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CBT and Me: A Beginning Therapist's Journey Utilizing Client Feedback

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CBT AND ME: A BEGINNING THERAPIST'S JOURNEY UTILIZING CLIENT FEEDBACK

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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ABSTRACT OF THESIS

CBT AND ME: A BEGINNING THERAPIST'S JOURNEY UTILIZING CLIENT FEEDBACK

Cognitive behavioral couple therapy (CBCT) is a model of therapy targeting cognitions, emotional responses, and behavioral interactions between couples experiencing relationship distress. Routine outcome monitoring (ROM) is a tool that clinicians can use to track the progress of their clients in therapy from the perspective of the client. This study aimed to use MFT-PRN, a type of ROM, to gather client progress throughout CBCT treatment. Prototypical change trajectories were created in Microsoft Excel for examination of presenting problem progress, couple satisfaction, and overall relationship functioning. It was found that small data sensitivity affected the trajectories immensely, though ROM outcomes revealed how couples did experience more relationship satisfaction over the course of CBCT treatment.

KEYWORDS: Cognitive behavioral couple therapy; Routine outcome monitoring; Trajectory; MFT-PRN; Systemic therapy

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CBT AND ME: A BEGINNING THERAPIST'S JOURNEY UTILIZING CLIENT FEEDBACK

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DEDICATION

To my parents, Kelly and Jamey Scruggs, who have supported my academic career from the beginning. Thank you for being my greatest cheerleaders throughout the years.

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In addition to the technical and instrumental assistance above, I received equally important assistance from family and friends. My parents, Kelly and Jamey Scruggs, my fiancé, Joseph Austin, and numerous close friends, provided on-going emotional support throughout the thesis process. Finally, I wish to thank the respondents of my study, my first clients (who remain anonymous for confidentiality purposes), for assisting my growth as a therapist through this process.

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CHAPTER 1. INTRODUCTION

1.1 Background

The first instances of talking to others for healing have dated back to 3,500 years ago (Maddox, 2023). While many practices similar to therapy have been documented since ancient Greece, the term "psychotherapy" was first used in the early 1800s (Maddox, 2023). Today, there are various mental health fields offering different modalities, theoretical models, and treatment options. One of these fields is marriage and family therapy, which is also known as couple and family therapy (C/MFT).

The field of C/MFT exploded in popularity in the 1950s, with many of the early practitioners believing mental health symptoms exhibited in an "identified patient" were actually caused by relational dynamics within the family system (Gerhart, 2018). Thus, the best way to help someone recover from mental health problems was to treat the family system, not separate the individual from the family. Meta-analyses studying systemic therapy outcomes have shown significant data that systemic therapy is effective for a range of problems that individuals, families, and couples face (Carr, 2018; Gurman et al., 2022). In some cases, systemic therapy was shown to be more effective than individual therapy (Carr, 2018; Epstein & Zheng, 2017).

As the C/MFT field developed over the years, cognitive behavioral couple therapy (CBCT), was introduced by CBCT pioneers Baucom and Epstein (Baucom et al., 2008). CBCT is an extension of Beck's (1963) efficacious cognitive behavioral therapy (CBT) which can be successfully applied to couple/marriage therapy today (Bodenmann et al., 2020; Beck & Fleming, 2021). CBCT continues to change with findings of new research

and interventions are adapted to address the needs of treatment for couples experiencing relationship distress (Baucom et al., 2022).

While meta-analyses and efficacy studies are helpful in revealing the effectiveness of therapy by focusing on modalities; routine outcome monitoring (ROM; Lambert et al., 2018) is another option for clinicians to assess the effectiveness of therapy by focusing primarily on the client. This thesis intends to use client feedback about CBT-led couple therapy to understand effectiveness, inform therapeutic intervention, and provide clinicians with more knowledge surrounding ROM and CBCT in everyday practice.

1.2 Cognitive Behavioral Therapy (CBT): Application to Couples

CBT is widely known and utilized in therapy across the world. Aaron Beck, psychiatrist and researcher in psychopathology, is globally referred to as the "father" of cognitive behavioral therapy (Beck & Fleming, 2021). Since its conception in the 1960s and 1970s, many have believed that CBT is one of the most efficacious treatment models known to date, as evidenced by over 2000 clinical trials for a variety of psychological disorders (Beck & Fleming, 2021; Baardseth et al., 2013). By applying this cognitive behavioral approach to couples, a healthy relationship is defined through CBCT using a contextual perspective, meaning the relationship is contributing to the growth and well-being of both partners, the partners function as a unit well, and the couple adapts to their physical and social environment together over time (Baucom et al., 2022). To reach this definition of health, CBCT targets the cognitions, emotional responses, and behavioral interactions between partners currently at play in the relationship (Epstein & Zheng, 2017).

A core tenet of CBT is that maladaptive or unhelpful cognition creates problems that arise within clients, this is also true for CBCT, as an individual's experience of their relationship is related to how they cognitively process it (Baucom et al., 2022; Epstein & Zheng, 2017; Wenzel, 2017). This leads clinicians to focus on cognitive restructuring as

an intervention to help diminish these maladaptive cognitions. Cognitive restructuring is a process in which clinicians guide clients to recognize, evaluate, and modify maladaptive thinking (Wenzel, 2017). This process can be applied to specific thoughts often automatic to the client, also known as automatic negative thoughts, commonly called ANTs. CBT clinicians do not assume their client's thinking is dysfunctional, but rather, encourage their clients to evaluate if their thinking is as balanced and accurate as possible (Wenzel, 2017). This is applied in couple therapy very similarly to its traditional application in individual therapy. Sometimes, ANTs described in individual therapy revolve around the client's partner (Dattilio, 2005). In couple therapy, that partner is present in the room with your client. Clients can freely express what ANTs they have, in a space where their partner can hear them and provide feedback to the client, with the assistance of therapeutic intervention in the room to ensure a productive discussion has been facilitated. A CBCT therapist can listen for such ANTs and offer modifications or challenge alternatives to such thoughts (Epstein & Zheng, 2017).

Cognitive attributions are another focus of CBT and CBCT. Attribution is defined as "the process of inferring causes of events or behaviors" (Cherry, 2023). In psychology, fundamental attribution error consists of a person's tendency to overemphasize personal characteristics in someone and underemphasize situational factors (Gawronski, 2007). For example, if someone was upset with their fiancé for running late for an event, they might say he's not a punctual person. This is an attribution error, as they have not considered situational factors (i.e. traffic accidents, etc.) that could also be the cause (or attribution) of their late appearance. In CBCT, clinicians assist their clients in thinking of alternative attributions for events to eliminate attacking and blaming, and facilitate a constructive discussion (Baucom et al., 2022). CBCT therapists use strategies to remind couples to evaluate the validity of the attributions they make, as attributions, expectancies, and assumptions can be prime factors in relational distress (Epstein & Zheng, 2017).

Behavioral activation is another strategy of CBT widely used by clinicians. Behavioral activation typically addresses depression in individual therapy (Gepp & Villines, 2021), but also serves to help couples struggling with connection through CBCT. The idea of behavioral activation is to guide clients to engage in activities that allow them to take care of themselves, contribute to their relationships, and make them feel a sense of accomplishment and purpose by "activating" a positive emotional state even when they may not want to initially (Wenzel, 2017). There are different ways in which behavioral activation can take place, two of which being: activity monitoring and activity scheduling. Activity monitoring refers to clients keeping track of activities they engage in during their time outside of session (Wenzel, 2017). For a couple, a clinician might ask each member to keep a journal and write down each time they shared a meal together, spent time together, felt connected to each other that week, etc. Some responses might be different from each other, which allows for the couple to hear alternative perspectives they might not have considered before. Activity scheduling involves determining when clients plan to engage in certain activities they might not do if not scheduled (Wenzel, 2017). For couples therapy, a common scheduled activity is sex. With mixed libidos, work schedules, and children, many clients find that it can be difficult to make time in their schedule to have sex. Scheduling sex can allow couples to feel excited about that specific time and prepare themselves for the event to come.

CBCT has not always been favorably viewed by couple/marriage and family therapists (Dattilio, 2005). Over time, however, MFTs' perspectives have changed. A survey conducted by the American Association for Marriage and Family Therapy (AAMFT) indicated that CBCT was most frequently mentioned as a primary treatment modality for MFTs, getting 27.3% of the vote out of 292 randomly selected clinicians (Dattilio, 2005). This increased adoption of CBT techniques by MFTs can be traced to a number of explanations. The first being that these techniques appeal to clients that are seeking "tips and tricks" to problem solving and building skills that the family can use to

prevent and cope with future strains. CBCT also offers a collaborative relationship between clients and their therapist, an approach that Dattilio (2005) found was increasing in popularity among MFTs at the time of his research. In recent years, these CBCT techniques have become one of the most widely applied couples' interventions (Bodenmann et al., 2020). One misconception of CBT is that a focus on cognitions, rather than emotions, means the therapist will appear cold and less approachable in therapy. This could not be further from the truth, as many clinicians utilizing CBT techniques also recognize the importance of emotions and utilize empathy and genuine curiosity during their sessions, which can be a great model for couples to witness (Moorey & Lavender, 2018). CBCT does not work under the assumption that every issue a couple faces will be resolved after treatment, but instead that the couple will be better prepared and equipped to tackle remaining and future distressing events on their own (Baucom et al., 2022).

However, to gain a true understanding of the client's perspective of CBT, and their therapy experience, receiving client feedback can be imperative (Janse et al., 2016). Baucom and Boeding (2013) outline how the outcomes of assessments become relevant factors to focus of treatment. Through assessments addressing cognitive, behavioral, and emotional factors, treatment planning can occur and subsequently, interventions can be utilized to produce change and lessen maladaptive processes that currently occur within the relationship (Baucom & Boeding, 2013).

1.3 Routine Outcome Monitoring (ROM)

For over 100 years, mental health clinicians have utilized client feedback in the form of assessments to track the clinical progress of their clients (Gregory, 2015). ROM is a mechanism in which clinicians use assessments to track this progress routinely, whether monthly, biweekly, or weekly (Solstad et al., 2020). These assessments can cover a variety of topics, including presenting problem progress, familial or romantic relationships, overall

well-being, therapeutic alliance, perceived stress, and much more (Solstad et al., 2020; Sales et al., 2019; Wampold, 2015). This approach was previously referred to as patient/client-focused research (Barkham et al., 2023; Carlier et al., 2010). This term is rooted in the idea that ROM focuses on clients' self-reports of progress in their presenting problems and symptoms. ROM is used not only to track client progress, but also to inform treatment provided by therapists (Pinsof et al., 2015; Barkham et al., 2023). A clinician using ROM receiving positive or negative feedback from their client can use this information to make decisions in their treatment moving forward that will elicit or continue positive change (Sales et al., 2019). Previous research has found that therapy with ROM is statistically more effective than therapy without ROM for adult individuals (Boswell et al., 2015; Lambert et al., 2018) and couples (Anker et al., 2009). Therapy with ROM has been linked to reduced deterioration rates and increased improvement rates (Lambert et al., 2018).

In therapy, routine outcome monitoring can also be motivating for clients. Barkham and colleagues (2023) recommend therapists to not only have a conversation with clients about their data, but to also facilitate a conversation surrounding shared decision-making in the future course of treatment. This can help motivate clients by either confirming that therapy has been helpful, or highlighting which path therapy should follow moving forward, which in turn helps the client feel less like a number or "score." This feeling is thought to increase the quality of the therapeutic alliance (Brattland et al., 2019; Wiebe et al., 2021). Brattland would assert that the transparency of Barkham's (2023) recommended approach helps to facilitate a sense of trustworthiness and care felt by the client. Additionally, clients can gain reassurance of improvement, even when improvement is

small, giving them confidence in the therapy process and in their own healing journeys (Boswell et al., 2015). Consistently tracking progress also allows therapists to be more responsive to client needs (Lambert et al., 2018). Even if clients are uncomfortable sharing concerns about improvement with their therapist verbally, the therapist can tell whether a client is improving based on their assessment responses and begin that conversation themselves, thus partially alleviating that burden from the client.

Not only is ROM beneficial for the client, but it is also helpful for therapists. Without ROM, therapists tend to view client progress inaccurately (Lambert et al., 2018; Lambert & Harmon, 2018; Johnson et al., 2017). With ROM, therapists can gain a more accurate understanding of the clients' perspectives of their progress, leaving little room for assumptions, unconscious biases, or hypotheses. The data shows where clients are at, from their point of view. This can also vary weekly, depending upon the type of assessment the client completes. Some assessments ask questions in comparison to the previous week, whereas others ask questions more generally.

There are several limitations to ROM, however, specifically impacting MFTs. One of these limitations is logistics. It can be difficult to find space in a clinic to confidentially store questionnaires. Other clinicians might need time familiarizing themselves with writing case notes that incorporate such assessments (Johnson et al., 2017). Another limitation is twofold, involving both infrastructure and expenses. Since many MFT clinics are significantly smaller than other clinics, it might be difficult to budget for tablets for client use, computers for therapists, scoring/tracking software, or questionnaires that are costly (Johnson et al., 2017). Lastly, ROM until recent years has been unidimensional, meaning it does not assess multiple dimensions of a client's life and multiple perspectives

within the same relationship (Pinsof et al., 2015). This is contradictory to the nature of MFTs, where systems impact much of the therapeutic experience for their clients.

1.4 Marriage and Family Therapy Practice Research Network (MFT-PRN)

While some have noted the limitations of client-focused research, arguably, most notable of those limitations could be that many ROM assessments are unidimensional, and therefore are lacking in assessing multiple dimensions of a client's life (Pinsof et al., 2015). It is imperative that a clinician (specifically an MFT) utilizing ROM should gather data that covers an array of dimensions in the client's life and multiple perspectives. A current example of ROM with this previous limitation in mind is the Marriage and Family Therapy Practice Research Network (MFT-PRN; Johnson et al., 2017) developed at Brigham Young University (BYU).

Aimed to bring clinicians and researchers together to improve client care, MFT-PRN offers assessments of varying topics relevant to a client's life that the clinician can use (Johnson et al., 2017). Clinicians and agencies can join MFT-PRN free of charge and are able to access its suite of assessments. Clinicians at MFT-PRN sites use the data for their clients as ROM is a clinical tool. It is important to note that therapists are not able to access other client information within each member site as well as the entire MFT-PRN Network. The Individual, Relational, and Financial Therapy Clinic (I-RAFT Clinic) at the University of Kentucky is a community outreach clinic that provides individual, couple, and family therapy and is part of the MFT-PRN network.

1.5 The Individual, Relational, and Financial Therapy Clinic (I-RAFT Clinic)

The I-RAFT Clinic is an on-campus clinic wherein graduate students in a COAMFTE accredited couple and family therapy program provide individual, couple, and family

therapy to the University of Kentucky and greater Lexington community under the supervision of licensed therapists. The I-RAFT Clinic does not bill or interact with any insurance company for remuneration. All client fees are determined by a sliding fee scale and clients pay for services via check or credit card. The I-RAFT Clinic has been a part of BYU's MFT-PRN since 2019 and utilizes their ROM as part of its clinical training and day-to-day client care. For example, all of its graduate student therapists are trained in the use of the MFT-PRN prior to seeing clients and use it in their clinical work with clients routinely. All clients who receive services from any MFT-PRN site are given the option to have their de-identified data be used for future research purposes.

1.6 Research Objective

The literature suggests that use of ROM can help give therapists insight into their work. The first goal of the present project is to test that assertion. In other words, how does the use of ROM provide insights into *my* clinical work? The first part of this project involves utilization of existing, and de-identified, MFT-PRN data to create prototypical change trajectories for multiple therapy modalities (i.e., individual, couple, family) and presenting problem types (e.g., depression, anxiety, partner relationship problems, parent-child relationship problems, etc.). Having these trajectories will enable me to systematically evaluate the general effectiveness of my clinical work as compared to the prototypical change trajectories. The second goal is to explore if my use of CBCT is reflected in my clients' answers on *theoretically consistent* measures/items and if clients from the overall MFT-PRN repository also change on those same items/measures.

CHAPTER 2. METHODOLOGY

2.1 Participants

Participants for this study ranged from ages 18 to 80 (average = 32.49). The full MFT-PRN data set included 4423 clients, 2627 of which were females, 1792 were males, and 3 were intersex. Ethnicity and race differed across participants. Income was self-reported based on options ranging from less than $10,000 annually to more than $100,000 annually. Level of education varied across participants, with responses ranging from Junior High School or less to Graduate degree. The full MFT-PRN dataset contained 36,230 sessions of progress data, the I-RAFT Clinic dataset held 6,774 sessions, and there were 273 sessions of data from my clients (See Table 2.1).

Table 2.1 Client Type and Quantity

Client Type	# of People in Each Client Type	Average # of Sessions
Couple	15	11.066
Family	10	14.4
Individual - Adult	10	12.636

2.2 Procedure

All the data used for this project were collected as part of the routine therapy processes at the I-RAFT Clinic via MFT-PRN. To identify overall trends in therapy progress based on treatment modality and/or presenting complaint, a request for access to the entire MFT-PRN dataset was made to the MFT-PRN oversite committee. Once approved by UK's IRB, the MFT-PRN oversight committee distributed a de-identified dataset to the researchers. Prototypical change trajectories were then created utilizing the entire MFT-PRN database. Trajectories for other scales for this study were specific to all clients of the I-RAFT Clinic that agreed to have their anonymized data used for research purposes.

All the de-identified data was stored on systems requiring Link Blue credentials and 2-step verification.

2.3 Measures

2.3.1 The Couple Relationship Scale (CRS)

The Couple Relationship Scale (CRS) is a 10-item measure of relational functioning that assesses emotional intimacy, commitment, trust, safety, cohesion, acceptance, conflict, physical intimacy, overall happiness, and personal well-being (Anderson et al., 2022). The emergence of this scale was due to a need for a couple-focused measure with clinical utility. The CRS is theoretically consistent to CBCT by assessing for potential cognitive attributions one might assign to their partner in the relationship. The scale starts with a prompt of "Tell us how you have been feeling about your relationship with your partner over the last week…" and is followed with items such as "distant" (1), "close" (100), "criticized" (1), "accepted" (100) and others. While previous measures proved to be valid, the CRS offers a brief assessment that is less burdensome to clients. The CRS was also developed with clinicians in mind, as it can be used across theoretical approaches (Anderson et al., 2022). This scale is administered every 4th session on MFT-PRN until session 16. After session 16, the scale is administered every 8th session (see Appendix 2).

2.3.2 Couple Satisfaction Index (CSI)

The Couple Satisfaction Index (CSI) was created as a result of previous satisfaction measures not being as precise or informative as they could be (Funk & Rogge, 2007). The CSI offers efficient methods of assessing relationship satisfaction. The

increased precision of the CSI offers researchers a method of reducing measurement error and increasing power without increasing the length of assessment (Funk & Rogge, 2007). There are 3 main versions of the CSI: the CSI-4, the CSI-16, and the full CSI which has a total of 32 items. MFT-PRN uses the CSI-16. This version is theoretically consistent for CBCT clinicians in that it gives the clinician an idea of the perception that each client has of their relationship. For example, one item asks clients to indicate the degree of happiness, all things considered, of their relationship. This is where clinicians can potentially gauge "ANTs" a client may have about their partner and give them insight on where to begin with cognitive restructuring. Clinicians should pay attention to clients responding, "extremely unhappy," "never," and "not at all" often on the CSI-16, as these are warning signs for ANTs. This scale is administered every 4th session on MFT-PRN until session 16. After session 16, the scale is administered every 8th session (see Appendix 3).

2.3.3 Presenting Problem Progress

Presenting problem progress is evaluated on PRN by the clients specifically based on key themes clients choose as their "problems" they are seeking help with during the first session. Clients can select up to 3 problems, which they report progress on weekly. Answer options include a range of options from "Problem is Much Worse" (-3) to "Problem is Solved" (3) with a mid-range response choice of "No Change in the Problem" (0). Clinicians can gather where the client views their own progress based on their responses to the 3 problems they've selected. This scale is administered every session on MFT-PRN, and is the driving measure of the client progress trajectories to follow.

2.4 CBT and Me

CBCT will look different in every therapy room. Why? Because each therapist represents a different personality with varying levels of experience and bias in certain areas of life. Coming from a background in psychology, CBT felt natural and made sense to me as a therapeutic model. It clicked. Next, add the systemic perspective of CBCT and I was hooked. As someone who believes firmly in empowerment and confidence as being cognitive game-changers, one intervention that I do with every client towards the beginning of therapy involves a "strengths"-based worksheet (Therapist Aid, 2024; see Appendix 1). This worksheet assesses the client's cognitions about self and others, including thoughts they have about themselves as positive influences in the lives of their system. This worksheet may also reveal potential attribution errors. Partners are encouraged to use their strengths to the benefit of their relationship. After defenses have lowered, partners are asked to circle 5 strengths that their significant other has and describe specifically why they chose those strengths. This activity not only gets the individuals feeling confident about their own strengths, but it increases both partners' sense of feeling respected, valued, and loved by their significant other.

Automatic negative thoughts (ANTs) are discussed often in my therapy room, as they contribute to cognitive distortions that kill intimacy in relationships. Partners learn about ANTs as thoughts that resemble house ants; they appear out of nowhere, take over and multiply easily, and are frustratingly difficult to get rid of. Partners are encouraged to challenge the ANTs that come to their mind by considering at least 2 positive alternatives that could also be true. In session, when I hear either partner share an ANT, it is gently called out and challenged. This is to model behavior that would be beneficial for clients if

they challenged themselves outside of therapy and thought of alternatives without direct therapeutic intervention. Clients are also encouraged to initiate behavioral activation by journaling alternatives to ANTs, spending quality time together participating in a mutually enjoyed activity (e.g. watching a movie, doing a shared hobby together, eating a meal together, etc.), or beginning steps of sensate focus, to increase the ratio of positive to negative interactions between the couple.

Nontraditional to purist CBT therapists, I often utilize softening, genuineness, and unconditional positive regard in each session with clients. This is intentional for three reasons: 1) I intend to model behavior in which their partner or family would respond well if reacted to the same way, 2) I intend to bring clients who have heightened their emotions in session back to a more relaxed state, in order to ensure to both partners that the therapy room is a space that is different from home, 3) I intend to strengthen the therapeutic alliance with each session I see my clients, as being a therapist clients trust to be vulnerable and comfortable with is important to me personally and professionally. While I was unaware at the time, I was implementing several treatment strategies consistent with Jacobson & Christensen's (1997) model of integrative behavioral couple therapy, one of those being "emotional acceptance as a basis for concrete change" (American Psychological Association, n.d.).

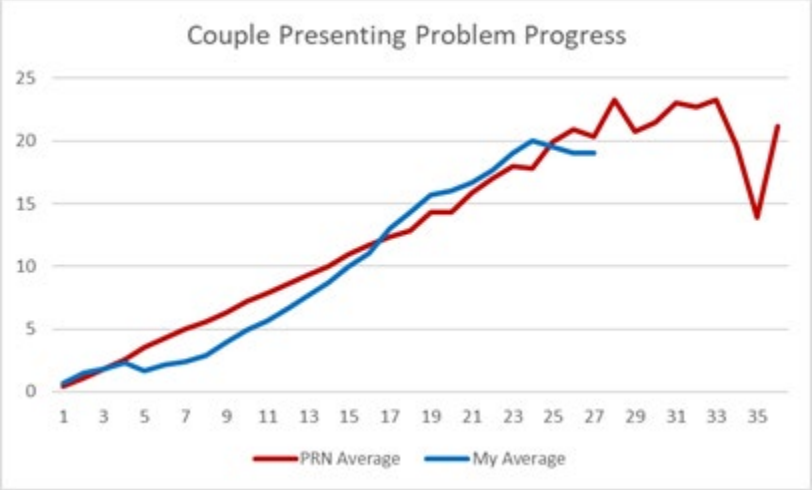
ROM is also used in therapy sessions throughout treatment. Clients complete MFT-PRN assessments at the beginning of each session; I stay in the room while they complete these assessments if they have questions. Typically, clients may have questions about specific items during the first session, which is the first time they are completing the assessments. Consistent with previous literature, I intend to build the therapeutic alliance

and trust by bringing MFT-PRN outcomes into the room (Brattland et al., 2019; Wiebe et al., 2021). My clients and I will discuss their CRS and CSI outcomes and how they change over time. Specifically, if an outcome is not positively progressing, I ask my clients where they still find themselves struggling outside of therapy and begin to write new goals for treatment based on their responses. These are typically behavioral activation or cognitive restructuring opportunities. If clients are positively progressing, their progress is celebrated as reinforcement. Clients are asked to share how they have witnessed progress over the course of therapy thus far as a form of activity monitoring. I will also occasionally bring up specific topics that the couple seems to be struggling with according to their outcome results on my own, to alleviate this burden from my clients (Lambert et al., 2018).

CHAPTER 3. RESULTS

Data received from the MFT-PRN (PRN) oversight committee and the University of Kentucky I-RAFT Clinic were analyzed in Microsoft Excel. Course of treatment trajectories were made and analyzed using a narrative description of the results.

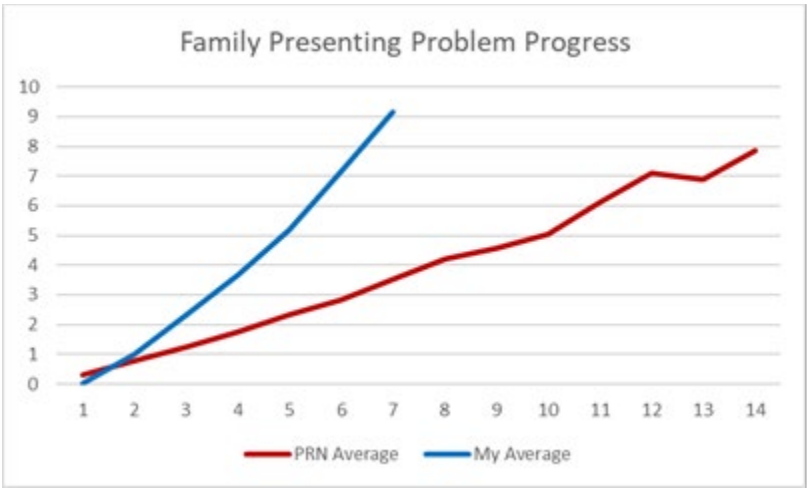
Figure 3.1 Couple Trajectory



This data represents the average trajectory of clients' perceptions of their progress in couple therapy. The average trajectory for couple therapy in the entire PRN-Network is in red while the average trajectory for my couples is in blue. Upon looking at the data, my clients' trajectory follows an almost identical trajectory to the PRN client average for the first 4 couple's sessions. After session 4, my clients' trajectory drops in comparison to the PRN average. This drop stays relatively consistent with the slope of the PRN average. Both trajectories begin to follow a similar upward trend, with my clients slightly below the PRN average until about session 16. At this time, the data shows that my clients' trajectory surpasses the PRN average slightly, while still following a consistent upward trend until session 24. My clients' trajectory shows a subtle drop from session 25 to session 27.

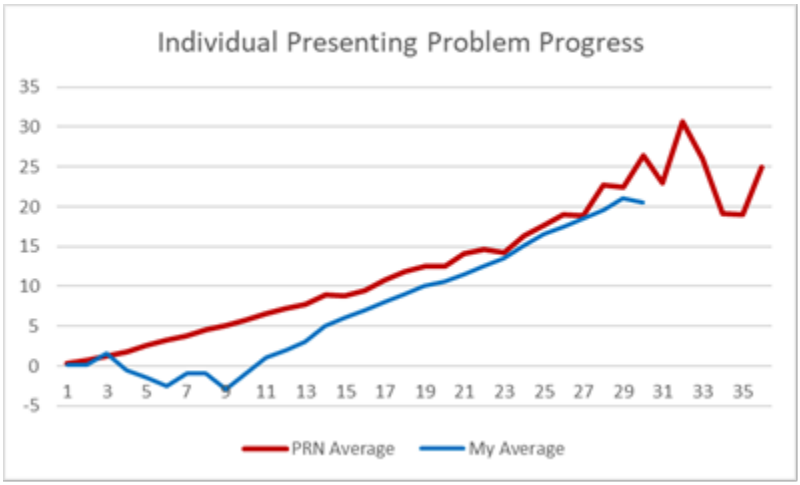
Ultimately, both the PRN average couple's trajectory and my clients' average couple's trajectory appears to follow very similar upward trends over the course of treatment.

Figure 3.2 Family Trajectory



This data represents the average trajectory of clients' perceptions of their progress in family therapy. The average trajectory for family therapy in the entire PRN-Network is in red while the average trajectory for my families is in blue. At session 1, the data appears to show my clients' trajectory at a slightly lower starting point than the PRN average. Session 2 shows a similar data point for both my clients' trajectory and the family PRN average. By session 3, there is a spike in my clients' trajectory, which follows a continued steep upward slope until about session 7. This data shows how my clients' presenting problem progress appears to increase over a short period of time, surpassing the PRN client average as early as session 3. The family trajectory of PRN averages follows an upward slope, with more data indicating longer periods of time in therapy.

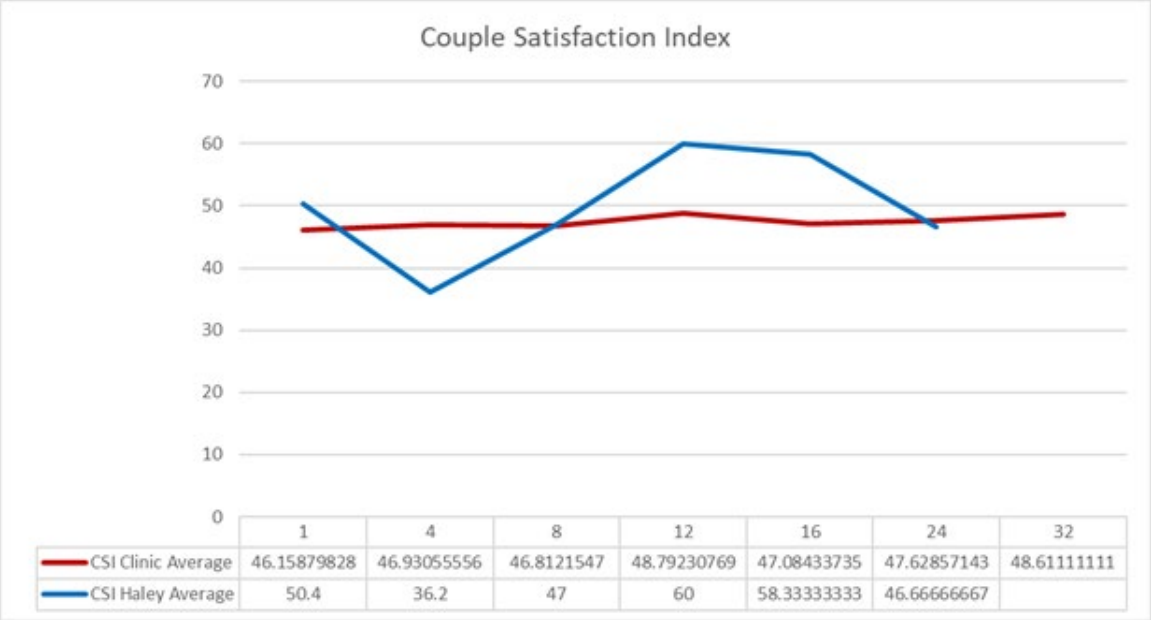
Figure 3.3 Individual Trajectory



This data represents the average trajectory of clients' perceptions of their progress in individual therapy. The average trajectory for individual therapy in the entire PRN-Network is in red while the average trajectory for my individuals is in blue. From session 1 to 3, the data for both my clients' trajectory and the PRN average individual trajectory appear almost identical. After session 3, my clients' trajectory begins to drop greatly in comparison to the PRN average individual trajectory. This drop continues until about session 6, where my clients' trajectory increases slightly, is fixed from session 7 to 8, and drops again beneath 0 by session 9. During this period, according to data from the PRN average, the individual trajectory increases steadily from session 1 to session 14. Interestingly, after session 9, my clients' trajectory was based on one to two clients until session 31. With this in mind, after session 9, my clients' trajectory spikes. It follows a close parallel path to the PRN average individual trajectory until session 29, just slightly beneath it. This indicates that from session 9 to 29, those one to two individuals are progressing at a similar slope to the PRN average individual trajectory. My clients'

presenting progress trajectory appears slightly behind the progress of the individual PRN average, however, this could look different if more data were available.

Figure 3.4 Couple Satisfaction Index Outcomes

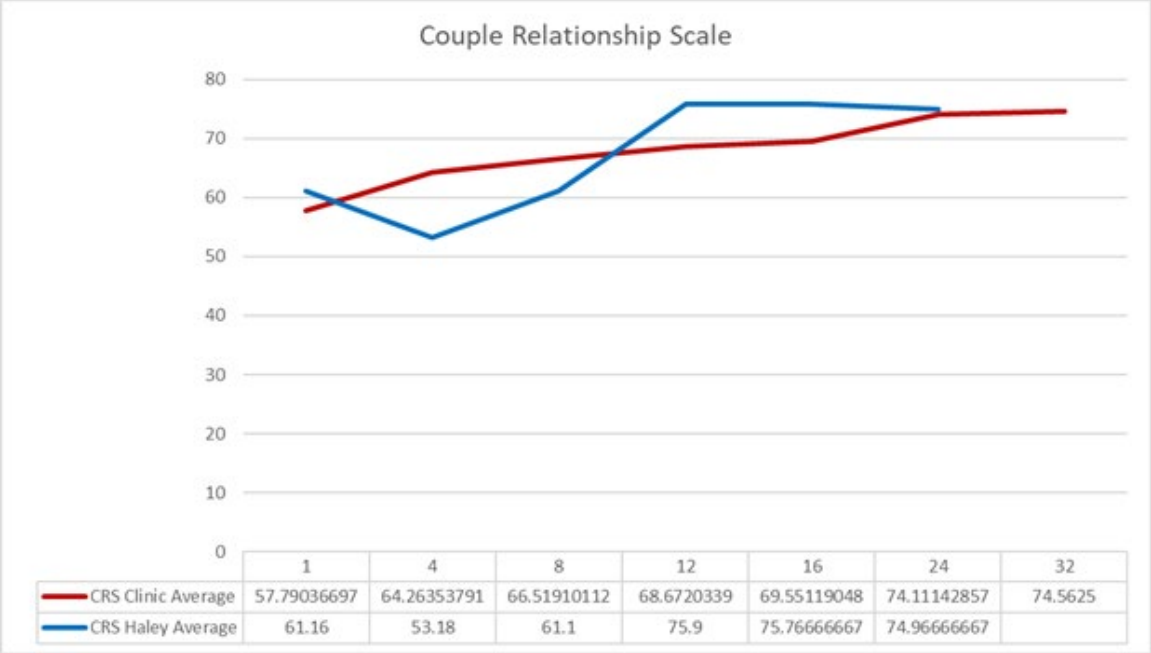


	1	4	8	12	16	24	32
CSI Clinic Average	46.15879828	46.93055556	46.8121547	48.79230769	47.08433735	47.62857143	48.61111111
CSI Haley Average	50.4	36.2	47	60	58.33333333	46.66666667	

This data represents global relationship satisfaction outcomes according to the CSI-16, which has theoretically consistent items to CBCT. The I-RAFT Clinic clients' average responses are indicated in red, while my clients' average responses are indicated in blue. At session 1, my clients' average responses were slightly higher than the overall clinic's clients' responses. When assessed for the second time at session 4, my clients' responses drop, while the clinic's clients' responses stay relatively the same with a slight increase. By the third assessment at session 8, my clients' satisfaction intersects with the overall clinic's satisfaction responses. When assessed a fourth time, session 12 data shows my clients' satisfaction surpassing the clinic's client's satisfaction at that time. At session 16, both my clients' satisfaction and the clinic's clients' satisfaction appear to drop slightly at

very similar rates. Eight sessions later, session 24 shows my clients' satisfaction dropping to a similar point, yet slightly below the clinic's clients' satisfaction at that time.

Figure 3.5 Couple Relationship Scale Outcomes



	1	4	8	12	16	24	32
CRS Clinic Average	57.79036697	64.26353791	66.51910112	68.6720339	69.55119048	74.11142857	74.5625
CRS Haley Average	61.16	53.18	61.1	75.9	75.76666667	74.96666667	

This data represents global relationship outcomes according to the CRS, which has theoretically consistent items to CBCT. The I-RAFT Clinic clients' average responses are indicated in red, while my clients' average responses are indicated in blue. At session 1, my clients' average is slightly higher than the overall clinic's clients' average. By the next assessment at session 4, my clients' relationship responses drop while the clinic's clients' relationship responses increase. The following assessment at session 8 shows my clients' relationship responses increasing closer towards the clinic's clients' responses at that same time in therapy. At session 12, my client's relationship responses surpass the clinic's clients' responses. From session 12 to 24, the clinic's clients' relationship responses continue to increase over time. At this same point in therapy, my clients' relationship

responses continue to remain fairly consistent, ending at session 24 around the same point that the clinic's clients' responses show.

CHAPTER 4. DISCUSSION

The results above provide potential insight into what outcomes appear using CBCT and ROM in therapy. First, the trajectories for different client types (e.g., individual, couple, and family) gave excellent feedback for areas of growth and critical times in therapy. The presenting problem progress couple trajectory showed my clients being relatively "on track" in comparison to the overall MFT-PRN data, which includes not only therapists in training, but licensed therapists as well. I witnessed a drop in progress from sessions 4 to 5, indicating that these couples might need more direct CBCT intervention around a month into therapy. The following sessions of the trajectory matched fairly consistently to the overall MFT-PRN average. This is helpful information as I was able to see that my clients are progressing as I'm utilizing CBCT interventions, such as cognitive restructuring and behavioral activation, further along in therapy.

The presenting problem progress family trajectory was a great surprise to discover, as my clients' progress increased earlier into therapy than anticipated. It is important to note that I had the least amount of data for family clients, yet their progress is still noteworthy and helpful for growth. I have thoroughly enjoyed working with families and found family work to mesh well with core concepts of CBT.

The individual trajectory gave potential insight into growth areas for me as a therapist, especially towards the beginning of therapy. Many individuals do not come to therapy at the first sight of struggle, but after much time of attempting to feel better on their own (Midgley et al., 2014). My individual client trajectory appears to show signs of struggle to see progress over the first month of therapy. After some time, however, the individual clients that continued with therapy appeared to progress at a similar increasing

rate to the overall MFT-PRN average individual progress. Interestingly, after a deeper dive into the data set, it was discovered that clients from sessions 1-12 were not the same clients for sessions 21-30. This allows us to view data as instructive, rather than conclusive, and might explain the difference of the presenting problem progress from early sessions to later sessions for these clients.

The CBCT outcome scales offered insight into how CBCT was impacting my clients in relationships over the course of treatment. Other CBCT outcome studies have utilized measures such as the Dyadic Adjustment Scale (DAS), the Marital Social Skills Inventory (Inventário de Habilidades Sociais Conjugais [IHSC]), Walker and Thompson's Intimacy Scale, and more (Durães et al., 2020; Maleki et al., 20217). Consistent with other outcome studies using CBCT, I looked at global relationship satisfaction. The results indicated that my clients in a relationship felt more satisfied over time with the CBCT model than when they first began therapy. This statement excludes session 24 of the CSI-16 data, which indicated couples felt less satisfied than they were at the beginning of therapy. However, this does differ from another CBCT outcome study that ended therapy at all clients by session 12, indicating an area of growth for myself as a CBCT therapist to complete therapy sooner and highlighting how other CBCT therapists practice more concisely (Durães et al., 2020).

4.1 Clinical Implications

For clinicians interested in this research, I highly recommend utilizing ROM to assess client progress. Whether it is relationship satisfaction, anxiety, depression, or another presenting problem, ROM is a useful tool to gauge how clients view their therapeutic experience and progress. This data is beneficial for understanding the client's

perspective, strengthening the therapeutic alliance, and tweaking the course of treatment to ensure positive change (Barkham et al., 2023; Sales et al., 2019; Pinsof et al., 2015).

Clinicians who are hesitant to incorporate CBCT into their work can also use this data to feel confident that positive change is possible using this model, even for a beginning therapist or therapist in training/under supervision. Challenging unhelpful cognitions, pinpointing attribution errors, and utilizing behavioral activation interventions have appeared to produce positive results for change in couples, families, and individuals according to my client's trajectories.

Future work could build on this by looking at other systemic therapy models such as emotion-focused therapy, acceptance and commitment therapy, or narrative therapy. This work could also be built upon by therapists who are fully licensed, as I am still a therapist in training. Even still, there is evidence to support that graduate student therapists are just as effective as seasoned/licensed therapists (Walsh et al., 2019). Aforementioned limitations to ROM for MFTs were also present in this study, as the sample sizes for this study are relatively small, therefore making this study more sensitive to change than if there were more client data. It is also important to note that while there is data for clients in therapy long-term, there are limited participants as sessions go on. That said, clinicians wanting to track client progress would have to ensure clients complete assessments for each session they attend to avoid misleading conclusions. This further alludes that the charts are instructive, yet not definitive, conclusions based on trajectories. However, this study combats previous limitations for MFTs since the I-RAFT Clinic is open to more than just university students. This clinic data represents more than students on a college campus, as anyone from the community is welcome to

receive services at the I-RAFT Clinic. Having data for such long-term clients is particularly instructive of the potential therapeutic alliance. Clients with long-term data could indicate that they enjoy CBT and the experience with their therapist. This data is also instructive for clinicians hesitant to begin ROM. The use of ROM was not only beneficial by informing me as the therapist of client progress, but it also allowed for such client trajectories to be made and analyzed for the purpose of this study. However, it is important to understand that progress trajectories are most beneficial when every client is completing every assessment at every session, as even one client who's struggling or missing data can derail results. Future clinicians wanting to build upon this work would need to account for this small data sensitivity by either collecting data from more clients, or ensuring that each client is consistently completing assessments.

CHAPTER 5. CONCLUSION

This thesis provided a review of the literature and current data supporting how ROM can benefit therapists and clients by offering insight into their clinical work from the perspective of the clients. This was done so through the lens of a graduate student attempting CBT techniques in systemic therapy (i.e., CBCT), which has been shown to be more effective than individual therapy in many cases (Carr, 2018; Epstein & Zheng, 2017). From the assessment responses of client's utilizing ROM on MFT-PRN, it was found that CBCT techniques such as cognitive restructuring and behavioral activation in couple therapy led to certain progress and relationship satisfaction over time. Progress was also witnessed over time in family therapy and individual therapy utilizing similar techniques. ROM is encouraged to therapists who seek to build a stronger alliance with their clients, who hope to reassure their clients of progress in therapy, and who wish to understand a client perspective to ensure treatment is catered to where the client actually is, not where the therapist believes they are (Sales et al., 2019; Lambert et al., 2018; Boswell et al., 2015).

APPENDICES

Appendix 1. Strengths-Based Worksheet

Circle your strengths from the choices below, or add your own add the bottom.

Wisdom	Artistic Ability	Curiosity	Leadership
Empathy	Honesty	Open Mindedness	Persistence
Enthusiasm	Love	Kindness	Social Awareness
Fairness	Bravery	Cooperation	Forgiveness
Modesty	Common Sense	Self-Control	Patience
Gratitude	Love of Learning	Humor	Spirituality
Ambition	Creativity	Confidence	Intelligence
Athleticism	Discipline	Assertiveness	Logic
Optimism	Independence	Flexibility	Adventurousness

Appendix 2. Couple Relationship Scale

Please tell us how you have been feeling about your relationship with your partner over the last WEEK:

I FEEL…

1. Distant 1……..100 Close
2. Like giving up 1……..……..100 Completely committed
3. Suspicious 1……...……100 Trusting
4. Not at all safe 1…...……100 Perfectly safe
5. All alone 1……100 Like part of a team
6. Criticized 1…….100 Accepted
7. Like we are always fighting 1……..……100 Like we get along perfectly
8. None of my needs for physical intimacy are met 1……...……..100 All of my needs for physical intimacy are met
9. Extremely unhappy 1……..…..100 Perfectly happy

Overall (not just in my relationship) I feel…

10. The worst I have ever felt 1……...……..100 The best I have ever felt

Appendix 3. Couple Satisfaction Index

1. Please rate the degree of happiness, all things considered, of your relationship.

Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

2. In general, how often do you think that things between you and your partner are going well?

All the time	Most of the time	More often than not	Occasionally	Rarely	Never

3. Our relationship is strong.

Not at all true	A little true	Somewhat true	Mostly true	Almost completely true	Completely true

4. My relationship with my partner makes me happy.

Not at all true	A little true	Somewhat true	Mostly true	Almost completely true	Completely true

5. I have a warm and comfortable relationship with my partner.

Not at all true	A little true	Somewhat true	Mostly true	Almost completely true	Completely true

6. I really feel like part of a team with my partner.

Not at all true	A little true	Somewhat true	Mostly true	Almost completely true	Completely true

7. How rewarding is your relationship with your partner?

Not at all	A little	Somewhat	Mostly	Almost completely	Completely

8. How well does your partner meet your needs?

Not at all	A little	Somewhat	Mostly	Almost completely	Completely

9. To what extent does your relationship meet your original expectations?

Not at all	A little	Somewhat	Mostly	Almost completely	Completely

10. In general, how satisfied are you with your relationship?

Not at all	A little	Somewhat	Mostly	Almost completely	Completely

For each of the following items, select the answer that best describes *how you feel about your relationship.* Base your responses on your first impressions and immediate feelings about the item.

11. Interesting…….5……....4…..…..3…..…..2……....1…..….0…….Boring

12. Bad…….5…….4…….3…….2…….1…….0…….Good

13. Full…….5…….4……3……2…….1…….0…….Empty

14. Sturdy……5…….4…….3…….2…….1……0…….Fragile

15. Discouraging…….5…….4……..3…….2…….1…….0…….Hopeful

16. Enjoyable…….5…….4…….3…….2…….1……0…….Miserable

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