Journal of Marital & Family Therapy

Journal of Marital and Family Therapy
doi: 10.1111/jmft.12099

THE NORWAY COUPLE PROJECT: LESSONS LEARNED

Jacqueline A. Sparks
University of Rhode Island

Couple therapists in routine practice may find it difficult to apply findings from an increasingly expanding and complex body of couple therapy research. Meanwhile, concerns have been raised that competency in evidence-based treatments is insufficient to inform many practice decisions or ensure positive treatment outcomes (American Psychological Association Presidential Task Force on Evidence-Based Practice, American Psychologist*, 2006, 271). This article aims to narrow the research/practice gap in couple therapy. Results from a large, randomized naturalistic couple trial (Anker, Duncan, & Sparks,* Journal of Consulting and Clinical Psychology*, 2009, 693) and four companion studies are translated into specific guidelines for routine, eclectic practice. Client feedback, the therapeutic alliance, couple goals assessment, and therapist experience in couple therapy provide a research-informed template for improving couple therapy outcomes.*

There is little debate that working with couples presents special challenges, even for seasoned clinicians. High levels of negativity and the need to balance therapeutic relationships in the midst of conflict are just some of the hurdles couple therapists routinely encounter (Symonds & Horvath, 2004). Moreover, in a global society moving rapidly toward marriage equality, couple diversity is no longer an exception but an expectation; therapists must be comfortable implementing a range of strategies that resonate with each couple's unique culture and preferences (American Psychological Association, 2003). In short, couple work is not for the faint of heart.

Even with its difficulties, couple therapy is worth the effort. Meta-analytic research and reviews indicate that couples who undertake therapy have a greater chance of improving their relationships than those who do not (Christensen et al., 2004; Gollan & Jacobson, 2002; Lebow, Chambers, Christensen, & Johnson, 2012; Shadish & Baldwin, 2005). The effect size for couple therapy is large to moderate, ranging from .86 (Christensen et al., 2004) to .59 (Shadish & Baldwin, 2005), meaning that approximately 40–50% of treated couples achieve clinically significant change. Despite this, many couples do not benefit from therapy. By some counts, as many as 25–30% of couples fail to improve with treatment (Snyder & Halford, 2012), and up to 45% initially realizing gains deteriorate at 2-year follow-up (Christensen et al., 2004; Snyder, Wills, & Grady-Fletcher, 1991).

To improve the chance that couples will get better and remain so over time, new couple therapy models have appeared with regularity since the late 80s. Notwithstanding these innovations, meta-analyses and reviews, when allegiance effects are controlled, have failed to find differential efficacy among approaches (Christensen et al., 2004; Snyder, Castellani, & Whisman, 2006; Sparks & Duncan, 2010). As far as how they work, findings are equivocal. Snyder and Halford (2012) report that many models that include specific ingredients designed to alter hypothesized mediators of change fare no better than models that do not incorporate these components. For example, integrative behavioral couple therapy, which includes cognitive change strategies, and behavioral couple therapy, which does not, produce roughly equivalent alterations in negative cognitions. Further, changes in hypothesized mediators (e.g., communication or cognitions) are unclearly

Jacqueline A. Sparks, Ph.D., Department of Human Development and Family Studies, University of Rhode Island.

The author would like to acknowledge and thank Barry L. Duncan, Psy.D. for his invaluable input and Morten Anker, Ph.D. for his helpful critique of this manuscript.

Address correspondence to Jacqueline A. Sparks, Ph.D., Department of Human Development and Family Studies, 2 Lower College Rd., Kingston, RI 02881; E-mail: jsparks@uri.edu

linked to changes in couple distress (Snyder & Halford, 2012). To date, the specific mechanisms of change in couple therapy remain elusive.

While couple therapy research has reached what Gurman (2011) has called a "critical mass of clinically compelling theory... and an increasingly visible and nuanced research base" (p. 281), clinicians may lack concrete guidance in making routine practice decisions. Couple and family therapy's historic disinterest in empirical evidence (Dattilio, Piercy, & Davis, 2014) likely reinforces this deficit. As a result, couple therapists may feel adrift in stormy waters. The purpose of this article is to provide guidelines to those who do the difficult work of helping couples improve their relationships. Specifically, the article translates lessons learned from five recent studies based on data collected in the largest clinical couple trial to date, Anker, Duncan, and Sparks (2009), which compared systematic collection and integration of client feedback to treatment as usual. First, the context of feedback measurement trials is discussed. Next, the article distills findings from Anker et al. and four companion studies, situating these within the broader couple therapy outcome literature. Finally, recommendations for concrete strategies informed by this body of research and relevant across couple therapy treatments are proposed.

USING CLIENT FEEDBACK TO IMPROVE OUTCOMES

In 2009, "Using Client Feedback to Improve Couple Therapy Outcomes: A Randomized Clinical Trial in a Naturalistic Setting" was published in the *Journal of Consulting and Clinical Psychology* (Anker et al., 2009). The Norway Couple Study (NCS) spawned a series of studies using its data and data collected at an additional site (see, Anker, Owen, Duncan, & Sparks, 2010; Anker, Sparks, Duncan, Owen, & Stapnes, 2011; Owen, Duncan, Anker, & Sparks, 2012; Owen, Duncan, Reese, Anker, & Sparks, 2014). In the NCS, feedback refers to routine and continuous monitoring of client perceptions of progress and the therapeutic alliance throughout the course of therapy utilizing the Partners for Change Outcome Management System (PCOMS; Duncan, 2012, 2014; Duncan & Sparks, 2010). PCOMS is based on a paradigm known as patient-focused research (Howard, Moras, Brill, Martinovich, & Lutz, 1996), which involves ongoing, real-time comparison of client views of progress with an expected treatment response statistically derived from the client's initial intake score on a valid measure of global distress. The expected treatment response trajectory serves as a yardstick for gauging client progress and signaling when change is not occurring as predicted. With this alert, clinicians and their clients have an opportunity to discuss such topics as the need to shift focus, re-visit goals, or alter treatment interventions before deterioration or possible dropout.

Michael Lambert and colleagues pioneered the development of a feedback measurement system and research on the effects of routinely incorporating feedback in individual psychotherapy. In a meta-analysis of six randomized trials testing Lambert's Outcome Questionnaire 45.2 (OQ) System (Lambert et al., 1996), clients at-risk (not progressing as expected) in feedback groups fared significantly better than at-risk clients in treatment as usual (TAU; no feedback) groups (Lambert & Shimokawa, 2011). Specifically, those in the feedback group were less than half as likely to experience deterioration and 2.6 times more likely to reach reliable change than those in TAU.

Although consistent with a patient-focused paradigm, PCOMS differs from Lambert and colleague's system in several ways. First, PCOMS instruments are brief, requiring in most circumstances only 5 min to administer, score, and discuss. The Outcome Rating Scale (ORS) (Miller, Duncan, Brown, Sparks, & Claud, 2003; Figure 1) provides client-reported ratings of progress. Rather than a symptom checklist, the ORS is a visual analog scale consisting of four 10 cm lines, three corresponding to the three domains of the OQ (individual, interpersonal, and social) and one, overall. Clients place a mark on each line to represent their perception of their functioning in each domain. Therapists use a 10-cm ruler (or calculations are performed automatically in computerized versions) to sum the client's total score, with a maximum score of 40. Lower scores reflect more distress. The cutoff, or score that delineates clinical versus nonclinical clients, for adults is 25.

The Session Rating Scale (SRS) (Duncan et al., 2003) (Figure 2), also a visual analog scale, serves to measure clients' views of the therapeutic alliance. The SRS contains 4 lines, 3 of which correspond to Bordin's (1979) classic delineation of components of the alliance—the relational

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Sex: M / F
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Individually
(Personal well-being)
I----------I

Interpersonally
(Family, close relationships)
I----------I

Socially
(Work, school, friendships)
I----------I

Overall
(General sense of well-being)
I----------I

The Heart and Soul of Change Project

https://heartandsoulofchange.com

Figure 1. For examination only. Download a free working copy at https://heartandsoulofchange.com.

bond, agreement on goals, and agreement on tasks. The fourth line, "Overall", taps into confident collaboration, another aspect of the alliance considered predictive of outcome (Hatcher & Barends, 1996). The SRS is given toward the end of a therapy session. Use of the SRS encourages all client feedback, positive and negative, thus creating a safe space for clients to voice their honest opinions about their connection to their therapist and to therapy. In this way, it allows the expression of negative feelings, identified by Hatcher and Barends (1996) as an additional key alliance factor. Similar to the ORS, each line on the SRS is 10 cm and can be scored manually or electronically. Given that clients tend to score high on alliance measures, a total score below 36 signals the possibility of a problematic alliance and prompts a frank discussion about steps needed to increase client connection to the therapist and the process.

The ORS and SRS represent attempts to balance the reliability and validity of longer measures with the feasibility required for routine practice (Duncan, 2012; Duncan & Reese, 2013). The ORS has been found to have a moderately strong correlation with the OQ (ranging from .53 to .74; Gillaspy & Murphy, 2011), supporting concurrent validity. Additionally, the ORS has been shown to be sensitive to change and to correctly distinguish clinical and nonclinical populations (Duncan, 2011), evidence of construct validity. In their review, Gillaspy and Murphy also reported average Cronbach's alpha coefficients for ORS scores were .85 (clinical samples) and .95 (nonclinical samples), demonstrating the instrument's reliability. Concurrent validity for the SRS averaged .48 (Pearson product moment coefficient) in comparison with the Revised Helping Alliance Questionnaire (HAQ-II) and .58 in comparison with the Working Alliance Inventory (WAI), both widely used measures of therapeutic alliance. These correlations suggest that the SRS references similar domains (Duncan et al., 2003). In several studies, early scores on the SRS (2nd and 3rd sessions)

Session Rating Scale (SRS V.3.0)

Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. I---------- I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I---------- We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapistís approach is not a good fit for me. I---------- The therapistís approach is a good fit for me.

Overall

There was something missing in the session today. I---------- Overall, todayís session was right for me.

The Heart and Soul of Change Project

https://heartandsoulofchange.com

Figure 2. For examination only. Download a free working copy at https://heartandsoulofchange.com.

have been found to predict outcome, consistent with alliance findings across the literature and supporting the measure's construct validity (Duncan, 2011). Test–retest reliability for the SRS also has compared favorably with the HAQ-II and WAI, and internal consistency estimates for the SRS over four studies yielded an average alpha of .92 (Gillaspy & Murphy, 2011). These findings provide support that both the ORS and SRS reliably report what they intend and can be used as substitutes for longer instruments without sacrificing trustworthiness.

Besides the brevity of its measures, PCOMS also differs from Lambert and colleague's system in that both client perceptions of progress and the therapeutic alliance are obtained at each session. Given the well-established link between the alliance and outcome, PCOMS attempts to ensure that therapists assess and minimally address any potential alliance ruptures before clients leave the therapy room or site of service. Lambert and colleagues, in contrast, utilized alliance measures only for those cases deemed at-risk.

Finally, whereas Lambert and colleagues' research periodically involved clients in reviewing scores, client involvement in PCOMS is routine and expected; client scores on the ORS and SRS are openly shared and discussed with clients at each administration. Client views of their progress serve as a basis for beginning therapeutic conversations, and their assessments of the alliance mark an endpoint to the same. With this transparency, the measures provide a mutually understood

reference point for reasons for seeking service, progress, and engagement. Thus, clients and therapists are likely to view the measures as integral to the therapy process.

Prior to the NCS, evidence existed that use of PCOMS improves outcome in individual psychotherapy. In a randomized controlled trial using PCOMS in a university counseling center and graduate training clinic, Reese, Norsworthy, and Rowlands (2009) found that clients in the PCOMS condition experienced significantly more change than those in TAU (80% vs. 54% in one setting; 67% vs. 41%, the other). Gains for feedback groups extended to all clients, not just those identified as at-risk, and were realized significantly more quickly than in TAU groups. While these findings added to the literature of use of client feedback with individuals, no studies before the NCS had examined whether such a system would similarly benefit couples.

THE NORWAY COUPLE STUDY

The primary rationale for Norway Couple Study (NCS) (Anker et al., 2009) was to explore how outcomes for couples and therapists receiving routine feedback via the Partners for Change Outcome Management System (PCOMS) differed from outcomes for couples not receiving feedback. The study also sought to determine whether a systematic feedback system was transferrable into a routine clinical environment. How would outcomes for couples treated by busy clinicians practicing diverse approaches be impacted by the systematic incorporation of client feedback? The design for the NCS mimicked key elements of previous feedback trials conducted by Lambert and colleagues. These included the following: (a) random assignment to treatment groups; (b) therapists serving as their own controls (i.e., alternately in feedback and TAU groups); and (c) therapists choosing the clinical approach they thought most appropriate, typical of routine practice. As therapists participated equally in both treatment groups, variability in therapist effectiveness (Beutler et al., 2004; Duncan, Miller, Wampold, & Hubble, 2010; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011) was controlled. Similarly, given that clinicians were free to practice as they ordinarily would, findings would not be impacted by therapists using an approach not within their skill set or that they believed would not be effective.

The NCS enrolled 205 Euro-Scandinavian, heterosexual couples ranging in age from 20 to 71 seeking couple counseling in an outpatient office in Norway. Couples were randomly assigned to one of two groups—feedback (PCOMS) or TAU. Of the 235 couples allocated to intervention, 30 (13%) either did not attend at least two sessions or complete pre-post outcome measures, lower than drop-out estimates for behavioral health practice settings. For example, Reese, Duncan, Bohanske, Owen, and Minami (2014) report losing 26% of their data due to attrition between sessions one and two. In the NCS, rates of attrition were similar between the two groups (12 in PCOMS; 18, TAU).

Couples were seen by 10 therapists (7 female and 3 male) trained in standard professional disciplines and practicing eclectically (e.g., solution-focused, narrative, cognitive behavioral, humanistic, systemic), typical of a routine outpatient setting. The results indicated that couples in the PCOMS feedback group had nearly 4 times the rate of clinically significant change than the TAU group. When data were collected from the couples 6 months after they completed treatment, those in the feedback group were still doing significantly better (2 times better) than those in TAU. In terms of "real-world" outcomes, feedback couples were 46% less likely to be separated or divorced at 6 months posttreatment than nonfeedback couples. In sum, this study made a strong case for the systematic use of client feedback with couples.

Finally, the question of whether such a system was transferrable as a quality improvement strategy into a typical outpatient agency setting was answered affirmatively. Only 17 hr of PCOMS training were required compared with, for example, certification in emotionally focused couple therapy (EFCT) which requires a minimum of 42 hr of training and 32 hr of supervision with a certified EFCT supervisor (http://www.eft.ca/training2.htm). Therapists were free to choose approaches in which they were already trained, further circumventing the need for additional agency funding. Although training requirements were minimal, implementation of PCOMS did require sustained effort to systematically collect data and identify at-risk clients.

THERAPIST EFFECTS

There is some dispute regarding the magnitude of therapist effects (Crits-Christoph & Gallop, 2006; Wampold & Bolt, 2006). However, most investigations have found that therapist variability is the rule rather than the exception (Baldwin & Imel, 2013; Beutler et al., 2004; Duncan et al., 2010; Kraus et al., 2011). The proportion of outcome variance attributable to the therapist in individual psychotherapy trials has been found to range from 5% to 10%, (Kim, Wampold, & Bolt, 2006) considerable in comparison to the 1–2% for model effects, as suggested by meta-analyses (Wampold, 2001). Researchers continue to explore which variables likely account for these substantial differences among therapists (Beutler et al., 2004; Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013). In general, research strongly suggests that clients seen by therapists with higher average alliance ratings have better outcomes. For example, Baldwin, Wampold, and Imel (2007) reported that therapist average alliance quality accounted for 97% of therapist variability. Reviews, however, of individual psychotherapy have shown none or only modest effects for therapist gender, type of training, and theoretical orientation (Baldwin & Imel, 2013; Beutler et al., 2004). Regarding the effects of therapist experience, findings have generally found little impact related to this variable (Beutler et al., 2004), although some studies have reported better outcomes for therapists with domain-specific experience, or experience treating certain conditions (Kraus et al., 2011).

While therapist effects in individual psychotherapy have garnered considerable attention, therapist factors in couple therapy have been less studied (Blow, Sprenkle, & Davis, 2007; Sparks & Duncan, 2010). In light of these gaps, Owen et al. (2014) re-analyzed NCS data to examine therapist variability in a naturalistic setting with couples, specifically looking at therapist gender, discipline, experience, and ability to establish a working alliance. As reported in Anker et al. (2010), therapist effects in the NCS were significant. Therapists accounted for 8% of the variance in outcome, similar to that found in individual studies. Moreover, therapists' average alliance quality accounted for 50% of the variance in outcome among therapists. This means simply that therapists who formed better alliances across more clients had better overall outcomes. Based on these findings, therapists clearly play a significant role in both the process and outcome of couple therapy.

While therapist ability to form alliances proved pivotal in Owen et al. (2014), therapist gender and specific professional discipline did not. However, therapist experience was predictive. Specifically, therapists who had more experience working with couples did significantly better, accounting for 25% of the outcome variance attributable to therapists. The researchers concluded that, based on their analysis, there are at least two clear pathways for therapists to become better at couple therapy—alliance building and time "in the trenches" with couples. However, therapist experience and average alliance quality were nonsignificantly associated. Therefore, the findings do not suggest that more experienced therapists form better alliances. Instead, the researchers proposed that the effect of experience in couple therapy and the alliance are independent of each other.

THE ALLIANCE

Given the remarkably consistent association between the alliance and outcome across treatment modalities and clinical presentations (Castonguay & Beutler, 2005; Horvath, Del Re, Flückiger, & Symonds, 2011), NCS researchers were particularly interested in examining the study's alliance data (see, Anker et al., 2010). Meta-analyses of individual trials have found that the alliance accounts for 5–7% of the overall variance (Crits-Christoph et al., 2013; Horvath & Bedi, 2002), with a more recent study finding a slightly higher 7.5% (Horvath et al., 2011). The association between alliance and outcome also holds true for couple therapy. The alliance has been found to be associated with greater retention in marital therapy (Knobloch-Fedders, Pinsof, & Mann, 2004; Raytek, McCrady, Epstein, & Hirsch, 1999) and improvement in marital distress (Bourgeois, Sabourin, & Wright, 1990; Brown & O'Leary, 2000; Knobloch-Fedders, Pinsof, & Mann, 2007). In one couple study, the alliance explained as much as 22% of the outcome variance at posttreatment and 29% at follow-up (Johnson & Talitman, 1997).

While researchers remain united in the importance of the alliance in couple work, examining how it impacts this modality is challenging. Couple therapy involves multiple relationships and typically mixed genders (in heterosexual couple counseling), and disparities in partner's alliance scores, or split alliances, are common (Knobloch-Fedders et al., 2007; Pinsof, Zinbarg, & Knobloch-Fedders, 2008; Symonds & Horvath, 2004). Moreover, the alliance includes a partner's perceptions not only of his or her alliance with the therapist but also his or her partner's and the couple's alliance with the therapist and therapy process (Pinsof & Catherall, 1986; Symonds & Horvath, 2004). Finally, patterns of increasing or decreasing alliances and junctures during treatment critical for alliance formation remain of particular interest (e.g., Symonds & Horvath, 2004).

With these variables in mind, NCS researchers had several objectives. First, they wanted to learn if an individual's first and last session alliance scores predicted outcome, not only for that individual but also for his or her partner. Second, the researchers explored whether the alliance, when measured at traditional data points (sessions 2 and 3), predicted outcome above and beyond early change. This focus was spurred by the debate regarding the actual nature of the association between the alliance and outcome (Barber, 2009; Kivlighan & Shaughnessy, 2000; Stiles et al., 2004). Specifically, is the alliance/outcome link simply a by-product of therapy going well, thus strengthening client alignment with the therapist? Or, do strong alliances lead to positive therapeutic progress and consequently better outcomes? The researchers hypothesized the latter. Finally, researchers were interested in whether different patterns of alliance development would differentiate couple outcomes.

When the alliance data for the full sample were examined, NCS researchers found that first session alliance scores did not significantly predict outcome whereas last session scores did. Intuitively, this is not surprising given the temporal link between the end of therapy and clients' ratings of their connection to their therapist. The last session alliance/outcome link held up for an individual as well as that individual's partner's alliance with the therapist. This association was stronger for men than for women, a difference that remained at 6-month follow-up.

A second and more important finding involved the question of whether the alliance predicted outcome over and above early change. To answer this, researchers controlled for early change in third and last session calculations, using a stringent criterion of reliable change (a change of 6 or more points) on the Outcome Rating Scale (ORS). Third and last session alliances did indeed predict outcome, and this link was not the result of early symptom relief. In other words, this study demonstrated that the alliance was not merely a by-product of change but played an important role in producing change. Since the publication of the NCS, the significant impact of the alliance on outcome separate from clients' experience of improvement has been further supported (e.g., Crits-Christoph et al., 2013).

Finally, researchers assessed patterns of increasing or deteriorating alliances. They found three clusters of alliance trajectories and corresponding relationships with outcome. First, when scores at session one were above average and then trended upward for the remainder of therapy, couples had the best outcomes. Couples who had moderate alliance scores at the first session which then continued to increase over the course of therapy fared the next best. Finally, those couples who had lower than moderate first session alliance scores that progressed unevenly did the poorest, even if ending higher than session one. That initial above average scores that increased had the most favorable outcomes perhaps was not surprising. However, the finding that rising moderate scores also resulted in positive outcomes was somewhat unexpected and provides encouragement for couple cases beginning with slightly lower alliance scores.

The NCS researchers administered a short post-therapy questionnaire at 6-month follow-up to supplement the quantitative data collected in the feedback trial (see, Anker et al., 2011). The survey included two broad, open-ended questions not intended to elicit client views of the alliance but simply to inquire about clients' experiences in couple treatment. However, after 742 written client responses from 382 individuals were analyzed, two overarching domains emerged, relationship and tasks. These domains mirror Bordin's (1979) principle aspects of the working alliance and correspond with similar groupings in couple therapy literature dealing with the therapeutic alliance (Bischoff & McBride, 1996; Green & Herget, 1991; Sells, Smith, & Moon, 1996). Not surprisingly, more favorable responses fell into the relationship category. For example, statements regarding therapist warmth, friendliness, and ability to listen were well represented, as they are in the

literature (Bischoff & McBride, 1996; Bowman & Fine, 2000; Green & Herget, 1991). At the same time, respondents expressed that they valued therapist neutrality, wanting their therapist to consider equally both partners' points of view even when these differed.

In the tasks domain, comments were more negative. Many respondents complained that they wished their therapist had structured interviews more to provide a safe place for highly charged discussions. Notably, tasks mattered a great deal to the couples who responded to the post-therapy survey—they wanted therapists who were not only easy to talk to but who could direct the therapy conversation, provide tools for problem resolution, and even give advice when needed. These findings fall in line with previous studies highlighting the importance clients place on more active aspects of couple therapy (Bowman & Fine, 2000; Helmeke & Sprenkle, 2000; Sells et al., 1996).

A somewhat surprising finding in this study had to do with clients wishing their therapist had been more proactive in arranging appointments and being flexible in scheduling. According to Bordin (1979), these types of tasks do not lie outside the realm of the therapeutic alliance but include "... collaboration between patient and therapist [that] involves an agreed-upon contract, which takes into account some very concrete exchanges" (p. 254). Interestingly, clients in the feedback group had fewer negative comments in this area than those in the nonfeedback group, suggesting that routine use of client feedback may allow greater opportunity to elicit and respond to a range of clients' requests. Alternatively, clients whose views are regularly sought may feel more attended to by their therapists.

COUPLE GOALS

That clients come into couple therapy for different reasons with different implications for outcome is likely not news to seasoned couple therapists. In particular, challenging and not uncommon are situations where one partner wants to improve the relationship and the other seeks to clarify whether the relationship is viable. In confirmation, the fourth study utilizing the Norway Couple Study (NCS) data reinforced the importance of each partner's goal for treatment, including congruence between them. Owen et al. (2012) examined the relationship between client initial goals and outcomes and relationship status (separated or together) at 6-month follow-up. As might be expected, when both members of the couple wanted to improve the relationship, the majority of them did. Of couples who both reported an initial goal to strengthen the relationship, only 7.8% separated or divorced 6 months post-therapy. In contrast, when both in couple sought clarification of the relationship, 56% had separated by follow-up. For those couples where one member wanted to improve the relationship and the other desired clarification, 45.6% separated 6 months post-therapy. Importantly, however, all couples on average, regardless of their goal category, benefitted from therapy. For example, many couples ambivalent about staying together, including those that eventually separated, reported improvements in their overall sense of well-being. Thus, therapists can be encouraged that couple work is generally beneficial for participants, regardless of the relationship status at termination or follow-up.

Given the importance of consistency between the client and therapist goals (Bordin, 1979), this study has implications for the therapeutic alliance. Pinsof (1995) described the systemic therapeutic process in couple therapy as involving not only partners' mutual goals but the agreement regarding goals between each partner and the therapist. Therapists need to be responsive to both partners (Lebow, 2004; Stiles, Honos-Webb, & Surko, 1998). Not actively seeking to determine client goals early in therapy could lead to a mismatch between the therapist's assumptions and the real reasons clients have sought help, resulting in compromised alliances and early dropout, even if the therapist only erred with one partner. Moreover, assuming *a priori* that couples seek counseling to stay together can short-circuit the opportunity to engage in a transparent goal negotiation and assist couples toward their preferred outcome, however, they define it.

LESSONS LEARNED

As a body of work, the Norway Couple Project offers clinician's specific points of reference to guide them in negotiating treatment decisions with couples:

1. *Use valid, feasible instruments to routinely monitor client progress and the therapeutic alliance to increase the chance of a positive outcome*. Findings from Anker et al. (2009) support a growing body of evidence that outcomes are enhanced when therapists systematically monitor treatment response. Anker et al. results are consistent with findings supporting the efficacy of the Partners for Change Outcome Management System (PCOMS; Reese et al., 2009; Reese, Toland, Slone, & Norsworthy, 2010; Schuman, Slone, Reese, & Duncan, 2014), including a recent meta-analysis (Lambert & Shimokawa, 2011) that reported PCOMS clients 3.5 more likely to experience reliable change and half as likely to deteriorate as TAU. Regarding couple therapy, Reese et al. (2010) replicated the NCT with nearly equivalent results. There now appears to be a consensus among many that, in the words of Michael Lambert, "Yes, it is time for clinicians to routinely monitor treatment outcomes" (Lambert, 2010, p. 239).
2. *Monitor the therapeutic alliance at each session*. Anker et al. (2010) joined the extensive ranks of couple and individual studies confirming the link between the alliance and outcome. According to their findings, therapists stand to increase their chances of success in couple therapy by tracking alliance scores from the first session onward, with the goal of increasing lower scores, particularly by session three. Owen et al.'s (2014) reporting that therapist average alliance quality accounted for 50% of the variance among therapists regarding outcome underscores the crucial role of this factor in couple work. Couple allegiance, or the loyalty members of a couple have for each other despite disagreements, may be an important consideration for therapists seeking to strike the right balance when forming therapeutic alliances in this modality (Symonds & Horvath, 2004). Knowing how well each partner is engaged in the process and connected to the therapist *at each meeting* can help therapists negotiate this delicate equilibrium. Given the lack of association between first session alliance scores and outcome at posttreatment (Anker et al., 2010), therapists who may not have established a strong starting alliance could still have a positive outcome; what happens beyond the first session is key.
3. *Determine each partner's goal for seeking therapy early in the treatment process*. Owen et al. (2012) found a direct relationship between couple goals at the beginning of therapy and outcome. Whether both partners sought therapy to strengthen the relationship or to clarify it or whether each had different goals for seeking help made a significant difference, on average, in whether the couple would be together 6 months beyond therapy. The choice and timing of therapist intervention, whether for improvement, resolving ambivalence, or facilitating separation (see, Tremblay, Wright, Mamodhouseen, McDuff, & Sabourin, 2008), ought to align with the goals of each member of a couple and the couple as a unit. This can only happen through a transparent discussion early in treatment about clients' reasons and hopes for service. A standard brief goal assessment can facilitate this process. Early goal identification can assist therapists to work toward client-defined better futures, whether that means couples remaining together or moving apart
4. *Use valid outcome instruments, not only relationship status, to determine treatment success or failure*. According to Owen et al. (2012), all clients, on average, benefitted from treatment, regardless of relationship status at termination or follow-up. As the researchers noted, individual rather than couple outcomes may be better markers of success in couple therapy. That is, couples may dissolve, but one or both partners may view this positively. Individual measures of progress can facilitate a correct determination of actual outcome, even in instances of separation or divorce.
5. *Gain experience working with couples*. Owen et al. (2014) found that therapist experience working with couples may provide a benefit to overall outcomes in this modality. Beginning therapists can seek supervision from experienced couple therapists to develop the skill set required to manage a couple session, likely including how to moderate conflict and direct in-session interaction. More experienced therapists can add more couples into their caseloads, providing the training ground for improvement. The authors note, however, that mere experience is not enough. Learning from that experience is key. They advocate that therapists monitor their experience with available feedback systems,

allowing a process of continual reflection and learning, or what Orlinsky and Rønnestad (2005) termed cumulative career development.

6. *Attend to men's alliances in heterosexual couple therapy*. Men's alliance scores were a stronger predictor of outcome at posttreatment than women's in Anker et al. (2010), a finding similar to that in previous studies (Bourgeois et al., 1990; Brown & O'Leary, 2000; Knobloch-Fedders et al., 2007; Symonds & Horvath, 2004). Women in the study initiated treatment 62% of the time, suggesting that perhaps commitment is the salient variable, not gender, and therapists would do well to focus on engaging the less committed partner, regardless of gender. However, until this can be explored further, the consistency of findings pointing to the importance of men's connection to the therapist and the therapy process invites therapists to meaningfully involve men early and throughout treatment.
7. *Become skilled at incorporating task activities, including structuring, directing, and giving input as appropriate*. Findings from Anker et al. (2011) indicate that many couples, while appreciative of therapist relationship skills, wished their therapist had been more active. This finding has emerged in numerous studies (e.g., Bowman & Fine, 2000; Christensen Russell, Miller, & Peterson, 1998; Helmeke & Sprenkle, 2000). This may be particularly salient in couple therapy as therapists may need to interrupt negative or volatile communication interchanges between couples to establish a climate of safety and one different from that typically occurring outside of therapy. The ability of the therapist to construct this type of experience for the couple may enhance hope and play a role in actively teaching couples how to communicate more effectively. More training may be required for therapists to comfortably assume these types of in-session activities.
8. *Maintain contact with couple clients between sessions as necessary and be flexible in scheduling*. Many couples in Anker et al. (2011) reported feeling dissatisfied that their therapists were not responsive to their needs to reschedule appointments or be available for contact between sessions if requested. Therapists may be so focused on in-session process, they fail to consider the implications of "nuts and bolts" service delivery for the alliance. Clinic and supervisory policies could be instituted that encourage therapists to resolve scheduling difficulties and be flexible in accommodating client wishes for more or fewer meetings.

DISCUSSION

Conclusions of the Norway Couple Study (NCS) are limited by the fact that only one instrument was used to measure pre-post outcomes. However, results from two outcome instruments and couple satisfaction survey at 6 month follow-up support post-therapy findings. Additionally, the instruments used were ultra-brief and may not have captured the complexity of the couple therapy process. For example, the 12-item Couple Therapy Alliance Scale Revised Short Form (CTASr-SF) (Pinsof et al., 2008) measures not only the individual's alliance with the therapist (Self-therapist), but three other interpersonal dimensions, including the individual's view of his or her partner's alliance with the therapist (Other-therapist), the individual's view of the couple's alliance with the therapist (Group-therapist), and the individual's view of his or her alliance with partner (Within-system). Whether using a more systemically dimensioned scale would have altered NCS findings and re-analyses is unknown.

While all NCS authors held allegiance to feedback procedures, a prestudy survey reported that participating therapists did not use the instruments and believed that informal feedback would suffice. After data collection, therapists were again polled, revealing inconsistencies in their beliefs that feedback had been helpful. These minimal tests for allegiance effects suggest that any bias transmitted by the researcher was negligible. Finally, couples in the NCS were all heterosexual and Euro-Scandinavian. It is not known if similar feedback effects would have been found in more diverse samples.

The NCS supports a burgeoning interest in the incorporation of client feedback in psychotherapy. The American Association for Marriage and Family Therapy Task Force on Core Competencies (Nelson et al., 2007) and the American Psychological Association Presidential Task Force on

Evidence-Based Practice (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006), for example, have recommended routine assessment of client response to treatment. Sparks, Kisler, Adams, and Blumen (2011) have articulated the value of integrating an outcome management system into graduate family therapy clinical training to enhance trainee outcomes and skill development. Common factors and evidence-based treatment proponents alike have recognized that, even with highly effective therapists and best practices, favorable outcomes are not guaranteed (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Duncan & Reese, 2012)). Continuous monitoring of client feedback and responsive adjustment of treatment unites therapists practicing across orientations, settings, and client populations around a common process.

In their review of couple therapy research over the past decade, Lebow et al. (2012) outline promising findings for the overall efficacy of couple therapy, including substantial support for evidence-based approaches and advances in methods of couple assessment and research. The Norway Couple Project partially addresses the problem of representativeness of couple therapy research discussed by Lebow et al. as data were collected from a naturalistic setting. Nevertheless, additional research is needed to examine the impact of feedback in more diverse practice settings. Lebow et al. summarize five principles of couple therapy that transcend approach proposed by Christensen (2010): (a) dyadic conceptualization; (b) modifying emotion-driven maladaptive behavior; (c) fostering productive communication; and (d) emphasizing strengths and positive behaviors. Given the evidence presented in the current article, a preliminary case can be made for adding a sixth principle: systematic inclusion of client feedback.

As seen through the lens of research covered here, couple therapy consists of themes likely to resonate with everyday clinicians. First, feedback exerted a large effect, contributing substantial benefit to clients. Second, despite its complexity in couple work, the alliance, as in other modalities, emerged as a prominent factor. The interaction of feedback and the alliance and with other common factors in couple therapy warrants further study. For example, does feedback recruit client resources by fostering strong alliances, thereby enhancing outcomes? In the NCS, 9 of 10 therapists benefitted from using feedback, and those who had lower rates of effectiveness improved the most (Anker et al., 2009). Feedback may be the great leveler, moving less effective therapists into moderate to high ranges of effectiveness.

Lastly, the NCS supported the transportability of feedback procedures to routine clinical settings. Systems that require little time and have high "face validity" (clients find the measures easy to understand and nonintimidating) may be adopted more readily by both staff and clients and therefore be more easily assimilated into busy practices (Duncan, 2014). Feedback systems are applicable across therapist training and professional backgrounds, aligning with the realities of typical practice. Finally, given the Partners for Change Outcome Management System is listed by the Substance Abuse Mental Health Services Administration in the National Registry of Evidence-based Programs and Practices, it offers a valid choice for clinicians wishing to integrate a feasible feedback system into their couple work.

Lessons learned from the Norway Couple Project provide a template for informing treatment decisions and resolving some of the challenges inherent in work with couples. Therapist variables (including therapist ability to form strong alliances and experience working with couples) and the alliance (including goal alignment and directive skills) join with routine incorporation of client feedback to create a practical, research-informed clinical framework for safely navigating the difficult passages of couple therapy. Importantly, utilization of client feedback privileges the voices of clients over manuals and theories, promoting idiosyncratic and culturally responsive intervention with diverse clientele. Lastly, couple therapists transcend the perennial barrier between research and practice as they utilize client-generated data to chart a therapeutic course one couple at a time.

REFERENCES

American Psychological Association (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, *58*(5), 377–402. doi:10.1037/0003-066X.58.5.377.

American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285. doi: 10.1037/0003-066X.61.4.271.

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology*, *77*(4), 693–704.

Anker, M. G., Owen, J., Duncan, B. L., & Sparks, J. A. (2010). The alliance in couple therapy. *Journal of Consulting and Clinical Psychology*, *78*, 635–645.

Anker, M. G., Sparks, J. A., Duncan, B. L., Owen, J. J., & Stapnes, A. K. (2011). Footprints of couple therapy: Client reflections at follow-up. *Journal of Family Psychotherapy*, *22*(1), 22–45.

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed.). (pp. 258–297). New York: Wiley.

Baldwin, S.A., Wampold, B.E., & Imel, Z.E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*, 842–852.

Barber, J. P. (2009). Towards a working through of some core conflicts in psychotherapy research. *Psychotherapy Research*, *19*, 1–12.

Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., et al. (2004). Therapist effects. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). (pp. 227–306). New York: Wiley.

Bischoff, R. J., & McBride, A. (1996). Client perceptions of couples and family therapy. *American Journal of Family Therapy*, *24*, 117–128.

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, *33*, 298–317.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy*, *16*, 252–260.

Bourgeois, L., Sabourin, S., & Wright, J. (1990). Predictive validity of therapeutic alliance in group marital therapy. *Journal of Consulting and Clinical Psychology*, *58*(5), 608–613.

Bowman, L., & Fine, M. (2000). Client perceptions of couples therapy: Helpful and unhelpful aspects. *American Journal of Family Therapy*, *28*, 295–310.

Brown, P. D., & O'Leary, K. D. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology*, *68*, 340–345.

Castonguay, L. G., & Beutler, L. E. (2005). Common and unique principles of therapeutic change: What do we know and what do we need to know? In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 353–369). New York, NY: Oxford University Press.

Christensen, A. (2010). A unified protocol for couple therapy. In K. Hahlweg, M. Grawe-Gerber & D. H. Baucom (Eds.), *Enhancing couples: The shape of couple therapy to come* (pp. 33–46). Göttingen, Germany: Hogrefe.

Christensen, A., Atkins, D. C., Berns, S., Wheeler, J., Baucom, D., & Simpson, L. E. (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed married couples. *Journal of Consulting and Clinical Psychology*, *72*, 176–191.

Christensen, L.L., Russell, C.S., Miller, R.B., & Peterson, C.M. (1998). The process of change in couples therapy: A qualitative investigation. *Journal of Marital and Family Therapy*, *24*(2), 177–188.

Crits-Christoph, P., Connolly Gibbons, M., & Mukherjee, D. (2013). Process-outcome research. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavioral change* (6th ed.). (pp. 298–340). New York, NY: Wiley.

Crits-Christoph, P., & Gallop, R. (2006). Therapist effects in the National Institute of Mental Health Treatment of Depression Collaborative Research Program and other psychotherapy studies. *Psychotherapy Research*, *16*(2), 178–181.

Dattilio, F. M., Piercy, F. P., & Davis, S. D. (2014). The divide between "evidence-based" approaches and practitioners of traditional theories of family therapy. *Journal of Marital and Family Therapy*, *40*(1), 5–16. doi:10.1111/jmft.12032.

Duncan, B. L. (2011). *The Partners for Change Outcome Management System (PCOMS) administration, scoring, and interpretation manual update for the Outcome and Session Rating Scales*. Jensen Beach, FL: Author.

Duncan, B. (2012). The Partners for Change Outcome Management System (PCOMS): The Heart and Soul of Change Project. *Canadian Psychology*, *53*(2), 93–104. doi:10.1037/a0027762.

Duncan, B. (2014). *On becoming a better therapist* (2nd ed.). Washington, DC: American Psychological Association.

Duncan, B. L., Miller, S. D., Reynolds, L., Sparks, J., Claud, D., Brown, J., et al. (2003). The session rating scale: Psychometric properties of a "working" alliance scale. *Journal of Brief Therapy*, *3*(1), 3–12.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works* (2nd ed.). Washington, DC: American Psychological Association.

Duncan, B. L., & Reese, R. J. (2012). Empirically supported treatments, evidence based treatments, and evidence based practice. In G. Stricker, T. Widiger, & I. Weiner (Eds.), *Handbook of Psychology* (2nd ed., Vol. 8: Clinical Psychology, pp. 977–1023). Hoboken. NJ: John Wiley & Sons.

Duncan, B. L., & Reese, R. J. (2013). Clinical and scientific considerations in progress monitoring: When is a measure too long? *Canadian Psychology*, *54*(2), 135–137. doi:10.1037/a0032362.

Duncan, B., & Sparks, J. (2010). *Heroic clients, heroic agencies: Partners for change* (2nd ed.). Jensen Beach, FL: Author.

Gillaspy, J. A., & Murphy, J. J. (2011). The use of ultra-brief client feedback tools in SFBT. In C. W. Franklin, T. Trepper, E. McCollum & W. Gingerich (Eds.), *Solution-focused brief therapy*. New York, NY: Oxford University Press.

Gollan, K. K., & Jacobson, N. S. (2002). Developments in couple therapy research. In H. A. Liddle, D. A. Santisteban, R. F. Levant & J. H. Bray (Eds.), *Family psychology: Science-based interventions* (pp. 105–122). Washington, DC: American Psychological Association.

Green, R. J., & Herget, M. (1991). Outcomes of systemic/strategic team consultation: II. The importance of therapist warmth and active structuring. *Family Process*, *30*, 321–336.

Gurman, A. S. (2011). Couple therapy research and the practice of couple therapy. Can we talk? *Family Process*, *50*, 280–292.

Hatcher, R.L., & Barends, A.W. (1996). Patient's view of psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology*, *64*, 1326–1336.

Helmeke, K. B., & Sprenkle, D. H. (2000). Clients' perception of pivotal moments in couples therapy: A qualitative study of change in therapy. *Journal of Marital and Family Therapy*, *26*(4), 469–483.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 37–69). New York: Oxford University Press.

Horvath, A., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, *48*, 9–16.

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist*, *51*, 1059–1064.

Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy*, *23*(2), 135–152.

Kim, D. M., Wampold, B. E., & Bolt, D. M. (2006). Therapist effects in psychotherapy: A random effects modeling of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Psychotherapy Research*, *16*, 161–172.

Kivlighan, D. M., & Shaughnessy, P. (2000). Pattern of working alliance development. A typology of client's working ratings. *Journal of Counseling Psychology*, *47*, 362–371.

Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2004). The formation of the therapeutic alliance in couple therapy. *Family Process*, *43*, 425–442.

Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2007). Therapeutic alliance and treatment progress in couple psychotherapy. *Journal of Marital and Family Therapy*, *33*(2), 245–257.

Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S., & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research*, *21*, 267–276.

Lambert, M. J. (2010). Yes, it is time for clinicians to routinely monitor treatment outcome. In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble (Eds.) *The heart and soul of change. Delivering what works* (pp. 239–266). Washington, DC: American Psychological Association Press.

Lambert, M. J., Hansen, N. B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G., et al. (1996). *Administration and scoring manual for the OQ 45.2*. Stevenson, MD: American Professional Credentialing Services.

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). (pp. 203–223). New York: Oxford University Press.

Lebow, J. (2004). Separation and divorce issues in couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed.). (pp. 459–477). New York, NY: Guilford Press.

Lebow, J., Chambers, A., Christensen, A., & Johnson, S. (2012). Research on the treatment of couple distress. *Journal of Marital and Family Therapy*, *38*(1), 145–168. doi:10.1111/j.1752-0606.2011.00249.x.

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, *2*(2), 91–100.

Nelson, T. S., Chenail, R. J., Alexander, J. F., Crane, D. R., Johnson, S. M., & Schwallie, L. (2007). The development of core competencies for the practice of marriage and family therapy. *Journal of Marital and Family Therapy*, *33* (4), 417–438.

Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC: American Psychological Association.

Owen, J., Duncan, B., Anker, M., & Sparks, J. (2012). Initial relationship goal and couple therapy outcomes at post and six-month follow-up. *Journal of Family Psychology*, *26*(2), 179–186. doi:10.1037/a0026998.

Owen, J., Duncan, B. L., Reese, J., Anker, M. G., & Sparks, J. A. (2014). Accounting for therapist variability in couple therapy: What really matters? *Journal of Sex and Marital Therapy*. doi: 10.1080/0092623X.2013.772552.

Pinsof, W. M. (1995). *Integrative problem centered therapy: A synthesis of biological, individual and family therapies*. New York: Basic Books.

Pinsof, W. B., & Catherall, D. (1986). The integrative psychotherapy alliance: Family, couple, and individual therapy scales. *Journal of Marital and Family Therapy*, *12*, 137–151.

Pinsof, W. M., Zinbarg, R., & Knobloch-Fedders, L. M. (2008). Factorial and construct validity of the revised short form integrative psychotherapy alliance scales for family, couple, and individual therapy. *Family Process*, *47*, 281–301.

Raytek, H. S., McCrady, B. S., Epstein, E. E., & Hirsch, L. S. (1999). Therapeutic alliance and the retention of couples in conjoint alcoholism treatment. *Addictive Behaviors*, *24*(3), 317–330.

Reese, R. J., Duncan, B. L., Bohanske, R. T., Owen, J. J., & Minami, T. (2014). Benchmarking outcomes in a public behavioral health setting: Feedback as a quality improvement strategy. *Journal of Consulting and Clinical Psychology*, *82*(4), 731–742. doi:10.1037/a0036915.

Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training*, *46*, 418–431. doi:10.1037/a0017901.

Reese, R. J., Toland, M. D., Slone, N. C., & Norsworthy, L. A. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy: Theory, Research, Practice, Training*, *47*, 616–630. doi:10.1037/a0021182.

Schuman, D., Slone, N., Reese, R. J., & Duncan, B. (2014). Efficacy of client feedback in group psychotherapy of soldiers referred for substance abuse treatment. *Psychotherapy Research*. doi:10.1080/10503307.2014.900875.

Sells, S. P., Smith, T. E., & Moon, S. (1996). An ethnographic study of client and therapist perceptions of therapy effectiveness in a university-based training clinic. *Journal of Marital and Family Therapy*, *22*(3), 321–342.

Shadish, W. R., & Baldwin, S. A. (2005). Effects of behavioral marital therapy: A meta-analysis of randomized controlled trials. *Journal of Consulting and Clinical Psychology*, *73*(1), 6–14.

Snyder, D. K., Castellani, A. M., & Whisman, M. A. (2006). Current status and future directions in couple therapy. *Annual Review of Psychology*, *57*, 317–344.

Snyder, D. K., & Halford, W. K. (2012). Evidence-based couple therapy: Current status and future directions. *Journal of Family Therapy*, *34*, 229–249. doi:10.1111/j.14676427.2012.00599.x.

Snyder, D. K., Wills, R. M., & Grady-Fletcher, A. (1991). Long-term effectiveness of behavioral versus insight-oriented marital therapy: A four-year follow-up study. *Journal of Consulting and Clinical Psychology*, *59*, 138–141.

Sparks, J. A., & Duncan, B. L. (2010). Common factors in couple and family therapy: Must all have prizes? In B. L. Duncan, S. C. , Miller. , B. E. Wampold & M. A. Hubble (Eds.), *Heart and soul of change: Delivering what works in therapy* (2nd ed.). (pp. 357–392). Washington, DC: American Psychological Association.

Sparks, J. A., Kisler, T. A., Adams, J. F., & Blumen, D. G. (2011). Teaching accountability: Using client feedback to train effective family therapists. *Journal of Marital and Family Therapy*, *37*(4), 452–467.

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Sharpiro, D. A., Agnew-Davies, R., et al. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships U-shaped or V-shaped? *Journal of Counseling Psychology*, *51*, 81–92.

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*, *5*, 439–458. doi:10.1111/j.1468-2850.1998.tb00166.x.

Symonds, B. D., & Horvath, A. O. (2004). Optimizing the alliance in couple therapy. *Family Process*, *43*, 443–455.

Tremblay, N., Wright, J., Mamodhouseen, S., McDuff, P., & Sabourin, S. (2008). Refining therapeutic mandates in couple therapy outcome research: A feasibility study. *American Journal of Family Therapy*, *36*, 137–148. doi:10.1080/01926180701236175.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Hillsdale, New Jersey: Lawrence Erlbaum.

Wampold, B. E., & Bolt, D. M. (2006). Therapist effects: Clever ways to make them (and everything else) disappear. *Psychotherapy Research*, *16*(2), 184–187.