30,000	15	12.1%	17	13.7%
\$30,001 to \$40,000	31	25.0%	30	23.2%
Over \$40,000	40	32.3%	36	29.0%
<b>Education (4%)</b>				
GED/High School	49	39.5%	24	23.6%
Vocational/Associates	13	10.5%	26	22.0%
Bachelor's Degree	24	19.4%	45	36.3%
Master's Degree	16	12.9%	11	8.9%
Other	17	13.7%	13	10.9%

## **Procedure**

Quantitative data, gathered from the Outcome Questionnaire (OQ-45.2; Lambert et al., 1996), the Revised Dyadic Adjustment Scale (RDAS; Spanier, 1976), and the Couple Therapy Alliance Scale (CTAS; Pinsof & Catherall, 1986) were collected through files from males and females in committed relationships receiving therapy at the AUMFTC between January 2005 and May 2011.

The information acquired for this study, came from self-reported questionnaires, which were administered by intern therapists for clinical assessment purposes, future research, and administrative records. Before the first session of therapy, clients all received the same intake packet, which contained the OQ 45.2 (symptom distress measure), and the RDAS (revised dyadic adjustment measure). After completing four sessions of therapy, clients were given the same intake packet to reassess their progress, including the Couple Therapy Alliance Scale (Pinsof & Catherall, 1986). Clients were asked every 4<sup>th</sup> session to reevaluate the experience using the same packet. Participants in this study were seen in therapy sessions by Master level intern therapists, typically on a weekly basis. The therapeutic approach of the intern therapist varied according to was supervising that session.

## **Measures**

**Outcome Questionnaire 45.2.** (OQ 45.2). Clients completed the OQ 45.2 (Lambert et al., 1996) beginning with the first session, and then at every 4<sup>th</sup> session of therapy. This measure was designed to assess client progress throughout therapy treatment. The measure includes 45 questions, consisting of three subscales: Symptom Distress, Interpersonal Relations, and Social Role. For the purposes of this study, only the Symptom Distress Subscale will be utilized. There are 25 questions found under symptom distress that assess for anxiety and depression. For

example, “I blame myself for things,” “I feel worthless,” “I feel something is wrong with my mind,” are a few of the items the clients answered. The individual questions, pertaining to their respectful categories, are scored on 5-point Likert-type scale, ranging from 0-4. Internal consistency for this instrument ranges from .70-.91, and .78-.84 from test to re-test (Lambert, et al., 1996). The symptom distress subscale questions are scored and totaled providing an overall rating of anxiety and depression. Cronbach’s Alpha for this study is .90 for males, and .93 for females, respectively. Levels of symptoms are discussed as greater (negative) or fewer (positive) reported levels of symptoms, where greater would suggest above the mean score, and fewer below.

**Revised Dyadic Adjustment Scale.** (RDAS; Busby, Crane, Larson, & Christensen, 1995). The RDAS is a frequently used 14-item self-report revision from the original 32-item Dyadic Adjustment Scale (Spanier, 1976). The ratings range from “always disagree” (0) to “always agree” (5) on a six-point Likert-type scale. The Satisfaction subscale has 4 items and attempts to measure each partner’s current level of satisfaction with the relationship based on each partner’s reports of stability, as well as conflict in the relationship. The ratings for Satisfaction range from “all the time” (0) to “never” (5) on a six-point Likert-type scale. The Cohesion subscale is a 4-item scale measuring the degree of closeness and shared activities experienced by each partner. The ratings for the Cohesion subscale range from “never” (0) to “more often” (5) on a six-point Likert-type scale, with one item ranging from “never” (0) to “every day” (4) on a five-point Likert-type scale. The subscales are then summed to create an overall marital satisfaction score. The range of scores on the RDAS range from 0 to 69, with lower scores indicating greater relationship distress, accordingly, a score of 36 is the typical cutoff score discriminating between distressed and non-distressed couples. Internal consistency

reliability for this instrument ranges from .90-.95, and has good to excellent psychometric (Busby et al., 1995; Ward et al., 2009). Cronbach's Alphas in this study for both male and female across rating periods ranged from .85 to .88, respectively. Levels of dyadic adjustment are discussed as high (positive) and low (negative) as found above and below the mean.

**Couples Therapy Alliance Scale-Revised.** (CTAS-R; Pinsof, 1994). At every 4<sup>th</sup> session, participants filled out the CTAS-R (Pinsof, 1994). The CTAS-R is a 40-item revision of Pinsof and Catherall's (1986) original 29-item scale. It is designed to measure the therapeutic alliance. It measures three content areas of the alliance: tasks ("The therapist and I are in agreement about the way the therapy is being conducted"), goals ("The therapist and I are not in agreement about the goals for this therapy"), and bonds ("I do not care about the therapist as a person"). Items are scored on a 7-point Likert-type scale, with higher scores indicating higher alliance. The test-retest reliability is reported to as  $r = .84$  (Pinsoff & Catherall, 1986). The internal consistency of the scale has an alpha of .93 for the total score (Heatherton & Friedlander, 1990). The Cronbach's Alphas for this study are estimated at .94 for males and .95 for females.

## **Results**

Therapeutic alliance, the collaborative relationship between client(s) and therapist, has been established as an essential aspect of therapy with individuals (Martin et al., 2000) and couples (Anker et al., 2010; Symonds & Horvath, 2004), and is associated with therapeutic outcomes (Knobloch-Fedders, Pinsof, & Mann, 2007; Horvath & Bedi, 2002; Horvath & Symonds, 1991). Specific client characteristics such as individual psychiatric symptoms and marital distress influence the formation of the alliance in couple's therapy (Knobloch-Fedders et al., 2004; Mamodhousen et al., 2005). What has not been studied is the interaction of individual symptoms and relationship adjustment as factors affecting alliance formation. Thus, the purpose of this study is to explore the interaction of individual symptoms at intake and relationship adjustment as they affect the formation of the alliance.

Within this sample, individual symptom distress at intake is explored, attempting to find whether it significantly relates to fourth session therapy alliance ratings for males and females. It is also explored whether dyadic adjustment at intake is significantly related to fourth session therapy alliance ratings for males and females in couple therapy. Likewise, the interaction between individual symptom distress and relationship adjustment are examined as moderators for the therapeutic alliance. Separate analyses are conducted for males and females.

### **Preliminary Analysis of Univariate and Descriptive Statistics**

SPSS statistical software is used to create means and standard deviations for all continuous variables included in this study: relationship satisfaction at intake, individual symptoms of anxiety and depression at intake, and fourth session therapy alliance scores. Upon

examination of the plots, no outliers are identified in the analysis of the univariate statistics, and the data appears normally distributed, thus no transformations are needed. Means, standard deviations, and Alpha coefficients are illustrated in Table 2.

Table 2

*Sample Descriptive Statistics of Main Construct Variables*

Variable	N	Mean	SD	A	Excluded
RDAST1	112/112	43.60/40.78	8.69/10.14	.85/.88	12/12
OQT1	93/91	31.61/36.89	12.89/15.73	.90/.93	31/33
CTAST4	106/96	216.51/216.63	31.53/20.09	.94/.95	18/28

*Note.* Male Partners/Female Partners. RDAST1 (Rating of Relationship Satisfaction at time 1). OQ SDT1 (Rating of individual depression/anxiety at time 1). CTAST4 (Rating of therapy alliance at time 4)

**Non-Completers and Completers**

In this study, non-completers are considered any person(s) attending therapy, who fail to fill out fourth session paperwork and/or do not complete at least four sessions of therapy.

Completers are those who finished intake assessments as well as fourth session assessment paperwork. The attrition of clients is examined, as non-completers could be different from completers, thus posing a threat to validity. Chi-square analyses and independent sample *t*-tests are used to examine if differences exist between completers and non-completers ( $N = 288$ ) across the demographic variables of age, education, and income.

Chi-square analyses indicate no significant differences between non-completers in relation to male and female race and marital status. However, independent *t*-tests indicate significant differences for females in relation to income  $t(288) = -2.5, p < .05$  and relationship satisfaction at intake  $t(288) = -2.1, p < .05$  (See Table 3). Female non-completers report higher (more positive) relationship adjustment (RDAS) ratings ( $M = 41$ ) than female completers report,



( $M = 39$ ), on average. Female non-completers report earning less income per year ( $M = \$22,500$ ) than completers ( $M = \$26,000$ ), on average.

Table 3

*Comparison of Means for Non-Completers and Completers (N = 288)*

	Males			Females		
	<i>t</i> -score	$X^2$	Sig. (2-tailed)	<i>t</i> -score	$X^2$	Sig. (2-tailed)
Age	-.24	-	.81	.24	-	.81
Race	-	.02	.50	-	1.28	.17
Education	-.66	-	.51	-1.38	-	.17
Income	-.75	-	.45	-2.5	-	.01*
Marital Status	-	.79	.22	-	.79	.22
RDAS (Intake)	-1.7	-	.08	-2.1	-	.03*
OQ (Intake)	.90	-	.37	-.38	-	.71

Note. \*  $p < .05$ .

### **Married Versus Non- Married**

The next step included analysis of differences between non-married and married couples within the completion group ( $n = 248$ ). Independent t-tests indicated that a significant positive difference between being married and not being married exists in relation to female relationship satisfaction (RDAS intake rating)  $t(248) = 2.22$ ,  $p < .05$ . Further exploration indicates no significant differences within the demographic variable (See Table 4). However, because a difference exists in relation to one of the independent variables, married and non-married females will be analyzed separately within this study.

Table 4

*Comparison of Means for Non-married vs. Married (N = 248)*

	Males			Females		
	<i>t</i> -score	$X^2$	Sig. (2-tailed)	<i>t</i> -score	$X^2$	Sig. (2-tailed)
Age	-.58	-	.57	-.69	-	.50
Race	-	1.39	.24	-	.89	.35
Education	-1.14	-	.26	-.17	-	.86
Income	-	1.65	.20	-	1.75	.19
RDAS (Intake)	1.66	-	.10	2.22	-	.03*
OQ (Intake)	-.93	-	.36	-.40	-	.69
CTAS (Session 4)	.22	-	.83	1.17	-	.25
RDAS*OQ (Intake)	-.23	-	.82	.88	-	.38

Note. \*  $p < .05$ .

### Correlation Analyses

Correlations among the main constructs are observed in order that the proposed moderation models can be analyzed as described by Baron and Kenny (1986): dyadic adjustment at intake, individual symptom distress ratings at intake, and fourth session therapy alliance ratings. There is a strong significant negative correlation between male  $r = .85, p < .001$  and female  $r = .77, p < .001$  symptom distress ratings at intake and the interaction of symptom distress and dyadic adjustment. Due to strong correlations that exist between the interaction terms, the means are centered to avoid issues of possible multi-collinearity. New correlations are subsequently assessed using variables centered to the mean. The results of these correlations are shown in table 8. Weak negative correlations exist for males  $r = -.31, p < .001$  and females  $r = -$

.37,  $p < .001$  between symptom distress at intake and dyadic adjustment at intake. For males, therapeutic alliance has a weak significant negative correlation with the interaction of symptom distress and dyadic adjustment at intake  $r = -.28, p < .01$ . For females, therapy alliance has a weak negative correlation with symptom distress ratings at intake  $r = -.32, p < .001$ . Therefore, as significant correlations between variables are found, it is justifiable and appears beneficial to assess the significance of the proposed models using multiple regression with the variables centered to the mean (Shieh, 2011).

Table 5

*Summary of Correlations of Centered Main Constructs for Males and Females*

	RDAST1	OQT1	T1 RDAS*OQ	CTAST4
RDAST1	-	-.308***	-.042	.099
OQT1	-.368***	-	.205*	-.077
T1 RDAS*OQ	-.172	.153	-	-.283**
CTAST4	.079	-.324***	.013	-

*Note.* Males are above the diagonal, females are below the diagonal  
 \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

**Regression Analysis**

Following a preliminary analysis of univariate and descriptive statistics using SPSS, a series of four hierarchical regression models are fit for males. These models are fit in order to test for moderation as explained by Baron and Kenny (1986). The first model regresses fourth session therapy alliance on dyadic adjustment at intake. The second model regresses fourth session therapy alliance on individual symptom distress at intake, controlling for dyadic adjustment at intake. The third model regresses fourth session therapy alliance on the interaction

of dyadic adjustment and symptom distress at intake, controlling for dyadic adjustment and symptom distress at intake. The fourth model includes marital status as a control variable (see Table 6 for regression results).

Initial t-test analyses reveal a significant difference for marital status among females within this sample ( $t(248) = 2.22, p < .05$ ), but not for males. Therefore, regression models are fit, including marital status as one of the control variables for males, but not for females as married vs. non-married females are already analyzed with separate regression models (see Tables 7 and 8 for regression results).

The results for each research question are reported below.

### **Relationship of Main Effects and Therapy Alliance**

#### **RQ1: What is the relationship between relationship adjustment ratings at intake and 4<sup>th</sup> session alliance ratings for males and females?**

In model 1 fourth session therapy alliance is regressed on dyadic adjustment ratings at intake for males and the two female groups. Male partner regression results reveal a non-significant model fit ( $F(1, 98) = 1.30, ns$ ), as well as no significant relationship between therapy alliance and dyadic adjustment ( $\beta = -.57, ns, R^2 = .01$ ; see Table 6). Regression results also reveal a non-significant model fit for married ( $F(1, 66) = 0.01, ns$ ) and non-married females ( $F(1, 29) = 0.62, ns$ ). Additionally, no significant relationship is found between female fourth session alliance ratings and relationship adjustment ratings at intake for married ( $\beta = -.01, ns, R^2 = .00$ ; see Table 7) and non-married females ( $\beta = -.14, ns, R^2 = .02$ ; see Table 8).

#### **RQ2: What is the relationship between individual symptom distress ratings at intake and 4<sup>th</sup> session alliance ratings for males and females?**

In model 2, fourth session therapy alliance is regressed on individual symptom distress at intake for the male and the two female groups, while controlling for dyadic adjustment. Model fit was not significant for males ( $F(2, 97) = 0.72, ns$ ). Regression results for males reveal no significant relationships ( $\beta = -.13, ns, R^2 = .02$ ; see Table 6).

However, model 2 does demonstrate a good model fit for married female ( $F(2, 65) = 3.51, p < .05$ ). The results of this model indicate a significant negative relationship between symptom distress at intake and fourth session alliance ( $\beta = -.34, p < .01$ ) for married female partners ( $n = 68$ ), while controlling for dyadic adjustment scores at intake. Thus, on average, for every one unit difference in married female therapy alliance scores, there is a negative .34 difference in individual symptom distress ratings. Ten percent of the variance in fourth session alliance is accounted for by the symptom distress and dyadic adjustment model for married females sub-sample ( $R^2 = .10$ ) (see Table 7).

Likewise, there is a good model fit for non-married females ( $F(2, 28) = 3.32, p < .05$ ). The results of this model indicate a significant negative relationship between symptom distress ratings and fourth session alliance scores ( $\beta = -.45, p < .05$ ) for non-married female partners ( $n = 31$ ), when controlling for dyadic adjustment ratings at intake. Thus, on average, for every one unit difference in non-married female partner alliance ratings, there is a negative .45 difference in symptom distress ratings at intake. In this model, 19% of the variance in alliance at fourth session was accounted for by symptom distress ratings and dyadic adjustment scores at intake ( $R^2 = .19$ ) (see Table 8).

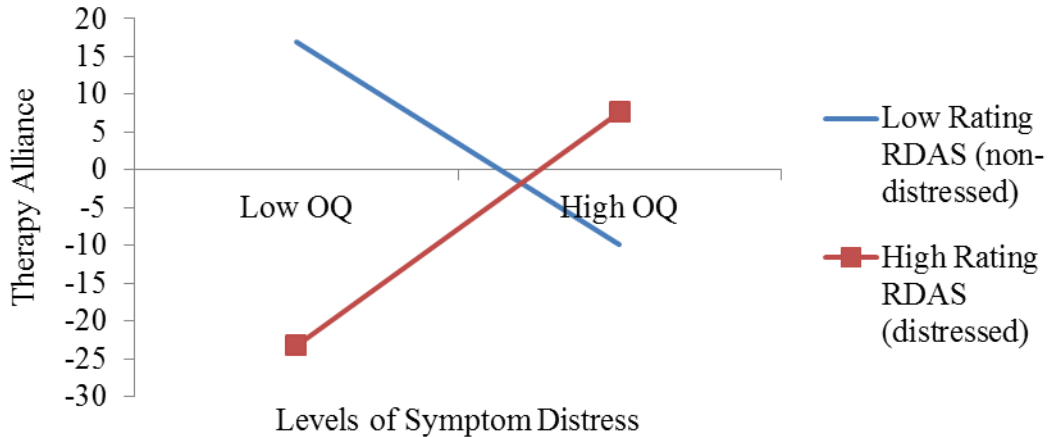
**RQ3: Do individual symptom distress ratings at intake moderate the relationship between dyadic adjustment ratings at intake and 4<sup>th</sup> session alliance ratings for males and females?**

In model 3 regressing fourth session therapy alliance onto the interaction between dyadic adjustment and symptom distress at intake, while controlling for dyadic adjustment and symptom distress at intake, demonstrates a good model fit ( $F(3, 96) = 3.44, p < .05$ ) and a significant, negative relationship for males ( $\beta = -.11, p < .01$ ). Thus, on average, for every one unit difference in male fourth session therapy alliance, there are a negative .11 difference in the interaction between dyadic adjustment and symptom distress ratings at intake. Neither dyadic adjustment ( $\beta = -.62, ns$ ) nor symptom distress ( $\beta = .07, ns$ ) are significantly related to therapy alliance, within the model. This model accounts for 10% of the variance in fourth session therapy alliance ratings ( $R^2 = .10$ ) (see Table 6).

Interaction results reveal that, on average, when the couple relationship is rated high (positive) and males report individual symptoms are less severe (low), the therapy alliance (TA) at fourth session is the strongest (TA = 17). When the couple relationship is rated low (negative) and greater (negative) levels of individual symptoms are reported, the alliance is also in the positive range of the mean alliance split, but not as strong (9 points lower) as the positive relationship/fewer symptoms group (TA = 8). When the couple relationship is rated high (positive) by males, but individual symptoms are high (negative), the alliance falls below the alliance mean split and is much weaker (TA = -11). This is 19 points lower than the negative relationship/high symptom group, and 28 points lower than the positive relationship/fewer symptoms group. Finally, when males rate the couple adjustment low (negative), but report fewer individual symptoms (positive), the alliance at fourth session is the weakest (TA = -24), or 13 points lower than the negative relationship/greater symptoms group. This is all together 32 points lower than the negative relationship/greater symptoms group, and 41 points lower than the positive relationship/fewer symptoms group (see Figure 1).

Figure 1.

Graph of Male Symptom Distress and Dyadic Adjustment Ratings at Different Levels of Alliance



For married and non-married females, model 3 regresses fourth session therapy alliance on the interaction between dyadic adjustment and symptom distress at intake. The model fit for married females is not significant ( $F(3, 64) = 2.73, ns$ ) but the model fit for non-married females is significant ( $F(3, 27) = 3.42, p < .05$ ). The relationship between the interaction term and therapy alliance is not significant for either married females ( $\beta = -.13, ns$ ; see Table 7) nor non-married females ( $\beta = .37, p = .09$ ; see Table 8). A negative relationship between therapy alliance and symptom distress, when controlling for all else in the model, remains significant ( $\beta = -.33, p < .05$ ) for married females. However, this same relationship between therapy alliance and symptom distress, when controlling for all else in the model, is not found for non-married females ( $\beta = -.23, ns$ ), even though a significant relationship had been found in the second model. Overall variance explained in these third models was 11% for married females ( $R^2 = .11$ ) and 28% for non-married females ( $R^2 = .28$ ).

Table 6

*Four Regression Models of Centered Means for Males (n=124)*

Model	Intercept (se)	Predictors				R <sup>2</sup>
		Main Effects		Interactions		
		RDAS (se)	OQ (se)	Marital Status (se)	RDAS *OQ (se)	
M1	2.5 (4.3)	-.57 (.54)				.01
M2	2.4 (4.4)	-.50 (.54)	-.13 (.35)			.02
M3	-2.1 (4.5)	-.62 (.52)	.07 (.34)		.11* (.04)	.10
M4	-2.1 (4.4)	-.57 (.50)	.02 (.34)	-.58 (.91)	.10* (.04)	.09

*Note.* Values represent standardized Beta coefficients.

\*  $p < .01$



Table 7

*Three Regression Models of Centered Means for Married Females (n=68)*

Model	Intercept (se)	Predictors			R <sup>2</sup>
		Main Effects		Interactions	
		RDAS (se)	OQ (se)	RDAS *OQ (se)	
M1	-2.6 (5.8)	.01 (.56)			.00
M2	-2.8 (5.6)	.15 (.58)	-.34* (.39)		.10
M3	-.59 (6.0)	.13 (.58)	-.33* (.40)	-.13 (.03)	.11

*Note.* Values represent standardized Beta coefficients.

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

Table 8

*Three Regression Models of Centered Means for Non-married Females (n=56)*

Model	Intercept (se)	Predictors			R <sup>2</sup>
		Main Effects		Interactions	
		RDAS (se)	OQ (se)	RDAS *OQ (se)	
M1	6.0 (7.7)	-.14 (.76)			.02
M2	7.6 (7.1)	.03 (.77)	-.45 *(.44)		.19
M3	4.4 (7.1)	.07 (.75)	-.23 (.51)	.37 (.04)	.27

*Note.* Values represent standardized Beta coefficients

\*  $p < .05$

In conclusion, the overall results, using the third model, reveals the interaction between dyadic adjustment and symptom distress at intake is a significant predictor of fourth session therapy alliance for males. Neither dyadic adjustment nor symptom distress is a significant predictor of therapy alliance at fourth session, but the interaction between these two variables is significant. Ten percent of the variance of therapy alliance is explained when both predictors and their interaction effect are included in the model.

For married and non-married females, the second model is significantly different from the other models and represents significant findings. The results of the second model demonstrate that while dyadic adjustment at intake is not a significant predictor of therapy alliance at fourth session, symptom distress at intake is a significant predictor, regardless of marital status. However, marital status demonstrates differing levels of variance explained within these models for the two female groups, with 10% of therapy alliance explained for married females, and 19% of therapy alliance explained for non-married females.

For married and non married females the second model was significantly different from the other models in explaining alliance formation. It needs to be noted that while the third model for non-married females predicted 27% and the model is significant, the  $R^2$  Change is not significantly different from model two to model three, thus model two is the preferred model. Small sample size and non-significant individual variables probably accounts for lack of change.

## Discussion

This study examines the relationships between therapy alliance at the fourth session, dyadic adjustment, individual symptom distress, and the interaction between dyadic adjustment and symptom distress at intake. Therapy alliance is a common predictor of therapeutic outcomes on both an individual (Martin et al., 2000) and a dyadic level (Anker et al., 2010). Therapy alliance is also therapeutic in and of itself (Symonds & Horvath, 2004). Relationship distress (Knobloch-Fedders et al., 2004; Mamodhoussen et al., 2005) and individual symptoms (Raue et al., 1993) influence how the alliance is formed between clients and therapists. Individual symptoms and dyadic adjustment are established predictors of the alliance, in the individual and couple literature respectively. An exploration of the interaction between individual symptoms and dyadic adjustment at intake has the potential of further clarifying the relationship with the therapy alliance. Specifically, this study examines the combined role of symptom distress and dyadic adjustment in predicting therapy alliance. The interaction between symptom distress and dyadic adjustment is of specific interest as a predictor of therapy alliance due to the common nature of these two events in treating couples. A sample of 124 couples attending at least four sessions of relationship therapy participated. The results of this study will now be discussed.

### Discussion of Results

**RQ1: What is the relationship between relationship adjustment ratings at intake and 4<sup>th</sup> session alliance ratings for males and females?** In model 1, analyses indicated no significant relationship between ratings of dyadic adjustment and therapy alliance for both males and females, regardless of marital status. These results differ from earlier findings by both Knobloch-Fedders et al. (2004), which suggest that both male and female dyadic adjustment ratings at intake predict later alliance formation. It is important to note Knobloch-Fedders et al.

used the Marital Satisfaction Inventory-Revised (MSI-R; Snyder, 1997) to measure relationship satisfaction. The current study used the Revised Dyadic Adjustment Scale (RDAS; Busby et al. 1995) as its measure of relationship satisfaction. Furthermore, the MSI-R measures marital distress, whereas the RDAS measures couple consensus, cohesion, and satisfaction.

It can be surmised that different constructs of relationship satisfaction might demonstrate varying relationships with therapy alliance. Future studies need to examine how different constructs of relationship satisfaction influence the formation of therapy alliance. In addition to issues of measurement differences, it is noted that the samples examined may also have several key differences. The Knobloch-Fedders et al. (2004) study utilized a sample of 80 participants, from which only 35 couples were examined, limiting the overall generalizability of their results, due to the small sample size. The current study utilized a sample of 124 couples, providing more power to the analyses compared to Knobloch-Fedders et al. One other possible area for future direction is to explore the motivations behind why clients attended therapy, as this motivation might be related to dyadic adjustment ratings and the formation of therapy alliance.

**RQ2: What is the relationship between individual symptom distress ratings at intake and 4<sup>th</sup> session alliance ratings for males and females?** For males, the relationship between symptom distress and therapy alliance for males was not significant, after controlling for dyadic adjustment. This result coincides with findings from Knobloch-Fedders et al. (2004), whose study established marital satisfaction as a significant predictor of alliance at eighth session, but found no relationship between individual pre-treatment symptoms and therapy alliance.

A possible explanation why no relationship exists between symptom distress and therapy alliance could be the therapeutic focus might be directed towards the problems in the relationship

and not towards individual symptoms. It may be that individual symptoms, unless assessed early in therapy, were not revealed until later, after the relationship problems were introduced and clarified. However, it may be that therapists need to engage male participants early and often in the therapy process, so that they are provided with opportunities to reveal potential individual symptoms (Knobloch-Fedders et al., 2004). This could increase the possibility of forming an alliance.

For females, whether married or non-married, symptom distress has a significant negative relationship with therapy alliance. Greater (negative) reported levels of symptom distress are related to lower levels of therapy alliance, and vice versa. This negative relationship has been supported in the literature, such that early depression influences the alliance later in treatment (Johnson, Wright, & Ketring, 2002). Specifically, higher levels of alliance helped to promote positive changes in depressive symptoms. Females may enter therapy with the expectations of positive change. Therefore, their rating of alliance may be dependent on experiencing change before the fourth session. Another possibility comes from Rogers (1959), who identified the therapist as being responsible for the creation of the therapeutic relationship. It is possible the therapists in this study felt overwhelmed by the female's heightened affective state, and were thus unable to personally and empathically reach out early in session, which could have hindered the overall alliance.

Conversely, married and non-married females who report fewer (positive) symptoms of anxiety and depression have stronger alliances with the therapists. This stronger relationship might be a result not only of less emotional distractions expressed by the female partner in-session, but also of an increased ability by the therapist to control the sessions. Suggesting, that therapists were possibly more proactive in establishing the alliance (Rogers, 1959), as opposed to

being reactive to the client. Thus, females' ability to feel understood, express themselves in a way that properly portrayed their situation, and listen to the therapist might have changed their view of the therapeutic relationship (Bordin, 1979).

A finding that requires attention is the unexpected difference in variance based on marital status of females. Specifically, this finding is unexpected because non-married female ratings of individual symptom distress at intake account for nearly double the variance in alliance ( $R^2 = .19$ ) than married female's ratings ( $R^2 = .10$ ). Based on the self-reported scores for dyadic adjustment and individual symptom distress in this study, married females have statistically significant poorer dyadic adjustment scores ( $M = 39$ ) than non-married women ( $M = 43$ ). Married females also report greater (negative) levels of individual symptoms ( $M = 38$ ) than non-married females ( $M = 36$ ), although this difference is not statistically significant. As such, married females report more relational stress and greater (negative) levels of depression and anxiety than non-married females, on average, which may have prompted them to attend therapy initially. Unfortunately, this study does not examine the motivations behind therapy attendance. Additionally, this study does not examine the level of functioning in other aspects of the relationship, such as conflict, attachment, and health. If married females lack energy and motivation, fostering a relationship with the therapist may be difficult. Since it appears that individual symptoms have a greater impact in lower alliance ratings for non-married females, future research should compare other intake and demographics differences between these two groups. Future research is needed to examine the motivations behind attending therapy. In addition, this future research also needs to focus on measuring the levels of functioning at intake in other areas (e.g., conflict, attachment, etc.), possibly identifying potential differences between married and non-married females.

**RQ3: How do individual symptom distress ratings at intake moderate the relationship between dyadic adjustment ratings at intake and 4<sup>th</sup> session alliance ratings for males and females?** For males, the interaction between dyadic adjustment and symptom distress at intake significantly and positively relates to therapy alliance at fourth session, when controlling for dyadic adjustment and symptom distress. While the interaction is significant, neither dyadic adjustment nor symptom distress is related to therapy alliance. This interaction indicates that symptom distress does moderate the relationship between dyadic adjustment and therapy alliance among the male sample of this current study.

The results of these regression analyses do not illustrate a similar pattern for females. For married females, the interaction term is not significant, but symptom distress is a positive predictor of therapy alliance, after controlling for all else in the model. For non-married females, no predictor variable, including symptom distress and the interaction significantly predicts therapy alliance, when controlling for all else in the model. As such, it can be concluded, the interaction between symptom distress and relationship adjustment does not predict therapy alliance for females. Garfield (2004) stated that women carry the emotional power in relationships, which means they often carry the responsibility for the emotional state of the relationship. Garfield's statement applied to this study could suggest that negativity in the relationship might be expressed through individual symptoms of depression and anxiety. Females may blame themselves for a poor relationship, which may then present itself as individual symptoms of depression or anxiety.

Because gender differences are found in the role of moderation, it is important to highlight how these results add to the alliance literature by outlining why this moderation might occur. Specifically, four patterns of interaction are presented among the male sample used in this



current study. These patterns are (1) high (positive) relationship adjustment combined with fewer (positive) individual symptoms, (2) low (negative) relationship adjustment combined with greater (negative) individual symptoms, (3) high (positive) relationship adjustment combined with greater (negative) individual symptoms, and (4) low (positive) relationship adjustment combined with fewer (positive) individual symptoms.

### **Pattern 1: High Relationship Adjustment Combined with Fewer Individual Symptoms**

Detailed analysis of the male interaction between dyadic adjustment and symptom distress, as it influenced alliance, reveals when both relationship adjustment is high (positive) and reported levels of symptom distress ratings are fewer (positive), the therapy alliance is rated the highest. In other words, when male partners are not severely depressed or anxious, and report a healthy relationship with their partner, the alliance is strongest. It is essential to evaluate this finding from both the client's and the therapist's perspective.

First, males entering therapy with high relationship adjustment/fewer symptoms may have beliefs that therapy carries little risk to their personal lives. With little risk, perhaps male partners were more willing to express emotions, state their reasons for therapy clearly, and be properly understood by the therapist. Another possibility for a strong alliance is from the client's perspective. At high (positive) relationship adjustment/low (positive) symptoms for males, strong alliance ratings might be that the therapist is seen either as an ally to the dyadic relationship or for the man's personal progress and change. Perhaps male partners are able to more clearly demonstrate and postulate their goals early in the course of treatment, creating a clearer picture for the therapist about why the couple is in therapy. Likewise, if male clients experience progress, they might attribute that progress to the therapist fully understanding them and guiding them to their desired outcomes.

Another explanation about high male alliance ratings is from the therapist's perspective. Male partners expressing positive levels of symptoms and relationship adjustment might assist novice therapists to control their own nervous and anxious affective responses towards the couple and therapy as a whole, simply because therapy might be calmer. Thus, the therapist could be more likely to relax and demonstrate genuine, personable responses towards males in session, creating a stronger alliance. Garfield (2004) stated that males often exhibit the "positional power" in relationships, corresponding to control and status. It is possible when male partners enter therapy without a high degree or need for control and power therapists do not feel resisted or threatened by client attitudes and emotional expressions. This could give the therapist more courage to risk intervening and creating goals, while also furthering the alliance formation.

### **Pattern 2: Low Relationship Adjustment Combined with Greater Individual Symptoms**

In the second pattern, fourth session male alliance ratings is strong as well. Fourth session alliance ratings in this pattern are influenced by the interaction between low (negative) ratings of relationship adjustment and high (negative) levels of symptoms. In other words, males report their relationships as distressed and their depression and anxiety as more severe, but have strong alliances at fourth session. Davila et al. (2003) stated couple marital satisfaction and depressive symptoms impact one another over time. The causality of how marital satisfaction and depression impacted each other was no stronger from one direction than another direction. Other authors discussed when therapists focus on treating marital satisfaction that depressive symptoms begin to also shift. They suggested for males, that couples therapy might be most beneficial for males when they report co-morbid interpersonal distress and depressive symptoms (Whisman & Baucom, 2012). Perhaps then, alliance ratings could be influenced depending on what the focus for treatment is. If males come to therapy as customers for change, willing to accept any help

they can find, it might be more likely that relationship issues are discussed first. This could create progress and change for males' relationships and symptoms, which could be reflected by a stronger alliance.

It makes sense, that, if male clients are experiencing both poor relationship adjustment and greater individual symptoms, they could be more willing to change and be more cooperative, especially if male partners were approachable and willing to listen. This desire for help could provide the therapist with the advantage of male client's willingness to receive guidance. Thus, if therapists are also more willing to understand the perspective and experiences of the male client, then creating a stronger relationship could be more likely. Of course, many of these situations are based upon clinical experience, but lack research evidence. However, future research needs to investigate client cooperation with relation to the amount of symptoms experienced interpersonally and intra-personally. Future research would also be essential to evaluate the role of therapists' reactivity to clients and later therapy alliance ratings.

It could also be possible that a strong alliance is found among the low (negative) relationship adjustment/greater (negative) symptoms group because the male feels supported by his partner and/or the therapist. Johnson, Ketring, and Wright (2002) suggested when men feel supported, that depression often declines. If male partners enter therapy with greater reported depression or anxiety, then finding support through treatment could not only help symptoms, but also form bonds, mutual trust, and shared meaning within the experience (Bordin, 1979).

### **Patterns 1 and 2 Compared**

First, the interactions at intake that influence the strongest fourth session alliance ratings are high (positive) relationship adjustment and fewer (positive) reported symptoms. However, when male partners rate low (negative) relationship adjustment and greater (negative) reported

symptoms, the alliance is strong as well. It appears that the therapy alliance is not much different for males who report fewer symptoms and a positive relationship compared with those who report greater symptoms and low relationship adjustment. While on the surface there does not appear to be a consistent explanation for this similarity it might be explained by willingness to cooperate. It appeared that both groups were willing to cooperate and follow the therapeutic intent, but for different reasons. Although the reasons behind client's willingness to cooperate are yet to be studied, the practicality of knowing a strong alliance can be established, despite poor relationship adjustment and high symptom distress, is encouraging.

Likewise, further explanation for the strong alliance formation within the high (positive) relationship adjustment/low (positive) symptoms group and low (negative) relationship adjustment/greater (negative) symptoms group is the therapist's ability to work with these two groups. Horvath and Symonds (1991) stated that therapeutic alliance is a collaboration between the therapist and the client. While collaboration is often based upon client/therapist interactions, the comfort level for the therapist is often established by the client's reactivity within the session. Males who come to therapy reporting high (negative) levels of individual symptoms and low (negative) relationship adjustment might be less combative and more cooperative because they have reached a point of desperation.

Additionally, with less stressed clients, particularly males, the therapist might not fear impairing the client's relationship because the partner relationship was already at a stable level. When therapy issues are extemporaneous to the couple relationship (e.g. in laws, childhood trauma), then there could be less emotional liability within the relationship. Therefore, the therapist is more at ease and personable conducting the session. This could allow for easy collaboration and genuine empathy—creating a stronger alliance.

### **Pattern 3: High Relationship Adjustment Combined with Greater Individual Symptoms**

In the third pattern, which indicates a weaker alliance at session four, findings reveal that male partners' relationship adjustment ratings are high (positive), and individual symptom reports are greater (negative). The first impression pertinent to why this pattern might be influencing a weak alliance pertains to male clients not being ready to change. Not surprisingly, women are often the first in the relationship to ask to go to therapy (Leong & Zachar, 2004). If the man is not ready to go to therapy, but is there despite not desiring to attend, his attitude might be very cold, insincere, and defensive. Thus, if a therapist pushed too hard too early to form a relationship, it could unintentionally create distance between the male client and the therapist. Perhaps the male client already feels he is the problem, and therapy is one more spotlight referencing his failure within the relationship.

Often times, depression and anxiety can be camouflaged by emotional outbursts, such as anger or criticism. If this happens, it could be the therapist is unable to see through the anger, and instead focuses on the dyadic relationship, rather than focusing on issues at an individual level. Whisman and Baucom (2012) did suggest that focusing on the relationship issues can help influence male depressive symptoms. However, if males exhibit greater symptoms at intake, it might be beneficial to at least get his experience first, establishing some rapport with him, and then moving onto the relational issues.

Another reason a lower alliance was reported might be the element of support. Lower alliance ratings could be influenced by male clients, who enter therapy with little desire to change, and feel little support from the therapist. The attitude reflected by male clients, that they do not desire to change, could in some way influence therapists' beliefs about their own competence as a therapist. Thus, therapists might struggle showing empathy, genuine concern,

and patience, because they are worried about how they were being perceived, which ultimately could hurt the alliance.

#### **Pattern 4: Low Relationship Adjustment Combined with Fewer Individual Symptoms**

The last pattern, which indicates the weakest alliance at session four, is influenced by the interaction between ratings of low (negative) relationship adjustment and fewer (positive) levels of individual symptoms. One of the most disconcerting reasons male clients might report weak alliance ratings could be an element of contempt. In other words, the man may no longer feel angry, upset, sorry, or hurt, and simply no longer care about the relationship (Gottman, 2000). Plus, if the therapists fails to recognize this indifference and continued interventions for the couple, the male client may suspect the therapist does not understand the male partner's perspective and, therefore, gives up on the therapists' ability to help. From another angle, these male clients may blame the partner for the problems being presented in therapy. Hence, male clients might desire the attention to be placed on the partner, so as to fix her "problems." This approach could impede the formation of an alliance from forming or improving, simply because the male clients do not desire an alliance.

Lastly, therapists play a strong role in the alliance formation process (Horvath, 2000). If the therapists displayed elements of frustration, impatience, or anger with these male clients, the alliance may be impaired. It seems at low relationship adjustment/low symptoms, therapy sessions might become intense. Thus, if therapists neglect the alliance before trying to intervene and create change, they may lose the opportunity to establish an alliance.

#### **Patterns 3 and 4 Compared**

At first glance, it would seem odd that if male clients exhibit both inter- and intrapersonal problems, they would have a higher alliance, but when they report poor scores in one or the

other, the alliance is poor. One explanation is that these males are not at a point of desperation. They are still able to deflect responsibility given the situation. It is possible that blame is contributing to a weaker alliance. Within either scenario, the males can externalize the blame for the suffering they are experiencing. The partner can be culpable for the intrapersonal symptoms of depression or anxiety or the interpersonal problems of the relationship. These males might be more antagonistic or abrasive within session. It would seem that externalizing responsibility might be the reason for the poorer therapy alliance.

Externalizing responsibility may also influence the results found in the group experiencing weaker relationships despite less severe symptomology. In this grouping, male partners may view themselves as being exempt from participating in therapy, placing the blame on the female partner. Thus, any therapeutic attempt to form a relationship could be denied because the male partner does not see it as necessary. Males are typically not customers for change when coming to therapy (Leong & Zachar, 2004). In other words, it can take a few sessions for men to accept the therapist, the therapists' help, and ultimately the motivation to change. Thus, entering therapy and feeling pressure to expose and reveal vulnerable experiences early in treatment, could create hostility and defense, rather than trust and understanding.

One final item warrants discussion. Among non-married females, the third model, which regresses therapy alliance on the interaction between dyadic adjustment and symptom distress, controlling for all else in the model, is significant ( $p = .31$ ). However, the F-change between models 2 and 3 is not significant ( $p = 0.89$ ), even though the level of variance explained increases from 19% ( $R^2 = .191$ ) to 28% ( $R^2 = .28$ ). Also, no individual variables within this model demonstrate significant results, although the interaction term approaches significance ( $p = 0.89$ ). Because none of the variables within this model reach significance, no more can be done

to evaluate these results. The small sample size of 32 non-married females could account for the non-significant findings at the individual variable level. However, this is a good first step in evaluating that females might be influenced by both intrapersonal and interpersonal variables and their interaction, which needs further research.

### **Implications and Benefits**

This study revealed benefits many clinicians, until now, were perhaps unaware of, especially for male clients. Knowing how male interactional patterns of symptoms and relationship adjustment at intake influenced the alliance at fourth session was one of the overarching benefits relevant to this study. These interactional patterns should forewarn and prepare therapists with added insight into the alliance formation process. It was found, for example, that fourth session alliance ratings were the worst for men reporting fewer symptoms were less severe, but whose relationship adjustment ratings were strong. This interaction could help clinicians for a variety of reasons. For one, clinicians should know that the alliance formation process will probably not be easy, and that stronger emphasis should be placed on assessing the male client's true experience. Second, if clinicians are attempting to build an alliance and notice resistance, these results indicate the importance of the therapist to reassess why the couple came to therapy—e.g. to save the relationship or end it. This could grant further insight into whether the male client is a customer of change, or a challenger of change.

Likewise, therapists going into first session can have greater insight into what might be expected from their clients in forming a relationship. If male clients rated their symptoms less severe and relationship as healthy, and their partners rated their symptoms as less severe, it could be anticipated that building an alliance would be relatively easier than if otherwise reported. Additionally, these findings can give therapists comfort, that if they assess their clients and their



ratings of symptoms are more severe, and the male client's relationship adjustment is poor, that it might not be so difficult to experience cooperation and to establish a healthy alliance.

Finally, in this study, it was revealed that alliance was negatively affected when females' (married or non-married) ratings of depression and anxiety were more severe. Hence, if the therapist assesses for pretreatment levels of more severe symptoms of depression and anxiety with either partner, it would be important that severity and influence of each person's symptoms be addressed.

### **Limitations**

**Attrition bias.** In this study, independent t-tests reveal that there is a significant negative relationship for female partners' dyadic adjustment ratings at intake, among completers and non-completers ( $t(288) = -2.1, p < .05$ ). Specifically, females who complete at least four sessions of therapy rate their dyadic adjustment scores at intake lower than females who do not complete at least four sessions. This difference creates possible issues of attrition bias within the sample of completers. This bias could nullify the ability to generalize these findings to a larger population. Because this is a clinical sample of couples attending therapy, it makes sense that participants with worse relationships would stay in therapy longer (at least 4 sessions) than participants with healthier relationships. Thus, although attrition bias is revealed, the attrition itself does not seem to nullify extrapolation to clinical samples—that healthy relationships would, on average, need fewer sessions.

Although this study provides insight concerning specific client factors affecting the alliance formation process, it is difficult to generalize these results to a larger population, even though attrition bias may not have negatively influenced these results. These results may be generalizable to other MFT Training Centers. However, generalizing these findings to the

population should be cautioned because of a smaller sample size, as this study used data from 124 couples (248 participants), which is relatively small, especially considering categorizing into subgroups further reduced this sample size (e.g., non-married females = 32 participants).

Additionally, the sample was a convenience sample, meaning the clients entered therapy of their own choice. They were not randomly sampled, thus it is not possible to determine whether the alliance formation is caused by the interaction of symptoms and dyadic adjustment or other factors, such as client motivation, not examined within the current study.

Finally, all measures were self-report questionnaires. Anytime data is collected through self-report, a level of reporter bias will result. In other words, the data may not be objectively quantifiable, which these findings were not.

### **Future Research**

This study is among the first to analyze individual symptom distress moderating the relationship between dyadic adjustment and therapy alliance. As such, it is salient that further research be conducted creating insight into that which accounts for the establishment of a healthy therapeutic relationship. Replication of this study, with a larger sample size is needed. Results of this study need additional research, in order to further understand the reason these results were not consistent with existing literature, especially in relation to dyadic adjustment not influencing fourth session alliance ratings.

Future research should be conducted observing partner interaction effects between ratings of dyadic adjustment and symptom distress, assessing whether partners rated each differently than the other. Furthermore, it could be beneficial to analyze the relationship between symptom distress and alliance ratings at later session intervals—eighth, twelfth, etc. This could expose the process of alliance change throughout the therapy process, rather than at one point in time. This

approach could also reflect the effect individual symptoms have on the alliance later in therapy, when individual symptoms could be specifically diagnosed to either the individual partner or the relationship as a whole.

Additionally, future research could also include how different constructs of relationship satisfaction predict or influence later alliance formation. Future research would also be essential to evaluate the role of therapists' reactivity to clients and later therapy alliance ratings. Future research needs to investigate client cooperation with relation to the amount of symptoms experienced interpersonally and intra-personally.

Lastly, examining male and female social desirability scores, assessing for how honest they are in their ratings could create interesting findings. Perhaps themes of denial, stonewalling, or contempt could be seen. Further research that could create clinical insight, and if added to this study, could assess change in the predictor variable (RDAS and OQ) ratings from intake to fourth session and beyond.

## **Conclusion**

In conclusion, this study finds valuable results applicable and practical for the therapy alliance formation process. It was found for married and non-married female clients, that their ratings of individual symptoms of anxiety and depression at intake influence later alliance formation. It was found for male clients that only the interaction between dyadic adjustment and symptom distress at intake significantly influences fourth session alliance ratings. Specifically, the therapy alliance was strongest at levels of strong relationship adjustment/low symptoms, moderately strong at levels of poor relationship adjustment/high symptoms, weak at levels of strong relationship adjustment/low symptoms, and the weakest at levels of poor relationship adjustment/high symptoms. These interactions prompt thoughtful exploration of why fourth

session alliance ratings at each of these levels might be reported, such as whether or not therapists should focus first on relational issues (e.g. at strong relationship adjustment/low symptoms), or individual issues (strong relationship adjustment/high symptoms) when attempting to form an alliance.

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## Appendices

## Appendix A

Name \_\_\_\_\_

Date \_\_\_\_\_

### Revised Dyadic Adjustment Scale

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

	<u>Always Agree</u>	<u>Almost Always Agree</u>	<u>Occasionally Agree</u>	<u>Frequently Disagree</u>	<u>Almost Always Disagree</u>	<u>Always Disagree</u>
1. Religious matters						
2. Demonstrations of affection						
3. Making major decisions						
4. Sex relations						
5. Conventionality (correct or proper behavior)						
6. Career decisions						

	<u>All the time</u>	<u>Most of the time</u>	<u>More often than not</u>	<u>Occasionally</u>	<u>Rarely</u>	<u>Never</u>
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?						
8. How often do you and your partner quarrel?						
9. Do you ever regret that you married (or lived together)?						
10. How often do you and your mate "get on each other's nerves"?						

	<u>Every Day</u>	<u>Almost Every Day</u>	<u>Occasionally</u>	<u>Rarely</u>	<u>Never</u>
11. Do you and your mate engage in outside interests together?					

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

	<u>Never</u>	<u>Less than once a month</u>	<u>Once or twice a month</u>	<u>Once or twice a week</u>	<u>Once a day</u>	<u>More often</u>
12. Have a stimulating exchange of ideas						
13. Work together on a project						
14. Calmly discuss something						

## 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
1. The therapist cares about me as a person	7	6	5	4	3	2	1
2. The therapist and I are not in agreement about the goals for this therapy.	7	6	5	4	3	2	1
3. My partner and I help each other in this therapy.	7	6	5	4	3	2	1
4. My partner and I do not feel the same ways about what we want to get out of this therapy.	7	6	5	4	3	2	1
5. I trust the therapist.	7	6	5	4	3	2	1
6. The therapist lacks the skills and ability to help my partner and myself with our relationship.	7	6	5	4	3	2	1
7. My partner feels accepted by the therapist.	7	6	5	4	3	2	1
8. The therapist does not understand the relationship between my partner and myself.	7	6	5	4	3	2	1
9. The therapist understands my goals in therapy.	7	6	5	4	3	2	1
10. The therapist and my partner are not in agreement about the about the goals for this therapy.	7	6	5	4	3	2	1
11. My partner cares about the therapist as a person.	7	6	5	4	3	2	1
12. My partner and I do not feel safe with each other in this therapy.	7	6	5	4	3	2	1
13. My partner and I understand each other's goals for this therapy.	7	6	5	4	3	2	1
14. The therapist does not understand the goals that my partner and I have for ourselves in this therapy.	7	6	5	4	3	2	1
15. My partner and the therapists are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
16. The therapist does not understand me.	7	6	5	4	3	2	1
17. The therapist is helping my partner and me with our relationship.	7	6	5	4	3	2	1
18. I am not satisfied with the therapy.	7	6	5	4	3	2	1
19. My partner and I understand what each of us is doing in this therapy.	7	6	5	4	3	2	1
20. My partner and I do not accept each other in this therapy.	7	6	5	4	3	2	1
21. The therapist understands my partner's goals for this therapy.	7	6	5	4	3	2	1
22. I do not feel accepted by the therapist.	7	6	5	4	3	2	1
23. The therapist and I are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
24. The therapist is not helping me.	7	6	5	4	3	2	1
25. The therapist is in agreement with the goals that my partner and I have for ourselves as a couple in this therapy.	7	6	5	4	3	2	1

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

## Appendix C

### 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. Please do not make any marks in the shaded areas.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ yrs.  
 Sex  
 M  F   
 ID# \_\_\_\_\_

Session # \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

						SD	IR	SR
	Never	Rarely	Sometimes	Frequently	Almost Always	DO NOT MARK BELOW		
1. I get along well with others.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
2. I tire quickly.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
3. I feel no interest in things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
4. I feel stressed at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
5. I blame myself for things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
6. I feel irritated.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
7. I feel unhappy in my marriage/significant relationship.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
8. I have thoughts of ending my life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
9. I feel weak.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
10. I feel fearful.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
12. I find my work/school satisfying.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			<input type="checkbox"/>
13. I am a happy person.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>		
14. I work/study too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
15. I feel worthless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
16. I am concerned about family troubles.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
17. I have an unfulfilling sex life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
18. I feel lonely.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
19. I have frequent arguments.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
20. I feel loved and wanted.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
21. I enjoy my spare time.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			<input type="checkbox"/>
22. I have difficulty concentrating.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
23. I feel hopeless about the future.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
24. I like myself.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>		
25. Disturbing thoughts come into my mind that I cannot get rid of.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
27. I have an upset stomach.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
28. I am not working/studying as well as I used to.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
29. My heart pounds too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
30. I have trouble getting along with friends and close acquaintances.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
31. I am satisfied with my life.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>		
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
33. I feel that something bad is going to happen.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
34. I have sore muscles.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
36. I feel nervous.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
37. I feel my love relationships are full and complete.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
38. I feel that I am not doing well at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
39. I have too many disagreements at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
40. I feel something is wrong with my mind.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
41. I have trouble falling asleep or staying asleep.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
42. I feel blue.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
43. I am satisfied with my relationships with others.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
44. I feel angry enough at work/school to do something I might regret.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
45. I have headaches.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
						+	+	
						<b>Total=</b>		

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