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Footprints of Couple Therapy: Client Reflections at Follow-Up

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This study explores client experiences in couple therapy through analysis of written client responses at 6-month follow-up. A subsample participated in a randomized trial comparing outcomes for couples that used routine client feedback with no-feedback couples. Thematic analysis indicates that clients prefer personable and active therapists who maintain neutrality. Women and men expressed dissatisfaction with lack of therapist structuring and challenge. Lack of therapist initiative and flexibility in scheduling emerged as most problematic, with nonfeedback clients most dissatisfied. Most clients rated use of feedback very helpful. The study's method provides a way to use posttherapy client feedback to improve services.

KEYWORDS couple therapy, follow-up, gender, alliance, feedback

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Couple therapy has a proven record of efficacy over no treatment, with an effect size (ES) ranging from of 0.59 (Shadish & Baldwin, 2005) to 0.84 (Shadish & Baldwin, 2002). However, couple treatment in routine care often falls short of controlled trials outcomes (Christensen & Heavey, 1999). For example, Hahlweg and Klan (1997) reported an ES of 0.28 for practicing couple clinicians in Germany. Anker, Duncan, and Sparks (2009) found that only 10.8% of couples receiving usual care in a naturalistic setting achieved clinically significant change (Jacobson & Truax, 1991) compared to 40.8% of couples in the experimental feedback condition. Findings regarding the durability of couple treatment are similarly mixed. Several reviews have concluded that as many as 30% to 50% of couples relapse 1 to 4 years post-treatment (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Christiansen & Heavey, 1999; S. Johnson & Lebow, 2000). In contrast, gains at 2-year follow-up after brief couple clinic treatment in Sweden were largely maintained (Lundblad & Hansson, 2006). In a study of long-term follow-up of 130 couples, 69% of couples receiving integrative behavioral therapy were improved at follow-up compared to 60% of those receiving traditional behavioral therapy (Christensen, Atkins, Yi, Baucom, & George, 2006). Both groups initially dipped in marital satisfaction immediately post termination but rebounded and remained significantly improved throughout the remainder of the 2-year follow-up period.

Despite variations in rates of success and durability of effects, couples receiving treatment do better, on average, than those untreated. One variable consistently associated with outcome in couple work is the therapeutic alliance (e.g., Bourgeois, Sabourin, & Wright, 1990; Brown & O'Leary, 2000; Raytek, McCrady, Epstein, & Hirsch, 1999). In one study, the alliance explained as much as 22% of the variance in outcome (Johnson & Talitman, 1997), with the bulk attributable to the task subscale of the alliance measure—couples who felt that the therapist's method was relevant to their presenting concern did the best, accounting for 27% of posttreatment variance in outcome and 36% at follow-up. Knobloch-Fedders, Pinsof, and Mann (2007) found that the therapeutic alliance is a strong predictor of marital distress posttreatment, explaining 5% of the variance in marital distress for men and 17% for women. Analyzing alliances of couples treated in a naturalistic setting, Anker, Owen, Duncan, and Sparks (2010) reported that the alliance predicted outcome over and above early change suggesting that the alliance is not simply a by-product of successful treatment. Moreover, couples with ascending alliances reported significantly better couple outcomes, suggesting that ongoing alliance assessment is warranted.

Client perceptions of fit appear to play a role in alliance formation, as clients tend to experience therapy idiosyncratically. Bischoff and McBride (1996) found that clients held definite views regarding the helpfulness of techniques, but these views varied from one client to another. One study

of therapists' and clients' perceptions of critical change incidents in couple therapy reported little resemblance between the two perspectives (Wark, 1994). Bedi, Davis, and Williams (2005), analyzing client perceptions of critical incidents, found a discrepancy between clients', therapists', and investigators' views of the alliance. Similarly, Helmeke and Sprenkle (2000) reported that spouses concurred very little with one another and with the therapist in identifying pivotal moments in their therapy. In another study, clients appreciated therapists who encouraged them to determine the session focus without having to adopt a particular world view and who ensured that discussions were relevant to presenting concerns (Quinn, 1996). Similarly, Kuehl, Newfield, and Joanning (1990) found that clients welcomed therapists generating directions when these fit with clients' unique views of change. Finally, although general domains of change were identified in an analysis of interviews with 13 heterosexual couples, the specific pathways to change were variable and multiple (Christensen, Russell, Miller, & Peterson, 1998).

Gender weighs in as an important consideration in couple therapy alliances although findings vary. Bourgeois et al. (1990) found that men's alliance ratings at the third session more strongly predicted outcome than women's. Knobloch-Fedders et al. (2007) reported that when men scored the alliance higher than their partners at mid-treatment, couples showed greater improvement. Similarly, the correlation between alliance and outcome was greater when males rated the alliance higher than females in one study (Symonds & Horvath, 2004), and men's alliance scores were stronger predictors of therapy outcomes at post and follow-up as compared to their partners in another (Anker et al., 2010). In contrast, Knobloch-Fedders et al. found that women's ratings of the couple's alliance at mid-treatment uniquely predicted improvement beyond that accounted for by early alliance ratings. In addition, Pinsof, Zinbarg, and Knobloch-Fedders (2008) reported that women's first session alliance scores predicted eighth session individual and couple outcomes. Finally, Knobloch-Fedders et al. found that both men's and women's early and mid-treatment alliance scores predicted improvement. In sum, how gender influences couple alliance formation and outcome needs more investigation.

Although there are few studies in the couple therapy literature regarding therapist variability (Blow, Sprenkle, & Davis, 2007; Sparks & Duncan, 2010), data suggest that the therapist's ability to forge a working alliance with both members of a couple impacts how well couples do in treatment. Owen, Anker, Duncan, and Sparks (2010) found that therapists accounted for 6% of the variance in outcome in their study of 118 couples, with alliance scores at the third session explaining 33% of that variability. Therapists working with couples must form simultaneous, nonconflicting working alliances in an often emotionally charged atmosphere. Qualitative analyses of client

perceptions indicate that therapists who are accepting, caring, and empathic and who also are capable of providing structure may be the most adept in negotiating these types of complex relational tasks with couples (Bischoff & McBride, 1996; Bowman & Fine, 2000; Green & Herget, 1991; Kuehl et al., 1990; McCollum & Trepper, 1995). One ethnographic study found that clients want therapists to provide safety and meaningful input (Sells, Smith, & Moon, 1996). Clients expressed dissatisfaction when goals were unclear and therapy lacked direction. Safety and therapist qualities of being nonjudgmental, validating, and supportive while showing genuine interest were mentioned as helpful in interviews with five heterosexual couples (Bowman & Fine, 2000). Holtzworth-Munroe, Jacobson, DeKlyen, and Whisman (1989) concluded that client involvement in the tasks of therapy, considered a product of the therapeutic alliance, predicted the success of 32 couples in their study. They suggested that the proportional contributions of the client and therapist in this process needed further examination.

The impact of using client feedback to inform treatment decisions (see Howard, Moras, Brill, Martinovich, & Lutz, 1996) was recently tested in a large ($N = 205$ couples) randomized trial in a naturalistic setting in Norway (Anker et al., 2009). Investigators found that couples whose therapists continuously incorporated alliance and outcome feedback throughout treatment achieved nearly four times the rate of clinically significant change compared to their nonfeedback counterparts (40.8% and 10.8%, respectively). Moreover, couples in the no-feedback condition were more likely to be divorced or separated (34.2%) than those in the experimental feedback condition (18.4%) 6-months posttreatment. These findings are consistent with those from individual feedback trials. For example, Lambert (2010) summarized the findings of five randomized clinical trials and found that at-risk cases where therapists and clients had routine access to client feedback were over twice as likely to reach reliable and clinically significant change (Jacobson & Truax, 1991) compared to treatment as usual at-risk cases. Although Anker et al. (2009) admit that the "how and why" of feedback needs more study, they suspect that greater attention to the alliance may prevent deterioration and dropout (p. 702).

Understanding how clients experience therapy contributes to knowledge of therapeutic process with implications for predicting outcome and improved effectiveness (Elliott, 2008). The current study hopes to expand the emerging picture of couple therapy through an analysis of couples' reflections posttreatment. It examines the written client responses to three open-ended questions about client experiences in couple therapy as part of a 6-month follow-up at two community counseling agencies in Norway. Answers from clients who had completed a randomized trial comparing outcomes for continuous feedback and nonfeedback couples (Anker et al., 2009) allowed a comparison of qualitative responses between these groups.

A subset of clients were asked to rate their experience of the use of feedback instruments during their treatment; an analysis of these ratings is included.

The following questions guided the current study:

1. What aspects of couple therapy do couples identify as most salient?
2. How do aspects identified by couples as meaningful expand understanding of the alliance, the role of the therapist, and gender in couple treatment?
3. What different experiences, if any, emerge for couples whose therapists used systematic feedback compared with those who did not?
4. How did couples experience their use of feedback protocols during therapy?

The study utilized thematic analysis (Braun & Clarke, 2006) to generate categories, domains, and evaluations of responses and quantitative methods to compare responses based on gender and study condition (i.e., feedback vs. nonfeedback).

METHOD

Sample

Couple clients were invited to participate in a research study about improving the benefits of therapy. At 6-month follow-up, 519 of 918 clients (56.54%) responded to the questionnaire. Couples were white, Euro-Scandinavian, and heterosexual from two outpatient counseling offices in Norway providing free government subsidized services in southern Norway. Participants were recruited from October 2005 to December 2007. Respondents' ages ranged from 20 to 72; mean age was 38.2 years ($SD = 8.71$). Mean years as a couple was 10.87 ($SD = 7.89$). Couples had between 1 and 16 sessions; mean number of sessions, 4.03 ($SD = 2.73$); 66 clients (12.7%) had 1 session; modal number of sessions was 2 (121 clients; 23.3%). Three hundred and sixty-three (69.9%) participants were employed full time and 58 (11.2%) were employed part time, whereas 98 (18.9%) were unemployed or did not work outside the home.

Regarding education levels, 125 (24.1%) had completed lower secondary school, 193 (37.2%) had completed upper secondary school, and 195 (37.6%) had completed university or college. Six individuals left this question blank. Couples self-referred to the agencies with a broad range of typical relationship problems, including communication difficulties, loss of feeling for partner, jealousy/infidelity, conflict, and coping with partner's physical or psychological problem. Couples were excluded at phone intake

when one member refused to attend, one or both members of the couple expressed the desire to end the relationship, or one or both refused informed consent.

Before the first session, study participants were asked to identify their goals on a standard intake form. Three hundred seventy-nine (73.03%) participants marked the goal of achieving a better relationship, whereas 118 (22.74%) sought clarification regarding whether the relationship should continue. Fourteen individuals (2.7%) indicated a goal of terminating the relationship in the best possible way and another 8 (1.54%) marked "other" without elaboration. Three hundred sixteen (60.89%) individuals were in a relationship where both marked the goal of achieving a better relationship, while 203 (39.11%) were in a relationship where both had not marked the goal achieving a better relationship. The mean intake score of the 519 participants on the Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) was 18.96 ($SD = 7.54$), indicative of a clinical population and similar to distress levels of other clinical sites (Miller & Duncan, 2004). Similarly, the mean marital satisfaction score on the Locke-Wallace Marital Adjustment Test (Locke & Wallace, 1959) was 73.88 ($SD = 25.93$), indicative of a dissatisfied relationship and well under the traditional cutoff score of 100.

Of those responding to the questionnaire, 382 (73.6%) answered the two open-ended questions about their experiences in therapy. These respondents (225 women and 157 men) constituted our qualitative subsample. In this sample, women had contacted the family counseling office 61% of the time. A portion of these 382 respondents ($n = 197$) had participated in a large, randomized clinical trial comparing feedback and nonfeedback conditions in routine practice (Anker et al., 2009). These individuals comprised the randomized clinical trial (RCT) subsample. Also of the 519 clients responding to the questionnaire, 377 marked the check-off survey questions regarding their experience of their use of feedback instruments in therapy. These respondents made up the feedback survey subsample.

Clients from the RCT and feedback survey subsamples had been given the ORS[1]at the beginning of each session. Results from this measure were scored by the therapist and discussed with couples at each session (see Duncan, Miller, & Sparks, 2004). The ORS asked clients to rate their view of distress along individual, interpersonal, social, and overall domains. In addition, the Session Rating Scale (SRS; Duncan et al., 2003) was administered at the end of each session. This instrument asked clients to score their view of the strength of the therapeutic alliance based on dimensions of the alliance described by Bordin (1979). These included clients' felt connection to the therapist as well as agreement on goals and tasks.

[1]The ORS is free for individual clinician use and can be downloaded at www.heartandsoulofchange.com

Questionnaire

Each member of the couple received their own questionnaire. Respondents formulated their answers in writing in their own home without a researcher present. The questionnaire asked clients to respond to a series of questions regarding outcome and satisfaction. These questions inquired about the current status of the couple (e.g., together, separated, or divorced), the problem presented in the prior therapy (e.g., better, worse), and the quality of the couples' communication since the end of therapy (Anker et al., 2009). Those clients who had utilized feedback instruments throughout treatment were asked to check the box that best matched how they had experienced the feedback process (e.g., helpful, not important). The questionnaire concluded with three questions, inviting clients to express their views further in writing (see Appendix 1):

> How did you experience the contact with the family counseling office and the therapist?
> Was there something missing?
> Was there something you were satisfied with?

Client answers to these three questions and the checked boxes regarding experiences using feedback provided the data for the current study.

Therapists

Couples were seen by 20 therapists (13 women and 7 men). Therapists worked at two family counseling agencies in Norway, 10 therapists from each agency. Ten were licensed psychologists, nine were licensed social workers, and one was a licensed psychiatric nurse. All therapists professed an eclectic orientation using a variety of approaches—solution-focused, narrative, cognitive-behavioral, humanistic, and systemic—similar to those typically practicing in Norway family counseling agencies. The average age of the therapists was 44 years (SD = 12.6 years), age ranged from 26 to 61 years. The mean years of experience with couple therapy was 6.7 years (SD = 6.98 years) experience ranged from 0 to 19 years.

Analysis

Two researchers independently read all client responses to 6-month follow-up, open-ended questions several times, dividing clients' written replies into statements. Statements consisted of clients' descriptions, generally a phrase or brief sentence, of a dimension of their therapy. Next, statements were coded thematically. Themes emerged from the data (Glaser & Strauss, 1967; Kvale, 1996). Similar themes were collected into a category, which was

then given a cue word or words (Thagaard, 1998). Clients' statements were also categorized into subcategories of evaluation (satisfied/problematic). To maintain an open mind and to view client statements from a fresh perspective, the couple therapy research literature was reviewed after categorization.

After independent coding, we compared our separate analyses. Categories derived independently from multiple readings produced a saturation of content (Strauss & Corbin, 1998), suggesting that relevant meaning units were reached from the existing data. Fifteen final categories (numbered 0–14) surfaced in this step. Finally, we examined this list for connections between categories to create an additional level of general domains.

The following illustrates the method described previously, using the following client's statement:

> Was very satisfied to have a neutral conversation partner who had a structure for the conversation, provided competence with different strategies we could use, gave feedback on the good things we did that contributed so that we found and can find solutions ourselves.

This response was coded in the following way:

Neutral conversation partner = satisfied (neutrality)
Who had a structure for the conversation = satisfied (therapist's structure/guiding the session)
Competence with different strategies we could use = satisfied (instrumental)
Gave feedback on the good things we did that contributed = satisfied (acknowledging positive actions)

Descriptive statistics were used to illustrate the number of responses by category and by evaluation (satisfied/problematic). Analysis by feedback condition utilized chi-square analyses to determine significance of differences in responses based on feedback and nonfeedback conditions.

RESULTS

In the qualitative subsample, 225 woman and 157 men answered the open-ended questions with 742 statements about their experience with the family counseling office and the therapist. The mean number of statements was 1.94 (SD = .93) and the median was 2 (range 1–7). Ninety-eight clients provided statements from the feedback condition in the RCT subsample and 99 nonfeedback clients responded. Respondents from the RCT subsample made 385 statements (approximately 52% of the total statements). There were

191 statements made by feedback clients compared to 194 by nonfeedback clients. The mean numbers of statements in the feedback and nonfeedback groups were 1.95 (SD = 1.11) and 1.96 (SD = .87), respectively, with a median of two statements in each, representing a nondifferential distribution of numbers of statements among responders in each group, $t(195) = -0.08$, $p > .05$. In response to the feedback survey, 377 persons responded to check-off questions indicating their experience of use of the measures.

Categories

The following 15 categories (with exemplars) emerged from analyses of the 742 statements:

0. Unspecified: "Satisfied with the therapy." "Was very satisfied with the work you did."
1. Therapeutic setting: "To have an arena to raise the problems." "Easy and calm atmosphere." "Good to talk to a third party."
2. Therapists' characteristics: "Humor, the therapist was very sympathetic, so it was easy for both of us to talk." "The therapist showed insight and was skilled."
3. Relationship with the therapist: "Established a good trusting relationship with the therapist." "The therapist also revealed some information from his personal life experience. That makes it easier for others to open up."
4. Therapist's structure/guiding the session: "Having an objective chairman." "The possibility to speak without interruption." "Having a more explicit guiding from the therapists of the sessions."
5. Neutrality: "We only had one session, but it was nice that my husband also felt appreciated." "I felt the therapist was objective and neutral." "That the therapist understood both sides of the case."
6. Individual sessions: "Missed time alone with the therapist." "Could have had more sessions separately." "Satisfied with the separate conversations"
7. Acknowledging positive actions: "In the first session we got a homework assignment to search for positive signs that was a very good start." "A positive acknowledging to both." ". . .focus on the positive"
8. Instrumental: "I missed that we could end the sessions with a plan so we could continue the work at home." "We got good suggestions about what we could do, and it helped." "Missed a bit more concrete homework. For example to do something concrete, not only reflect on what has been said or what we ought to do."
9. New angle: "Felt that we were helped to put things in perspective." "I missed greater input to new ways of thinking." "We were helped to frame the problems in a very different way than what we could have done ourselves."

10. Challenge/straightforward: "I missed some critical comments from the therapist to both him and myself." "More direct questions because I omitted to tell everything." "Demanded answers and opinions—pushed us a little."
11. Central/depth/causal connections: "Go more in depth in what I/we thought was important." "Missed dealing with the essential aspects of the problems." "He helped me go further into my self than I ever had done before."
12. Communication in session: "The way we talked all three of us." "We managed to say a lot more to each other, than we would have managed at our own." "It was easy to talk about the problems without us screaming at each other."
13. Service delivery: "We had too few sessions." "The second session was cancelled due to illness at the family counseling office. It was especially at that point we needed the session." "Missed the possibility to have sessions outside my work schedule." "The therapist should have insisted on scheduling more sessions." "The therapist was nice but forgot to schedule another session." "The therapist was especially conscientious with regards to phoning us to make a new appointment or when I had some questions." "That we could have follow-ups at regular intervals."
14. Relapse: "After three sessions the problems did not appear so huge, but in a short time we were back to quarrelling, irritated about the same issues, and continued in the same pattern." "During the period we were in therapy things were better, but now things fell back into their old groove."

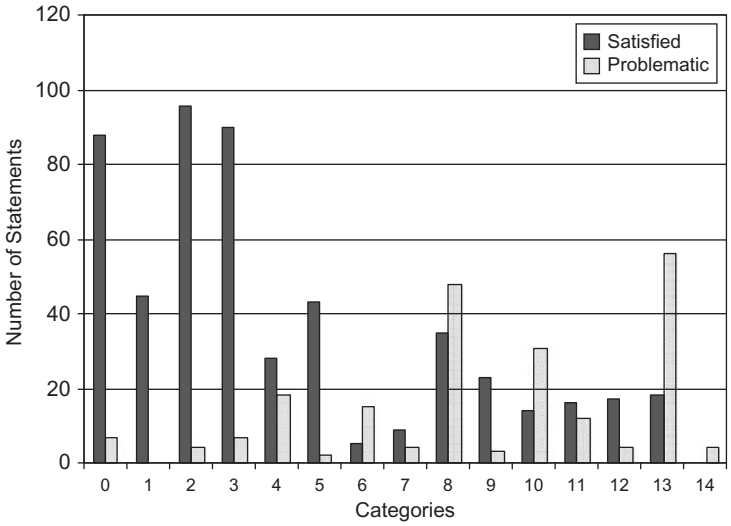
Figure 1 illustrates the distribution of evaluations (satisfied/problematic) for each category for the qualitative subsample. Of a total of 742 statements, 527 were determined "satisfied" compared with 215 statements, "problematic."

Domains

Two groups of general domains emerged when exploring connections between categories—relationship and tasks. Domains included the following categories:

Relationship: therapeutic setting, therapists' characteristics, relationship with the therapist, and neutrality

Tasks: therapists' structure/guiding the session, individual sessions, instrumental, new angle, challenge/straightforward, making central/depth/causal connections, communication in session, and service delivery



0. Unspecified: good/satisfied-not satisfied.
1. Therapeutic setting.
2. Therapists´ characteristics.
3. Relationship to the therapist.
4. Therapist's structure/guiding the session.
5. Neutrality.
6. Individual sessions.
7. Acknowledging positive actions.
8. Instrumental.
9. New angle.
10. Challenge/straightforward.
11. Central/depth/causal connections.
12. Communication in session.
13. Service delivery.
14. Relapse.

FIGURE 1 Profile of Client Evaluations of Categories (742 Statements) From Qualitative Subsample (n = 382 Clients)

The role of the therapist, and qualities valued, or disliked, related to the therapist, were embedded within these two domains. For example, in addition to the straightforward therapist's characteristics, respondents expressed their views about what helped them feel comfortable and safe with their therapist, what they liked about what the therapist did, and what they wish the therapist had done differently. Acknowledging positive actions encompassed elements of the relationship and tasks. Relapse was not grouped under either domain, appearing to represent general feelings of disappointment in lack of overall progress.

Of all statements, 38.7% (287 statements) expressed relationship categories (1, 2, 3, and 5). As Figure 1 depicts, clients felt satisfied with these elements of their therapy by an overwhelming margin. Following are examples of client statements in categories 2, 3, and 5, those with the most responses in the relationship domain.

Therapists' characteristics (2):

Had a good sense of humor.
Humor, therapist was very sympathetic/pleasant, in a way that it was easy for both of us to talk.
She had good motivating skills.
Our therapist was very professional and nice.
Satisfied with her humanity.
The therapist appeared insightful and competent.
Very nice therapist and helpful and clever.
Very positive that it was a man, thinking in relationship to my husband.
He was calm and warm.
A good listener.
A comfortable therapist. Got me to relax. Had a bit of humor.
Experience the therapist as open, competent, flexible.
The therapist had the skill to get the conversation started

Relationship to the therapist (3):

Good connection.
Felt that we got a very good connection with the therapist
Established fast a good and trusting relationship to the therapist.
Therapist did even reveal some personal matter. This makes it easier for others to open up.
The chemistry with the therapist.

Neutrality (5):

He was good at meeting both of us.
Satisfied with her neutrality.
Competent therapist that managed to see both parties.
That both parties were listened to and valued equally.
Skillful in illuminating both sides.
That the therapist was neutral to both of us.

The tasks domain encompassed eight categories (4, 6, 8, 9, 10, 11, 12, and 13), including the therapist's activities of structuring the session, being instrumental, providing a new angle, challenging, making central or causal connections, and providing an effective service delivery framework for sessions and therapy in general. Statements (261) in these categories cover 35.2% of all statements. Clients experienced more problems in this domain than in the relationship domain (see Fig. 1). The category service

delivery contained 56 statements, the most for any category in the tasks domain. These statements were particularly negative:

> We had too few sessions.
> More sessions and the possibility to meet in the evening.
> The sessions ended because the therapist had excuse on account of illness.
> Therapist should be more firm to schedule more sessions.
> We had to change the session and the session we changed to, did not fit the therapist. And we heard nothing from him. The follow up was bad.

Many clients in this study expressed the desire for the therapist to follow them more closely and take the initiative for a new session, regardless of whose fault it was for missed sessions. Couples frequently stated that they wanted the therapist to provide more and flexible meetings. Some clients stated that they wished to have individual sessions or the opportunity to have more individual sessions than they were granted.

Clients requested more instrumental action and challenge from their therapist. The following are examples of these sentiments:

> Missed some concrete matters that we could work on. The conversations often do not lead to or end in something tangible that we could work further on.
> It was too much focus on how things were before. That was not positive for us. Missed ideas on how we could get a better life now!
> I missed more structure. Constructive advice—not so much talk about feelings ("What do you feel when he says that?").
> Everything was too uncertain and vague; we were in need of advice and guiding with different specific problems.

In this category, negative statements referred exclusively to a desire for greater instrumentality; there were no statements expressing dissatisfaction with too much therapist instrumental activity.

Although therapist's structuring/guiding the session had more satisfied than problematic comments, this category garnered the fourth most negative statements in the tasks domain. The following client's response illustrates the importance of this therapist activity:

> I missed that the therapist structured the dialogue onto a constructive track. Our sessions degenerated in a way that my partner exclusively monopolized the time and continually lied and raged against me. I experienced this as very insulting and definitively not constructive. In my opinion it was the therapist's responsibility to stop/subdue this, which

> the therapist did not do. It was a painful and a degrading experience to have to go through this.

The category communication in session encompassed couples views of whether they found new ways of talking or repeated negative communication in the therapy sessions. In general, respondents expressed satisfaction that therapy was a place where a different kind of communication could occur between partners.

Gender

The 382 informants in our qualitative subsample consisted of 225 women and 157 men. Of a total of 742 statements, 478 were made by women and 264 by men. Women had 335 satisfied and 143 problematic statements compared with 192 satisfied and 72 problematic for men. Based on these numbers, women had 2.34 times as many positive to negative statements, whereas men had 2.67 times as many positive than negative. We conducted a 2 (Statement) × 2 (Gender) repeated measures analysis of variance (ANOVA). The main effects for Statement was statistically significant, $F(1, 380) = 144.03$, $p < .001$, but the Statement by Gender interaction was not statistically significant, $F(1, 380) = 0.44$, $p > .05$. There was a significant effect for Gender, $F(1, 380) = 22.20$, $p < .001$, as women listed more statements ($M = 2.13$, SD = .97) as compared to men ($M = 1.68$, SD = .78). Collectively, these results suggest that although women listed more statements than men, both men and women reported more satisfied than problematic statements.

Women's and men's interest in categories largely mirrored one another. In fact, only two categories revealed gender differences. Figure 2 shows the distribution of clients with satisfied and problematic statements by gender. As seen in Figure 2, women had more satisfied responses in the category relationship to the therapist $\chi^2(1, N = 382) = 11.44$, $p < .05$. Approximately 29% of women and 14.6% of men listed a comment reflective of this category. For example, one woman commented: "We felt that we had very good contact with the therapist."

Although the base rates for satisfied with service delivery were low, women (6.7% of all women) listed more satisfied comments than men (1.9% of all men) for this category, $\chi^2(1, N = 382) = 4.66$, $p < .05$. There were no other significant differences between men and women for the other categories (ps > .05).

Feedback and Nonfeedback Conditions

Figure 3 depicts the total distribution of clients who reported satisfied and problematic statements for feedback and nonfeedback conditions derived

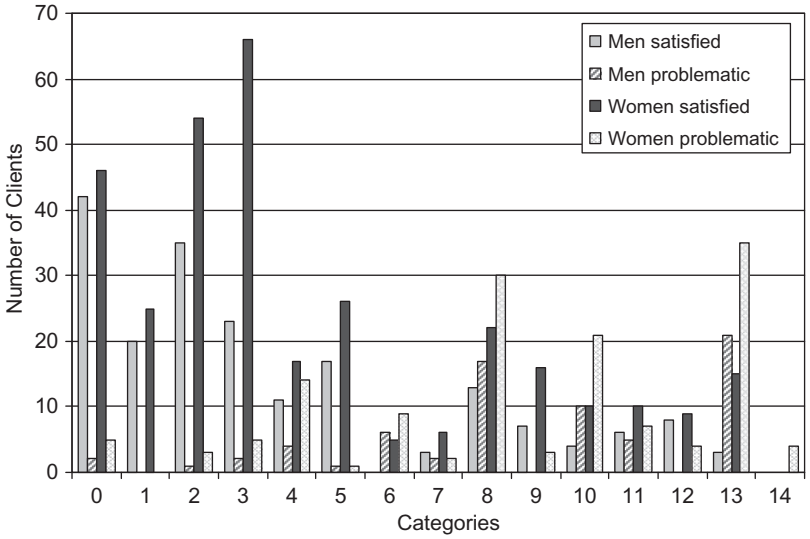


FIGURE 2 Profile of Problematic/Satisfied Categories for Men and Women From the Qualitative Subsample ($n = 382$ Clients)

from our RCT subsample. As indicated, most statements fell within categories 2, 3, 8, and 13 (excluding unspecified). The clients and feedback condition did not differ in their satisfied or problematic statements for categories 2, 3, and 8 ($ps > .05$). However, nonfeedback clients made more negative statements related to category 13, service delivery, $\chi^2(1, N = 197) = 6.49$, $p < .01$. More nonfeedback clients were unhappy with the therapist's attempts to follow up with them or take the initiative for a new session, even if the client had dropped out or misunderstood when a session was scheduled.

Fit

This study found evidence that, even when clients had the same therapist, experiences tended to be unique to the therapy dyad. This phenomenon is vividly illustrated with the following examples from two different clients with the same therapist.

Client A:

> Was very satisfied to have a neutral conversation partner who had a structure for the conversation, provided us with competence with different strategies we could use, gave feedback on the good things we did that contributed so that we found and can find solutions ourselves.

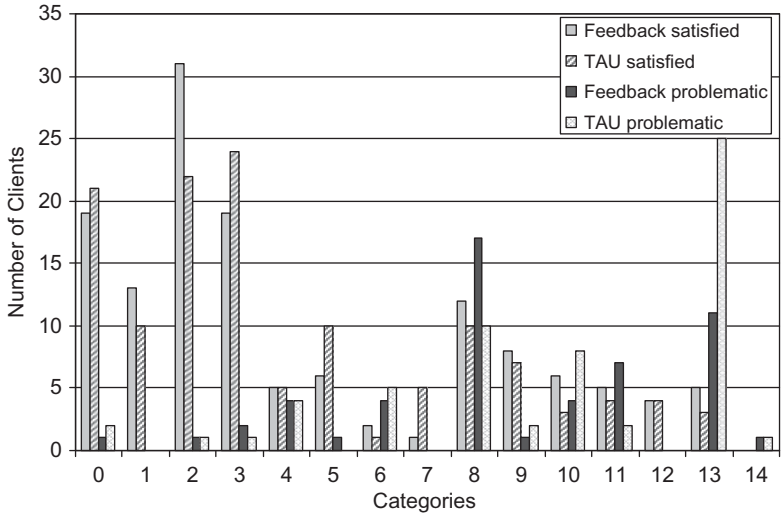


FIGURE 3 Profile of Satisfied/Problematic Categories for Feedback and Nonfeedback Conditions From the Randomized Clinical Trial (RCT) Subsample ($n = 197$ Clients)

Client B:

> I missed more structure. Constructive advice—not so much talk about feelings ("What do you feel when he says that?"). Everything was too uncertain and vague, we were in need of advice and guidance on different specific problems.

Even when the therapist was the same person, clients differed in their views of that therapist's effectiveness. Interestingly, in the previous example, client B was in the nonfeedback condition in which the therapist was not provided alliance feedback. Comments from other clients in the feedback condition illustrated the value of attending to unique client meanings and preferences for how the treatment should proceed:

> Felt that the therapist came up with several bad ideas in the beginning of the therapy, but I think the ideas got better and better every time (from session to session) Yes, and the therapist's skills in improving their techniques and ideas, I think this is the key to solving many conflicts in relationships.

Experience of Feedback

Clients from the feedback survey subsample ($n = 377$) rated their experience of using feedback instruments routinely during treatment. The fixed alternatives they could mark were "disturbing," "not important," "useful/helpful,"

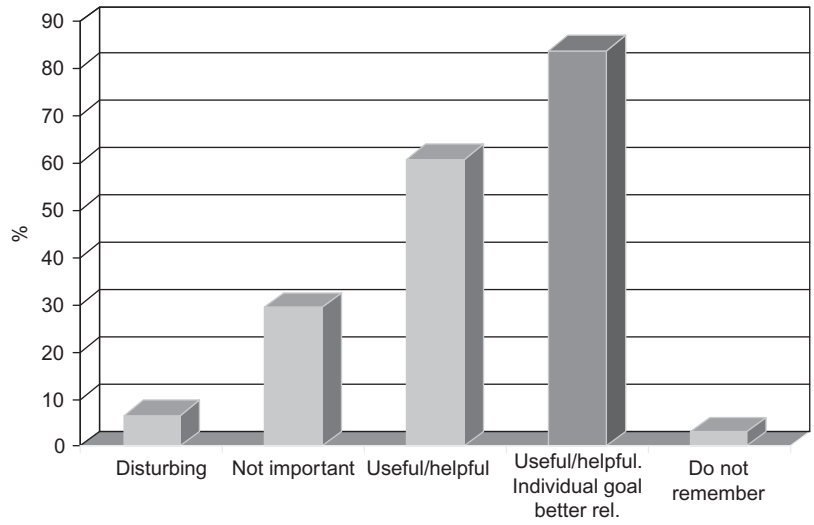


FIGURE 4 Distribution of Clients' Responses of Their Experience of Use of Feedback From the Feedback Survey Subsample (n = 377 Clients)

and "do not remember" (see Appendix 1). Of these clients, 60.7% marked "helpful/useful," rising to 83.7% when their own goal was achieving a better relationship, compared to 6.6% who marked "disturbing." Figure 4 indicates the distribution of clients' responses of their experience of use of feedback.

DISCUSSION

This study analyzed 742 written client responses from 382 individuals in our qualitative subsample to three questions as part of a 6-month follow-up of couple therapy in a routine clinical setting in Norway. Because of the number of respondents and statements, the categories generated were particularly robust, and the emergent themes more likely reflect attitudes couples might hold about what is helpful and unhelpful in couple counseling. By responding without a therapist or researcher present, at their own pace, and 6 months after the conclusion of therapy, clients may have provided particularly thoughtful reflections unencumbered by concerns for the therapy relationship. Additionally, responses from the RCT subsample provided data to compare the experiences of clients who utilized routine feedback measures throughout their treatment with those who did not. Finally, check-off questions answered by our feedback survey subsample added to the picture of how clients experienced the use of a feedback protocol in their therapy.

Our analysis of client responses to open-ended questions about their therapy experiences connected categories under two broad domains: relationship and tasks. These domains correspond with similar groupings in couple therapy literature (Bishcoff & McBride, 1996; Green & Herget, 1991; Sells et al., 1996). Moreover, they mirror Bordin's (1979) definition of the alliance. In total numbers, more comments referred to relationship categories, and these comments more often expressed satisfaction than those in the tasks domain. Statements regarding therapist warmth and friendliness along with the therapist's ability to listen well and remain neutral were well represented, as they are in the literature. Respondents frequently commented on therapist neutrality and these comments were largely positive. Neutrality perhaps represents a unique quality of couple therapy. Many individuals in this study did not appear to want the therapist solely on his or her side. Instead, respondents often expressed an appreciation for therapists' forming balanced relationships during their therapy. That respondents commented frequently in these areas may reflect the value clients place on feeling at ease with their therapist and trusting that the therapist has the couples', not just the individuals', best interest at heart.

The greatest number of negative comments occurred in the tasks domain. Specifically, respondents often wrote that they wished their therapist had given more tangible and usable advice. These findings support conclusions from Helmeke and Sprenkle (2000) and Denton, Burleson, Clark, Rodriguez, and Hobbs (2000) that stressed the importance clients place on practical suggestions relevant to their lives. Similarly, Sells et al. (1996) concluded that many clients value having clear directions from session to session. Studies further indicate that couples want their therapist to provide structure and a safe space for frank and often highly charged conversation (Bowman & Fines, 2000; Christensen et al., 1998). The number of negative expressions in instrumental and challenge/straightforward categories suggests that these are areas that could benefit from greater attention by practicing clinicians.

That more problematic statements emerged in tasks categories overall suggests that therapists may be less practiced in, or deem less valuable, behaviors clients want, specifically a willingness and ability to challenge, push clients in new directions, and offer new input into the therapy process. Many respondents also stated that they wanted therapists to more actively engage them and be flexible with session scheduling. In fact, the most problematic statements in our study fell in the service delivery category, with both women and men surprisingly vocal and dissatisfied. To our knowledge this aspect of therapy is not well researched (see Orlinsky, Ronnestad, & Willutzki, 2004), perhaps because it is seen as not integral to actual therapy. In our sample, how therapists handled appointments, maintained an active outreach to clients in scheduling, and provided enough and flexible meetings mattered a great deal. We speculate that this disregarded aspect

of therapy has implications for the therapeutic alliance. Although Bordin (1979) described the working alliance primarily in terms of in-session therapeutic process, he also included other structural aspects of therapy such as the payment of the therapist and frequency of meetings, stating that "collaboration between patient and therapist involves an agreed-upon contract, which takes into account some very concrete exchanges" (p. 254). Therapist accommodation to client preferences regarding these elements may impact the maintenance of viable partnerships.

The striking agreement between women and men preferences in our sample was surprising. In addition, expressed views were not stereotypically gender-based, with women desiring an active, challenging therapist and men valuing connection with a personable therapist. Quinn, Dotson, and Jordan (1997) found that when wives scored higher on the Task subscale of the Couple Therapy Alliance Scale (CTAS; Pinsoff & Catherall, 1986) than their husbands', outcomes were better. In heterosexual couples, women's views of the therapist's approach may warrant particular attention. The greater frequency of satisfied comments by women in the relationship to therapist categories suggests that an empathic relationship with men may need to be cultivated more systematically in couple treatment.

An analysis of feedback and nonfeedback study conditions indicated no significant differences in satisfied and problematic statements with the exception of one category. Clients in the nonfeedback group were significantly more likely to complain about the therapy service delivery than feedback clients. This finding raises intriguing questions. Were therapists who regularly received feedback more responsive to clients' wishes regarding the scheduling of sessions? Did asking for and following client feedback prompt therapists to take greater responsibility for this aspect of the work? That only this one area emerged as different between the two groups did not conform to our initial expectations. It may be that participants felt more comfortable expressing negativity about the impersonal service delivery of therapy, even if their dissatisfaction had more to do with relationship or in-session process. Alternatively, the "nuts and bolts" of therapy simply may have greater import for the alliance and client engagement than commonly thought.

Therapist skill and attributes emerged as central points in respondents' feedback. However, when matched to therapists, statements indicated that one person's "good therapist" was another's "not so good." In other words, different clients described their experience with the same therapist differently. This suggests that simply learning to be more instrumental or straightforward may miss the mark. What may matter more is how to ensure the fit of one's approach with each particular client. In sum, our findings suggest that both relationship and task activities of therapists as well as therapists' personal attributes have implications for client satisfaction and are likely components of the alliance.

The majority of clients giving feedback routinely during treatment rated this process as very helpful. Interestingly, this assessment rose to nearly 84% when examining individuals who had the goal of improving the relationship. It is possible that the initial level of commitment to preserve the relationship translated into greater openness to all aspects of the treatment process compared to a less open engagement for more ambivalent clients. It may be worthwhile to assess the motivation for seeking couple counseling prior to the first session and make particular efforts to engage less committed clients. Clients seeking clarification regarding their relationship may have experienced the outcome measure, measuring distress, as less relevant to this goal. Similarly, those wishing to terminate the relationship may have believed that the feedback instruments were designed to keep couples together and would experience their use problematic. Providing information on the SRS that pertained to goals, for example, may promote anxiety if a person does not want to divulge a goal of relationship dissolution. A clearer explanation of how and why outcome and alliance feedback measures are used could offer greater comfort for clients with divergent goals.

Generalization of our findings is limited by the fact that our sample clients, though diverse in presenting concerns, were white, Scandinavian, and heterosexual. The inclusion of same-sex couples and more racially and ethnically diverse couples might produce different categories and evaluations. Furthermore, we did not analyze responses at a couple level. It would have been informative to explore differences between responses of members of the same couple. The check-off questions in the follow-up were answered by feedback respondents prior to the open-ended questions. This may have undercut the emergence of feedback as a salient category, as respondents may have assumed this area was already covered with the check-off portion of the form. Additionally, we missed an opportunity to more fully understand how obtaining regular feedback was experienced by clients by asking an open-ended question about this topic. Finally, despite our efforts to see the data with fresh eyes, it is likely that our experiences and training played a part in how categories and domains were constructed. Returning to respondents with our findings for additions or corrections may have enhanced trustworthiness (see Lincoln & Guba, 1985).

The current study's findings suggest that couples therapists could benefit by becoming more comfortable with and adept in providing structure, making definitive suggestions, challenging, and engaging in other instrumental types of behaviors. Based on this and supporting findings in the literature, therapists can feel confident adding a more directive style to their work. At the same time, becoming more active should not diminish personable qualities such as friendliness and warmth that help forge viable therapeutic connections. Moreover, therapists may wish to learn what each client means by instrumental or structure, including therapist qualities or

activities that promote a sense of safety, neutrality, and comfort for each client. A continuous feedback protocol, deemed of value by the majority of respondents, is one method for monitoring therapist and client fit. Findings further suggest that it is important for therapists to determine scheduling problems proactively and respond flexibly to client wishes. Perhaps the "extra mile" therapists go in this way could make the difference in failure or success.

Finally, this study describes a feasible method for supplementing existing outcome and follow-up efforts. Agencies, private offices, or other sites of therapeutic services could integrate the method described into existing assessments for the purpose of improving services and providing a fuller picture of outcome. Client reflections also offer a multilayered vantage point for determining more targeted research initiatives. Client comments post-therapy provide a unique footprint of client experiences. Retracing these can inform researchers and clinicians regarding what it takes to be effective guides on this journey.

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APPENDIX 1

1. *[This question only to feedback group] Regarding the sessions, you completed the same forms in each session. These were used as feedback from you to the therapist. One of the forms you completed was about your experience since your last session, and the other, how you experienced the session.*
   ☐ I experienced the forms as disturbing.
   ☐ I experienced the forms as not important for me.
   ☐ I experienced the forms as helpful/useful.
   ☐ I do not remember.

2. *How did you experience the contact with the family counseling office and the therapist? Was there something missing?*
   _____
   _____
   _____
   _____

3. *Was there something you were satisfied with?*
   _____
   _____
   _____
   _____

   Thank you!