EXPECTANCY EFFECTS IN COUPLE THERAPY

by

RACHEL B. TAMBLING

(Under the direction of Lee N. Johnson)

ABSTRACT

Researchers in the field of marital and family therapy have demonstrated that couple therapy is generally effective for resolving a number of intra- and interpersonal problems. Lambert (1992), in his analysis of common factors across models of psychotherapy, identified hope or placebo effects as the third most influential factor contributing to client change, accounting for approximately 15 percent of the variation in therapy outcome. Despite research on expectancy effects in individual and group therapy, little is known about the role of expectations in couple therapy. The present study explored qualitative and quantitative data to determine the role of expectations in couple therapy. Participants were 26 individuals representing 13 couples engaged in couple therapy. Participants were predominantly Caucasian, educated at the high school level or beyond, and had a wide range of household incomes. Participants completed quantitative assessments and participated in semi-structured interviews four times during treatment: before the first session, and after the second, third, and fourth sessions. Results of a qualitative content analysis of interview data suggested that clients in couple therapy form expectations similar to those formed by clients in individual therapy. Expectations for couple therapy were grouped into three categories: role expectations, including expectations about the age, training, and personality of the therapist; process expectations, beliefs about the things that would happen during therapy; and outcome expectations, ideas about the eventual outcome of

therapy. Quantitative data were examined using a pooled-regression test of the Actor-Partner Interdependence Model (Kenny, 1995). Though the extremely small sample size prevented complete testing of the hypotheses, results suggest that individuals who expect that they will be more personally responsible for therapy and a have a therapist who is genuine, trustworthy, and accepting develop stronger therapeutic alliances. Further, results indicated that individuals who expect greater nurturance and empathy from their therapist are generally more relationally distressed at the fourth session. Combined, these results suggest that couples in therapy form expectations about their therapy experience and that these expectations influence the process and outcome of therapy. Future research is merited to continue the examination of expectancy effects in couple therapy.

INDEX WORDS: Expectations, Expectancy Effects, Preferences, Couple Therapy, Outcome, Pooled Regression

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RACHEL B. TAMBLING

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RACHEL B. TAMBLING

Major Professor:	Lee Johnson
Committee:	David Wright
	Jerry Gale

Electronic Version Approved:

Maureen Grasso

Dean of the Graduate School

The University of Georgia

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CHAPTER 1

INTRODUCTION

It is generally accepted that all forms of psychotherapy yield positive results for most clients. Those results depend upon a variety of factors including client-related variables, therapy-specific variables, and some variables that are common to all types of therapy experiences. Of particular interest in psychotherapy are those factors that are common to all types of therapy experiences. Lambert (1992), in his analysis of common factors across therapy experiences, delineated the unique contributions to therapy outcome of a number of factors. He identified hope, defined as client expectations for change and placebo effects, as the third most influential factor contributing to client change, accounting for 15 percent of the variation in psychotherapy outcome. Lambert's work articulated the degree to which client expectations could be expected to influence the course and outcome of psychotherapeutic treatment. This research supports the idea that clients' expectations for therapy influence the outcomes they experience.

The phenomenon that occurs when expectations influence outcomes is referred to as an expectancy effect. The study of expectancy effects began with the study of placebo effects in medical trials. This research determined that the administration of a drug with no relevant pharmaceutical properties could elicit the same response as a drug that was thought to be efficacious (Frankenhaeuser, Jarpe, Svan, & Wrangsjo, 1963). Researchers suggested that placebos were effective simply because subjects expected them to produce a particular result. Expectancy effects have been found in a variety of interpersonal domains.

The study of placebo effects was expanded by researchers in the field of interpersonal communication, who sought to determine whether placebo-like effects occurred in human interactions. This research found that individuals in social situations behave in accordance with

their expectations for the interaction partner, creating an environment in which it is likely that their expectations will be confirmed. Other researchers examined expectancy effects in specific interpersonal situations, such as classroom interactions between students and teachers.

In educational psychology, researchers have clearly documented a teacher expectancy effect, referred to as the Pygmalion effect (Rosenthal, 1967; Rosenthal & Jacobson, 1968). The Pygmalion effect occurs when teachers behave differently and create a learning environment more conducive to success for those students who they believe are most likely to be successful scholastically. Most recently, the study of expectancy effects has been extended to the domain of psychotherapy. A large body of research addresses the role of client expectations and placebo effects in individual psychotherapy.

Expectancy effects in individual therapy have consistently predicted a number of therapeutic processes and outcomes. Past research has suggested that client expectations are influential factors in one's decision to enter into therapy (Meyer, Pilkonis, Krupnick, Egan, Simmens, & Sotsky, 2002); clients who expect therapy to be helpful in remedying their problems are more likely to enter in to therapy. Expectations for therapy also influences clients' efforts to make changes during therapy (Glass, Arnkoff, & Shapiro, 2001; Greenberg, Constantino, & Bruce, 2006; Noble, Douglas, & Newman, 2001) and obtain benefits from treatment (Glass et al., 2001; Joyce, McCallum, Piper, & Ogrodniczuk, 2000; Tinsley, Brown, de St. Aubin, & Lucek, 1984; Tinsley & Harris, 1976; Tinsley, Workman, & Kass, 1980). Studies focusing on both naturally occurring pre-therapy expectations, as well as expectations induced by providing clients with specific information prior to therapy, have confirmed the importance of expectancy effects in individual psychotherapy (Bordin, 1955; Glass et al., 2001; Greenberg et al., 2006; Joyce et al., 2000; Joyce & Piper, 1998; Meyer et al., 2002; Noble et al., 2001; Rosenthal &

Frank, 1956; Tinsley, Bowman, & Ray, 1988; Tinsley & Harris, 1976; Tinsley et al., 1980; Wilkins, 1979). Despite strong support for the role of expectations in individual therapy, very little is known about the ways in which expectations influence outcomes in relational therapies.

An understanding of the role of expectancy effects in couple therapy could support Lambert's (1992) contention that expectations about therapy influence outcomes in all types of therapy. Although the evidence is clear that expectations influence individual therapy processes and outcomes, confirmation that the same effects occur in couple therapy would be a beneficial extension of the research literature. Further, an understanding of the processes by which expectations are communicated in therapy may explain how expectations influence outcomes and may provide information about why some clients achieve better results than others. An understanding of the ways in which expectations influence outcomes may aid therapists and clinics in enhancing the efficacy of therapy.

To understand the role of expectancy effects in couple therapy, it is necessary to examine expectancy effects research in its historical and theoretical context. In the second chapter, models describing the process by which expectancy effects are developed intrapersonally and communicated interpersonally are presented. The historical development of the study of expectancy effects in a variety of settings is also described. In the third chapter, the methodology used in the present study is described. Results of the study are presented in the fourth chapter. Finally, in the discussion section, an analysis of the present study and suggestions for future research integrating the concept of expectancy effects into couple therapy research are presented.

CHAPTER 2

REVIEW OF LITERATURE

In general, psychotherapy is an efficacious form of treatment for many problems. Positive results may be due, in part, to the expectations clients have for therapy. Expectancy effects, the process by which expectations become self-fulfilling prophecies, have been found in a variety of research settings and are generally powerful predictors of outcomes. Although a significant body of literature exists addressing the role of expectations in outcomes in a variety of fields, little is known about the role of expectations in couple therapy. A better understanding of expectancy effects in couple therapy would not only provide evidence that hope and positive expectations are important in couple therapy, but also provide information about the ways in which expectations influence outcomes.

In this section, models describing the process of expectancy effect formation, communication, and influence are described to explain the mechanisms though which expectations are communicated. Next, the development of the study of expectations is traced historically, beginning with its early roots in placebo trials and extending to current findings on expectations in psychotherapy and other interpersonal relationships. Finally, the models analyzed in the present study are outlined.

Mechanisms by which Expectations Influence Outcomes

Several models have been proposed to account for the effects of expectations on outcomes. Most are based on social learning theory or symbolic interactionism and include mechanisms by which perceptions influence behaviors. The earliest model (Bellamy, 1975) proposed that expectancy effects were based on the prediction that certain events would occur.

Beliefs that these events would occur subsequently prompted an anticipatory behavioral response. That is, individuals behaved as if an expected event had occurred, thus experiencing an outcome similar to that which would have been experienced had the even actually occurred. This model, although appropriate for animal learning, was discounted as too behaviorally-oriented. Other theorists argued that Bellamy's model did not account for humans' ability to think about reactions, form perceptions about their environment, and evaluate their expectations intrapersonally.

Expanding upon the early behaviorally-based models to incorporate peoples' perceptions of one another, Brophy (1983) and Darley and Fazio (1980) developed parallel models. The models were grounded in learning theory and included ideas consistent with a symbolic interactionist perspective. These models proposed that the formation and communication of expectancy effects occurred on both intra- and interpersonal levels. The models described a process by which individuals formed representations of other people in their minds and that these perceptions influenced expectations (Brophy, 1983; Darley & Fazio, 1980). That is, individuals were able to form representations of others in their mind and make predictions and evaluations based on the represented other. Both models proposed that expectancy effects were formed and communicated through a similar series of steps (Brophy, 1983; Darley & Fazio, 1980). The general steps are: the perceiver develops an expectation; the perceiver acts toward the target in accordance with the expectation, often treating the target in a differential fashion; the target interprets the behaviors of the perceiver and responds to the perceiver; and, the perceiver interprets the targets actions which reinforce the perceiver's expectations (Darley & Fazio, 1980). This sequence repeats itself, ultimately producing clear rules for behavior, establishing norms of interaction, confirming the perceiver's beliefs, and impacting outcomes (Brophy,

1983). Despite increasing complexity in the models that described the process by which expectancy effects become self-fulfilling prophecies, these models did not address factors that mediate the formation and communication of expectancy effects such as perceiver personality or actual behavior of both the perceiver and the target.

Meaning-making in Relationships

Symbolic interactionism provides a set of theoretical assumptions with which one can understand the acquisition and generation of meaning. When applied to the phenomenon of expectancy effects, symbolic interactionism provides a mechanism for understanding the means by which expectations can be communicated to others, influencing social behaviors.

Symbolic interactionism provides a framework for understanding how people create symbolic worlds and how these worlds influence perceptions and behaviors. Symbolic interactionism relies on the assumption that people act towards things on the basis of the meanings they have attributed to those things (Blumer, 1955; Blumer, 1980; LaRossa & Reitzes, 1993; Turner, 1978). Individuals do not just respond to their environment and others in their environment, they interpret their experiences based on the meanings they attribute to those experiences, and respond based on the interpretation made. Meanings are then created through social interactions with others in which individuals are able to relate to and influence one another's perceptions about the environment (Blumer, 1955). In the case of expectancy effects, individuals form perceptions of others based on the meanings they attribute to symbols in their environment. Interactions with others who have attended therapy, television shows and movies in which therapists are featured, and a social understanding about therapy contribute to each client's understanding of what therapy will be like. Through this understanding, clients form expectations about the symbols they expect to encounter in their therapeutic environment.

The most recent and most comprehensive model developed to account for the effect of expectancy on outcomes is the 10-arrow model (Rosenthal, 1994). This model is based in social learning theory and symbolic interactionism, describing the ways in which perceptions are communicated and reinforced through social interactions and the meaning-making process. This model also describes mediating and moderating variables that impact expectation formation and communication. It is the most sophisticated model to date that explains why, how, and through what behaviors expectancy effects develop.

The 10-arrow Model

The 10-arrow model describes ten links between five groups of variables: (a) distal independent variables, (b) proximal independent variables, (c) mediating variables, (d) proximal dependent variables, and (e) distal dependent variables (see Figure 1; Rosenthal, 1994). Distal independent variables, or moderators, are preexisting variables or characteristics of the perceiver such as age, gender, and personality. These moderators influence the magnitude and type of expectancy effects (Harris & Rosenthal, 1985). Proximal independent variables are the feelings and cognitions related to the expectation of certain occurrences. Mediating variables are the behaviors through which expectations are communicated to the target individual (Rosenthal, 1994), usually through spoken words, tone of voice, and nonverbal behaviors such as posture and facial expression. Proximal and distal dependent variables are the short- and long-term outcomes influenced by the expectancy effects, respectively.

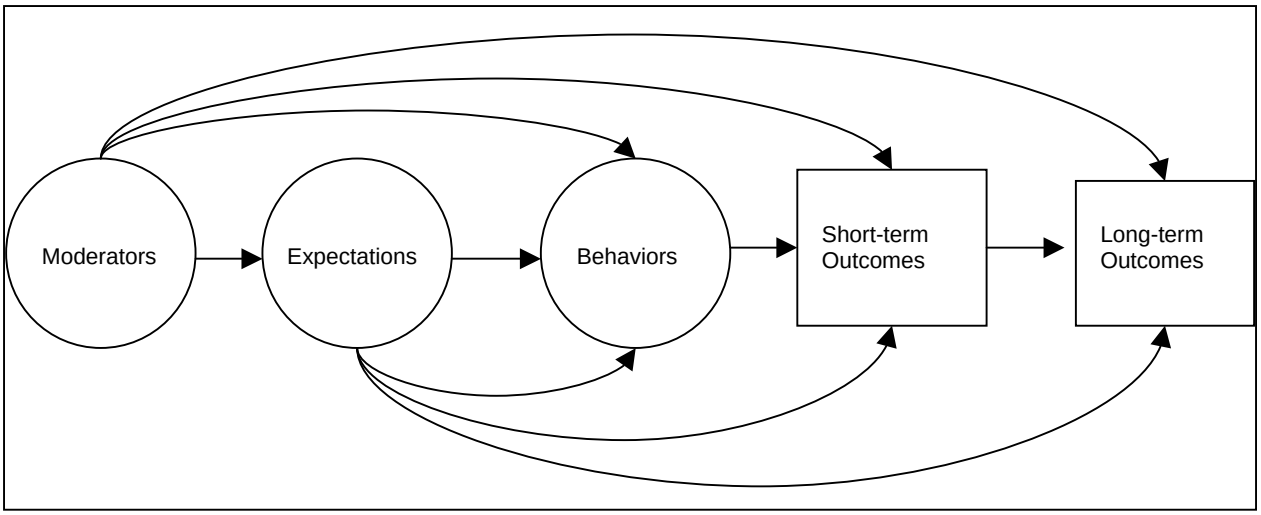

Figure 1: The 10-arrow model of expectancy effects (adapted from Rosenthal, 1994)

Expectancy Effects and Placebos

The study of interpersonal expectancy effects began when researchers expanded the study of placebo effects in medical studies to suggest that a similar mechanism affected outcomes in other types of experimental studies and naturally occurring social situations (cf. Kirsch, 1999; Rosenthal, 1994). This work was based on the conceptualization that placebo-like effects occur when people are exposed to interpersonal expectations. For example, individuals in a social setting may behave in accordance with their expectations, treating the interaction partner differentially depending on those expectations. The exposure to differential treatment then influences the behavior of the partner and the outcome of the interaction.

Exposure to the expectations, and associated differential treatment, of a partner in social interaction is thought to create a social situation in which actors and partners mutually influence the outcomes experienced through confirmation or disconfirmation of expectations. Interest in interpersonal expectancy effects and placebo effects has spurred a large body of research in a variety of fields including medical and clinical trials, human and animal learning, education, and psychotherapy.

Placebo Effects

Research on expectations has its roots in the study of placebo effects in medical and pharmacological research. A placebo is a substance that has no relevant pharmacological properties that is administered in the place of an active drug. Placebos are effective at reducing or eliminating a wide range of clinical symptoms such as nausea or pain. Further, placebos are successful in creating a variety of clinical symptoms such as intoxication or arousal. In addition to the subjective experience of symptom reduction or creation, physiological changes are often recorded as a result of the placebo's administration. For example, in one classic study, healthy subjects who believed they were receiving a tranquilizer actually received a stimulant (Frankenhaeuser et al., 1963). These individuals reported the subjective experience of sedation and had physiological responses indicative of circulatory and muscular sedation, despite never having received a tranquilizing agent (Frankenhaeuser et al., 1963). The researchers suggested that the expectation of sedation triggered an anticipatory reaction in the body, creating the sedation response. Placebos are thought to be effective only by virtue of the fact that the suggestion of effectiveness is present upon administration and that individuals receiving the placebo are susceptible to the suggestion of effectiveness.

The strength of the placebo's effect generally corresponds to one's knowledge or beliefs about the type of medicine or preparation they think they are going to receive. Individuals' faith in the supposed effect of the placebo is believed to create physiological and psychological changes as a result of the administration of a placebo. Findings about the important role of expectations in placebo studies inspired some researchers to examine the potential of placebo-like effects occurring in social and educational settings.

Interpersonal Expectancy Effects and the Pygmalion Effect

Following inquiry into placebo effects in medical and pharmacological research, researchers in the field of educational psychology expanded the study of expectations to include placebo-like effects that occur when individuals expect certain behaviors in social situation. This research sought to determine the influence of individuals' expectations of one another on their behaviors in interpersonal interactions. Interpersonal expectancy effects refer to the process by which one individual's expectations of another become self-fulfilling prophecies (Rosenthal, 1967). Such reactions are formed when actors in social situations develop expectations and communicate these expectations to the interaction partner, which results in the elicitation of the expected behaviors in the partner.

Educational researchers became interested in the potential influence of teachers' expectations on their students' educational outcomes. Specifically, researchers sought to better understand how teachers' perceptions about their students influenced students' classrooms experiences, students' educational achievement, and students' performance on standardized tests. The teacher expectancy effect, also referred to as the Pygmalion effect, is the idea that students perform better when their teachers expect them by creating environments more conducive to student learning. In their classic experiment, Rosenthal and Jacobson (1968) found that if teachers were told to expect excellent performance from some students, those students received differential teacher treatment and actually performed better, confirming the teacher's expectations of superior outcomes.

Subsequent interest in interpersonal expectancy effects has developed into a large body of research representing studies in a variety of fields. It is clear that expectations exist, and that the

communication of expectations often creates self-fulfilling prophecies. As Blanck and Rosenthal (1984) commented regarding the state of interpersonal expectancy research:

> Perhaps the most compelling and most general conclusions to be drawn from the findings to date are (a) that human beings can engage in highly effective and influential communication with one another in talking about others and (b) that such communication is in part responsible for the self-fulfilling prophecies that we see in interpersonal relationships. (p. 419)

It seems that all types of interpersonal relationships are impacted in some way by expectations. Rosenthal and Rubin (1978), in their meta-analysis of the early work on interpersonal expectancy effects examined over 300 studies. The analysis included studies of interpersonal expectancy effects in classrooms, psychological experiments, perception tasks, and other interpersonal situations. The contemporary study of expectancy effects has moved past general interpersonal dimensions and into more specific environments such as individual psychotherapy.

Expectancy Effects in Individual Psychotherapy

In psychotherapy, both the therapist and the client form expectations about the behaviors and experiences that will define therapy. These expectations impact the therapeutic relationship, the course of therapy, and therapy outcomes. Research suggests that clients in individual therapy form expectations regarding several aspects of psychotherapy that can be grouped into three categories: role expectations, process expectations, and outcome expectations. Role expectations are expectations about the personality, training, and behavior of the therapist as well as the behavior of the client. Process expectations include beliefs about the tasks will be helpful and the

things that will happen during therapy. Outcome expectations refer to the expectation that therapy will be either efficacious or ineffective in reducing symptoms.

Role expectations, process expectations, and outcome expectations similarly influence psychotherapy processes and outcomes. Generally, positive expectations and congruency between expectations and experience result in improved outcomes. In contrast, negative expectations and disconfirmations of expectations result in negative outcomes. Though the results are similar, the expectations which influence those results are different. Conceptually, role, process, and outcome expectations are disparate and a separate examination of their effects is merited.

Role Expectations

Role expectations are typically defined as personal traits expected of a particular person in a given situation. In psychotherapy, clients approach therapy with expectations regarding the personal characteristics of their therapist and the nature of the therapeutic relationship (Bordin, 1955; Rosenthal & Frank, 1956; Tinsley & Harris, 1976; Tinsley et al., 1980; Tinsley et al., 1988; Wilkins, 1979). Research has clearly established that clients enter individual therapy with expectations about their therapists. When surveyed, clients express preferences and expectations about the personality (Joyce et al., 2000; Joyce & Piper, 1998; Meyer et al., 2002; Noble et al., 2001) and appearance (Barnes & Rosenthal, 1985; Harris & Rosenthal, 1986) they expect of their therapist. Clients expect therapists to be kind and supportive in the therapy relationship. More specifically, clients expect to work with a therapist who is warm, genuine, nurturing, and empathetic (Atkinson, Poston, Furlong, & Mercado, 1989; Burckell & Godfried, 2006; Kupst & Schulman, 1979; Mindingall, 1985; Tinsley et al., 1980; Tinsley et al., 1984). The research also indicates that clients expect their therapist to be experienced and possess expertise in

interpersonal relationships (Tinsley & Harris, 1976; Tinsley et al., 1980). Clients also expect therapists to be trustworthy, to value their clients' thoughts, and to maintain confidentiality (Tinsely et al., 1984). Some studies have found that clients preferred older therapists (Boulware & Holmes, 1970) or therapists they perceived as having more education (Atkinson et al., 1989). In addition, clients are able to articulate clear preferences and expectations related to the physical appearance of their therapist. Research indicates that clients expect their therapist to be attractive (Green, Cunningham, & Yanico, 1986; Harris & Rosenthal, 1986; Tinsley et al., 1980; Vargas & Borkowski, 1983) and maintain a professional appearance, including good grooming and professional attire (Harris & Rosenthal, 1986; Tinsley et al., 1980). These attributes can be combined into the picture of an expected therapist, one who is warm, supportive, and attractive in appearance.

The influence of role expectations on psychotherapy outcomes. Client role expectations have been linked to a number of factors important to clinicians and researchers. Research indicates that client role expectations influence help-seeking behavior and are related to persistence in therapy. Clients are more likely to seek help for personal problems from a therapist who has the attributes they expect, such as warmth, compassion, and empathy (Tinsley et al., 1984; Vogel, Wester, Wei, & Boysen, 2005). Therapists perceived as empathetic by their clients were perceived more favorably and were more likely to have met their clients' expectations than therapists who were not perceived as empathetic (Abramowitz, Abramowitz, & Weitz, 1976). Further, attractive therapists tended to inspire more positive evaluations of the therapeutic process than their unattractive counterparts (Cash et al., 1975; Green et al., 1986). In general, clients whose therapist meets their expectations are more likely to experience positive outcomes than their counterparts whose therapists do not meet their expectations (Wilkins, 1973a; Wilkins,

1973b). Congruency between client role expectations and therapist factors positively influences the outcome of therapy.

Alternatively, discrepancies between actual and expected roles result in negative outcomes in psychotherapy. Poor attendance is related to incongruence between actual and expected roles (MacNair-Semands, 2002). Clients whose therapists' personality is dissimilar to what they expected are likely to drop out of therapy prematurely (Glass et al., 2001). This suggests that incongruence between expectations and experience may be responsible for clients failing to keep therapy appointments or dropping out of therapy altogether. When client role expectations are not met, clients are more likely to report being dissatisfied with therapy and their level of goal achievement (Gladstein, 1969). Role expectations are not only influential in determining psychotherapy outcomes, but have also been linked to alliance formation.

Role expectations and the therapeutic alliance. One key area of research related to clients' role expectations is the way in which confirmation or disconfirmation of expectations influences the formation of a positive alliance between therapists and clients. Clients whose role expectations are met by a warm and caring therapist are likely to develop a close, productive relationship with that therapist. Congruence between client expectations of personality of their therapist and characteristics of their actual therapist is positively related to successful alliance formation and maintenance of a positive working alliance (Glass et al., 2001). Congruence between role expectations and experiences not only influences alliance formation, but also alliance stability over time. When clients' expectations about their therapists' personal characteristics are met, the alliance is generally more positive over time and is characterized by fewer disruptions or alliance ruptures (Joyce, McCallum, Piper, & Ogrodniczuk, 2000). Further, role expectation congruence is associated with clients' perceptions that therapy sessions are

useful and the tasks of therapy relevant to their problems (Joyce & Piper, 1998). In general, role expectation congruency aids in the formation of a positive therapeutic alliance. Although many researchers have examined client role expectations, a much smaller body of research exists examining client expectations for the process of therapy.

Process Expectations

Process expectations refer to preferences about specific activities that may happen and the tasks that may be required of the client during therapy. Research inquiry into expectations of the psychotherapy process has shown that clients enter into therapy with expectations about the course and duration of therapy, as well as expectations about appropriate and helpful in-session behaviors engaged in by both clients and therapists.

The expectation of the duration of psychotherapy is one of the more consistent findings in the process expectations literature. Research indicates that clients typically have a sense of how long they expect to be in therapy before they are able to resolve their symptoms and find relief from their presenting complaint (Greenberg et al., 2006; Kupst & Schulman, 1979). These expectations are often unrealistic and incongruent with therapist expectations about the duration of therapy (Kupst & Schulman, 1979; Tinsley, Bowman, & Barich, 1993); clients typically expect that therapy will take a shorter period of time than do their therapists.

Another type of process expectation is the expectation of what will happen during therapy. In general, clients expect that seeing a therapist will require them to talk about their problems, feelings, and experiences (Bordin, 1955; Gladstein, 1969). Clients expect that therapists will ask questions (Gladstein, 1969; Glass et al., 2001; Joyce et al., 2000). More specifically, one study (Joyce et al., 2000) found that clients expected their therapist to ask questions about their symptoms, childhood memories, the here-and-now relationship, and the

relationship between past experiences and current difficulties. Therapists are expected to be active and problem-centered (Tinsley et al., 1980; Tinsley & Harris, 1976; Yuen & Tinsley, 1981) and provide an environment in which clients feel comfortable discussing their problems (Joyce & Piper, 1998). In addition to expectations about their therapists, research also indicates that clients have expectations about their responsibility for the process of therapy. Clients expect to be active (Joyce & Piper, 1998; Yuen & Tinsley, 1981), by talking, suggesting topics for discussion, expressing feelings, and asking questions. Clients expect to help determine what topics are discussed and how information that is shared will relate to their plans for change. Clients expect to talk about the treatment they will receive before engaging in a behavior change program (Glass et al., 2001) and may be resistant to ideas incongruent with their beliefs about tasks that will solve their problems. It seems that clients expect a dynamic relationship in which two active individuals come together to discuss key issues and emotions related to those issues.

The influence of process expectations on psychotherapy outcomes. Studies suggest that improvement in therapy is associated with congruence between process expectations and actual experiences (Gladstein, 1969; Glass et al., 2001; Rosenthal, 1969). Results of meta-analyses (Arnkoff, Glass, & Shapiro, 2002; Noble et al., 2001) and single studies (Hunsley, Aubry, Vestervelt, & Vito, 1999; Schedin, 2005) indicate that incongruence between clients' expectations of what will happen during therapy their actual experience is related to negative outcomes and poor evaluations of therapy. Further, clients who perceive therapy tasks as relevant to their problems are more likely to persist in treatment, resulting in a decrease in missed appointments and reduced likelihood of premature termination (MacNair-Semands, 2002).

Clients who attend fewer sessions than they expect are more likely to be dissatisfied with treatment than those clients who attended the number of sessions they expected or more (Mueller

& Pekarik, 2000). Alternatively, clients who do not experience positive changes by the time they expect to experience them are more likely to terminate therapy prematurely (Pekarik, 1992; Wierzbicki & Pekarik, 1993). Clients who do not experience changes by the desired time are also less likely to have achieved treatment goals upon termination from therapy and are more likely to be dissatisfied with the therapy experience and the type of treatment received (Pekarik, 1992). This evidence suggests that clients not only have expectations about what will happen in therapy, but that they expect their preferences to be honored and outcomes achieved in a timely fashion.

Process expectations and the therapeutic alliance. In addition to the relationship between process expectations and outcomes, research has confirmed the importance of process expectations in alliance formation. Process expectations regarding the experience of therapy sessions are strongly and directly related to alliance formation and indirectly related to outcome (Joyce & Piper, 1998; Joyce, Ogrodniczuk, Piper, & McCallum, 2003). Clients who perceive the tasks they engage in during therapy as congruent with the tasks they think will help solve their problems are more likely to develop a positive alliance (Meyer et al., 2002). This research indicates that when clients find what they expect to happen in therapy happening in their sessions, they are more likely to form a strong working relationship with their therapist.

Outcome Expectations

The expectation of a successful outcome plays an important role in many forms of healing (Evans, 1974; Frank, Nash, Stone, & Imber, 1963). In general, therapy clients expect to improve and expect a wide range of treatment modalities to be helpful (Noble et al., 2001; Rosenthal & Frank, 1956; Wilkins, 1973b). This expectation of a positive outcome can developed before treatment begins. Early researchers documented symptom reduction in psychiatric patients before treatment began based on their expectations of improvement (Frank et

al., 1963). The belief that therapy will be helpful is clearly associated with positive therapeutic outcomes.

The influence of outcome expectations on psychotherapy outcomes. Expectations of positive outcomes influence help-seeking behavior and actual outcomes. When individuals believe that psychotherapy will help solve their problems and reduce their feelings of distress, they are more likely to initiate help-seeking contact (Vogel et al., 2005). Expectations of improvement are also a powerful determinant of psychotherapy effectiveness. Findings indicate that individuals with positive expectations about therapy, that is that they expect therapy will be useful to them in alleviating their symptoms or solving their problems, experience more positive outcomes than their counterparts with ambivalent or negative expectations (Frank, 1968; Gladstein, 1969; Greenberg et al., 2006; Greer, 1980; Joyce et al., 2003; Page, 1972; Tinsley et al., 1980; Tinsley et al., 1988; Vogel et al., 2005). Expectations which arouse hopeful feelings are especially important in that they seem to produce early relief of symptoms, thus improving overall outcomes (Glass et al., 2001). In addition to contributing to therapy continuation and early treatment gains, positive expectations influence the successful long-term maintenance of treatment gains (Frank et al., 1963; Gladstein, 1969). It is clear that positive expectations regarding the efficacy of psychotherapy are beneficial to clients' outcomes.

Expectancy Effects in Couple Therapy

Research has confirmed that expectancy effects not only exist, but substantially influence therapy outcomes (c.f. Rosenthal, 1969; Rosenthal, 1994; Rosenthal & Rubin, 1978). Examinations of expectancy effects in individual psychotherapy have confirmed that clients' expectations about therapy impact therapy outcomes. Although expectancy effects have been

clearly documented historically throughout the individual therapy literature, little is known about the role of expectancy effects in couple therapy.

Although no study has overtly examined the role of expectancy effects in couple therapy, evidence indicates that such an examination is merited. Research indicates that gender differences exist in the formation and communication of expectations. Such differences not only impact the nature and strength of expectancy effects, but may influence the outcome of couple therapy with male-female couples. Further, preliminary examinations of expectations about couple therapy suggest that clients enter into couple therapy with expectations about what that experience will be like.

Gender as a Moderator of Expectancy Effects

Information about the ways in which expectations are formed and communicated and the potential impact of expectations in couple therapy can be obtained by examining literature related to characteristics that influence expectancy effects. Several factors have been identified as moderators of expectancy effects. In the 10-arrow model (see Figure 1, page 8), moderators are identified as pre-existing conditions or characteristics that influence the formation, communication, and influence of expectancy effects. Gender is one moderating factor that has been subject to examination. Some researchers have found that there are gender differences in the formation, communication, and influence of interpersonal expectations; however, others have questioned those effects. Research about gender differences in expectation formation and communication provides some insight into how expectancy effects may be different in couple therapy than in individual therapy.

Evidence from research on interpersonal expectancy effects suggests that individuals differentially experience expectancy effects depending upon their gender. Studies examining

gender differences of perceivers, the individuals who form expectations, suggest that males produce stronger expectancy effects than females (Christensen & Rosenthal, 1982). That is, males are more likely to form expectations about individuals in interpersonal situations and then to have those expectations confirmed. Other researchers examined gender differences in targets of expectations, suggesting that females are more likely to be susceptible to perceivers' expectations. Females are more adept at decoding nonverbal communication, including the communication of interpersonal expectancy effects (Christensen & Rosenthal, 1982). Perhaps as a result of their superior decoding abilities, females are more likely to integrate expectations into their experience, displaying the types of behaviors expected of them in social situations (Christensen & Rosenthal, 1982; Rosenthal & DePaulo, 1979).

In the case of psychotherapy, several studies have examined gender differences in expectations in conjunction with other variables. Potential clients in one study (Hardin & Yanico, 1983) reported that they expected female therapists to be more open, to be more responsible for the therapy process, to provide more immediate relief of symptoms, and to provide clients with better outcomes. The potential clients expected male therapists to be more directive and to disclose more about themselves (Hardin & Yanico, 1983). Other researchers found that female therapists were expected to be more nurturing, more accepting, more genuine, and less self-disclosing than male therapists (Subich, 1983). Other researchers have examined gender differences among clients, rather than among therapist. Researchers found that female clients had more specific expectations about the psychotherapy process, though the researchers did not determine whether those expectations were communicated to the target and influential on therapists' behaviors (Robitschek & Hershberger, 2005).

Although these findings provide some evidence that there are gender differences in expectancy effects, they may also be an artifact of research. Most studies of expectancy effects have been unbalanced in the gender of the targets and perceivers. In most early studies of interpersonal expectancy effects, the researchers were males who examined the performance of both male and female participants. Many studies of expectations in individual therapy have used male targets and female perceivers. Limited variability in the gender of researchers and participants presents a threat to the validity of these studies and increases the likelihood that the results are an artifact of the research design. Further examination of gender differences is merited to determine if gender influences expectation formation and communication in a mixed-gender sample.

Evidence of Expectations in Couple Therapy

Limited evidence exists that suggests that couple therapy clients may have expectations about therapy. In one study, married college students were surveyed to assess their attitudes about marital therapy (Richards & Richards, 1979). Most respondents indicated that they expected marital therapy to be helpful to people in general, though it might not be helpful for them in their own relationship (Richards & Richards, 1979). Participants reported positive attitudes about marital therapy, indicating that they expected active guidance, concrete suggestions, and communication skills training from their couple therapist (Richards & Richards, 1979). Another study found similar results in relation to premarital therapy. Participant couples reported that they thought communication and problem solving skills training would be the most effective components of premarital couple therapy (Valiente, Belanger, & Estrada, 2002). Although the conclusions of this research were tentative, they offer support for the hypothesis that couples enter into therapy with expectations about its process and efficacy.

Other research confirmed the idea that individuals approach couple therapy with specific expectations about the characteristics of the therapist. Findings from one study (Ripley, Worthington, & Berry, 2001) suggested that highly religious couples had a clear preference for a therapist who respected and supported their spiritual beliefs. Specifically, results of this study indicated that couples high in Christian religiosity preferred a Christian therapist who used Christian practices (Ripley et al., 2001). In another study, Gale, Odell, and Nagireddy (1995) found that one couple in couple therapy had clear process expectations. In this study, one couple participated in both therapy and an interpersonal process recall study in which they discussed their experiences in therapy with a researcher. The couple's expectations for therapy were a theme throughout the research interview (Gale et al., 1995). This couple expected that they would not discuss heated issues or make any changes during the first interview and that the therapist would serve as an objective third party during their interactions (Gale et al., 1995). These expectations became consistent themes in the couple's dialog.

Together, these studies offer some indication that couple therapy clients form expectations about their therapy experience. The studies do not address how expectations are formed and communicated or what influence expectations have on couple therapy processes and outcomes.

Summary

Research has clearly established that interpersonal expectancy effects exist and substantially influence cognitions, behaviors, and outcomes of interpersonal processes. The study of expectancy effects has grown to include a conceptualization of expectancy effects in a number of diverse fields and in a variety of settings. Models describing the process by which expectancy effects are developed intrapersonally and communicated interpersonally have been developed

and such models could be expanded for use in understanding expectancy effects in couple therapy.

Adapting the 10-arrow Model to Couple Therapy

In couple therapy, clients and the therapist must work together to create the shared experience of couple therapy. This shared experience is created through the process of meaning-making that happens in interactions with others in social situations. In contrast to individual therapy, in couple therapy two joined individuals have the opportunity to interact with one another, creating a different and potentially more complicated set of symbols and expectations prior to entering into a therapy relationship with a therapist. Likely, one partner's expectations and behaviors will influence the other partner's perceptions of the therapist and therapy environment. Changes in perceptions would subsequently influence behaviors and the couple would likely then adjust their expectations accordingly. This process of shared meaning-making influences both intra- and interpersonal events and is expected to impact the process and outcome of couple therapy.

The 10-arrow model, as depicted in Figure 1 (page 8), provides a framework for understanding the process by which expectations become perceptions and the representative symbols are created in therapy. Through communication about these symbols, expectations are shared with others and often become self-fulfilling prophecies that influence outcomes. Adapting the 10-arrow model to couple therapy requires the addition of arrows to represent mutual influence between each partner's expectations and behaviors. The resulting model would be exceptionally complex, containing many arrows and many variables. A more parsimonious model is depicted in Figure 2. Figure 2 presents a graphic depiction of the 10-arrow model

adapted to represent a dyadic understanding of expectancy effects that combines interpersonal communication of meaning.

To create a manageable, more parsimonious, model for examination, the proposed relationships between expectations and outcomes have been simplified. The model presents the proposed relationship between expectations, relevant generic independent variables, and one outcome. Although a more complex relationship is both possible and likely, this preliminary study focuses on only those variables central to understanding expectancy effects in couple therapy.

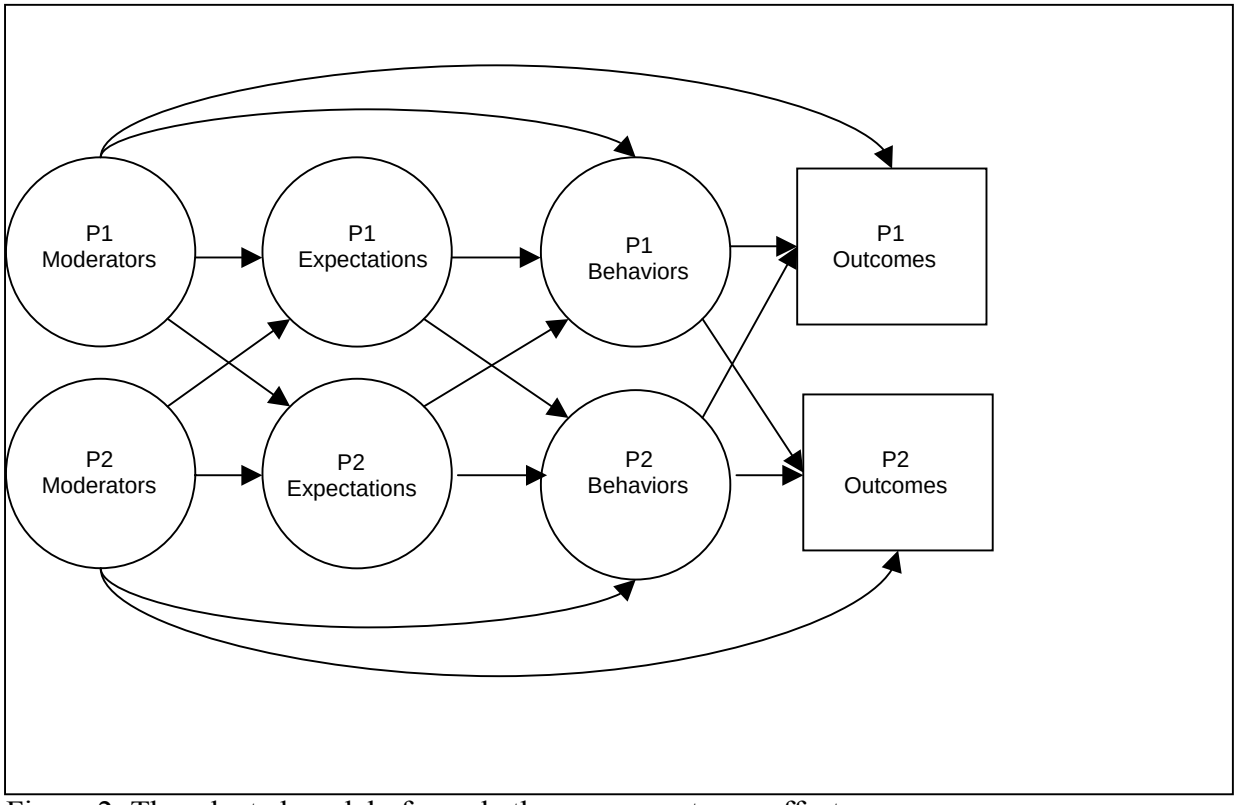

Figure 2: The adapted model of couple therapy expectancy effects.

Despite advances in researchers' understanding of expectancy effects in interpersonal situations, more studies are needed that address expectancy effects in complex relational settings such as couple therapy. The present study focused on determining which mechanisms are

responsible for expectancy formation and communication in couple therapy. By expanding the 10-arrow model to the study of dyadic expectancy effects in couple therapy (see Figure 2, page 24), the present study provides researchers and clinicians with valuable information about the role of expectations in couple therapy. The following general research questions guided the study:

1. What expectations do couples form for therapy?
2. What couple and individual factors are associated with the formation of expectations?
3. Do expectations about psychotherapy influence couple adjustment/marital satisfaction?
4. How do expectations influence the experience of therapy?

CHAPTER 3

METHODOLOGY

Participants

Participants for this study were recruited from the McPhaul Family Therapy Clinic. Participants were 26 individuals representing 13 couples who presented for couple therapy at the clinic between June 1, 2007 and April 1, 2008. Of the couples, eight (61%) were married, one couple (8%) was a committed homosexual couple, and all others identified their relationship type as committed heterosexual. Four couples (31%) had at least one child. Participants were predominantly Caucasian, (n=22; 85%). Other ethnic groups represented by the individuals sampled were Hispanic, (n=2; 8%) and Asian, (n=1; 4%). Most participants had achieved at least a Bachelor's degree, (n=18; 69%) and had reported household incomes ranging from less than $5,000 annually, to more than $40,000, with an equal distribution across income groups. Clients were 29.5 years old, on average, with a range in age from 21 to 45.

Procedures

Study participants were recruited from the general population of couples who requested couple therapy at the McPhaul Family Therapy Clinic during the period of June 1, 2007 to April 1, 2008. In addition to clients who referred themselves to the clinic, participants were recruited through flyers posted across the university and local area. Potential clients phoned the clinic to request services and completed an intake assessment over the phone. At that time, clinic staff notified potential clients of the opportunity to participate in this project. Clients were informed that participation in the study involved meeting with a researcher for a short interview four times

during treatment, before the first session of therapy and after the second, third, and fourth sessions of therapy, and completing questionnaires at four times during the study.

Consenting clients were instructed to arrive forty-five minutes prior to their first session to obtain complete information about the study and participate in the first interview, if they opted to participate in the study. During the course of therapy, couples scheduled ongoing sessions of therapy with their therapist directly. Therapists instructed the clients to remain in the clinic after the second, third, and fourth sessions for a thirty minute interview with the researcher. Therapists were five masters and four doctoral students in the marriage and family therapy program. Student therapists were supervised by professors of marriage and family therapy both to enhance training and improve the quality of services provided. All supervisors held the American Association for Marriage and Family Therapy Approved Supervisor designation. Therapists practiced a variety of therapeutic models and had a wide range of clinical experiences prior to joining the McPhaul Family Therapy Clinic. No demographic information was collected from therapists.

Client interview data was obtained through a semi-structured interview with the researcher or one of four undergraduate research assistants. The protocol for the interviews appears in Appendices F and G. Interviews were not iterative in nature, as responses in one interview did not prompt questions for future interviews. Each interview was treated as a single experience. Interviews were transcribed by the undergraduate research assistants.

Participating couples were compensated for their participation in the study. Four times during the intervention, both members of participant couples participated in a short interview about their expectations and therapy experience, as described above. As compensation for

participation in the research, each couple received a $5 gift card to a local store for each interview in which they participated. Compensation was provided immediately after each interview by the interviewer. Couples who participated in all four data collection points had the potential to be compensated up to $20 total for participation in the study.

Measures

Revised Dyadic Adjustment Scale

The Revised Dyadic Adjustment Scale (RDAS, Busby, Crane, & Larson, 1995) is an updated version of the Dyadic Adjustment Scale (Spanier, 1976). A copy of the RDAS appears in Appendix A. The RDAS consists of fourteen items designed to measure adjustment in dyadic relationships on three subscales, Consensus, Satisfaction, and Cohesion. The subscales can be summed to create a total score representative of marital satisfaction. The subscales were developed to represent the multifaceted nature of the construct. A cutoff score of forty-eight was established to indicate clinical distress with higher scores being representative of increased distress (Crane, Middleton, & Bean, 2000). In this study, the total score was used to be representative of global relational distress.

Evaluation of the RDAS has demonstrated adequate construct and criterion validity (Busby et al., 1995) and demonstrates convergent validity as scores on the RDAS correlate highly with similar measures of marital distress (Crane et al., 2000). Past estimates of internal consistency reliability have ranged from $\alpha = .90$ to .95 for the total scale (Busby et al., 1995). The internal consistency reliability for this sample was $\alpha = .92$ at intake and $\alpha = .66$ at the fourth session. Low estimates of internal consistency reliability at the fourth session were likely the result of the extremely small sample size.

Outcome Questionnaire

Data representing individuals' level of individual distress were obtained from scores on the Outcome Questionnaire (OQ-45.2; Lambert et al., 1996). The OQ-45.2 appears in Appendix B. The OQ-45.2 consists of three subscales, Symptom Distress (SD), Interpersonal Relationships (IR), and Social Role (SR). These subscales can be summed to create a total score representative of individual distress in the domains of intrapsychic functioning, client's interpersonal relationships, and client's functioning at important tasks such as school and work. Psychometric evaluation of the instrument has assessed the OQ-45.2. Evaluations indicate that the OQ-45.2 has high internal consistency and good construct validity (Doerfler, Addis, & Moran, 2002; Umphress, Lambert, Smart, Barlow, & Clouse, 1997). The OQ-45.2 is sensitive to changes in levels of distress and is an adequate measure of change in therapy (Doerfler et al., 2002; Vermeersch, Whipple, Lambert, Hawkins, Burchfield, & Okiishi, 2004). Despite the empirical support for and wide clinical use of the OQ-45.2, some researchers (Mueller, Lambert, & Burlingame, 1998) have called into question the multidimensionality of the scale. Critics have suggested that only the SD subscale be used, as it is the most reliable and valid and has the strongest links between individual items and the factor (Mueller et al., 1998; Vermeersch et al., 2004). Based on this criticism, and concerns about the relatively small sample size, the more stable SD subscale was used as a measure of individual distress in this study. The internal consistency reliability estimate for this sample was $\alpha = .95$.

University of Rhode Island Change Assessment

The University of Rhode Island Change Assessment (URICA; McConnaughy, Prochaska, & Velicer, 1983) was used to measure client stage of change. The URICA appears in Appendix C. The URICA is a 32-item self-report measure on which individuals rate their agreement on a five point scale with statements reflecting each stage of change. The URICA was designed to

provide a continuous score of readiness to change (McConnaughy et al., 1983). There are four sub-scales on the URICA, Precontemplation (e.g. "I am not the problem one, it doesn't make sense for me to be here"), Contemplation (e.g. "I have a problem and I really think I should work on it"), Action (e.g. "I am finally doing some work on my problem"), and Maintenance (e.g. "It worries me that I might slip back on a problem I already have, so I am here to seek help"). Subscale scores are obtained by summing each item score, and a total score representing readiness to change is obtained by summing the scores on Contemplation, Action, and Maintenance, and the reverse scored Precontemplation scale. There are no cutoff scores on the URICA indicating overall readiness or commitment to change (Project MATCH Research Group, 1997).

The URICA has been used extensively in studies of behavior change and has undergone several evaluations. Psychometric evaluation of the URICA has shown that the measure has good theoretical consistency, concurrent, and discriminant validity (Blanchard, Morgenstern, Morgan, Labouvie, & Bux, 2003; McConnaughy, DiClemente, Prochaska, & Velicer, 1989) and internal consistency reliability estimates have ranged from .78 to .85 in previous studies of behavior change (Carbonari & DiClemente, 2000; McConnaughy et al., 1989; Project MATCH Research Group, 1997). The continuous measure of change method for interpreting URICA scores is the preferred method of data collection as it conforms to the original usage and intent of the scale developers (Blanchard et al., 2003). A total score representing readiness to change was used in the present study to represent the continuous nature of the change process. In this sample, the internal consistency reliability was estimated at $\alpha = .83$.

Expectations about Counseling Questionnaire

The Expectations about Counseling Questionnaire-Brief Form (EAC-B; Tinsley, 1980) was used to assess client expectations and preferences. A copy of the EAC-B appears in Appendix D. The EAC-B was developed from two earlier versions of the Expectations about Counseling Questionnaire: the original version (Tinsley & Harris, 1976), and a factor analysis of the domain of client expectations for therapy (Tinsley et al., 1980). The EAC-B consists of 66 items on 20 subscales, arranged within four factors. The factors have received some tentative support from the results of a factor analysis (Tinsley et al., 1980). The four-factor model was found to be an adequate fit for the data; the four-factor model also represents a theoretically sound arrangement of the subscales (Tinsley et al., 1980). The four factors are Personal Commitment, Facilitative Conditions, Counselor Expertise, and Nurturance. The Personal Commitment factor consists of the following subscales: Responsibility, Openness, Motivation, Attractiveness, Immediacy, Concreteness, and Outcome. The Facilitative Conditions factor includes the Acceptance, Confrontation, Genuineness, Trustworthiness, Tolerance, and Concreteness subscales. The Nurturance factor contains the following subscales: Acceptance, Self-Disclosure, and Attractiveness. Finally, the Counselor Expertise factor contains the Defectiveness, Empathy, and Expertise subscales.

Each statement on the EAC-B is prefaced by the words “I expect to” or “I expect the counselor to” and statements address many common expectations about psychotherapy (i.e. “I expect to talk about my presenting concerns”). Scores on the EAC-B are obtained by summing the responses to the items assigned to each scale and dividing by the number of items on the scale. There is a fifth construct, Realism, included in the measure that is not identified as a factor. This construct measures the degree to which the client has realistic expectations about the psychotherapy process such as the duration of psychotherapy. Only the four factors, Personal

Commitment (hereafter identified as Personal), Facilitative Conditions (hereafter identified as Facilitative), Nurturance (hereafter identified as Nurture), and Counselor Expertise (hereafter identified as Expert), were used for the purposes of analysis in this study.

Analysis of the EAC-B yielded subscale scores that correlate at .82 or higher with the longer version of the measure (Tinsley, 1980). The internal consistency reliabilities for the EAC-B subscales range from .69 to .82, with a median reliability of .76 (Tinsley, 1980). Test-retest reliability over a two-month interval ranged from .47 to .87, with a median reliability of .71 (Tinsley, 1980). All subscales but the Responsibility subscale has a test-retest reliability of .60 or higher (Tinsley, 1980). Consequently, the EAC-B is typically considered to have adequate internal consistency and reliability (Tinsley, 1980; Tinsley et al., 1980). In this study, the internal consistency reliability was estimated four times, once at each data collection point. Estimates were $\alpha = .95$ at time one, $\alpha = .95$ at time two, $\alpha = .92$ at time three, and $\alpha = .93$ at time four.

Couple Therapy Alliance Scale

The Couple Therapy Alliance Scale measures therapeutic alliance between the couple and therapist (CTAS, Pinsof & Catherall, 1986). A copy of the CTAS appears in Appendix E. The CTAS assesses the degree to which the couple and the therapist are able to work together on goals, the client's perceptions of the therapist's competence, and the level of trust between the couple has in the therapist. The scale accesses the alliance from the perspective of each individual participating in therapy in a seven point Likert-style format. The twenty-nine questions address both the individual's experience in therapy (i.e. "The therapist and I are not in agreement about the goals for this therapy") and the conjoint experience of couple therapy (i.e. "My partner and I do not feel the same ways about what we want to get out of this therapy"). Estimates of reliability have ranged from .70 to .94, dependent upon the study and the nature of

the estimate. The test-retest reliability at seven days was estimated at .79 in one study (Pinsof & Catherall, 1986), subscale to full scale intercorrelations ranged from .77 to .97 (Heatherington & Frielander, 1990), and internal consistency reliabilities ranged from .70 to .94 (Heatherington & Frielander, 1990). The scale authors indicate that the measure correlates well with other similar measures, and indication that construct and criterion validity are good (Pinsof & Catherall, 1986). For this sample, the internal consistency reliability was estimated at $\alpha = .47$. The low estimate is likely the result of having an extremely small sample size at the fourth session.

Expectations Interview

To obtain additional information about couples' expectations for their therapy, they participated in semi-structured interviews. Each couple was interviewed conjointly at each data collection point: prior to the first session, and after each of the next three sessions. Interviews were conducted either by the researcher or one of four undergraduate research assistants. Research assistants had training in interviewing and were directly supervised by the researcher. The interviewers completed a semi-structured protocol that encouraged interaction with the interviewing couple. There were two interview protocols: one for interviews prior to the first session and another for second and later sessions that was adapted to reflect having begun therapy. During the interviews, the interviewers focused on obtaining in-depth information from couples. Interviewers used the interview questions as a guide for the interview and asked follow-up questions to solicit additional information. The interviews were not iterative in nature and responses to questions in one interview generally did not influence subsequent interviews. Both interview protocols were developed using research findings related to expectancy effects in psychotherapy as a guide for question formation.

First session protocol. Questions were adapted from the findings of past studies and reflected a number of constructs known to be related to expectancy effects in individual therapy. One question addressed role expectations ("What do you think your therapist will be like?"); two addressed process expectations ("What do you think will happen during therapy?"; "What will you talk about with your therapist?"); and one question addressed outcome expectations ("Think about the problems that brought you to therapy. What do you expect will change about these problems as a result of therapy?"). A copy of the first session interview protocol appears in Appendix F.

Second and later session protocol. During the second, third, and fourth session interviews, the interview protocol included questions about the actual experience of therapy as well as ongoing expectations that had persisted or changed after the first session. Questions addressed confirmations and disconfirmations of expectations ("In what ways was your therapist like or not like what you expected?"; "In terms of what happened during therapy today, how did this fit or not fit with what you expected?"; Were you surprised by anything in therapy that you did not expect?"), changes in expectations since the previous session ("Do you have any new expectations for therapy after today's session?"), and expectations for the outcome of therapy ("Think about the problems that brought you to therapy. What do you expect will change about these problems as a result of therapy?"). A copy of the second and later session interview protocol appears in Appendix G.

CHAPTER 4

RESULTS

Data from this study were collected and analyzed in two parts. First, a qualitative analysis was conducted to explore couples' experiences of expectancy effects and provide a rich understanding of how expectations were formed and communicated. To enhance the results of the qualitative analysis, a quantitative inquiry provided information about the influence of variables measured via questionnaire on one another. These methods together provided new information about the development and effect of expectations in couple therapy. In this chapter, the results of the qualitative analysis are presented. Following that, data analytic issues inherent in the analysis of dyadic data and strategies for approaching the analysis of dyadic data are presented. Finally, the results of the quantitative analyses are presented.

Qualitative Data Analysis

Reliability and Validity

Qualitative research relies strongly on impression, induction, and self-reflection. As such, some have called into question whether qualitative research can be believed to be both reliable and valid. Reliability and validity, or trustworthiness of the qualitative results, were enhanced using several strategies designed to increase the quality of the data and the analysis.

Validity, whether or not the results accurately represent the phenomena under consideration (Silverman, 2000), was enhanced in two ways. First, throughout the coding and data analysis process, a recursive analysis process was used. The researcher first read through all transcripts to get a sense for the data as a whole. During this first read, the researcher kept careful notes of observations, questions, and ideas. Next, codes were developed during a second read of

the transcripts and emerging themes were developed, modified, and compared during subsequent readings of the transcripts. This process increased the likelihood that the codes captured all relevant data and that codes represented good descriptors of the data as a whole (Silverman, 2000) due to the recursive nature of the data analysis. In addition, records of instances of each code's occurrence were kept. Tabulations of the frequency of each code's use enabled the researcher to determine how common particular codes were across participants and interviews (Silverman, 2000). Such a process provided a sense of the density and distribution of codes, which enabled the researcher to evaluate the completeness of the coding scheme.

Reliability refers to the level of consistency in observations and the coding strategy used to capture consistencies in the observations (Silverman, 2000). Reliability was enhanced in several ways. First, all procedures were carefully documented. The researcher and her research assistants kept detailed field notes. In these notes, impressions, questions, and ideas were recorded and each person read all entries and reflected upon the impressions of the other researchers. Further, the researcher kept a detailed process journal of impressions, ideas, and emerging themes during coding. These notes provided an opportunity for the researcher to reflect upon her impressions, develop emerging themes, and attend to her own influence on the data (Silverman, 2000). Finally, to ensure that the interpretation of the data was reliable, two other people were asked to read a random sample of transcripts to evaluate whether the coding of those sections was reasonable and credible. The two individuals were undergraduate research assistants who were familiar with the project and had transcribed the interviews, but had no experience with therapy or qualitative research. These individuals were selected because they were believed to be more open to alternative explanations and themes. After the research assistants coded their sections, they met with the researcher and each other as a group. During this meeting, codes were

discussed and clarified. The researcher then conducted a final read of the data to determine that the codes represented were those that were a good fit for the data and reflected the content of the discussions.

Qualitative Analysis

Interview data were analyzed qualitatively to explore themes related to expectations in couple therapy. The analysis was discovery-focused; the task of this analysis was to identify patterns consistent in participants' experiences. Data were collected and analyzed systematically and recursively in an effort to locate and identify emerging themes. A complete listing of themes identified, as well as information regarding the emergence and naming of these themes, is presented in Table 1.

For the analysis, the researcher reviewed the transcripts of the couple interviews using a content analysis framework. ATLAS.ti software was used to aid in the management and organization of the data. The ATLAS.ti software enabled the researcher to easily manage a large number of original documents and provided a system for linking journal notes to the data during analysis. Before beginning the coding process, several key questions were developed to provide a framework for the analysis. The questions that guided the analysis were:

1. What expectations do clients form prior to beginning therapy?
2. How do these expectations influence the clients' experience of therapy?
3. How do expectations change and stay the same over the course of therapy?

Transcripts were separated into four groups based on the session at which the interview took place: first, second, third, or fourth session. The researcher first read through all the transcripts from all the groups to get a sense of the data as a whole. Next, a preliminary code list was developed. During later readings of the transcripts, they were read in groups (i.e. all first session

interview transcripts were read as one group, followed by all second session interview transcripts, etc.). This enabled the researcher to get a sense of the timing of the occurrence of various expectations as well as the changes in expectations over time. Coding proceeded in this manner, with transcripts being read within their organizational group until the final reading. After meeting with her research assistants to check the credibility of the codes, the researcher read through all the transcripts together as a single group a final time to confirm that the final codes seemed to represent the content of all the transcripts.

During the coding, emerging themes were identified and the researcher revisited reviewed transcripts several times to locate comments and experiences missed in earlier reviews. The analysis was aimed at developing a system of basic categorization in which key content areas could be represented by codes. The recursive nature of the analysis allowed the researcher to develop, confirm, disconfirm, modify, and discard themes and theories throughout the analytic process.

Table 1: Themes identified in interviews.

Family	Theme	Origination of Theme		Number of Observations
		Researcher, as informed by the literature	Participants	
Role Expectations	Young		√	11
	Graduate student		√	8
	Experienced/professional	√		10
	Attractive	√		9
	Female		√	8
	Empathetic/relatable	√		11
	What I expected	√		19
	Unexpected characteristics	√		8
Process Expectations	Talk		√	10
	Issues that we have	√		18
	Personal reflection		√	5
	Suggestions/direction/advice		√	5
	Outcome	√		32
	Length of time	√		7
	What I thought	√		15
	Surprised	√		15
None	Uncertain		√	9
	Unhappy		√	3
	Helpful/Positive experience		√	19

Results – Qualitative

The following themes were drawn from 31 interviews: thirteen first session interviews, six second session interviews, six third session interviews, and six fourth session interviews. As was mentioned previously, transcripts were organized into groups depending on the session at which the interview occurred. Analysis focused on the formation of expectations prior to the first session, themes present in those expectations, and changes in expectations over the course of therapy.

Quotations from the transcripts are identified and used to describe each theme and provide a rich description of each theme. Quotations are identified by a numerical code representing the participant number, a period, and a number representing the session number at which the statement was made.

Uncertainty

Many participants did not have clear expectations for couple therapy. These participants expressed uncertainty about their expectations, or simply reported that they had not thought about what they expected about their therapy experience.

"I don't know. I came in here pretty much as a blank slate." [281.1]

"I don't have any preconceived notions." [051.1]

"No actually I don't really know what to expect." [281.1]

Despite some uncertainty, most participants had formed expectations about therapy prior to entering therapy. These expectations generally conformed to the three categories of

expectations found in individual therapy: role expectations, process expectations, and outcome expectations.

Role Expectations

Most participants identified expected features of their therapist's personality, training, and behavior. Participants also had a sense of the gender and appearance they expected of their therapist. Of all the expectations identified by participants, role expectations were the most clear. Participants were able to articulate a wide range of role expectations and typically reported a number of these expectations.

The most common expectation was an expectation regarding the age of the therapist. Most participants expected their therapist to be a young adult.

"I would say young, but younger than I am, maybe mid to late twenties." [731.1]

"I'm imagining, I mean I'm picturing someone in their 30's…" [112.1]

For many participants, their sense of the age of the therapist was closely linked to their perception of graduate students. All clients were informed on intake that their therapist was a graduate student. For some people, this information helped them identify and approximate age range for their therapist.

"…Oh well I'm assuming he's in graduate school here in some capacity but so I'm thinking he probably gonna be in his I'll say mid to late twenties maybe." [052.1]

"…But I would have thought, being that it's with the university it would be somebody young." [742.1]

Despite believing that their therapist would be both young and a student, many participants also expected that their therapist be experienced and professional.

"I would hope that they have a certain amount of experience even if they were still relatively new at their job." [852.1]

"Um, hopefully informed, hopefully know what they're talking about. I'm sure they will, I mean that's why we're here." [741.1]

"… you know I was expecting a level of professionalism…" [051.1]

Many participants expected that this professionalism would be exhibited through a professional wardrobe and appropriate grooming. Expectations about appearance were closely linked to gender. Most participants knew the name of their therapist, and from that were able to guess the gender, and expected appearance, of their therapist.

"I knew it was going to be a woman and I don't know I just imagined she would look like, you know, a UGA grad student woman, professional looking." [751.1]

"[Therapist's name] seems like a sweet soft spoken petite person is kinda the image that I have…" [732.1]

"I think she will probably be attractive." [762.1]

"I'm thinking blonde…" [762.1]

Finally, most participants articulated expectations about the personality of their therapist. In general, participants expected a warm, caring therapist who was open-minded and who was willing to relate to the clients with honesty and compassion.

[Participant] "I think things like age and appearance, education and personality might have a direct effect on how much someone opens up as far as you know, I mean honesty sure, but the depth of what they would talk about I could see being a factor."

[Interviewer] "So you're saying that how [Therapist] looks or acts, or personality characteristics would influence how much you would want to share, or…"

[Participant] "Yeah, I mean it's not so much how she looks but you know, if she's like calm and it feels like she's not afraid to be in the room with someone who would be honest, because that would obviously definitely make me recoil, you know as far as like telling her something personal, you know." [761.1]

"I just had hoped that it would be a very straightforward person. Not unkind, but straightforward. And would, you know, call us out basically." [732.1]

"…easygoing, probably pretty… pretty rational…" [741.1]

"I hope she'll be empathetic, or as much as you can be empathetic. Sympathetic definitely. Um, nonjudgmental." [761.1]

"…as long as I can talk to someone and they can relate to me on some level that's not strictly educational and approach it as a real life situation since we are talking about real life and not data points and so forth then I'm, we'll be fine…" [851.1]

"Um, yeah like I expect that we'll have the proper uh kind of proper ambience that's where we can express our feelings properly, because that's very important." [791.1]

In general, participants seemed to have an accurate picture of how their therapist would look, act, and behave.

Confirmation of role expectations. After beginning therapy, most participants found that their role expectations were confirmed. Most participants determined that their therapists were as they expected in terms of personality and behaved as they expected during sessions. Clients also reported that they expected consistency from their therapists in terms of their role expectations – and indicated that therapists were generally stable over time.

"Well by now she's pretty much can tell what I expect I guess... or you know she's pretty consistent so I expect of her to ask the same kind of questions that she's been asking and um kind of structure the sessions the same and that was right on." [042.4]

"She was just like I expected her to be." [742.2]

"She's like what I expected because… um … she is very professional and she creates a calm environment where it's very easy to be open and talk about things." [111.3]

"Well, she did fit kind of our stereotype of what we would have thought." [751.2]

"She's interested and you know that's important I think. As far as what we were expecting, I think she meets our expectations." [742.2]

For most clients, therapy presented an opportunity to confirm their expectations, as most clients experienced their therapist as warm, empathetic, and helpful. In contrast, other clients were surprised by the personality or behavior of their therapist.

Disconfirmation of role expectations. Some clients experienced a disconfirmation of their role expectations. Despite experiencing some shock at the discrepancy, most participants reported that they adjusted well to the reality of their therapy experience. Some participants even reported being pleasantly surprised by their therapist's behavior, which resulted in a better experience than they expected.

[Participant] "Well besides that, not blonde, um I guess I sort of expected her to be a little more superficial or like bubbly."

[Partner] "Yeah"

[Participant] "Which I'm glad she's not."

[Partner] "I thought she was smarter than I might have expected." [762.2]

"I didn't expect her to be so observant I guess, I think maybe in the beginning I was expecting some sort of generic kind of feedback and not as much insight but she's you know based on, she tied together something that you had said from last session and something that you said this session and how those didn't really go together so..." [762.4]

"You know we expected him to be experienced but I think he may even be more deeply experienced than we thought." [052.3]

Though some clients were surprised by their therapist and experienced the disconfirmation of their expectations, none were disappointed. All the participants who indicated that their role expectations were disconfirmed were happy with the unexpected experience.

Process Expectations

Participants seemed to have expectations regarding the process of therapy including what tasks would be helpful and what things would happen during therapy. Overwhelmingly, and not surprisingly, almost all participants reported that they expected to talk with their therapist during treatment.

"*Umm, well I hope that it just gets, Well I'm really looking forward to us both being able to talk to someone and get an unbiased opinion because I know that I talk to a lot of people but they're all really close to me and I know we've never been able to talk to someone together and I feel like that would be really helpful just to get a level playing ground for, I don't know. And just hopefully um I think we'll just have to talk about our problems and issues and maybe get a better understanding of each other." [082.1]*

"We talk, they talk, we talk some more, they talk. They advise. We go ok or no and we talk some more." [851.1]

"Yeah, that's what I was imaging - a lot of talking and hopefully we'll just start to I don't know, I guess I imagined us spilling our guts about our problems, talking about the issues um..." [112.1]

"I think it will probably at some point they will encourage us to talk to each other and have them sort of be a third party listening kind of thing. Probably in the first session though I would expect that maybe each of us will talk and then they'll talk a little bit and then maybe in subsequent sessions it'll be more us talking I would think…" [852.1]

In general, participants expected that they would talk about their problems in therapy. Most mentioned that they expected to talk about their reasons for seeking treatment, and the historical events that led up to their seeking treatment.

"Umm maybe our marriage, how we met, when we met, how long we've been together umm our jobs, our son and personal individual issues we have that may be contributing to our marriage issues" [071.1]

"Yeah I guess I would think umm I would expect to talk about umm the problems that are going on now if we have made any conclusions, decisions how we feel about them what we want to see happen with them." [072.1]

"Yeah, that's kind of what I imagine like you write down a list of things, your list of gripes and then I write down my list of gripes and we reconcile the things, I don't know…" [112.1]

Many participants also expected the content of the conversations to have a relational focus. Participants expressed and expectation that they would talk about individual issues as well as relational issues.

"It's not gonna be just the marriage problems I don't think. It will be a lot of individual stuff too." [731.1]

"I mean work on communication and stuff like that, it's the joint stuff but I think we both each have issues and baggage that we kind of brought into the situation which has made the marriage worse." [732.1]

"I think also maybe just things that might change would be how we see ourselves personally because I mean there'll be a lot of personal reflection going on and you'll probably take that with you once you leave. You know it all builds on each other until you know, because you have to take care of ourselves and look at ourselves as individuals before a couple so..." [111.1]

In addition to expecting to talk about themselves and their presenting problems, clients also expected their therapist to take an active role in the session. For most participants, this entailed an expectation that the therapist would be directive and would provide suggestions for the couple.

"Yeah, yeah that's kind of what I was expecting. Something like ok, this is, not to think that you know our problems are just that cut and dry like ok this is the problem and this is what you need to do, but I would like, what I expect is like, advice on how to work through these problems that we have, you know." [112.1]

"I think she will give us advice. That's all." [282.1]

"Yeah…I expect the therapist to lead the conversation because we're not gonna just come spill our guts, but, so, the therapist will provide structure and kind of like an arena for mediation I guess." [012.1]

Generally, participants seemed to have a sense that therapy would involve self-disclosure on the part of the clients to promote discussion about the issues that brought them to therapy. On the part of the therapists, participants expected their therapist to guide them by structuring the discourse and providing suggestions.

Confirmation of process expectations. For most participants, their experience of therapy matched the expectations they formed prior to beginning therapy. Participants reported that they talked about their presenting problems, and, over time, continued their discussions of their reasons for seeking therapy.

"It went along with what I thought we'd be doing. We talked more in depth about our relationship and I think we discovered some things that we need to talk about more and I think it was very productive which is what I would expect." [742.3]

"I think it fit kind of exactly what I thought." [751.2]

"I think today was the first day that my expectations for like therapy being challenging were met, the last two sessions have been sort of easy and so that...and today it was sort of a heavier, you know she was pushing us in a direction that I think we have been resisting so that was neat." [752.3]

"…we are talking about the things I suspected we would be talking about and umm I mean I don't know and I guess umm his role in helping us talk about those things is pretty much what I would have expected his role be..." [052.2]

In general, participants seemed to experience the things they expected in therapy. For some clients; however, the tasks they engaged in during therapy were a surprise.

Disconfirmation of process expectations. Some participants reported experiencing techniques and tasks in therapy that were unexpected. For these clients, the unexpected tasks represented a disconfirmation of their expectations.

"…this is not a criticism but he was really wanting to get to this certain… umm… I don't even know how to describe it, he… he wanted to get us to acknowledge something with, course he wasn't just telling us but he's trying to get us to understand something and he really pushed it and pushed it until we understood it and maybe that kinda surprised me that he made us really work at it." [052.3]

"I guess I was surprised when she asked us to bring a picture of our wedding." [112.3]

"Yeah, I don't think I was surprised by anything that happened, but it was challenging, you know. Based on what we talked about at the beginning of the session we never would have suspected possibly that it would have gotten as challenging as it did." [751.3]

For these clients, the interventions suggested by their therapist came as a surprise. Although none expressed disappointment with the process, some did express confusion about the relationship between the task and their goals for therapy.

Outcome Expectations

Outcome expectations refer to the hope or expectation that therapy will be efficacious in reducing symptoms and helping clients achieve their goals. Most participants expressed a belief that therapy would be helpful to them. For some clients, helpfulness meant resolving their presenting concerns. For others, therapy was expected to be helpful because it would provide a sense that their experiences were normal or provide clients with a safe space in which to discuss their concerns.

> *"I think another thing is just uh coming here on a routine basis and learning that what you're going through is like you know uh, other people are going through it, you're not alone, you're not you know, a complete freak show." [111.3]*

> *"And yeah I think, nobody can sort of say that this is the solution to your problem but I think we're hoping that we'll get some strategies so that when we confront problems that we'll do a better job dealing with them or that I don't know maybe we'll understand each other better." [052.1]*

> *"I think it will be, it will serve as a good conversation starter. Like when we go home we'll probably have a ton of things just to talk about. I don't think there will ever be anything that surprises us that much that comes out in therapy but I think it will just be useful things to talk about." [761.2]*

> *"I don't expect it to solve any of our problems and I don't think that they'll just disappear but maybe I just feel especially lately that we've been having the same*

conversation a lot and maybe this will give me a different angle to come at towards our relationships and the things that we're struggling with and maybe lead somewhere to some kind of resolution. I don't know, I just really care about this relationship and I feel like it was spinning out of control for us and hopefully this will give us more than we could have by ourselves." [082.1]

"I'm hoping we'll communicate better, um just in general after therapy. I mean I think we're both very good communicators but there is specific issues that we need to work on more um and especially the things that caused us problems before, you know those kind of communication traps." [751.1]

"I think that's, that's the big thing. That's sort of what led us here, is that that idea of not repeating all those things that led to us breaking up to begin with and I think a lot of that had to do with communication and the the breakdown in communication that happened after a certain point in our relationship." [752.1]

"I feel that like when we should feel comfortable, like we should feel better off after be coming. That's what I think." [791.1]

"I just said that [Partner] and I hopefully will understand each other better. We have a lot of similar personal traits but also very different and he's coming from a different place than I am so we help other learn that the way that I argue or I see something or

how I approach a situation isn't completely different than the way he does it and I guess to be tolerant of each other." [882.1]

Only a few participants expressed expectations about the duration of therapy. These participants seemed to believe that their problems might take a long time to conquer. For those clients who reported expectations about the duration of therapy, these expectations seemed to have been formed after meeting at least once with the therapist.

[Participant] "I guess I sort of expected um, even though I knew that we didn't really need or we weren't coming here for a specific problem, I still sort of expected the counselor to um have us come to more sessions whether we felt like we needed it or not. I guess I just sort of assumed, maybe that's from previous experience working with..."

[Partner] "No, I think you're right. Like twice a week or something." [761.4]

"I think it'll take some time and eventually maybe we can understand where each other is coming from and form some sort of way that we can actually resolve things to arguing about the issues and that's when it would stop."[851.1]

Overall, clients expected therapy to be helpful to them and expected that their experience in therapy would be both positive and beneficial.

Experiences of Therapy

Most participants reported that therapy was a helpful and positive experience for them. Clients expressed satisfaction with the process of therapy and the tasks they had engaged in with their therapist.

"She was really good, [Therapist] seemed really good. Felt like she was pretty easy to talk to and helpful but not overly talkative I guess, not too verbose. Um, I think it was a good experience." [741.4]

"I think our communication overall has already changed as a result of therapy. We jokingly throw therapy terms at each other when we talk." [752.4]

"I can just say that I'm very satisfied with where things are going." [111.3]

"No I mean I expect it will be like this I mean these past two sessions have been pretty good and I can't imagine that I mean that the rest of the time is like this then it will be perfectly satisfactory I think..." [051.2]

Overall, clients seemed pleased with the process of therapy and expressed happiness about the goals they had achieved. Unfortunately, one couple who persisted in treatment became dissatisfied with the therapy process. The participants expressed concerns that therapy was not meeting their needs, yet were reticent to discuss this concern with their therapist.

"Well one thing I would, one thing I, I don't know what question this goes under but, one thing that I kind of, I don't know if I expected or maybe I just hoped for but I hoped for more concrete explanations sometimes. Because I know everyone's different in every situation and the relationship is different but sometimes I would just hope that you know she could tell me 'Well oh this, that follows this prior behavior like so this is what you can expect later' or 'This fits in with this kind of situation' but things just don't fit in like that and it's hard to put labels on things and I guess that would make it easier for me

because that's just the kind of person I am but that's one thing that, I don't know if I'd say I'm disappointed in because I know that it's not really a realistic expectation to have..." [042.4]

Overall, participants seemed pleased with their therapy experience. Participants reported that they experienced what they expected in therapy and were pleasantly surprised by unexpected occurrences. Clients seemed to believe that therapy would help them and that the process of therapy was beneficial.

Expectations over Time

An interesting theme that emerged during data analysis was the idea that clients actively thought about their expectations and formed some meta-expectations. Meta-expectations took two basic forms: expectations about the way that their expectations might influence the process of therapy, and predictions about expectations for the future. Some participants discussed the role that they believed their expectations would play in their experience of therapy.

"I tried not to have any, I've had to divorce myself as much as possible from having any like set expectations because I thought that might make...if I had this sort of idea of what my therapist would be like then that would, maybe if she didn't meet those expectations, would get in the way of us having like sort of a clean therapy experience. So I didn't really have a like a sort of a grocery bag of expectations for what she would be like." [751.2]

Other participants articulated impressions about things they might expect in the future. Participants talked about their current expectations, as well as expectations about future expectations.

"I'm afraid we're going to have to role play, she mentioned that. I'm like scared. That's about it, I don't know. I think it's going to get tougher. The first two times were easier just trying to identify where the issues are so now we're going to have to talk about those issues." [742.2]

"No, I do actually have one something that I suspect might happen is that it'll get a little more focused on us as individuals too. I actually expect that to happen maybe even after a couple sessions where we're not in here at the same time and kind of like, I can see that happening." [111.3]

"Well the whole thing seems kind of more self, a little more self motivated than I would have expected before so I guess I'm kind of expecting now that we'll continue to bring things in to talk about and kind of work them through through the course of the session. But it seems like we're also starting to do like homework assignment kind of things as well, so if that continues it'll probably become more of a focus in sessions like what to do over the week for homework and how that'll all pan out." [752.2]

The emergence of meta-expectations was an unexpected and interesting finding. It seems that the participants in this study began to think about their expectations and develop beliefs and meaning systems around those expectations.

Quantitative Data Analysis

To enhance the qualitative results and provide support for the qualitative findings, a quantitative analysis was performed. Quantitative records for each case included data from the measures obtained during the study. Prior to the first session and after the fourth session of

therapy, client participants completed an assessment packet as part of the clinic's routine data collection. The client intake assessment packet was completed by the clients prior to the first session. In addition to a demographic information form (which appears in Appendix I), the client intake assessment packet included the RDAS, URICA, OQ-45.2. The fourth session assessment packet was completed by the clients after their fourth session of therapy and included the RDAS, CTAS, and other measures of health collected as a part of the clinic's routine data collection process. Participant clients also completed the EAC-B before their first session and after their second, third, and fourth sessions.

Reliability and Validity

In quantitative studies validity refers to the principles that are used to evaluate the quality of the conclusions reached by the study (Shadish, Cook, & Campbell, 2002). Validity represents the extent to which an inference or conclusion approximates the truth (Shadish et al., 2002). In this study validity was enhanced in several ways. First, the measures used to represent various phenomena under examination were carefully selected. The measures that were selected are all widely used and have been subjected to psychometric evaluation. Participants were systematically recruited and participated in the study following uniform procedural guidelines. Finally, the data were managed using statistical software and analyzed using a common method of analysis to reduce the likelihood of data loss or miscalculations.

Reliability, in quantitative studies, refers to the level of consistency in of the measures used (Trochim, 2005). Classical test theory, also referred to as true score theory, states that all measurements are the sum of an individual's real, or true, score on a particular instrument and the error in measurement. An instrument that is reliable within a particular sample provides more consistent scores and is thought to more accurately capture the phenomenon of interest. Internal

consistency reliability is one way to estimate reliability (Trochim, 2005). Internal consistency reliability estimates represent to degree to which items that reflect the same construct yield similar results. Internal consistency estimates of reliability were provided following the description of each individual instrument used in this study.

Dyadic Data and Non-independence

In the social sciences, observations and data points are frequently not independent of one another. Dependence among observations can come from a variety of sources. Observations may be dependent because they are from correlated groups, share some common feature, or are arranged sequentially in time. Correlated groups within data most commonly arise when individual data points are nested within a grouping variable. Individuals in this study were nested within couples, resulting in non-independence in the data.

Non-independence is of concern in this study for two reasons. First, dependence among observations violates a key assumption of most inferential statistics. Most inferential statistics assume that the errors in observations are independently sampled and, thus, uncorrelated. If correlation exists among the errors, this source of variance remains included in the residual, or error, term and the resulting inferential statistics are biased (Kenny, 1995; Kenny & Judd, 1986). Depending on the size and direction of the interaction among data points, violation of the assumption of independence can bias test statistics, in some cases underestimating and in some cases overestimating errors (Cook, 1998; Kenny, 1995; Kenny & Judd, 1986). In the case of couple data, observations from the two members of the couple are commonly positively related, leading to an underestimation of the standard errors and an increased risk of Type I error (Newsom, 2002). Second, interdependence among people and observations are of interest in this study. Information about the degree to which partners influence one another addresses a key

research question in this study. Ignoring interdependence among partners would limit the information available to answer questions of influence.

Methods for addressing interdependence. Several methods for dealing with interdependence among observation have been developed. First, some researchers chose to split couple data, treating partners as independent units for the purpose of analysis (Kenny, 1995; Kenny, Kashy, & Cook, 2006). If both members of the couple are then analyzed, this approach does not remedy the problems inherent in nested observations. Errors may be over- or underestimated and interdependence cannot be modeled.

This has led other researchers to analyze data separately for each group of individuals if the members of the dyad are distinguishable by some feature such as gender. Using this approach, husbands and wives could be analyzed as separate groups of males and females. This does not violate the assumption of independence because only one individual per dyad is analyzed in each analysis; however, this approach makes it impossible to analyze shared variance or differences within and between couples (Kenny, 1995).

Others choose to combine data from both individuals to create a single couple score. Data are added or averaged to create one single score representative of the total or average couple observation (Kenny et al., 2006). Because there is only one observation per couple, the independence assumption is not violated. Though popular, this approach has serious conceptual and methodological problems. Theoretically, it implies that individuals within couples are lacking in difference so much so that they can effectively be combined into one person, and that the relationship can simply be represented by a sum of the parts. Methodologically, differences in partners' scores are obscured when they are combined (i.e. 50 and 100 can be combined for a score of 150 and an average of 75, as can two scores of 75; eliminating the meaningful

differences between those observations), resulting in the loss of valuable information (Kenny et al., 2006) and resulting in the inability of researchers to model differences within dyads.

Finally, a fourth approach to analyzing couple data is to analyze only the data from the most extreme partner (Kenny et al., 2006). This approach is commonly used in studies of phenomenon in which one partner has data that are very different from their partner such as in the study of psychopathology or depression in couple relationships. Though the assumption of independence is not violated, including in the analysis data from only one member of a couple eliminates the dyadic aspect of the data.

None of these methods are ideal. Although each approaches the study of nested observation from a slightly difference perspective, all gain independence of data points at the expense of valuable information about dyadic relationships. Rather than working to eliminate interdependence among observations, Kenny and colleagues (Cook, 1994; Kashy & Snyder, 1995; Kenny, 1995; Kenny & Judd, 1986; Kenny et al., 2006) have developed an analytical strategy that captures interdependence and explicitly models sources of interdependence in data.

The Actor-Partner Interdependence Model

The Actor-Partner Interdependence Model (APIM; see Cook & Kenny, 2005, for a description) was developed to explicitly model interdependence among observations. In this model, individual data are retained, allowing for the estimation of individual and dyadic features of the data (Kenny, 1995). The APIM is based on a longitudinal framework in which dyadic data are obtained at two time points or as an independent variable and outcome of interest. Figure 3 is the basic path model that represents the APIM.

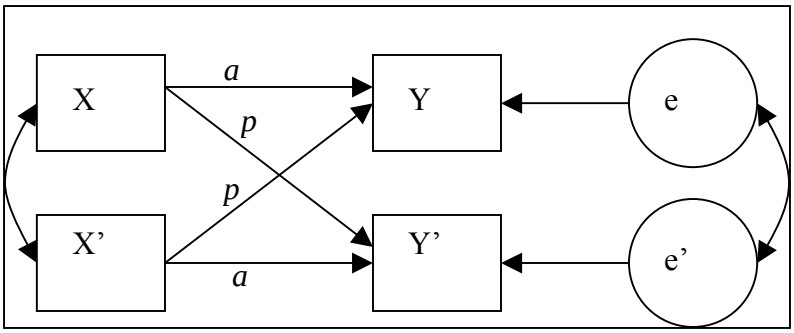

Figure 3: The Actor-Partner Interdependence Model. Adapted from Cook & Kenny (2005) and Kenny (1995).

Note: X = data for partner 1 at time 1; Y = data for partner 1 at time 2, or outcome; X' = data for partner 2 at time 1; Y' = data for partner 2 at time 2, or outcome; e = error; a = actor effects; p = partner effects

The two central components of the APIM are the *actor effect* and the *partner effect*. The actor effect, the straight lines noted by *a* in the figure, are an estimate of an individual's impact on herself. Actor effects represent intraindividual effects. Interdependence is modeled through the partner effect, represented by the diagonal lines and noted as *p* in the figure. A partner effect is the degree to which one partner's outcome is influenced by the other individual. Actor effects, if measured properly, should be estimated while controlling for partner effects (Cook & Kenny, 2005; Kenny, 1995). This provides an accurate estimate of one's own effect on oneself and one's effect on the partner. The APIM can thus accurately model interdependence dyadic data.

There are two additional noteworthy features of the APIM. First, independent variables are correlated in this model, as represented by the curved, bidirectional arrow between *X* and *X'* in the figure. By allowing the independent variables to correlate, one can control for shared variance in the outcomes. If either *X* variable predicts a *Y* variable, it can be done while controlling for the other *X* variable (Kenny, 1995). Through this statistical control, actor effects can be estimated while controlling for partner effects and partner effects estimated while controlling for actor effects. Thus, both actor and partner effects can be independently estimated. In addition, error terms are freed to correlate in this model. The extent to which the *X* variables

do not predict the *Y* variables is error. If the actor and partner effects were the only source of variation in the outcomes *Y*, when the partner effect is removed, *Y* and *Y'* should no longer be correlated. This is rarely the case. There are many likely sources of covariation in *Y* and *Y'* other than the partner effect, all of which are a part of the error in the measurement. Error terms are represented by *e* in the figure. The curved, double headed arrow in the diagram denotes that the errors can be correlated even after the covariation due to partner effect is removed. Specifying this type of correlation between the residuals models other sources of error, making it possible to control for other sources of non-independence.

Analysis of the APIM. The statistical analysis of the APIM is fairly straightforward for dyads in which persons are distinguishable by some characteristic. In all couples but one, the partners were distinguishable by gender. To analyze the quantitative data using the APIM, the one homosexual couple was removed from the data set so that the resulting couples represented distinguishable dyads.

The most common and simplest approach for estimating the components of the APIM is based on ordinary least squares regression analyses (Kenny, 1995). The pooled regression approach is one such method for estimating the APIM parameters. In this approach, two regression equations are estimated and the results are pooled together to obtain the APIM parameters (Kashy & Kenny, 2000; Kenny et al., 2006). One of the regression equations tests the within-dyad effects of the predictor variable. The other tests the between-dyad effects. The dyad is the unit of analysis so the assumption of independence is not violated. The researcher is interested in the magnitude and significance of the actor and partner paths. Estimates of the actor and partner effects are obtained when the results of the two regressions are pooled and can be interpreted as unstandardized regression coefficients. The significance of the paths is tested using

the *t* statistic. The presence of any partner effects indicates that there is some interpersonal influence or interdependence in the dyad.

To estimate the actor and partner effects using the pooled regression approach, two regression equations are computed. In the within-dyads regression, the difference between each partner's scores on the predictor variable (X_1 - X_2) are regressed on the difference between each partner's scores on the outcome variable (Y_1 - Y_2). The direction of the difference between *X*s and *Y*s is arbitrary. Because of this, the intercept should not be estimated in the within-dyads regression (Kenny et al., 2006). This results in a within-dyads regression equation of:

$$Y_{1i} - Y_{2i} = b_w(X_{1i} - X_{2i}) + E_{wi}$$

The between-dyads regression involves predicting the dyad mean of the outcome variable [(Y_1 + Y_2) /2] using the dyad mean of the predictor variable [(X_1 + X_2)/2]. This results in a between-dyads regression of:

$$\frac{Y_{1i} + Y_{2i}}{2} = b_0 + b_b \frac{X_{1i} + X_{2i}}{2} + E_{bi}$$

The regression coefficients from these two equations (b_b and b_w) are then used to estimate the actor and partner effects (Kenny et al., 2006):

$$actor = \frac{(b_b + b_w)}{2} \qquad partner = \frac{(b_b - b_w)}{2}$$

As was mentioned previously, both the actor and partner effects can be interpreted as unstandardized regression coefficients. To determine whether these effects differ significantly from zero, a *t* statistic can be calculated using the following equation for the pooled standard error (Kenny et al., 2006):

$$SE_p = \sqrt{\frac{s_b^2 + s_w^2}{4}}$$

The estimate of the effect is divided by the standard error to obtain a *t* statistic. The degrees of freedom for the *t* tests can be calculated as follows (Kenny et al., 2006):

$$df = \frac{([s_b^2 + s_w^2])^2}{\frac{s_b^4}{df_b} + \frac{s_w^4}{df_w}}$$

Significance testing of the *t* statistics can be done by examining a *t* table and locating the cut-off value for the desired level of significance with the correct number of degrees of freedom.

An example of the computation of the actor effect, partner effect, and associated parameters is illustrated following, in the "EAC-B factors and outcome" section. Because the use of hand calculation increased the likelihood of computational errors, a second individual who was not associated with the study was asked to confirm the computations. This individual was familiar with the APIM and regression-based statistical models but was blind to the research questions of the present study. She confirmed that all calculations were correct.

Models tested in the present study. Due to the very small sample size, the original research questions had to be modified to accommodate the limits of the data. The CTAS was not used as an outcome variable in this study. The instrument's reliability estimates were extremely low and there were insufficient observations to create a suitably stable distribution of outcomes. For these reasons, the CTAS was not used in any analysis. The RDAS at the fourth session was used as the outcome of interest in all equations.

A complex model with a large number of predictors simply could not be tested within the constraints imposed by the limits of the data. Therefore, the original model was separated into several smaller models, each of which could be tested with the extant data. The pooled-regression approach to testing the APIM was used to analyze the following research questions, depicted in Figures 4 – 7:

1. Do males and females differ significantly on scores on the EAC-B, URICA, RDAS, or SD subscale?
2. Do any of the four factors of the EAC-B at intake predict RDAS scores at the fourth session?
    a. Are actor effects significant?
    b. Are partner effects significant?

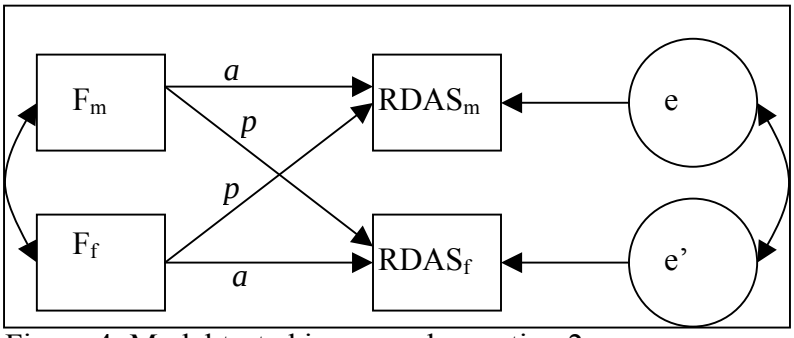

Figure 4: Model tested in research question 2.

3. Do URICA scores at intake predict RDAS scores at the fourth session?
    a. Are actor effects significant?
    b. Are partner effects significant?

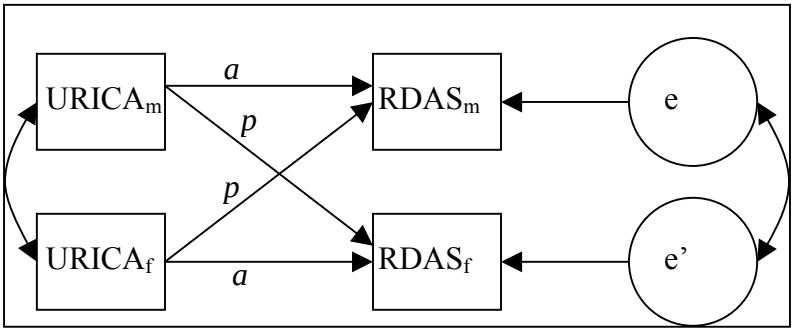

Figure 5: Model tested in research question 3.

4. Do SD subscale scores at intake predict RDAS scores at the fourth session?
    a. Are actor effects significant?
    b. Are partner effects significant?

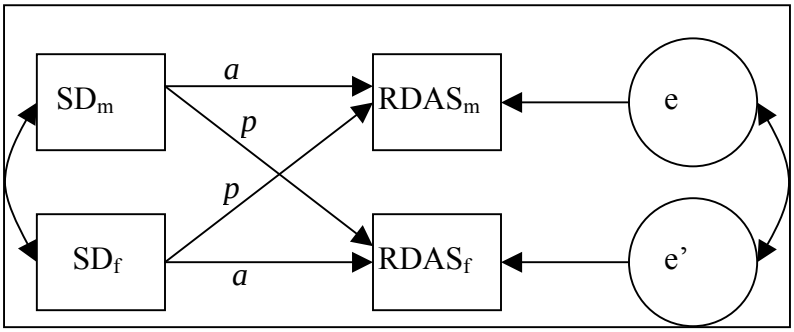

Figure 6: Model tested in research question 4.

5. Do RDAS scores at intake predict RDAS scores at the fourth session?
    a. Are actor effects significant?
    b. Are partner effects significant?

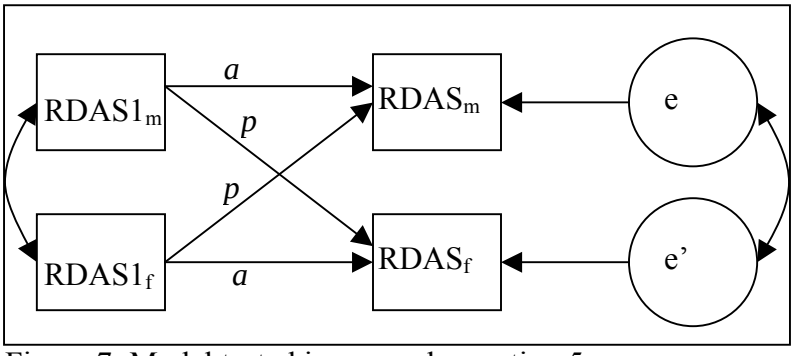

Figure 7: Model tested in research question 5.

Results –Quantitative Data Analysis

Preliminary Data Analysis

Attrition analysis. Data for many couples in this study were incomplete. Seven couples terminated from therapy prior to the end of the study. Six of those couples terminated therapy

after the first session; one other couple terminated therapy after the second session. Due to their nonparticipation in therapy, they were unable to continue research participation. An attrition analysis (Miller & Wright, 1996) was conducted to determine if differences existed between those individuals who continued treatment and complete the protocol and those who do not. There were no significant differences between those individuals who completed the protocol and those who did not.

Basic properties of the data. Means and standard deviations for each variable are presented in Table 4.2. Males' and females' scores on the instruments were combined for the correlation tables in order to present the results more simply. Correlations between quantitative variables are presented in Tables 2 – 6.

Table 2: Means and standard deviations for quantitative variables.

	Males			Females		
Variable	*M*	*SD*	n	*M*	*SD*	n
OQ Intake	48.1	24.0	14	60.2	24.5	12
SD Intake	26.7	13.1	14	35.8	15.5	12
URICA Intake	103.9	8.4	14	103.8	18.2	12
RDAS Intake	44.5	16.2	14	44.9	10.3	11
URICA 4th	110.5	6.5	6	100.6	8.4	5
RDAS 4th	52.8	3.2	4	49.4	6.5	5
Personal	6.8	0.7	14	6.0	0.7	11
Facilitative	6.1	0.6	14	5.4	0.7	11
Expertise	5.9	0.7	14	4.6	1.1	12
Nurture	4.8	0.5	14	4.7	0.9	12
Personal 2nd	5.9	0.8	6	6.2	0.5	3
Facilitative 2nd	5.6	0.5	6	5.4	1.0	5
Expertise 2nd	4.2	0.5	6	4.5	1.5	5
Nurture 2nd	4.8	0.9	6	5.0	1.3	5
Personal 3rd	6.0	0.6	8	6.0	0.6	4
Facilitative 3rd	5.5	0.7	8	5.1	0.7	5
Expertise 3rd	4.3	0.7	8	4.4	0.7	6
Nurture 3rd	4.9	0.8	8	4.6	0.6	6
Personal 4th	5.8	0.8	6	6.4	0.6	4
Facilitative 4th	5.3	0.7	6	5.6	0.7	5
Expertise 4th	4.3	0.7	6	4.8	0.8	5
Nurture 4th	5.0	0.5	6	5.2	0.6	4

Table 3: Correlations.

Variable	1	2	3	4	5	6	7	8
1. OQ 1st	--							
2. SD 1st	.97**	--						
3. URICA 1st	.21	.20	--					
4. RDAS 1st	-.36	-.28	-.25	--				
5. OQ 4th	.90**	.92**	-.64	-.91**	--			
6. SD 4th	.89**	.92**	.21	-.87*	.98**	--		
7. URICA 4th	-.34	-.32	.69*	.13	-.62	-.62	--	
8. RDAS 4th	-.59	-.53	.36	.95**	-.87*	-.89**	.08	--

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

Table 4: Correlations.

Variable	9	10	11	12	13	14	15	16
9. Personal 1st	--							
10. Facilitative 1st	.78**	--						
11. Expertise 1st	.60**	.62*	--					
12. Nurture 1st	.70**	.84**	.71**	--				
13. Personal 2nd	.92**	.80*	.49	.69	--			
14. Facilitative 2nd	.78*	.93**	.75**	.83**	.88**	--		
15. Expertise 2nd	.45	.62	.96**	.72*	.35	.69*	--	
16. Nurture 2nd	.85**	.84**	.82**	.86**	.72*	.88**	.69*	--

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

Table 5: Correlations.

Variable	17	18	19	20	21	22	23	24
17. Personal 3rd	--							
18. Facilitative 3rd	.77**	--						
19. Expertise 3rd	.18	.36	--					
20. Nurture 3rd	.53	.83**	.46	--				
21. Personal 4th	.46	.14	-.70*	-.11	--			
22. Facilitative 4th	.16	.30	-.43	.05	.74	--		
23. Expertise 4th	-.36	-.16	-.04	-.01	.07	.68*	--	
24. Nurture 4th	-.03	.21	-.33	.32	.48	.72*	.64*	--

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

Table 6: Correlations.

Variable	1	2	3	4	5	6	7	8
9	.21	.28	.24	-.06	-.14	-.01	.29	-.07
10	.05	.10	.29	-.19	-.45	-.37	.36	-.04
11	.34	.36	.30	-.45*	.61	.67	.04	-.16
12	.06	.13	.38	-.13	-.79*	-.72	.38	.47
13	-.12	-.11	.30	-.28	1.0**	1.0**	.54	-.24
14	.23	.27	.72*	-.31	-.44	-.50	.75	-.55
15	.79**	.80**	.63*	-.63	.92**	.89	-.43	-.18
16	.15	.24	.53	-.28	-.10	-.17	.49	-.51
17	-.25	-.16	-.15	.07	.08	.17	.24	-.17
18	-.50	-.39	-.09	.57*	-.56	-.49	.22	.41
19	.01	.13	-.31	.09	.53	.50	-.30	-.07
20	-.93**	-.58*	-.03	.58*	-.95**	-.93**	.25	.64*
21	-.24	-.29	-.04	-.19	-.29	-.21	.01	-.18
22	-.22	-.25	-.30	-.05	-.29	-.28	-.32	.04
23	.08	.09	-.38	.14	.08	.01	-.71*	.25
24	-.46	-.41	.11	.50	-.83*	-.82*	-.21	.57

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

Many correlations were in the expected direction and of the expected significance (i.e. subscales were highly positively correlated with their measure; scores on measures were highly positively correlated across time points). One other correlation is of particular interest. Scores on the SD subscale and the Nurture subscale at the fourth session are negatively correlated, $r = -.82$, $p < .05$, suggesting that individuals who have expectations of a nurturing, accepting, and attractive therapist are those who are less individually distressed at the fourth session.

Main Data Analysis

The purpose of the quantitative analysis was to determine to extent to which intake variables predicted scores on the RDAS at the fourth session. The intake variables examined were the four factors of the EAC-B, the URICA, the SD subscale of the OQ-45.2, and the first session RDAS scores. To capture the dyadic features of the data, the APIM was used and actor

and partner effects tested. Gender differences in actor and partner effects were not tested because it was impossible to do so within the limits of the sample size.

Individual differences. To determine whether individuals in couple therapy had similar scores on the EAC-B factors, URICA, RDAS, and the SD subscale of the OQ-45.2, several paired-samples *t* tests were conducted. Results revealed no differences between males and females on any variable. Males and females were similar with regard to initial marital distress, as measured by the RDAS, $t(10) = .40$, $p = .70$ and initial individual distress, as measured by the SD subscale of the OQ-45.2, $t(11) = -1.52$, $p = .16$. Individuals also had similar scores on the URICA, $t(11) = -.27$, $p = .79$, and all four factors of the EAC-B [Personal, $t(10) = -1.71$, $p = .12$; Facilitative, $t(10) = -.85$, $p = .42$; Expertise, $t(11) = .33$, $p = .75$; and Nurture, $t(11) = .33$, $p = .75$]. At the fourth session, scores did not differ on the RDAS, $t(3) = .90$, $p = .44$. These results indicated that males and females had similar scores on all measures of interest in this study.

EAC-B factors and outcome. To determine if any of the four factors measured by the EAC-B were predictive of RDAS scores at the fourth session, four pooled-regression tests of the APIM were conducted. To obtain results for the four factors, eight separate regressions were run. To reduce the likelihood of Type II errors, a Bonferroni correction was used to adjust the *p* value required to determine a test result significant. A *p* value of .01 (.05/8 = .00625) was used to determine whether the actor and partner effects differ significantly from zero.

To illustrate the calculations required for a test of the actor and partner effects using the pooled regression approach, the estimation of the parameters for the first model are described. Data required to perform the calculations for the estimation of all other models appear in Tables A1 – A4 in Appendix J. In the first model, scores on the Facilitative factor of the EAC-B were

used to predict RDAS scores at the fourth session. First, the actor effect was estimated using the formula described above.

$$actor = \frac{(b_b + b_w)}{2} = \frac{(-8.51) + (-4.17)}{2} = -6.34$$

Next, the partner effect was estimated.

$$partner = \frac{(b_b - b_w)}{2} = \frac{(-8.51) - (-4.17)}{2} = -2.17$$

As was mentioned previously, both the actor and partner effect estimates can be interpreted in the same way as unstandardized regression coefficients (Kenny et al., 2006). To determine whether actor and partner effects differed significantly from zero, a *t* test was conducted. To do this, the pooled standard error was calculated.

$$SE_i = \sqrt{\frac{s_b^2 + s_w^2}{4}} = \sqrt{\frac{7.61^2 + 12.62^2}{4}} = \sqrt{\frac{57.91 + 159.26}{4}} = \sqrt{54.29} = 7.37$$

To obtain the *t* statistic, the actor and partner effects are divided by the pooled standard errors associated with the between and within regression coefficients.

$$t_a = \frac{a}{SE_i} = \frac{-6.34}{7.37} = -0.86$$

$$t_p = \frac{p}{SE_i} = \frac{-2.17}{7.37} = -0.29$$

To determine if the results of the *t* tests were significant at the $p = .00625$ level, the degrees of freedom were calculated.

$$df = \frac{\left([s_b^2 + s_w^2)\right]^2}{\frac{s_b^4}{df_b} + \frac{s_w^4}{df_w}} = \frac{(57.91 + 159.26)^2}{\frac{3353.81}{4} + \frac{25365.15}{4}} = \frac{47162.81}{838.45 + 6341.29} = 6.57$$

After consulting with published *t* tables, it was determined that neither the actor nor the partner effect was significant at the required level. Neither the actor nor the partner effect of scores on the Facilitative factor of the EAC-B predicted RDAS scores at the fourth session. Following this

example, only the results of the analyses are presented. The reader can calculate the APIM parameters using the information provided in Appendix J.

Tests of the Personal and Expertise factors determined that neither actor nor partner effects were significant for those factors. Results of the effect of the Personal factor on RDAS scores were not significant for either effect, actor = -2.44, $t(4.94) = -1.10$, $p > .05$, partner = 5.69, $t(4.94) = 2.56$, $p > .01$. For the Expertise factor, the results were also not significant, actor = -2.65, $t(3.12) = -.42$, $p > .05$, partner = -3.28, $t(3.12) = -.52$, $p > .05$. These results suggest that the actor and partner effects of the Personal and Expertise factors of the EAC-B did not significantly influence RDAS scores at the fourth session.

Results of the tests of the actor and partner effects of the Nurture factor on RDAS scores at the fourth session were significant for the actor effect, actor = 14.98, $t(6.38) = 3.76$, $p < .01$, partner = 1.45, $t(6.38) = .36$, $p > .05$. As was mentioned previously, the actor and partner effects can be interpreted as unstandardized regression coefficients. This result can, then, be interpreted to mean that for each one point increase in one's own scores on the Nurture factor of the EAC-B, one's own RDAS scores at the fourth session increase by 14.98 points, on average. The average RDAS score at the fourth session was 51.1, with a standard deviation of 4.85. A 14.98-point difference in RDAS scores represents a change more than two standard deviations above the mean, which is an important difference. This indicates that individuals who expect greater nurturance and empathy from their therapist are generally more relationally distressed at the fourth session. For all individuals, scores on the Nurture factor at the first session and the RDAS at the fourth session were moderately positively correlated, $r = .47$, $p > .05$, indicating that individuals with higher scores on the Nurture factor were more relationally distressed.

URICA scores and outcome. To determine if the actor or partner effects for URICA scores on RDAS at fourth session were significant, a pooled-regression test of the APIM was conducted. To perform this test, two regressions were completed. To reduce the likelihood of Type II errors, a Bonferroni correction was used to determine the adjusted *p* value of .025 (.05/2 = .025) was used. Results indicated that neither the actor nor the partner effect of URICA scores on fourth session RDAS scores were significant, actor = .07, $t(6.55) = .15$, $p > .05$, partner = .11, $t(6.55) = .23$, $p > .05$. These results suggest that actor and partner effects of the URICA are not significant predictors of RDAS scores at the fourth session of therapy.

SD scores and outcome. To determine if the actor or partner effects of the scores on the SD subscale of the OQ-45.2 were predictive of RDAS scores at the fourth session, a pooled-regression test of the APIM was conducted. In this test, the extremely small sample size resulted in two few degrees of freedom to analyze the actor and partner effects. Despite the inability to test the significance of the effects, the *t* test values were high, which may indicate that the results would have been significant had there been sufficient data [actor = -.44, $t(E) = -4.89$; partner = -.20, $t(E) = 2.22$]. Unfortunately, insufficient data prevented further testing of this model

RDAS and outcome. Finally, a pooled-regression test of the APIM was conducted to determine if one's own or one's partner's scores on the RDAS at intake were predictive of scores on the RDAS at the fourth session. In this test, as in the previous test, there was insufficient data to determine the degrees of freedom, which prevented significance testing. Results suggested that had there been sufficient data to merit a test of significance that the actor effect may have been significant [actor = 1.05, $t(E) = 6.56$; partner = .05, $t(E) = .31$]. Again, the shortage of data prevented significance testing of this model.

CHAPTER 5

DISCUSSION

This study provides some initial evidence that couples in therapy form expectations about their therapy experience. Previous research in an individual therapy setting has suggested that clients form expectations regarding several key aspects of psychotherapy. These expectations have been grouped into three categories: role expectations, process expectations, and outcome expectations. Role expectations are expectations about the personality, training, and behavior of the therapist as well as the behavior of the client. Process expectations include beliefs about the things that will and should happen during therapy. Outcome expectations refer to the hope or expectation that therapy will be effective and results will be achieved in a timely fashion. Results of this study tentatively support the existence of role, process, and outcome expectations in couple therapy.

Discussion of Qualitative Results

Most participants in this study identified a wide range of role expectations and generally had more than one expectation which could be categorized as a role expectation. Clients described expected aspects of their therapists' personality, education, and training and were able to articulate ways they expected such traits to influence their therapy experience. Clients expected to be challenged and supported by an empathetic and caring therapist. Participants also expected that their therapist would have sufficient experience and training to provide them with the help they were seeking. Interestingly, clients also expressed a clear expectation that their therapist would be both young and a student in graduate school. It seems that clients may have expected a graduate student, but hoped that this student would have the skills and experience

necessary to help them. Perhaps clients were able to develop a picture of a therapist that balanced their desire for an experienced helper with the information they received prior to therapy regarding their therapists' student status.

Role expectations, in this study, were generally confirmed. Most participants found that their therapist was helpful, warm, and empathetic. Participants also expressed satisfaction with their therapists' level of training and experience. Some clients experienced disconfirmation of their role expectations. Generally, this disconfirmation was the result of a therapist differing in appearance or behavior from that which was expected. Research in individual therapy has suggested that clients who experience disconfirmation of their role expectations are generally dissatisfied with treatment (Gladstein, 1969; Glass et al., 2001; MacNair-Semands, 2002; Wilkins, 1973a; Wilkins, 1973b). However, this did not appear to be the case for the couples participating in this study. Clients seemed able to easily adjust to unexpected role experiences. Perhaps this is because clients had a partner with whom they could discuss discrepancies between their experiences and expectations. This discussion may have enabled clients to develop a shared meaning of the disconfirmation and incorporate new meanings into their expectations. It is also possible that one partner's expectations were disconfirmed, while the other partner's expectations were confirmed. Through discussion about their experiences, couples may have been able to process their experiences and form beliefs about the disconfirmed expectations. It is possible that having one's partner in therapy enabled participants to discuss disconfirmations with a trusted individual and incorporate new information into their understanding of therapy.

Results of the qualitative inquiry also suggested that clients in couple therapy formed process expectations prior to their first therapy session. Nearly all participants reported that they expected to talk about their problems, the events that led up to their problems' development, and

the ways in which those problems impacted their individual and couple functioning. This finding was consistent with findings from individual therapy (Bordin, 1955; Gladstein, 1969; Glass et al., 2001; Joyce et al., 2000). An interesting finding related to process expectations was the discovery that many clients expected their therapy dialog to include both individual and shared problems. These clients expected to talk about the ways in which individual concerns impacted their couple relationship. This relational focus has not been found in previous studies of individual therapy, perhaps because clients in individual therapy expect therapy to focus solely on individual problems. That participants in this study were able to articulate systemic elements of the conversations that they expected in couple therapy suggests that some clients have a fairly sophisticated understanding of couple therapy. Participants in this study seemed to believe that individual and relational dynamics were influential in the formation of their problems. This finding is promising in that marital and family therapy may be increasing in visibility and public understanding of the field.

In general, clients reported that they experienced a confirmation of their process expectations. Participants reported that they did talk about their problems with their therapist and that these experiences were helpful. Again, this result is consistent with findings from research in individual therapy (Joyce et al., 2003; Meyer et al., 2002; Mueller & Pekarik, 2000; Pekarik, 2002). Participants in this study also reported that they believed most of the tasks of therapy were related to their presenting problem. For a few clients; however, some tasks of therapy seemed strange or confusing. These participants reported that they were, at times, confused about the relationship of the tasks of therapy to their presenting problems, but reported that they were not disappointed or displeased with the tasks. Despite their confusion, the clients reported that they trusted their therapists' judgment and were pleased with the progress of therapy.

Participants in this study reported that they expected therapy to be helpful to them in achieving their goals. Clients generally expected the outcome of therapy to be positive and continued to have positive expectations about therapy following the first session. This finding is consistent with results obtained in studies of individual therapy outcome expectations (Noble et al., 2001; Rosenthal & Frank, 1956; Wilkins, 1973b). Participants had differing views about what type of positive results they would experience. Some clients reported that therapy would be a positive experience because it would resolve their presenting concerns; others reported a belief that therapy would help them understand their partner better, and some reported that therapy would be helpful because it would normalize their experiences.

In general, participants reported that they were pleased with their therapy experience. Most clients reported that their therapist was helpful and that the tasks of therapy aided them in achieving their goals. Unfortunately, six couples discontinued therapy prior to the end of the study. It is possible that these couples were dissatisfied with therapy; however, no information was obtained from them after they discontinued treatment. Overall, clients seemed to have a positive experience in therapy.

Discussion of Quantitative Results

Results of the quantitative analysis included several promising findings. First, internal consistency coefficients were high for the EAC-B. Though the EAC-B is frequently used in studies of expectations in therapy, little is known about its psychometric properties. High internal consistency ratings provide some psychometric support for the use of this instrument in couple therapy.

Results of the examination of the actor and partner effects of various variables on scores on the RDAS at the fourth session showed mixed results. Tests indicated that only the actor

effect of the Nurture subscale of the EAC-B was significant in predicting RDAS scores at the fourth session. This result indicates that clients who expect their therapist to be nurturing and empathetic generally experience an increase in their own RDAS scores at the fourth session. This indicates that individuals who expect greater nurturance and empathy from their therapist are generally more relationally distressed at the fourth session. Perhaps this is because clients who expect that their therapist will be nurturing and comforting feel comfortable in sessions to express more negative emotion and hostility, which results in increased distress. It is possible that clients who expect an empathetic therapist feel free to discuss the extent of their distress and to do so in great detail, which may temporarily increase feelings of relational distress. No information was available on clients past the fourth session to determine if clients experienced relief of their relational distress after the fourth session.

Several tests of relationships between variables in this study yielded nonsignificant results. First, none of the partner effects were significant in any test. For this sample, partner effects were not significant predictors of outcome. The extremely small sample size prevented the significance testing of the actor and partner effects of the SD subscale and the RDAS scores at intake on the RDAS scores at the fourth session. It is likely, due to the size of the effects, that these results may have been significant. The small sample size also prevented the testing of gender differences in expectancy effects. There were insufficient observations to determine if males' and females' outcomes differed based on actor or partner effects. Unfortunately, the small sample size presented a challenge for data analysis.

Implications

The results of this study are valuable to researchers and clinicians in family therapy for a number of reasons. First, the results of this study provide tentative support for the conclusion that

clients form expectations about couple therapy prior to engaging in therapy. The findings extend the literature on expectancy effects into the couple therapy domain. Further, the results of this study suggest that clients in couple therapy form expectations that are similar in content to the expectations formed in individual therapy. These expectations can be categorized as role expectations, process expectations, and outcome expectations.

Of all the expectations elicited from clients as a part of this study, role expectations seem to be the most important. During the interviews, participants stated more role expectations than any other type of expectation. Clients generally reported more than one role expectation, and seemed to have formed a clear picture of what they expected their therapist to be like. Role expectations were also likely to be confirmed during the course of therapy. These findings suggest that clients enter into therapy with a clear sense of the traits their therapist will possess. Participants in this study expected a warm, empathetic, and supportive therapist who was able to challenge them and provide advice when necessary.

Therapists should be sensitive to clients' expectations for the roles that they and the clients will play in therapy. It may be helpful for the therapist to ask clients about their expectations. Knowing what clients expect could provide therapists with valuable information about the preferences of the clients. For example, the client who expects a therapeutic environment in which they will be comforted and supported may not be satisfied with a therapist who is confrontational. Alternately, the client who expects immediate advice and suggestions for improvement may not be satisfied with therapy sessions that focus on self-disclosure and understanding. Simply knowing what clients expect may aid the therapist in either meeting the needs of the client.

In addition to the personal traits of the therapist, clients seemed to form clear expectations about the age and training of their therapist. Several participants reported that this was the result of their advance research, including internet-based research, about the therapist. Individual therapists and clinics or practice groups should be aware of the information that is available about their practice and therapists on the internet. Clinics may wish to enhance the quality and quantity of information about therapists and therapy available to potential clients in brochures or on the internet. The availability of such information could serve as a good introduction to therapy, aiding clients in the formation of expectations that are both realistic and conducive to a successful therapy experience.

Though most participants expressed some expectations about the process of therapy during the qualitative interviews, these expectations were not directly linked to any quantitative variable. In addition, process expectations were occasionally disconfirmed by actual therapy experiences. One possible explanation for these findings is that clients who have not participated in therapy have limited exposure to therapy conditions and may simply not have a clear picture of what happens during therapy. Most participants in this study expected that therapy would involve talking, both on their part and the part of the therapist. In most depictions of therapy in the media, the participants are all talking (Orchowski, Spickard, & McNamara, 2006). Psychotherapy is colloquially referred to as "talk therapy". It is safe to assume that most clients who enter into therapy will expect to talk.

This research is useful because it provides preliminary information about what, specifically, couple therapy clients expect to talk about. Not surprisingly, most clients expected to talk about their problems. Some participants were able to articulate a clear, and occasionally lengthy, list of the topics they believed to be important. Clinicians and researchers should

explore this information with clients. Therapists could ask clients what things they would like to talk about and explore with clients the topics that the clients believe are relevant to their problem as a way to join with clients early in therapy. Researchers and therapists may wish to explore clients' conceptualizations of the problems they experience. It would be interesting to learn why clients believe certain topics are related to their presenting problem. It may also be helpful to determine what topics clients believe are relevant to the domain of particular presenting problems. For example, it may be useful to clinicians and researchers to determine which things clients think would be relevant to the presenting problem of poor communication.

Finally, participants in this study had positive outcome expectations. Participants expected that therapy would be successful and most reported that they were pleased with the results they achieved. Despite the general expectation that therapy would be helpful, there was little agreement across participants about how therapy would be helpful. For some participants, a successful therapy experience meant that their presenting problems would be resolved. For others, a successful outcome would be achieved if they were supported by the therapist as they struggled with a problem or difficult experience. Therapists may wish to define a successful outcome with clients early in therapy. Knowing what outcome clients expect and the things they perceive as essential to a successful outcome would aid therapists in planning a course of treatment that meets the needs of the clients.

Differing definitions of success has ramifications for researchers, as well. In most studies of psychotherapy dropout, dropout is defined as discontinuing attendance prior to discussing termination with a therapist or prior to the agreed-upon number of sessions (Pekarik, 1992; Wierzbicki & Pekarik, 1993). It is possible that some of the clients who have been identified as dropouts for research purposes may simply have achieved their therapy goals in a short period of

time. If the clients' goal for treatment is to be supported and to have their problems normalized, it is possible that they could achieve this goal in a very short period of time. Researchers could benefit from an analysis of clients' goals for treatment as indicators of successful, or timely, termination.

Overall, this study makes several important contributions of the study of expectancy effects. It has provided support for the conclusion that therapy clients form expectations about therapy. Results of this study enhance the body of knowledge related to client expectations for therapy. Though this study makes several meaningful contributions to the literature, there are some limitations that must be considered when interpreting the results of this study.

Strengths and Limitations

As with any research, this study has strengths and limitations. Several challenges existed that likely influenced the results of this study. The primary limitations of this study have to do with the sample size. Having so few participants limited data analytic options and weakened the power of the tests. Other limitations were related to the study design and the sample solicited for analysis.

External Validity

There are several factors which may influence the external validity of this study. One such factor is both a strength and limitation. The sample was a convenience sample gathered from a single university training clinic in the Southeastern United States, which led to over-representation of certain populations and under-representation of others. Participants in this study were generally young, highly educated Caucasians. Such a population is different from the populations served by many local clinics. Furthermore, therapy was conducted by students under supervision. The results of this study may not apply to licensed therapists operating in private

practice as educational settings differ from community-based settings. Despite these limitations, the sampling procedure offered some benefits. First, the population served at the clinic represents individuals with a wide range of socioeconomic statuses. The participants were generally participating in therapy for the first time, and may have had limited exposure to therapy through family and friends. Such characteristics of the sample offered an opportunity to access a diverse sample.

Construct Validity

Threats to construct validity are important areas of concern in this study. Several measures used in this study were developed for use in individual therapy. These measures may not have measured the constructs of interest in the same manner for all individuals. In addition to challenges presented by the instrumentation, no information was collected as to the nature of the therapists' expectations or the therapy received.

The measure of expectations used in this study may have been limited in its utility for capturing the nature of couple therapy expectations. The EAC-B was developed for use with individuals in psychotherapy based on the domain of individual psychotherapy expectations. For example, the questions are worded in the first person (e.g. "I expect…) and do not address partner experiences (e.g. "My partner expects…). It is possible that aspects of the domain of couple therapy expectations are not represented by the constructs measured in the EAC-B. Further, there have been no studies of measurement invariance of the EAC-B. It is not known if the EAC-B measures the construct of expectations consistently across income groups, or between males and females, both ways in which participants in this sample differed from one another. The researcher attempted to reduce the impact of this limitation by including other measures of the construct of expectancy. Interviews with participants provided additional

information about expectancy effects in couple therapy; however, measurement problems may have impacted the results.

Both the OQ-45.2 and the URICA were also developed for use in individual therapy. There is some evidence to indicate that both of these scales fail to provide consistent measures of the constructs in couple therapy. Several researchers have called into question the factor structure of the OQ-45.2 (Mueller at al., 1998) and the relevance of particular questions (Vermeersch et al., 2000). Most concerning, there is some evidence to indicate that there is measurement variance between males and females on the OQ-45.2 (Johnson, Ketring, Anderson, & Tambling, under review). Specifically, results of this study indicated that the OQ-45.2 may measure males and females on different latent scales and that the SD subscale was measured more reliably for females than males (Johnson et al., under review).

Similar concerns exist regarding the URICA. It was developed for use with individual respondents. It is possible, despite its widespread use, that it does not appropriately measure stages of change in relational therapy. Preliminary evidence from one study (Tambling & Johnson, in press) suggested that males exhibited more variable scores on the URICA than did females. Further, it is possible that an individual may be motivated to change their partner, but not themselves, and thus engage in couple therapy. The URICA does not address motivation to change one's partner. To remedy this deficiency, Schneider (2003), developed the Stages of Relationship Change Questionnaire. This instrument represents a new, but important contribution to the field of couple therapy. The Stages of Relationship Change Questionnaire was not used in this study for several reasons. First, at the time of this study's inception, the measure had not been published. Further, the URICA has been examined psychometrically and has a wide range

of data to support its validity. Without such evidence to support the Stages of Relationship Change Questionnaire, it did not seem prudent to use the newer measure.

There was no information obtained about the nature of the therapy participants received. Multiple therapists were used in this study and it is likely that they had different styles or approaches to therapy. Some therapists may have addressed expectations overtly with clients; others may not have done so. One participant commented that his therapist had asked him about his expectations for therapy. This was the only mention of such an occurrence; however whether therapists address expectations or not has the potential to influence behaviors and impact the outcomes of interest.

Therapists' expectations for couple therapy may have impacted the results, as well. Therapists may expect their clients to be more self-disclosing, to be more active, or to be more resistant to changes. Therapists may expect different behaviors from themselves during therapy. Some therapists may see their role in therapy as that of the supporting, empathetic therapist; others may be more challenging, confronting clients more often than their counterparts. It is possible that therapists' expectations influenced the therapy experience in important ways. For example, if a therapist expects that she will be nurturing and facilitative of self-disclosure on the part of the clients and her clients expect that she will provide immediate and concrete suggestions about how to resolve their problems, this mismatch in expectations may influence the outcome of the therapy. It is unknown how these differences might have impacted the results of the study. Future research should include an assessment of therapist expectations to address this concern.

Conclusion Validity

Finally, there are several threats to conclusion validity in the present study. The sample size was extremely small, particularly at the fourth session. The veracity of the results of the tests that were conducted is called into question in the case of extremely small samples. It is likely that there was insufficient statistical power to accurately observe differences in the data, rendering the statistical tests ineffective. The results of the analyses that were conducted may be limited in their validity due to instability in the data. With a small sample, outliers in the data are over-represented and any measurement error is especially problematic. Such problems in the data may impact the validity of the statistical tests. Further, limitations based on the size of the sample prevented the analysis of several research questions. Having a small number of participants and a large number of variables of interest presented a challenge for data analysis. Methods for answering research questions had to be adjusted to accommodate the limitations of the data.

There are drawbacks to the ordinary least squares regression approach to testing the APIM. First, this method does not allow a researcher to test for differences between the two actor effects or the two partner effects. This makes it impossible to determine if one partner in the dyad is more influential than the other or to determine if there are gender differences in actor and partner effects. Second, it does not allow for a test of differences between actor and partner effects within on individual. In other words, one cannot determine whether the actor or the partner is responsible for more variation in the outcome of the actor. The regression based model also does not allow for negative non-independence. Non-independence can be negative as well as positive, though it is typically interpreted as being positive in nature (Kenny, Mannetii, Pierro, Livi, & Kashy, 2002). Negative non-independence occurs when dyadic partners differentiate from one another and their mutual influence separates their opinions or beliefs. It is not possible

to model negative effects in the regression-based model. Finally, the regression-based approach does not permit the researcher to pool effects across partners. It is possible that neither partner effect alone is significant, but that the pooled partner effect is significantly different from zero. From this, one could conclude that there are partner effects, but that both partners have a similar level of influence or that partner effect is a result of a shared meaning-making process rather than of direct influence. Tests of pooled effect generally have more power than tests of single effects (Kenny & Cook, 1999), though this type of testing is not possible in the ordinary least squares approach. To address these deficits, several researchers have suggested as multilevel approach to the examination of the APIM (Cook & Kenny, 2005; Kenny et al., 2002; Raudenbush, Brennan, & Barnett, 1995). Unfortunately, the sample size in this study was not sufficient to permit a multilevel approach to the analysis.

Limitations of the Qualitative Analysis

Like the quantitative component of this study, the qualitative design and analysis presented several limitations. First, couples were interviewed conjointly. It is possible that individuals within couples formed expectations that were dissimilar to those of their partner. Individuals may have been hesitant to mention expectations that conflicted with or were in contrast to those that their partner presented during the interview. Future research which examines individuals separately would be beneficial. Next, qualitative interviews were conducted by five different people, the researcher and her four undergraduate assistants. It is likely that each person conducted the interviews differently. Though training was provided by the researcher and a protocol was established and discussed frequently, interview styles undoubtedly varied. Variation in the interviews may have elicited different things from participants. Further, the researcher is a therapist herself and many of the participants knew this.

It is possible that the researcher's therapist status afforded her different access to participants' expectations. Finally, the qualitative analysis was undoubtedly influenced by the researcher's biases. The researcher is a therapist and has researched couple therapy processes and outcomes. The researcher also conducted a thorough review of the expectancy effects literature prior to beginning this study. Through these experiences biases and expectations have been formed which likely influenced the categorization, coding, and naming of themes.

Future Research

Though this study provides some preliminary evidence that couple therapy expectancy effects exist and are similar to the effects clients experience in individual therapy, there were several areas of concern. Additional research is merited to determine what role expectations play in couple therapy. Future research that addresses the limitations of the present study could enhance the quality of research on couple therapy expectancy effects.

Future research which examines the psychometric properties of the URICA, OQ-45.2, and EAC-B in samples of couple therapy clients would be beneficial. As mentioned previously, it is unknown whether these three instruments are appropriate for use in a couple therapy setting. Further, future studies which affirm measurement invariance of the URICA, OQ-45.2, and EAC-B among diverse groups are merited. In particular, little is known about the measurement properties of the EAC-B and the URICA. As mentioned previously, it is possible that these instruments provide inconsistent or variant measurement among males and females or among members of different ethnic or income groups. Additional information about the psychometric properties of these instruments, particularly in a relational therapy setting, would enhance the study of expectations in couple therapy.

Future research should include therapist reports of their expectations. It is likely that therapists' expectations for therapy influenced therapy outcomes. Obtaining information about therapists' expectations, either through questionnaires or observational coding of therapists' in-session behaviors related to expectations, would likely be valuable. By adding an additional level of data, future researchers could determine the extent to which therapists' expectations and behaviors influence expectation communication and therapy outcomes. Future research should also interview members of couples separately to obtain information about individuals' expectations. More information about the expectations formed by each individual for couple therapy would make a valuable contribution to the expectancy effects literature.

Future research should examine expectancy effects in diverse populations and from diverse service areas. It is unknown whether clients in community-based therapy settings form different expectations than clients in university-based settings. Few studies have addressed demographic differences in expectancy effects. It is unknown whether clients who are members of an ethnic minority group form expectations that differ from those formed by members of a majority group. It is also unknown whether clients of differing incomes levels form different expectations for therapy. Future research which includes samples drawn from diverse populations would be beneficial.

Finally, future researchers should attempt to obtain larger sample sizes than that which was used in this study. This study was limited by the very small sample size. Future studies which have larger samples will have more options for data analysis, including multilevel analysis. Having larger samples available for analysis will also permit the analysis of gender differences, pooled effects testing, and the consideration of negative non-independence. Future studies of larger samples will also assure that there is sufficient statistical power for the desired

analyses. Sample sizes which permit adequate analysis are essential to further the research on couple therapy expectancy effects.

Conclusion

Despite these areas of concern, the present study makes a contribution to the literature in the area of expectancy effects. It is the first study to assess couple expectations and examine the influence of expectations on outcome in a couple therapy setting. Data gained from this study will provide information about the nature, content, and formation of expectations in couple therapy. It will also provide preliminary evidence about the influence of those expectations on a variety of factors related to couple therapy outcome.

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APPENDICES

Appendix A

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 or 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 are your partner quarrel?	_____	_____	_____	_____	_____	_____
9. Do you ever regret that you married (or live together)?	_____	_____	_____	_____	_____	_____
10. How often do you and your mate “get of each other’s nerves”?	_____	_____	_____	_____	_____	_____

	Every Day	Almost Every Day	Occa-sionally	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	_____	_____	_____	_____	_____	_____

Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name:_____ Age:____yrs.

Sex

ID#_____ M☐ F☐

Session #_____ Date___/___/_____

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

+	+

Total=

For More Information Contact:
AMERICAN PROFESSIONAL CREDENTIALING SERVICES LLC
E-MAIL: APCS@EROLS.COM
WEB: WWW.OQFAMILY.COM
TOLL-FREE: 1-888-MH SCORE, (1-888-647-2673)
FAX/VOICE: 1-973-366-8665

Appendix C

University of Rhode Island Change Assessment

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

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

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

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

Appendix D

Expectations about Counseling Questionnaire – Brief Form

Instructions: The following statements refer to things you might be thinking or feeling before starting therapy. Your ratings are confidential and will not be shown to your therapist or other family members and will only be used for research purposes. 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

1. I expect to take psychological tests.	7	6	5	4	3	2	1
2. I expect to like the counselor.	7	6	5	4	3	2	1
3. I expect to see a counselor in training.	7	6	5	4	3	2	1
4. I expect to gain some experience in new ways of solving problems within the psychotherapy process.	7	6	5	4	3	2	1
5. I expect to openly express my emotions regarding myself and my problems.	7	6	5	4	3	2	1
6. I expect to understand the purpose of what happens in the interview.	7	6	5	4	3	2	1
7. I expect to do assignments outside of the psychotherapy interviews.	7	6	5	4	3	2	1
8. I expect to take responsibility for making my own decisions.	7	6	5	4	3	2	1
9. I expect to talk about my present concerns.	7	6	5	4	3	2	1
10. I expect to get practice in relating openly and honestly to another person within the psychotherapy relationship.	7	6	5	4	3	2	1
11. I expect to enjoy my interviews with the counselor.	7	6	5	4	3	2	1
12. I expect to practice some of the things I need to learn in the psychotherapy relationship.	7	6	5	4	3	2	1
13. I expect to get a better understanding of myself and others.	7	6	5	4	3	2	1
14. I expect to stay in psychotherapy for at least a few weeks, even if at first I am not sure it will help.	7	6	5	4	3	2	1
15. I expect to see the counselor for more than three interviews.	7	6	5	4	3	2	1
16. I expect to never need psychotherapy again.	7	6	5	4	3	2	1
17. I expect to enjoy being with the counselor.	7	6	5	4	3	2	1

18. I expect to stay in psychotherapy even though it may be painful or unpleasant at times.	7	6	5	4	3	2	1
19. I expect to contribute as much as I can in terms of expressing my feelings and discussing them.	7	6	5	4	3	2	1
20. I expect to see the counselor for only one interview.	7	6	5	4	3	2	1
21. I expect to go to psychotherapy only if I have a serious problem.	7	6	5	4	3	2	1
22. I expect to find that the psychotherapy relationship will help the counselor and me identify problems on which I need to work.	7	6	5	4	3	2	1
23. I expect to become better able to help myself in the future.	7	6	5	4	3	2	1
24. I expect to find that my problem will be solved once and for all in psychotherapy.	7	6	5	4	3	2	1
25. I expect to feel safe enough with the counselor to say how I really feel.	7	6	5	4	3	2	1
26. I expect to see an experienced counselor.	7	6	5	4	3	2	1
27. I expect to find that all I need to do is answer the counselor's questions.	7	6	5	4	3	2	1
28. I expect to improve my relationships with others.	7	6	5	4	3	2	1
29. I expect to ask the counselor to explain what s/he means whenever I do not understand something that is said.	7	6	5	4	3	2	1
30. I expect to work on my concerns outside the psychotherapy interviews.	7	6	5	4	3	2	1
31. I expect to find that the interview is not the place to bring up personal problems.	7	6	5	4	3	2	1
32. I expect the counselor to explain what's wrong.	7	6	5	4	3	2	1
33. I expect the counselor to help me identify and label my feelings so I can better understand them.	7	6	5	4	3	2	1
34. I expect the counselor to tell me what to do.	7	6	5	4	3	2	1
35. I expect the counselor to know how I feel even when I cannot quite say what I mean.	7	6	5	4	3	2	1
36. I expect the counselor to know how to help me.	7	6	5	4	3	2	1
37. I expect the counselor to help me identify particular situations where I have problems.	7	6	5	4	3	2	1
38. I expect the counselor to give me encouragement and reassurance.	7	6	5	4	3	2	1
39. I expect the counselor to help me to know how I am feeling by putting my feelings into words for me.	7	6	5	4	3	2	1

40. I expect the counselor to be a "real" person, not just a person doing a job.	7	6	5	4	3	2	1
41. I expect the counselor to help me discover what particular aspects of my behavior are related to my problems.	7	6	5	4	3	2	1
42. I expect the counselor to inspire confidence and trust.	7	6	5	4	3	2	1
43. I expect the counselor to frequently offer advice.	7	6	5	4	3	2	1
44. I expect the counselor to be honest with me.	7	6	5	4	3	2	1
45. I expect the counselor to be someone who can be counted on.	7	6	5	4	3	2	1
46. I expect the counselor to be friendly and warm towards me.	7	6	5	4	3	2	1
47. I expect the counselor to help me solve my problems.	7	6	5	4	3	2	1
48. I expect the counselor to discuss his or her own attitudes and relate them to my problem.	7	6	5	4	3	2	1
49. I expect the counselor to give me support.	7	6	5	4	3	2	1
50. I expect the counselor to decide what treatment plan is best.	7	6	5	4	3	2	1
51. I expect the counselor to know how I feel at time, without my having to speak.	7	6	5	4	3	2	1
52. I expect the counselor to do most of the talking.	7	6	5	4	3	2	1
53. I expect the counselor to respect me as a person.	7	6	5	4	3	2	1
54. I expect the counselor to discuss his or her own experiences and relate them to my problem.	7	6	5	4	3	2	1
55. I expect the counselor to praise me when I show improvement.	7	6	5	4	3	2	1
56. I expect the counselor to make me face up to the differences between what I say and how I behave.	7	6	5	4	3	2	1
57. I expect the counselor to talk freely about him or herself.	7	6	5	4	3	2	1
58. I expect the counselor to have no trouble getting along with people.	7	6	5	4	3	2	1
59. I expect the counselor to like me.	7	6	5	4	3	2	1
60. I expect the counselor to be someone I can really trust	7	6	5	4	3	2	1
61. I expect the counselor to like me in spite of the bad things that he or she knows about me.	7	6	5	4	3	2	1
62. I expect the counselor to make me face up to the differences between how I see myself and how I am seen by others.	7	6	5	4	3	2	1
63. I expect the counselor to be someone who is calm and easygoing.	7	6	5	4	3	2	1
64. I expect the counselor to point out to me the differences between what I am and what I want to be.	7	6	5	4	3	2	1

65. I expect the counselor to just give me information.	7	6	5	4	3	2	1
66. I expect the counselor to get along well in the world.	7	6	5	4	3	2	1

Appendix E

Couple Therapy Alliance Scale

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

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

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

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

15. My partner and the therapists are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
16. The therapist does not understand me.	7	6	5	4	3	2	1
17. The therapist is helping my partner and me with our relationship.	7	6	5	4	3	2	1
18. I am not satisfied with the therapy.	7	6	5	4	3	2	1
19. My partner and I understand what each of us is doing in this therapy.	7	6	5	4	3	2	1
20. My partner and I do not accept each other in this therapy.	7	6	5	4	3	2	1
21. The therapist understands my partner's goals for this therapy.	7	6	5	4	3	2	1
22. I do not feel accepted by the therapist.	7	6	5	4	3	2	1
23. The therapist and I are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
24. The therapist is not helping me.	7	6	5	4	3	2	1
25. The therapist is in agreement with the goals that my partner and I have for ourselves as a couple in this therapy.	7	6	5	4	3	2	1
26. The therapist does not care about my partner as a person.	7	6	5	4	3	2	1
27. My partner and I are in agreement with each other about the goals of this therapy.	7	6	5	4	3	2	1
28. My partner and I are not in agreement about the things that each of us needs to do in this therapy.	7	6	5	4	3	2	1
29. The therapist has the skills and ability to help me.	7	6	5	4	3	2	1

Appendix F
First session interview

The following are questions about any expectations you may have prior to therapy. You may not have thought about some of these questions and if that is the case, you may leave that question blank. Please think about the therapy you are about to begin when you answer the questions.

1. What do you think your therapist will be like (anything from age, to appearance, to education, to personality and anything else)?

2. What do you think will happen during therapy?

3. What do you think you will talk about with your therapist?

4. Think about the problems that brought you to therapy. What do you expect will change about these problems as a result of therapy?

Appendix G

Expectations Interview – 2nd and Later Session

1. In what ways was your therapist like or not like what you expected?

2. In terms of what happened during therapy today, how did this fit or not fit with what you expected?

3. Were you surprised by anything in therapy that you did not expect?

4. Do you have any new expectations for therapy after today's session?

5. Think about the problems that brought you to therapy. What do you expect will change about these problems as a result of therapy? Why?

Appendix I
Demographic Information

Please provide the following personal information. If a question does not apply to you write NA for Not Applicable. All information is confidential.

1. Your age: _____ 2. Your Sex: _____

3. Your current relationship/marital status is:

A. Single/Never Married	B. Married	C. Divorced	D. Separated
E. Widowed	F. Significant Other—Heterosexual	G. Significant Other—Homosexual	H. Significant Other-Bisexual

4. If you are married or living together, how long have you been with your current partner?_____.

5. If you have children, please provide the following information. Use the back of this page if more space is needed.

Child	Sex	Age	Race	Name	Stepchild, adopted, biological	Who does this child live with?		
1st	M F	___	_____	_____	_____	You	Other parent/ guardian	On their own
2nd	M F	___	_____	_____	_____	You	Other parent/ guardian	On their own
3rd	M F	___	_____	_____	_____	You	Other parent/ guardian	On their own

6. What is your racial/ethnic group? _____ (Please Specify)

7. What is your current occupation? _____ (Please Specify)

8. What is the highest level of education you attained?

A. Grade School	B. Junior High School	C. GED
D. High School	E. Vocational/Technical School	F. Associate Degree/2 years
G. Bachelor degree	H. Master's degree	I. Other _____(Specify)

9. Your yearly income is: (Please indicate your combined income with your partner)

A. Under $5,000	B. $5,000 to $10,000	C. $10,001 to $15,000
D. $15,001 to $20,000	E. $20,001 to $25,000	F. $25,001 to $30,000
G. $30,001 to $35,000	H. $35,001 to $40,000	I. Over $40,001

10. What is your current religious/spiritual preference?

_____

11. Do you have current or previous experiences with psychotherapy or therapy? YES NO

12. List any current physical health problems

_____

13. List any medication you are currently taking

_____

14. Please answer questions for the **family in which you now live** and the **family in which you grew up**.

In your family were/are there problems with	In the family in which you now live		In the family in which you grew up	
A. Alcohol, drug substance, or prescription abuse	YES	NO	YES	NO
B. Physical abuse or violence	YES	NO	YES	NO
C. Sexual abuse	YES	NO	YES	NO
D. Emotional abuse	YES	NO	YES	NO
E. Mental illness	YES	NO	YES	NO
F. Trouble with the law	YES	NO	YES	NO
G. Religious/spiritual practice	YES	NO	YES	NO
H. Suicide/attempted suicide	YES	NO	YES	NO

15. How much did someone else pressure you to come for therapy?

Not at all pressured	A little pressured	Somewhat pressured	Quite pressured	Very pressured
1	2	3	4	5

16. Starting with the most important, please list the problems that brought you to therapy?

A. _____ B. _____

C. _____ D. _____

17. Do you consider the problems that brought you to therapy to be the responsibility of:

A. Yourself	B. Your spouse/partner	C. One of your children
D. You & your	E. The whole family	

spouse/partner

18. Who referred you to the MFT clinic?

A. Friend
B. Spouse/partner
C. Teacher
D. Minister/Clergy person
E. Physician
F. Former or current client
G. Advertising
H. Self referral
(specify)_____
I. Other
_____

Appendix J

Table A1: Summary of Regression Analysis for EAC-B Factors and RDAS at Time 4

	Model 1a			Model 1b		
	Predictor: Facilitative			Predictor: Personal		
	B	*SE(B)*	*df*	*B*	*SE(B)*	*df*
Between	-8.51	7.61	4	3.25	2.23	4
Within	-4.17	12.62	3	-8.13	3.84	3

	Model 1c			Model 1d		
	Predictor: Experience			Predictor: Nurture		
Variable	*B*	*SE(B)*	*df*	*B*	*SE(B)*	*df*
Between	-5.93	1.80	4	16.42	6.78	4
Within	.63	12.54	3	13.53	4.17	3

Table A2: Summary of Regression Analysis for URICA and RDAS at Time 4

	Model 2		
	Predictor: URICA		
	B	*SE(B)*	*df*
Between	.18	.59	4
Within	-.04	.71	3

Table A3: Summary of Regression Analysis for SD and RDAS at Time 4

	Model 2		
	Predictor: SD		
	B	*SE(B)*	*df*
Between	-.24	.16	3
Within	-.64	.01	3

Table A4: Summary of Regression Analysis for RDAS at Time 1 and RDAS at Time 4

	Model 2		
	Predictor: RDAS1		
	B	*SE(B)*	*df*
Between	1.10	.30	3
Within	1.00	.09	3