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Your Problem or our Problem: How Clients' Evaluation of the Problem Affects Therapeutic Progress in Therapy

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YOUR PROBLEM OR OUR PROBLEM:
HOW CLIENTS' EVALUATION OF THE PROBLEM AFFECTS THERAPEUTIC PROGRESS IN THERAPY

THESIS

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Family Sciences in
the College of Agriculture, Food and Environment
at the University of Kentucky

By
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Lexington, Kentucky

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2023

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ABSTRACT OF THESIS

YOUR PROBLEM OR OUR PROBLEM:
HOW CLIENTS' EVALUATION OF THE PROBLEM AFFECTS THERAPEUTIC PROGRESS IN THERAPY

As systems theory has become the foundation of interpreting family interactions in therapy, it has become apparent that taking a systemic approach correlates with improved client growth and satisfaction outcomes. Clients' systemic orientation to their problems may be influential in determining these outcomes in therapy. Thus, this study focused on how client's systemic agreement can impact the outcomes of therapy and problem progress. We had 968 partnered individuals with differing economic backgrounds, education levels, and religious backgrounds participated in the study, as well as couples from age 18-72 with the mean age of 31.3. The couples' SES ranged from below the poverty line to middle and upper class. MANCOVA was conducted to examine how clients' systemic attributions to their presenting problem in therapy correlated with client couple satisfaction and presenting problem progress after accounting for the therapeutic alliance and initial relationship distress. Results show a statistical trend showing that clients' perception of therapy progress over the course of therapy may be different depending on the type of systemic attribution they bring into therapy. Implications for the lack of statistically significant findings are discussed.

Claire Elizabeth Nickell

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04/17/2023

Date

YOUR PROBLEM OR OUR PROBLEM:
HOW CLIENTS' EVALUATION OF THE PROBLEM AFFECTS
THERAPEUTIC PROGRESS IN THERAPY

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DEDICATION

To my mother, Fiona Fox

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CHAPTER 1. INTRODUCTION

1.1 Background

Couple and family therapy focuses on the relationships and relational dynamics that influence one's life and overall health. Thus, it is critical to determine which relational dynamics are most important in the overall health of individuals and relationships. For example, negative attributions and blaming of partners lead to couples to have more negative communication and are more distressed in their relationships (Cheung, 1996, O'Leary et al., 1990; Fincham & O'Leary, 1980; Hrapczynski et al., 2012). Previous work has attempted to define and organize these blaming and negative attribution strategies in order to decrease their frequency (Patrika & Tseliou, 2016, Smoliak et al., 2021). However, some research has uncovered that some of the methods that therapists used actually increased blaming attitudes (Patrika & Tseliou, 2016). What many of these studies have failed to recognize is the potential power of a conscious, working understanding of the blaming and negative attributions that individuals bring into the therapy room. Their personal beliefs about the etiology of their problems that brought them into therapy may impact the therapy process in addition to simply observing and seeking to combat these negative attributions. This study explored how couples' perspective of partner blame or joint responsibility for the problem that brought them to therapy (e.g., a systemic attribution) will impact their progress in therapy and relationship satisfaction at the end of therapy.

1.2 Systems Theory

Systems theory describes the interactions and processes by which families or individuals relate to each other. It supports the notion that people behave according to underlying structures, expectations and communication patterns within the family rather than operating individually and separately based on their own intentions and characteristics. From a systems perspective, partners in a committed relationship equally contribute to, and are effected by, the cyclical interaction pattern they experience in their relationship thereby necessitating a treatment focus on the interaction pattern between the partners. An individualistic, or reductionistic perspective on the other hand attempts to identify who is primarily responsible for causing the problem thereby necessitating a treatment focus on the individual that is to blame.

The extent to which clients' demonstrate an intuition of a systemic perspective in their interactions and beliefs about the etiology of their problems that brought them into therapy may impact the therapy process. The concept of partners approaching life with a systemic orientation is not new, as the theoretical construct of "we-ness" (Buehlman, Gottman, & Katz, 1992) has been studied in depth for decades and has been correlated with positive relationships. We-ness describes the degree to which a couple views their lives, goals, values and hopes as intertwined and values their togetherness more than their separateness (Topcu-Uzer et al., 2020). In a new questionnaire to assess we-ness, the frequency which partners use the term "we" rather than "I, he, or she" was evaluated (Topcu-Uzer et al., 2020). This reference of "we" instead of singling out one partner may be a pragmatic way of demonstrating whether a couple holds a practical understanding of systems theory.

Expanding this concept of we-ness into distressed couples seeking therapy and whether or not they see their problems in an orientation of "we-ness" may shed light on how couples perceptions influence the therapy process. These empirical findings may inform more dimensions of mental health care, than family therapy alone. The current study will address this research gap by analyzing how a client's systemic orientation relates to their progress with therapeutic goals. The outcome of this analysis, if shown to be effective, will add to the literature about client's perspective of the therapy process and may promote the use of systemic orientation toward problems in healthcare.

1.3 Couples' Perception and Application of Systems Theory

While the systemic approach is the core of family therapy and nearly all professionals understand it as the foundational theory of family therapy, little research has been done on clients' systemic vs nonsystemic perspectives of their problems in therapy and how those agreements of perspective influence therapeutic progress (see Wu et al., 2020 for a notable exception). A systemic perspective is the belief that the problem is due to a structural process or relational issue instead of a specific person. A nonsystemic perspective is the belief that a problem is due to a person and their intrinsic qualities or behavior. As previously stated, there is scant research that describes clients' systemic agreements in therapy.

These perspectives are important because for many years clients' attributions of their problems have been viewed as important contributors to therapeutic change (Wu et al., 2020, Stratton, P., 2003a). Understanding partners' differences in attributions of responsibility can shed light on how these perspectives impact the therapeutic process.

Entering therapy with conflicting ideas of who is responsible for the problem can detriment the therapy process This is highlighted in the research of blaming behaviors of clients as they enter therapy (Whiting & Cravens, 2016; Smoliak et al., 2021; Stratton, 2003a; Stratton, 2003b;; Patrika & Tseliou, 2016; Strong & Pyle, 2012; Stancombe & White, 2005). This research is useful in understanding how clients' differing attributions in the form of behavior impact therapy. Clients' beliefs about their relationship to the problem can result in singularly blaming other members of their family or taking all the blame themselves (Smoliak et al., 2021; Wu et al., 2020). These behaviors are not helpful when families need to change altogether. Acting as if only one person has responsibility for the problem may stunt them in progressing toward their therapeutic goals (Wu et al., 2020; Bowen et al., 2005). The current study will examine how couples' agreements surrounding responsibility for the problem may impact their presenting problems and couple relationship.

Similar to Wu et al., (2020), a systemic agreement is one in which both partners believe the problem is systemic (e.g., *both* partners see that they each have a role to play in the problem as well as the solution) rather than blaming one person for the problem. A systemic disagreement is one in which one partner has a systemic perspective of the problem while the other is blaming their partner for the problem. Dyadic blame is the case where *both* partners believe that their partner is responsible for the problem bringing them into therapy.

1.4 Blaming and Negative Attribution in Couples

Clients' blaming and responsibility of denial dialogues are widely discussed in the literature as obstacles to obtaining therapeutic goals (Whiting & Cravens, 2016; Friedlander et al., 2000; Smoliak et al., 2021; Bowen et al., 2005). When couples engage in elevated conflict and arguments, the therapist may struggle to make meaningful discussion or conduct therapy at all. Therapists also can get pulled into the content of the conflict and find themselves focusing too much on elaborate details the partners have to offer (Friedlander et al., 2000). Additionally, attribution theory has been used to describe the interactions that occur in the therapeutic setting. Often, distressed couples attribute responsibility to their partner for the marital discord or choose to focus on negative actions more often than positive ones (Holtzworth-Munroe & Jacobson, 1988). This behavior impacts the therapeutic process because partners are unable to agree on mutual goals. It may also negatively impact the therapeutic alliance as the therapist takes a systemic approach, which may feel like blaming to one of the partners.

1.5 Factors for Therapeutic Success

1.5.1 Therapeutic Alliance

The therapeutic alliance is the working relationship between client and therapist in the context of therapy. It has been empirically validated as a determining factor in therapeutic success, and for this purpose Wu et al., (2020) examined how the systemic agreements of couples entering therapy impacted the therapeutic alliance. In an attempt to expand upon this study, we will be controlling for therapeutic alliance and testing for

how systemic agreements correlate directly with the presenting problem progress and couple relationship outcomes.

1.5.2 Presenting Problem Progress

The presenting problem progress is a constant indicator of whether therapy is "working," as a major purpose in providing therapy is to reduce clinical symptoms in clients and in their families (Werbart et al., 2019). Clients who seek out therapy are given opportunities to outline why they have come and participate in setting goals to resolve whatever problems they have presented; studies have been done to include clients by asking them which qualities of therapists have helped them to fix their presenting problems and achieve their goals (D'Aniello & Tambling, 2019). Thus, selecting presenting problem progress as a primary dependent variable tackles the main indicator of whether therapy is going well according to clients.

1.5.3 Couple Relationship Outcomes

Couple satisfaction is one of the most commonly accepted indicators of the effectiveness of couple therapy. If couple satisfaction is high at the end of couples' therapy, therapy is most likely seen as a positive and helpful experience for the couple (Anderson et al., 2021). There is significant evidence supporting the idea that systemic views held by the couple may influence the level of couple satisfaction at the start of therapy and throughout therapy. This is because blaming behaviors have been linked to lower couple satisfaction in therapy (Péloquin et al., 2018; Smoliak et al., 2021). It is also an accepted fact in the literature that couples who blame each other often create great difficulty for the therapist to facilitate positive change in the couple relationship (von

Sydow et al., 2010, Strong et al., 2012). An understanding of clients' systemic beliefs early on can help the therapist focus on helping the clients shift their views to be more willing to take responsibility for the presenting problem.

1.6 The Current Study

The current study will examine how a clients' systemic or nonsystemic view of their presenting problem in therapy correlates with therapy outcomes such as presenting problem progress, and couple satisfaction.

1.6.1 Research Question 1

Does client perceived progress on meeting therapeutic goals correlate with couple's systemic agreement, disagreement, or dyadic blame of the presenting problem after controlling for the therapeutic alliance and clients' initial reported relationship satisfaction?

1.6.2 Research Question 2

Are there statistically different couple satisfaction improvement rates depending on the type of systemic agreement of the clients in couples therapy after controlling for the therapeutic alliance and clients' initial reported relationship satisfaction?

CHAPTER 2. METHODOLOGY

2.1 Participants

The initial sample size for this study was 968 individuals who were a member of a partnership attending therapy were selected from a large, international database called the Marriage and Family Therapy Practice Research Network (MFT-PRN, Johnson et al.,

2017) designed to gather demographic and assessment-based information from individuals, couples, and families attending therapy in an effort to provide clients and clinicians real-time information regarding the effectiveness of therapy. This information allows therapists to make adjustments to their approach if needed to maximize the possibility of client success (Johnson et al., 2017). The participants were selected to be in this study if they met for counseling sessions at a MFT-PRN practice/institution, signed an agreement that their data could be used for research studies, were over 18, in a committed relationship, and pursued couples therapy.

We analyzed 504 self-identified women and 463 self-identified men within the study. Ages in the sample ranged from age 18-72 years old with the mean age of 31.3. 22.9% of the sample had the highest level of education as a GED, 16.9% had an associate's degree, 35.8% had a bachelor's degree, and 18.9% had a graduate degree. 24.1% of the sample ranged from $10,000-$30,000 in household income, 27.1% ranged from $30,000-$60,000, 19.7% ranged from $60,000-$99,000, and 18% had over $100,000, 11.3% of the sample reported their religious preference as Protestant, 2.2% were Roman Catholic, 59.4% were Latter-day Saints, 0.2% were Muslim, 0.1% were Buddhist, 2.7 % were atheist, 3.2% were agnostic, 5.2% were nothing in particular and 6.0% were spiritual but not affiliated with any religion. 91.7% of the sample self-identified as heterosexual or straight, 1.9% as gay or lesbian, and 6.3% as bisexual.

2.2 Procedure

As previously stated, the MFT-PRN is a network designed to gather assessment-based data from couples, families, and individuals who attend therapy. These data are

routinely collected in the normal course of therapy by informing the therapeutic process and improve client outcomes. These data can also be used by clinical researchers to help them better understand how people act and change in therapy, as well as to aid clinical administrators in providing more effective service in their clinics and to document this to their stakeholders (Johnson et al., 2017). Before every therapy session, the receptionist or the therapist gives the clients an ipad containing the surveys they are to answer. There are also standard assessments that every clinic must use, such as the demographic assessment and the presenting problems assessment while additional surveys are chosen individually by each clinic out of a large database that the MFT-PRN generates (Johnson et al., 2017). Clients are asked permission to have their data anonymized and be available for research. If they decline, only their therapist will have access to their data, as it helps the therapist provide the highest quality of care. There is no compensation given to the couple for this consent, so the process is entirely dependent upon their willingness to share their results.

Access to the anonymized MFT-PRN dataset requires a formal application process with MFT-PRN along with a copy of the primary investigator's institutional IRB approval. Prior to data distribution, the MFT-PRN team will create an anonymized dataset with the researcher's requested variables. Presenting problems as answered from pre-populated list

2.3 Measures

2.3.1 Systemic Perspective

The items for the systemic perspective scale were created by the MFT-PRN team. The scale consists of a question that evaluates the participants' opinions of who is

responsible for the problem. The independent variable was the type of systemic agreement that the clients had of the presenting problem, as demonstrated in the study of Wu et. al (2020). This variable was measured by a question given to clients in their first session assessment, "who is responsible for the problems that brought you to therapy?" Response options used in this study were, "Myself and my partner," and "my partner."

For the purposes of the present study, a three-level dyadic variable was created and assigned to both individuals in a partnered relationship: *systemic agreement, systemic disagreement,* and *dyadic blame*. If partnered individuals *both* selected "Myself and my partner", each partner was coded as *systemic agreement*. If one partner chose "my partner" and the other chose "myself and my partner", it was coded as *systemic disagreement*. If both individuals chose "my partner", it was classified as *dyadic blame*. Participants were often given the option of "myself only," "my parents," or "my children," but we chose to exclude these data so as to narrow the nature of the problem to be relational between the couple.

2.3.2 Presenting Problem

At the initial appointment, each adult in the relationship is asked to identify three main problems they want help with. The presenting problem survey includes the question "Please select the biggest issue or problem that brought you to therapy" after which a set of possible problems are displayed. Participants were selected into the study if they chose any of the following options as their first, second, or third presenting problem: divorce/separation concerns, financial decisions/problems, sex/physical affection, trust, arguing or fighting too much, gender roles in parenting, parenting, problem solving or decision making, communication, lack of emotional intimacy, infidelity, lack of love,

mental health of one partner, my partner is overly critical of me, physical violence, or social activities/time together.

2.3.3 Presenting Problem Progress

Presenting problem progress was assessed by the MFT-PRN software every session. Participants were asked to respond to the question "rate how the progress of your presenting problem is going" and responded on a likert-type scale with 7 responses ranging from "problem is much worse" (-3), "no change in the problem" (0), and "problem is resolved" (3). For the purposes of this study, all the presenting problem progress scores were summed and divided by the number of sessions that had presenting problem progress scores. This average presenting progress score standardizes change across clients regardless of the number of sessions they attended as well as smooths out any large fluctuations in the score that may have occurred on a session to session basis. The sample average for this score was 1.33 (s.d.1.25) showing that clients, on average, reported that the "problem is a little better" each session they returned to therapy.

2.3.4 Couple Relationship Scale

The couple relationship scale (CRS, Anderson et al., 2021) was given to each couple before their first session and at every subsequent session. The couple is presented with a virtual presentation of the assessment that provides a scale for each question along which the participant moves a slider to indicate their answer. There are 10 items that measure 10 aspects within a relationship; emotional intimacy, commitment, trust, safety, cohesion, acceptance, conflict, physical intimacy, overall happiness, and personal well-being. Each item ranges from 0-100, where the slider measures on a continuum between a

negative representation of the aspect and a positive representation of it. For example, for emotional intimacy, the negative evaluation of the variable is “distant” which is placed right next to the “0” on the scale, and “close” which indicates the “100” value of the scale. This scale has been used widely in clinical assessment and has been recently tested to determine its 70.9 cutoff scale, validity and reliability (Anderson et al., 2021). The total score is constructed by adding all of the item answers together and dividing by 10. Higher scores indicate higher relationship satisfaction.

The first CRS score where clients also filled out presenting problem progress was used as a covariate in the analysis ($\bar{x}$ = 69.768, s.d.= 21.863). This score means that individuals were similar to other clients who also were in therapy for relationship challenges. The final CRS score available for each client was used as one of the dependent variables in the study ($\bar{x}$ = 72.717, s.d. = 23.307). This score means, on average, clients were above the cutoff suggesting that they were similar to couples not in therapy. A maximum change score was also created as a dependent variable for the study. This was calculated by taking the highest CRS score at any point in the therapy process and subtracting the lowest CRS score at any point in therapy for each person. The average change in CRS for the present sample was 26.99 (s.d.=16.22). This change score is substantially larger than the reliable change index of 16 that was established for the CRS (Anderson et al., 2022) showing that the growth clients experienced was beyond chance, or in other words, real growth.

2.3.5 Therapeutic Alliance

The CTAS revised-short form scale was used to measure the therapeutic alliance levels as reported by participants in the study (Pinsoff et al., 2008). The scale measured

the therapeutic alliance of the participant with the therapist with a Likert-type scale ranging from 1 (completely agree) to 7 (completely diaagree) They were asked questions such as, “the therapist cares about me as a person,” and “The therapist and I are in agreement about the way therapy is being conducted.” The cronbach’s alpha reliability for this sample was .939.

CHAPTER 3. RESULTS

In order to answer research questions 1 and 2, I used MANCOVA to test the association of systemic agreement type (i.e., systemic agreement, systemic disagreement, dyadic blame) and overall therapy progress, change in relationship satisfaction, and final relationships satisfaction while accounting for clients’ relationship satisfaction at intake and therapeutic alliance. Two separate MANCOVA analyses were run, one for male partners and another for female partners. This was done so that the statistical assumption of data independence was not violated. Furthermore, separating the sample by gender maximizes the sample size for analytic purposes as opposed to randomly selecting one partner from each couple to be included in the analysis. Means, standard deviation, and correlations between the variables of interest are found in Table 1, Table 2 shows group differences by agreement type and gender.

Table 3.1 Means, standard deviations and correlations of the dependent variables and covariates

	Mean	Std. Dev.	1	2	3	4
1. first session with CRS	69.768	21.863	--			
2. last session with CRS	72.717	23.307	.531**	--		
3. Total CRS Change	29.678	17.923	-.232**	-.317**	--	
4. Average therapeutic alliance score	5.7194	0.704	.247**	.254**	-.083*	--
5. Average Per-session Progress	1.332	1.246	.442**	.480**	-.173**	.136**

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Table 3.2 Dyadic Agreement Type Mean, SD and N overall values for Female and Male Participants

Dependent Variable	Dyadic Agreement	Female Mean (SD)	N	Male Mean (SD)	N
CRS Change	Agree dyad	33.29 (18.63)	137	31.63 (19.65)	128
	Disagree dyad	32.62 (18.00)	75	26.08 (16.56)	70
	Dyadic Blame	25.91 (16.90)	26	23.25 (12.45)	25
Final CRS	Agree dyad	76.25 (21.92)	137	76.13 (21.85)	128
	Disagree dyad	72.74 (23.45)	75	76.29 (24.60)	70
	Dyadic Blame	75.27 (22.90)	26	77.46 (21.15)	25
Average per-session progress	Agree dyad	1.42 (1.07)	137	1.42 (1.09)	128
	Disagree dyad	1.15 (1.21	75	1.85 (0.96)	70
	Dyadic Blame	1.11 (1.07)	26	1.39 (1.36)	25

Table 3.3 Between Subject Effects for Females and Males.

		Female Sample		Male Sample	
		F	Sig	F	Sig
Dyadic Agreement Type	Max CRS Score-Min CRS Score	1.073	0.344	1.934	0.147
	Last CRS	1.189	0.306	0.5	0.607
	Average progress	2.825	0.061	2.638	0.074

My first research question was how couple's systemic agreement, disagreement, or dyadic blame of the presenting problem after controlling for the therapeutic alliance and clients' initial reported relationship satisfaction correlated with clients' perceived progress on meeting therapeutic goals. There was no statistically significant difference between the type of systemic agreement between partners and their average presenting problem progress after accounting for the therapeutic alliance and relationship satisfaction at intake (see Table 3). This result held for both male and female partners. It is important to note that while there was not a statistically significant difference between groups, the results show that there is a strong trend toward significance for both genders ($p = .061$ for females and $p = .074$ for males).

My second research question was in relation to the possible group differences in relationship satisfaction and change in relationship satisfaction at the end of therapy. There was no statistically significant difference between the type of systemic agreement between partners and couple relationship satisfaction after accounting for the therapeutic alliance and relationship satisfaction at intake (see Table 3). This was the result for both male and female partners.

CHAPTER 4. DISCUSSION

This study was designed to extend understanding of how clients' etiological description of the problems that led them to seek therapy impact actual therapy progress and relationship satisfaction. I wanted to test the unique influence of systemic agreement on therapy progress and outcomes and control for therapeutic alliance because it did prove to be predictive in the Wu et al., (2020) article; I also added how the level of distress at intake may influence presenting progress and couple satisfaction because the level of couple satisfaction/distress may to some degree depend on the respective realms of systemic attribution that they hold. The presence of the covariates may influence why difference between dyadic agreement types were not significant because of the differing places couples started from and the differing levels of therapeutic alliance throughout, which is highly correlated with progress in therapy. This could indicate that the level of couple distress and therapeutic alliance is extremely indicative of therapy progress when evaluating the type of systemic views that couples hold. The dyadic agreement type is trending towards statistical significance, and may indicate a relationship between dyadic agreement type and therapy progress exists, but the presence of the covariates may lessen the power of that relationship. A larger sample size in future research may also be able to determine if the trend holds or becomes statistically significant.

Dyadic agreement influencing therapeutic progress may be supported in part by the research of Wu et al., (2020) in which they found how couples who disagreed on their systemic view of the problem at the onset of therapy demonstrated a weaker therapeutic alliance initially compared to couples in which both members held a systemic view. Wu

et al., (2020) found that holding a shared systemic view of the problem correlated with the strength of the therapeutic alliance, a well-established indicator and promoter of therapeutic progress and couple satisfaction (Wu et al., 2020). This stands as a potential indicator of the moderating nature therapeutic alliance, which was not modeled in the present study, may hold in the relationship between systemic agreement and therapeutic progress (presenting problem and couple satisfaction progress). The trending nature of the relationship between systemic agreement and presenting problem progress may be shadowing a significant relationship through the controlling of therapeutic alliance. This should be studied further to examine the moderating or mediating effects of therapeutic alliance on systemic agreement and therapeutic progress.

The findings from the present study add to the literature surrounding couples that blame, how they blame, and why they blame. Peloquin et al., (2018) and Smoliak et al., (2021) both studied the types of blaming and denials that couples perform and the negative impacts of those behaviors on the relationships. As can be seen in Figure 1, partners who blamed each other for their problems (coded as "dyadic blame" in the present study) had the lowest scores of the three agreement types across 5 of the 6 outcome variables. Specifically, dyadic blame for men and women and the lowest relationship satisfaction scores at the end of therapy. The trend of systemic agreement influencing therapeutic progress would add more validity to those studies and further encourage future study on types of blaming and denial in couple relationships.

An additional insight that the present study may offer is the association of systemic agreement based on gender, which Wu et al., (2020) did not assess. As seen in Table 2, a systemic disagreement generally trended with lower means of presenting

problem progress as compared to outcomes seen with couples presenting with systemic agreements. However, for women, if one partner perceived the problem as a joint problem and the other was blaming, their therapy progress and couple relationship satisfaction rates appeared to trend lower in their mean results than that of the men's outcomes if there was a systemic disagreement of problems in their relationship. This may indicate that for women, blaming the responsibility of the problem on one member of the couple can hold more debilitating effects on treatment. This could be due to the societal role women generally have to be the "caretaker" of their relationship and the gendered power imbalance that women experience in being primarily responsible for the success of their relationship (Knudson, 2013; Sassler & Miller, 2011). If they are out of sync with their partner in their agreement of the systemic nature of the problem, the woman may feel discouraged, disconnected, or lack confidence in her ability to improve their problems or couple satisfaction measures.

Research question 2 was answered in that systemic agreement type does not show any group differences for the change in relationship satisfaction throughout or at the end of therapy. However, the covariate of therapeutic alliance being controlled could be a strong reason for this. This may be consistent with the findings in Wu et al (2020) as they found that systemic attribution did influence the overall therapeutic alliance of the therapist and couple. This may indicate that systemic agreement type does not uniquely predict couple relationship satisfaction above and beyond the impact therapeutic alliance has on couple satisfaction. Therapeutic alliance is a common factor in successful psychotherapy progress and couple relationship satisfaction (see Davis, 2022; Knoblach-Fedders et al., 2007)

In the case of the other covariate, it is possible that if any changes did occur in the couple relationship satisfaction score based on systemic agreement, it was linked with the level of distress upon intake. This claim is supported by research that has been established for decades that determines higher rates of couple distress for couples who hold negative attributions of their partner's actions (O'Leary et al., 1990; Fincham & O'Leary, 1980; Hrapczynski et al., 2012). As heightened distress at intake can provide a greater potential for therapeutic growth than a moderately distressed or less distressed couple , controlling for this variable may have removed the impact that a systemic agreement held for influencing the course of couple relationship functioning. This could be tested as an interaction effect in future research as systemic agreement may have influence on therapy progress depending on relational distress.

CHAPTER 5. LIMITATIONS AND FUTURE DIRECTION

Those participants who participated in the study were a convenience sample. It was simply the clients who presented themselves to therapy who were generated to participate in the study. This, along with a moderate sample size, removes the randomization of participants and reduces the generalizability of the study. This study could be repeated with a randomized group of participants who are then given an option to attend therapy if they want to participate in the study. This would meet the requirement of randomization in order for this study to be an experiment. Another limitation of this study was the representativeness of the sample. Due to the nature of the student clinics and the low prices they charge, clients are generally from lower SES backgrounds. This may affect the external validity of the experiment and the ability of the results to be extrapolated to the greater population.

A future direction to correct this would be to use data from clinics that are not student-led and accept client health insurance to ensure more diversity of clients in terms of their SES. A final limitation of this study is the internal validity and the potential confounding variables that are created from the presenting problem description. It is difficult to track each presenting problem and determine how the type of problem may be influenced by a systemic view. For example, a couple who comes into therapy because of one person's infidelity as the presenting problem may not have a systemic view of the problem and still have immense progress. It may actually hinder their growth if they see the problem entirely systemically. Additionally, a couple may have a presenting problem such as a communication issue. If they view this as systemic they may see great progress in their couple satisfaction and their problem progress. Both of these presenting problems have their own inherent factors that can be confounding when examining whether a systemic view helps or does not help the problem. In future studies, the internal validity can be improved by organizing and classifying presenting problems and selecting the participants who have the specific problems that are of specific interest. Doing so will remove unique confounding variables that are inherent to the different types of problems that clients present with.

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