Reason for Referral and Treatment Focus as Moderators of Alliance and Individual Symptom Distress in Couple Therapy

by

Catherine Claire Herren

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Approved by

Scott Ketring, Chair, Associate Professor and Director of Marriage and Family Therapy Program, Human Development and Family Science
Thomas Smith, Associate Professor Emeritus, Human Development and Family Science
Paul Springer, Associate Dean for Student Success, Professor, Child, Youth and Family Studies, University of Nebraska

Abstract

Therapeutic alliance is a significant predictor of positive treatment outcomes for individuals and couples undergoing therapy (Davis et al., 2012; Baldwin, Wampold, & Imel, 2008; Horvath, 2001; Flükiger et al., 2019; Wiseman, 2017). Client-therapist agreement on the goals and tasks of therapy is essential to the alliance (Bordin, 1979), suggesting that couples in therapy may demonstrate improved alliance when the therapist focuses treatment on the primary type of problems reported at intake. This study sought to understand how therapeutic alliance formation was affected by the interplay between a couple's presenting problem (symptom distress or relational adjustment) and the therapist's treatment focus. While a hierarchical multiple regression demonstrated no significant findings for the therapist focus match by a change in symptom distress interaction term, several unique findings were observed. These included a significant influence of symptom distress upon alliance formation and the absence of a significant relationship between change in relational distress and alliance formation. Potential clinical applications and future directions for study are explored.

Keywords: couple, alliance, individual symptom, reason for referral

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Chapter 1: Introduction

Researchers and clinicians have consistently identified the therapeutic alliance as a crucial component of change in couple therapy, linked to improvements in communication, interpersonal well-being, and relationship adjustment (Castonguay, Constantino, & Holtforth, 2006; Johnson, Wright, & Ketring, 2002; Knoblock-Fedders, Pinsof, & Mann, 2004). While couple therapy demonstrated effectiveness in treating clients diagnosed with obsessive-compulsive disorder, bipolar disorder, and schizophrenia, there is limited information concerning changes in individual symptoms and the couples therapy alliance (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Friedlander et al., 2011; Hagen et al., 2016; Smerud & Rosenfarb, 2007).

A gap exists in the literature regarding the therapeutic alliance and individual symptoms, with some researchers reporting an association (Anker et al., 2010; Knerr et al. 2011), while others report that change in individual symptoms is not associated with the alliance in couple therapy (Knobloch-Fedders, Pinsof, and Mann, 2004; Mamodhoussen et al., 2005). It is theorized that the formation of the alliance in couple therapy is a more complex process that engages both the within couple relationship and the relationship between the therapist and couple to collaborate as a team; addressing individual symptoms (Bartle-Haring et al., 2007; Kivlighan, 2007). Clinical consensus has historically held that while an alliance formation leads to individual symptom relief, the alliance in couple therapy primarily impacts the couple's relational outcomes and is driven by relational change (Knobloch-Fedders, Pinsof, & Mann, 2004, Mamodhoussen et al, 2005). Given the importance of individually diagnosed symptoms to both individual and couple functioning, researchers must examine the relationship between individual symptoms and couple alliance.

Alliance Theory

Edward Bordin's theory of alliance posits that the relationship between the client(s) and therapist is a central determining factor in the process of therapeutic change. Alliance theory defines this central connection as requiring therapist and client(s) to establish three primary relational components: an emotional bond, a collaborative understanding of therapy tasks, and a mutual agreement about therapy goals (Bordin 1979, 1994). Thus, alliance theory posits that clients will build a strong alliance when they build a bond with their therapist and feel that their therapist focuses on the couple's goals and tasks as most important.

Alliance theory would suggest that couples who seek therapy primarily for one partner's individual symptoms will value change in those same symptoms. This change would provide evidence of agreement about therapy goals. As a result, such couples could exhibit increased therapeutic alliance if the therapist treatment focus matches the client presenting problem and positively impacts individual symptoms. Although couple therapy has been empirically validated as an effective tool to address diagnostic concerns, it remains unknown why inconsistencies are present in past findings regarding the relationship between alliance and individual symptom improvements. These anomalies significantly constrain both clinical and theoretical understanding about the role of the alliance in couple therapy and the importance of individual symptom change to and alliance formation.

Researchers have hypothesized that alliance in couple therapy is primarily related to relational change for various reasons, including that couple clients may experience unique dynamics related to an agreement about the tasks and goals of therapy (Knerr et al., 2011). However, focusing couple therapy interventions solely on relational distress would limit potential therapeutic benefits for couples with significant symptom distress. For clients managing

severe or complex concerns, systemic therapy is especially relevant and has been found to offer an improved prognosis for lasting change (Carr, 2019).

It is consistent with alliance theory to expect collaboration on goals and tasks to facilitate alliance development in couple therapy. The first step to evaluating existing discrepancies in findings should be to evaluate the client's primary presenting problem and connect it with the therapist's primary treatment focus. Those two steps directly align with the goals domain of the alliance and are also indirectly related to the tasks domain. The inconsistent findings related to alliance formation and individual symptoms in couple therapy suggest two potential hypotheses that have not been addressed. First, in the studies not finding a relationship between individual symptom relief and alliance formation, it is possible that the therapist disproportionately focused on relationship concerns, which led to an improved couple alliance but only indirectly impacted individual symptoms. The second hypothesis might be that most cases evaluated in prior couple therapy research were primarily referred for relationship difficulties with individual symptoms considered secondary by the clients and the therapist. While some researchers reported changes in individual symptoms, individual symptom distress was not the primary therapeutic focus and did not appear to impact alliance. Both outcomes could be verified if an alliance study examined both the primary reason for referral by the client and the subsequent focus of treatment by the therapist.

An examination of the existing literature on couple therapy alliance suggests that reason for referral and treatment focus have been largely unexamined as predictors of couple therapeutic alliance, which leaves a blind spot in the alliance and symptom relief literature. While previous studies have engaged in a rigorous examination of the relationship between couple client outcomes, the majority of the researchers failed to consider the couple's reported reasons for

pursuing therapy – often called the “reason for referral” or “presenting problem” – nor did these authors examine the therapist’s primary focus of treatment. In the body of existing couple therapeutic alliance literature, both the couple’s presenting problem and treatment focus are conspicuously absent (Knobloch-Fedders, Pinsof, & Mann, 2005; Mamodhoussen et al., 2004).

As the match between the clients’ intended goals for therapy and the therapist’s focus has been previously identified as an important component in the development of therapeutic alliance (Bordin, 1979), this oversight is potentially significant to our understanding of the relationships between the focus of treatment and alliance formation in couple therapy. The apparent absence of data in the existing body of literature about both the presenting problems and treatment focus of the therapist in couples alliance research suggests that there could be a moderating interaction between the focus of therapy (relational or individual) in treating problems and the client's primary presenting problems (relational or individual).

To better understand the complex interplay between alliance formation and individual symptoms in couple therapy, the current study hypotheses include the following:

Research Hypotheses

Individual Diagnostic Hypotheses

1. **Change in individual client symptom distress during the initial treatment stage will not be related to couple therapy alliance**. This would be consistent with existing findings of the relationship between client symptom distress and alliance (Knobloch-Fedders, Pinsof, & Mann, 2005; Mahmodhoussen et al., 2004) and is determined through simple correlations.
2. **When the client’s primary presenting problem is symptom distress, the change in symptom distress will be associated with the therapy alliance as reported by each**

client individually. Given the importance of "goals" to the overall formation of alliance and alliance to the accomplishment of therapeutic tasks that are created to achieve the goals, it seems likely that clients who experience a match in tasks and goals experience greater bonding with the therapist along with decreased symptom distress (Hagen et al., 2016; Sparks, 2015; Knobloch-Fedders, Pinsof, and Mann, 2004).

3. **When the client presenting problem is individual symptoms, the change in relationship satisfaction will still demonstrate association with the therapy alliance.** Because the dynamic of couples therapy is relationally focused, relationship satisfaction will be associated with the therapy alliance whether the referral and treatment focus is individual symptom-focused. This might be the moderating factor that explains why some researchers have found that only relational change impacts alliance in couples therapy (Knobloch-Fedders, Pinsof, & Mann, 2005; Mahmodhoussen et al., 2004), while others have found the diagnostic change to be relevant (Anker et al., 2010; Knerr et al. 2011).
4. **When the client presenting problem is individual symptoms, the relationship between the change in symptom distress and the therapy alliance will be moderated by the match between the client presenting problems and treatment focus.** Alliance theory suggests that for couples whose primary presenting problem is a diagnostic concern, a combination of diagnostic change (accomplishment of the clients' stated goals) and client-therapist agreement on treatment focus (evidence of client-therapist agreement on the tasks subcategory of alliance) may represent the best predictor of alliance scores and thus of positive therapeutic outcomes (Bordin, 1979).

To fully address the individual symptom distress hypotheses and determine whether couple clients who report diagnostic presenting problems will respond differently to the study moderators than those reporting relational presenting problems, we will control presenting problems by analyzing these groups separately. Thus, comparable hypotheses are listed below relating to the group of couples who reported relational distress as their primary presenting problem.

Relationship Distress Hypotheses

1. Change in relationship satisfaction during the initial stage of treatment will be correlated with couple therapy alliance.
2. When the client presents with relational distress, the relationship satisfaction change will be positively related to a stronger therapy alliance.
3. When the client presents with relational distress, the change in individual symptom distress will be associated with the therapy alliance.
4. When the client presenting problem is relational distress, the relationship between change in relationship satisfaction and the therapy alliance will be moderated by the match between the client presenting problems and treatment focus.

Chapter 2: Literature Review

This review will address existing research related to the alliance in couple therapy, including existing knowledge about the role of the alliance in couple therapy, the unique relationship between alliance and outcomes in couple therapy, and the interactions between individual symptoms and alliance formation, especially in couple therapy settings. Alliance theory will be used as the primary theoretical orientation for this review, as it informs several essential elements of the research questions and methodology for this study.

Couple Therapy

Adult committed relationships have long functioned as a fundamental unit of organization for human societies, which continues to be true in the 21st century. While relationship norms in many Western cultures underwent significant changes over the past century, approximately 85% of adults reported that they had been married by age 50 while numerous others reported being in a long-term committed couple relationship, including 30% of first-time parents in the United States (Halford & Snyder, 2011; Kennedy & Bumpass, 2008; Hayes, Weston, Lixia, & Gray, 2010; Halford & Pepping, 2019). Couples in committed relationships have been found to experience various common stressors and report varying levels of relational distress related to their relationship dynamics. When couple therapy clients were asked to describe the concerns that prompted them to seek treatment from a therapist, some themes emerged, which were observable across geographic, socioeconomic, and demographic groups. These included concerns about communication, conflict resolution, parenting, sexual intimacy, and finances (Halford & Pepping, 2019). Couple therapy represents a highly effective treatment modality to address concerns commonly experienced by adults in committed relationships.reference?

Beyond its efficacy for couples and their families, systemic therapy also represents a highly effective use of community resources. Research on systemic therapy has demonstrated effectiveness in addressing clients' needs while also reducing clients' subsequent healthcare services usage. This effect has been documented across a variety of client diagnoses, including substance use disorder, schizophrenia, sexual problems, major depression, somatic disorders, and relational problems (Wood et al., 2005; Caldwell et al., 2007; Crane & Christenson, 2014; Benson & Christensen, 2016). The effectiveness of couple therapy for individually diagnosed concerns appears to persist across therapy modalities and presenting problems. Similar improvements in couple distress have been demonstrated when couples received cognitive behavioral therapy or traditional systemic couple therapy (Baucom et al., 2015; Byrne et al., 2004a).

A group of couples facing various physical and mental health concerns also demonstrated similar improvements despite groups receiving couple therapy representative of multiple modalities (Fischer et al., 2016). Thus, couple therapy can be seen as a highly effective intervention for various couple concerns related to individual symptoms, almost regardless of the therapist's specific treatment modality. Systemic therapy is not only effective for these concerns but can also be completed in a relatively brief period. Many couples can expect to see measurable improvements after spending only six months attending approximately 20 sessions of couple therapy (Lebow et al., 2012; Halford & Snyder, 2012; Benson & Christensen, 2016). These findings offer hope for couples when relationships and diagnoses collide and represent opportunities for clinicians to expand their reach to new client populations (Carr, 2019).

As a result of particular presenting concerns being most frequently cited by couples entering therapy, significant academic and clinical research has utilized these commonly cited

concerns as normative “couple issues” informing clinical interventions. However, both researchers and clinicians must remain mindful of other factors, which demonstrate bidirectional influence with couple relationship variables; these include both partners' mental and physical health status. While these concerns may fall outside of the normative couple issues, they are pervasive problems present in couple therapy. Couples whose primary presenting concern involves the individual symptoms of one or both partners, focusing on relational distress – despite the recognized importance of relational distress in couple therapy - might not be the primary directive. The therapeutic alliance theoretical perspective suggests that the professional relationship would solidify the immediate treatment needs (Bordin, 1979). When clients present with individual individually diagnosed concerns, alliance theory would suggest that agreement on goals and tasks would likely form the primary association with the therapeutic alliance, rather than alliance forming based upon the relational concerns typically associated with alliance and couple therapy.

Alliance

In clinical settings, the connection between therapist and clients has implications for the client’s outcomes upon completing treatment and the working relationship between the therapist and clients during treatment. In the literature, this client-therapist relationship is known as the therapeutic or “working” alliance (Bordin, 1979; Bordin, 1994; Daly & Mallinckrodt, 2009). Therapeutic alliance encompasses a wide range of interpersonal variables present in a therapeutic relationship, including trust, affinity, consensus about goals, feelings of caring, and mutual respect between client and therapist (Horvath & Bedi, 2002). Edward Bordin first described the therapeutic alliance as being composed of three elements: the agreement between clinician and client about the goals for therapy, agreement about the tasks to be undertaken during treatment,

and the emotional bond created between the client(s) and clinician (Bordin, 1994; Degnan, Seymour-Hyde, Harris, & Berry, 2016). Bordin elaborated on the importance of the working alliance in a 1979 article, saying: "I propose that the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not the key, to the change process." Other scholars and clinicians have provided working definitions for use with Bordin's 'goals, tasks, and bonds' framework, explaining that the "bonds" dimension measures mutual attachment and trust within the therapeutic relationship. In addition, Bordin's "tasks" subscale includes activities engaged in during treatment sessions, and the "goals subscale refers to the specific objectives and areas targeted for improvement, which must be a product of shared understanding between the client(s) and therapist (Raue, Castonguay, & Goldfried, 1993). The bonds, tasks, and goals subscales form the basis of the therapeutic alliance between the couple and the therapist, serves as a powerful predictor of therapeutic outcomes.

In the context of couple therapy, the alliance is an essential ingredient for successful treatment, and past research has indicated that when couple clients report low levels of a therapeutic alliance, their prognosis for improvement is poor (Anker, Owen, Duncan, & Sparks, 2010; Davis, LeBow, & Sprenkle, 2012). Higher therapeutic alliance levels have been found to explain as much as 29% of the clients' treatment outcomes across many client groups. This finding appears even more notable when one considers that some research indicates the influence of therapeutic model – the focus of much psychotherapeutic training and many a debate between colleagues – may contribute less than 1% of the client outcome (Davis et al., 2012; Baldwin, Wampold, & Imel, 2008; Horvath, 2001; Flükiger et al., 2019; Wiseman, 2017).

Any discussion of alliance and therapeutic outcomes must note the relevance of non-modal elements in the process of alliance formation. A key concept to consider when exploring

predictors of therapeutic outcome is that of common factors. The concept of common factors describes many elements of the psychotherapeutic relationship and process which are not specific to a given modality, technique, or setting. Some examples of common factors include empathy and affirmation, but therapeutic alliance is also sometimes considered a common factor (Wampold, 2015). Common factors have been found to explain a significant portion of therapeutic effectiveness and change across all treatment modalities, and are especially important to the effectiveness of couple therapy (Davis, Lebow, & Sprenkle, 2012). While the scope of this study does not include data regarding the specific impact of common factors, any examination of alliance formation undoubtedly must recognize the central role of common factors in alliance formation.

While findings have varied in their reports of the exact statistics, many authors have conducted research validating the significance of alliance to therapeutic outcomes. A meta-analysis conducted by Martin, Garske, & Davis in 2000 examined 79 studies focusing on the relationship between alliance and therapeutic outcomes. Of the 79 studies, 53 were studies published in an academic journal, and 21 were unpublished master's theses or doctoral dissertations. The authors found that the weighted correlation between alliance and outcome was 0.22 (n = 68, SD = 0.12). This finding suggests that alliance plays a significant role in the therapeutic process and acts as a significant predictor by exerting approximately 22% influence on achieving desirable client outcome(s) during and after psychotherapeutic treatment. Similar research findings estimate alliance's impact ranging from 5% to 29% of therapeutic outcome (Bourgeois, Sabourin, & Wright, 1990; Johnson & Talitman, 2007; Knobloch-Fedders, Pinsof, & Haase, 2015).

Some data suggests that alliance may be an even more important predictor of positive outcomes for partners who participate in therapy together than for clients who engage in other types of individual or relational (i.e., parent-child) treatment, with couple therapy clients showing a more robust effect size (d = 0.37) (Friedlander et al., 2011). Additional research indicated that therapist, client, and spouse alliance ratings were relevant to positive outcomes (Kuhlman, Tolvanen, & Seikkula, 2013). As such, alliance in couple therapy is a critical focus for therapists and a fundamental predictor of clients' desirable outcomes.

Even when treatment modalities, therapy setting, and population are changed, the alliance remains a central variable to the effectiveness and outcome of psychotherapeutic treatment (Blow, Sprenkle, & Davis, 2007; Bourgeois et al., 1990; Castonguay et al., 2006; Horvath et al., 1991; Knoblock-Fedders et al., 2007). The importance of alliance across modalities and therapist factors suggests that synthesizing all existing knowledge elements to form a cohesive, clinically applicable understanding of alliance in couple therapy is essential for researchers in the field. Although alliance in couple therapy continues to be an area of active research interest, a critical gap in understanding remains due to the apparent absence of rigorous exploration into the interplay between alliance and individually diagnosed symptom change.

Alliance in Couple Therapy

In their theoretical application of alliance to systemic therapy models, Pinsof and Catherall (1986) included the original three components which Borden suggested form the foundation of alliance development - Goals, Tasks, and Bonds – as part of the measurement scales they created to evaluate alliance and alliance formation in systemic therapy. In applying alliance theory to couple and family systems, Pinsof and Catherall expanded the existing understanding of alliance beyond that of a phenomenon solely occurring between a single

therapist and a single client. The alliance could also be understood as an essential theoretical formulation for explaining the impacts of complex relationship dynamics between the therapeutic system and the client system, regardless of the number of individuals acting as members of each system. While this study ultimately yielded mixed findings of the impact of alliance upon necessary treatment and outcome variables in systemic therapy, it established an initial base of findings upon which other researchers could build their research questions.

Other authors have reported findings that indicate that working alliance may act as a "pan-theoretical" component of treatment, with the therapeutic alliance appearing to be predictive of improvements and therapeutic outcomes cross a variety of modalities and therapeutic interventions (Glazer, Galanter, Megwinoff, Dermatis, & Keller, 2003; Wampold, 2001). Existing research suggests that alliance is a critical protective factor in couple therapy independent of other factors, including therapist modality, client factors, and potentially even the reason for treatment (Anker et al., Wampold, 2001). Horvath and Bedi (2002) noted that the strength of the therapeutic alliance was predictive of client improvement during and after psychotherapeutic treatment. These findings suggest that therapists engaging in couple treatment would be well-served to focus their treatment goals and efforts toward factors that are most important to forming and maintaining alliance within the couple therapy setting. However, identifying these critical predictive factors has often been a complicated and contradictory venture.

Alliance and Individual Symptoms

The relationship between therapeutic alliance, individual symptomology, and therapy focus has proven difficult to define in couple therapy. Different authors report various findings of the role of moderators and predictors in this interaction. Several authors have suggested that

alliance is related to relational change but not to diagnostic change in couple therapy. In a 2004 study of 35 couples (77% white, *m* annual income = $50,000) ranging in age from 21 to 74 (*m* = 34) who sought therapy in a Midwestern teaching clinic, Knobloch-Fedders, Pinsof, and Mann found that reported changes in either partner's symptoms were not predictive of alliance formation or maintenance (2004). However, it is important to note that the authors did not report the client presenting problem or therapist focus of treatment, the interplay between which might have impacted their findings regarding individual symptoms and alliance formation. Additional research has supported Knobloch-Fedders et al.'s 2004 findings suggesting that individual symptoms changes do not represent significant predictors of alliance in couple therapy (Mamodhoussen, Wright, Tremblay, & Poitras-Wright, 2005). In their study, Mamodhoussen et al. analyzed data from 79 couples in Quebec who had lived together for at least 12 months. Average annual income was $30,000 to $34,000 Canadian dollars for women (SD = $15,000) and $50,000 to $54,000 for men (*SD* = $20,000), and age ranged from 23 years old to 70 years old (*m* = 40 for both males and females). The majority of couples were married (57%), with the remainder of couples cohabiting (43%), and all couples completed at least three sessions of couple therapy. The authors administered the Psychiatric Symptoms Index (PSI), an assessment of psychiatric symptoms experienced during the seven days preceding the start of treatment.

They found that female clients reported various psychiatric symptoms consistent with depression, cognitive disturbances, hostility, and anxiety (mean PSI score = 38.40, *SD* = 18.85). In contrast, male clients primarily reported depression and hostility (*m* = 26.2, *SD* = 14.76). However, when the authors found that PSI reported psychiatric symptoms were not predictive of the alliance for male or female participants in couple therapy. It is relevant to note that Mamodhoussen et al. (2005, also did not include therapist treatment focus or client presenting

problem in their examination of the relationship between psychiatric symptoms and alliance formation, thus preventing these results from clearly defining whether psychiatric symptoms might prove more relevant to alliance formation when a couple's primary goal for therapy is to address such symptoms.

In contrast, other researchers have suggested that individual symptoms distress may be significant to couple therapy alliance (Wampold, 2001; Porter & Ketring, 2011; Knerr et al., 2011). In their 2011 article, Porter and Ketring examined data from a low-income, 80% white sample of 181 couples (*M* income = $25,000) receiving therapy services through a university training clinic in the southeastern United States. The authors used accepted measures including the Outcome Questionnaire (OQ-45.2; Wells et al., 1996) and the University of Rhode Island Change Assessment (URICA; McConnaughy, Prochaska, & Velicer,1983), as well as intermittent assessments (every four sessions) using the Couple's Therapy Alliance Scale-Revised (CTAS-R; Pinsof, 1994); data were analyzed using regression analysis. Researchers concluded that male partners report lower earlier pre-contemplation stages than female partners upon initiation of therapeutic couple treatment. This lower level of engagement may explain weaker initial alliance scores reported by male clients. Interestingly, the authors also found that while males reported symptom distress correlated strongly with male motivation for change, the inverse was true for the therapeutic alliance for those same male partners. The authors reported the most males reporting significant symptom distress were likely to yield the lowest alliance scores (Porter & Ketring, 2011).

This finding provides an essential precursor to the proposed study, in that symptom distress appeared to have a strong influence on alliance formation for some clients and thus would likely exert even more significant influence in the systemic context of couple therapy.

Other authors have also found that couples differ in their experience and report of therapeutic variables, including alliance. In a 2011 study, Knerr and colleagues examined alliance formation in couple therapy. They determined that client ratings of working alliance frequently differ significantly at the start of treatment, and the alliance continues to develop differently for each partner throughout the treatment process (Knerr et al., 2011).

Knerr and colleagues explored alliance formation using a sample of 457 clients at a teaching clinic (243 individuals and 107 couples), the majority of whom identified as Caucasian (68.8%) and reported making less than $50,000 per year (>75%). The authors used multilevel modeling to examine differences in the alliance formation process between individual and couple clients. They found that emotional reactivity was an essential predictor of alliance formation for wives, while depressive symptoms and intrusive thoughts were critical to forming an alliance for husbands. These individual symptom distress measures impacted the alliance formation in the couple therapy setting for both male and female couple clients, independent of relational factors within the coupled system. The authors also found that alliance formation and perception of alliance differed between male and female clients receiving couple therapy.

In their 2003 meta-meta-analysis, Shadish & Baldwin reported robust findings regarding the impact of couple therapy. The authors reviewed 20 previously completed meta-analyses of studies documenting the effectiveness of systemic interventions, including couple therapy. They found that systemic interventions demonstrated an effect size of 0.84 for couples, indicating that more than 80% of couples receiving couple therapy improved more than matched control couples who did not engage in couple therapy. Another meta-analysis conducted by Pinquart and colleagues indicated that adults with psychiatric diagnoses reported more significant improvement in symptoms when systemic therapy was included in treatment than when treated

with medication alone (Pinquart et al., 2016). Pinquart and colleagues conducted a meta-analysis of 37 randomized controlled trials involving adults with psychiatric disorders who received systemically focused therapy. The authors found that clients with five common psychiatric disorders receiving systemic therapy demonstrated more robust positive treatment responses in both short-term (g = .51) and long-term (g = .55) when compared to similar adults in a control group and when compared to alternative active treatment (g = .25). Clients receiving medication in conjunction with systemic therapy showed even stronger positive responses, both for short-term (g = .71) and long-term (g = .87) assessments (Pinquart et al., 2016). These meta-analyses provide strong evidence that couple therapy can help couples address diagnostically relevant symptoms if the therapeutic intervention is focused on the diagnostically related presenting problem.

In a recent review of research conducted by Byrne and colleagues, the authors found that couple therapy was effective at reducing panic and agoraphobic symptoms in 54 – 86% of couples and had a positive effect on couple relationship quality, despite treatment being focused on the diagnostic concern(s) of one member of the couple (Byrne et al., 2004b). Byrne et al.'s data indicated that couple treatment focusing on one partner's individually diagnosed concerns could produce relational improvements not explained by the treatment focus or therapist goals.

Findings such as these raise questions about whether both relationship distress scores and alliance scores in couple therapy may be moderated by the fit between therapist focus and couples' presenting problems. Byrne and colleagues' data also suggest that identifying relational change as the primary predictor of alliance in couple therapy may fail to provide a full explanation of the dynamic interplay between alliance and other clinical variables. It is conceivable that findings reporting that relational change was a significant predictor of alliance

formation may instead demonstrate the moderating effect of the agreement between therapist and couple about the primary goals of therapy. Exploring the impact exerted by therapist-client agreement on goals/treatment focus might provide the missing information necessary to fill gaps in understanding how the alliance is related to the diagnostic change in couple treatment.

Individual symptoms as a primary therapeutic focus

The existing body of research is primarily composed of studies in which the participant couples enrolled to focus on a specific relational problem which the therapist already intended to address, leaving a significant gap related to couples who present with diagnostic concerns as their primary intended focus for treatment (Knobloch-Fedders, Pinsof, & Mann, 2004; Mamodhoussen et al., 2005). Alliance data in which authors have controlled the match between presenting problem and treatment focus is mainly absent from the current literature. As with other research areas in which conflicting findings are demonstrated, this issue is likely more complex.

One explanation might suggest that this is due to the historical pattern of couples who seek therapy presenting primarily relational concerns. Clinicians then provided treatment focusing mainly or even exclusively on relationship satisfaction. Because clients must "opt-in" to human research studies and are likely not to join a couple therapy study unless the issue being addressed during the research matches the couple's own goals for therapy, this type of study design would likely be characterized by a very high level of agreement between couple's presenting problem and the therapist's focus of treatment. The same could be valid for the studies mentioned previously, which found that couple therapy is a highly effective treatment for diagnostic concerns. Studies demonstrating the effectiveness of couple therapy for presenting diagnostic problems are likely to have co-occurring high client-therapist agreement on treatment

focus. In this way, the informed consent process effectively guarantees that both the volunteer participant couples and the therapists conducting the interventions are likely in agreement regarding the primary treatment focus.

For example, when studies utilize a therapeutic model that guarantees a good fit between the couple's reported concerns and the therapist's treatment focus, the impact of individual symptoms on the alliance is minimal (Knobloch-Fedders et al., 2004). It is notable that although client presenting problem and therapist focus of treatment were not reported, this study utilized a problem-focused therapy model (IPCT; Pinsof, 1995). Such a model increased the likelihood that the therapist would be responsive to the clients' identified concerns (including client concerns about individual symptoms) as a byproduct of using a model focusing on the clients' stated presenting problem(s). The therapist was already focusing on diagnostic concerns for couples whose primary concern was diagnostic may explain why the data did not indicate that alliance was significantly affected by any additional therapist focus on diagnostic symptom change.

While sampling effects are likely relevant to confusing findings regarding diagnostic change and alliance in couple therapy, this apparent contradiction in conclusions can be more fully explained as an effect of systemic interactions, which are an inherent and unalienable positive impact of any couple therapy, regardless of treatment focus or presenting problems. Goal-setting and routine assessments have been shown to produce relational improvements in couple clients due to systemic components of participation in therapy (Halford et al., 2015; Cordova et al., 2014; Halford, Osgarby, & Kelly, 1996). The documented systemic effects of therapy participation must influence therapeutic alliance examination in couple therapy as primarily or exclusively responsive to changes in relational distress.

Existing data indicates that couples who receive any intervention involving interpersonal interaction and couple cooperation report improved functioning compared to couples who receive no social intervention (e.g., couples in a waitlist condition). This "treatment effect" is a well-documented phenomenon in the statistical literature and underscores the importance of controlling for the systemic influences before reporting a causal relationship between intervention and outcome. The treatment effect concept might be applied to suggest that simply engaging in couple therapy may produce results that indicate that couples who report decreases in relational distress are the most likely to show improved alliance.

The mutual collaboration between couple sessions is likely to prompt both partners to report the improvements in relational distress previously identified as moderating couple-therapist alliance. Moreover, couple relational distress may also decrease due to systemic treatment components, including therapy participation and periodic assessments.

The Present Study

The hypothesis is that couples reporting that individual symptoms are the primary reason for seeking therapy, alliance ratings are responsive to individual change and demonstrate some response to relational change. This is likely due to the systemic elements inherent to the couple therapy process, regardless of treatment focus. It is also possible that when clients present in couple therapy for individual symptom distress, therapists may overly focus on the relationship dynamics and not address the individual symptoms, which would impact the relationship between alliance and symptom relief. Previous research might have missed these two primary factors, thus clouding the actual interaction between alliance and symptom improvement. If so, this analysis should identify these couples' alliance scores as being most responsive to diagnostic

change, in addition to reporting some relational improvement due to systemic factors of therapy participation.

It is further hypothesized that when a therapist focuses on individual symptoms in the couple relationship, both the individual and relational distress measures will improve for two primary reasons. First, when the therapist accurately fits the treatment focus to reflect the couple's presenting problem(s), all parties would experience a greater degree of felt congruence regarding the "goals" subset of the therapeutic alliance. Because goal-setting and shared purpose in completing therapeutic tasks is a critical component of initial therapy sessions, and early alliance scores show significant predictive validity for therapeutic outcomes, the agreement between therapist and couple on goals and tasks may be uniquely important to couple outcomes because of the collaborative nature of couple therapy (Flükiger et al., 2019; Knerr et al., 2011).

Second, couple therapy is an inherently systemic enterprise in which both members of the couple are required to build a new relationship, learn new things, and cooperate in new ways, supported and encouraged by a third member of the system, the therapist. Systems theory would suggest that improvements in relationship distress measures noted by previous authors may simply be evidence that the clients are indeed attending couple therapy. Alliance and systems theories suggest that systemic factors inherent during couple therapy – cooperative social interaction between the partners and a benevolent third party - may improve relational distress scores even when treatment does not focus on the couple's reported category of presenting problem.

For this analysis, the sample of couples receiving therapy services will be examined based upon the client-reported primary presenting problem. Each case will be categorized according to the primary and secondary treatment focus chosen by the therapist. Finally, couple

data will be examined separately by gender, consistent with previous findings indicating that gender may impact client reports on various measures (Knerr et al., 2011; Wampold, 2001; Bedi & Horvath, 2004). The authors will then utilize this grouping system to explore the influence of match or mismatch between therapist focus and couple presenting problem as a process variable mediating the relationship between alliance and therapy outcomes.

It is hoped that this study may contribute greater nuance and specificity to the theoretical and clinical understanding of the links between client-therapist consensus on therapy tasks, goals, and bonds of the alliance and outcomes in couple therapy. If the hypotheses and research questions in this study prove accurate, therapists who default to relational focus with couples may be missing essential nuances related to symptom distress and diagnostic change. For couples whose primary presenting problem is diagnostic, the effective formation of therapeutic alliance may depend upon the therapist's ability to create a strong match between the presenting problem and therapist focus, likely by adjusting treatment goals to address diagnostic couple concerns.

Chapter 3: Method

This study utilized data from the Auburn University Marriage and Family Therapy Center (AUMFTC). AUMFTC provides low-cost individual, couple, and family therapy sessions to the community. These services are provided by graduate students currently enrolled in the marriage and family therapy master's program at Auburn University. The AUMFT clinic data collection required that all participants provided informed consent for training and research data collection and was approved by the Auburn University Institutional Review Board (IRB).

Participants

For this study, all relevant data was provided by 387 couples who received couple therapy services between 2005 and 2015 and followed an IRB-approved informed consent process. Demographic data for the sample of 387 couples indicated that 61.6% of couples reported annual household incomes ranging from $5,000 to $40,000, with the remaining 38.4% reporting annual incomes exceeding $40,000. The participant group was 51.9% female and 48.1% male, ranging in age from 17 to 61 (m = 31.38), with the majority of clients identified as White (80.0%), 13.0% identifying as African American, 1.9% as Hispanic, 1.4% as Asian American, and the remainder reporting biracial or other race/ethnicity. The highest level of education completed varied across the sample, with 27.0% reporting high school diploma, 32.8% reporting associate's, vocational, or bachelor's degrees, and 26.8% reporting graduate or professional degrees. (See Table 1).

Procedure

Couples included in this research sample contacted the marriage and family therapy center by telephone or in-person and spoke with a clinic's administrative staff member. During this initial interaction, one or both members of a couple were asked to describe the primary

concerns prompting them to seek couple therapy services, called “presenting problem” in this study. This report was recorded on an intake form by the clinic staff member and was made available to the intern therapist before the first therapy session. Upon initiation of treatment (intake session), couples completed individual self-report questionnaires which included components of the Revised Dyadic Adjustment Scale (RDAS) - a measure of relational distress - the Outcome Questionnaire (OQ) - a measure of anxiety and depressive symptoms - and the Couple Therapy Alliance Scale-Revised (CTAS-R). The RDAS, OQ, and CTAS-R were re-assessed before the fourth session. As moderate levels of early attrition due to drop out have been consistently observed in couple therapy studies, we expect to identify a population of couples who discontinue treatment before the 4th session (Miller & Wright, 1995). Due to the necessity of having both intake and follow-up paperwork, couples who did not complete fourth session paperwork will be considered non-completers. Non-completers and drop-outs were compared statistically to determine whether any significant differences exist between completers (included in the sample) and non-completers or drop-outs.

Measures

The Revised Dyadic Adjustment Scale. The Revised Dyadic Adjustment Scale (hereafter RDAS) was created by Busby, Christensen, Crane & Larson (1995) by adapting the Dyadic Adjustment Scale (Spanier, 1976) to measure adjustment in committed relationships. The RDAS has consistently demonstrated effectiveness as a highly valid measure of relationship quality for several decades (Ward, Lundberg, Zabriskie & Barrett, 2009). The RDAS is also considered a highly reliable measure and has been found to have a Cronbach’s alpha of .90 (Crane, Middleton, and Bean, 2000). The RDAS measures three subscales of adjustment-satisfaction, cohesion, and consensus –assessed using 14 items. All questions are rated using

Likert scales, with the 4 Satisfaction items measured from "all the time" (0) to "never" (5). In comparison, the four Cohesion items are rated using "Never" (0) to "more often" (5), and the 6 Consensus items include response options which range from "Always Disagree" (0) to "Always Agree" (5).

Outcome Questionnaire. The Outcome Questionnaire (OQ-45.2; Lambert et al., 1996) is a measure of symptoms distress. The OQ contains 40 questions in its entirety and addresses three subscales: Symptom Distress, Interpersonal Relations, and Social Role. For this study, the 25 item Symptom Distress Subscale of the OQ will be used to measure and assess changes in diagnostically related symptoms. Each subscale of the OQ contains questions that can be reliably measured individually. The Symptom Distress subscale is composed of items that have been found to reflect the symptoms of anxiety disorders, affective disorders, and adjustment disorders. A high score indicates that patients are bothered by these symptoms, while low scores indicate either absence or a denial of the symptoms. Symptoms scores correlate highly with the Beck Depression Inventory and the State-Trait Anxiety Inventory. The Symptom Distress subsection measures depression and anxiety symptoms by measuring client agreement with a variety of statements such as "I feel worthless" and "I tire quickly" using a Likert scale of 0 (least agreement) to 4 (greatest agreement). Lambert and colleagues found that the Test-retest reliability of the OQ ranges from 0.78 to 0.84 and the Internal Consistency ranges from 0.70 to 0.91, with a Cronbach's alpha of 0.91 – 0.92 depending on responder gender (Lambert et al., 1996), while Cronbach's Alphas for this study were .89 for males and .91 for females.

Couple's Therapy Alliance Scale-Revised. The Couple's Therapy Alliance Scale-Revised (CTAS-R) was developed by Pinsof and published in 1986. The CTAS-R assesses the three subcategories of the alliance – bonds, goals, and tasks – via client self-reported responses

to 40 items according to a 7-item Likert scale ranging from 1 (“completely disagree”) to 7 (“completely agree). Each subcategory is assessed individually, with the Goals subsection including questions such as “The therapist does not understand the goals my partner and I have for ourselves in therapy,” the Bonds subsection including statements like “My partner feels accepted by the therapist,” and “The therapist does not understand me.” Similarly, the Tasks subsection asks clients to rate their level of agreement with statements such as “The therapist has the skills to help my partner and me,” and “The therapist is not helping my partner and me.” The CTAS-R reports test-retest reliability of $r = .84$ (Pinsof & Catherall, 1986). Heatherton and Friedlander (1990) examined the internal consistency of the scale. They reported an alpha of .93 for the total score, while Cronbach’s Alphas for this study were .95 for males and .96 for females.

The CTAS-R was administered as part of individual questionnaires completed by each couple before the fourth session, which is consistent with findings indicating that early alliance is the most potent predictor of treatment outcomes (Munder et al., 2019). While some researchers have hypothesized that client reports of the alliance during treatment could be inflated due to perceived social obligations to the therapist, previous research has indicated that client reports of the alliance are similar when reported directly to the therapist or reported in a blinded arrangement (Knobloch-Fedders, Pinsof, & Mann, 2004).

Primary Reason for Referral

Upon initial contact with the AUMFTC, the clients were asked to describe their primary reason(s) for initiating therapy treatment, and a clinic administrator recorded the clients’ responses.

Therapist Treatment Focus

Graduate and undergraduate interns reviewed the first four sessions of therapy to identify the primary treatment focus.

Coding for Reason for Referral and Therapist Treatment Focus

All treatment records were coded by four graduate students who received group training, including 10 cases with guidance from the principal investigator and 10 cases individually with supervision and feedback from a senior member of the research faculty. Each reviewer completed a training set of file reviews with direct supervision and inspection from a senior faculty member. Using direct instruction and feedback about the reviewer's work, the faculty member continued training until each reviewer attained a high level of proficiency and demonstrated the ability to code at least ten files accurately without input from the faculty member.

A group of four master's level graduate students acting as independent raters reviewed detailed case notes for the first four couple therapy sessions and rated both the primary reason for referral and the student therapist's primary treatment focus during the first four sessions as either "treatment primarily focused on diagnostic criteria included in the DSM-5" – coded as "1", or as "treatment primarily focused on relational symptoms" – coded as "2". Two coders were assigned to a specific year. While one coder reviewed primary reason for referral, the other reviewed primary treatment focus. The raters would then switch roles. The rating system was blind for the raters, with the data being paired after all couple therapy cases were rated for a given year. The raters demonstrated interrater reliability for each year varying from 94 to 99% inter-rater reliability for reason for referral and 90 to 95% for primary focus of treatment.

In cases of rater disagreement about initial coding, raters were able to reach consensus in ratings which were confirmed by the principal investigator for all remaining cases; rater disagreement was noted almost exclusively in cases in which couples presented with a combination of diagnostic and relational concerns of similarly reported severity, as would be the case with couples experiencing both an affair and a co-occurring substance use disorder. Each reviewer coded the couple's reported presenting problem by reviewing the couple's referral form and categorizing the primary problem as "primarily related to diagnostic symptoms" – coded as "1", or as "primarily related to relational symptoms" – coded as "2". Raters also identified a specific presenting problem for each case file by providing two to three-word descriptions; interrater reliability for this descriptive coding also demonstrated 90% - 95% levels. Consensus was achieved with the raters and the principal investigator after reviewing clinical information.

Covariates

Several significant covariates will be controlled for during the analysis process. Due to the established relationship between education and alliance (Bartle-Haring et al., 2012), we will control education within our sample. Additional previous studies have indicated that length of the relationship is essential to the formation of the alliance in couple therapy because of the impact of relationship duration on within-couple dynamics so that we will control for the length of relationship for couples in the sample (Mamodhoussen et al., 2005; Knobloch-Fedders, Pinsof, & Mann, 2004).

Chapter 4: Results

The purpose of this study was to examine the impact exerted upon alliance formation by the categorical match or mismatch between a couple's reported presenting problem and their therapist's treatment focus. Descriptive statistics were run to improve understanding of sample distributions and characteristics.

Missing Data Analysis

To ensure accurate and complete data, participants who completed intake assessments but did not complete assessments at the fourth session were excluded from the sample. To identify and describe missing data patterns, the authors used the expectation maximization (EM) technique to complete a Missing Value Analysis (see Table 3). Most variables exhibited less than 5% missingness, although client-reported alliance and client-reported income showed slightly higher levels of missingness (8.5% and 8.0%, respectively).

Furthermore, Little's MCAR test yielded a non-significant chi-square [$\chi 2(192) = 179.263$, $p = .736$], indicating that data are missing completely at random. Thus, no cases were deleted listwise or imputed individually. Additionally, the continuous predictor (e.g., client-reported alliance) and moderator (e.g., change in symptom distress and change in relational distress) variables were mean-centered for the regression analyses to reduce potential multicollinearity (Dawson, 2014).

The majority of the study variables were normally distributed. However, the client-reported alliance variables at the fourth session and client-reported relational distress at the first session were slightly leptokurtic. Otherwise, a visual inspection of the residual scatterplot also appeared normally distributed, meeting the assumption of homoscedasticity. Data were checked for multi-collinearity, with no independent variables displaying strong correlations. Thus, data

appeared to meet the assumptions of multiple regression. Regression analyses were conducted using SPSS (version 24; IBM Corp, 2016) and completed in a stepwise fashion (see Table 2). In addition, males and females were analyzed separately to avoid the multicollinearity of male and female partner data. Regression coefficients and model statistics are presented below.

Hypothesis Testing Using Hierarchical Multiple Regression

A four-stage hierarchical multiple regression was completed for both males and females to test our hypotheses, using client-reported therapeutic alliance as the outcome variable (see Table 2). Model 1 regressed alliance formation onto symptom distress, and Model 2 added length of the relationship, presenting problem, level of education, and dyadic adjustment as control variables. Length of relationship was the only significant control variable for females, and no significant control variables were found for males. Consequently, all other control variables were excluded, and the most parsimonious model was chosen for each group.

Model 1 demonstrated a statistically significant regression for females [$F(1, 164) = 9.594$, $p = .002$, $R^2 = .055$] and for males [$F(1, 155) = 5.009$, $p = .027$, $R^2 = .031$]. Model 2 demonstrated improved fit for females, due to the significant impact of length of relationship on alliance scores for female participants [$\beta = -.155$, $B = -.023$, $SE = .011$, $p = .043$], but length of relationship was not a significant predictor of alliance formation for male participants. As a result, Model 2 demonstrated a better model fit for females [$F(4, 161) = 3.493$, $p = .009$, $R^2 = .080$] but not for males [$F(4, 152) = 2.202$, $p = .071$, $R^2 = .055$].

For Model 3, therapist focus match - a variable created for this study to identify whether the therapist’s focus of treatment reflected the category of distress reported by the couple as most pressing – was regressed onto therapeutic alliance, and the relevant aforementioned control variables for each group. The R^2 change from Model 2 to Model 3 indicated that the therapist

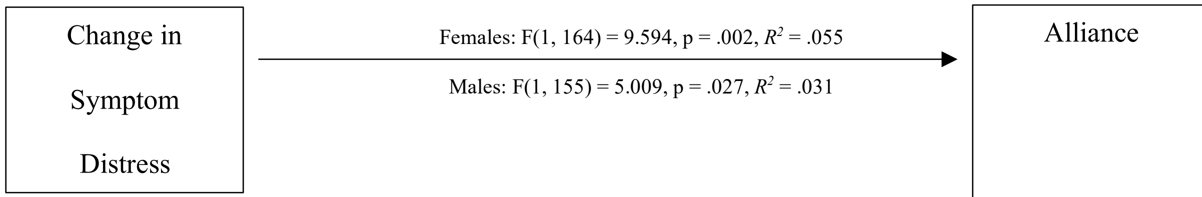
focus match variable accounted for 0.0% (females) and 3.0% (males) of the variation in therapeutic alliance, which was not statistically significant for females (p = .019) or males (p = .105). While the p values for females was significant, this did not improve the overall model fit from Model 2 to Model 3, confirming Model 2 as the best fit for female participants. Model 3 did not demonstrate statistical significance for females [F(5, 160) = 2.796, p = .019, R^2 = .080] or males [F(5, 151) = 1.860, p = .105, R^2 = .058]. To test for a moderation effect, an interaction term (change in symptom distress × therapist focus match) was added to Model 4, but the interaction term did not improve model fit for females [F(6, 159) = 2.319, p = .036, R^2 = .080] or males [F(6, 150) = 1.543, p = .168, R^2 = .058]. Thus, the interaction term did not moderate the relationship between symptom distress and therapy alliance scores in this sample.

Main findings include that Model 2 best fit the data for females, with a statistically significant negative relationship between length of relationship and therapy alliance (β = -.154, B = -.023, SE = .012, p = .048). Beyond Model 1, none of the models found a statistically significant main effect for male participants. The sum of these findings suggests that therapist focus match did not significantly affect alliance formation for couples in this sample.

The initial regression of alliance formation onto change in symptom distress (Model 1) exposed a statistically significant correlation for both the males and females [males: β = .177, B = .432, SE = .193, p = .027; females: β = .235, B = .459, SE = .148, p = .002], suggesting that change in symptom distress is a statistically significant predictor of alliance formation, even before controlling for clients' presenting problem. The finding in Model 1 contradicts some prior research findings that changes in symptom distress does not have a statistically significant impact on alliance formation in couple treatment (Knobloch-Fedders, Pinsof, & Mann, 2004;

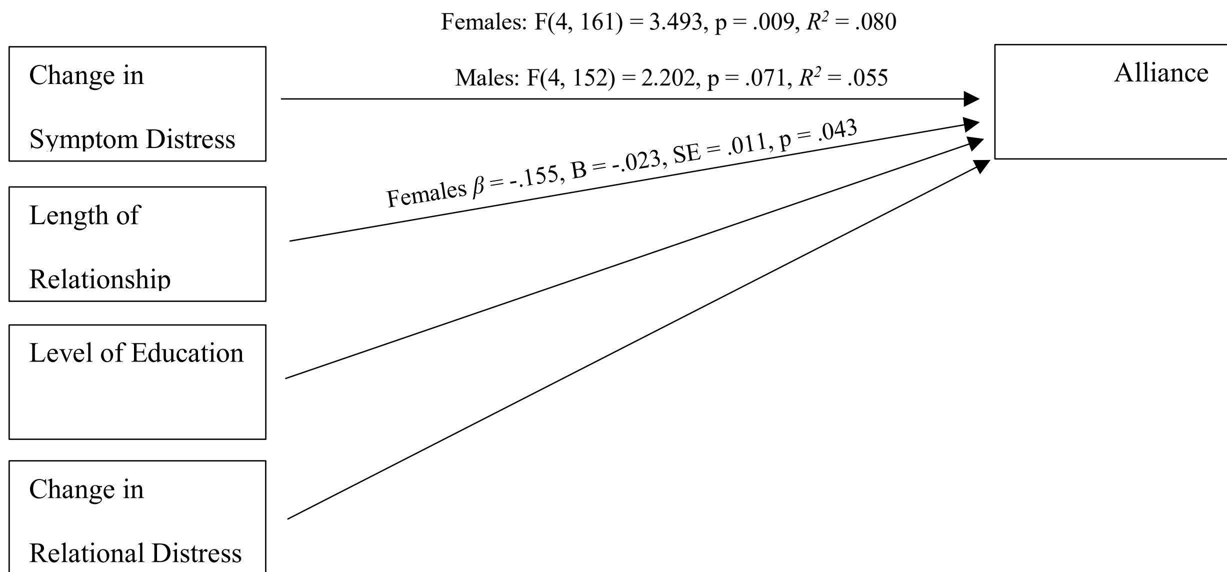
Mamodhoussen et al., 2005), and suggests that addressing symptom distress is relevant to alliance formation in couple therapy.

Figure 1. Symptom Distress Model 1



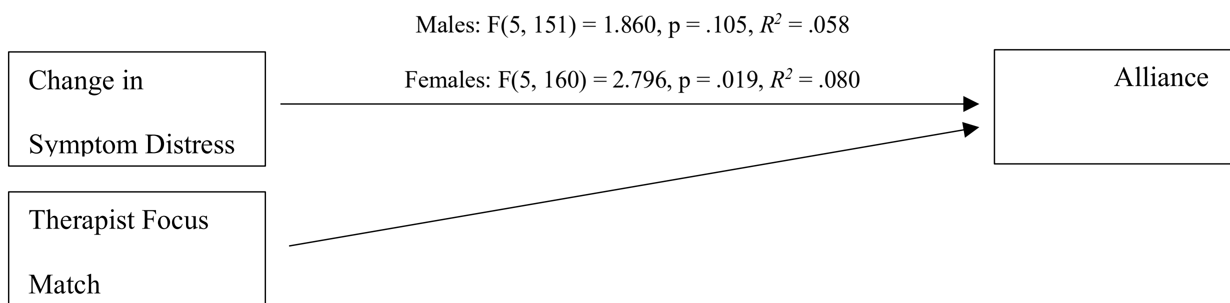
The addition of education, length of relationship, presenting problem, and relationship adjustment in Model 2 improved the fit slightly, with the additional covariates accounting for an increase in R^2 from .055 to .082 ($p < .05$) due to significant correlations for both change in symptom distress (t = -3.091, p = 0.02) and length of relationship (t = -1.994, p = .048). Adding the covariates in Model 2 accounted for additional variation in couple alliance formation. For females, length of relationship was inversely related to alliance scores (β = -.155, B = -.023, SE = .011, p = .043). These results suggest that length of relationship moderated the already statistically significant inverse association between change in symptom distress and alliance formation in couple therapy.

Figure 2. Change in Symptom Distress Model 2



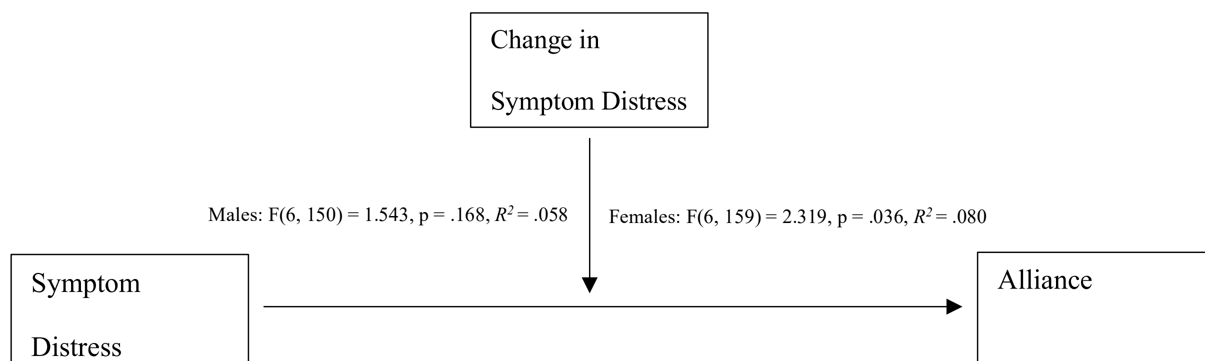
Contrary to the research hypotheses, the addition of therapist focus match as a variable in Model 3 did not significantly improve the model fit for males or females (females β = .023, B = .062, SE = .209, p = .768; males β = -.058, B = -.165, SE = .230, p = .473).

Figure 3. Change in Symptom Distress, Model 3



In order to test for interaction effects, an interaction term (Change in Symptom Distress x Therapist Focus match) was added to Model 4, but Model 4 did not demonstrate increased statistical significance (Males: β = .061, B = .079, SE = .572, p = .891; Females: β = -.041, B = -.044, SE = .343, p = .897). In fact, adding the interaction term did not lead to any statistically significant increase in *R* values between Model 3 and Model 4.

Figure 4. Change in Symptom Distress x Therapist Focus Match, Model 4



Relationship Distress

The second set of analyses included changes in RDAS scores, relevant control variables, and the interaction between RDAS scores and therapist focus as predictors and alliance formation as the outcome. Models 5 through 8 tested the research questions about relational adjustment by regressing couple alliance formation (CTAS) onto the change in relational distress according to the RDAS while controlling for length of the relationship, level of education,

change in symptom distress, and therapist focus match. Of the three models fit, no significant independent or interactive effects emerged from the analyses, and null results are not presented to conserve space. Model statistics can be found in Table 2. Covariates intended for use in Models 4-6 included education, length of the relationship, presenting problem, and change in dyadic adjustment. Still, only length of relationship and change in symptom distress was found to improve model fit, so these models had no unique findings.

Exploratory Analyses

After observing the inverse correlation between relationship length and alliance formation for female participants receiving couple therapy, we conducted an additional exploratory analysis to determine whether this relationship might be impacted by higher average client age, as clients reporting longer relationships are likely to be older. Our exploratory analysis indicated that for females participating in couple therapy, increased age was negatively related to alliance formation (Females β = -.155, B = -.023, SE = .011, p = .043).

Chapter 5: Discussion

This study was initiated to examine the impact of change in symptom distress and client-therapist agreement regarding treatment on alliance formation in couple therapy. Although our research sample did not yield significant findings relating to therapist focus match and alliance formation, analyses uncovered other correlations. The most notable finding to the research hypotheses were the strong relationship between the fourth session reported change in symptom distress and alliance formation in couple therapy. Some previous research, including Knobloch-Fedders, Pinsof, & Mann, 2004 and Mamodhoussen et al, 2005, found no statistically significant relationship between individual symptom distress and alliance formation in couple therapy. However, our study engaged more deeply with symptom distress by examining change in symptom distress across multiple sessions to understand better how this variable might impact alliance formation.

The therapeutic alliance is well supported in existing research as an essential component of successful psychotherapeutic treatment. Clients reporting low therapeutic alliance levels have consistently demonstrated decreased prognosis for improvement (Anker, Owen, Duncan, & Sparks, 2010; Davis, LeBow, & Sprenkle, 2012). Higher levels of the therapeutic alliance have been found to explain at least three to ten percent of the clients' treatment outcomes across many client groups (Davis et al., 2012; Baldwin, Wampold, & Imel, 2008; Horvath, 2001; Flükiger et al., 2019; Wiseman, 2017). It is important to note that various factors influence therapeutic outcomes. The Common Factors theory's components discussed earlier in this paper must also be considered in any discussion of predictive factors in the therapeutic process.

Previous studies have found that alliance is an essential predictor of therapy outcomes and is especially important to the continuation and successful completion of couple treatment

(Glazer, Galanter, Megwinoff, Dermatis, & Keller, 2003; Wampold, 2001). We theorized that the previous studies did not identify a change in symptom distress as a predictor of alliance formation because they did not examine the level of agreement between the couple's presenting problem and the therapist's focus of treatment. Such an examination of the interaction between client presenting problem and therapist focus, we posited, would provide additional nuance regarding at least two of Bordin's significant alliance tenets: goals and tasks. Thus, this study had hoped to explore whether previous findings can be attributed to a lack of agreement between therapist and couple related to the presenting problem and the focus of treatment. Specifically, it was hypothesized that when the presenting problem was symptom-related, a therapist treatment focus that aligned would directly relate to alliance formation. The limited number (n = 33 couples) of couples reporting individual symptom distress as the primary reason for referral in our sample decreased statistical power. It may have prevented the authors from reporting significant findings based specifically on the category of the reported presenting problem.

However, our findings suggest that change in symptom distress was a significant predictor of alliance formation for all couples, even couples who reported initiating therapy to address relational distress, not symptom distress. This finding is consistent with some previous research indicating that individual symptoms are significant to alliance formation in couple therapy, including work by Porter and Ketring (2011) and Knerr et al. (2011). Porter and Ketring examined a sample of 181 couples using the same measures of alliance and symptom distress utilized in the present study (CTAS-R and Outcome Questionnaire). Still, they did not evaluate the couples' reported reasons for seeking treatment. While the research was primarily focused on the stage of change, Porter and Ketring reported that higher levels of symptom distress were significantly predictive of lower reported alliance scores for male partners.

In contrast, symptom distress did not appear to impact female partners' reported alliance. Our study also found that symptom distress was the most impactful predictor of alliance formation for male participants. At the same time, the length of the relationship was a more significant predictor for females. Porter and Ketring hypothesized that males may be more motivated to change when experiencing increased symptom distress, while women may assess alliance based on different variables. Our findings support this theory and suggest that clinicians may wish to be especially attentive to male partners' reported individual symptom distress.

In their article, Knerr and colleagues also found a relationship between symptom distress and alliance formation but used a different alliance measure (Working Alliance Inventory-Shortened Version) and only measured specific categories of symptom distress related to stress (Impact of Events Scale) and depression (Center for Epidemiologic Studies Depressed Mood Scale). Despite these differences in measures, their data still indicated a significant relationship between symptom distress and alliance formation, suggesting that this correlation may be robustly present across measures.

Other previous research (Knobloch-Fedders, Pinsoff, & Mann, 2004; Mamodhoussen et al., 2005) contradicted these findings by indicating that individual symptom distress was not related alliance formation in couple therapy. However, relevant design and methodological differences exist between our study and these findings, which provide context for the conflicting outcomes. In the Knobloch-Fedders et al. 2004 article, only 35 couples were studied during their couple therapy treatment, and neither the client-reported presenting problem nor therapist focus of treatment was examined. As such, it is difficult to determine whether the omission of these variables might explain the author's finding that alliance is related to relational change but not to change in individual symptoms. Also, our study examined total change in symptom distress over

time, while Knobloch-Fedders, Pinsof, and Mann utilized a median split to examine individual symptom distress. Omitting this change value is a potentially significant difference between our findings and previous conflicting findings.

Likewise, Mamodhoussen et al., 2005 examined data from 79 couples in Quebec and determined that psychiatric symptoms were not predictive of alliance formation for male or female participants in couple therapy. However, in this study, a different measure (the Psychiatric Symptoms Index) was used to assess symptom distress, and this measure was only administered once. As a result, the authors were unable to examine whether the change in symptom distress during or after treatment might impact alliance. Additional research is needed to determine whether such methodological differences might explain differences in our study findings and others. Of particular relevance is our conclusion that change in symptom distress score was related to the client reported- alliance rating at session four. The aforementioned authors did not find a relationship between symptom distress and alliance formation in the couple therapy setting. This finding raises interesting questions about the relevance of symptom distress as a therapeutic focus in couple therapy. It can contribute to a more robust understanding of therapeutic alliance formation in the couple therapy setting.

It is also notable that both Porter & Ketring (2011) and Knerr et al. (2011) studies utilized samples of 181 and 107 couples, respectively. Thus, our research and both of the studies which found a relationship between symptom distress and alliance formation used a significantly larger sample of couples than the Knobloch-Fedders and Mamodhoussen studies, which did not identify a link between symptom distress and alliance formation in couple therapy. It is possible that our larger study population of couples included more individuals experiencing significant symptom distress and can therefore provide a more complete picture of the relationship between

change in symptom distress and alliance formation. Using the larger sample size (n = 387), our study found that symptom distress was significantly related to the client-reported alliance in couple therapy, such that decreases in symptom distress were related to increases in client reported alliance with the therapist. This finding is consistent with Borden's concepts of alliance theory. Clinical improvements in functioning are typically understood by clients as progress toward a shared goal and would therefore be expected to strengthen therapeutic alliance. Future studies should continue to explore Bordin's theoretical formulation of the goals and tasks components of alliance in the clinical setting.

The current study was also intended to analyze several variables not included in previous studies: the client's reported presenting problem, the therapist's primary focus of treatment, and the match or mismatch between these variables. This match or mismatch was considered essential to examine. As client presenting, problem and therapist focus is representative of "goals and tasks", two of the three components forwarded by Bordin are essential to alliance formation. Thus, the match or mismatch between these variables could be seen as representative of client-therapist agreement on goals and tasks, two of the essential elements of Bordin's alliance theory. However, analyses in the current study did not indicate this match variable significantly related to alliance formation, perhaps due to the small number of clients in the sample who reported individual symptom distress as a primary presenting concern. As a result, we cannot clarify whether excluding client-reported presenting problem and therapist focus might explain previous conflicting findings or whether the inclusion of these variables might be expected to yield additional or different findings in future studies of alliance formation in couple therapy.

Furthermore, the current study's analyses suggest that client-reported relationship adjustment was not related to alliance formation during the study period. For both male and

female participants receiving couple therapy, change in dyadic adjustment was not found to explain variance in the relationship between change in symptom distress and client-reported alliance scores (Males: β = .007, B = .007, SE = .082, p = .935; Females: β = 0.030, B = 0.028, SE = .071, p = .695). While it is conceivable that this lack of significance is indicative of an error in analysis, the null finding was replicated in several groups, suggesting that the null finding is valid for this sample. As relationship adjustment failed to demonstrate significance as a predictor of alliance across multiple sample groups analyzed in this study, it appears that for the sample providing data for this paper, relationship adjustment did not predict alliance formation in couple therapy. This finding is inconsistent with previous data reported by other authors, who have consistently found that client-reported relationship adjustment is a key predictor of alliance formation in couple therapy (Knerr et al., 2011; Knobloch-Fedders, Pinsof, & Mann, 2004; Mamodhoussen et al., 2005, Wampold, 2001). However, it is important to note that some authors examined relationship adjustment at a later point in treatment than our study was able to do, indicating that relationship adjustment is a slower process than improvement in symptom distress. For example, Knobloch-Fedders, Pinsof, and Mann assessed dyadic adjustment at the eighth session. Therefore, they might have captured more relational improvement due to their assessment occurring four sessions later than the assessment used in this study. As dyadic adjustment has long been considered a key indicator of improvement, alliance formation, and goal achievement in couple therapy, our study's null finding presents a potential challenge to the concept of relational improvement as a primary mechanism for building alliance in couple therapy.

Our exploratory analyses also noted a significant relationship between age and alliance formation. This relationship between age and alliance formation in couple therapy has not been

extensively explored in the existing literature, although some findings have been reported relating age and alliance formation in individual settings (Connors et al., 2000; Knerr et al., 2011). Of particular note is a study in which Knerr et al. reported that for clients in couple treatment, younger client age predicted higher client scores on both the 'bond' and 'work' subscales of an alliance measure (2011), a finding similar to that demonstrated by the sample in our study. These findings suggest that younger age is a positive predictor of alliance in individual therapy, while increased age is negatively related to alliance formation in couple treatment. Variables affecting alliance formation with older clients may include younger age of student therapists in the studies, which may lead older clients to perceive student therapists as less knowledgeable or approachable. It is also possible that increased age is associated with increased length of the relationship and potentially with a greater duration of maladaptive relationship dynamics before seeking treatment. Additional research is needed to understand the age-alliance relationship in couple therapy better.

Limitations and Future Directions

A significant limitation of this study was the relatively small number of couple clients who presented for relational therapy with symptom distress as their primary reason for treatment. Out of a sample of approximately 380 individuals who received couple-focused therapy treatment and provided complete data for analysis, only about 33 individuals reported symptom distress as their primary reason for seeking therapy. As a result, regression analyses conducted on this group lack sufficient statistical power to make meaningful statements about the impact of therapist focus match on couples seeking treatment primarily for symptom distress. Future studies may benefit from larger samples, including many clients seeking couple treatment related principally to one partner's symptomology.

It is also important to note that the vast majority of client-therapist pairs experienced a match between the reported problem and therapist focus, with 91.5% of therapists focusing treatment on the same category of problem reported by the couple as most important. While this speaks positively to the responsiveness of the therapists in the study, the lack of “mismatch” cases may have limited our ability to determine whether match is an essential variable in alliance formation for couple therapy. Furthermore, alliance scores reported by the sample were also consistently high (M = 5.488, SD = .0478), which reduced variance in the outcome variable and likely reduced the strength of findings.

Another significant limitation of the data involved collecting each couple's reported presenting problem, also phrased as the reason for seeking treatment. Although this data was collected by trained administrative assistance, the accuracy of the information reported was impacted by which partner in the couple's relationship made initial contact with the MFT training clinic. Therefore, it is conceivable that the report made during the initial scheduling contact is only reflective of one partner’s perspective regarding the couples’ primary reason for seeking treatment and may have unintentionally omitted the other partner’s primary presenting problem and goals for therapy. Anecdotal descriptions provided by an administrative assistant working in the clinic suggest that female partners in a couple relationship may be more likely to initiate initial contact with the MFT clinic.

While this study did not explore the potential impact of a heterosexual couple’s reason for seeking treatment being more frequently reported by the female rather than the male partner, this is a potential limitation of the data, which should be further explored in future studies. However, even if the vast majority of therapy initiators were female, it might still be expected that change in the reported area of concern would improve client-reported alliance scores for females. Still,

this study found that neither change in symptom distress nor change in relationship adjustment were predictive of client-reported alliance scores for female participants. Thus, additional research is needed to determine why some clients' alliance scores appear to be relatively unresponsive to either relational or symptomatic improvement during couple therapy.

Clinical Implications

Although additional research is needed, the current study offers some clinically relevant outcomes. First, clinicians should consider the possibility that symptom distress operates as a significant predictor of therapeutic alliance in couple therapy, especially for male heterosexual clients. This relationship is potentially crucial to the process of alliance formation, both for couples reporting individual symptom distress and those reporting relational distress as their primary reason for seeking treatment. While it may seem intuitively true that rapid change in symptom distress is desirable, clinicians may wish to consider that significant change to symptomology may temporarily destabilize the couple system or create other challenges that appear to nullify any significant positive impact on the female partner's reported alliance. Clinicians might consider providing additional support to both partners and taking steps to stabilize the system to ensure effective join and reduce a possible negative impact on client-reported alliance.

Another finding in this study also merits additional consideration in clinical and teaching settings. For female clients in a committed relationship, the data indicated that age was inversely related to alliance formation, such that older female clients reported significantly lower alliance scores. While the analyses conducted for this study did not suggest a clear explanation for this finding, slight adjustments to clinical practice may be warranted in response to the findings. For example, student therapists might wish to seek additional supervisory guidance or employ

additional joining and alliance-building techniques when working with heterosexual couples in older adulthood. This finding should also be explored more fully using a sample in which the therapists represent a wider range of ages and experience. Our teaching clinic therapists are primarily master's students in their twenties. Future training clinic research might also explore how therapist age interacts with client age to impact the alliance formation process.

Conclusion

This study attempted to determine the impact of client-therapist goal match on alliance formation in couple therapy. While the sample lacked sufficient statistical power to identify a significant impact of the match for couples presenting with symptom distress as a primary concern, both male and female samples demonstrated an unexpected but statistically significant correlation between change in symptom distress and alliance formation. Female clients in couple therapy also exhibited an inverse correlation between age and therapeutic alliance and relationship length and therapeutic alliance. Older female clients reported lower therapeutic alliance levels. Future research is needed to replicate these findings, determine the etiology of this inverse relationship, and provide guidance to assist therapists in addressing the potential impacts of symptom distress and age on therapeutic alliance formation.

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Appendix A – Reason for Referral Assessment

Client Reason for Therapy Question

NOTES FOR THERAPIST:

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The Office Administrator was trained to ask about the client's reason for therapy/the reason for referral. The Office Administrator informed the client that these were notes for the therapist to help prepare for the first meeting. Clients were advised that while the reason might be embarrassing or stressful, it was helpful to be honest, and upfront.

In 2017 these notes were coded as 0 for Relational Problems or 1 for Diagnostic Problems. Likewise, therapist notes were coded as 0 for not matching client reason for referral or 1 for a match with client reason for referral. The clinic administration tracked the percentage of time therapist treatment notes matched the initial reason for therapy. These are stored in the intake database.

Appendix B – Outcome Questionnaire (OQ)

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.

ID# ___ _________ Sex MD FD

Session #______ Date / /

SD IR SR

#	Item	Never	Rarely	Sometimes	Frequently	Almost Always
1.	I get along well with others.	O4	O3	O 2	DI	D 0
2.	I tire quickly.	O 0	O1	O2	O3	O4
3.	I feel no interest in things.	DO	O1	O2	O3	O4
4.	I feel stressed at work/school.	O 0	OJ	O2	O 3	O4
5.	I blame myself for things.	DO	O1	O2	O3	O4
6.	I feel irritated.	O 0	DI	O2	O3	O4
7.	I feel unhappy in my marriage/significant relationship.	DO	O1	O2	O3	O4
8.	I have thoughts of ending my life.	D 0	DI	O2	O3	O4
9.	I feel weak.	DO	O1	O2	O3	O4
10.	I feel fearful.	O 0	DI	O2	O 3	O4
11.	After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	DO	OJ	O2	O3	O4
12.	I find my work/school satisfying.	O 4	O3	O2	O1	D 0
13.	I am a happy person.	O4	O3	O2	DI	D 0
14.	I work/study too much.	O 0	O1	O2	O3	O4
15.	I feel worthless.	DO	O1	O2	O3	O4
16.	I am concerned about family troubles.	O 0	O1	O2	O3	O4
17.	I have an unfulfilling sex life.	DO	DI	O2	O3	O4
18.	I feel lonely.	D 0	O1	O2	O3	O4
19.	I have frequent arguments.	DO	O1	O2	O3	O4
20.	I feel loved and wanted.	D 4	O3	O2	OJ	DO
21.	I enjoy my spare time.	O4	O3	O2	DI	D 0
22.	I have difficulty concentrating.	D 0	OJ	O2	O3	O4
23.	I feel hopeless about the future.	DO	DI	O2	O3	O4
24.	I like myself.	O 4	O3	O2	O1	DO
25.	Disturbing thoughts come into my mind that I cannot get rid of.	DO	DI	O2	D3	O4
26.	I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	O 0	DI	O2	O3	O4
27.	I have an upset stomach.	DO	DI	O2	O3	O4
28.	I am not working/studying as well as I used to.	O 0	DI	O2	O 3	O 4
29.	My heart pounds too much.	DO	DI	O2	O3	O4
30.	I have trouble getting along with friends and close acquaintances.	O 0	DI	O2	O3	O4
31.	I am satisfied with my life.	D 4	O3	O2	D 1	DO
32.	I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	O 0	DI	O2	O 3	O4
33.	I feel that something bad is going to happen.	DO	DI	O2	D3	O4
34.	I have sore muscles.	O 0	DI	O2	O3	O4
35.	I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	DO	O1	O2	D3	O4
36.	I feel nervous.	O 0	O 1	O2	O3	O4
37.	I feel my love relationships are full and complete.	O4	O3	O2	OJ	DO
38.	I feel that I am not doing well at work/school.	O 0	DI	D 2	O3	O4
39.	I have too many disagreements at work/school.	DO	O1	O2	O3	O4
40.	I feel something is wrong with my mind.	O 0	DI	O 2	O3	O4
41.	I have trouble falling asleep or staying asleep.	DO	O1	O2	O3	O4
42.	I feel blue.	D 0	DI	O 2	O3	O4
43.	I am satisfied with my relationships with others.	O4	O3	O2	DI	DO
44.	I feel angry enough at work/school to do something I might regret.	D 0	O1	O 2	O3	O 4
45.	I have headaches.	DO	O1	D 2	O3	O4

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Appendix C – Revised Dyadic Adjustment Scale (RDAS)

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.

	Always agree	Almost Always Agree	Occasionally Agree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Religious matters						
2. Demonstrations of affection						
3. Making major decisions						
4. Sex relations						
5. Conventionality-correct/proper behavior						
6. Career decisions						

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
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 live together)?						
10. How often do you and your mate "get on each other's nerves"?						

	Every Day	Almost Every Day	Occasionally	Rarely	Never
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?

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

Appendix D – Couple Therapeutic Alliance Scale (CTAS)

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. 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	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree
7	6	5	4	3	2	1

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

Completely Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree
7	6	5	4	3	2	1

Item							
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
41. I am comfortable disagreeing with or challenging my therapist.	7	6	5	4	3	2	1

Tables

Table 1

Demographics of Couples in Committed Relationships (N= 387)

Demographics	**N**	**Percent**
Gender		
Male	186	48.1%
Female	201	51.9%
Other/Did not report gender	0	0.0%
Racial Group		
White, non-Hispanic	296	80.0%
African American	48	13.0%
Hispanic/Non-white	7	1.9%
Asian/Pacific Islander	5	1.4%
Biracial/Other	14	2.4%
Annual Income		
Less than $5,000	27	7.5%
$5,000 to $10,000	18	5.0%

$10,001 to $15,000	25	6.9%
$15,001 to $20,000	24	6.6%
$20,001 to $25,000	25	6.9%
$25,001 to $30,000	23	6.4%
$30,001 to $35,000	37	10.2%
$35,001 to $40,000	44	12.2%
Over $40,000	139	38.4%
Highest Level of Education Completed		
GED / High School Diploma	177	27%
Vocation Training / Associate’s Degree	33	5.6%
Bachelor’s Degree	159	27.2%
Master’s Degree	85	14.5%
Other (e.g., Ph.D., J.D.)	72	12.3%

Table 2

Model Fit and Test

Controls:	*b(se)*	t_b	R^2	ΔR2
Male Relationship Length	-.023	-1.635	.031	.031
Male Level of Education	-.049	-.798		
Female Relationship Length	-.023	-1.994	.055	.055
Female Level of Education	.013	.214		
Main Effects:				
Male Δ Symptom Distress (OQ)	-.429	-.528	.058	.027
Male Δ RDAS	.016	.193		
Male Therapist Focus Match	-.165	-.727		
Female Δ Symptom Distress (OQ)	-.459	-.618	.081	.025
Female Δ RDAS	.023	.318		
Female Therapist Focus Match	.057	.280		
Interaction:				

Male Therapist Focus Match*Symptom Distress	.079	.138	.058	.000
Female Therapist Focus Match*Symptom Distress	-.044	-.129	.081	.000

Note: Therapist Focus Match*Symptom Distress = Interaction term as moderator. * = p < .05. ** = p < .01. *** = p < .001.95%

Table 3

Missingness data

Univariate Statistics

	N	Mean	Std. Deviation	Missing		No. of Extremes[a]	
				Count	Percent	Low	High
ceducate	198	2.6818	1.12416	3	1.5	0	0
mcCTAS4_M	184	.0000	.86355	17	8.5	1	0
mcRDAS4_M	198	.0000	1.09161	3	1.5	3	1
mcRDAS1_M	200	.0000	1.22650	1	.5	2	1
mcOQSD1_M	195	.0000	.65156	6	3.0	0	0
mcOQSD4_M	199	.0000	.64633	2	1.0	0	1
TFmatch	201	1.8955	.30664	0	.0	.	.
intake	201	1.91	.286	0	.0	.	.
txfocus	201	1.92	.279	0	.0	.	.
sex	201	2.00	.000	0	.0	.	.
age	201	30.35	8.131	0	.0	0	9
marital	200	2.98	1.789	1	.5	0	47

race	193	1.44	1.189	8	4.0	.	.
educate	198	6.54	1.776	3	1.5	0	0
income	185	6.38	2.776	16	8.0	0	0

a. Number of cases outside the range (Q1 - 1.5*IQR, Q3 + 1.5*IQR).